CENTER FOR RACIAL & DISABILITY JUSTICE

REPRODUCTIVE JUSTICE COLLECTIVE | POLICY BRIEF NO. 2

MATERNAL MEDICAID MATTERS:
EXPANDING COVERAGE AND ACCESS FOR BLACK DISABLED MOTHERS

Megan Martin | Reproductive Justice Collective Member

Center for Racial and Disability Justice
Northwestern University Pritzker School of Law

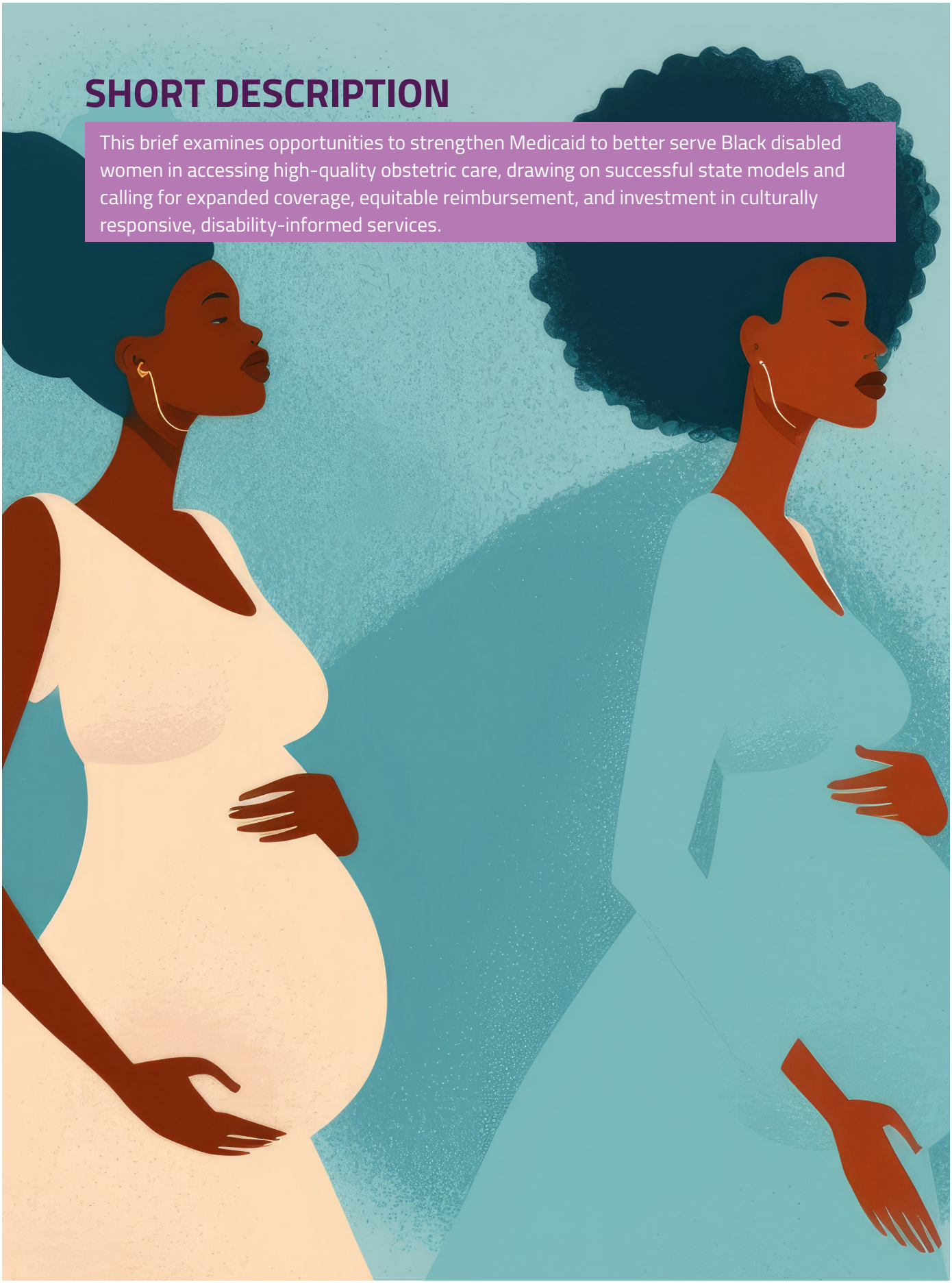
CRDJustice.org

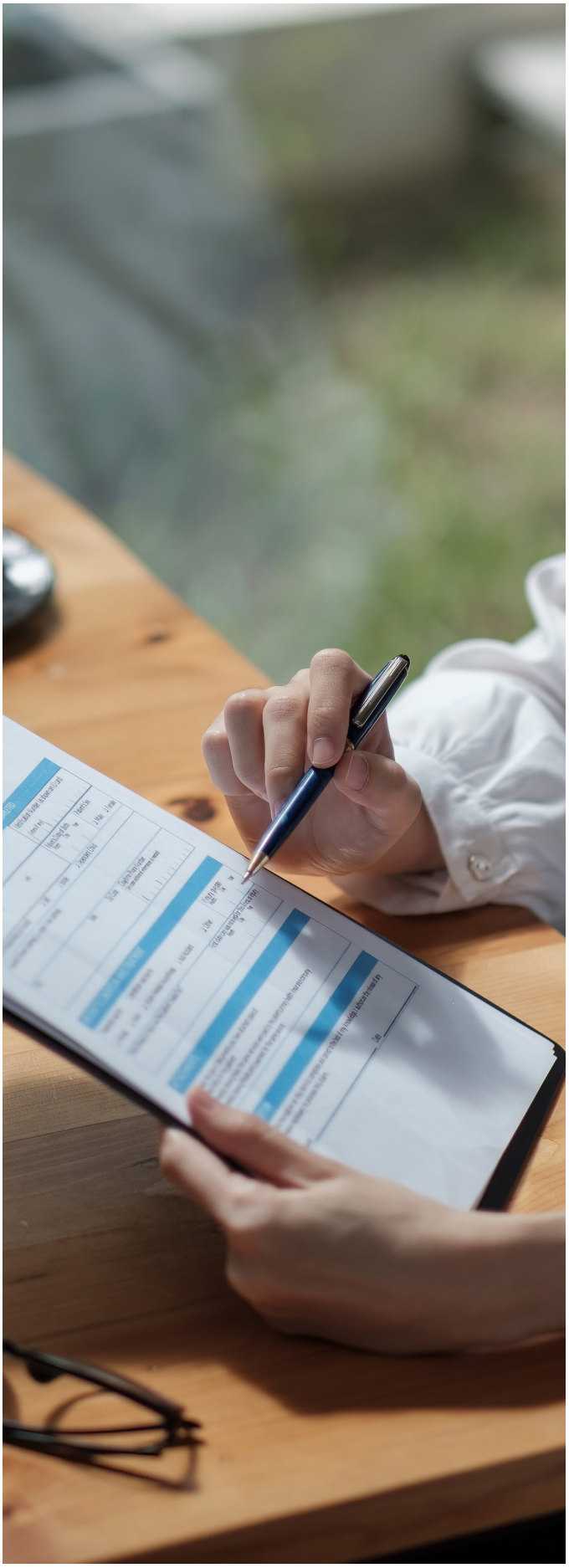
CONTENTS

Cover: A pregnant woman in a turquoise leisurewear outfit is sitting in front of her partner and a doula. The doula is wearing a white shirt and blue pants and is flacing her hands over the pregnant woman's stomach while the partner looks on.

SHORT DESCRIPTION

This brief examines opportunities to strengthen Medicaid to better serve Black disabled women in accessing high-quality obstetric care, drawing on successful state models and calling for expanded coverage, equitable reimbursement, and investment in culturally responsive, disability-informed services.





EXECUTIVE SUMMARY

Medicaid is a powerful program for advancing maternal health equity. It covers nearly half of all U.S. births, insures a majority of Black and disabled birthing people, and provides critical benefits that private insurance often excludes—including home-based care, transportation, and postpartum services.

For Black disabled women, who face some of the highest maternal mortality and morbidity rates in the country, Medicaid offers essential access to care. But in many states, Medicaid's full potential remains unrealized due to policy gaps, low reimbursement rates, and underinvestment in inclusive, community-based care.

Medicaid already works, but it must work better for everyone . This brief calls for policy to strengthen Medicaid to meet the needs of those it serves best:

1. **Expand Medicaid to ensure comprehensive coverage before, during, and after pregnancy.**
2. **Change Medicaid reimbursement structures and rates to support high quality and accessible obstetric care.**
3. **Invest in Medicaid-funded doula care as a community-based, race and disability-informed obstetric care model.**
4. **Build data systems that make disabled people of color visible in Medicaid programs and policy decisions.**

