Improving State Medicaid programs for pregnant women and children

by Ian T. Hill

Beginning in 1986, States have made the reduction of infant mortality a major policy priority. As progress on important maternal and infant health indicators has slowed and/or worsened, States have taken advantage of numerous Federal Medicaid options to implement innovative strategies to enhance low-income women's access to prenatal care and to improve the content of that care. Acting initially to expand Medicaid eligibility up to and above the Federal poverty level, States have moved to further improve programs by streamlining eligibility systems, enhancing outreach initiatives, attempting to recruit obstetrical providers into participating in Medicaid, and adding enriched nonmedical prenatal benefits to their State plans. Although policymakers must await formal evaluation results, State reforms appear encouraging.

Introduction

Beginning in the latter months of 1986, States made the reduction of infant mortality a paramount policy priority. As progress on major maternal and infant health indicators has slowed and, in some instances even reversed, States have taken advantage of numerous Federal Medicaid options to implement creative and innovative efforts to enhance low-income women's access to prenatal care and to improve the content of that care.

Acting first on new optional authorities to expand Medicaid eligibility up to and above the Federal poverty level, States have continued to improve programs by streamlining and simplifying eligibility systems, enhancing outreach and public information campaigns, attempting to recruit and retain adequate numbers of obstetrical providers to care for low-income pregnant women and children, and adding enriched nonmedical prenatal benefits to their State plans. Although the specific impact of these initiatives will not be known until formal evaluations are concluded, early anecdotal evidence indicates that State efforts are succeeding in making Medicaid programs both more accessible and effective.

Eroding health of American infants

States and the Nation's Governors have been forced to address the health care needs of mothers and infants because of two inescapable truths: First, the problems of infant mortality and low birth weight have reached "crisis" proportions throughout the country, and second, improving access to preventive prenatal care represents both a wise policy and a sound fiscal investment.

The positive effects of early, effective, and comprehensive prenatal care are well known. Increased use contributes directly to reduced incidence of infant mortality and babies born at low birth weight (Buescher, 1988; Efird, 1988; Meglen, 1987; van Dyck, 1987; Ward, 1988). The good news is that such preventive services are relatively inexpensive, an average of $400 for an uncomplicated pregnancy. Some research also suggests that an investment in prenatal care is cost-effective—an estimated savings of more than $3 is possible for every dollar spent on prenatal care for pregnant women at high risk of delivering a low-birth-weight baby (Institute of Medicine, 1985).

If prenatal care is not received, however, the consequences can be grave from both human and cost perspectives. Women who do not obtain sufficient prenatal care are about twice as likely (10 percent versus 5 percent) to have a low-birth-weight baby and more than 1½ times more likely to have their babies prematurely (13 percent versus 8 percent) than are women who receive adequate prenatal care (Gold et al., 1987). If a women receives no prenatal care, her likelihood of having a low-birth-weight baby is three times greater (U.S. General Accounting Office, 1987; Hughes et al., 1988).

Low birth weight, defined as 5½ pounds or less, is the single factor most commonly associated with the death and disability of newborns. Low-birth-weight babies are 40 times more likely to die during their first month of life than are babies who weigh more. If they do survive, they are twice as likely to suffer one or more disabilities during their lifetime (Southern Regional Task Force on Infant Mortality, 1985). The infant mortality rate in 1986 was 10.4 deaths per 1,000 live births in the United States, placing this country behind 17 other industrialized Nations when rank-ordering this measure. For black newborns, the infant mortality rate is nearly twice as high—18.0 deaths per 1,000 live births (Hughes et al., 1989).

Although nationally the average cost of an uncomplicated pregnancy resulting in a normal delivery is estimated at $2,900, these costs balloon to an average of $12,000 if birth is premature with major complications. If the infant is extremely premature, the average costs rise to $27,000 (Gold et al., 1987). Other estimates paint an even worse picture. For the smallest survivors in 1984, average initial hospital costs ranged from $31,000 to

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Reprint requests: Ian Hill, National Governors' Association, 444 North Capitol Street, Suite 250, Washington, D.C. 20001.

$71,000, with the cost for infants under 750 grams reaching $150,000 (Office of Technology Assessment, 1987). For the Medicaid program specifically, while neonatal intensive care is required for only 6 percent of all Medicaid births, the costs of these deliveries make up about 30 percent of all State Medicaid expenditures for maternity care (Kenney et al., 1986).

A substantial proportion of women do not receive adequate prenatal care in the course of their pregnancies. Thirty-four percent of pregnant women receive what is considered insufficient prenatal care. The rate is highest among unmarried women (58 percent), teenagers (56 percent), the least educated (53 percent), black women (51 percent), Hispanic women (47 percent), and poor married women (47 percent) (Gold et al., 1987). The U.S. General Accounting Office (GAO) found that about 63 percent of Medicaid recipients and uninsured women interviewed in 32 communities in 1986-87 did not begin their care early enough (within the first 3 months) and/or did not return for care often enough (eight provider visits or less). Compared with privately insured women of whom 81 percent received adequate prenatal care, only 36 percent of the Medicaid recipients and 32 percent of the uninsured received sufficient care (U.S. General Accounting Office, 1987). Of the babies born in the United States, 24 percent are born to women who do not receive care in their first trimester, the period deemed most critical in prenatal development. (This rate is 47 percent among teens.) The proportion of babies born to mothers who receive late or no prenatal care either grew larger or stayed the same for 7 consecutive years. In 1986, it was 6.0 percent for all women, 9.9 percent for women other than white, and 12.7 percent for all teenage mothers (Hughes et al., 1989).

Opportunities created by Federal legislation

The single most important barrier to prenatal care that faced low-income childbearing women in the mid-eighties was lack of insurance. Medicaid, this country's major payer of health care for indigent women, children, and families, no longer held the capacity to appropriately provide for these populations because of a steady erosion in income eligibility limits. Over the preceding decade, income eligibility thresholds for State Aid to Families with Dependent Children (AFDC) programs—the primary vehicle through which families could obtain Medicaid coverage—had slipped in the average State from 75 percent of the poverty level in 1975 to 48 percent of the poverty level in 1986. Realizing this, States sought a means of separating eligibility rules for public welfare programs from those of public health programs.

