

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID EXPANSIONS FOR  
PRENATAL CARE: STATE AND LOCAL  
IMPLEMENTATION**



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# EXECUTIVE SUMMARY

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## PURPOSE

This inspection describes State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care and to overcome barriers to accessibility and availability of prenatal care.

## BACKGROUND

Aimed at reducing the incidence of infant mortality and low birthweight, Federal legislation allows more women to meet the income criteria for Medicaid-covered prenatal care. States are now mandated to set income eligibility at 133 percent of the Federal poverty level, guarantee continuous eligibility until 60 days post partum, extend the presumptive eligibility period up to 60 days for States choosing this option, use special pregnancy-related application forms, use application sites other than where Aid to Families with Dependent Children applications are processed, and eliminate paternity establishment as a precondition to receive Medicaid-covered prenatal care. Additional Federal options allow States flexibility to set an income standard up to 185 percent of the Federal poverty level, use of presumptive eligibility to provide temporary ambulatory care while formal Medicaid determinations are being made, and to disregard assets when making eligibility determinations.

## METHODOLOGY

We conducted site visits in 19 communities within eight states (Alabama, Arkansas, Colorado, Florida, Maryland, New Jersey, New Hampshire, and Pennsylvania). Providers, eligibility supervisors and workers, and prenatal clients were interviewed and a number of implementation issues were identified. We also conducted a national telephone survey of 51 State and District of Columbia officials responsible for implementing the eligibility expansions. Along with self-reported information, we analyzed applicable Federal and State laws, policies and procedures, plus reviewed outreach materials and application forms.

## FINDINGS

*(All findings are based on information as of January 1991)*

- ▶ **All States Have Set Their Income Standard at 133 Percent of the Federal Poverty Level. In Addition, Many Others Have Endorsed Optional Eligibility Expansions.**
  - 46 States waive the asset/resource test.

- ▶ **Some States Are Taking Positive Steps to Address Problems with Access and Availability of Medicaid-Covered Prenatal Care.**
  - Comprehensive client outreach materials
  - Streamlined and simplified application processes
  - Provider participation incentives
  - Alternative health care providers
  - Case managers and enhanced prenatal care packages
  - Integrated data collection
- ▶ **Potential Cost Reductions Will Exceed \$97 Million if Neonatal Intensive Care Is Reduced by Just 1 Percent.**

## RECOMMENDATIONS

- ▶ *Develop A Comprehensive Outreach Strategy.*
- ▶ *Simplify and Streamline the Application Process.*
- ▶ *Develop Incentives to Increase Provider Participation.*
- ▶ *Clarify Policy and Monitor Implementation of Medicaid Expansions.*
- ▶ *Develop Data Collection Systems and Evaluation Processes to Measure Progress of the Eligibility Expansions and Future Program Effects.*
- ▶ *Establish a Centralized Authority with Full Responsibility for Implementing the Expansions.*

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# INTRODUCTION

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## **PURPOSE**

This inspection describes State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care and to overcome barriers to accessibility and availability of prenatal care.

## **BACKGROUND**

Congressional concern about the health status of pregnant women has led to significant Federal and State Medicaid eligibility expansions in recent years. (See Appendix B.) The impetus for these reforms stems from 1) the United States' poor showing among other nations in regard to infant mortality<sup>1</sup>; 2) concern over the excessive health care costs to maintain low birthweight babies vis-a-vis the low cost of providing prenatal care<sup>2</sup>; 3) growing numbers of low income women who are uninsured for pregnancy-related health care<sup>3</sup>; and 4) unsatisfactory progress in achieving the 1990 Health Objectives for the Nation<sup>4</sup>.

Today, states are Federally mandated to extend pregnancy-related care to women who have incomes up to 133 percent of the Federal poverty level, with an option to use 185 percent of the Federal poverty level. (See Appendix C.) Other Federal mandates affecting this group are:

- ▶ eliminating paternity establishment as a precondition to receive Medicaid-covered prenatal care;
- ▶ guaranteeing continuous eligibility throughout pregnancy until the end of the month in which 60 days postpartum occurs, regardless of income changes;
- ▶ applying at sites other than where Aid to Family with Dependent Children (AFDC) applications are normally processed (effective July 1, 1991);
- ▶ using specific application forms for Medicaid-covered prenatal care (effective July 1, 1991); and
- ▶ extending the time period for presumptive eligibility if a State chooses this option to provide temporary ambulatory care while a formal Medicaid application is being processed (effective July 1, 1991).

States also have the option to waive an asset test when determining a pregnant woman's income.

5) offering training and technical assistance to states wishing to implement presumptive eligibility, targeted case management, services for pregnant teenagers using EPSDT, additional care to high-risk mothers and infants through freedom-of-choice waivers, as well as other available options.

During 1990, HCFA developed a marketing guide for HCFA Regional Offices to use with State legislative, government, and finance staffs; held three multi-regional/State maternal and infant health conferences; and entered into a contract with the American College of Gynecologists and Obstetricians (ACOG) and the Public Health Service (PHS) to develop guides to promote provider recruitment and retention.

### *Healthy Start*

The Healthy Start program targets 10 project areas with exceptionally high rates of infant mortality. Some of the specific objectives of this initiative are: 1) enrolling more women in prenatal care during their first trimester; 2) decreasing the number of low birthweight babies; and 3) decreasing the infant mortality rate.

### *The Secretary's Task Force on Minority Health*

The Task Force on Minority Health was created to 1) identify and coordinate HHS programs that serve minority populations<sup>5</sup>; 2) address barriers to improved health among minority populations; 3) identify successful models of health interventions in specific minority populations; and 4) recommend actions to increase the number of minorities served by HHS, plus ways to improve the quality of services already delivered to these groups<sup>6</sup>. One of the major areas of Task Force concern is the delivery of services to pregnant women.

### Recent Office of Inspector General (OIG) Reports

A recent management advisory report, "Access to Medicaid-Covered Prenatal Care" (OEI, October 1990), presents preliminary findings regarding barriers to State and local implementation of Medicaid prenatal care expansions. Effective techniques used by states to implement these expansions were also highlighted. Another study assessed the implementation of the Comprehensive Perinatal Care Program (CPCP), an initiative of the PHS (OEI, May 1990). The OIG recommended that the PHS reexamine its method of allocating CPCP funds to assure community and migrant health centers in areas with high infant mortality rates receive this support. Finally, another study examined a local program to reduce infant mortality. Findings indicated that successful implementation strategies should include targeting client outreach, conducting risk assessments, ensuring adequate clinical services, and fostering indigenous community leadership (OEI, July 1989).

# FINDINGS

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The following findings are based on information as of January 1991.

- ▶ **ALL STATES HAVE SET THEIR INCOME STANDARD AT 133 PERCENT OF THE FEDERAL POVERTY LEVEL. IN ADDITION, MANY OTHERS HAVE ENDORSED OPTIONAL ELIGIBILITY EXPANSIONS.**

*An Overwhelming Majority of States Have Waived the Asset/Resource Test and Are Guaranteeing Continuous Eligibility.*

Forty-six States have waived the asset/resource test and 45 States guarantee continuous eligibility until the end of the month in which 60 days postpartum occurs. (Since the time of our data collection, States are now mandated to continue benefits until the end of the month in which 60 days postpartum occurs.)

*Twenty-four States Voluntarily Exceed the Mandated Federal Income Standard Used to Determine Eligibility.*

Eighteen States use an income standard up to 185 percent of the Federal poverty level to determine eligibility; one State is using 155 percent of the Federal poverty level; four at 150 percent of the Federal poverty level; and one at 140 percent of the Federal poverty level.

*Twenty-six States Are Using Presumptive Eligibility to Provide Temporary Ambulatory Prenatal Care.* (Over one-third of the States without presumptive eligibility report expedited formal eligibility determinations.)

Appendix E compares States' implementation of the eligibility expansions, as of January 1991. Shown are implementation dates for presumptive eligibility, asset test waiver, continuous eligibility, and Federal income standards used to determine eligibility, plus an indication of States reporting expedited eligibility determinations.

- ▶ **HOWEVER, SIGNIFICANT PROBLEMS PREVENT NEWLY ELIGIBLE WOMEN FROM RECEIVING MEDICAID-COVERED PRENATAL CARE.**

*Client Outreach Is Inadequate.*

Few States have coordinated, ongoing, and targeted client outreach. Although the majority of State respondents (84 percent) report some efforts to heighten awareness of the eligibility expansions, it is neither intensive nor extensive. Most States rely on the "welfare grapevine" (81 percent) as a primary means of

want[ing] to disclose their income"; "[not] really want[ing] prenatal care anyway"; and women "tending to be afraid of anything official."

Lengthy, complex forms<sup>7</sup>. Only 17 States use an application form tailored for Medicaid-covered prenatal care. Formal applications can vary in length from one page to over 30 pages. One respondent from a State using a 34-page application form described it as "somewhat complex."

