ACCESS TO MEDICAID-COVERED PRENATAL CARE

MANAGEMENT ADVISORY REPORT

OFFICE OF INSPECTOR GENERAL
OFFICE OF EVALUATION AND INSPECTIONS

OCTOBER 1990

OFFICE OF INSPECTOR GENERAL

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This management advisory report (MAR), Access To Medicaid-Covered Prenatal Care, presents preliminary findings regarding: 1) barriers to State and local implementation of optional eligibility expansions for Medicaid-covered prenatal care services and 2) effective techniques to implement these expansions. Two companion reports will be issued addressing more detailed findings from a two-phase study conducted at both State and local levels.

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PURPOSE

This management advisory report (MAR) presents preliminary findings regarding 1) barriers to State and local implementation of optional eligibility expansions for Medicaid-covered prenatal care services and 2) effective techniques to implement these expansions.

BACKGROUND

In the early 1980s, the Congress provided a way for more women to receive temporary assistance with pregnancy-related health care through Medicaid (title XIX of the Social Security Act). This preventative prenatal care was aimed at reducing the incidence of infant mortality and low birthweight babies (LBW).

Catastrophic Costs Related to Inadequate Prenatal Care

LBW babies are three times more likely to be born of women who receive no prenatal care (U.S. General Accounting Office, 1987). Costs to maintain these babies in neonatal intensive care units can range from $12,000 to $150,000 per child (Office of Technology Assessment, 1987).

Closely linked to LBW is infant mortality. In 1985, two-thirds of infant deaths occurring during the first month of life were LBW babies (U.S. GAO, 1987). Those surviving risk long-term physical and mental disabilities. Receipt of insufficient prenatal care[1] is also a contributing factor to infant mortality. Of women receiving insufficient care, infant mortality rates are highest among unmarried women, teenagers, the least educated, blacks, Hispanics, and poor married women (Gold, Kenney, and Singh, 1987).

Of all groups, teens are the least likely to get early prenatal care, thus placing themselves, as well as their babies, at the highest risk of health complications (Children's Defense Fund, 1989). Data from the National Infant Mortality Surveillance project (Centers for Disease Control, 1987) confirms that infants born of teen mothers are more likely to be LBW and more likely to die in the first year of life.

The U. S. Department of Health and Human Services has long contended that three-fourths of associated health risks may be detected during the first prenatal care visit (Committee on Government Operations, 1988). Cost savings from subsequent interventions could greatly reduce expenditures for direct medical care of LBW babies. The Institute of Medicine (1988) calculated that in 1985 for every $1 spent

on insuring adequate prenatal care for low-income, poorly educated women, total expenditures could be reduced by $3.38 from costs accrued during a LBW baby's first year.

Federal Legislative Changes Expand Eligibility

Some of the most sweeping legislative changes in eligibility for Medicaid-covered prenatal care were authorized by the Sixth Omnibus Budget Reconciliation Act (SOBRA-86).[2] It decoupled Medicaid eligibility from Aid to Families with Dependent Children (AFDC), which could promote a new mindset of non-welfare related Medicaid-covered prenatal care. Through this enabling legislation, States were given the option to set eligibility limits up to 185 percent of the Federal poverty level (FPL).

Other State options authorized by SOBRA are:

> Continuous Eligibility--After a pregnant woman's initial eligibility is determined, she is guaranteed Medicaid coverage throughout her pregnancy and 60 days postpartum, regardless of income changes.
>
> Presumptive Eligibility--Based on a cursory review of income, a pregnant woman may be immediately presumed eligible at time of application and may be temporarily covered for ambulatory prenatal care until formally accepted into the program.[3]
>
> Resources (Asset) Test--Resources and assets, e.g., a car, home, and savings, could be disregarded in processing a pregnant woman's application.

As of April 1, 1990, States were mandated to provide Medicaid-covered prenatal care services to women with family incomes up to 133 percent FPL ($13,380 for a family of three).

Other OIG Reports Address Issue of Infant Mortality

In recent OIG reports, two programs aimed at reducing infant mortality were reviewed. One study reported that supplemental funding to areas with high rates of infant mortality are available to community and migrant health centers through the Comprehensive Perinatal Care Program (OEI, May 1990) but that these grants need to be more widely distributed. In another study, a local program to reduce infant mortality was analyzed. 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).