The National Governors' Association (NGA), adopting a proposal developed by the Southern Regional Task Force on Infant Mortality, worked with Congress and key advocate groups such as the Children's Defense Fund to define the parameters of what was to become the Omnibus Budget Reconciliation Act (OBRA) of 1986.

The Act, certainly the most important single piece of legislation affecting pregnant women and children passed during the eighties, provided States the flexibility they sought in order to sever the historical link between Medicaid programs and AFDC programs. Beginning in April 1987, OBRA 1986 gave States the option to raise income eligibility thresholds above AFDC levels to as high as the Federal poverty level for pregnant women, infants, and on an optional basis, children up to 5 years of age.

In subsequent years, Congress continued developing legislation liberalizing coverage of these populations.

- OBRA 1987, effective July 1988, expanded optional authority to allow States to raise income thresholds for pregnant women and infants to 185 percent of the Federal poverty level, and to raise poverty-level coverage of children to as high as 8 years of age.
- The Medicare Catastrophic Care Amendments (MCCA) of 1988 mandated, for those States that had not already expanded on their own, minimum coverage of pregnant women and infants at 100 percent of the poverty level. (This expansion was to take place over a 2-year phase-in—75 percent of the poverty level in July 1989, 100 percent of the poverty level in July 1990.)
- OBRA 1989 superceded MCCA's mandate schedule by requiring States to cover, at minimum, pregnant women and children up to 6 years of age at 133 percent of the poverty level. These provisions were effective April 1990.

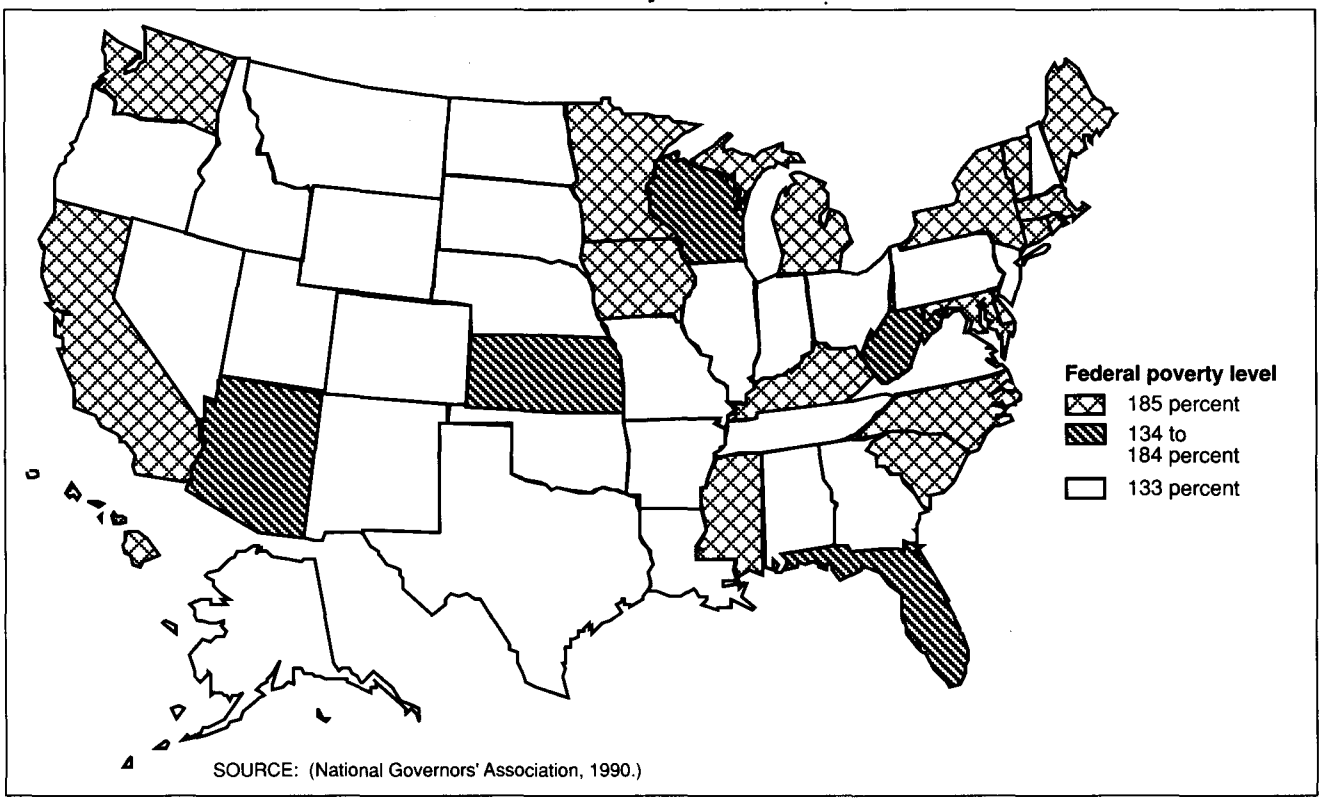
States rapidly expand eligibility

In response to OBRA 1986, States "put their money where their mouths were." Within 1 year of the initial effective date of the law, one-half of the States had expanded eligibility to 100 percent of the Federal poverty level. By the 2-year anniversary of OBRA 1986, 44 States and the District of Columbia had coverages at 100 percent or higher. (Eighteen of these had used OBRA 1987 authority to raise thresholds above the poverty level, most to the upper limit of 185 percent.) By July 1989, the effective date of MCCA, only five States were required by the law to adjust eligibility thresholds to 75 percent of poverty.

The impact of OBRA 1989 was felt more widely by States. Thirty-two States did not have thresholds at 133 percent of the poverty level for pregnant women and infants and were required to adjust incrementally, most from 100 percent to 133 percent. A much larger effect surrounded the mandated expanded coverage of children, however. Only 14 States were already covering children to 6 or 7 years of age in April 1989. Twenty-five States were phasing-in coverage of children from 2-5 years of age, and 12 States covered only infants to 1 year of age under the special expanded coverage group. All were brought into compliance with the minimum floor of age 6 as of April 1990 (National Governors' Association, 1990) (Figure 1 and Table 1).