In several local welfare offices, some women only wanting Medicaid-covered prenatal care felt coerced into applying for additional public assistance programs. Their frustrations are exemplified by such statements as: "*[I] wasn't sure what to fill out because all I wanted was Medicaid for prenatal care. I didn't want Food Stamps or AFDC. I didn't even start filling [the application form] out. I looked through it and said 'E-GADS';*" or "*We knew we weren't going to need this [Medicaid-covered prenatal care] once my husband had a job. The social worker at social services kept pushing us to sign up for other programs and all we wanted was [Medicaid-covered prenatal care]. All this pushing made me not want to go back; they didn't seem to understand all we wanted was [Medicaid-covered prenatal care].*"

Multiple application sites and appointments. During our local visits, 87 percent of the presumptively eligible women reported changing sites to reapply for continued Medicaid-covered prenatal care, with 91 percent of this group going to a local welfare agency. In most cases, these women were not able to complete this task on the same day they were determined presumptively eligible. Before an interview with a formal application intake worker, they either made an appointment and returned another day or first attended an orientation.

As pointed out by one State respondent, "*Appointments for formal application are set arbitrarily and the women do not get to choose their appointment time.*" This additional step is especially burdensome for working women and parents who must rearrange their work schedules. Over half of 92 local supervisors, eligibility workers, and providers confirmed this delay as a problem for women seeking prenatal care. Even though most local sample States (6 out of 8) report outstationing eligibility workers in places where women are more likely to seek prenatal care, we did not observe its widespread use. The majority of eligibility workers (31 out of 41) and supervisors (9 out of 15) confirmed this finding. Also, while over half of the State respondents report outstationing eligibility workers, it is usually at selected sites.

"Welfare stigma." Closely associated with requiring women to go to the local welfare office to formally apply for Medicaid-covered prenatal care is the fear of being thought of as a welfare recipient. Such comments by State respondents as, "*The welfare stigma is a big problem. Underemployed, intact families don't want*

concern is expressed in such statements as: "*OB's are setting quotas on the number of Medicaid clients they will accept*"; "*[we have] less than a 25 percent physician participation rate [in our State]*"; and "*Doctors claim they have plenty of paying customers so they don't need Medicaid patients.*"

Several State respondents think providers' attitudes toward "welfare women" limit their acceptance of Medicaid patients. They believe providers view women as entering prenatal care later in their pregnancy than non-welfare patients, not being as cooperative, and not keeping their appointments as well.

Some providers have problems with presumptive eligibility. Eight of the 26 State respondents from presumptive eligibility States report problems with some providers not making presumptive eligibility determinations; 10 of these 26 say some providers are not willing to accept presumptive eligibility cards.

During the site visits, we found that restricting presumptive eligibility coverage to ambulatory care was a problem in some instances. If the need arises for hospital inpatient care (for such complications as miscarriage, premature delivery, or an ultrasound), a presumptively eligible woman is not covered. As pointed out by one provider affected by this situation and who no longer accepts presumptively eligible women, "*Most providers feel morally obligated to offer the full-range of services for women once they are in [his/her] care. My first three presumptively eligible patients all had to be admitted to the hospital: one delivered, one needed a D & C [dilation and curettage]; and one miscarried.*"

Limited access to eligibility verification systems hampers provider participation and creates billing problems. Although 92 percent of the States have an automated verification system, only 53 percent allow provider access. One-third of the States report this is a problem for providers. Also, restricting provider access increases the likelihood of billing errors, especially for services rendered during the presumptive eligibility period.

Reimbursement rates are low and reimbursement turnaround is slow. Eighty-two percent of State respondents say low reimbursement rates contribute to provider dissatisfaction; over 50 percent say slow turnaround for reimbursements is also a disincentive.

Liability issues hinder participation. Sixty-nine percent of the State respondents think providers don't participate in Medicaid-covered prenatal care because of the high cost of liability insurance. Also, 61 percent of the State officials say providers' perception that Medicaid clients are more likely to sue makes it difficult to recruit providers.

eligibility incorrectly so that "*workers must identify rejected cases and redetermine eligibility.*"

Despite these complaints about slow policy communication and lack of training, 80 percent of the State respondents do find HCFA helpful in providing technical assistance. Also, when policy guidance is issued, 71 percent of State respondents report it is usually clearly written.

However, when asked how HCFA could be even more helpful, the State officials request clearer and less complicated policy statements; pre-printed State Plan amendments; and, as one administrator indicated, "*HCFA should coordinate the sharing of information among States.*"

► **HCFA AND MOST STATES CANNOT MEASURE THE PROGRESS AND IMPACT OF THE EXPANSIONS.**

*State-Reported Data on Program Participation Appears Incomplete and of Questionable Accuracy.*

Respondents from 22 States could not or did not estimate the number of new eligibles served, or to be served, in 1990 and/or 1991. (See Appendix G.) Only 17 State representatives could report the total number of formal applications made by new eligibles for any (or all) of the past four years. Additionally, 10 of the 26 respondents from presumptive eligibility States do not keep data on the number of women currently presumptively eligible. Also, just 11 representatives from presumptive eligibility States submitted the number of presumptively eligible women who were subsequently denied formal eligibility.

Along with some of the State respondents, we question the accuracy of this incomplete program participation data. A cursory examination of Appendix G raises several concerns about the validity of the provided data.

- Several of the States with large populations do not report data, and in other States some of the estimates do not seem to be consistent with the size of their Medicaid populations.
- We are concerned that the reported increases in non-AFDC women may include not only new eligibles but also significant numbers of AFDC-eligible women who are being enrolled more rapidly under the new, less restrictive eligibility requirements. This concern was supported by the four State representatives who submitted data on the number of new eligibles who later qualified for AFDC. For example, in one State over two-thirds of the new

postpartum care (Ginsburg, Lewis-Idema, and Pettigrew 1989), it is not surprising they cannot report this information. Even when they can, only 16 State respondents could identify the agency collecting the number of prenatal visits.

Only 20 State representatives claim they can provide information about the trimester a newly eligible woman enrolls in prenatal care. Of these, only three States actually submitted this requested data. Also, almost one-fourth of the State respondents say they do not capture race/ethnicity for the new eligibles. (See Appendix F.)

Local sites also reflect problems with collecting data. Almost two-thirds of 51 local supervisors and providers do not have access to completely computerized data collection systems. Even when they do, new eligibles are not usually distinguished from AFDC-eligible pregnant women.

► **SOME STATES ARE TAKING POSITIVE STEPS TO ADDRESS PROBLEMS OF ACCESS AND AVAILABILITY OF MEDICAID-COVERED PRENATAL CARE.<sup>12</sup>**

*Several States Have Developed Comprehensive Client Outreach Materials.*

Unique logos are being used to heighten awareness of the benefits of receiving early and continuous prenatal care. Distinctive logos used to identify a State's outreach campaign are "HealthStart" (New Jersey), "Healthy Start" (Ohio, Wisconsin, and Massachusetts), "Baby Your Baby" (Utah); "MICHcare" (Michigan); and "Baby Care" (Colorado). These themes are found throughout all their outreach materials.

Materials describe the benefits and availability of prenatal care. In a Massachusetts' "Healthy Start" brochure, Medicaid-covered prenatal care service is not referred to as a welfare program but rather as a way to receive health insurance for pregnancy-related care. It also lists a toll-free telephone number so pregnant women can locate a doctor or nurse-midwife and provides information about food assistance programs and other community resources.

Current income eligibility levels are clearly stated in brochures developed by Michigan. From this information, a woman can quickly see if she meets the income and family-size qualifications used to determine eligibility for Medicaid-covered prenatal care. Documentation required at the time of application and available enhanced services (transportation to provider sites and educational classes) are also listed. A separate two-sided leaflet describes Michigan's 24-hour prenatal care telephone line which provides information about service benefits and availability, as well as information on WIC.

Arkansas and Louisiana to simplify the application process; however, the women are still required to change application sites.

Some States are expediting formal eligibility determinations once all the required documentation is received. Over one-third of the States report expedited formal determinations, with Alaska and Oregon reporting five day processing times. Other States claiming to expedite formal determinations are Virginia (10 days), Vermont (10 days), West Virginia (13 days), Arizona (14 days), Minnesota (15 days), and Washington (15 days).

Eligibility workers are being outstationed by some States. Some of the alternative sites that States are using to outstation eligibility workers include: high-volume hospitals (Florida, Louisiana, Mississippi, Missouri, North Carolina, Texas, and the District of Columbia); perinatal clinics (California); and WIC sites and health offices (Vermont). This approach puts eligibility workers in locations where pregnant women are most likely to seek prenatal care and, also, separates the application site from the welfare office, thus helping diffuse the "welfare stigma."

*Some States Offer Provider Incentives to Increase Participation.*

Special efforts are being made to recruit providers. Currently, 75 percent of the States report efforts to encourage new providers to accept women eligible for Medicaid-covered prenatal care. Many States are conducting educational training to dispel negative provider attitudes toward "welfare" women. States are meeting with medical societies and physician groups, forming task groups and conducting provider surveys to identify barriers to provider participation.