Rooted in the principles of reproductive and disability justice, these recommendations affirm that all birthing people—especially Black disabled women—deserve access, autonomy, and care that is culturally responsive, community-driven, and free from systemic harm [1].

UNDERSTANDING THE PROBLEM

MATERNAL MORTALITY DISPARITIES

Black women in the U.S. face maternal mortality rates nearly 3 times the rate of white women [2], and women with physical disabilities face maternal mortality rates nearly 11 times higher than those without disabilities [3]. For Black disabled women, these risks are compounded. One national study found Black women with disabilities were over six times more likely to experience severe maternal morbidity than white nondisabled women [4], while another found that the combined effect of being both Black and disabled results in significantly worse maternal outcomes than either factor alone [3]. These disparities are driven by structural racism and ableism, which show up through discriminatory medical practices, inaccessible care environments, and chronic underinvestment in the health of marginalized communities [5,6,7,8].

LINK BETWEEN POVERTY, DISABILITY, AND RACE

Largely due to ableist systems and structures, a disproportionate number of disabled people live in poverty. Poverty can increase the risk of disability, and ableist systems push and trap many disabled people into poverty [9,10,11]. As one Black disabled woman explained, "We fear being one medical accident away from being in poverty again." [11]. Poverty increases the risk and severity of disability by limiting access to safe housing, employment, and care [9], while disability can drive poverty through added healthcare costs and support needs [9,12,13]. Systemic racism compounds the poverty-disability cycle by limiting access to quality jobs and healthcare and exposing Black communities to harmful conditions, resulting in higher rates of poverty, disability, and poor health outcomes compared to white communities [8,9].

> *"We fear being one medical accident away from being in poverty again."*
>
> - Black disabled woman [11].