While OBRA 1986 (and each of its subsequent sibling acts) opened new doors for States through which financial access to health care could be extended to thousands of families, they also represented only a first step toward the goals of improving birth outcomes and maternal and child health status. By themselves, these laws were simply eligibility expansions. They did not directly address a broad range of issues and problems confronting

Figure 1
States broadening Medicaid eligibility for poverty-related coverage of pregnant women and children: July 1990



SOURCE: (National Governors' Association, 1990.)

publically-funded perinatal programs that more directly prevent women from giving birth to healthier babies. To achieve this ultimate goal, States were faced with much more complex challenges.

- In order to enroll potentially eligible women and children, States needed to simplify, streamline, and make more accessible their complicated and onerous eligibility systems.
- In order to make persons aware of the availability of this new coverage and to stress the importance of early and continuous prenatal care, public awareness needed to be raised through outreach and education efforts.
- In order to ensure that women seeking care could find it, States needed to confront multiple problems fueling a severe shortage of obstetrical providers.
- If women and children were to be served appropriately, States would need to directly focus on the quality of care provided under Medicaid and develop strategies to improve the scope, comprehensiveness, and continuity of perinatal services.
- To assess the impact of various initiatives, States would have to improve their capacity to measure and evaluate the effects and effectiveness of program changes.
- To achieve any of these objectives, States would have to build collaborative working relationships among numerous State agencies involved with serving low-income families, namely, Medicaid, Maternal and Child Health (MCH), and public assistance.

Fortunately, a strong majority of States have not simply expanded eligibility for pregnant women and children. The rest of this article will describe how most have implemented significant reforms aimed at the challenges described previously in hopes of making their Medicaid programs more accessible and effective.

Streamlining eligibility systems

A growing body of research has made it clear that eligibility systems for Medicaid are themselves serving to inhibit many women from enrolling in the program. Although OBRA 1986 severed the income linkage between AFDC and Medicaid, it did not separate the processes through which persons become eligible for the two programs. The Medicaid eligibility process is still intimately linked to the AFDC eligibility process, which creates a number of vexing dilemmas for pregnant women seeking prenatal care.

- The traditional welfare stigma attached to applying for public aid can inhibit many women who might need or want only prenatal care.
- The fact that Medicaid eligibility workers are typically located in county welfare offices, rather than prenatal care provider sites, contributes to this stigmatization and also poses an access barrier since applying for coverage involves a second, separate trip to the welfare office.

Table 1

Omnibus Budget Reconciliation Act of 1986 and 1987 summary status of Medicaid coverage options for pregnant women and children, by State: January 1990

State	Pregnant women and infants percent poverty	Original effective date	Older children covered under the Federal poverty level by age					
			Age 2	Age 3	Age 4	Age 5	Age 6	Age 7
Total	[1]46		6	9	4	6	9	5
Alabama	100	July 1988						
Alaska	100	January 1989		X				
Arizona	100	January 1988		X				
Arkansas	100	April 1987					X	
California	185	July 1989						X
Colorado	[2]75	July 1989						
Connecticut	185	April 1988					X	
Delaware	100	January 1988		X				
District of Columbia	100	April 1987		X				
Florida	150	October 1987					X	
Georgia	100	January 1989			X			
Hawaii	185	January 1989						X
Idaho	[2]75	January 1989						
Illinois	100	July 1988						
Indiana	100	July 1988		X				
Iowa	185	January 1989					X	
Kansas	150	July 1988				X		
Kentucky	125	October 1987	X					
Louisiana	100	January 1989					X	
Maine	185	October 1988				X		
Maryland	185	July 1987	X					
Massachusetts	185	July 1987				X		
Michigan	185	January 1988		X				
Minnesota	185	July 1988				X		
Mississippi	185	October 1987				X		
Missouri	100	January 1988		X				
Montana	100	July 1989						
Nebraska	100	July 1988		X				
Nevada	[2]75	July 1989						
New Hampshire	[2]75	July 1989						
New Jersey	100	July 1987				X		
New Mexico	100	January 1988			X			
New York	185	January 1990						
North Carolina	150	October 1987					X	
North Dakota	[2]75	July 1989						
Ohio	100	January 1989	X					
Oklahoma	100	January 1988	X					
Oregon	85	November 1987			X			
Pennsylvania	100	April 1988		X				
Rhode Island	185	April 1987					X	
South Carolina	185	October 1987					X	
South Dakota	100	July 1988	X					
Tennessee	100	July 1987					X	
Texas	130	September 1988			X			
Utah	100	January 1989						
Vermont	185	October 1987						X
Virginia	100	July 1988	X					
Washington	185	July 1987						X
West Virginia	150	July 1987						X
Wisconsin	[3]82	April 1988						
Wyoming	100	October 1988						

[1]Forty-six States set levels more generous than the Federal mandate.
[2]Compliance with minimum mandated coverage.
[3]State funded program covers pregnant women and infants below 130 percent of the poverty level.

SOURCE: (National Governors' Association, January 1990.)

- Application forms for Medicaid are often also used to determine eligibility for AFDC and other public programs and are, therefore, incredibly complex, require intensive verification, and can number as long as 45 pages in some States.
- Finally, States have, by law, up to 45 days to make eligibility determinations. Because applications are so long and involved, States have traditionally used that much time. This delay is especially problematic for pregnant women who need to access prenatal care as early as possible in their pregnancy.

These factors contribute to a situation whereby a very large percent of women applying for assistance are denied not because they have excess income or excess resources, but because they "do not comply with procedural requirements." Federal AFDC data consistently show that 60 percent of all AFDC application denials are in this category (Hill, 1988). Not complying with procedural requirements could mean that women have missed appointments with eligibility workers, income verification was not collected, or that the right number of bank statements, pay stubs, birth certificates, etc. were not submitted. In simple terms, these persons are denied eligibility because they cannot complete the process.

