

Medicaid Outreach and Enrollment for Pregnant Women: What Is the State of the Art?

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Executive Summary

Over the past twenty years, the United States has experienced divergent trends in birth outcomes, with some key indicators improving and others worsening. In that same time, the level of attention that the federal and state governments have focused on publicly sponsored health insurance for pregnant women has fluctuated, with major efforts to expand health insurance coverage and access to prenatal care concentrated in the early years of this period, and considerably less activity in recent years as child health insurance expansions have been in the policy spotlight. The last two decades have also witnessed major changes within health care delivery and financing systems, with expansion in the use of managed care as well as new family planning initiatives that target low-income women of childbearing age. Given these trends, the March of Dimes asked the Urban Institute, with its partner the National Academy for State Health Policy, to assess the current “state of the art” of state Medicaid program efforts to reach out to and enroll pregnant women into coverage. The results of this assessment are summarized below.

Findings from 50-State Survey on Medicaid Outreach and Enrollment

Medicaid officials were surveyed on policies affecting pregnant women in all 50 states and the District of Columbia. The findings of this survey are presented in three categories: enrollment policies and processes, outreach strategies, and enhanced prenatal benefits.

Eligibility and Enrollment Efforts

- All but 11 states have increased their income eligibility limits for pregnant women in Medicaid above the minimum requirement of 133 percent of the federal poverty level (FPL). Thirty-six states cover pregnant women at 185 percent FPL or above.
- In 25 states, pregnant women can apply for Medicaid using a shortened, simpler application for pregnancy coverage.
- Forty-nine states allow pregnant women to mail in their applications, thus avoiding the need for a face-to-face interview at a county social services office.
- In 2007, 43 states did not consider pregnant women’s assets when determining Medicaid eligibility, making more women eligible and simplifying the eligibility determination process.
- Currently, 18 states allow pregnant women to self-declare their income. These states verify income in other ways (for example, cross-checking against other state databases), rather than requiring the applicant to provide documentation.

- Forty-five states have their applications available on their web sites. In these states, a woman can download a copy of the form, fill it out, and (in most cases) submit it by mail.
- In fifteen of these 45 states, pregnant women can submit their applications over the Internet, allowing for an entirely electronic application process.
- Twenty nine states grant presumptive eligibility to pregnant women—during which time women can receive prenatal care for which providers are reimbursed and states receive federal matching funds—while final determinations on their applications are being made.
- Eleven states have alternative processes for expediting eligibility determination for pregnant women.
- In 2007, 34 states and Washington, DC outstationed Medicaid eligibility workers in the community to facilitate the application process.

For the most part, our survey found that state Medicaid agencies have maintained a strong focus on simplifying eligibility and enrollment for pregnant women over the past 20 years, even during a period when children's coverage has been a more dominant policy focus. It was striking to find, for example, that so many states are taking advantage of the Internet to facilitate access to program applications. However, states have lost ground in some areas. For example, in 2007, seven states required that pregnant women document their assets and denied eligibility for those whose resources were above a certain level; in 1992 only three states looked at pregnant women's assets as part of the eligibility determination process. States have also lost ground in meeting federal requirements to outstation eligibility workers. In 1992, all but one state outstationed eligibility workers in community health centers and public hospitals, compared to 34 states in 2007. Additionally, the survey found that 25 states had shortened Medicaid applications for pregnant women in 2007, down from 31 states in 1992; however, overall enrollment simplifications during this time have made the application process less burdensome.

Outreach Strategies

If a pregnant woman does not know she may be eligible for Medicaid, she will not apply for coverage. Therefore, in addition to expanding eligibility and simplifying enrollment procedures, many states have adopted strong outreach efforts to encourage pregnant women to apply for Medicaid and to begin receiving early prenatal care. The survey questioned states about the extent to which they conducted targeted outreach designed to inform pregnant women of the importance of prenatal care and/or the availability of Medicaid coverage. The survey's key findings include:

- In 2007, just 14 states dedicated Medicaid funding to support outreach for pregnant women.

- Ten states conduct outreach through the media, including three that utilize unpaid television or radio and four states that use paid television or radio in their outreach strategies.
- Twenty-six states produce printed materials to encourage pregnant women to apply for Medicaid.
- Twenty-two states fund community-based outreach, including 19 that make grants to community-based organizations to support their outreach efforts.
- Eighteen states target outreach efforts towards specific, high-risk populations, such as adolescents and immigrants.
- Thirty states produce outreach materials in multiple languages and 36 states operate toll-free hotlines to provide information to women interested in enrolling in Medicaid.

While these findings illustrate the broad range of strategies that some states continue to use to reach out to and inform pregnant women of the availability of coverage, the absolute number of states engaging in each of these strategies is lower than it was in the early 1990s. Thus, overall, states appear to be making fewer investments in outreach to pregnant women than in the past.

Enhanced Prenatal Benefits

The survey also explored the extent to which states cover enhanced prenatal care benefits under Medicaid, beyond basic medical obstetrical care. According to the survey findings:

- The majority of states continue to cover a broad range of nonmedical, psychosocial support services for pregnant women, including such services as prenatal risk assessments (35 states), home visiting (30), health education (28), nutritional counseling (27), psycho-social counseling (30), smoking cessation (32), transportation (37), dental care (26), substance abuse treatment (32), and targeted case management (32), as part of their enhanced prenatal benefits packages. In addition, 19 states offered preconception counseling to pregnant women as an enhanced benefit in 2007.

As was the case with outreach, these findings reveal slight decreases, since the early 1990s, in the number of states that provide some enhanced services, including prenatal risk assessments, home visiting, health education services, nutritional counseling, targeted case management, and preconception counseling. However, there were increases in the number of states covering transportation services, smoking cessation, substance abuse treatment, psycho-social counseling, and dental benefits to pregnant women.

Findings from Case Studies of Selected Innovative States

Following the 50-state survey, evaluators conducted follow-up telephone interviews with Medicaid officials in 10 states that appeared to be implementing innovative outreach and enrollment strategies. From these, two states were chosen for more in-depth study, and multi-day site visits were conducted. Highlights from case studies of the efforts in Louisiana and New York appear below.

Louisiana

Historically and at the start of this decade, Louisiana has ranked very poorly among the states in its low weight birth and infant mortality rates. This reflected the fact that the state had taken little advantage of federal authority to expand coverage for pregnant women to that point, and only covered pregnant women with incomes up to 133 percent of the federal poverty level. In 2003, however, building on the success of its State Children's Health Insurance Program—LaCHIP—Louisiana officials placed new emphasis on outreach and enrollment of pregnant women into Medicaid by launching its LaMOMS initiative and expanding eligibility up to 200 percent of poverty.

LaMOMS entails a multi-faceted outreach and public relations campaign, as well as a new program for expediting the processing of Medicaid applications made by pregnant women. Full-time outreach staff are funded at the state level and deployed to each of the state's nine public health regions. Working closely with the state Office of Public Health, these staff emphasize grassroots outreach and partnerships with faith- and community-based organizations as well as local and mobile health clinics. State and regional personnel are regularly out of their offices and working in the community, at clinics, church fairs, and other social gatherings to reach out to potentially eligible pregnant women. To further reduce barriers to coverage, Louisiana Medicaid dropped its requirement for medical verification of pregnancy, and allows eligibility workers to exercise "reasonable certainty" in determining women's income when they are unable to produce verification documents.

Through its combination of intensive outreach coupled with expedited eligibility processing, Louisiana has witnessed dramatic improvements in recent years. For example, the state has significantly reduced the processing time for eligibility determination from an average of 19 days in 2004 to less than five days currently. In addition, Medicaid now covers two-thirds of all births in the state, and Louisiana is now ranked 6th best nationally in the rate of women who receive "adequate prenatal care" during their pregnancies.

New York

New York State has long been a pioneer in efforts to improve perinatal outcomes and was a leader during the 1980s in efforts to improve pregnant women's coverage and access to care under Medicaid. During that decade, New York took advantage of optional authority contained in multiple federal omnibus budget reconciliation acts to expand

Medicaid eligibility for pregnant women to 200 percent of the federal poverty level. In conjunction with these expansions, the state created its Prenatal Care Assistance Program (PCAP), which certified providers in conducting presumptive eligibility while also establishing new standards for the delivery of comprehensive prenatal care and support services to low-income women and infants.

Working with the Office of Family Health, New York Medicaid also developed a broad range of outreach strategies, including: grass-roots efforts employing community health workers; regional Comprehensive Perinatal Services networks; targeted outreach to neighborhoods with poor birth outcomes, and home visiting programs for high-risk women. In the 1990s, as New York expanded its enrollment of families and children into managed care arrangements, the state successfully transitioned its perinatal initiatives to this new environment. All participating health plans must today have capacity to conduct presumptive eligibility for pregnant women and must also meet PCAP standards of care. To meet these requirements, most health plans include PCAP providers in their networks. New York's Medicaid program also monitors the quality of care provided through health plans by tracking several key perinatal outcome measures and has begun adjusting payment levels to plan based on their performance on these measures. Growing from these efforts, Medicaid now finances over 40 percent of all deliveries in New York, and the state's infant mortality rate has fallen to 6 deaths per 1,000 live births, ranking it 6th best, nationally.

Conclusions and Policy Recommendations

Compared to the late 1980s and early 1990s, when pregnant women were targeted by state Medicaid programs as a high-priority group, states have continued to place strong emphasis on expanded coverage and simplified enrollment for this population. A vast majority of states continue to enforce a series of policies that facilitate pregnant women's access to coverage, and states have recently made progress in the area of online application availability and submission.