Connecticut has provider-relation representatives to assist with problems encountered with Medicaid patients; Minnesota has hired a staff person designated to handle provider problems. Maryland and Texas use nurses to recruit providers. Michigan has billing representatives who help doctors file Medicaid claims.

Some States have increased reimbursement rates and provide assistance with liability protection. The state of Washington allows higher reimbursement rates for primary care clinics located in distressed areas. Louisiana reimburses at 90 percent of private insurance rates. Maine offers \$5000 - \$10,000 supplements toward medical insurance if obstetricians and gynecologists agree to practice in areas where there are provider shortages. A state legal defense fund to help with malpractice litigation has been established in Missouri. Florida extends sovereign immunity (legal protection) to providers of Medicaid services.

► **POTENTIAL COST REDUCTIONS WILL EXCEED \$97 MILLION IF NEONATAL INTENSIVE CARE IS REDUCED BY JUST 1 PERCENT.**

The link between infant mortality, low birthweight, and lack of adequate prenatal care has been well-documented (Children’s Defense Fund 1989; Committee on Government Operations 1988; GAO 1987). A woman who does not receive early and continuous prenatal care triples her risk of delivering a low birthweight baby (GAO 1987). Among low birthweight babies, about half require expensive neonatal intensive care, costing from \$12,000 to \$150,000 per child (Office of Technology Assessment 1987). Unfortunately, low birthweight babies are 40 times more likely to die during their first week of life (GAO 1987). Even if low birthweight babies survive, they are at significantly increased risk of suffering lifelong physical or mental disabilities.

*Low Birthweight Babies Are Very Costly.*

Low birthweight babies account for a very disproportionate share of the costs of maternity care paid for by Medicaid. As shown in Figure 1, the Alan Guttmacher Institute (Torres and Kenney 1989; Kenney, Torres, Dittes, and Macias 1986) has estimated that six percent of all Medicaid-subsidized deliveries require expensive neonatal intensive care which comprise fully 30 percent of Medicaid maternity care costs. The average cost of neonatal intensive care is \$15,814, as contrasted with a normal birthweight delivery which costs \$2,948.

Figure 2

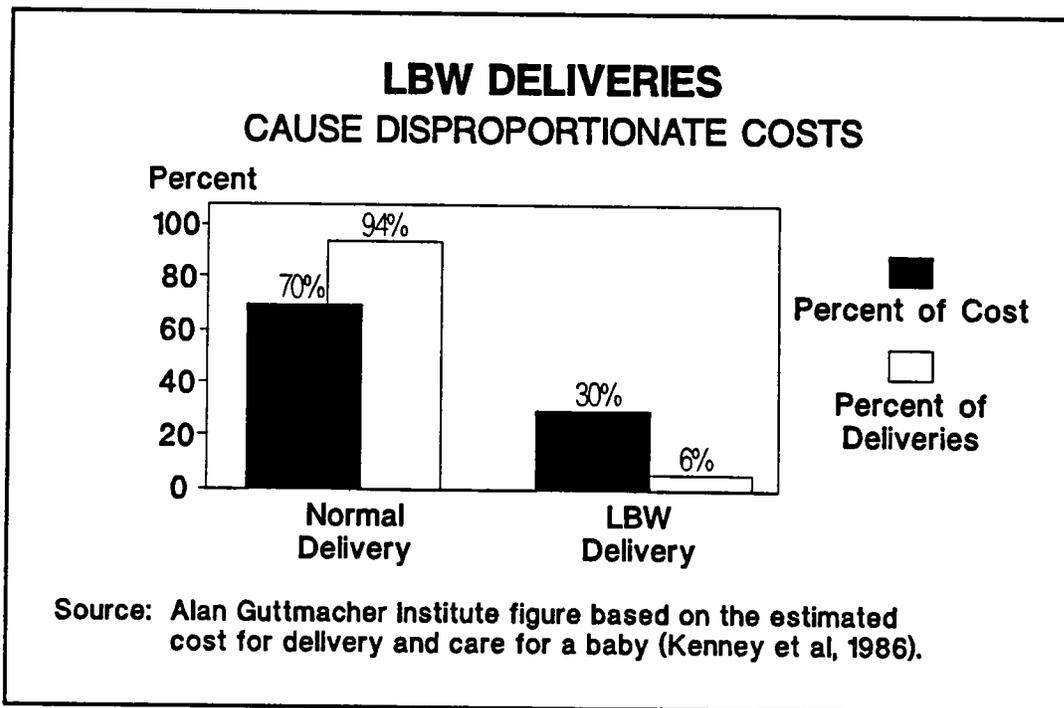
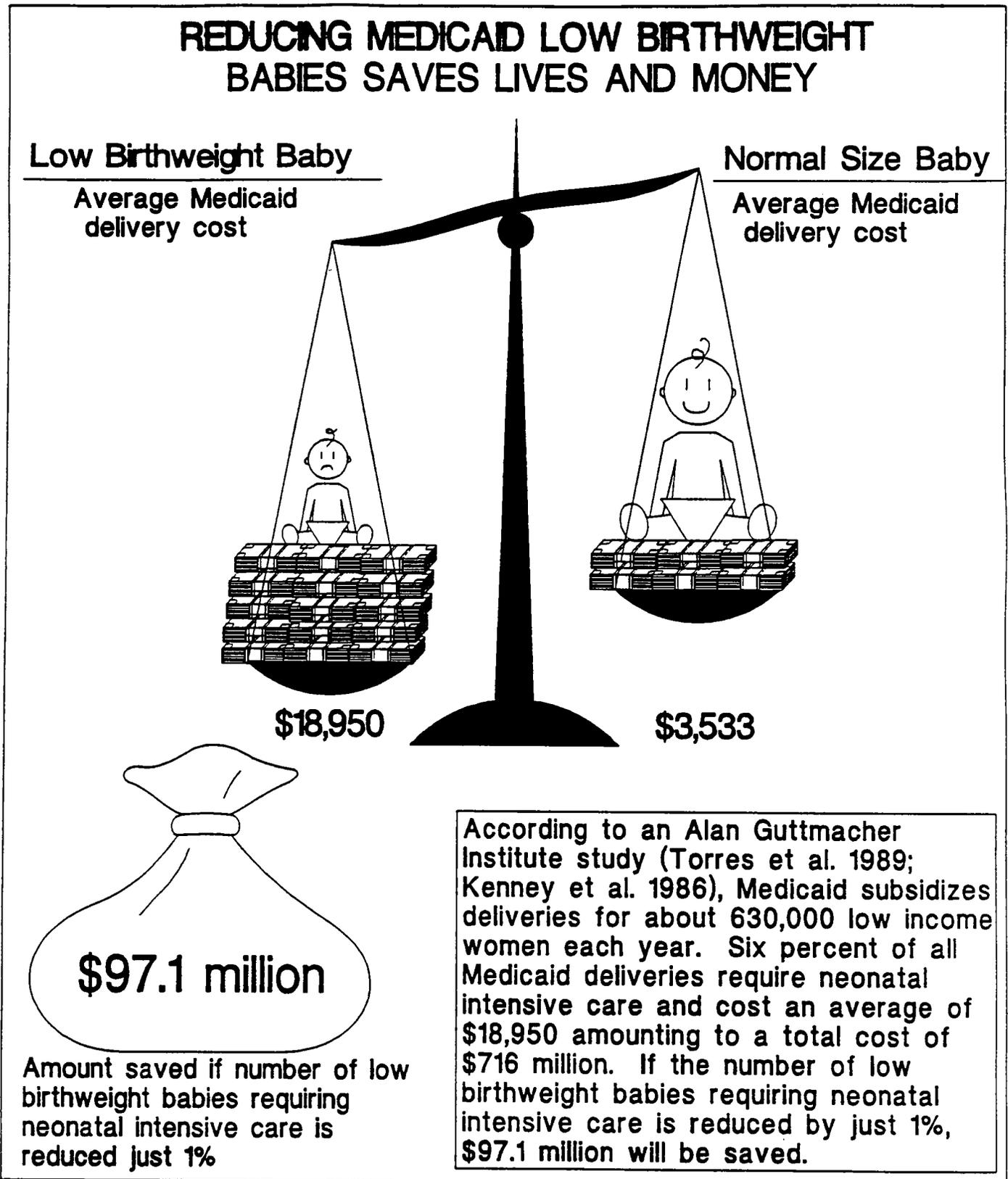


Figure 2



testing, and even grocery stores, laundromats, and shopping centers to locate new eligibles.

- Use community residents, women who have received Medicaid-covered prenatal care and AFDC recipients in the Federal Jobs Opportunity and Basic Skills (JOBS) program as outreach workers.

► **HCFA could:**

- Collaborate with the National Center for Education in Maternal and Child Health, supported by PHS, to serve as a repository and distribution center for State and nationally-developed Medicaid-covered prenatal care outreach materials. The HCFA central office, coordinating with regional HCFA and PHS staff, would need to periodically identify, collect, and issue a compendium of information to the National Center. State Medicaid and Maternal and Child Health directors would need to be notified of available materials and subsequent updates.
- Clarify that matching Federal funds are available to assist with State efforts to conduct client outreach.<sup>13</sup>
- Coordinate outreach efforts with the Healthy Start National Public Information Campaign. Such efforts should stress the benefits of Medicaid-covered prenatal care as preventive health care rather than welfare-related assistance.