Evidence indicates that States have recognized that their eligibility systems often inhibit the enrollment of potentially eligible women in need of care. As described in the NGA report, *Reaching Women Who Need Prenatal Care*, numerous strategies are currently being employed by States to create eligibility systems that are simpler, more accessible, and allow for earlier, more timely receipt of care.

The first three strategies that allowed States to simplify and liberalize eligibility rules were made possible by optional authority contained in the OBRA 1986 statute. One permits States to ignore all personal assets during the eligibility determination process, another allows States to extend continuous eligibility to pregnant women throughout their pregnancies regardless of fluctuations of income, and a third gives States the authority to establish programs of presumptive eligibility that extend immediate, short-term Medicaid coverage to women while their formal eligibility review is taking place.

Dropping assets restrictions

As of July 1990, 46 States (including the District of Columbia) had elected to remove assets restrictions from their eligibility requirement for pregnant women and children. Often one of the more stringent aspects of States' criteria, and certainly the one that demands the most careful and complete verification, assets tests have been overwhelmingly identified as a primary barrier. Doing away with assets restrictions, as will be discussed later, also obviates much of the need for long, complicated application forms and the need for specially qualified eligibility workers to obtain and review applicant information.

Allowing continuous eligibility

A strong majority of States (43) have also elected to extend to pregnant women continuous eligibility throughout their pregnancy and a 60-day post-partum period of coverage, regardless of fluctuations in income. State policies generally require Medicaid and AFDC eligibles to return to local welfare offices to reconfirm eligibility status on a regular basis, be it monthly, every 3 months, or every 6 months. Rather than subject pregnant women to the burden of proving eligibility more than once, nearly all States have decided that it is more important to guarantee continuous access to coverage than to eliminate the risk that a family's income might increase above eligibility limits.

Implementing presumptive eligibility programs

Twenty-eight States have adopted the complex but promising option of presumptive eligibility. Presumptive eligibility offers States two main advantages over traditional eligibility processes: It improves access, at least initially, by allowing primary care providers to approve a simple, short-term, income-related eligibility status, and it provides immediate coverage of Medicaid-reimbursed prenatal care by insuring women on a same-day basis for a limited period of time. Although these advantages are easily grasped, the option is not universally preferred by States because it brings with it several complicated administrative problems as well. For example, States adopting presumptive eligibility must also designate which providers are to be qualified to determine presumptive eligibility, design unique application forms and Medicaid cards for presumptively eligible populations, and adjust computerized eligibility systems to track specific 5-, 14-, and 45-day eligibility periods. Most importantly, presumptive eligibility still requires that women make a contact with the official welfare agency in order to apply for and gain full Medicaid-eligible status.

In the absence of other reforms, presumptive eligibility offers States a significant avenue for improvement. However, in lieu of presumptive eligibility, States have also devised three alternative solutions that are simpler to achieve and can be, perhaps, even more effective.

Outstationing eligibility workers

Nineteen States have actively engaged in the practice of posting official Medicaid eligibility workers at the sites where prenatal care is rendered to low-income women. Like presumptive eligibility, this strategy allows women to encounter the State's eligibility system at the provider site rather than a county welfare office. However, an advantage this strategy has over presumptive eligibility is that it does not require applicants to make a second, subsequent contact with the welfare agency—the information made available to the eligibility worker on the first visit to the provider is often all that is needed to make an official eligibility determination. Typically, States have outstationed workers at sites where high patient volume justifies such an arrangement—public hospitals, local health departments, Community and Migrant Health Centers. One issue that makes this strategy problematic for States is that it places significant demands on State and/or county staffing. A beneficial side effect reported by States is that outposted workers often experience improved morale as members of a State's infant mortality "team."

Shortening application forms

Twenty-five States have succeeded in shortening their application forms for pregnant women and/or children. Given the ability to exclude a resource test from eligibility considerations, States have actively explored how the application can be reduced in size to collect only those pieces of information needed to determine eligibility for these populations. The goals of such strategies are

twofold: A shorter application is more quickly and easily completed by applicants and also can be processed by State agencies more quickly, thereby reducing the waiting time for determination. With less information to verify, the chance that applicants will be rejected for "procedural" reasons is greatly reduced. New short forms range in size from one to nine pages. In many of these States, short forms have been made so simple that State welfare agencies have agreed to leave blank forms in provider offices. This allows women to either take the forms home and complete the process by mail, or to receive assistance from a provider's administrative staff and complete the application in the caregiver's office.

Expediting maternity-related applications

Recognizing the typically long delays inherent in existing eligibility systems, 11 States have developed processes that expedite applications by pregnant women, allowing for processing to occur more quickly than for other Medicaid applications. With turnaround times ranging in these States from 5 to 10 days, program officials have justified placing priority on maternity-related applications because of the especially critical importance of timely prenatal care.

Table 2 illustrates which States have taken these steps to streamline eligibility systems for pregnant women and/or children. It is notable that most States have combined several strategies for maximum impact. For example, a State that outstations eligibility workers may equip that worker with a shortened form so that the intake of larger numbers of clients can take place during a health department's prenatal clinic hours.

Refining outreach and information campaigns

Revamping eligibility processes so that pregnant women seeking Medicaid coverage can enroll in the program more easily is one strategy that a majority of States engaged in shortly after implementing poverty-level expansions. Another challenge, however, that stands in the way of States trying to maximize client enrollment is figuring out how best to inform the thousands of potentially eligible women of the availability of new coverage. At the same time, effectively spreading the message that early entry into prenatal care and continuous receipt of prenatal care throughout pregnancy are important, constitute additional challenges. To meet these objectives, a large number of States have implemented diverse and multi-faceted outreach initiatives in tandem with their poverty-level expansions.