WHY MEDICAID MATTERS

Medicaid was established in 1965 to provide healthcare for low-income people, especially those excluded from private insurance, including many Black and disabled individuals [14,8]. Importantly, Medicaid is one of the most popular and cost-efficient health programs in the U.S [15,16]. The vast majority of Americans support it, including across party lines, and majorities even in non-expansion states want it

expanded [15]. Cutting Medicaid is deeply unpopular, with fewer than 1 in 5 voters favoring reductions, making such cuts both politically risky and harmful to public health [15]. Though Medicaid has become the nation's largest public insurance program and a key source of reproductive and disability care, it remains shaped by racialized, classist policies that limit access through restrictive eligibility rules, job loss penalties, and underfunding [14]. These barriers disproportionately affect Black, disabled, and low-income people.

Importantly, Medicaid remains one of the few healthcare programs that actively reduces disparities and improves healthcare access for structurally marginalized communities, including Black and disabled people. More than one in three working adults with disabilities rely on Medicaid. Studies show that disabled people on Medicaid are *less* likely to report unmet care needs **(Figure 1A)** or be unable to pay their medical bills **(Figure 1B)** than those with private insurance or Medicare alone – highlighting Medicaid's critical role in affordability and healthcare access. Medicaid also reduces care delays, improves access to preventive services, and helps narrow racial and geographic disparities in healthcare access [17,18].

Disabled people with Medicaid, alone or in combination with Medicare, have decreaseed unmet needs and inability to pay healthcare bills.

Figure 1A. Unmet Healthcare Needs

Unmet need for healthcare among disabled adults 19-64, by primary coverage, controlling for age & disability type

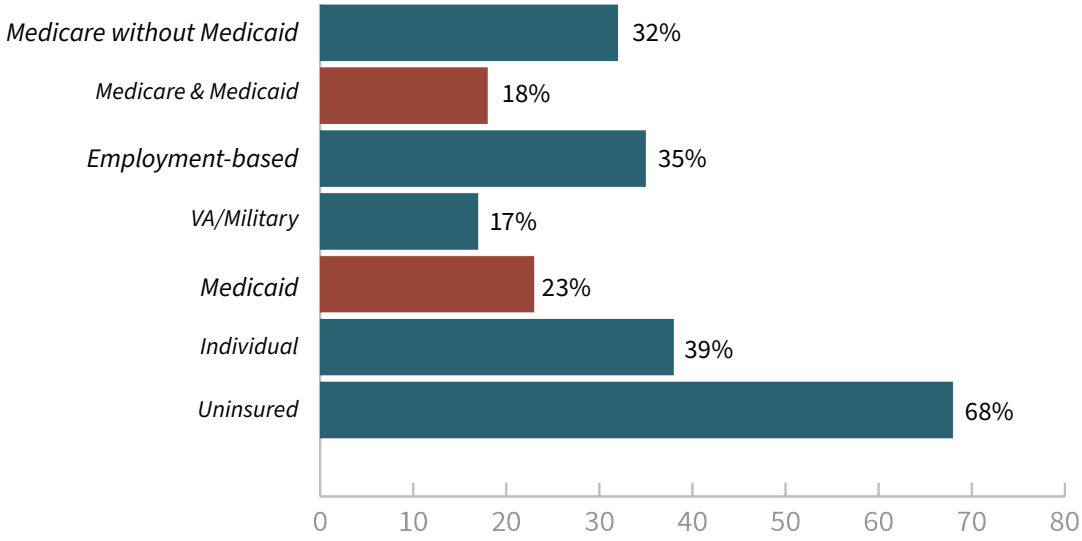


Figure 1B. Inability to Pay Healthcare Bill

Inability to pay healthcare bills, among disabled adults 19-64 living alone, by primary coverage, controlling for age & disability tpe

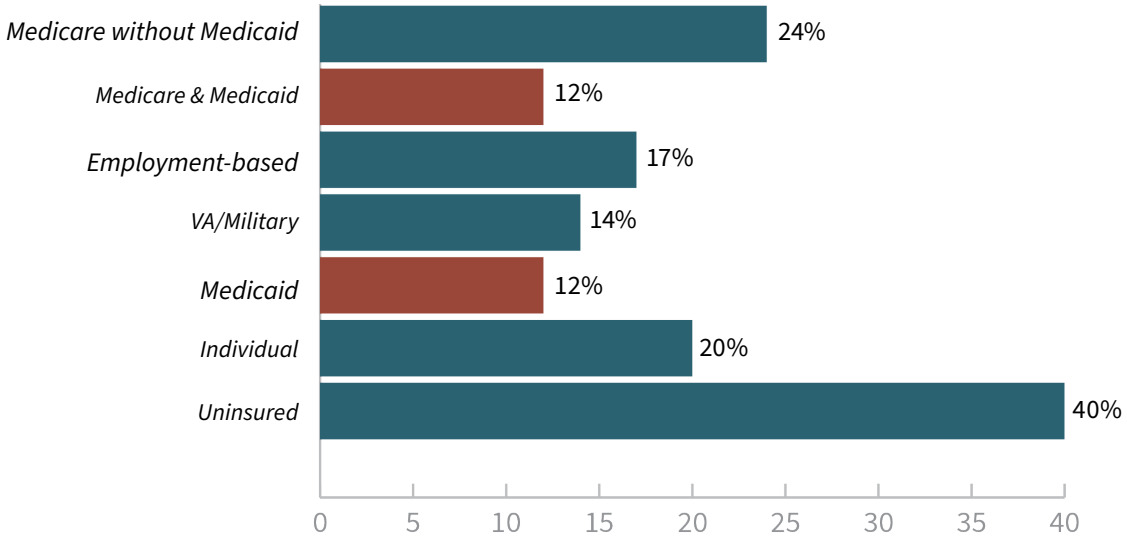


Figure 1A. *People with Medicaid, either alone or in combination with Medicare, report fewer unmet healthcare needs than those with other forms of insurance. Only 23% of Medicaid-only enrollees and 18% of dual Medicare-Medicaid beneficiaries report unmet needs, compared to 32% of those with Medicare alone, 35% with employer-based coverage, and 39% with individual private insurance. VA or military coverage performs similarly to dual coverage. Data from DREDF analysis of data from the National Health Interview Survey, (2019– 2023), as reported in Kaye 2025* [17].