METHODOLOGY

A descriptive analysis of Federal and State eligibility expansions for Medicaid-covered prenatal care services was undertaken in a two-phase study at the State and local level. Phase 1 involved onsite visits in one to two counties per State in eight States. Sample selection depended on whether the county had the highest volume of Medicaid births and/or it was identified by the State as having difficulties with access/delivery of Medicaid-covered prenatal care.

Data collection for Phase 1 was completed in June 1990. Visits were made to Alabama, Arkansas, Florida, Maryland, Pennsylvania, Colorado, New Jersey, and New Hampshire. The first five States represent a sample of those most eagerly endorsing all federally mandated and optional eligibility expansions for Medicaid-covered prenatal care since SOBRA-86. Colorado represents a State most recently implementing all the expansions; New Jersey, a State with all the options but with permission from HCFA to remain at 100% FPL until their legislature meets in 1991; and New Hampshire, a State not yet adopting any optional expansion categories.

A total of 233 persons were surveyed: 15 Medicaid-eligibility supervisors, 44 eligibility intake/determination workers, 36 providers, and 137 women who are either currently receiving or have received Medicaid-covered prenatal care.

Phase 2 involves telephone and mail surveys with key informants in all 50 States plus the District of Columbia. As of this writing, 43 States have been contacted.

PRELIMINARY FINDINGS

The following preliminary findings are based on selected Phase 1 and Phase 2 data.

1. **State Implementation of Optional Authorities for Medicaid-Covered Prenatal Care Services Is Mixed.**

   - Of the 43 States surveyed so far, 40 have waived the asset/resource test; 41 have opted for continuous eligibility.

   - Far fewer States (19) have elected to voluntarily raise the level of poverty above 133 percent FPL. Fifteen States are at 185 percent FPL, with 6 at this level since 1988 and 5 since 1989.

   - Only 21 States have adopted presumptive eligibility. Either administrative complexity or having a streamlined eligibility process already in place are cited as reasons for not using presumptive

eligibility. For example, Vermont reports a 10-day expedited formal determination process; Minnesota, a 15-day turnaround.

2. **Significant Barriers Still Exist to Accessing and Delivering Medicaid-Covered Prenatal Care Services.**

Even though potentially one of the least complicated and easiest Medicaid programs to administer, barriers still hinder access to, and delivery of, prenatal care services.

o Insufficient Client Outreach Often Keeps Medicaid-Covered Prenatal Care a Well-Hidden Secret

When asked to identify SOBRA women to be interviewed, most States and providers had difficulty with this request. Most women receiving Medicaid-covered prenatal care services were either borderline welfare cases or already eligible Medicaid recipients.

Knowledge of Medicaid-covered prenatal care services is still being spread primarily through the "welfare grapevine." Eighty-nine percent of the States rely on this informal means of communication. Ninety-four percent of Medicaid eligibility supervisors interviewed during Phase 1 say their agency relies on clients telling clients.

Even among the States reporting some form of active outreach, over half neither target new eligibles (SOBRAs) nor high-risk women. (SOBRA eligibles include women who are above the poverty level used for other government-sponsored programs and who are usually married, better educated, regularly employed in low paying jobs, as well as those who are underinsured. Women who are substance abusers, medically high-risk, teenagers, welfare recipients, and women in their mid-thirties or above are considered high-risk.)

o Conflicting Timeframes to Process Presumptive Eligibles Leave Some Women Without Medicaid-Covered Prenatal Care Services

SOBRA-86 allows a maximum presumptive eligibility period of 45 days. This timeframe includes 1) application for continued Medicaid-covered prenatal care services within 14 days of being presumed eligible and 2) the determination of formal eligibility. If a woman waits until the 14th day to make a formal application, eligibility workers would then have up to 31 days to make a formal eligibility determination (initial 14 days of presumptive eligibility + 31 days to process case = 45 days to inform a woman of her formal eligibility status).

A few States are not adhering to this timeframe but are allowing an additional 2 weeks to process a formal eligibility application (initial 14 days of presumptive eligibility + 45 days to process case = 59 days to inform a woman of her formal eligibility status). In such cases a woman could potentially be without Medicaid coverage for prenatal care services for up to 14 days. Clearly, such States are not following the legislative timeframe established by SOBRA-86.

o The Application Process is Cumbersome

Complexity of the application form, use of multiple application sites, and uncertain eligibility status are hindering access to Medicaid-covered prenatal care services.