Outreach and public education continue to be controversial and problematic issues for public perinatal programs. Financing has always been a problem as outreach is typically the "last funded, first cut" activity in most States' budgets. Moreover, trying to determine a strategy that is both broad enough to inform all pregnant women, yet targeted enough to reach women who are most in need is extremely difficult. Cost effectiveness is always at issue and, perhaps most importantly, if outreach is designed to try to draw women into a system that is regarded as unresponsive, difficult to access, and unsatisfying to use, a campaign may be doomed to failure from the start. By clients and providers alike, Medicaid has often been viewed this way.

Both the NGA report, *Reaching Women Who Need Prenatal Care*, and the Institute of Medicine report, *Prenatal Care: Reaching Women, Reaching Infants,* caution against funding outreach programs unless reforms and improvements have already been made to the system into which one is trying to draw women. It is therefore encouraging to observe that so many States are investing in streamlining and simplifying their eligibility systems at the same time that outreach plans are being developed.

Outreach activities by States in recent years have focused on both innovative and traditional strategies, including establishment of:

- Newly expanded statewide public information campaigns.
- Targeted case-finding projects.
- Toll-free hotlines.
- Networks of local community organizations that conduct referral and information dissemination.

The most promising initiatives typically combine several of these strategies within one overarching system.

Better use of mass media

Realizing that the traditional stigma attached to the receipt of "welfare" could discourage women from seeking Medicaid, many States have consciously developed program materials with the intention of creating a new image for the Medicaid program. Utilizing softer, more positive images, bright colors, creative photography and graphic arts, and employing friendly themes like "Baby Love" (North Carolina), "Baby Your Baby" (Utah), and "Beautiful Babies Right from the Start" (District of Columbia), State programs are attempting to alter the public's perception of them and thereby attract new clients.

The use of broadcast public service announcements is not a new outreach strategy by any means. However, a growing number of States have taken steps to more successfully tap that industry's creative and persuasive talents. Understanding the media's need to not only make a profit and get high audience ratings, but to also earn the public's favor by demonstrating concern about social issues, these States have convinced television and radio stations that there is value in being identified as the station in the community that "cares" about moms and kids. A growing list of States have, in return for relatively small financial investments, begun receiving impressive levels of in-kind support from broadcasters (free air time, artwork and materials design, targeted marketing, etc.).

Providing toll-free hotlines

Many of the States that have expanded their coverage of poor pregnant women and children have incorporated a toll-free, 1-800 number into their outreach plans. The value of the hotline, however, goes beyond that of providing interested women with a means of receiving additional information. The telephone lines also have played a key role in assessing the relative effectiveness of

Table 2

Strategies to streamline eligibility, by State: July 1990

State	OBRA 1986 options			Other State initiatives		
	Dropped assets test	Continuous eligibility	Presumptive eligibility	Outstationing eligibility workers	Shortened application	Expedited eligibility
Total	46	43	28	19	25	11
Alabama	X	X	X	X	X	
Alaska	X	X				X
Arizona	X	X				
Arkansas	X	X	X	X		
California				[1]X		
Colorado	X	X	X		X	
Connecticut	X	X	X			
Delaware	X	X		X	X	X
District of Columbia	X	X	[1]X			
Florida	X	X	X	X	X	
Georgia	X	X			X	X
Hawaii	X	X	X			
Idaho	X	X	X			
Illinois		X	X			
Indiana	X	X	X			
Iowa		X	X			
Kansas	X					X
Kentucky	X	X		X	X	
Louisiana	X	X	X	X	X	
Maine	X	X	X			
Maryland	X	X	X		X	
Massachusetts	X	X	X		X	
Michigan	X	X			X	
Minnesota	X	X			X	X
Mississippi	X	X		X		
Missouri	X	X	X	X	[1]X	
Montana	X		[1]X			
Nebraska	X	X	X			
Nevada	X					
New Hampshire	X			X		
New Jersey	X	X	X		X	
New Mexico	X	X	X		X	
New York	X	X	X			
North Carolina	X	X	X	X	[1]X	
North Dakota						
Ohio	X	X		[1]X	[1]X	
Oklahoma	X	X				
Oregon	X	X			X	X
Pennsylvania	X		X			
Rhode Island	X					
South Carolina	X	X		X	X	
South Dakota	X	X			X	
Tennessee	X	X	X	X		
Texas		X	X	X	X	
Utah	X	X	X	X		
Vermont	X	X		X	X	X
Virginia	X	X		X	X	X
Washington	X	X			X	X
West Virginia	X	X		X	X	X
Wisconsin	X	X	X		[1]X	X
Wyoming	X	X	[1]X			

[1]Future implementation date.

NOTE: OBRA is Omnibus Budget Reconciliation Act.

SOURCE: (National Governors' Association, July 1990.)

various outreach efforts (telephone operators ask clients, "how did you hear of this program?") and in diagnosing which areas of a State seem to be exhibiting the most interest or greatest need.

Initiating case-finding programs

It is often argued that public education campaigns are most successful in facilitating access for women already inclined to seek care, or improving the chances that women already in care will receive earlier or more

frequent care. However, some believe that such outreach does not succeed in reaching those women most in need—women in remote, rural areas, those living in extreme poverty in inner-city ghettos, or women suffering from serious problems such as drug or alcohol dependence. For such groups, more targeted, door-to-door case-finding strategies have been employed in the past.

Such grassroot efforts also have their detractors. They are labor intensive, requiring extensive use of staff. They are, therefore, expensive and call into question cost effectiveness. Data are typically scarce as to how successful such programs are in bringing clients into care who would not have accessed it otherwise.

Still, a small number of States have explored this form of outreach. Using either time-limited foundation support or ongoing administrative funding, programs have typically utilized indigenous community members and/or former welfare recipients to seek out peers in need of prenatal care.

Developing statewide community networks

More targeted than general public information campaigns, but broader and more efficient than door-to-door efforts, is an intermediate strategy that may combine the best of both. The development of a comprehensive network of community organizations that can act both to disseminate information on available State services on behalf of the State, and serve as a referral link between needy women in the community and the State Medicaid program is a strategy that has been adopted by many States in the aftermath of OBRA 1986 expansions. Through a careful identification of community organizations that may, in some capacity, come in contact with low-income pregnant women, States have been able to distribute program information and materials and enlist the cooperative assistance of these groups to act as both mouthpiece and referral point for the State.