Figure 1B. *Percentage of disabled working-age adults unable to pay healthcare bills, by type of insurance coverage. Forty percent of uninsured disabled adults report being unable to pay their healthcare bills, compared to just 12% of those on Medicaid (with or without Medicare). Rates are higher for other coverage types: 24% for Medicare without Medicaid, 20% for individual private coverage, and 17% for employment-based coverage. Source: DREDF analysis of National Health Interview Survey (2019–2023), as reported in Kaye 2025* [17].

Medicaid is often the only reliable, comprehensive, and affordable source of maternal healthcare for low-income, Black, and disabled women. For pregnant women, Medicaid provides full coverage of prenatal, childbirth, and postpartum care with no out-of-pocket costs [19]. In 2018, Medicaid covered 42% of all births in the U.S., and 65% of births to Black women [20]. In 2021, 82% of Medicaid-covered births had a timely prenatal visit and 75% had a postpartum visit [21]. For disabled pregnant women, Medicaid coverage can include critical services like transportation, home-based care, and long-term supports that private insurance often excludes [19].

Medicaid expansion has allowed more low-income people to qualify for coverage before, during, and after pregnancy [26,27]. Research overwhelmingly shows that this expansion strengthened healthcare infrastructure [28], improved maternal health outcomes and decreased maternal mortality [26,29], improved postpartum health [30,31], and reduced racial disparities in preterm birth and low birth weight [29]. For example, expansion is associated with a 17% reduction in postpartum hospitalizations during the first 60 days after birth [30].

> *Overall, Medicaid plays a critical role in advancing maternal health equity, particularly for Black and disabled women. Medicaid protection and expansion is essential to closing persistent gaps in access to prenatal and postpartum care, disparities in maternal morbidity and mortality, and lack of culturally competent, disability-informed support.*

Black women in expansion states are more likely to receive timely prenatal and postpartum care and less likely to be uninsured compared to those in non-expansion states [19]. Hospital financial performance also improved under expansion, particularly among facilities serving high volumes of low-income patients, which in turn stabilized access to care in underserved areas [28].

Overall, Medicaid plays a critical role in advancing maternal health equity, particularly for Black and disabled women. Medicaid protection and expansion is essential to closing persistent gaps in access to prenatal and postpartum care, disparities in maternal morbidity and mortality, and lack of culturally competent, disability-informed support.

POLICY GAPS

This section outlines five critical policy challenges: threats to funding, inadequate provider reimbursement, coverage gaps from non-expansion, inadequate implementation of Medicaid-funded doula programs, and gaps in intersectional data infrastructure.

1. BUDGET CUTS THREATEN ESSENTIAL MEDICAID FUNDING

In 2025, House Republicans proposed a budget to reduce the federal deficit by at least $880 billion over ten years that will require massive cuts to Medicaid funding in order to pay for tax cuts for billionaires [22].

These cuts to the Medicaid budget would have devastating consequences. Slashing Medicaid would trigger rural hospital closures, increase uncompensated care costs, and strip millions of people—especially Black, disabled, and low-income communities—of the healthcare they need [14]. These are not simply budget decisions—they are deliberate policy choices that will deepen poverty, worsen health outcomes, and increase preventable deaths for disabled, poor, and Black communities [14].

2. LOW REIMBURSEMENT RATES FOR MEDICAID UNDERMINES QUALITY OF CARE

Medicaid's reimbursement system pays providers lower rates than private insurance, and the fee-for-service model incentivizes high-volume, short visits over appointments that support quality, patient-centered care [23]. In maternal health, this means that evidence-based services to decrease maternal mortality, like group prenatal care and extended postpartum support, are often underfunded or not reimbursed at all [23]. For disabled patients, rushed appointments severely limit providers' ability to communicate clearly, address access needs, and offer individualized care essential for safe pregnancies and births [24].

Because of low reimbursement rates, many providers opt out of Medicaid altogether. Clinics that do accept Medicaid may face budget constraints, limited staffing, or fewer service offerings—conditions that reduce care quality and availability. These structural barriers are especially pronounced in areas with high concentrations of Medicaid patients, contributing to maternal care deserts that disproportionately affect

disabled, Black, and rural communities [25] — some are referring to this as maternal care apartheid. [32]

