

2025 Progress Across 50 States and DC: State Policy Wins in Maternal Health

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This analysis of the year in early childhood state policy advocacy relies on data from a survey of early childhood policy advocates in all 50 states and the District of Columbia, conducted May 2025 through December 2025. The survey asked them for highlights from the year, so the results are representative and not comprehensive. Policy "wins" include legislation, funding increases, executive actions, and regulatory changes.

The survey was developed and executed by Dr. Lisa Kerber of Frontera Strategy. Frontera supports advocacy efforts nationwide by providing qualitative and quantitative research services, including needs assessments and environmental scans, program and policy evaluation, statistical analyses, and survey research for associations, foundations, and nonprofit service organizations active in state capitols.

Jason Sabo
sabo@fronterastrategy.com

Lisa Kerber, PhD
kerber@fronterastrategy.com

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Medicaid and Private Coverage for Care Provided by Doulas

Arkansas

Act 965 – a companion piece of legislation to the Healthy Moms, Healthy Babies Act – creates a certification process for community-based doulas, defines the scope of practice for doulas, including prenatal and postpartum home visitation care, and requires other health benefit plans to provide compensation to a certified community-based doula. Act 435, another piece of related legislation, sets out similar requirements specific to Community Health Workers.

Target population: Pregnant and postpartum women and their children.

State funding: Relatively small increase of state funding

Quantify: There are approximately 35,000 births in Arkansas each year but currently fewer than 50 trained doulas, according to studies by the University of Arkansas for Medical Sciences. This legislation aims to increase the number of doulas and community health workers in the state and, subsequently, the number of women who have access to these health providers.

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Illinois

SB2437, Medicaid omnibus, includes language that requires hospitals and birthing centers to allow patients to have Medicaid-approved doulas present during all phases of labor and birth. The doula will not count toward the number of guests permitted to a patient.

Maine

Legislation was enacted to require the state's Department of Health and Human Services to initiate a rate determination process to provide coverage for Doula services under Maine's Medicaid program by January 1, 2028. The law also requires the creation of a Doula Council to make recommendations to the Department regarding rate setting. The Department is required to report to the Joint Select Committee on Health and Human Services on the status of the Doula coverage under MaineCare (Maine's Medicaid program) no later than February 2027.

Target population: Individuals covered by MaineCare (Maine's Medicaid program).

State funding: No change in state funding related to this win

Quantify: Approximately 4,300 individuals would be impacted based on the number of births covered by Medicaid.

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Montana

SB 319, Generally revise health care laws related to doulas, creates doula licensure requirements and ensures that doula services can be covered under Medicaid.

Target population: Doulas and families expecting a child, tribal and rural families

State funding: Relatively small increase of state funding

Quantify: Expanding doula supports will improve maternal and birth outcomes by offering emotional, physical, and informational support to mothers. Ensuring doula care can be covered by Medicaid expands access to families who otherwise could not afford doula services and those in rural areas. Cost estimated around \$117,627 for FY 2027.

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New Mexico

Doula Credentialing and Access Act establishes a voluntary credentialing process for doulas who want to enroll as Medicaid providers so that their services are more accessible. Doula care is proven to: reduce unnecessary c-sections, improve maternal and infant health outcomes, lower postpartum depression, and create culturally grounded support systems.

State funding: Relatively small increase of state funding

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Oregon

Doulas & Lactation Counselors (SB 692) requires public and private health insurance to cover a minimum of 24 hours and the birth event for doula and lactation counselors, regardless of birth outcome. This bill ensures 1) client flexibility in how to use their doula hours (birth event vs postpartum), 2) more than doubles the reimbursement rate for doula coverage, 3) expands access to lactation support services provided by Lactation Counselors and Lactation Educators (currently only Lactation Consultants are covered), 4) requires private health insurance coverage of birth and postpartum doulas, matching what is provided by Medicaid (OR is only the 8th state to expand doula coverage to private health insurance), and 5) creates a Community-Based Perinatal Services Access Fund, with \$1 million of new funding appropriated, to increase access to culturally specific and culturally competent community-based services.