Increasing provider participation

Just as States have begun extending Medicaid coverage to thousands of newly eligible pregnant women, they also confront an ironic and potentially crippling crisis—a severe shortage of obstetrical providers participating in Medicaid. A critical question has emerged regarding the potential success of program expansions: What purpose is served by providing new insurance to low-income pregnant women if they are unable to find providers willing to serve them?

Assuring adequate provider participation has been a perennial concern for Medicaid and other public programs for pregnant women and children. Over the years, low provider fees, programmatic complexity, and problems with Medicaid clients have been the principal explanations offered for poor provider participation. Today, new factors—especially the rising cost of malpractice insurance and fear of malpractice suits—are cited as major causes of declining participation among providers of prenatal and delivery services. A survey of State Medicaid and MCH agencies conducted in 1988 revealed that 89 percent of MCH programs and 63 percent of Medicaid programs were experiencing significant problems in provider participation for maternity care and, in turn, believed that access for pregnant women was being compromised (Lewis-Idema, 1988).

As described in the NGA report, *Increasing Provider Participation*, States have increasingly attempted to address these problems through widely ranging strategies, including:

- Raising obstetrical fees.
- Simplifying billing procedures.
- Utilizing alternative providers.
- Engaging in provider recruitment and retention efforts.
- Limiting the effect of malpractice costs and liability.

Enhancing reimbursement

Public programs like Medicaid generally have paid providers at rates below the prevailing community charge for private patients. Data from the NGA report for 36 States indicate that in 1986, the median State Medicaid program paid providers about 44 percent of the approximate community charge for total obstetrical care. To help offset this shortfall, nearly one-half the States have raised provider fees in the last several years—21 since 1987. Six more States currently have proposals before their State legislatures to increase rates. Some States believe that these increases will improve participation, while others are less optimistic, believing instead that increases may only stabilize current participation.

A growing trend aimed at making the system more attractive to providers is the alteration of fee structures. Although "global" obstetrical fees still predominate, some States are making it easier for physicians to shift from global to fee-for-service billing if the patient is seen for only part of a pregnancy. Others are expanding the scope of services for which bills can be submitted, differentiating fee schedules for physicians serving women who are high risk, providing extra payments to physicians serving a disproportionate share of Medicaid clients, and paying incentives to providers rendering care in underserved areas.

Simplifying billing procedures

An ongoing complaint among physicians participating in Medicaid involves the complexity and inefficiency of State claims submission and payment procedures. Given already low fees, the additional burden and inconvenience caused by an inflexible system through which these fees are reimbursed becomes a further disincentive to participate. Nearly one-fifth of the States report efforts to simplify and improve billing procedures, including designing more efficient and logical claims editing systems that provide for more prompt payment, special training seminars for providers' staffs on how to fill out Medicaid claims correctly, providing 1-800 numbers for physicians that have billing questions or are having trouble completing a claim, and designating administrative staff who are specifically responsible for overseeing the rapid processing of obstetrical claims.

Using alternative providers

Many States want to expand the use of certified nurse-midwives and nurse practitioners in maternity care programs. More than one-half the States have already implemented such endeavors, either as Medicaid payment policies or in staffing MCH programs. As will be discussed later, over one-half the States have implemented new programs of enhanced prenatal care benefits. Typically, these services are rendered by nonphysician providers, including registered nurses, social workers, nutritionists and dieticians, health educators, and lay health care workers.

Recruiting and retaining providers

Most States have ongoing communications with State medical societies. These allow for the opportunity to recruit obstetrical providers into their programs and provide a forum for providers to express their concerns about participating. Some States have gotten more aggressive in trying to recruit physicians by hiring nursing staff who travel around the State meeting with doctors, explaining new initiatives, and trying to persuade them to join up. Others have designated personnel within the State Medicaid agency to act as provider liaisons who will respond to specific problems and situations. Washington has developed a computer program that informs the Medicaid agency when providers quit participating, thereby allowing the agency to make contact and attempt to resolve whatever problems are being experienced by those providers. That same State is currently devising a system that will notify Medicaid when physicians become licensed to practice, permitting the State to contact these providers and attempt to persuade them to enroll in Medicaid.

Addressing malpractice issues

A limited number of States have attempted to directly address the access problems created by malpractice issues. In two States, Florida and Virginia, new "no-fault" liability coverage for newborn birth-related injuries provides payments through a workers' compensation-type system. Participation is voluntary for both physicians and hospitals, who pay fees to support the compensation fund. Another State, Missouri, has adopted a program that covers malpractice claims made against physicians under contract with local health departments, using the State's general liability fund for its employees. Five more States report that proposals are now being considered by their legislatures that would help cover malpractice claims made against physicians rendering services to indigent pregnant women. In addition to these efforts, a few States, such as North Carolina, are using public funds to assist providers directly with the payment of their malpractice insurance premiums.

Lack of adequate provider participation persists as perhaps the most complex and insoluble problem facing public perinatal programs. The relative success of efforts like those described previously must be watched closely in order to guide future policymaking.

Enhancing prenatal care

Improving the health status of low-income mothers and their children requires more than expanding financial access to care. Significant reduction in America's rates of infant mortality and low birth weight can be achieved only if serious attention also is paid to the content and quality of care rendered to women. When reviewing recent initiatives to reform public perinatal systems, it quickly becomes clear that these facts have not been lost on State policymakers. Indeed, momentum created by State expansions of eligibility up to and above the Federal poverty level has also generated numerous comprehensive reforms of services and service delivery systems for pregnant women. As of July 1990, 35 States have implemented broad new programs of enhanced prenatal care services financed through Medicaid (Figure 2).

As discussed in the NGA reports, *Enhancing the Scope of Prenatal Services* and *Coordinating Prenatal Care,* the primary vehicle used by States to enact these reforms has been authority originally granted by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA contained two provisions that allowed States increased flexibility. One waived traditional comparability rules by permitting States to adopt specialized services for pregnant women without requiring that these services be extended to all Medicaid recipients. The second allowed States to develop targeted case management programs for populations requiring extra assistance in gaining access to needed medical, social, educational, and other services. Many States have determined pregnant women to be such a deserving population.