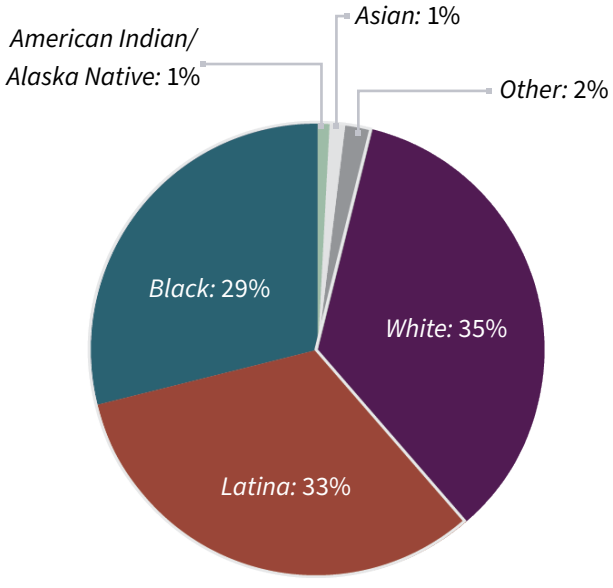
3. GAPS IN MEDICAID COVERAGE PRE- AND POST-PARTUM

While Medicaid plays a vital role in maternal health, major gaps remain, particularly in states that have not expanded coverage. In 2019, 810,000 low-income women of reproductive age were uninsured and fell into the Medicaid coverage gap before pregnancy, with 29% identifying as Black and 33% as Latina. This disproportionate impact on women of color underscores how Medicaid non-expansion limits access to essential preconception care and deepens existing health inequities **(Figure 2)**.

In non-expansion states, Medicaid coverage for pregnancy typically ends 60 days postpartum. This cutoff is too early and risky: over half of all maternal deaths occur after birth, with 12% classified as "late" deaths happening six weeks to one year postpartum [18]. Continuous access to care during the postpartum period is essential for both parent and infant well-being, as most of these deaths are preventable. The American Rescue Plan Act of 2021 gave states the option to extend Medicaid postpartum coverage to 12 months, and the Consolidated Appropriations Act of 2023 made this option permanent [19]. As of January 2025, 49 states have passed legislation to extend postpartum coverage to 12 months, but only 40 states have actually adopted this expansion [33]. In the 10 states that have not adopted Medicaid expansion, many low-income women remain uninsured during a critical window of health vulnerability [19,33].

Racial and Ethnic Breakdown of Reproductive-Age Women in the Medicaid Coverage Gap [27]

Figure 2: Two-Thirds of Reproductive-Age Women in Coverage Gap Are People of Color



Adapted from Center on Budget and Policy Priorities | CBPP.org

In 2019, two-thirds of uninsured women of reproductive age (19–49) in the Medicaid coverage gap were people of color. Specifically, 33% were Latina, 29% were Black, and 1% each were American Indian/Alaska Native and Asian. This disparity reflects the disproportionate impact of Medicaid non-expansion on communities of color. Source: Solomon (2021) [27], Center on Budget and Policy Priorities analysis of 2019 American Community Survey data.

Note: Reproductive age = 19-49. Totals may not sum due to rounding. Excludes estiated population lacking legal documentation. Latina category may include any race; all other categories non-Latina. Other includes those who identify as multiple races.

Source: CBPP estimates based on the 2019 American Community Survey

4. MEDICAID MUST COVER DOULA CARE

Doula care—nonclinical, culturally responsive support throughout pregnancy, birth, and postpartum—is a proven strategy for improving maternal health outcomes [34]. Research shows that doula care is associated with reduced rates of cesarean deliveries, NICU admissions, and postpartum depression, as well as increased breastfeeding rates and satisfaction with care [34]. For Black and disabled birthing people, doulas can provide culturally competent and accessible care, serve as advocates and a buffer against provider bias and medical neglect, and offer emotional support and assistance navigating the healthcare system [35,36].

Despite the well-documented benefits of doula care, access to doulas remains limited, with cost identified as the most significant barrier [34]. Currently, 20 states have Medicaid-funded doula programs, which increase access to doulas for low-income people. But, there have been persistent issues with the implementation of Medicaid-funded doula programs, which in turn has made this program vastly underutilized and inaccessible to doulas and patients both [37]. For doulas, challenges accessing and navigating state certification requirements, low reimbursement rates, and burdensome billing processes lead to workforce shortages and limited participation in Medicaid [37,38]. There is also a gap in disability competency training for doulas, an omission that limits doulas' ability to provide inclusive, responsive care [35,39]. For patients, these barriers translate to limited availability of doulas, and care that is not disability informed.

Community-based doula models offer a more promising approach. These programs are led by individuals from the communities they serve, and integrate culturally relevant practices and broader support services like housing referrals and parenting education [34,35]. However, state Medicaid certification and reimbursement requirements often fail to recognize this model's value, imposing restrictions that exclude many Black and disabled community-based doulas from participating [40].

5. INADEQUATE INTERSECTIONAL DATA

There is an alarming lack of intersectional data examining how maternal Medicaid policies affect Black disabled women. Failing to build and use inclusive, intersectional data systems allows ableism and racism to go unnamed and unchallenged in research, programs, and policy-making that affects Black disabled women [41]. The absence of intersectional data, beyond simply disaggregation, has real consequences: for instance, Medicaid-funded doula programs are supported as a strategy to reduce racial disparities in maternal outcomes, yet we have little to no data on whether Black disabled women are even able to access this doula care, or how effective that care is when they do. This lack of intersectional data shows the systemic exclusion of Black disabled women from the design, implementation, and evaluation of Medicaid programs [41]. Without data on their experiences and outcomes, we can't fully understand how these programs are failing them—or hold systems accountable for that failure. Policymakers must recognize this as a structural failure and invest in inclusive, equity-driven data systems and research.