However, in the areas of outreach and content of covered prenatal care benefits, states have generally slipped. Fewer states are conducting multiple and diverse outreach efforts compared to 20 years ago, and in an environment that has become increasingly dominated by managed care, somewhat fewer states are explicitly covering the full scope of nonmedical support services that were covered in earlier decades.

Given these trends, we conclude that while the overall picture with regard to outreach and enrollment of pregnant women is relatively good, there is still considerable room for improvement. With vast new opportunities presented by the prospect of broad health care reform under the Barack Obama Administration, we recommend that advocates and policymakers redouble their efforts to analyze available options and maximize use of existing federal authority to improve coverage and services for pregnant women. However, given tremendous variation in policies from state to state, it is clear that no single set of recommendations can apply to all states. Rather, our analysis of alternative state models illustrates that the options for reaching and enrolling pregnant women are

numerous and (to a large degree) interchangeable, that every state (and localities within those states) present somewhat unique environments and face different challenges, and that the “right” combination of outreach and enrollment policies and procedures may in fact be very different in one state than they are in another. Therefore, our recommendations present guiding principles rather than specific prescriptions for action.

Facilitating Coverage and Enrollment of Pregnant Women

Generally, states should assess the broad range of eligibility and enrollment options available and adopt a collection of policies that simplify rules and procedures to the maximum extent possible and that maximize the use of cutting-edge technology for receiving applications (e.g., through the Internet) and processing them as expeditiously as possible. Specifically, we urge policymakers to consider:

- ***Making upper income limits for pregnant women and children uniform;***
- ***Designing application forms that are short, clear, simple, and written at easy-to-read literacy levels (whether they are specific to pregnant women, or are intended for the entire Medicaid population);***
- ***Not requiring a face-to-face interview as part of the application process under any circumstances;***
- ***Allowing applications to be submitted online;***
- ***Minimizing requirements for submitting physical verification of such items as income, residency, citizenship, and pregnancy;***
- ***Adopting some form of expedited eligibility determination (whether or not that represents formal “presumptive eligibility”);***
- ***Making application assistors widely available at the community level; and***
- ***Building strong links between Medicaid pregnancy and family planning coverage.***

Raising Public Awareness of Available Coverage and Encouraging Enrollment

The most successful outreach models typically combine some form of broad social marketing, with more grass-roots, community-based interventions. Therefore, we recommend that policymakers strive to design multi-faceted outreach strategies that both raise women’s awareness of the availability of coverage, and have the capacity to provide hands-on, one-on-one assistance to individuals who may be interested in applying for coverage, but have questions about what is entailed or whether they might be eligible. Specifically, we urge policymakers to consider:

- *Supporting ongoing outreach in the form of social marketing, utilizing both electronic (radio and television) and print (posters, billboards, brochures, newspaper advertisements) media to build “brand identity” for the coverage program;*
- *Complementing broader media campaigns with funding that supports community-based outreach;*
- *Maintaining a toll-free hotline for interested parties to call for information and advice;*
- *Developing outreach materials in multiple languages; and*
- *Building outreach partnerships with managed care organizations.*

Broadening the Scope of Prenatal Care to Include both Medical and Nonmedical Services

State officials learned long ago that low-income, high-risk, and vulnerable populations often require benefits that go beyond traditional medical care to include a range of psychosocial support services that can address risks that are associated with poor birth outcomes. In an environment increasingly dominated by prepaid managed care arrangements, the challenge of extending such “enhanced prenatal care” is amplified, and requires rigorous contract development and monitoring to ensure that these benefits are available and accessible. We therefore recommend that policymakers consider the range of services that might benefit the populations of pregnant women in their states and communities, and adopt coverage of the package or combination of benefits that offers the best chance of improving outcomes. Specifically, we urge policymakers to consider:

- *Ensuring that some form of case management or “care coordination” is included in package;*
- *Allowing for home visiting as part of the enhanced benefit package; and*
- *Developing explicit contract language with managed care organizations surrounding the delivery of enhanced care.*

I. Introduction

Over the past twenty years, the United States has experienced divergent trends in birth outcomes, with some key indicators improving and others worsening. For example, rates of infant mortality have steadily fallen and the proportion of mothers who enter into prenatal care early has steadily risen, yet rates of preterm, low, and very low birth-weight births have all increased. Furthermore, serious racial disparities in these outcomes have persisted, with African American women and children, in particular, experiencing significantly worse outcomes.

During that same time period, the level of attention that federal and state policymakers have focused on publicly sponsored health insurance for pregnant women has fluctuated. The late 1980s and early 1990s marked an era when states and the federal government made concerted efforts to improve birth outcomes for vulnerable women and infants by improving access to prenatal care, as states made significant expansions in Medicaid eligibility followed by large investments in outreach, enrollment simplification, and the enhancement of prenatal benefits. In the last ten years, however, since the creation of the State Children's Health Insurance Program in 1997, children's coverage expansions arguably have received the lion's share of the attention of policymakers concerned with maternal and child health.

Finally, the last two decades have also witnessed major changes within health care delivery and financing systems, with dramatic expansion in the use of managed care for Medicaid enrollees (including mothers and children), as well as new family planning initiatives that target low-income women of childbearing age.

Given these trends, and the fact that no study has comprehensively looked at state Medicaid programs' perinatal policies in nearly a decade, the March of Dimes asked the Urban Institute and its partner—the National Academy for State Health Policy—to assess the current “state of the art” of state Medicaid program efforts to reach out to and enroll pregnant women into coverage. The purpose of this project would be two-fold: (1) to develop a 50-state database on state Medicaid program strategies for outreach, enrollment, and coverage of this population; and (2) to identify a range of “best practices,” based on our detailed analysis of states making special and innovative efforts in these areas. Ultimately, the product of this research would be a policy report that the March of Dimes and its state chapters across the United States could use to influence policy improvements at the national and state levels.

The study, as implemented by Urban and NASHP, comprised four distinct but inter-related activities:

- First, we conducted a comprehensive *review of the literature* to fully assess trends in perinatal outcomes and state Medicaid policies related to perinatal coverage and service delivery.
- Second, we administered a *50-state e-mail survey* to Medicaid officials to identify state policies related to pregnant women eligibility and enrollment, outreach, and benefits coverage for pregnant women.
- Third, following our analysis of survey results, we conducted detailed *follow-up interviews* (by telephone) with Medicaid officials in 10 states that appeared to be implementing particularly diverse and interesting outreach, enrollment, and coverage policies.
- Finally, multi-day *site visits* were conducted to two “model” states to learn, in depth, about the design and implementation of their systems of care, and to identify a series of lessons learned about successful strategies for reaching and enrolling pregnant women.

The results of this research are presented here, in the order described above.

II. Evolving Perinatal Trends, Policies, and Environments: A Review of the Literature

As described in the Introduction, the United States has experienced divergent trends in birth outcomes over the past two decades, as well as varying levels of attention by federal and state policymakers on publicly sponsored health insurance care for pregnant women. The period also witnessed major expansions in the use of managed care as well as new family planning initiatives that target low-income women of childbearing age. The following literature review attempts to summarize what research has learned about these diverse developments.

A. Divergent Trends in Birth Outcomes

A nation's infant mortality rate (IMR), defined as the number of deaths among infants under age one divided by the number of live births, is commonly used as an indicator for the overall health of a population. The United States' IMR has declined considerably over the past several decades, from 29.2 (deaths per 1000 live births) in 1950, to 20.0 in 1970, to 12.6 in 1980. In 2005, the infant mortality rate for the United States was 6.86 deaths per 1000 live births, which is not significantly different from the rate of 6.89 in 2000. Despite these declines, the United States has consistently lagged well behind other industrialized nations in this indicator, and in fact its ranking among industrialized nations has slipped over the past twenty years. In 1980, the United States was ranked 19th among developed countries in its rate of infant deaths; by 2004, it had slid to 29th in the international rankings.^{1, 2, 3} The current U.S. infant mortality rate is nearly 50 percent higher than the official national Healthy People goal of 4.5 deaths per 1,000.⁴

¹ National Center for Health Statistics [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention]. (1989). *Health, United States, 1988*. DHHS Publication No. (PHS)89-1232. Hyattsville, MD: U.S. Department of Health and Human Services.

Infant mortality rates vary by race—for example the rate among African Americans was 13.63 deaths per 1000 live births in 2005, more than double the overall rate. Indeed, a disparity between African American and White infant mortality rates has persisted over time, and the ratio of African American to White infant mortality has increased; in 1983 the ratio of African American to white IMRs was 1.76 (in other words, an African American infant was 1.76 times as likely to die in the first year of life than a white infant), while in 2003 IMR ratio for the two race groups was 1.99.⁵ From 2000 to 2005, the infant mortality rate did not change significantly for any race/ethnicity group, although a more than three-fold difference in infant mortality by race/ethnicity persists, from a high of 13.63 among African American women, to a low of 4.42 for Cuban American women.⁶

Like infant mortality, there have also been improvements in the proportion of U.S. mothers receiving early prenatal care. Receipt of early prenatal care, commonly defined as care received in the first trimester, increased by 12 percentage points over the past three decades, from 72 percent in 1975 to 84 percent in 2004.⁶⁷ Early prenatal care allows for identification and treatment of health problems and health-compromising behaviors that can lead to poor fetal development and/or birth outcomes. Early and continuous prenatal care can improve birth outcomes and lower health care costs by reducing the

² National Center for Health Statistics [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention]. (2006). *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services.

³ National Center for Health Statistics [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention]. (2008). *Recent Trends in Infant Mortality in the United States*. Hyattsville, MD: U.S. Department of Health and Human Services.

⁴ The New York Times Editorial Board. (2008) 29th on *Infant Mortality*. The New York Times. October 19, 2008

⁵ Ibid.