Target population: This bill primarily focused on improving Black maternal and child health in Oregon, but other under-resourced populations will likely benefit as well.

State funding: Relatively small increase of state funding

Quantify: This bill more than doubled the reimbursement rate for doula coverage. Max reimbursement was \$1500, now \$3,760, making this possibly the highest in the nation.

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Vermont

S. 53 continues the multi-year process necessary to cover doula services under Medicaid. It instructs the Office of Professional Regulation (OPR) to create the certification necessary for doulas who would like to access Medicaid funding and the Department of Vermont Health Access to submit the necessary paperwork to federal regulators to include the services in the state's Medicaid program.

Target population: Pregnant people receiving Medicaid

State funding: Relatively small increase of state funding

Quantify: In Vermont in 2021 there were 2,021 Medicaid births, about 38% of total births in the state. The state budget includes the funding necessary to support the Secretary of State's office to undertake the work to establish certification for doulas.

[Link](#)

Medicaid Expansion for Special Populations

Colorado

Cover All Coloradans provides Medicaid services to all people living in Colorado, regardless of their immigration status. These newly eligible populations now get the same support and services provided to Medicaid and CHP+ members, including preventative care, well-child visits, oral health care, behavioral health care, family planning services, and prenatal and postpartum care if they qualify based on income.

Target population: Cover All Coloradans is a state-funded program that provides Medicaid for undocumented children and pregnant people.

State funding: Relatively large increase of state funding

Quantify: This legislation adds \$26 million more in funding toward this program than the original \$4 million when the bill passed in 2021. More than 20,000 children and pregnant adults have been enrolled so far.

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Georgia

Recently the state applied for an extension of Georgia's Medicaid program for working adults, called Pathways to Coverage. If approved, this extension would include caretaking for children under the age of six as a qualifying activity to receive Medicaid coverage.

Target population: Medicaid-eligible parents of children under the age of 6

Quantify: 20% of Georgia families with children under age six live below 100% of federal poverty level. These parents would more easily be able to receive Medicaid coverage.

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Minnesota

HF1878/SF2117 instructs the Minnesota Department of Human Services to submit an 1115 Waiver for Medical Assistance (MA), Minnesota's Medicaid program, to cover traditional health care practices received through American Indian health service facilities. Expanding Medicaid coverage to traditional health care practices is a holistic strategy to address health disparities in the American Indian community, improve access to culturally appropriate care, and bridge the gap between traditional healing practices and the institutionalized health care model.

Requirements include "qualified providers" determining whether an enrollee is eligible to receive traditional health care practices. Qualified providers are employed or contract with Indian Health Services, a 638 Tribal clinic, or Title V urban Indian organization. Facilities are

responsible for ensuring traditional health care providers have the appropriate experience and training to provide traditional health care practices. Traditional healing practices take a holistic approach to addressing the physical, mental, and spiritual needs of their community and include ceremonies (birth, rites of passage, sweat lodge), traditional food intervention, talking circles, smudging, and substance use recovery programs.

Target population: American Indian families, tribal communities

State funding: Relatively large increase of state funding

Facilitating Care at Clinical Alternatives to Hospitals

Kentucky

HB 90 Free Standing Birthing Centers allows for the establishment and licensing of freestanding birth centers in Kentucky. By removing certificate of need requirements, it offers families a safe and equitable alternative to hospital settings for prenatal, delivery, and postpartum care, removing barriers to care for women with low-risk pregnancies. Research shows that freestanding birth centers use fewer medical interventions and achieve better outcomes than hospitals on quality measures such as cesarean rate for low-risk women, elective delivery prior to 39 weeks, and breastfeeding. There is also potential for reduced cost based on the Strong Start for Newborns and Mothers program, which has shown savings of about \$2,000 per birth at birthing centers.

Target population: Although this policy is applicable across all communities in the state, 46% of Kentucky counties, especially in rural areas, are considered maternity care deserts without access to birthing facilities or maternity care providers. By exempting freestanding alternative birthing centers from the certificate of need requirement, women of childbearing age in these communities will have a new option to support childbirth and newborn care using a midwifery and wellness model in a licensed facility.