► **States could:**

- Create a unique and readily identifiable theme and "logo" for the prenatal care campaign.
- Establish a statewide toll-free hotline, coordinated with existing MCH hotlines, to provide information about access and availability of Medicaid-covered prenatal care.

**2. Simplify and Streamline the Application Process.**

► **HCFA should:**

- Ensure, in reviewing and approving State Plans, that States comply with the requirements to:
  - Use outreach locations other than welfare offices to accept and begin processing applications for Medicaid-covered prenatal care.

- Provide sufficient reimbursement to ensure adequate numbers of providers are available to deliver Medicaid-covered prenatal care.
  - Specify the noninstitutional obstetrical payment rates in Medicaid State Plan amendments.
  - Provide payment for services rendered by certified nurse practitioners or certified family nurse practitioners if they are authorized under State law to perform those services.
- ▶ **PHS should:**
- Use loan repayment and the National Health Service Corp recruitment programs to increase the number of doctors, nurses, and other health professionals serving pregnant women.
- ▶ **States should:**
- Survey providers to assess how many are both available and willing to deliver Medicaid-covered prenatal care.
  - Set reimbursement rates for Medicaid-covered prenatal care at a level sufficient to ensure that an adequate number of providers are available to deliver this care.
  - Promote expanded use of alternative health care providers to deliver routine Medicaid-covered prenatal care.
  - Assess the feasibility of assisting providers with liability insurance to increase their participation in delivering Medicaid-covered prenatal care.
  - Allow provider access to state eligibility verification systems.
- ▶ **HCFA could:**
- Develop a legislative proposal to guarantee temporary Medicaid coverage until the end of the presumptive eligibility period. This coverage would allay provider apprehensions of having to continue care for women later found ineligible for full Medicaid benefits.
  - Develop a legislative proposal authorizing full Medicaid benefits for pregnancies deemed at high-risk during the presumptive eligibility period.

- Pending the development of such a system to track participation rates, consider using probability samples to estimate the number of newly eligible women enrolled in Medicaid-covered prenatal care.
  - Work with MCH, ACF, State Medicaid directors and State public health officials to develop minimum reporting requirements to measure the effects of the eligibility expansions on improved birth outcomes. Minimal data elements should include: the health status of all participants (substance abuser or medically high-risk pregnancy); demographic information (age, race, marital status, income, family size, educational level, and employment status); trimester enrolled for prenatal care; the number of prenatal care visits completed; birth outcomes (live or dead); and the baby's birthweight. Also, to avoid duplication of effort, HCFA should coordinate with the PHS Interagency Committee on Infant Mortality (ICIM), Data and Surveillance subgroup in its development of a Federal maternal and infant health data strategy.
- ▶ **States should:**
- Develop either a centralized data collection system or enter into formal agreements with other agencies to assure access to information needed for evaluating outcomes.
- ▶ **HCFA could:**
- Work with MCH, ACF, State Medicaid directors, State public health officials, and the State Bureaus of Vital Statistics to assess the potential of linking existing databases, e.g., eligibility, medical payments, vital statistics, to measure both participation rates and outcome measures.
  - Plan and seek funding for a multi-year evaluation of the effectiveness of the eligibility expansions on improved birth outcomes. The evaluations should be structured to permit separate analysis of women considered at high risk (substance abusers, medically high-risk, etc.).
- ▶ **States could:**
- Conduct an evaluation of implementation efforts and their subsequent impact on lowering infant mortality rates and the incidence of low birthweight babies. This could be done in conjunction with HCFA and other appropriate agencies.

# ENDNOTES

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1. In 1986, the United States placed eighteenth worldwide for overall infant mortality, behind such nations as Spain, Singapore, and Hong Kong. When considered alone, the black infant mortality rate placed the U.S. twenty-eighth, behind Cuba, Bulgaria, and Czechoslovakia, and tied with Poland, Hungary, Portugal, and Costa Rica (Children's Defense Fund 1989).
2. Children's Defense Fund (1989) projects that between 1989 and the year 2000, approximately \$6 billion will be spent in first-year costs alone to care for low birthweight infants whose mothers receive inadequate care during pregnancy.
3. In 1985, one out of four women of childbearing age had either no insurance or, if insured, were not covered for maternity care. The uninsured women were almost three times more likely to get delayed prenatal care than women with private health insurance (Children's Defense Fund 1989).
4. Goals directly related to prenatal care, low birthweight, and infant mortality are: 1) reducing the national infant mortality rate to no more than nine deaths per 1,000 live births; 2) reducing infant mortality rates for specific subgroups and regions to no more than 12 deaths per 1,000 live births; 3) reducing the national incidence of low birthweight to no more than five percent of all births; 4) reducing the incidence of low birthweight for specific subgroups and regions to no more than nine percent; 5) enrolling 90 percent of all pregnant women in prenatal care in their first trimester; 6) enrolling virtually all women in a regionalized system of primary, secondary, and tertiary care for prenatal, maternal, and perinatal health services; and 7) ensuring all women have appropriately attended deliveries (Children's Defense Fund 1989).
5. The Minority Health Initiative categorizes Blacks, Hispanics, Asian and Pacific Islanders, and American Indians/Alaskan Natives as the predominate U.S. minority populations.
6. To develop the Minority Health Initiative, an interdepartmental workshop was held to identify and recommend how to improve existing HHS services and how to reach increased numbers of minorities. Representatives from each Operating Division (OPDIV) and Staff Division (STAFFDIV) were members. In addition, key informants from each predominate minority group met for an informal discussion to exchange ideas on how service delivery of HHS programs to minority populations can be improved. A report was submitted to the Secretary on the Minority Health Initiative as an internal HHS document on November 13, 1990.
7. Subsequent to our field work, OBRA-90 mandated use of special application forms for Medicaid-covered prenatal care. Appendix F illustrates some of the problems this new legislation was designed to resolve.
8. Transportation services are available by invoking Section 1902(a)(8) of the Social Security Act which guarantees an individual the opportunity to apply for medical assistance and be helped with reasonable promptness; Section 1902(a)(19) requires that this guarantee be safeguarded and that eligibility for care and services will be provided in a way that is consistent with simplicity of administration and in the best interest of the recipient; and Section 1903(a)(17) provides that Federal matching funds are available for activities deemed necessary for the proper and efficient administration of the State Plan. However, the State must 1) use the least costly mode of transportation and 2) use any other available funding source(s) which provide transportation without charge, e.g., church groups or charitable organizations.

# APPENDICES

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- Appendix A:** Glossary of Terms
- Appendix B:** Significant Legislative Changes
- Appendix C:** 1991 Federal Poverty Guidelines for Pregnant Women
- Appendix D:** Methodology of Local Site Selection
- Appendix E:** Coverage Options for Pregnant Women, as of January 1991
- Appendix F:** Comparison of Select Information on Formal Eligibility Forms, as of January 1991
- Appendix G:** State Reported Statistics--Estimations for 1990, 1991
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# APPENDIX A

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## GLOSSARY OF TERMS

**Aid to Families with Dependent Children (AFDC):** Cash payments to eligible needy families with dependent children to cover costs for food, shelter, clothing, and other items of daily living deemed necessary by each State.

**Ambulatory Care:** Refers to outpatient services.

**Asset/Resource Test Waiver:** Assets and resources, e.g., a car, home, capital gain, gift, or loan (Federal Register, February 20, 1991), are not counted when calculating a woman's income to determine eligibility for Medicaid-covered prenatal care.

**Continuous Eligibility:** Guaranteed coverage for Medicaid services from the time a pregnant woman is formally accepted until the end of the month in which her 60 days post partum occurs.

**Federal Poverty Level:** A simplified version of the Federal Government's statistical poverty threshold used by the Bureau of Census in accordance with Section 673(2) of OBRA-81. The poverty income guidelines are used by the HHS for administrative purposes, i.e., persons are classified as being either above or below a set standard to determine eligibility for public assistance. Effective February 15, 1991, the base-line poverty threshold for a family of one is \$6,620; a family of two, \$8,880; a family of three, \$11,140; a family of four, \$13,400; a family of five, \$15,660; a family of six, \$17,920; a family of seven, \$20,180; a family of eight, \$22,440; and for each additional member above eight, \$2,600 per person. Financial eligibility for Medicaid-covered prenatal care is based on percentage multiples, e.g., 130 percent or 185 percent of the guidelines (Federal Register, February 20, 1991).

**High-Risk or Hard-to-Reach Pregnant Women:** For this study, women who are substance abusers, medically high-risk, teenagers, and women in their mid-thirties or above are included in this category.

**Infant Mortality Rate:** A ratio used to report the number of deaths among infants under one year of age per 1,000 live births.