⁶ Ibid.

⁷ Likewise, the percentage of mothers receiving late prenatal care (commonly defined as medical care beginning in the third trimester) or no prenatal care decreased during the same period, from 6 percent in 1975 to 3.6 percent in 2004.

likelihood of complications during pregnancy and childbirth. Unfortunately, racial disparities persist with regards to this important indicator, as well. For example, in 2004, 70 percent of American Indian/Alaska Native mothers sought care in the first trimester, 75 percent of African American mothers did so, and 85 percent of White mothers sought early prenatal care. Additionally, while trends document an increase in the receipt of early prenatal care over the past several decades, a closer look reveals that, since 2000, the percentage has been virtually unchanged, hovering somewhere between 83 percent and 84 percent.^{8,9}

Despite overall improvements in infant mortality and receipt of prenatal care, other birth outcome indicators have worsened. The rate of preterm births (those that occur before 37 weeks gestation) has risen steadily over the past decade, from 9.8 percent of all births in 1994 to 12.5 percent of births in 2004. In 2008, the March of Dimes, in its first state-by-state “Premature Birth Report Card,” did not award one state an “A” grade—signified by meeting the Healthy People 2010 preterm birth rate goal of 7.6 percent or less—and awarded the United States an overall grade of “D.”¹⁰ Prematurity, which is associated with increased rates of long-term neurological disorders, low birth weight, and infant mortality, can have detrimental consequences for infant health. Since 1999, prematurity has been the leading cause of neonatal mortality in the U.S. (surpassing birth

⁸ National Center for Health Statistics [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention]. (2006). *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services.

⁹ Public Health Service [U.S. Department of Health and Human Services]. (1989). *Caring for Our Future: The Content of Prenatal Care*. Washington, DC: U.S. Government Printing Office.

¹⁰ Kaiser Daily Health Policy Report [Kaiser Family Foundation]. (2008). *March of Dimes Report Card Give U.S. ‘D’ Grade for Preterm Birth Rate*. November 12, 2008.

defects).¹¹ According to a recent report from the Centers for Disease Control and Prevention, preterm birth accounted for over a third of all infant deaths (before age one) in 2002.¹² In addition to having grave impacts on infant health, preterm births are also costly—the Institute of Medicine estimated that the annual societal economic burden associated with preterm birth in the United States was at least \$26.2 billion in 2005. This translates to over \$50,000 per infant born preterm.¹³ Women known to be at greater risk for preterm birth include those with a history of preterm birth, those with cervical or uterine irregularities, and those expecting multiple births. African-American women, women younger than 17 or older than 35, and poor women are also more likely to have a preterm birth.¹⁴

Similar to rates of preterm birth, rates of births that are low or very low birth weight have also increased over time. If a newborn weighs less than 2500 grams (or 5.5 pounds) at birth, they are defined as low birth weight; those that weigh less than 1500 grams or 3.3 pounds at birth are defined as very low birth weight. The most recent data available, from 2004, indicate that 8.1 percent of all newborns are low birth weight and 1.5 percent of all newborns are very low birth weight. In 1975, these rates were 7.4 percent and 1.2 percent, respectively. Once again, there are also marked racial disparities in the number of low birth weight infants—for example, among African American live births the low

¹¹ National Center for Health Statistics, Centers for Disease Control and Prevention. *National Vital Statistics System: Linked Birth/Infant Death Data 1998-2001*.

¹² Callaghan WM, MacDorman MF, Rasmussen SA et al. (2006) The Contribution of Preterm Birth to Infant Mortality Rates in the United States. *Pediatrics* 118(4): 1566-1573.

¹³ Institute of Medicine. (2006) *Preterm Birth: Causes, Consequences, and Prevention*. Report Brief. Retrieved on March 30, 2007 from: <http://www.iom.edu/Object.File/Master/35/975/pretermbirth.pdf>.

¹⁴ Heffner L.J., Sherman C.B., Speizer F.E., and Weiss S.T. (1993). Clinical and environmental predictors of preterm labor. *Obstetrics and Gynecology* 81(5 Pt 1):750-7.

birth weight rate was 13.44 percent in 2004, almost double the rate among white live births (7.07 percent).¹⁵

The reasons why rates of certain poor birth outcomes (like IMR) are improving while other indicators (such as incidence of preterm birth, or low birth weight) are worsening are not completely clear. In all likelihood, a combination of factors is responsible for this incongruity: an increasing number of women receive early and consistent prenatal care; advances in medical technology—such as improvements in neonatal intensive care treatments (like steroids and surfactants)—increase the rate of survival of premature and low birth-weight infants; and the greater use of ultrasound technology allows for earlier identification of pregnancy complications, which may lead to earlier deliveries. Maternal demographics (childbearing later in life) and the increase in the incidence of multiple births (often associated with the use of fertility drugs) are among the other possible contributing factors.¹⁶

In addition to these clinically related factors, researchers have identified other potential risk factors for poor birth outcomes that are related to a mother's lifestyle and environment. For example, maternal smoking is associated with poor outcomes for newborns; in 2004, when compared to nonsmoking mothers, maternal smokers had higher rates of preterm births (13.3 percent vs. 12.3 percent), low birth weight (10.6 percent vs. 6.9 percent), and full-term low birth weight (5.9 percent vs. 3.0 percent).¹⁷

Maternal alcohol consumption is also related to poor outcomes—one study found that the

¹⁵ National Center for Health Statistics [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention]. (2006). *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services.

¹⁶ Alexander, G.G. and Slay, M. (2002). *Prematurity at Birth: Trends, Racial Disparities and Epidemiology*. Birmingham, AL: University of Alabama.

¹⁷ Centers for Disease Control and Prevention. *2004 Pediatric and Pregnancy Nutrition Surveillance Data; Table 13D: Maternal Weight Gain and Birth Outcomes by Select Health Indicators and Table 19D: Summary of Infant Health Indicators*. Retrieved on March 30, 2007 from <http://www.cdc.gov/pednss/>

risk of preterm delivery was greater among women who consumed more than 3 alcoholic drinks per day; consumption of alcohol during pregnancy also puts a newborn at risk for fetal alcohol syndrome.¹⁸

CDC surveillance of infant health outcomes also indicates that maternal pre-pregnancy body mass index (BMI) and maternal weight gain are associated with poor birth outcomes; in 2004, underweight mothers had a higher rate of preterm births (14.3 percent) than normal weight mothers (12.0 percent). Mothers with less than ideal pregnancy weight gain had a higher rate of preterm births (16.4 percent) than mothers with ideal pregnancy weight gain (12.2 percent).¹⁹ The rising rate of obesity in the U.S. has also brought attention to the association between maternal obesity and poor birth outcomes; researchers note that neural tube defects, preterm delivery, diabetes, cesarean section, and hypertensive and thromboembolic disease are among the adverse perinatal outcomes associated with this maternal condition.²⁰

Finally, evidence exists for a link between periodontal disease and preterm birth, though it is still not clear that treating periodontal disease can reduce risk of preterm birth. Various factors seem to predispose women to both periodontal disease and preterm birth, however, such as increased age, diabetes, and smoking.^{21, 22}

¹⁸ Parazzini, F, Chatenoud, L., Surace, M., Tozzi, L., Salerio, B., and Bettoni, G. et al. (2003). Moderate Alcohol Drinking and the Risk of Preterm Birth. *European Journal of Clinical Nutrition* 57: 1345-1349.

¹⁹ Centers for Disease Control and Prevention. 2004 *Pediatric and Pregnancy Nutrition Surveillance Data; Table 13D: Maternal Weight Gain and Birth Outcomes by Select Health Indicators and Table 19D: Summary of Infant Health Indicators*. Retrieved on March 30, 2007 from <http://www.cdc.gov/pednss/>

²⁰ Centers for Disease Control. (2006). *Recommendations to Improve Preconception Health and Health Care—United States*. Morbidity and Mortality Weekly Report Recommendations and Reports 55(RR06);1-23.

²¹ Scannapieco F.A., Bush R.B., and Paju S. (2003). Periodontal disease as a risk factor for adverse pregnancy outcomes. A systematic review. *Ann Periodontol* 8(1): 70-76.

²² Jeffcoat M.K., Geurs N.C., Reddy M.S., Cliver, S.P., Goldenberg, R.L. and Hauth, J.C. (2001). Periodontal Infection and Preterm Birth: Results of a Prospective Study. *J Am Dent Assoc*, Vol. 132(7): 875-880.

While there are many potential risk factors associated with poor birth outcomes and the cause of preterm birth remains elusive, clinicians and public health officials alike have embraced timely prenatal care as one intervention that can help improve birth outcomes. Researchers have not been able to identify what aspects of prenatal care or which mechanisms in prenatal care delivery are responsible for improvements, nor have they been able to pinpoint just how much prenatal care a woman needs to achieve a good pregnancy outcome.²³ Regardless of these uncertainties, the cost-effectiveness of timely prenatal care is not in doubt; in 1985, an analysis conducted by the Institute of Medicine concluded that for each dollar spent on providing adequate prenatal care to low-income women, \$3.38 could be saved through reduced expenditures for direct medical care of their low birth-weight infants during the first year of life.²⁴ Widely accepted guidelines for prenatal medical care include (for a low-risk pregnancy): a preconception visit, a visit as soon as possible after determination of pregnancy (ideally six to eight weeks gestation), and visits every four to six weeks until birth. Clinician guidelines also include screening tests, education, and immunizations; a comprehensive risk assessment and appropriate risk-related interventions (including risks for preterm labor); and, for patients with previous Cesarean section, provide education of risks and benefits associated with vaginal birth after Cesarean (VBAC).²⁵

Additionally, certain non-medical interventions and psychosocial support services have been shown to improve birth and other outcomes, such as nurse home visiting

²³ Alexander G.R. and Kotelchuck M. (2001). Assessing the Role and Effectiveness of Prenatal Care: History, Challenges, and Directions for Future Research. *Public Health Reports*, Vol. 116.