Sixty-eight percent of the States say they have a problem with women not completing the application process. Few States use a simplified application form tailored to collect only the few eligibility requirements needed to get Medicaid-covered prenatal care. In addition, women are having to make a formal application at a site other than where their pregnancy is verified or where they were determined presumptively eligible. Over three-fourths of the women report having to go to another location. Other listed factors contributing to lack of follow-through are requiring face-to-face interviews with the formal eligibility worker to get an application form, the stigma attached to going to the welfare office, lack of transportation to application sites, and formal eligibility intake workers asking for too much information in an attempt to see if a woman qualifies for other programs.

o Reimbursement and Liability Issues Are Disincentives for Providers to Accept Medicaid Eligibles

- Providers Not Accepting Medicaid Is a Major Problem

  Eighty-eight percent of the States say they have problems with health care providers not accepting Medicaid. More than half of the Medicaid eligibility supervisors think women don't even apply for Medicaid-covered prenatal care services because women feel providers don't accept Medicaid; nearly a third of the women in Phase 1 report the same.

- Low and Slow Reimbursement Are Major Obstacles to Provider Participation

  Eighty-six percent of the States say low reimbursement rates contribute to provider dissatisfaction; 60 percent of the States say slow turnaround for reimbursement discourages provider participation.

- Cost of Liability Insurance and Belief that Medicaid Clients are More Likely to Sue Keep Some Providers from Accepting Medicaid

  Seventy-one percent of the States think providers don't participate in Medicaid-covered prenatal care services because of the high cost of liability insurance. Also, 62 percent of the States say providers' perception that Medicaid clients are more likely to sue is a problem in getting providers to participate.

  Only ambulatory care can be paid for by Medicaid while a woman is presumptively eligible. Hospital inpatient care for such pregnancy-related complications as miscarriage, early delivery, or need for sophisticated procedures such as an ultrasound are not covered during this period. Therefore, some women may not be receiving medically necessary services. Additionally, some doctors are reluctant, or flatly refuse, to accept presumptively eligible women, judging the financial or liability risks of serving them too great.

o Too Few Obstetrician/Gynecologists (OB/GYN) Remains a System Capacity Issue

  Over half of the States report a shortage of OB/GYNs in both urban and rural areas, with a quarter of States experiencing a shortage in rural areas only.

3. **Innovative Practices to Enhance Access to, and Delivery of, Medicaid-Covered Prenatal Care Services Do Exist.**

o Client Outreach

- Examples of well-developed print materials are found in New York's brochures, handouts that hang on doorknobs, and posters. Printed in both English and Spanish, they include listings of services available, income requirements to qualify for Medicaid-

covered prenatal care, and a toll-free number for more information.

- Designating a special name to Medicaid-covered prenatal care services also heightens women's awareness. Ohio calls its program "Healthy Start"; Utah, "Baby Your Baby"; and Colorado, "Baby Care". Since June of this year, Ohio's "Healthy Start" campaign has done intensive television advertising, run over 1000 newspaper ads, used a marketing firm to do speeches and participate in talk shows, as well as running "Baby Fairs" to let women know about Medicaid-covered prenatal care services.

- Several States have solicited non-profit and private organizational support for client outreach. The March of Dimes assists Arkansas, Blue Cross-Blue Shield aids New Hampshire and Maryland, and private organizations are used by South Carolina.

- In 12 South Carolina counties, networks of nonprofessionals (lay women) are used to contact the hard-to-reach population. In Virginia, lay women act as "mother" role models for pregnant teens.

- Florida and Alabama have outstationed eligibility workers, lessening the welfare stigma and making the application process more accessible.

- South Carolina and Colorado give coupon books to women receiving prenatal care.

o <u>Application Form</u>

- Several States have developed shortened application forms to collect only the information required for Medicaid-covered prenatal care eligibility. Colorado, Ohio, and Vermont report using a shortened application form designed especially for Medicaid-covered prenatal care services.

o <u>Provider Incentives to Accept Medicaid</u>

- Maine offers OB/GYNs between $5000 and $10,000 supplements toward medical insurance in exchange for practicing in shortage areas.

- Washington State uses a Physician Marketing Plan to contact new providers. Also, primary care clinics in distressed areas are given higher reimbursement rates.

- Missouri is establishing a State legal defense fund, as well as a provider education program.

- Maryland has hired seven nurses to do provider outreach.