**Insufficient Prenatal Care:** As defined by the Alan Guttmacher Institute (1987:14), it is "poor or no care and less-than adequate care. Care is considered poor if started in the third trimester, or if there had been only one prenatal visit and gestation was 22-29 weeks, two visits and gestation was 30-31 weeks, three visits and gestation was 32-33 weeks, or four visits and gestation was 34 weeks or longer. Care is considered less than adequate if the first visit did not occur before the second trimester, or if there were only three prenatal visits and gestation was 22-25 weeks, or four visits and gestation was 26-29 weeks, or five visits and gestation was 30-31 weeks, or six visits and gestation was 32-33 weeks, or seven visits and gestation was 34-35 weeks, or eight visits and gestation was 36 weeks or longer."

**Low Birthweight:** Weight at birth that is less than five and one-half pounds.

**Medicaid-Covered Prenatal Care:** A fixed period of time in which a pregnant woman can receive Medicaid services. She is eligible for these services: 1) by virtue of her income and family size (see Appendix C) or 2) by already being an AFDC recipient. Benefits begin from the time a woman is determined formally eligible until the end of the month in which 60 days postpartum occurs. At the end of this time period, if she needs continued Medicaid assistance, she must reapply and meet AFDC eligibility requirements.

# APPENDIX B

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## **SIGNIFICANT LEGISLATIVE CHANGES TO EXPAND ELIGIBILITY FOR MEDICAID-COVERED PRENATAL CARE SERVICES**

Title XIX of the Social Security Act has been amended through the: *(Given the scope of this study, only the effect of expansions on prenatal care are discussed, although changes affect children as well.)*

- Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) of 1982
- Deficit Reduction Act (DEFRA, P.L. 98-369) of 1984
- Consolidated Omnibus Reconciliation Act (COBRA, P.L. 99-272) of 1985
- Omnibus Budget Reconciliation Act (OBRA, P.L.99-509) of 1986
- Omnibus Budget Reconciliation Act (OBRA, P.L.100-203) of 1987
- Medicare Catastrophic Coverage Act (MCCA, P.L.100-360) of 1988.
- Omnibus Budget Reconciliation Act (OBRA, P.L.101-239) of 1989.
- Omnibus Budget Reconciliation Act (OBRA, P.L.101-508) of 1990.

TEFRA-82 allowed States to consider pregnant women as an optional eligibility group under their Medicaid programs. Both DEFRA-84 and COBRA-85 mandated or permitted eligibility expansions for new groups of pregnant women. Mandated eligibility included 1) pregnant women who met Aid to Families with Dependent Children (AFDC) eligibility standards for income and resource requirements; 2) a new definition for a two-member family, i.e., the woman's unborn child could now be considered a member of the household; and 3) an extension of 60 days post partum eligibility to all pregnant women enrolled in an approved Medicaid plan, regardless of eligibility group. Optional eligibility extended flexibility to target pregnant women.

COBRA-85 also allowed State flexibility to modify existing Medicaid service delivery systems (National Governors' Association 1989). As an option, States can use targeted case management without first obtaining a Federal waiver, thus permitting services to pregnant women as a target group. This change lets States offer enhanced prenatal care benefit packages to pregnant women without having to offer the same services to other groups of Medicaid recipients.

Through OBRA-86, States were given the option to raise the Medicaid income standard to 100 percent of the Federal poverty level and to waive an asset test when calculating a woman's income to determine her eligibility. For States not waiving the asset test, the test used could be the same as or more liberal than the one under the cash assistance programs. Additionally, States were given the option to guarantee continuous eligibility throughout pregnancy until 60 days post partum, regardless of income changes. It also authorized a period of presumptive eligibility in which a pregnant woman can receive ambulatory care before being formally accepted for Medicaid. Determination is based solely on income and pregnancy verification.

OBRA-87 gave States further options to cover all pregnant women with family incomes under 185 percent of the Federal poverty level, as well as to impose premiums on the eligibility of a pregnant women whose family income fell between 150 and 185 percent of the Federal poverty level. MCCA-88 mandated the income standard be set at 100 percent of the Federal poverty level. It also extended continuous eligibility to all eligible pregnant women who would lose eligibility because of income changes.

OBRA-89 mandated the income standard to be set at 133 percent of the Federal poverty level, with the option to increase it up to 185 percent of the Federal poverty level.

# APPENDIX C

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## 1991 FEDERAL POVERTY INCOME GUIDELINES FOR PREGNANT WOMEN ALL STATES (EXCEPT ALASKA AND HAWAII), PLUS D.C.

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### Mandated: 133 Percent of 1991 Federal Poverty Income Guidelines

Family Size	Annual Income	Monthly
1	\$ 8,804.60	\$ 733.72
2	11,810.40	984.20
3	14,816.20	1,234.68
4	17,822.00	1,485.17
5	20,827.80	1,735.65
6	23,833.60	1,986.13
7	26,839.40	2,236.62
8	29,845.20	2,487.10

For family units with more than 8 members, add \$3,005.80 to annual income for each additional member.

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### Optional: 150 and 185 Percent of 1991 Federal Poverty Income Guidelines

Family Size	150% Annual Income	185% Annual Income
1	\$ 9,930	\$12,247
2	13,320	16,428
3	16,710	20,609
4	20,100	24,790
5	23,490	28,971
6	26,880	33,152
7	30,270	37,333
8	33,660	41,514

For family units with more than 8 members, add \$3390 for 150% and \$4181 for 185% to annual income for each additional member.

*\*Based on income guidelines published in the Federal Register on 2/20/91.*

# APPENDIX D

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## METHODOLOGY OF LOCAL SITE SELECTION

A purposive sample was drawn of eight States representing different combinations of the four Federal options to expand eligibility for Medicaid-covered prenatal care (using 100-185 percent of the Federal poverty level, using presumptive eligibility, guaranteeing continuous eligibility, and dropping the asset test). Selected were Alabama, Arkansas, Florida, Maryland, Pennsylvania, Colorado, New Jersey, and New Hampshire. The first five States have had all four options in place for the longest time; Colorado had recently implemented all these expansions; New Jersey had adopted all options but also had permission from the Health Care Financing Administration to remain at 100 percent of the Federal poverty level until their legislature met in early 1991; and New Hampshire had not yet adopted any optional expansions.

Within each State, we selected a minimum of two counties with the highest volume of Medicaid births and/or the counties identified by the State as having difficulties delivering prenatal care. The 19 counties were Alabama: Autauga, Jefferson, Montgomery, and Shelby; Arkansas: Chicot, Desha, and Phillips; Colorado: Denver and El Paso; Florida: Alachua and Hillsborough; Maryland: Alleghany and Baltimore City; New Jersey: Ocean and Union; New Hampshire: Hillsboro and Sullivan; and Pennsylvania: Delaware and Philadelphia.

Next, we asked the State agency responsible for implementing eligibility expansions for Medicaid-covered prenatal care to identify their counterpart within each county. In turn, these local contacts were asked to identify supervisors and intake workers for both presumptive eligibility and formal intake/determination. The State agency also assisted in identifying one to three health care providers in each county who had seen the most Medicaid-eligible pregnant women in the prior year. Once the providers were selected, we originally asked them to identify and arrange interviews with women who were currently receiving, or had received, Medicaid-covered prenatal care and who fit the description of a new eligible. (See Appendix A.) However, due to provider difficulty in distinguishing new eligibles from AFDC-eligibles, we subsequently asked to contact only women who had accessed Medicaid-covered prenatal care through presumptive eligibility rather than through AFDC (excluding New Hampshire).

As shown in Table 1, we interviewed a total of 233 persons. In addition, we analyzed State and local policies and procedures and examined available outreach materials and application forms.

# APPENDIX E

## COVERAGE OPTIONS FOR PREGNANT WOMEN, AS OF JANUARY 1991

	Presumptive Eligibility	Dropped Asset Test	Continuous Eligibility	Eligibility as a % of Poverty & Date Implemented	
Alabama	7/88	7/88	7/88	133%	4/90
Alaska	*	1/89	1/89	133%	4/90
Arizona	*	1/88	1/88	140%	10/90
Arkansas	4/87	10/88	4/87	133%	4/90
California	No	No	No	185%	7/89
Colorado	1/90	6/90	6/90	133%	4/90
Connecticut	No	1/89	1/89	185%	1/89
Delaware	No	1/88	1/88	133%	4/90
DC	No	4/87	4/87	185%	6/90
Florida	10/87	10/87	10/87	150%	7/90
Georgia	No	1/89	1/89	133%	4/90
Hawaii	1/89	1/89	1/89	185%	1/90
Idaho	1/89	1/89	1/89	133%	4/90
Illinois	5/90	No	4/87	133%	4/90
Indiana	10/88	7/88	7/88	133%	4/90
Iowa	1/90	No	7/89	185%	7/89
Kansas	*	7/88	No	150%	7/89
Kentucky	No	6/89	8/88	185%	7/90
Louisiana	1/89	1/89	1/89	133%	4/90
Maine	10/88	10/88	10/88	185%	10/88
Maryland	7/87	7/87	7/87	185%	7/89
Massachusetts	4/88	7/88	7/88	185%	7/88
Michigan	No	1/88	1/88	185%	10/88
Minnesota	*	7/88	7/88	185%	7/88
Mississippi	No	10/87	10/87	185%	1988
Missouri	7/90	7/90	7/90	133%	7/90
Montana	1/91	7/90	1/91	133%	4/90