²⁴ Institute of Medicine. (1985). *Preventing Low Birthweight*. Washington, DC: National Academy Press.

²⁵ Institute for Clinical Systems Improvement (ICSI). (2006). *Routine prenatal care*. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI). Retrieved on March 30, 2007 from National Guidelines Clearinghouse (www.guideline.gov).

programs. A study of one such program—a nurse home visiting model championed by David Olds which provided an average of 6.5 nurse visits during pregnancy and 21 visits from birth to the baby’s second birthday—produced significant effects, including lower smokers’ cotinine levels from intake to the end of pregnancy; fewer subsequent pregnancies; longer delay before a subsequent pregnancy; working more during second year after the birth of their first child; and more responsive child-mother interaction. Nurse-visited infants were less likely to exhibit emotional vulnerability or language delay, and had superior mental development. Nurse activities included: promotion of improvements in women’s (and other family members) behavior thought to affect pregnancy outcomes, health and development of children, and parents’ life course; helping women to build supportive relationships with family members and friends; and linking women and their family members with other needed health and human services.^{26,27}

In addition to the more traditional concepts of timely prenatal care and support services during and after pregnancy, clinicians and public health officials have recently begun to support the notion of ‘preconception care’ as a means to improve birth outcomes. This type of care aims to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes. It includes screening and interventions for women of reproductive age to reduce factors that might

²⁶ Olds, D.L., Robinson, J., O’Brien, R., Luckey, D.W., Pettitt, L.M., and Henderson, C.R., et al. (2002). Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial. *Pediatrics* 110;486-496.

²⁷ Olds, D.L., Henderson, C.R., Kitzman, H.J., Eckenrode, J.J., Cole, R.E. and Tatelbaum, R.C. (1999). Prenatal and Infancy Home Visitation by Nurses: Recent Findings. *Future of Children* 9(1) :44-65.

affect future pregnancies, and should be an essential part of primary and preventive care, rather than an isolated visit.^{28,29}

B. The Role of Public Health Insurance Coverage

A precursor to accessing timely prenatal care is having the finances or insurance coverage to pay for the cost of care. For example, a study of prenatal care initiation among urban mothers found variables related to insurance coverage and financial status showed the greatest difference between early and late attenders at prenatal care.³⁰ Yet, public health insurance coverage for prenatal care and delivery services were not always widely available for low-income women. In 1986, the upper income threshold for Medicaid in the average state was less than half of the federal poverty level (48 percent).³¹ Thanks to the work of many dedicated advocates, providers, and policymakers this situation dramatically improved beginning in the mid-1980s, when the United States witnessed an upsurge in support for expanded coverage of pregnant women through state Medicaid programs. The Consolidated Omnibus Budget Reconciliation Act (COBRA) set the stage in 1985 by requiring states to cover postpartum Medicaid clients an additional 60 days after delivery and allowing states to offer enhanced services to pregnant women, such as health education and case management. During the remainder of that decade, three additional Omnibus Budget Reconciliation Acts (OBRA) went further to expand pregnancy coverage for low-income women:

²⁸ Centers for Disease Control. (2006). *Recommendations to Improve Preconception Health and Health Care—United States*. Morbidity and Mortality Weekly Report Recommendations and Reports 55(RR06):1–23.

²⁹ Jack, B. W. and Culpepper, L. (1990). Preconception Care. Risk Reduction and Health Promotion in Preparation for Pregnancy. *JAMA* 264:1147–49.

³⁰ Petitti D, Coleman C, Binsacca D, and Allen B. (1990). Early Prenatal Care in Urban Black and White Women. *Birth*. 17(1):1–5.

³¹ Hill, I. (1990). Improving State Medicaid Programs for Pregnant Women and Children. *Health Care Financing Review*. 1990 Annual Supplement: 75–87.

- OBRA-1986 gave states the option to extend Medicaid income eligibility to pregnant women and children 0-5 up to 100 percent FPL, and allowed states to simplify enrollment processes;
- OBRA-1987 gave states the option to extend Medicaid income eligibility to pregnant women/infants to 185 percent FPL;
- OBRA-1989 mandated coverage for pregnant women up to 133 percent FPL, and;
- OBRA-1990 mandated continuous eligibility for pregnant women through 60-days postpartum, and for newborns living in mother's household up to age one.

States moved quickly to put coverage expansions into effect. Within two years of the passage of OBRA-86, half of the states had expanded eligibility up to 100 percent of poverty, and by the time OBRA-89 mandates occurred, a third of all states had already expanded income thresholds to or above 133 percent of poverty. Between 1986 and 1991, the average upper income threshold for pregnant women in Medicaid experienced unprecedented growth, more than tripling from just 48 percent of the federal poverty level to 159 percent of poverty.^{32,33,34} Furthermore, it appears that these coverage expansions have been maintained over the years; as of July 2006, just 7 states covered pregnant women at 133 percent of poverty—the federally mandated minimum level. The remaining 43 states and the District of Columbia covered pregnant women beyond this income level, with Minnesota having the highest upper income limit for pregnant women under Medicaid, at 275 percent FPL.³⁵

³² Ibid.

³³ National Governor's Association. *MCH Updates, 1986-1992*. Washington, DC: National Governor's Association.

³⁴ Hill, I. (1992) *The Medicaid Expansions for Pregnant Women and Children: A State Program Characteristics Information Base*. Prepared for the Health Care Financing Administration, DHHS. Health Systems Research, Inc. Washington, DC: Health Systems Research, Inc.

³⁵ Cohen Ross, D, Cox, L, and Marks, C. 2007. *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Washington DC: Kaiser Family Foundation.

Today, Medicaid is not only the nation's largest health insurance program for low-income people—the program covered over 57 million people in fiscal year 2004—it is also the single largest financier of births in the U.S.³⁶ In 2002, the program covered more than 1.6 million births (a 3.47 percent increase over the number of Medicaid births for 2001), representing nearly 41 percent of total births nationwide. The percentage of total births financed by the program varies by state—in New Mexico, about 2/3 of all births were financed by Medicaid (66.8 percent) and in New Hampshire just over a fifth (21.4 percent) were Medicaid births.³⁷ Still, the program is viewed as having even greater potential to improve maternal and child health outcomes by promoting timely access to preconception and interconception care. An expert panel that was convened in 2006 to address improvements to preconception care recommended that “as states seek to expand Medicaid coverage to persons with low incomes and adults who do not have health insurance, women of childbearing age should receive priority for qualifying for Medicaid coverage.”³⁸ There is considerable room for improvement with regards to this recommendation, as data from the U.S. Census Bureau shows that one in five women of childbearing age (15–44) was uninsured in 2005. This population has an uninsured rate of 20.8 percent (greater than that of the general population under age 65) and accounts for 28 percent of all uninsured Americans.³⁹

³⁶ Kaiser State Health Facts Online. *Total Medicaid Enrollment; Births Financed by Medicaid*. Retrieved June 26, 2007 from: <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?>

³⁷ Schwalberg, R., Mathis, S.A., Giffen, M., Mohamadi, L., and Zimmerman, B., et al. (2000) *Medicaid Coverage of Perinatal Services: Results of a National Survey*. Prepared for the Henry J. Kaiser Family Foundation. Washington, DC: Health Systems Research, Inc.

³⁸ Centers for Disease Control, Morbidity and Mortality Weekly Report; *Recommendations to Improve Preconception Health and Health Care—United States* (2006).

³⁹ U.S. Census Bureau. (2006) *2006 Current Population Survey Annual Social and Economic Supplement*. Data prepared for the March of Dimes.

C. Medicaid Outreach and Enrollment Practices

While increasing Medicaid income eligibility thresholds for pregnant women was a necessary step to improving access to prenatal care, states recognized from the start that merely putting this coverage into place was not sufficient in itself—efforts would also be needed to make pregnant women aware of the availability of coverage and to facilitate enrollment into Medicaid. Consequently, throughout the late 1980s and early 1990s, most states made substantial investments in outreach to low-income pregnant women and also adopted simplified enrollment procedures.

Many states launched mass-media efforts aimed at reaching large numbers of pregnant women in an entire state or broad geographic area—these efforts included television and radio advertisements, print materials distributed through social service providers or posted at public transportation sites, and toll-free hotlines, among others. For example, in 1987, Utah launched its ‘Baby Your Baby’ program which included a broad and multi-faceted mass-media component. The Utah Department of Health, which administers the Medicaid program, implemented a 1-800 statewide hotline and a television broadcasting affiliate developed a series of public service announcements (PSAs) and 30-minute special prime-time segments on the benefits of early and consistent prenatal care.⁴⁰ Other states adopted community-based approaches that relied on face-to-face contact with pregnant women, either as the sole outreach strategy or in combination with a mass-media campaign. For example, in the late 1980s, Arizona’s Department of Health Services awarded four grants to community-based projects whose allowing lay community volunteers to conduct culturally appropriate case-finding

⁴⁰ vanDyck, P.C., Nangle, B., McDonald, S.P., Wells, T.J., and Betit, R.L. (1991). *Baby Your Baby: Utah’s Program to Enhance Prenatal Care*. Salt Lake City, UT: Utah Department of Health Family Health Services Division.

programs. Comparatively, these types of efforts were more labor-intensive and required more staff and resources than mass-media efforts.⁴¹

To complement outreach campaigns, the vast majority of states took advantage of OBRA-1986 flexibility to adopt strategies to make enrollment into the Medicaid program easier for pregnant women. By the end of 1991, the simplified enrollment processes that they adopted included: shorter application forms (31 states); continuous eligibility through pregnancy and 60 days postpartum (all states and DC); presumptive eligibility (25 states and DC); outstationed eligibility workers in community health centers and safety net hospitals (49 states and DC); dropping assets tests (47 states and DC); and expediting eligibility determinations (16 states).⁴² The most recent study of some of these program characteristics—conducted in 2000—indicated that most states appeared to maintain these simplified procedures.⁴³

D. Content and Delivery of Prenatal Care in Medicaid

States' efforts to improve birth outcomes did not end with strategies to facilitate coverage through public health insurance programs. Rather, most states also took steps to improve the content and delivery of prenatal care covered under the programs. New authority contained in COBRA-85 allowed states to receive Medicaid matching funds to (1) provide targeted case management (TCM) to pregnant women (among other populations); and (2) to cover enhanced prenatal care benefit packages for pregnant enrollees (without extending them to the rest of the Medicaid population). By 1992, 38

⁴¹ Hill, I. (1988). *Reaching Women Who Need Prenatal Care*. Washington, DC: National Governor's Association.