State funding: No change in state funding related to this win

Quantify: As of the latest data, approximately 24% of Kentucky's population resides in areas classified as maternity care deserts—regions lacking hospitals or birth centers offering obstetric care and without obstetric providers.

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Minnesota

Minnesota passed maternal health bills about birth centers (HF1793/SF2109), birth services provided at home (HF96/SF1113), and midwifery services (HF1010/SF832). HF1793/SF2109 requires birth center facility fees to be reimbursed at the same rate as a hospital, for an uncomplicated vaginal delivery. HF96/SF1113 increases reimbursement for birth workers who provide services in the home by setting supply reimbursement to 70% of a hospital facility fee. HF1010 / SF832 creates a certified midwife licensure and expansion of Medicaid coverage to services provided by certified midwives, aiming to allow more candidates from diverse backgrounds and professions to complete the certification process to enter the midwifery workforce.

Target population: Cultural birth workers, midwives, home birth providers, pregnant people in rural Minnesota

State funding: Relatively small increase of state funding

Quantify: Increasing reimbursement for home birth providers will have an ongoing cost of \$7,000/year, the creation of a new certified midwife licensure will be absorbed by the Board of Nursing, and the increase for birth center reimbursement is \$322,000/year.

Presumptive Eligibility for Medicaid

Alabama

Presumptive Medicaid Eligibility establishes Presumptive Eligibility for Medicaid, enabling individuals to receive immediate medical services which cannot be denied for coverage later. With this new law, a pregnant woman will be presumptively eligible for coverage for ambulatory prenatal care under Medicaid if a qualified provider determines on the basis of preliminary information that her household income does not exceed the modified adjusted gross income limit for the eligibility of pregnant women, which is in effect under the state Medicaid plan. In 2023, Alabama had the highest maternal mortality rate in the U.S., and its infant mortality rate is above the national average.

Target population: This newly enacted law specifies that it applies to pregnant women in AL.

State funding: Relatively small increase of state funding

Quantify: Presumptive Medicaid Eligibility for pregnant women increases the state funding by \$1 million annually for fiscal years 2026, 2027 and 2028. The appropriated state portion for this law is \$237,700 of the \$1 million annually (with \$726,300 in federal funds). As of 2022, 45% of births in Alabama were covered by Medicaid.

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Arkansas

The Healthy Moms, Healthy Babies Act (Act 124) included presumptive Medicaid eligibility for pregnant women, allowing expectant, low-income moms to be approved for Medicaid coverage quickly and get access to prenatal care while waiting for their full Medicaid application to be processed, regardless of backlogs or state agency staff shortages.

Target population: This policy will benefit all mothers who receive or are eligible for Pregnancy Medicaid.

State funding: Relatively small increase of state funding

Quantify: As this law will not be in effect until August 2025, any exact projections are still to be determined. Medicaid pays for 41% of births in AR, so it has the potential to ensure that approximately 15,000 women annually can access more timely prenatal services.

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Increasing Access to Mental Healthcare

Momnibus 2.0/Senate Bill 246 is a maternal health package that delivers support for moms by: 1) Improving maternal mental health screening and reducing care barriers, 2) Training rural EMS providers on labor and delivery emergencies, and 3) Strengthening workforce protections for postpartum and pediatric appointments. On January 1, 2026, maternal mental health screenings at well-child visits will be covered by Medicaid and commercial insurance carriers. Commercial carriers will also begin to cover home visits. No employer with 20 employees or more can deny an employee leave from work for medical appointments related to birth, postpartum care, or the child's medical appointments within the first year of birth or adoption (up to 25 hours). In 2028, the Department of Health and Human Services will receive funding to establish a perinatal psychiatric provider consult line.

State funding: Relatively small increase of state funding

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Rhode Island

Rhode Island passed a new, permanent \$30 million state general revenue funding stream to support access to primary health care and other critical health care initiatives through an assessment on commercial health insurance coverage. This funding will keep the MomsPRN (Psychiatry Resource Network) and PediPRN programs operating to improve access to mental health care for moms and children by enabling primary health care providers to access consultation.

Target population: Pregnant and postpartum mothers (about 9,000/year).

