

Postpartum Healthcare Utilization Among Women with Medicaid Coverage

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Key Takeaways

- The American Rescue Plan Act (ARPA) authorized states to extend Medicaid postpartum coverage from the longstanding 60-day limit to 12 months.
- This analysis found that women continued to use a wide range of healthcare services throughout the first year after delivery, including preventive care, illness management, mental health/substance use disorder services, and emergency services.
- These findings highlight the importance of maintaining coverage continuity throughout the postpartum year, especially amid ongoing policy changes that may disrupt coverage.

Overview

Maternal mortality and morbidity during the postpartum period are high in the U.S., with health risks remaining elevated well beyond the early postpartum period.¹

Federal policies have expanded postpartum health coverage under Medicaid to facilitate access to care for women with low incomes. The American Rescue Plan Act (ARPA) of 2021 allowed states the option to extend Medicaid postpartum coverage from the longstanding 60 days to 12 months.² Initially a five-year program, this optional policy was made permanent by the Consolidated Appropriations Act of 2023.³

Lengthening postpartum coverage is anticipated to result in improved access to follow-up care, management of chronic conditions, and receipt of preventive services in the postpartum period.⁴ By July 2026, all states except Arkansas had implemented, or planned to implement, the 12-month Medicaid postpartum extension.⁵

This multi-state analysis compares healthcare use among women enrolled in Medicaid managed care organizations (MCOs) in the early postpartum period (days 7–60 after delivery) and extended postpartum period (days 61–365), and examines predictors of healthcare utilization during the extended postpartum period.



Postpartum Medicaid extensions aim to support continued access to care during a year of ongoing healthcare needs.

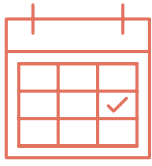
Background

Medicaid is a key payer for maternity care in the U.S., financing an estimated 41.5 percent of births in 2023.⁶ As such, extending pregnancy-related eligibility beyond 60 days postpartum has broad implications for maternal health and care continuity in the postpartum year.

A recent systematic review of studies in the U.S. and Canada found that postpartum morbidity and mortality extend well beyond 60 days after delivery, with complications such as depression, anxiety, hypertension, and hemorrhage occurring throughout the first year following delivery.⁷

Evidence remains limited and mixed on how extended Medicaid coverage during the postpartum period affects longer-term maternal outcomes. Some analyses have shown that postpartum coverage extension is associated with increased use of preventive, contraceptive, and mental health/substance use disorder (MH/SUD) services throughout the postpartum year, while others have found it was associated with fewer people being uninsured but was not associated with improvements in postpartum visit attendance, contraception use, breastfeeding, or depressive symptoms.^{8–12}

Studies examining the association between coverage extensions and maternal outcomes have generally been limited to single states, short follow-up periods, narrow sets of outcomes, or assessments under the traditional 60-day postpartum coverage model.¹³ Moreover, much of the



Understanding healthcare use beyond 60 days postpartum can inform policies that support continuity of care during the first year after delivery.

existing evidence evaluates outcomes unrelated to ARPA policies, such as the COVID-era continuous coverage requirement. Therefore, examining healthcare utilization during the entire year postpartum using a comprehensive multi-state analysis covering 2021–2025 offers a unique opportunity to assess maternal healthcare utilization patterns in the context of ARPA-related postpartum coverage extensions.

Using a large claims dataset, this study describes healthcare use during days 7–60 postpartum (early period) and days 61–365 postpartum (extended period) among women enrolled in Medicaid and examines predictors of utilization during the extended period. This analysis provides critical baseline evidence on maternal postpartum utilization under the 12-month coverage policy and may inform federal and state policy decisions aimed at preserving and strengthening access to postpartum care.

Methods

This study analyzed Elevance Health-affiliated plans' Medicaid claims and enrollment data, including diagnosis, procedure, and service codes from January 1, 2021, to June 30, 2025.