(continued on next page)

# APPENDIX F

## COMPARISON OF SELECT INFORMATION FOUND ON FORMAL ELIGIBILITY FORMS, AS OF JANUARY 1991 (PRIOR TO OBRA-90)\*\*\*

	UNIQUE APPLICATION FOR PREGNANT WOMEN	JOINT PE & FORMAL APPLICATION FORM	NOTICE OF REFERRAL FOR OTHER GOVT. PROGRAMS	LENGTH OF FORM	RACE/ETHNIC GROUP
AL			X	5 PG	X
AK		NO PE	X	16 PG	OPT.
AZ		NO PE	X	8 PG	OPT.
AR		X	X	4 PG	X
CA	*	NO PE			
CO	X			1 PG	
CT		NO PE	X	18 PG	OPT
DE		NO PE		5 PG	
DC		NO PE	X	6 PG	X
FL			X	1 PG	
GA	X	NO PE		3 PG	X
HI			X	34 PG	OPT.
ID	*				
IL			X	**	OPT.
IN	X			2 PG	
IA			X	10 PG	
KS		NO PE	X	29 PG	OPT.
KY	X	NO PE	X	4 PG	X
LA	X	X		3 PG	
ME			X	8 PG	
MD	X			5 PG	X
MA	X			3 PG	OPT.
MI	X	NO PE		3 PG	OPT.
MN	X	NO PE	X	2 PG	
MS		NO PE	X	11 PG	X
MO			X	15 PG	X
MT			X	14 PG	OPT.

# APPENDIX G

## State Reported Estimated Numbers and Costs to Serve Non-AFDC Medicaid-Covered Women in 1990, 1991

	Estimated # of Non-AFDC Medicaid-Covered Women		% Change	Estimated Cost to Enroll and Deliver PNC to Non-AFDC Medicaid-Covered Women (Millions)		% Change
	1990	1991		1990	1991	
Alabama •	20,500	20,500	0%	\$35.4	\$38.0	7.3%
Alaska •	2,181	2,390	9.58	\$13.5	\$17.9	32.6
Arizona •	5,784	NR		NR	\$17.2	
Arkansas +	5,000	5,300	6.0	\$10.7	\$11.3	5.6
California +	NR	NR		NR	NR	
Colorado • (1)	3,225	NR		\$5.0	NR	
Connecticut +	NR	NR		NR	NR	
Delaware •	1,824	2,449	34.3	\$3.6	\$7.9	119.0
DC +	350	600	71.4	\$1.5	\$2.8	86.7
Florida +	20,443	29,395	43.8	\$94.7	\$147.8	56.1
Georgia +	18,738	28,542	52.3	\$56.8	\$95.1	67.4
Hawaii +	2,258	NR		\$18.3	NR	
Idaho •	5,361	5,415	1.0	* \$14.1 ** \$3.7	* \$16.8 ** \$4.4	19.0
Illinois +	3,745	5,734	53.0	\$12.9	\$18.2	41.1
Indiana •	12,061	NR		\$18.4	NR	
Iowa +	3,000	4,500	50.0	* \$12.6	* \$18.9	50.0
Kansas + (1)	1,000	4,000	0	\$10.5	\$10.5	0
Kentucky +	8,972	10,400	15.9	\$38.3	\$44.4	15.9
Louisiana +	NR	NR		NR	NR	
Maine +	1,472	1,800	22.3	\$.5	\$.8	60.0
Maryland + (1)	(2) 11,398	13,500	19.4	(3) \$25.8	(3) \$31.9	23.6
Massachusetts +	NR	NR		NR	NR	
Michigan +	9,500	NR		NR	NR	
Minnesota +	11,500	11,500	0	\$2.5	NR	
Mississippi •	19,471	NR		NR	NR	

- (1) These States report they do not collect data on the number of non-AFDC women served, nevertheless, might have submitted estimates.
- (2) Cannot distinguish between women certified presumptively eligible and those women who applied directly to the local welfare office and were certified eligible without being first found presumptively eligible.
- (3) Without Administrative Costs
- (4) Average Monthly # of Women
- (5) Estimates as of 7/90
- (6) Estimates August-May 1990

- \* Includes Federal and State matching funds
- \*\* Only Includes State Portion
- CN Only
- + Both CN & MN

CN = Categorically Needy Individuals receiving Federally-supported financial assistance.  
MN = Medically Needy Individuals who are eligible for medical but not financial assistance.  
NR = States Not Reporting Information

Note: Estimates of participation may include AFDC-eligible women.  
Estimates of cost in some States might have included Federal and State matching funds in their estimates. This table gives baseline estimates.

# APPENDIX H

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# APPENDIX I

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## *SUMMARY OF HCFA'S COMMENTS TO SPECIFIC RECOMMENDATIONS AND OIG'S RESPONSE*

<b>SUMMARY: RECOMMENDATION 1a</b>
-----------------------------------

Develop a comprehensive outreach strategy.

**HCFA should:**

- **Work with PHS, Administration for Children and Families (ACF), State Medicaid Directors, and State MCH officials to develop a minimum set of standards to ensure effective client outreach to heighten awareness of Medicaid-covered prenatal care and to target new eligibles. Such guidelines should provide for:**
  - **Coordinating Medicaid outreach activities with Maternal and Child Health clinics, WIC centers, and community and migrant health centers.**
  - **Conducting ongoing, coordinated State and local ad campaigns.**
  - **Displaying Medicaid benefits and income eligibility requirements for Medicaid-covered prenatal care on media materials.**
  - **Using such locations as churches, housing projects, neighborhood health and recreation centers, provider sites where women go for pregnancy testing, and even grocery stores, laundromats, and shopping centers to locate new eligibles.**
  - **Using community residents, women who have received Medicaid-covered prenatal care and AFDC recipients in the Federal Jobs Opportunity and Basic Skills (JOBS) program as outreach workers.**

**HCFA Comments**

The HCFA **does not concur** with the part of the recommendation to develop a minimum set of standards. Because of the considerable differences among States, and their Medicaid and Maternal and Child Health programs, we believe it is not appropriate to pursue the development of sets of standards for outreach activities. However, we could collaborate with the Public Health Service (PHS), Administration for Children and Families (ACF), State Medicaid Directors, and State Maternal and Child Health (MCH) officials to identify common **elements** of effective targeted and community-wide outreach efforts, and develop guides for State agencies which illustrate those elements in practice.

The report also suggests that HCFA could through a national advertising campaign, stress the benefits of prenatal care. HCFA does not concur with this part of the recommendation. While we endorse such a campaign, we believe that it should be developed and implemented as part of the national public information and education effort for the "Healthy Start" initiative.

**OIG Response**

Collaboration is an excellent way to achieve common goals. If an agreement can be reached with the National Center for Education in Maternal and Child Health to keep an updated file of Medicaid-covered prenatal care materials and distribute them upon request, this approach would encourage State sharing and avoid duplication of effort. The HCFA central office, coordinating with regional HCFA and PHS staff, would need to periodically identify, collect, and issue a compendium of information to the National Center. State Medicaid and Maternal and Child Health officials would need to be kept apprized of available materials and subsequent updates.

As a part of the Healthy Start initiative, a national Healthy Start National Public Information Campaign is being developed in conjunction with the National Ad Council. During a five-year effort, national attention will be given to the benefits of prenatal care. The OIG encourages HCFA to collaborate in the development of the Healthy Start materials.

We revised parts of our recommendation to reflect these changes: (See page 21 for complete text.)

- *Collaborate with the National Center for Education in Maternal and Child Health, supported by PHS, to serve as a repository and distribution center for State and nationally-developed Medicaid-covered prenatal care outreach materials. The HCFA central office, coordinating with regional HCFA and PHS staff, would need to periodically identify, collect, and issue a compendium of information to the National Center. State Medicaid and Maternal and Child Health officials would need to be kept apprized of available materials and subsequent updates.*
- *Coordinate outreach efforts with the Healthy Start National Public Information Campaign. Such efforts should stress the benefits of Medicaid-covered prenatal care as preventive health care rather than welfare-related assistance.*

**SUMMARY: RECOMMENDATION 2a**

**Simplify and streamline the application process.**

**HCFA should:**

- **Ensure, in reviewing and approving State plans, that States comply with the requirements to:**

### **OIG Response**

Along with transportation and less stringent eligibility requirements, the targeted populations need assistance with child care even before they can consider applying. Without child care, many of the women will not be able to access these services. Since HCFA is responsible for Medicaid eligibility and does not presently have a way to handle this situation, the OIG recommends HCFA take the lead and collaborate with PHS and/or ACF to assure child care availability during the application process.

We revised parts of our recommendation to reflect these changes: (See page 22 for complete text.)