State funding: Relatively large increase of state funding

Quantify: \$750,000 in new state funding to sustain the MomsPRN program from a new \$30 million/year assessment on commercial health insurance. The program would otherwise have been terminated this year.

[Info about \\$750,000 for MomsPRN](#)

[Link](#)

[Link](#)

[Press release](#)

Increased State Investments

Alabama

Additional state funding for health care includes Public Health: \$22.1 million, an increase of \$2 million, Human Resources: \$106 million, an increase of \$7.7 million, Mental Health: \$84 million, an increase of \$4.9 million, Rehabilitation Services: \$62.7 million, an increase of \$6.4 million. State Agency Appropriations from the General Fund include Medicaid: \$1.18 billion, an increase of \$223 million, Mental Health: \$244 million, an increase of \$4.7 million, and Public Health: \$159.4 million, an increase of \$28.2 million.

State funding: Relatively large increase of state funding

Quantify: The nearly \$10 billion FY2026 Education Trust Fund budget (ETF) is a 6% increase over the FY2025 budget. The FY2026 ETF budget includes funding for the new paid parental leave

and workman's compensation and a \$99.2 million increase for education employees' health insurance (the Public Education Employees' Health Insurance Plan or PEEHIP).

[House](#)
[Senate](#)
[Story](#)

Unbundling of Medicaid Coverage for Pregnant Women

Arkansas

The Healthy Moms, Healthy Babies Act will unbundle Medicaid coverage for pregnant women – medical providers will receive separate payments for various prenatal, delivery, and postpartum services rather than a global payment, which should increase the likelihood of medical providers participating in the Medicaid program and, in turn, increase access to prenatal and postpartum services for women covered by Medicaid.

Target population: Pregnant and postpartum women

State funding: Relatively small increase of state funding

Quantify: A fiscal impact statement was not provided with Act 124. Medicaid pays for 41% of births in AR, so it has the potential to ensure that approximately 15,000 women annually have better access to Medicaid providers.

[Link](#)
[Story](#)

Improved Technology to Increase Access to Medicaid and SNAP

Texas

Legislators invested \$139 million in General Revenue (\$386 million in All Funds) in strategies to improve the Medicaid and SNAP eligibility system, including overhauling outdated technology and hiring additional staff. The goal is to address a backlog of more than 200,000 unprocessed Medicaid applications for most of 2024 -- parents wait an average of 41 days for a Medicaid eligibility determination, with some waiting more than 160 days.

Target population: Texans eligible for Medicaid or SNAP

State funding: Relatively large increase of state funding

Quantify: \$139 million in General Revenue (\$386 million in All Funds). Approximately four million Texans are enrolled in Medicaid.

[Link](#)
[Blog/Media](#)

Study on Public Health

Georgia

HR 847 creates a House study committee evaluating funding for the public health system.

Target population: The Georgia Department of Public Health and county health departments

State funding: No change in state funding related to this win

[Link](#)

[Press release](#)

Medicaid and Private Coverage to Cover Blood Pressure Monitor

Michigan

Public Acts 244 and 245 of 2024 (HBs 5167 and 5168) require Medicaid and private insurance coverage for any pregnant/postpartum enrollees to receive a home blood pressure monitor. The new laws took effect on April 2, 2025. Regulations were issued for private insurers through the Department of Insurance and Financial Services but the Medicaid agency, the Michigan Department of Health and Human Services, delayed issuing guidance over concerns about lack of funding for the new benefit until \$800,000 was included in the FY 26 state budget. MDHHS then issued guidance that went into effect December 1.

Target population: While this policy change applies to all pregnant and postpartum individuals, hypertensive disorders have a larger impact on Black individuals. Providing a blood pressure monitor will empower individuals to monitor regularly and for all to have the proper equipment to allow for safe virtual prenatal and postpartum visits.

State funding: Relatively small increase of state funding

Quantify: Elevated blood pressure is a leading cause of both maternal and infant mortality and morbidity. Almost 100,000 births per year will benefit from this funding and policy change.

[Link](#) (Medicaid policy is Bulletin MMP 25-48 Revisions to Blood Pressure Monitoring Policy)

[Story](#)