Women enrolled in an Elevance Health-affiliated Medicaid plan were included if they:

- Were aged 19–50 years
- Had a live birth between April 1, 2022, and June 30, 2024 (only the first eligible live birth per woman was included)
- Had no more than 36 weeks of Medicaid enrollment before delivery, to focus on women who enrolled in Medicaid during pregnancy
- Maintained continuous Medicaid coverage for 12 months postpartum
- Resided in states that had implemented the 12-month postpartum Medicaid extension by June 2024

Outcomes were defined using International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes, Current Procedural Terminology (CPT) procedure codes, and Healthcare Common Procedure Coding System (HCPCS) codes. They comprised repeat pregnancy identified from claims during days 90–365 postpartum and healthcare utilization during days 7–365 postpartum, including outpatient evaluation and management visits (for preventive/well care and acute and chronic illness), postpartum evaluation, contraceptive management, emergency department (ED) visits, and MH/SUD care which included psychotherapy visits and other visits with a MH/SUD diagnosis.

Predictors of postpartum healthcare utilization included baseline sociodemographic and geographic factors (age, race/ethnicity, urbanicity, region, and socioeconomic status [SES] index); clinical factors during the 36 weeks before delivery (anemia, hypertension, diabetes, obesity, tobacco use, and MH/SUD care); and pregnancy-related factors (preterm birth, cesarean delivery, emergency cesarean delivery, gestational

diabetes, preeclampsia, eclampsia, or Hemolysis, Elevated Liver enzymes and Low Platelets [HELLP] syndrome, multiple births, chorioamnionitis, and other less common complications such as uterine rupture, blood transfusion, and sepsis).

For each outcome, the proportion of women with at least one occurrence during the early (days 7–60) and the extended (days 61–365) postpartum periods was calculated. The mean number of visits per 1,000 women for each outcome was also calculated. Multivariable logistic regression models with stepwise variable selection were used to identify the five predictors most strongly associated with the probability of each outcome during the extended period.

Results

This study included 100,841 women across 22 Elevance Health-affiliated Medicaid plans. The mean age was 27.8 years and most women were aged 19–29 years (64.4%), resided in urban areas (54.1%) and in the South (70.6%), and had a low SES index (62.6%). The largest proportion (41.1%) of women were non-Hispanic White (Table 1).

Table 1
Sociodemographic and Geographic Characteristics of the Study Population

	N (%)
Age	
19–24	33,233 (33.0)
25–29	31,702 (31.4)
30–34	22,507 (22.3)
35–50	13,399 (13.3)
Race/Ethnicity	
White, non-Hispanic	41,471 (41.1)
Black or African American, non-Hispanic	26,732 (26.5)
Hispanic or Latino of any race	24,309 (24.1)
Asian, non-Hispanic	3,220 (3.2)
Other	5,109 (5.1)
Urbanicity	
Urban	54,508 (54.1)
Suburban	26,815 (26.6)
Rural	15,847 (15.7)
Unknown	3,671 (3.6)
Census Region	
Northeast	8,184 (8.1)
Midwest	15,279 (15.2)
South	71,155 (70.6)
West	6,223 (6.2)
Census Block-Level Socioeconomic Status (SES) Index	
First (lowest) quartile	33,367 (33.1)
Second quartile	29,727 (29.5)
Third quartile	21,691 (21.5)
Fourth (highest) quartile	10,021 (9.9)
Unknown	6,035 (6.0)