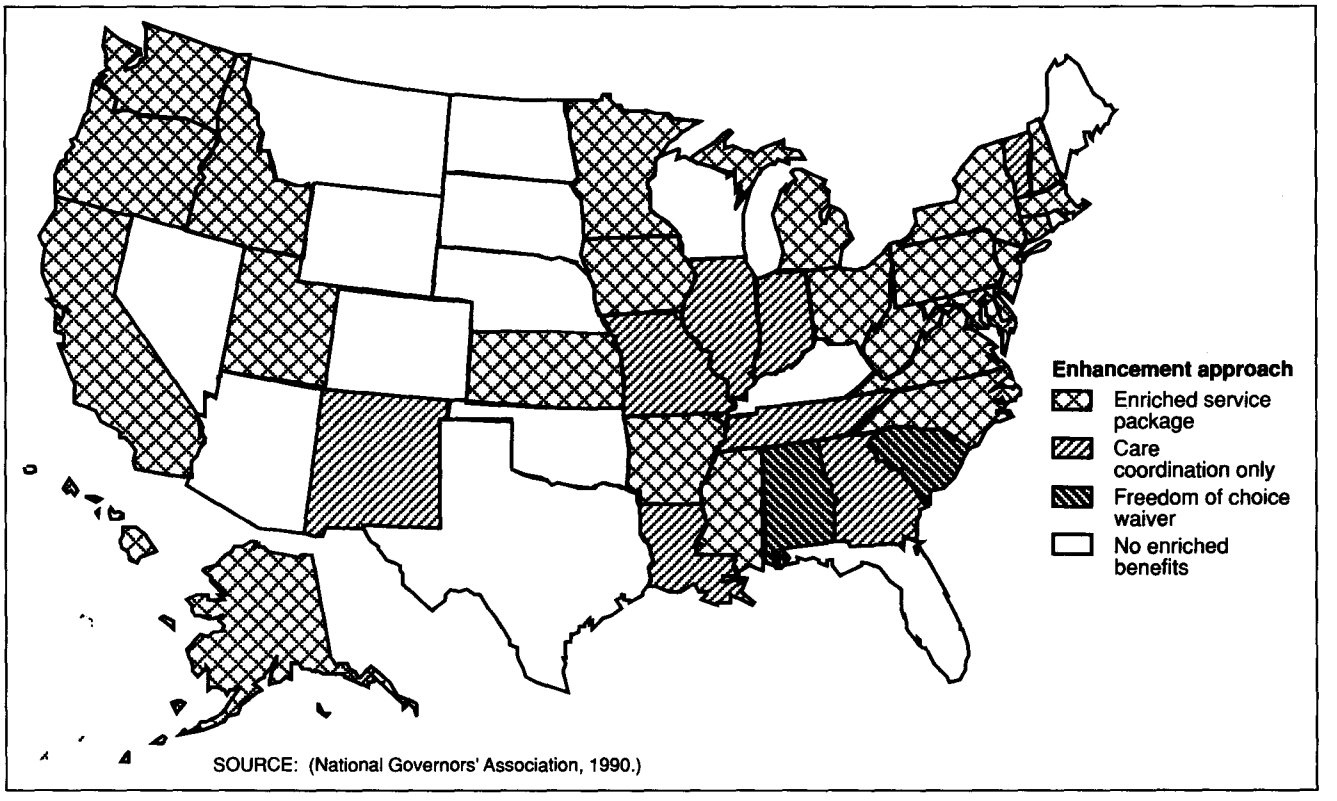
Although a great many policy decisions must be made by States wishing to develop programs of enhanced prenatal care, the most important one is determining which services should be added to the State plan. This process provides States with an ideal opportunity to assess the strengths and weaknesses of their existing public service delivery systems and to creatively design benefits that will better serve the needs of low-income women.

An impressive body of literature has demonstrated that appropriate prenatal care does not consist solely of medical services. Rather, a package of benefits to meet the diverse needs of childbearing women combines nutritional, psychosocial, and educational services, along with routine and specialized medical care. Given the historical orientation of Medicaid programs toward medical care, it is not surprising that most States have recognized that their most pressing need is for broader coverage of nonmedical, supportive, and preventive prenatal services. By working closely with MCH programs, Medicaid programs have typically added a core of new services such as care coordination (or case management), perinatal risk assessment, nutritional counseling, psychosocial counseling, health education, home visiting, and transportation (Table 3).

Care coordination

Nearly every State that has added enhanced prenatal benefits to its Medicaid program (33) has also added the service of care coordination. When asked if they

Figure 2
Medicaid enhanced prenatal benefit programs: July 1990



SOURCE: (National Governors' Association, 1990.)

considered any single new service to be most essential to program success, Medicaid and MCH officials typically identified care coordination as the critical component. This service was referred to as the "glue" holding the perinatal system together. Care coordination services tend to include four core functions: determining the various needs of a client by assessing the risk factors she is experiencing; developing a plan of care to address those needs that are identified; coordinating referrals of the client to appropriate service providers identified by the plan of care; and following up and monitoring to ensure that those services are received. Other innovative activities that have been included in the list of responsibilities of care coordinators include assisting clients with establishing Medicaid eligibility, performing outreach and community education, and assisting families with arranging transportation.

Risk assessment

Thirty States with enhanced prenatal care programs include risk assessment as a new benefit. Risk assessments help identify the various problems being experienced by a recipient and enable providers to plan for and organize the various services she needs. States can also use risk assessments to select those women whom they wish to target for services, e.g., women who are at highest risk of poor birth outcomes. Most States consider multiple medical and psychosocial factors in their risk assessment instruments.