- *Promote State efforts to 1) ensure the newly-developed application forms are not lengthy and 2) expedite processing time for formal Medicaid eligibility determinations and/or implement presumptive eligibility.*
- *Collaborate with PHS and ACF to promote state efforts to provide for child care during the application process.*

<b>SUMMARY: RECOMMENDATION 3a</b>
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**Develop incentives to increase provider participation.**

**HCFA should:**

- **Ensure, in reviewing and approving State plans, that States are complying with the requirements to:**
  - **Provide sufficient reimbursement to ensure adequate numbers of providers are available to deliver Medicaid-covered prenatal care.**
  - **Specify the noninstitutional obstetrical payment rates in Medicaid plan amendments.**
  - **Provide payment for services rendered by certified nurse practitioners or certified family nurse practitioners if they are authorized under State law to perform those services.**

### **HCFA Comments and OIG Response**

HCFA concurs with this part of the recommendation, subject to a revision of the opening statement: (See page 23 for complete text.)

- *Continue to ensure, in reviewing and approving State plans, that States are complying with the requirements to:*

#### **SUMMARY: RECOMMENDATION 4**

**Clarify policy and monitor implementation of Medicaid expansions for prenatal care.**

**HCFA should:**

- **Work closely with State Medicaid directors to identify needs for guidance, technical assistance and training and develop action plans to provide them.**
- **Inform States of new legislative options and mandates in a timely manner to allow for prompt implementation.**
- **Conduct local site visits to monitor the implementation of the Medicaid eligibility expansions. For example, have each regional office annually visit a sample of local presumptive eligibility and formal application sites, as well as service delivery sites.**

**HCFA Comments**

HCFA concurs with this recommendation. HCFA addresses these topics on an ongoing basis. These topics are regular agenda items for the Medicaid MCH-Technical Advisory Group. On a quarterly basis, HCFA's regional offices report to central office, the progress of individual States in implementing prenatal care initiatives, and any problems encountered by States in their regions. Also, regarding the local site visits to monitor the implementation of Medicaid eligibility expansions, site visits are a part of the current formal program management review protocols.

#### **SUMMARY: RECOMMENDATION 5**

**Develop data collection systems and evaluation processes to measure progress of the eligibility expansions and future program effects.**

**HCFA should:**

- **Work with State Medicaid and MCH directors to develop minimum reporting requirements to track participation rates. Minimal data elements should include: the number of women who could be eligible to receive Medicaid-covered prenatal care; the number who have been enrolled by various categories, such as AFDC, medically needy, and prenatal care only; the number presumptively eligible; and the attrition rate of women not completing the application process.**
- **Pending the development of such a system to track participation rates, consider using probability samples to estimate the number of newly eligible women enrolled in Medicaid-covered prenatal care.**

points in time. This makes it difficult to separate claims for mothers from those for infants, which, in turn, makes it difficult for HCFA to determine what service use and expenditures were for newborns.

In the second paragraph under this heading, the phrase "difficulty in accessing" does not provide a clear picture of the problem involved. State Medicaid agencies have access to their own Medicaid claims data. The "critical evaluative elements" listed are not necessary to pay claims and, therefore, are not included in these records. This information would be useful, but Medicaid State agencies are not currently required to collect it.

Relying on the linkage of infant birth, death, and Medicaid claims records to produce evaluative results will be frustrating, if not inconclusive. Also, as pointed out by the HCFA comments, the State Medicaid agencies are not currently required to collect the types of information needed to measure outcomes. For these very reasons, OIG urged that steps be taken to ensure the needed data is captured. Also, HCFA's own study, "Medicaid Statistical Abstracts: Results of the State Medicaid Agency Infant Mortality Data Survey: 1989" reports that Medicaid agencies have difficulty accessing critical evaluative elements. This survey was designed to "determine the availability of information related to the health of pregnant women and infants" (Health Care Financing Administration 1990:1).

Therefore, OIG continues to recommend that HCFA assure that critical evaluative elements are collected by the States, either through the Medicaid agency, PHS or Vital Statistics. HCFA should coordinate its efforts with the PHS Interagency Committee on Infant Mortality (ICIM), Data and Surveillance subgroup. This subgroup, under the direction of the Centers for Disease Control, is developing a Federal maternal and infant health data strategy, resulting in a Federal Data and Use Book.

Based on HCFA comments, OIG revised its recommendation. (See page 25 for full text.)

- *Work with MCH, ACF, State Medicaid directors and State public health officials to develop minimum reporting requirements to measure the effects of the eligibility expansions on improved birth outcomes. Minimal data elements should include: the health status of all participants (substance abusers or medically high-risk pregnancy); demographic information (age, race, marital status, income, family size, educational level, and employment status); trimester enrolled for prenatal care; the number of prenatal care visits completed; birth outcomes (live or dead); and baby's birthweight. Also, to avoid duplication of effort, HCFA should coordinate with the PHS Interagency Committee on Infant Mortality (ICIM), Data and Surveillance subgroup in its development of a Federal maternal and infant health data strategy.*

## TECHNICAL COMMENTS

In addition to the comments above, HCFA provided several technical comments which we used to make revisions as appropriate. [The full text of these comments is included in Appendix J.]

# APPENDIX J

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**DEPARTMENTAL COMMENTS:  
HEALTH CARE FINANCING ADMINISTRATION, PUBLIC HEALTH SERVICE,  
ADMINISTRATION FOR CHILDREN AND FAMILIES, AND  
THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION**



IG	✓
PDIG	✓
DIG-AS	
DIG-EI	✓
DIG-OI	✓
AIG-MP	✓
OGC/IG	✓
EX SEC	✓
DATE SENT	9/13

SEP 13 1991

# Memorandum

Date  
 From Gail R. Wilensky, Ph.D. *grw*  
 Administrator

Subject **OIG Draft Inspection: "Medicaid Expansions for Prenatal Care: State and Local Implementation," OEI-06-90-00160**

To **Inspector General  
 Office of the Secretary**

We have reviewed the subject draft inspection which describes State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care and to overcome barriers to accessibility of prenatal care. Mandatory changes in eligibility for pregnant women were addressed in the report. However, the main focus of the report was on the options available to States to increase the accessibility of prenatal care.

The report found that all States have set their income standard for poverty level pregnant women at 133 percent of the Federal Poverty Level (FPL), as required by law. Many States have also adopted some of the optional eligibility expansions, including waiver of the asset/resource test, continuous eligibility, extension of the FPL, and presumptive eligibility. However, a number of factors inhibit access to prenatal care for Medicaid-eligible women.

OIG recommends that HCFA develop a comprehensive outreach strategy, streamline the application process, develop incentives to increase provider participation, clarify policy and monitor implementation of Medicaid expansions for prenatal care, and develop data collection systems and evaluation processes to measure the progress of the eligibility expansions and future program effects. Although HCFA supports the general intent of the report, we cannot concur with the detailed recommendations presented by OIG. Our comments on the recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this report. We believe that the report is a useful critique that we will use as we continue to implement Medicaid's Maternal and Infant Health Initiative. Please advise us if you agree with our position on the report's recommendations at your earliest convenience.

Attachments

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- o Through a national ad campaign, stress the benefits of Medicaid-covered prenatal care as preventive health care instead of welfare-related assistance. Coordinate outreach efforts with the Healthy Start ad campaign.

### HCFA Response

HCFA does not concur with the part of the recommendation to develop a minimum set of standards. Because of the considerable differences among States, and their Medicaid and Maternal and Child Health programs, we believe it is not appropriate to pursue the development of sets of standards for outreach activities. However, we could collaborate with the Public Health Service (PHS), Administration for Children and Families (ACF), State Medicaid Directors, and State Maternal and Child Health (MCH) officials to identify common elements of effective targeted and community-wide outreach efforts, and develop guides for State agencies which illustrate those elements in practice.

HCFA also does not concur with the part of the recommendation to establish a centralized resource center. Given limited staffing and financial resources, we do not believe creating another resource center would be cost-effective. The National Center for Education in Maternal and Child Health, supported by PHS, serves that function. Regional HCFA and PHS staffs could identify innovative outreach materials and practices, and then HCFA's central office could issue a compendium of information through the existing centralized resource center.

OIG's recommendation also includes that HCFA could clarify that matching Federal funds are available to assist with State efforts to conduct client outreach. We concur with this part of the recommendation. HCFA has frequently clarified the availability of matching funds for outreach through memorandums, policy interpretations, and technical assistance directed to both Medicaid and Maternal and Child Health agencies, and we will continue to do so.

The report also suggests that HCFA could through a national advertising campaign, stress the benefits of prenatal care. HCFA does not concur with this part of the recommendation. While we endorse such a campaign, we believe that it should be developed and implemented as part of the national public information and education effort for the "Healthy Start" initiative.

### Recommendation 2

Simplify and streamline the application process.

Recommendation 3

Develop incentives to increase provider participation.

HCFA should:

- o Ensure, in reviewing and approving State plans, that States are complying with the requirements to:
  - Provide sufficient reimbursement to ensure adequate numbers of providers are available to deliver Medicaid-covered prenatal care.
  - Specify the noninstitutional obstetrical payment rates in Medicaid State plan amendments.
  - Provide payment for services rendered by certified nurse practitioners or certified family nurse practitioners if they are authorized under State law to perform those services.