PRELIMINARY RECOMMENDATIONS – ESSENTIAL ELEMENTS OF A MODEL SYSTEM

Certain essential elements for more effective access/delivery of Medicaid-covered prenatal care services emerged from both in-depth State and local interviews with key informants and recipients, as well as onsite observations.

1. **Getting the Word Out is Critical.**

   o Eight-five percent of the State respondents agree that active outreach needs to be conducted.

   o Increasing awareness of the need for prenatal care, as well as the availability of Medicaid funds to pay for these services, should be done at Federal, State, and local levels.

      - Conduct a national ad campaign similar to "Just Say No," supported through private sponsorship and grants from non-profit organizations.

      - Establish a statewide hot line to provide information about access/delivery of Medicaid-covered prenatal care services. Existing State maternal and child care hotlines could be shared for this purpose. Ninety-eight percent of the surveyed States agree on the need for a hot line.

   o Do statewide targeted marketing to SOBRA eligibles, high-risk, and hard-to-reach women. Such outlets as churches, housing projects, neighborhood recreation centers, and shopping centers would be helpful in identifying women early in their pregnancies (OEI, 1989).

2. **Drop the Asset Test.**

   - Ninety-eight percent of the State respondents agree that the asset test should be dropped as an eligibility condition for Medicaid-covered prenatal care services.

3. **Guarantee Continuous Eligibility Until 60 Days Postpartum.**

   - All State respondents believe continuous eligibility should be guaranteed until 60 days postpartum.

4. **States with Presumptive Eligibility Should Adhere to the 45-Day Determination Period.**

   - Assure States are abiding by the 45-day presumptive eligibility time frame as prescribed in SOBRA-86.

5. **Combine Both the Presumptive Eligibility and Formal Application Process into One Function, Whether Contracted Out or Kept Within the Medicaid Agency.**

   - Non-Medicaid intake workers can gather the needed information for application: income verification, family size determination, residency establishment (Federal and State), and identification of any children under 6 years old residing with the applicant. The application, plus the documentation needed to verify this information, can be sent for processing at the local welfare office, eliminating the need for a woman to go to another site to formally apply.

   - Sixty-two percent of the State respondents agree that this function could be combined. This process would eliminate the need for transportation to a second application site, as well as avoid the stigma associated with applying at a welfare office.

   - Develop a shortened application form to collect only the few eligibility items needed to get Medicaid-covered prenatal care services.

6. **Simplify the Eligibility Verification Process.**

   - To clarify eligibility status, issue two separate cards or letters: one to be used during the presumptive eligibility period and another for use after formal acceptance which is valid until 60 days postpartum. Fifty-seven percent of the States agree this would lessen confusion for both service recipients and providers.

- Use only one control number to track both presumptive eligibility and formal acceptance status. By doing so, billing will be less problematic for health care providers. Eighty-six percent of the State respondents concur.

- Have an on-line or telephone eligibility verification system to track the current status of women receiving Medicaid-covered prenatal care services. The system needs to be accessible to both health care providers and eligibility workers. Ninety-seven percent of the State respondents agree this service is needed.

7. **Assure Adequate Provider Participation to Deliver Medicaid-Covered Prenatal Care Services.**

   - Seventy-six percent of the States have already raised reimbursement rates; 17 percent offer some type of assistance with liability insurance.

   - Encourage use of such alternative health care providers as certified nurse midwives, family nurse practitioners, and physician assistants.

ENDNOTES

1. The Alan Guttmacher Institute (Gold, Kenney, and Singh, 1987:14) defined insufficient prenatal care as "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."

2. Title XIX of the Social Security Act has been amended through the:

- Tax Equity and Fiscal Responsibility Act (TEFRA, P.L.97-248) of 1982.
- Deficit Reduction Act (DEFRA, P.L.98-369) of 1985.
- 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/P.L.101-234) of 1988.
- Omnibus Budget Reconciliation Act (OBRA, P.L.101-239) of 1989.

3. Presumptive eligibility allows pregnant women to receive ambulatory prenatal care before being formally accepted into the Medicaid program. Determination is based on income and determined by a Medicaid-qualified provider or intake worker. If determined presumptively eligible, the woman remains in this status for 14 calendar days from the date of presumptive determination. If the woman makes a formal application for Medicaid within these 14 days, her temporary eligibility will continue until the earlier of the date the State makes a formal determination or 45 days after the presumptive determination is made. If the woman fails to make formal application within the 14-day period, presumptive eligibility ends on the 14th day after the presumptive determination.