POLICY RECOMMENDATIONS

Medicaid has the potential to narrow the maternal mortality gaps for Black disabled women. But to do so, it must be fully funded, equitably implemented, and designed with the needs of disabled, low-income, and Black communities at the center.

1. EXPAND MEDICAID COVERAGE

Adopt Medicaid Expansion Nationwide: States that have expanded Medicaid under the ACA demonstrate improved maternal health outcomes and better continuity of care before, during, and after pregnancy [19,26]. To achieve similar outcomes, all states should adopt Medicaid expansion and take up the now-permanent federal option to extend pregnancy-related Medicaid coverage to 12 months postpartum.

Raise Income Eligibility Levels for Parents: In the absence of full expansion, non-expansion states can reduce coverage gaps by increasing parental income eligibility under existing Medicaid categories [19].

Adopt Value-based Reimbursement Models: States should adopt value-based payment models that tie Medicaid reimbursement to quality, access, and patient outcomes, rather than volume of services. Strategies include implementing performance-based incentives, managed care reforms, and enhanced payments for care coordination, particularly for maternal and disability care providers serving high-need populations [42].

2. STRENGTHEN AND STANDARDIZE MEDICAID REIMBURSEMENT FOR DOULA CARE

Mandate Equitable Reimbursement Rates: States must establish reimbursement rates that reflect the time, scope, and value of doula care. States like Oregon and Minnesota initially set unsustainably low reimbursement rates, leading to minimal Medicaid doula participation. Thoughtful program design from the outset avoids costly legislative fixes later [40]. A minimum sustainable rate—such as $1000 for birth attendance, $100 per prenatal/postpartum visit, and $250 for abortion/miscarriage support—has been proposed to support workforce stability and birth justice [38].

Support Billing Infrastructure: Create and fund doula hubs or community-based agencies to manage Medicaid billing and remove administrative barriers for independent doulas [43].

3. ENSURE INCLUSIVE, COMMUNITY-BASED DOULA CARE IMPLEMENTATION

Fund and Partner with Black-Led Doula Organizations: States should defer to Black-led, community-based doula groups during all phases of policy development, implementation, and evaluation. These groups are best positioned to address the social, cultural, and structural barriers faced by Medicaid enrollees [40, 44].

Compensate Doulas for Policy and Implementation Work: Doulas must be paid for their participation in Medicaid design and rollout. Sustainable partnerships require financial support for community doulas doing this critical work [40].

Establish Doula Coalitions: Support the creation of statewide doula cooperatives and coalitions to help navigate bureaucratic processes, share resources, and foster peer support—as demonstrated by the Rhode Island Birthworker Co-op [40].

4. EXPAND DOULA TRAINING AND CERTIFICATION PATHWAYS

Fund Doula Training: Increase investments in doula education, especially for individuals from low-income, rural, disabled, and Black communities [34].

Incoprorate Disability-Inclusive Training: Most current programs do not prepare doulas to serve clients with intellectual, developmental, or physical disabilities [35,39]. States must ensure all Medicaid-approved training includes content on disability justice and inclusive reproductive care.

Remove Restrictive Certification Barriers: Many states require doulas to navigate complex and exclusionary certification processes. Medicaid programs should recognize diverse training models—especially those developed by community-based and disability-informed organizations.

5. ENHANCE INTERSECTIONAL DATA INFRASTRUCTURE

Intersectional Data: Require all state Medicaid programs to collect, analyze, and report intersectional maternal health.

Intersectional Reearch: Fund intersectional research on maternal health outcomes for disabled people of color—including community-led studies on Medicaid access, doula care, and postpartum supports.

CONCLUSIONS

Medicaid already plays a powerful role in advancing maternal health equity—especially for Black and disabled women, who are among those most failed by our current healthcare systems. But to fully realize its potential, Medicaid must be strengthened, expanded, and redesigned through an intersectional lens. We don't need to reinvent solutions—we need to implement what works, fund it equitably, and center the voices of those most impacted. Black disabled women deserve safe, affirming, and accessible maternal care. Medicaid can and must be the vehicle that delivers it.

SUGGESTED CITATION

Martin, M. (2025, April) *Maternal Medicaid Matters: Expanding Coverage and Access for Black Disabled Mothers.* Center for Racial and Disability Justice Reproductive Justice Collective (Policy Brief No. 2).

