Medicaid’s Moment for Protecting and Promoting Women’s Health

Medicaid is the safety net health insurance for the US, today covering more than 80 million individuals, including impoverished children, pregnant people, those with disability, and older adults. Medicaid is also the leading payer for pregnancies, covering more than 40% of them in the US and more than 60% of births in some states and serving as a crucial touchpoint for many individuals during critical periods in their lives. Because Medicaid eligibility is based on socioeconomic status, Medicaid recipients often enter the program in poorer health, are at higher risk for disease, and have greater health disparities.

Although perinatal mortality has been decreasing internationally, the US stands unique among resource-rich nations for increasing mortality rates, with individuals most affected mirroring disparity patterns of groups with disproportionately higher Medicaid enrollment. Medicaid can and does pay for some abortions. It is within this context that the recent US Supreme Court’s decision in Dobbs v. Jackson Women’s Health Organization (597 US 2022) raises concerns for all persons capable of carrying a pregnancy, but in particular for those whom Medicaid covers. State and territory Medicaid programs should take stock at this critical juncture of what they can do to safeguard perinatal health.

In the 1960s, Medicaid was designed as a jointly funded federal and state program attuned to state-specific priorities but also constrained within state budgets. Given the heterogeneity of needs and financial pressures among 50 states and 6 territories, the Centers for Medicare & Medicaid Services (CMS) sets minimum standards and guardrails on covered health services through its control of matching federal dollars known as federal medical assistance percentage (FMAP). State Medicaid agencies can pay for additional health-related services beyond those boundaries through waivers offered by CMS or via the use of state-only funding for some services not eligible for FMAP.

Regarding Medicaid’s payment for abortion services, the Hyde Amendment (1976) prevents the use of FMAP for abortion services except in cases of rape, incest, or life endangerment. Before Dobbs, all states had some form of Medicaid coverage for abortion even within such limitations. Sixteen states also offer coverage beyond that allowed by Hyde, using state-only dollars. Since the Dobbs decision, state Medicaid programs have begun to reevaluate their abortion coverage policies in the context of the new primacy of state authority.

As policy makers working in a variety of differential state responses to the Dobbs decision, we offer perspective on the pathways that advocates, policy makers, states, and Medicaid agencies can take in this shifting landscape and identify opportunities for state Medicaid agencies to protect and promote perinatal health.

In the 13 states that previously enacted laws enabling to take effect that restrict abortion after Dobbs and in follow-on state administrations pursuing the same, those respective state Medicaid agencies will have to comply with restrictions on abortion services, and data have shown that they should prepare for increases in adverse pregnancy outcomes. In such states, these changes in the policy situation should include an upswing in interest to support pregnant individuals and families with evidence-based policies.

Foremost should be any pursuable policy opportunities to increase family planning services, including access to same-day contraception and long-acting reversible contraception. Family planning is a mandatory benefit for all Medicaid recipients, yet states have had considerable latitude to decide what is included in this benefit. State Medicaid agencies should remove or relax utilization controls for all Food and Drug Administration-approved contraceptives such as dispensing limits, refill limits, prior authorizations, use of generics before brand-name products, step therapies (also known as “try and fail”), and limits to newer contraceptive products.

Other noteworthy options for Medicaid agencies, advocates, and others to pursue in abortion-restricted states include postpartum Medicaid coverage expansion for the 15 states that have yet to act, especially because this extends otherwise-expiring Medicaid coverage into the year after delivery, during which more than 50% of mortality outcomes occur. Additional options include moving doula benefits to covered services, expanding teen pregnancy community supports, creating perinatal medical home programs, maintaining parity for telehealth coverage for services
for pregnant individuals, and having additional accountable care frameworks to award provider systems with high-quality perinatal care.

As a supplement to these options, some states also use Medicaid as an important component of graduate medical education (GME) funding for the US physician workforce. Historically, the Accreditation Council for Graduate Medical Education has indicated that education and training concerning abortion procedures, complications, and miscarriages have been an important component of residency education in obstetrics and gynecology. As states restrict services, many programs in those states will have to seek out-of-state externships for their residents to receive this required training. Medicaid agencies in amenable states should consider increasing GME support to such programs for travel and for additional education expenses to those who sponsor in-state training. Even in abortion-restricted states, a well-trained clinician workforce able to handle pregnancy and miscarriage complications should be a priority.

Meanwhile, in states where the legal and health care landscape currently maintains pregnant people’s decision to bear their child or terminate their pregnancy, the Dobbs decision will still impact Medicaid services. Access to services may become affected as travelers from other states seek care unavailable in their own. This has prompted some state Medicaid programs to lower barriers to abortion services for their own population by removing prior authorization requirements, requiring that services be compensated for any willing and qualified abortion provider regardless of in-network status, and making nonemergency transportation for such services available. Medicaid call centers, often a front door to health care for Medicaid enrollees and those uninsured, should also be properly trained to provide important information and guidance to pregnant individuals about contraception, abortion services, and local clinicians. Additional consideration should be given to paying at parity for in-person, telehealth, and audio-only visits for medication-induced abortions with mifepristone and misoprostol. Such permissive states will also have to consider what support they are able to provide for individuals traveling from restricted states whether or not they establish residency in the permissive state.

Further issues will cross state lines and will affect interlocking state, Medicaid, and federal policies. Policy makers in permissive states should work with their governors’ offices to clearly lay out legal protections for those who perform abortions on out-of-state pregnant persons and plan how they will protect clinicians and patients from information reciprocity agreements with licensing boards or agencies in other states vowing to prosecute any actions regarding abortion.

Finally, 1 common source of care for Medicaid patients remains affected nationwide. In many states, large numbers of individuals with Medicaid receive their care in federally qualified health centers (FQHCs). Most FQHC funding, however, is federal and bound by the Hyde Amendment, precluding FQHCs from providing medical or surgical abortion services because of lack of other funding or fear of endangering their federal funding. Establishing state-driven alternate routes of augmented funding, waivers, and protections for clinicians at FQHCs to facilitate and compensate the increased effort in counseling and managing medication-induced abortions should be explored.

Although Dobbs has closed a major doorway in perinatal health and created an uneven national landscape, states and their Medicaid agencies should pursue each policy option available to them to maximize choice and improve perinatal outcomes and family supports.

References