Nutritional counseling

Understanding the crucial need for proper nutrition during pregnancy, 24 States have added enhanced coverage of nutritional counseling and education to their refined Medicaid prenatal services. Although the precise content of nutritional services varies greatly across the 24 States, service protocols generally highlight the relationship between proper nutrition and good health, special dietary needs during pregnancy, instructions for infant feeding (both breast and bottle), and guidance on weight gain and exercise. A few States specify interventions for women at special nutritional risk, such as those with gestational diabetes mellitus, gastrointestinal or renal disease, or metabolic problems. In nearly all cases, States have specifically tried to coordinate enhanced nutritional services with those already being offered and financed under the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Psychosocial counseling

More than one-half of the States with enriched prenatal benefits have included psychosocial counseling as a critical component (18). Maternal and infant health often hinge on stresses that have little to do with traditional medical problems. Many families suffer from inadequate income, unsafe housing, insufficient food, and unreliable transportation. Alcohol or drug use, physical abuse,

Table 3

Medicaid enhanced prenatal care services, by State: July 1990

State	Care coordination/ case management	Risk assessment	Nutritional counseling	Health education	Psychosocial counseling	Home visiting	Transportation
Total	33	30	24	23	18	24	4
Alabama	X	X				X	
Alaska	X	X	X			X	
Arizona							
Arkansas	X	X	X	X	X	X	
California	X	X	X	X	X	[1]X	
Colorado							
Connecticut		X		X		X	
Delaware	X	X	X	X	X	X	
District of Columbia							
Florida							
Georgia	X	X					
Hawaii	[1]X	[1]X	[1]X	[1]X			
Idaho	X		X		X	X	
Illinois	X	X					
Indiana	X						
Iowa	X	X	X	X	X		
Kansas		X	X	X		X	
Kentucky							
Louisiana	X	X					
Maine							
Maryland	X	X	X	X	X	X	
Massachusetts	X	X	X	X	X		
Michigan	X	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	
Mississippi	X	X	X	X	X	X	X
Missouri	X	X					
Montana							
Nebraska							
Nevada							
New Hampshire	X	X	X	X	X	X	
New Jersey	X	X	X	X	X	X	
New Mexico	X						
New York	X	X	X	X	X	X	
North Carolina	X	X		X		X	
North Dakota							
Ohio	X	X	X	X	X	X	
Oklahoma							
Oregon	X	X	X	X		X	
Pennsylvania	X	X	X	X	X	X	
Rhode Island							
South Carolina	X	X	X		X		
South Dakota							
Tennessee	X	X				X	
Texas							
Utah	X	X	X	X	X	X	
Vermont	X					X	X
Virginia	X	X	X	X		X	
Washington	X	X	X	X	X	X	X
West Virginia	X		X	X			
Wisconsin							
Wyoming							

[1]Future implementation date.

SOURCE: (National Governors' Association, July 1990.)

depression, and other social and psychiatric problems also bear attention. Interventions in most States consist of one-on-one counseling to help women deal with the challenges facing them during pregnancy.

Health education

Childbearing women need important information regarding the physiology of pregnancy, healthful behaviors during pregnancy, labor and delivery, basic infant care, and parenting. To provide such information, 23 States with enhanced perinatal programs have included

a health education component. Once again, the specific content of the education curriculum varies greatly across States. To supplement teachings on the issues listed above, some States provide guidance on issues such as pregnancy danger signs, risks of smoking and substance abuse, stress management, breathing and relaxation, and family planning. States vary between group and classroom settings and one-on-one models of health education.

Home visiting

Taking their cue from traditional models of public health nursing in this country and many European models for perinatal health service delivery, a growing number of States are developing programs of home visiting (24). Home visiting is seen as a potentially beneficial perinatal strategy that allows providers to better assess patient needs and to more effectively teach healthy behaviors. While some States have focused on visiting programs that assist during the prenatal period, others have developed programs that also emphasize post-partum support.

Transportation

An increasing number of States have tried to bolster their Medicaid programs' ability to improve childbearing women's access to transportation. To address a widespread problem that hinders all facets of perinatal health care delivery, transportation assistance has been folded into the responsibilities of care coordinators in most States. In a smaller number of States, direct financial assistance is extended to clients to cover the costs of buses, taxis, and gasoline.

Conclusion

The rapid progress by States to broaden and enhance Medicaid programs for pregnant women and children is very encouraging. A review of the widely ranging State initiatives that have been undertaken since 1986 attests to the fact that States understand that eligibility expansions, by themselves, are not enough. In addition to raising income eligibility thresholds up to and above the poverty level, a majority of States have also made their eligibility systems simpler and more responsive, have developed more attractive and multi-faceted outreach programs, have attempted to recruit greater numbers of obstetrical care providers into Medicaid, and have added exciting new benefits to their State plan in order to make their Medicaid programs' coverage of prenatal services more comprehensive and effective.

Adding programs to cover enhanced prenatal care services in particular may also result in an increased willingness of providers to serve Medicaid recipients. A number of States are trying to capitalize on the potential of these initiatives to also market their programs more positively to obstetricians and family practitioners. If these providers can be persuaded that coverage of comprehensive, nonmedical benefits can improve birth outcomes, then perhaps some of their fears of exposure to malpractice liability resulting from an adverse outcome can also be alleviated. In many States, care coordinators in the community are actively seeking out private providers and discussing with them the goals of Medicaid care coordination and enhanced prenatal benefit programs. Through these discussions, they hope to build new partnerships under which physicians agree to be the primary care providers and to deliver babies, and public health systems agree to provide care coordination and other support services designed to reduce the risk of adverse outcomes.

Although State perinatal reforms are promising, they do not permit public policymakers to assume that the health status of this country's mothers and children will improve. A critical transition period must first occur, so that initiatives are provided an opportunity to be fully and properly implemented, before impact can be assessed. Formal evaluations of program effects are being undertaken by many States, yet in most cases it is too early for meaningful results to be measured. Furthermore, the need for additional reforms to address the problems of other populations—namely, the primary and preventive care needs of children and the development of services for substance-abusing pregnant women and substance-exposed infants and children—must continue.

In spite of these remaining challenges, the sophistication and innovation being demonstrated through State initiatives provide cause for optimism regarding the future health of the Nation's mothers and children.

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