REFERENCES

1. **Caldwell, K.** (2025, April). *Reproductive Justice Policy & Disability.* Center for Racial and Disability Justice Reproductive Justice Collective (Policy Brief No. 1). https://www.crdjustice.org/repro
2. **Helm, K. V. T., Panko, T. L., Herschel, M., Smith, L. D., Mitra, M., & McKee, M. M.** (2023). Maternal Health Experiences of Black Deaf and Hard of Hearing Women in the United States. *Women's Health Issues, 33*(6), 610–617. https://doi.org/10.1016/j.whi.2023.07.005
3. **Akobirshoev, I., Jerome, S., Snowden, J. M., Slaughter-Acey, J., Valentine, A., Horner-Johnson, W., & Mitra, M.** (2024). Intersectional inequities in maternal mortality: Examining the compounded risks for black birthing individuals with physical disabilities. *Disability and Health Journal*, 101765. https://doi.org/10.1016/j.dhjo.2024.101765
4. **Horner-Johnson, W., Garg, B., Snowden, J. M., Caughey, A. B., Slaughter-Acey, J., Akobirshoev, I., & Mitra, M.** (2024). Severe Maternal Morbidity and Other Perinatal Complications Among Black, Hispanic, and White Birthing Persons With and Without Physical Disabilities. *Journal of Women's Health*, jwh.2024.0694. https://doi.org/10.1089/jwh.2024.0694
5. **Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T.** (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, 389(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X
6. **Mitra, M., Long-Bellil, L. M., Smeltzer, S. C., & Iezzoni, L. I.** (2015). A Perinatal Health Framework for Women with Physical Disabilities. *Disability and Health Journal*, *8*(4), 499–506. https://doi.org/10.1016/j.dhjo.2015.05.007
7. **Frederick, A., & Shifrer, D.** (2019). Race and Disability: From Analogy to Intersectionality. *Sociology of Race and Ethnicity, 5*(2), 200–214. https://doi.org/10.1177/2332649218783480
8. **Yearby, R.** (2018). Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism. *The American Journal of Economics and Sociology, 77*(3–4), 1113–1152. https://doi.org/10.1111/ajes.12230
9. **Goodman, N., Morris, M., & Boston, K.** (2017). *FINANCIAL INEQUALITY: Disability, Race and Poverty in America.* NATIONAL DISABILITY INSTITUTE. https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf
10. **Blick, R., Franklin, M., Ellsworth, D., Havercamp, S., & Kornblau, B.** (2015). The Double Burden: Health Disparities among People of Color Living with Disabilities. *Ohio Disability and Health Program*, 1–9. https://nisonger.osu.edu/sites/default/files/u4/the_double_burden_health_disparities_among_people_of_color_living_with_disabilities.pdf
11. **Buckles, M.** (2022, February 15). How To Make Policies Work for Black Women With Disabilities. *American Progress.* https://www.americanprogress.org/article/how-to-make-policies-work-for-black-women-with-disabilities/
12. **Gleason, J. L., Grewal, J., Chen, Z., Cernich, A. N., & Grantz, K. L.** (2021). Risk of Adverse Maternal Outcomes in Pregnant Women With Disabilities. *JAMA Network Open, 4*(12), e2138414. https://doi.org/10.1001/jamanetworkopen.2021.38414

13. **Folorunsho, S., Ajayi, V., Okyere, M., & Abdulganiyu, A.** (2024). *Health Disparities at the Intersection of Racialized Minority Groups and Disability Status.* https://doi.org/10.20944/preprints202401.1196.v1

14. Center for Racial and Disability Justice. (2025, March 19). Austerity is Violence: The Human Cost of Slashing Social Safety Nets. *Medium*. https://nlawcrdj.medium.com/austerity-is-violence-the-human-cost-of-slashing-social-safety-nets-f723839861b3

15. 7 Charts About Public Opinion on Medicaid. (2025, March 7). **KFF**. https://www.kff.org/medicaid/poll-finding/7-charts-about-public-opinion-on-medicaid/

16. **Machledt, D.** (2025, February 25). Medicaid is Even Leaner as Accountability Improves. *National Health Law Program.* https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/

17. **Kaye, S.** (2025). *Preserving Medicaid & the Affordable Care Act for Adults with Disabilities* (pp. 1–37). Disability Rights Education and Defense Fund. https://dredf.org/wp-content/uploads/2025/02/Kaye-Preserving-Medicaid-the-ACA.pdf

18. **FACT SHEET: Medicaid Works For Women & Children.** (2024, April 15). *Protect Our Care*. https://www.protectourcare.org/fact-sheet-medicaid-works-for-women-children-2/

19. **Gomez, I., Ranji, U., Salganicoff, A., & Published, B. F.** (2022, February 17). Medicaid Coverage for Women. *KFF*. https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/

20. **U.S. COMMISSION ON CIVIL RIGHTS.** (2021). *Racial Disparities in Maternal Health.* https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf

21. **Center for Medicaid and CHIP Services.** (2024). *2024 Medicaid and CHIP Beneficiaries at a Glance: Maternal Health.* Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf

22. **Williams, E., Burns, A., & Published, R. R.** (2025, March 24). Putting $880 Billion in Potential Federal Medicaid Cuts in Context of State Budgets and Coverage. *KFF*. https://www.kff.org/medicaid/issue-brief/putting-880-billion-in-potential-federal-medicaid-cuts-in-context-of-state-budgets-and-coverage/

23. **Bernstein, A., Flynn, A., & Smith-Ramakrishnan, V.** (2024, September 10). *Medicaid Has a Critical Role in More Equitable Maternal Health Care.* The Century Foundation. https://tcf.org/content/report/medicaid-has-a-critical-role-in-more-equitable-maternal-health-care/

24. **Iezzoni, L. I., Rao, S. R., Ressalam, J., Bolcic-Jankovic, D., Agaronnik, N. D., Donelan, K., Lagu, T., & Campbell, E. G.** (2021). Physicians' Perceptions Of People With Disability And Their Health Care: Study reports the results of a survey of physicians' perceptions of people with disability. *Health Affairs, 40*(2), 297–306. https://doi.org/10.1377/hlthaff.2020.01452

25. **Bailey, K.** (2025, April). *Reproductive Justice in Maternal Deserts: Confronting Racism and Ableism in Obstetric Care.* Center for Racial and Disability Justice Reproductive Justice Collective (Policy Brief No. 3). https://www.crdjustice.org/repro