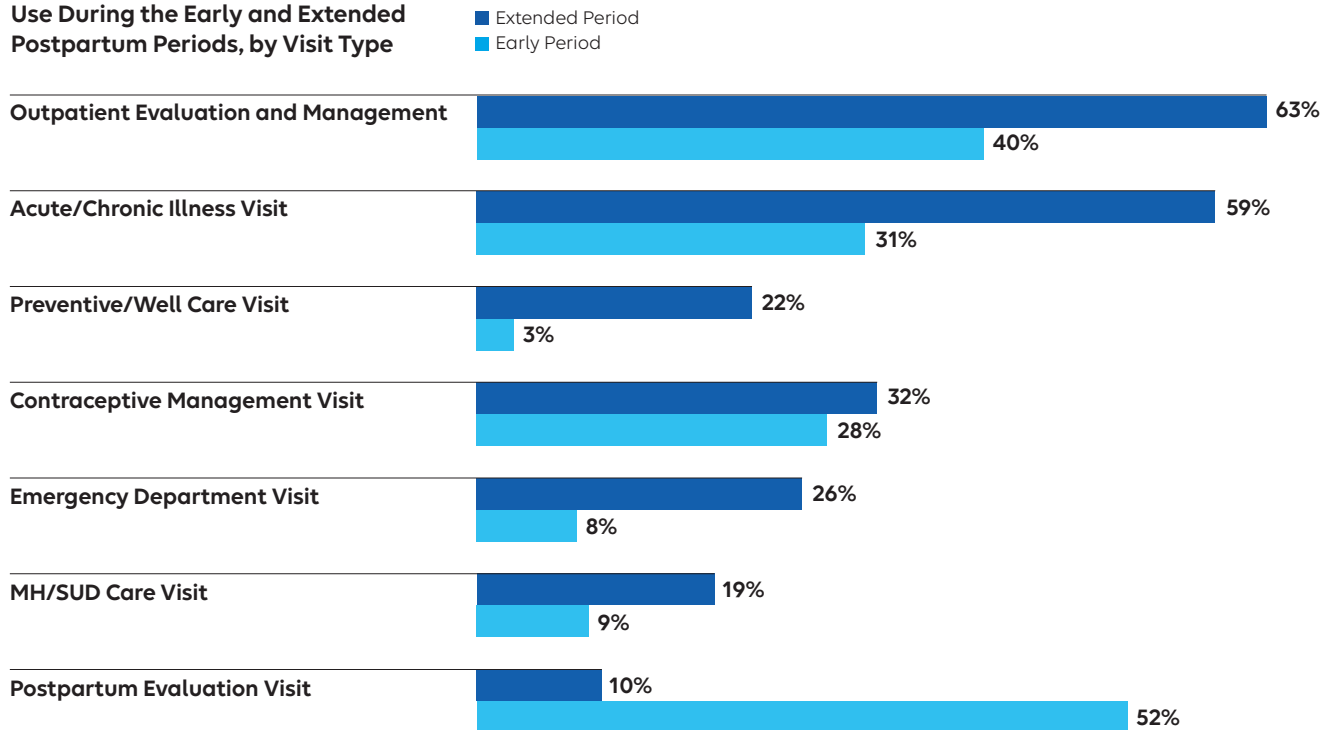
Note. Other race/ethnicity includes American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown.

During the 36 weeks before delivery, common maternal health characteristics included MH/SUD care (15.7%), gestational diabetes (9.9%), anemia (7.8%), gestational hypertension (7.6%), and tobacco use or nicotine dependence (6.1%). About a third of women had a cesarean delivery, including 8.2 percent with an emergency cesarean; 9.5 percent had preeclampsia/eclampsia/HELLP syndrome; and 7.6 percent had a pre-term birth. About 8 percent of women experienced a rapid repeat pregnancy, i.e., a new pregnancy within a year after delivery.

Healthcare utilization was substantial during the extended postpartum period, with higher use of outpatient evaluation and management visits (63% vs 40%), acute/chronic illness visits (59% vs 31%), contraceptive management (32% vs 28%), ED visits (26% vs 8%), and MH/SUD care (19% vs 9%) than during the early postpartum period. While postpartum evaluations were concentrated in the earlier period (52% vs 10%), preventive/well care visits were more common during the extended period (22% vs 3%) (Figure 1).