⁴² Hill, I. (1992) *The Medicaid Expansions for Pregnant Women and Children: A State Program Characteristics Information Base*. Prepared for the Health Care Financing Administration, DHHS. Health Systems Research, Inc. Washington, DC: Health Systems Research, Inc.

⁴³ Schwalberg, R., Mathis, S.A., Giffen, M., Mohamadi, L., and Zimmerman, B., et al. (2000) *Medicaid Coverage of Perinatal Services: Results of a National Survey*. Prepared for the Henry J. Kaiser Family Foundation. Washington, DC: Health Systems Research, Inc.

states had implemented either targeted case management or “care coordination” systems, which typically involved nurses, social workers, or other health care professionals conducting perinatal risk assessment, plan of care development, coordination and referral, and follow-up and monitoring activities. Additionally, some states included advocacy, outreach or community education, eligibility assistance, and transportation support within the definition of care coordination.⁴⁴ Similarly, by early 1992, the vast majority of states had also adopted enhanced prenatal care benefit packages that augmented traditional medical services with a range of non-medical, psychosocial support services deemed as important in supporting improved outcomes. Specifically, 30 states covered nutritional counseling, 30 covered health education, 24 covered psychosocial counseling, 38 covered perinatal risk assessment, 31 covered home visiting, and 9 covered special transportation services for pregnant women.⁴⁵ Several states emerged as frontrunners in the effort to deliver continuous and comprehensive packages of health care and related services to pregnant women, and rigorous evaluations of these programs demonstrated positive effects. For example:

- Under **New York’s Prenatal Care Assistance Program (PCAP)** health care providers offered Medicaid-enrolled pregnant women comprehensive prenatal services. This included risk assessment, nutritional services, and health education. An evaluation of *PCAP* found a consistent and positive association between participation in the program and improved infant health (including improvements in birth weight and lowered rates of low birth weight), a 20 percent increase in the likelihood of participation in WIC, and modest reductions in newborn costs.⁴⁶

⁴⁴ Hill, I.T. and Breyel, J. (1989). *Coordinating Prenatal Care*. Washington DC: National Governor’s Association.

⁴⁵ Hill, I. (1992) *The Medicaid Expansions for Pregnant Women and Children: A State Program Characteristics Information Base*. Prepared for the Health Care Financing Administration, DHHS. Health Systems Research, Inc. Washington, DC: Health Systems Research, Inc.

⁴⁶ Joyce, T. (1999). Impact of Augmented Prenatal Care on Birth Outcomes of Medicaid Recipients in New York City. *Journal of Health Economics* 18: 31-67.

- **North Carolina's Baby Love Care Coordination Program** extended intensive case management services (including risk assessment, plan of care development, referral to health and support providers, and follow-up) to all Medicaid-enrolled pregnant women beginning in 1987. Evaluations of the program found that, compared to women who received care coordination, those that did not experienced higher rates of low birth weight, very low birth weight, and infant mortality. This study also found that for each \$1.00 spent on maternity care coordination, an estimated \$2.02 was saved in medical costs for newborns up to 60 days of age.⁴⁷ In 1992, maternal outreach worker services were added to local Baby Love programs, providing monthly home visits generally beginning prior to 28 weeks gestation and continuing through an infant's first birthday. An evaluation of outreach worker services found that intensive levels of home visitor support were likely to improve aspects of psychological functioning among women at risk for poor psychological health.⁴⁸
- **California** added the *Comprehensive Perinatal Services Program* (CPSP) to its Medicaid program in 1987. Under CPSP, the state began providing care coordination, nutritional and psychosocial assessment and counseling, and health education to pregnant women through a network of qualified providers, such as local public health clinics. Evaluations of the program found increased prenatal care and support services use among enrolled women, and to a lesser extent, reduction in the incidence of adverse perinatal outcomes.⁴⁹ Two years later, the state implemented a Black Infant Health (BIH) program to improve birth outcomes specifically for African American infants. Project activities included early identification and enrollment into Medicaid and BIH, and also focused on social support, case management, family planning, and health behavior modification. Evaluation of the BIH program documented reductions in low birth weight and very premature births (under 32 weeks gestation).⁵⁰
- **Colorado's Prenatal Plus Program**, implemented in 1995, provides care coordination, mental health, and nutrition services to high-risk pregnant Medicaid enrollees, with a package of 10 visits to a care coordinator, dietician, or mental health professional. Services are available up to 60 days postpartum. An evaluation of the program found that babies born to program

⁴⁷ Buescher, P.A., Roth, M.S., Williams, D., and Goforth, C. (1991). An Evaluation of the Impact of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina. *American Journal of Public Health* 81(12).

⁴⁸ Navaie-Waliser, M., Martin, S.L., Tessaro, I., Campbell, M.K. and Cross, A.W. (2000). Social Support and Psychological Functioning Among High-Risk Mothers: The Impact of the Baby Love Maternal Outreach Worker Program. *Public Health Nursing* 17(4).

⁴⁹ Korenbrot, C.C., Gill, A., Clayson, Z., and Bonaparte, E.P. (1995). Evaluation of California's Statewide Implementation of Enhanced Perinatal Services as Medicaid Benefits. *Public Health Reports* 110(2): 125–33.

⁵⁰ Braveman P, Marchi K, Sarnoff R, Egerter S, Rittenhouse D, and Salganicoff A. (2003). *Promoting Access to Prenatal Care: Lessons from the California Experience*. The Henry J. Kaiser Family Foundation.

participants have significantly higher birth weights compared to group of high-risk mothers not receiving service.⁵¹

Other examples of state enhanced prenatal care initiatives launch during this period included The Montana Initiative for the Abatement of the Mortality of Infants (MIAMI) project, launched in 1989, which used the TCM benefit to provide a care coordination package consisting of nursing, dietician, social services, health education, and advocacy.⁵² Likewise, Louisiana's Nurse-Family Partnership program uses the TCM benefit to reimburse for nurse home visits to pregnant women and their infants.⁵³ Once again, in 2000, it appeared that many states continued to cover a range of enhanced prenatal support services.⁵⁴

E. Medicaid Managed Care

Soon after Medicaid expansions were enacted and beginning in the early 1990s, the U.S. health care system experienced major changes in the way that health care was delivered and financed—the expansion of managed care in both the public and private sectors had important implications for the delivery of prenatal care. By 2000, 82 percent of women covered by Medicaid were enrolled in managed care, and 44 states and the District of Columbia used some type of managed care strategy to serve pregnant women.^{55,56}

⁵¹ Glazner, J.E. and Beaty, B. (2002). *The Effects of the Prenatal Plus Program on Infant Birth Weight and Medicaid Costs*. University of Colorado Health Sciences Center.

⁵² Gallagher, J., Botsko, C., and Schwalberg, R. (2004). *Influencing Interventions to Promote Positive Pregnancy Outcomes and Reduce the Incidence of Low Birth Weight and Preterm Infants*. Prepared for the March of Dimes. Washington, DC: Health Systems Research, Inc.

⁵³ Hall, E., and Berlin, M. (2004). *Using Medicaid to Support Preterm Birth Prevention: Five Case Studies*. Prepared for the March of Dimes. Retrieved March 30, 2007 from: http://www.marchofdimes.com/Medicaid_and_Prematurity_II_Hall-Berlin.pdf.

⁵⁴ Schwalberg, R., Mathis, S.A., Giffen, M., Mohamadi, L., and Zimmerman, B., et al. (2000) *Medicaid Coverage of Perinatal Services: Results of a National Survey*. Prepared for the Henry J. Kaiser Family Foundation. Washington, DC: Health Systems Research, Inc.

⁵⁵ Ibid.

⁵⁶ Salganicoff, A., Beckerman, J.Z., Wyn, R., and Ojeda, V.D. (2002). *Women's Health in the United States: Health Coverage and Access to Care*. Washington, DC: Henry J. Kaiser Family Foundation.