HCFA could:

- o Develop a legislative proposal to guarantee temporary Medicaid coverage until the end of the presumptive eligibility period. This coverage would allay provider apprehensions of having to continue care for women later found ineligible for full Medicaid benefits.
- o Develop a legislative proposal authorizing full Medicaid benefits for pregnancies deemed at high-risk during the presumptive eligibility period.
- o Develop a standard definition of "qualified" provider, designating the minimum number of Medicaid recipients who must be annually served.

HCFA Response

HCFA agrees that provider recruitment and retention should be a priority of the Medicaid initiative. We are currently formulating regulations which implement obstetrical and pediatric payment rate requirements.

HCFA defers comment on the two legislative proposals. All legislative proposals will be considered within the A-19 process within HCFA.

**HCFA should:**

- o Work with State Medicaid and MCH directors to develop minimum reporting requirements to track participation rates. Minimal data elements should include: the number of women who could be eligible to receive Medicaid-covered prenatal care; the number who have been enrolled by various categories, such as AFDC, medically needy, and prenatal care only; the number presumptively eligible; and the attrition rate of women not completing the application process.**
- o Pending the development of such a system to track participation rates, consider using probability samples to estimate the number of newly eligible women enrolled in Medicaid-covered prenatal care.**
- o Work with MCH, ACF, State Medicaid directors and State public health officials to develop minimum reporting requirements to measure the effects of the eligibility expansions on improved birth outcomes. Minimal data elements should include: the health status of all participants (substance abuser or medically high-risk pregnancy); demographic information (age, race, marital status, income, family size, educational level, and employment status); trimester enrolled for prenatal care; the number of prenatal care visits completed; birth outcomes (live or dead); and the baby's birth weight.**

**HCFA could:**

- o Work with MCH, ACF, State Medicaid directors and State public health officials to assess the potential of linking existing databases, e.g., eligibility, medical payments, vital statistics, to measure both participation rates and outcome measures.**
- o Plan and seek funding for a multi-year evaluation of the effectiveness of the eligibility expansions on improved birth outcomes. The evaluations should be structured to permit separate analysis of women considered at high risk (substance abusers, medically high-risk, etc.).**

- o Providing a technical assistance document on using the two model simplified application forms. The first form is under Title V, for use in applying simultaneously under Head Start, Medicaid WIC, MCH, community/migrant/ or homeless health center programs. And, the second form is for use in applying for Medicaid only.

### Technical Comments

Page 2 The report's chart on this page is confusing. A complete briefing on how eligibility groups work is not appropriate in this response to your report; however, we will provide this information to your staff upon request. The first sentence of the last paragraph should be altered to read, "HCFA is continuing to implement a Medicaid Maternal and Infant Health Initiative..." The sentence, as it currently appears, infers that this is a new initiative. Also, within this sentence, the Technical Advisory Group (TAG) is called the Medicaid/MCH TAG. It includes representatives of both Medicaid and Title V agencies.

Page 12 Under the heading, "Further, HCFA and Most States Lack Centralized Data...", one problem that is not addressed is how Medicaid identification (ID) numbers are assigned to newborns. In some States, Medicaid numbers are automatically given to newborns; in other States, only infants with high expenses are given numbers; and, in the remaining States, the ID numbers are assigned to children at varying points in time. This makes it difficult to separate claims for mothers from those for infants, which in turn makes it difficult for HCFA to determine what service use and expenditures were for newborns.

In the second paragraph under this heading, the phrase "difficulty in accessing" does not provide a clear picture of the problems involved. State Medicaid agencies have access to their own Medicaid claims data. The "critically evaluative elements" listed are not necessary to pay claims and, therefore, are not included in these records. This information would be useful, but Medicaid State agencies are not currently required to collect it.

Page 14 Under the incentives offered by different States to encourage prenatal care, we suggest that the coupon books issued by Alabama be included.

Page 18 Based on the figures given by OIG in the chart, number 5 should be \$99,628,200 not \$96,642,000. Also, number 6 should be \$81,055,800 not \$78,069,600.



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Reg 6*

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Memorandum

NOV 21 1991

Date

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Medicaid Expansions for Prenatal Care: State and Local Implementation"

To Inspector General, OS

Attached are the PHS comments on the subject OIG report. The report provides useful information on State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care and to overcome barriers to accessibility and availability of prenatal care.

We concur with the report's recommendation directed to PHS. In our comments, we identify the actions taken or planned to implement this recommendation. In addition, we provide general comments concerning the on-going activities of the PHS Interagency Committee on Infant Mortality that relate directly to the issues addressed in this report.

*James O. Mason*  
James O. Mason, M.D., Dr.P.H.

Attachment

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EX SEC  
DATE SENT

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A model application developed by DHHS and the Department of Agriculture for streamlining applications for child assistance programs has been approved by both Departments and sent to OMB prior to publication in the Federal Register.

PHS also recommends that the OIG report point out the recent work of the National Governors' Association (NGA), in conjunction with HRSA, in the area of Medicaid reforms. Specifically, approximately 2 years ago, under a cooperative agreement with HRSA, NGA prepared reports which indicated that financing reforms alone were not sufficient to solve problems of access to the underserved. HRSA currently has a second cooperative agreement with NGA to examine more recent Medicaid expansions and reforms. Finally, the report might also note that BHCDA provides substantial technical assistance to health centers to help them implement Medicaid reforms.

#### OIG Recommendation

PHS should use loan repayment and the National Health Service Corps (NHSC) recruitment programs to increase the number of doctors, nurses, and other health professionals serving pregnant women.

#### PHS Comments

We concur. The NHSC program currently meets the intent of this recommendation. The NHSC specifically targets community-based systems of care in medically underserved areas for the placement of health professionals who become available through its scholarship program, loan repayment program, and the recruitment of volunteers. A high percentage of the patients seen in these primary health care programs are pregnant women and children.

The mission of the NHSC is to provide health personnel to urban and rural communities and underserved or unserved populations with the greatest need. NHSC's goal is the improvement of access to primary care services in these communities and populations.

Essentially, the NHSC has the mission of eliminating federally designated health professional shortage areas (HPSA) throughout the United States. To this end, the NHSC seeks to provide an adequate supply of primary care and mid-level health professionals to communities, special population groups and public or private non-profit health facilities in HPSAs.

The Nurse Practitioner and Nurse Midwifery Program awarded \$6,059,033 in FY 1990 for 36 projects that support preparation of nurses who are able to serve as nurse midwives, obstetrical and gynecological practitioners, and pediatric practitioners. In all cases, these nurses focus on patient teaching, guidance, counseling and health screening activities.

PHS funds have been used to support traineeships to improve administration and competency of personnel in maternal and child health programs. In FY 1990, \$187,241 was awarded for traineeship support in maternal and child health.

OTHER COMMENTS

Regarding the recommendation directed to HCFA and the States that they develop a comprehensive outreach strategy, caution must be exercised in emphasizing outreach activities. Outreach efforts have to be backed up by adequate system capacity.

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 PDIG ✓  
 DIG-AS ✓  
 DIG-EI ✓  
 DIG-OI ✓  
 AIG-MP ✓  
 OGC/IG ✓  
 EX SEC ✓  
 DATE SENT 10/8

**Memorandum**  
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Date *WAL 10 1991*  
 Richard P. Kusserow  
 From Inspector General

Subject **OIG Draft Report: "Medicaid Expansions for Prenatal Care: State and Local Implementation," OEI-06-90-00160**

To **Martin Gerry -- *Concur ✓***  
 Assistant Secretary for *Jerry Britten for*  
 Planning and Evaluation  
 SEP 25 1991



OFFICE OF INSPECTOR GENERAL  
 RT CBS CBS  
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Attached for your review and comment is a copy of our draft inspection report, "Medicaid Expansions for Prenatal Care: State and Local Implementation."

Our inspection describes State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care and to overcome barriers to accessibility and availability of prenatal care. We found that, as of January 1991, many States have endorsed the optional eligibility expansions. However, significant problems prevent newly eligible women from receiving Medicaid-covered prenatal care: inadequate client outreach, a cumbersome application process, difficulty recruiting prenatal care providers, problems implementing presumptive eligibility, staffing shortages, and the need for more timely information and training from the Health Care Financing Administration (HCFA). Also, data collection is insufficient to measure progress and outcomes, some States are innovatively implementing the expansions, and a 1 percent decrease in neonatal intensive care can potentially reduce Medicaid costs by over \$78 million.

We recommend actions by HCFA, the Public Health Service, and the States to develop a comprehensive outreach strategy, simplify and streamline the application process, develop incentives to increase provider participation, clarify policy and monitor implementation, develop data collection systems and evaluation processes to measure progress and outcomes, and establish a State centralized authority to fully implement the expansions.

We would appreciate receiving your comments on the draft report within 30 days of the date of this memorandum.

If you have any questions or comments about this report, please call me or have your staff contact Maruta Zitans at FTS 269-2678.

Attachment

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