Figure 1

Percent of Women with Healthcare Use During the Early and Extended Postpartum Periods, by Visit Type

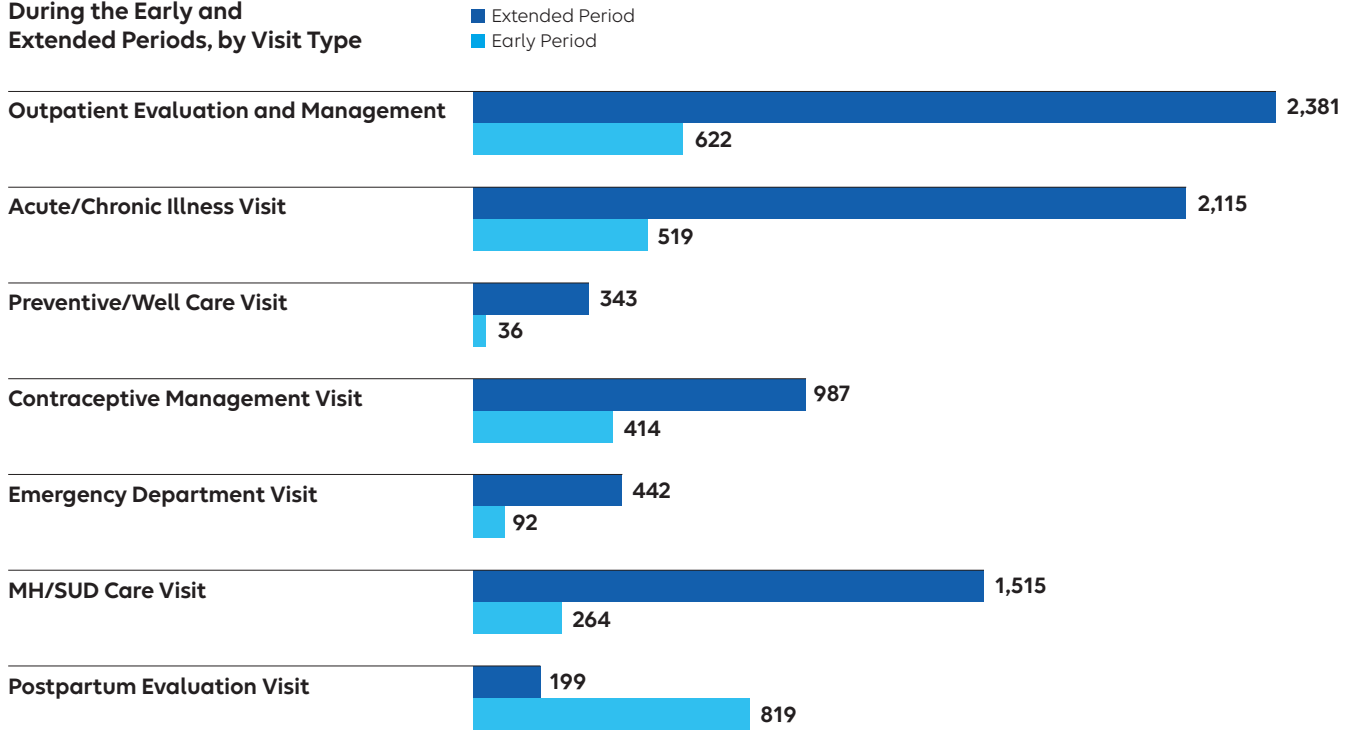


Note. MH/SUD = Mental health/substance use disorder; Office Visit for Acute/Chronic Illness and Preventive/Well Care Visits are a subset of Outpatient Evaluation and Management Visits.

Compared with the earlier postpartum period, average healthcare utilization per 1,000 women was also substantially higher during the extended postpartum period for outpatient evaluation and management visits (2,381 vs 622), acute/chronic illness visits (2,115 vs 519), preventive/well care visits (343 vs 36), MH/SUD care (1,515 vs 264), contraceptive management (987 vs 414), and ED visits (442 vs 92) (Figure 2).

Figure 2

**Healthcare Visits per 1,000 Women
During the Early and
Extended Periods, by Visit Type**



Region, race/ethnicity, age, and pre-delivery MH/SUD care emerged as the most consistent predictors of postpartum healthcare utilization during the extended period, appearing among the top five predictors across multiple outcomes (Figure 3). Additional factors associated with one or more outcomes included SES index, urbanicity, selected maternal health conditions, and pregnancy-related complications.