Though managed care arrangements are generally aimed at improving access to care, there is little consensus on the effects of managed care on prenatal care timing and birth outcomes. For example, one study found that mandatory HMO enrollment in Ohio's Medicaid program increased take-up of early prenatal care and also contributed to reductions in maternal smoking for non-Hispanic white,⁵⁷ but another found that pregnant women enrolled in fee-for-service arrangements received better prenatal care than those in managed care.⁵⁸ The structure of many managed care arrangements does present states with unique opportunities to identify and connect with pregnant enrollees. Specific examples of managed care innovations adopted by Medicaid programs include: decreased waiting period for Medicaid enrollment from 60 to 30 days, allowing pregnant women to be identified faster (Sentara Healthcare in Virginia); promoting completion of health risk assessments for new enrollees to facilitate early identification of pregnancies and associated co-morbidities (Coventry Health Care of Delaware), and; developing a bilingual newsletter that highlights good health habits for pregnant women and a prenatal care phone line (Colorado Access).⁵⁹

F. Medicaid Family Planning Demonstration Waivers

Another important development that followed on the heels of expansions for pregnancy-related health insurance coverage was expanded coverage of family planning services to low-income women (and men, in seven states) through Medicaid Section 1115 demonstration waiver from the Centers for Medicare and Medicaid (CMS). The premise

⁵⁷ Kenney G., Sommers A.S., and Dubay L. (2005). Moving to Mandatory Medicaid Managed Care in Ohio Impacts on Pregnant Women and Infants. *Medical Care* 43(7): 683-690.

⁵⁸ Schulman, E.D., Sheriff, D.J., and Momany, E.T. (1997). Primary Care Case Management and Birth Outcomes in the Iowa Medicaid Program. *American Journal of Public Health* 87:80-4.

⁵⁹ Oehlmann, M.L. (2001). *Toward Improving Birth Outcomes: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans*. Hamilton, NJ: Center for Health Care Strategies, Inc.

of these 5-year family planning demonstrations, which are supported by enhanced federal matching at the rate of 90 percent, is that providing coverage of family planning services increases the likelihood that low-income women will use the services and decrease the likelihood that they will have unintended pregnancies. Since many of the programs target postpartum women, another potential effect of the demonstration waivers is a longer interval between consecutive pregnancies, which also has implications for birth outcomes. A recent study found that women whose pregnancies were less than six months apart had a 40 percent higher risk of giving birth prematurely and a 61 percent higher risk of delivering an infant with low birth weight and the risk of prematurity increased 1.9 percent for each month under 18 months between pregnancies.⁶⁰ The States of Rhode Island and South Carolina were the first to take advantage of this waiver authority in 1993. By March 2006, 21 additional states had obtained federal approval to extend Medicaid eligibility for family planning services to individuals not otherwise eligible.⁶¹ Early studies have found important positive impacts resulting from these programs. For example, family planning demonstrations have been found to reduce unintended pregnancies, which are associated with delayed entry into prenatal care and other risk factors associated with poor birth outcomes.^{62, 63} A national evaluation of Medicaid family planning demonstration waiver programs in six states reported that the programs resulted in significant savings to federal and state governments, improved

⁶⁰ Conde-Agudelo, A., Rosas-Bermudez, A., and Kafury-Goeta, A.C. (2006). Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. *JAMA* 295:1809-1823.

⁶¹ Guttmacher Institute. (2006). *State Policies in Brief: State Medicaid Family Planning Eligibility Expansions*. Retrieved on February 28, 2007 from: http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

⁶² Henshaw, S.K. (1998). Unintended Pregnancy in the United States. *Family Planning Perspectives* 30(1): 24-29+46.

⁶³ Brown, S.S., and Eisenberg, L. (1995). *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Institute of Medicine.

geographic availability and expanded diversity of providers, a measurable reduction in unintended pregnancy, and expanded access to care.⁶⁴

G. State Children's Health Insurance Program

Finally, the most recent development in pregnancy-related public coverage relates to the State Children's Health Insurance Program (SCHIP), which began in 1997. Naturally, SCHIP covers pregnancy-related services to adolescents under age 19. But to use SCHIP funds to cover pregnant women age 19 and over, states can apply and receive approval for an 1115 waiver from DHHS. Additionally, in 2002 federal rules were modified to allow states to extend such coverage through an alternative method—they have the option to amend their SCHIP plans to cover prenatal care and delivery services for otherwise ineligible low-income women under the premise that funds are supporting the “unborn child.” In a 2005 national survey of SCHIP programs, five states reported covering pregnant women over age 19 under Section 1115 waiver authority and seven others reported adopting plan amendments to cover unborn children.⁶⁵ More recent data from the Centers for Medicare and Medicaid Services (CMS) indicate that an increasing number of states are adopting such measures—CMS reported that as of May 2007, six states used SCHIP to cover pregnant women under Section 1115 waivers⁶⁶ and as of June

⁶⁴ Edwards, J., Bronstein, J., and Adams, K. (2003). *Evaluation of Medicaid Family Planning Demonstrations*. Prepared for the Centers for Medicare and Medicaid Services under Contract No. 752-2-415921. Baltimore, MD: Centers for Medicare and Medicaid Services.

⁶⁵ Kaye N, Pernice C, and Cullen A. (2006). *Charting SCHIP III: An Analysis of the Third. Comprehensive Survey of State Children's Health Insurance Programs*. National Academy of State Health Policy. Retrieved on March 30, 2007 from: http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf.

⁶⁶ These states are Colorado, Nevada, New Jersey, Oregon, Rhode Island, and Virginia. Centers for Medicare and Medicaid Services. *State Children's Health Insurance Program Section 1115 Demonstration Projects*. Retrieved on June 20, 2007 from: <http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/Section1115ReportApprovedUnderReview.pdf>.

2007 eleven states had received federal approval to amend their SCHIP plans to cover unborn children.⁶⁷

Starting with the creation of SCHIP and continuing to the present day, federal and state policymakers have kept their maternal and child health interests primarily focused on children's health care issues. Over the last 10 years, actions to address children's coverage have followed a decidedly similar path to those taken when states were expanding financial access for pregnant women in the 1980s. Namely, they have gone beyond raising income eligibility thresholds (in 2006, all but 8 states had SCHIP programs with an eligibility threshold at 200 percent of poverty or above) by making significant investments in both statewide and community-based outreach, and by dramatically simplifying enrollment procedures for children through such strategies as shortened application forms, 12-month continuous eligibility, dropped assets tests, reduced documentation and self-declaration of income, paid application assistors, and presumptive eligibility, among others.^{68, 69} Several qualitative studies have described successful outreach and enrollment strategies for children under SCHIP and other public coverage programs. For example, one practice that has been identified as especially promising is the establishment of direct payment incentives to community-based

⁶⁷ These states are: Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Rhode Island, Texas, Washington, and Wisconsin. Centers for Medicare and Medicaid Services. *State Children's Health Insurance Program, Plan Activity as of June 1, 2007*. Retrieved on July 5, 2007 from: <http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf>.

⁶⁸ Kaye N, Pernice C, and Cullen A. (2006). *Charting SCHIP III: An Analysis of the Third. Comprehensive Survey of State Children's Health Insurance Programs*. National Academy of State Health Policy. Retrieved on March 30, 2007 from: http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf.

⁶⁹ Ian Hill, Mary Harrington, Corinna Hawkes. *Final Cross-Cutting Report on the Findings from Ten State Site Visits: Congressionally Mandated Evaluation of SCHIP*. Princeton, New Jersey: Mathematica Policy Research, Inc. December 2003. (Revised May 2004)

organizations and individuals for public coverage application assistance.^{70,71,72,73,74}

Additionally, a randomized control trial conducted over a two-year period in Boston demonstrated the effectiveness of community-based case managers in enrolling uninsured Latino children into public health insurance programs.⁷⁵

Two decades have passed since the first Medicaid expansions for pregnant women were enacted into law. Over that time, the health services landscape has changed dramatically, and a new array of public programs for low-income children and women of childbearing age have been introduced. During the same period, improvement in key measures of birth outcomes have either stagnated or, in some cases, worsened. Considering these factors, it is a critical time to re-assess states' efforts to reach out to and enroll pregnant women into Medicaid in hopes of improving access to care and birth outcomes.

⁷⁰ Hill, I. and Hawkes, C. (2002). *The State of New York's Child Health Plus Program: Site Visit Report from the Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. Princeton, NJ: Mathematica Policy Research, Inc.

⁷¹ Ian Hill and Corinna Hawkes. *The State of California's Healthy Families Program: Site Visit Report from the Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. Princeton, NJ: Mathematica Policy Research, Inc. November 2002.

⁷² Ross, D.C. and Hill, I. (2003). Enrolling Eligible Children and Keeping them Enrolled. *The Future of Children* 13(1).

⁷³ Hill, I., Courtot, B., Barreto, P., and Wada, E. (2005). *A Healthy Start for the Los Angeles Healthy Kids Program: Findings from the First Evaluation Site Visit*. Los Angeles, CA: First 5 LA.

⁷⁴ Courtot, B. and Howell, E. (2006). *Reaching out to Enroll Children in Public Health Insurance: The CKF Grantees and their Experiences*. Prepared for the Robert Wood Johnson Foundation as part of the Covering Kids and Families Evaluation. Washington, DC: The Urban Institute.

⁷⁵ Flores, G., Abreu, M., Chaisson, C.E., Meyers, A., Sachdeva, R.C., and Fernandez, H. et al. (2005). A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Latino Children. *Pediatrics* 116:1433-1441.

III. Survey Findings: Innovative Strategies in Medicaid Outreach and Enrollment of Pregnant Women

Medicaid officials in all 50 states and the District of Columbia were surveyed to gather detailed information regarding policies surrounding eligibility, enrollment, outreach, and prenatal care benefits for pregnant women. Surveys were administered via e-mail and the official(s) in each state who had lead responsibility for these policy areas completed the surveys and returned them by e-mail. Returned surveys were analyzed and informally “scored” based on an assessment of the extent and creativity of each state’s outreach efforts, facilitated enrollment processes, expanded eligibility criteria, and enhanced prenatal services. Based on the scoring process, ten states were chosen for follow-up telephone interviews to gather more detailed information on program design and implementation. Based on the outcomes of the telephone interviews, two states were chosen for still further in-depth study, and multi-day site visits to these states were conducted by the project team.