26. **Chatterji, P., Glenn, H., Markowitz, S., & Montez, J. K.** (2023). Affordable Care Act Medicaid expansions and maternal morbidity. *Health Economics, 32*(10), 2334–2352. https://doi.org/10.1002/hec.4724

27. **Soloman, J.** (2021). *Closing the Coverage Gap Would Improve Black Maternal Health.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health

28. **Johnston, E. M., Strahan, A. E., Joski, P., Dunlop, A. L., & Adams, E. K.** (2018). Impacts of the Affordable Care Act's Medicaid Expansion on Women of Reproductive Age: Differences by Parental Status and State Policies. *Women's Health Issues, 28*(2), 122–129. https://doi.org/10.1016/j.whi.2017.11.005

29. **Kumar, N. R., Borders, A., & Simon, M. A.** (2021). Postpartum Medicaid Extension to Address Racial Inequity in Maternal Mortality. *American Journal of Public Health, 111*(2), 202–204. https://doi.org/10.2105/AJPH.2020.306060

30. **Steenland, M. W., & Wherry, L. R.** (2023). Medicaid Expansion Led To Reductions In Postpartum

Hospitalizations: Study examines the impact of Medicaid expansion on postpartum hospitalizations of low-income enrollees. *Health Affairs, 42*(1), 18–25. https://doi.org/10.1377/hlthaff.2022.00819

31. **Gordon, S. H., Hoagland, A., Admon, L. K., & Daw, J. R.** (2022). Extended Postpartum Medicaid Eligibility Is Associated With Improved Continuity Of Coverage In The Postpartum Year: Study examines stability of health insurance enrollment in Colorado for people who retain Medicaid coverage for the entire postpartum year. *Health Affairs, 41*(1), 69–78. https://doi.org/10.1377/hlthaff.2021.00730

32. What We Name, We Can Dismantle: Shifting from "Maternal Health Care Deserts" to "Maternal Health Care Apartheid." (2025, May 6). **Madeline T. Morcelle**. https://www.madelinemorcelle.com/blog/what-we-name-we-can-dismantle-from-pregnancy-care-deserts-to-pregnancy-care-apartheid

33. **Medicaid Postpartum Coverage Extension Tracker.** (2025, January 17). *KFF*. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

34. **Bey, A., Brill, A., Porchia-Albert, C., Gradilla, M., & Strauss, N.** (2019). *ADVANCING BIRTH JUSTICE: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (pp. 1–33). ANCIENT SONG DOULA SERVICES & VILLAGE BIRTH INTERNATIONAL & EVERY MOTHER COUNTS. https://blackmamasmatter.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf

35. **Robles-Fradet, A.** (2024). The Disability Community Deserves Inclusive and Accessible Doula Care. *National Health Law Program*. https://healthlaw.org/the-disability-community-deserves-inclusive-and-accessible-doula-care/

36. **McGarry, A., Stenfert Kroese, B., & Cox, R.** (2016). How Do Women with an Intellectual Disability Experience the Support of a Doula During Their Pregnancy, Childbirth and After the Birth of Their Child? *Journal of Applied Research in Intellectual Disabilities, 29*(1), 21–33. https://doi.org/10.1111/jar.12155

37. **Everson, C., Crane, C., & Nolan, R.** (2018). *Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment* (pp. 1–90). Estacada, OR: Oregon Doula Association. https://www.oregon.gov/oha/EI/Documents/Doula%20Workforce%20Needs%20Assesment%20Full%20Report%202018.pdf

38. **Chen, A., & Berquist, A.** (2022, May 20). Medi-Cal Coverage for Doula Care Requires Sustainable and Equitable Reimbursement to be Successful. *National Health Law Program*. https://nhelprestordev.wpenginepowered.com/medi-cal-coverage-for-doula-care-requires-sustainable-and-equitable-reimbursement-to-be-successful/

39. **Ransohoff, J. I., Sujin Kumar, P., Flynn, D., & Rubenstein, E.** (2022a). Reproductive and pregnancy health care for women with intellectual and developmental disabilities: A scoping review. *Journal of Applied Research in Intellectual Disabilities, 35*(3), 655–674. https://doi.org/10.1111/jar.12977

40. **Chen, A.** (2022, November 14). Current State of Doula Medicaid Implementation Efforts in November 2022. *National Health Law Center*. https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/

41. **Center for Racial and Disability Justice.** (2024). *RE: Notice of Availability and Request for Information; Federal Evidence Agenda on Disability Equity.* Northwestern Pritzker School of Law. https://www.crdjustice.org/_files/ugd/84abb6_a3f87c69f35f4b9c8bb78aac06481510.pdf?index=true

42. **National Conference of State Legislatures.** (2023). *10 State Strategies for Improving Medicaid. National Conference of State Legislatures*. https://www.ncsl.org/health/10-state-strategies-for-improving-medicaid

43. **Kaye, T. P., Neva.** (2020, July 13). Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid. *NASHP.* https://nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/

44. **Black Mamas Matter: Policy and Advocacy Department.** (2023). *Black Mamas Matter: In Policy and Practice. A policy agenda for the black maternal health, rights, and justice movement.* Black Mamas Matter. https://blackmamasmatter.org/wp-content/uploads/2023/04/0411_BMMA_PolicyAgenda_v5.pdf

CENTER FOR
RACIAL & DISABILITY
JUSTICE