Figure 3

Top Five Predictors of Postpartum Healthcare Use, by Visit Type

Acute/Chronic Illness Visit	Preventive/Well Care Visit	Contraceptive Management Visit
1. Past MH/SUD Care 2. Region (Northeast) 3. Race/Ethnicity (NH White) 4. Obesity 5. Gestational Hypertension	1. Region (Northeast) 2. Age (25–50) 3. Race/Ethnicity (NH Asian) 4. Urbanicity 5. Past MH/SUD Care	1. Region (Northeast) 2. Age (19–24) 3. Race/Ethnicity (Hispanic) 4. Past MH/SUD Care 5. SES Index (first/lowest quartile)
Emergency Department Visit	MH/SUD Care Visit	Postpartum Evaluation Visit
1. Past MH/SUD Care 2. Age (19–24) 3. Race/Ethnicity (NH Black) 4. Tobacco Use 5. Obesity	1. Past MH/SUD Care 2. Race/Ethnicity (NH White) 3. Tobacco Use 4. Region (West) 5. Gestational Hypertension	1. Region (Northeast) 2. Past MH/SUD Care 3. Preterm Birth 4. Age (25–29) 5. Obesity

Note. The group listed in parenthesis for each predictor had the highest predicted probability for the outcome, although pairwise differences between that group and all other groups were not always statistically significant; NH=Non-Hispanic; MH/SUD=Mental health/substance use disorder.

Discussion

This study found that women enrolled in Medicaid plans used a broad range of healthcare services throughout the first postpartum year. Utilization patterns differed between the early postpartum period and the longer extended period. Cumulative visit counts per 1,000 women were higher during the extended period for illness-related care, ED visits, contraceptive management, and MH/SUD care, reflecting continuing healthcare needs during the longer follow-up window.

Though not common, rapid repeat pregnancy was also observed in some women, which may require more intensive clinical management due to possible adverse pregnancy outcomes associated with shorter interpregnancy intervals.¹⁴

These findings are consistent with prior claims-based research which showed substantial healthcare use among Medicaid-insured women beyond 60 days postpartum, even prior to the implementation of the ARPA 12-month postpartum Medicaid extension option.^{15–17} This study's observed high rates of illness-related visits suggest women are receiving ongoing management of chronic and acute health conditions.

Similarly, use of services for MH/SUD and contraceptive management indicates behavioral health and reproductive health needs continue beyond 60 days postpartum. Taken together, these findings align with evidence that maternal healthcare needs extend well beyond 60 days postpartum.¹⁸



Women's continued healthcare use beyond 60 days postpartum underscores the importance of sustained coverage throughout the first year after delivery.

Region, race/ethnicity, age, and pre-delivery MH/SUD care were the most consistent predictors of healthcare utilization during the extended period suggesting that postpartum healthcare utilization is influenced by both clinical needs and broader demographic and geographic factors. These patterns are consistent with prior research showing variation in postpartum utilization by demographic, clinical, and policy-related factors, and may help identify Medicaid enrollees who could benefit from personalized outreach or care coordination.¹⁹ For instance, the finding that pre-delivery MH/SUD care was one of the top five predictors for each of the six visit types analyzed underscores the importance of identifying women with MH/SUD needs before delivery and maintaining care continuity throughout the postpartum year.^{20,21}

States are currently facing increasing fiscal pressures with respect to their Medicaid programs and may be looking for opportunities to trim enrollment, benefits, or other costs. Findings from this study provide important evidence that supports states' decisions to extend postpartum coverage to 12 months by demonstrating that women continue to use a broad range of healthcare services across this extended time frame, in particular MH/SUD care, preventive services, and illness-related office visits.

Conclusion

Postpartum utilization across multiple service categories demonstrates that healthcare needs persist throughout the first postpartum year.

These findings underscore the need to sustain ARPA-authorized 12-month postpartum Medicaid coverage to help facilitate access to preventive, MH/SUD, reproductive health, and illness-related care during a period of ongoing need.

Endnotes

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