Presented below are the summary results from the 50-state survey. (Highlights from our telephone interviews and detailed case studies are presented in subsequent chapters.) Survey results are organized into the three sections: enrollment policies and processes; outreach strategies; and enhanced prenatal care benefits.

A. Enrollment Policies and Processes

Based on the findings of the March of Dimes Survey of Medicaid Strategies for Outreach and Enrollment of Pregnant Women, it appears that states continue to place a high priority on providing health services for pregnant women and have made significant efforts to simplify enrollment of this population into coverage. States reported on the multiple options available to them for improving enrollment processes and the study

found wide variation among states in how they enroll pregnant women into Medicaid.

States were surveyed about a range of policy options, including

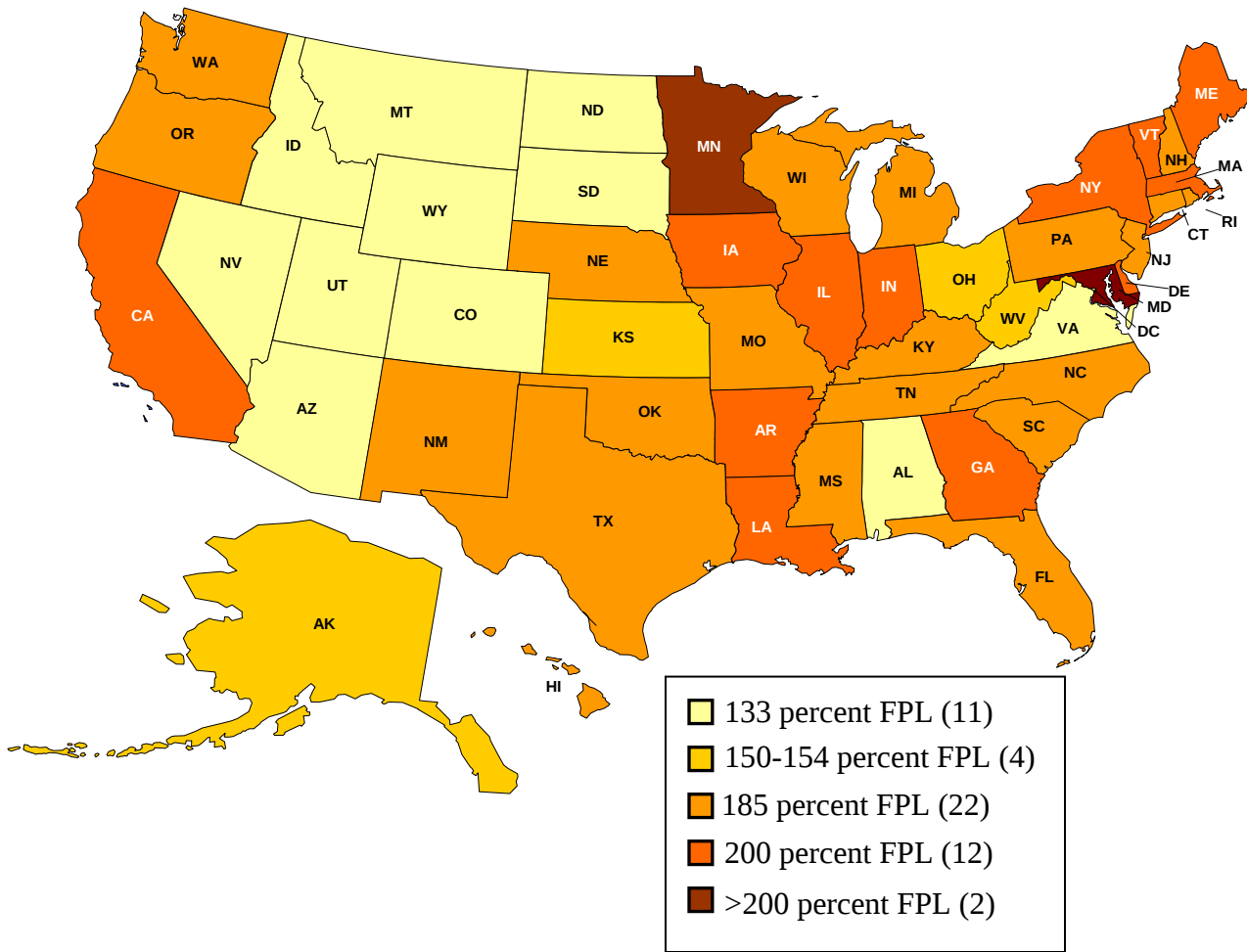
- Income eligibility limits;
- Medicaid applications and options for application submission;
- Verification requirements with regard to assets, income, and citizenship;
- Processes for expediting enrollment of pregnant women into coverage, including (but not limited to) presumptive eligibility; and
- Community-based placement of application assistors and/or outstationed eligibility workers to help women in completing program applications.

Income Eligibility

The Omnibus Budget Reconciliation Act of 1989 required states to extend Medicaid coverage to all pregnant women with household incomes up to 133 percent of the federal poverty level (FPL). Today, only 11 states set their upper income eligibility threshold at this minimum mandated level; nine of these states (Arizona, Colorado, Idaho, Montana, Nevada, North Dakota, South Dakota, Utah, and Wyoming) are located in the mountain west region of the country.

The vast majority of states go beyond the income eligibility mandate. As illustrated in Figure 1, in 2007, 22 states covered pregnant women with incomes up to 185 percent FPL, and 12 states cover them up to 200 percent of poverty. Maryland covers pregnant women with incomes to 250 percent and Minnesota has the highest upper income limit, covering women up to 275 percent of the federal poverty level.

Figure 1:
Medicaid Upper Income Eligibility for Pregnant Women by State as a Percent of the Federal Poverty Level (FPL), 2007



For comparison purposes, just 16 states cover parents in Medicaid with incomes up to 185 percent of poverty; but 36 states cover infants ages 0 to 1 at or above 185 percent FPL; 17 states cover children ages 1 to 5 at that level; and 16 states cover children ages 6 to 19 at 185 percent of poverty in their Medicaid programs.⁷⁶

⁷⁶ Ross, Donna Cohen et al, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," The Kaiser Commission on Medicaid and the Uninsured, January, 2008.

How Pregnant Women can Apply for Medicaid

Before states expanded coverage for pregnant women in the 1980s and 1990s, application forms were long, complicated, and a barrier to enrollment. To simplify the process, as summarized in this paper's literature review, many states made efforts to shorten applications for pregnancy coverage to reduce the amount of paperwork pregnant women were required to complete.

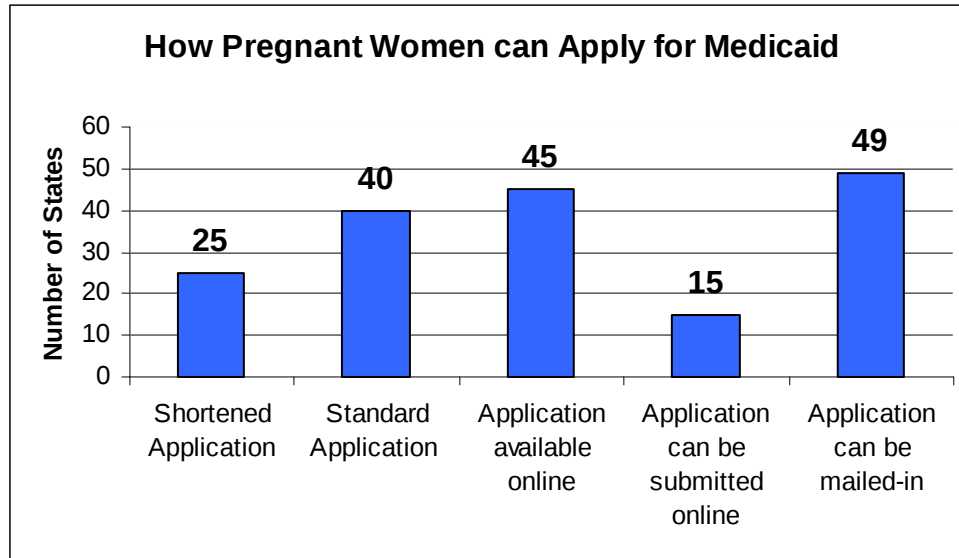
In 2007, our survey found that half the states continue to make shortened applications available for pregnant women, compared to 31 states in 1992 (see Figure 2). However, having a shortened application for pregnant women is no longer a clear indicator of an effort to facilitate enrollment into pregnancy coverage. Since the early 1990s, many states have made efforts to simplify their standard Medicaid application form (used for all populations), and pregnant women can apply using this standard application in all but eleven states. Georgia, for example, does not have a shortened application specifically for pregnant women but recently reviewed its standard application and simplified the form by adding pictures, color, and plain language explanations for the questions. Their single, four-page application provides links to several social service programs in addition to Medicaid.

Every state except California and New York allows pregnant women to apply by mail (see Figure 2).⁷⁷ Additionally, 45 states have applications for pregnancy coverage available on the Internet. In almost all cases, pregnant women can go online and print an application for pregnancy coverage, then complete it and submit it by mail. Among the states that make their applications available online, 15 states allow pregnant women to

⁷⁷ California and New York require face-to-face interviews, which may explain why they do not accept mailed-in applications.

complete and submit their applications online, allowing for an entirely electronic application process.

Figure 2: Methods of State Medicaid Program Application Available to Pregnant Women, 2007



Pennsylvania, for example, has a shortened application for pregnant women, and both the shortened and standard applications can be submitted online. Currently, only about 12 percent of their applications are submitted online; however, in an effort to increase the use of online applications, they are beginning to implement a project to put kiosks in all county offices to allow more clients to complete and submit applications electronically.

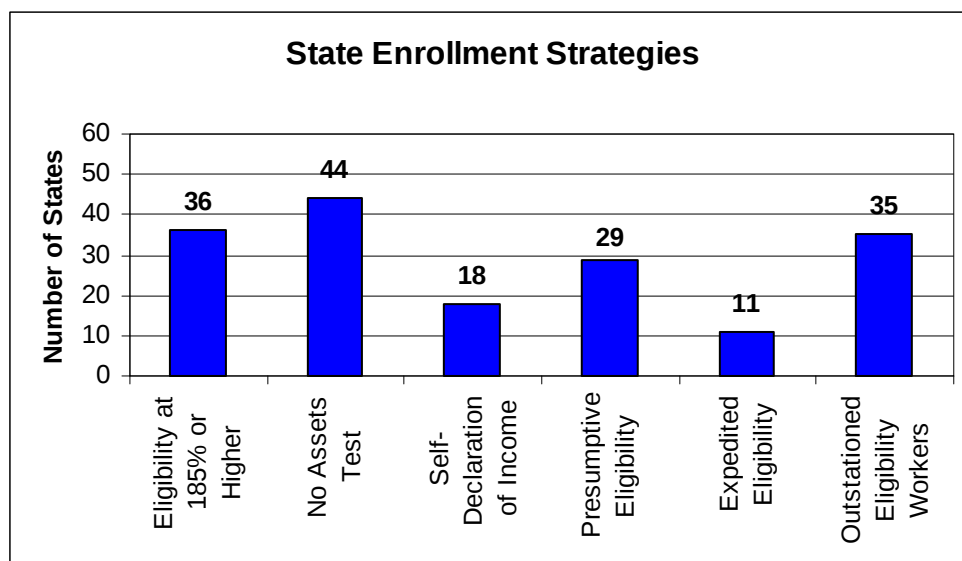
Online applications make it easier for some individuals to apply for Medicaid. In 2007, Wisconsin put its Medicaid application on its program web site and permits applicants to fill it out and submitted it online. The state's online application has seen a

lot of traffic and has been quite popular; however it is unclear how much of that traffic is pregnant women.

Asset Tests and Self-Declaration of Income

When determining eligibility for Medicaid, a few states continue to consider pregnant applicants' assets, which may include cash, bank accounts, and vehicles. Without asset tests, a woman only needs to verify her pregnancy, income, and provide proof of residency to complete the application process for pregnancy coverage. Almost all states have eliminated asset restrictions from their Medicaid eligibility criteria, making the application process less burdensome and allowing more women to qualify. Currently, as seen in Figure 3, 44 states do not require applicants meet asset requirements to qualify for coverage, while seven states (Arkansas, Idaho, Iowa, Montana, South Carolina, South Dakota, and Utah) continue to consider assets when determining if a pregnant woman is eligible. States have lost some ground in respect to asset tests; in 1992 only three states required asset tests to determine Medicaid eligibility for pregnant women.

Figure 3: State Medicaid Enrollment Strategies for Pregnant Women, 2007



States also have the option to allow pregnant women to self-declare their income, or not submit income documentation when applying for Medicaid coverage.

Documentation of income can be difficult for some applicants and can slow down the eligibility determination process. For example, paycheck stubs may be unavailable and applicants may not feel comfortable asking their employers to provide them with the proper documentation. States can use federal and state databases to verify self-reported income, rather than require the applicant to provide proof. Currently, 18 states accept self-declaration of income, including eight states that allow all pregnant women applying for coverage to self-report their household's earnings (Figure 3). In three states (Colorado, Delaware, and Massachusetts), self-declaration of income is acceptable only for women during presumptive eligibility, while in seven other states self-declaration is only allowed under some other circumstances. In Louisiana, self-declaration of income is only allowable if the applicant's declared income is less than 75 percent of the state's income eligibility limit.

The number of states with policies of self-declaration of income has not changed significantly since at least 2002, when a study by the National Governor's Association found that 11 states allowed pregnant women applying for Medicaid to self-report their income.⁷⁸

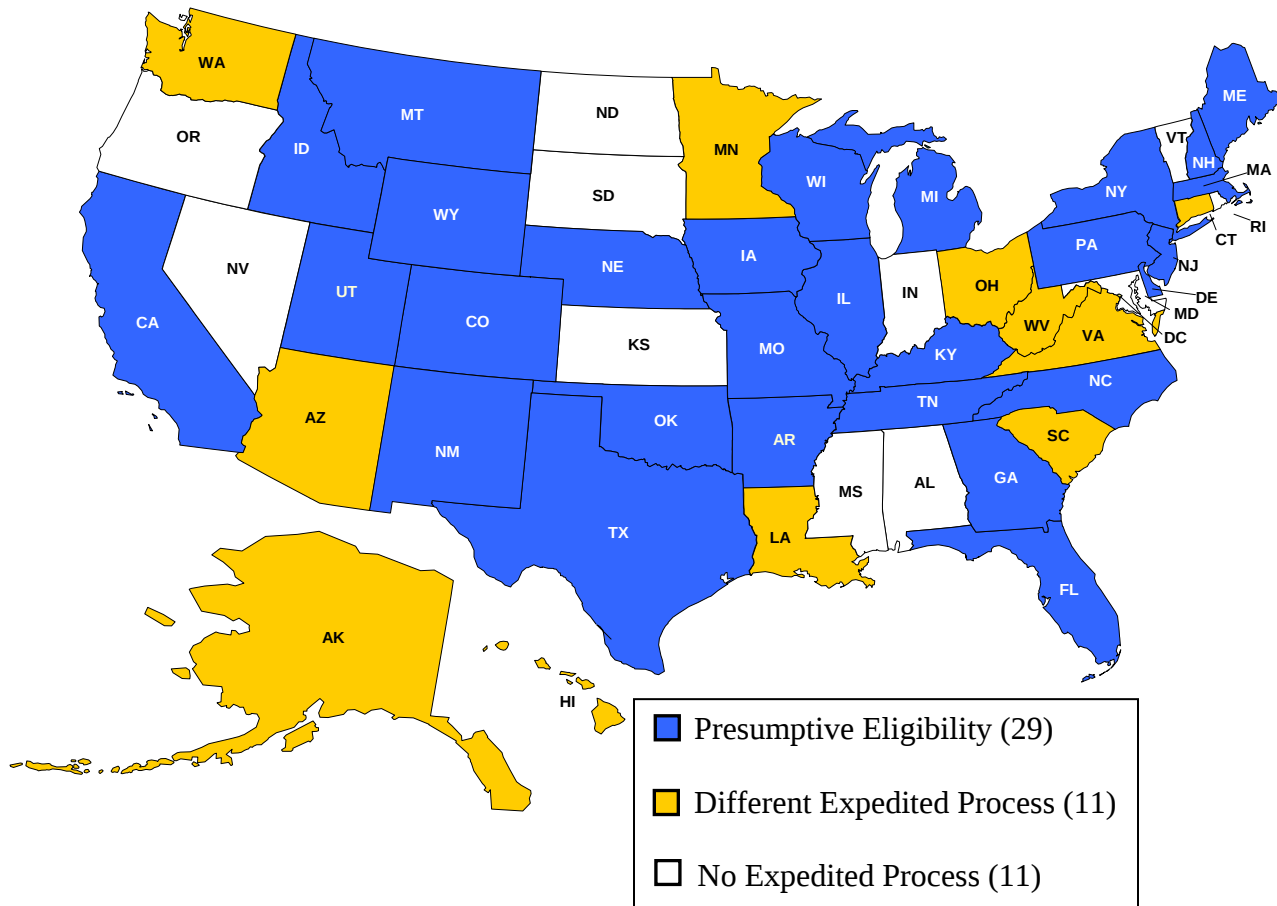
⁷⁸ NGA Center for Best Practices, "MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents," June 9, 2003.

Presumptive Eligibility for Pregnant Women

Presumptive eligibility is an option that permits states to allow certain qualified providers (which may include community and rural health centers, hospitals, physicians, local health departments, and family planning agencies, among others) to conduct a preliminary eligibility determination for pregnant women, grant short-term eligibility, and receive federally matched Medicaid reimbursement for prenatal care rendered to women who appear to be Medicaid eligible. This temporary eligibility continues for up to 60 days, during which time women must complete a formal application for ongoing coverage beyond the 60 days. (If they don't complete this process, "presumptive" coverage expires.) The option is important because it allows pregnant women to access critical care quickly, providers are guaranteed payment from Medicaid for the care they provide, and states receive federal matching of state spending. Figure 4 illustrates that 28 states and DC currently grant presumptive eligibility for pregnant women.

Presumptive eligibility is not the only strategy that a state can use to put pregnancy-related coverage in place quickly. Figure 4 also indicates that an additional 11 states have adopted a different process for expediting application processing for this population. Generally, these approaches involve placing priority status on applications from pregnant women and establish more rigorous turn-around times for their processing. For example, eight states (Colorado, Hawaii, Louisiana, Minnesota, Missouri, Virginia, Washington, and West Virginia) expedite applications for pregnant women so that eligibility is determined in three to 15 days.

**Figure 4:
States with Presumptive Eligibility for Pregnant Women or a Different Expedited Process, 2007**



In 2007, Louisiana eliminated its policy of presumptive eligibility for pregnant women. The state had experienced difficulty finding providers that were willing to serve presumptively eligible women, because many felt obligated to continue providing care, without compensation, to women who lost their temporary coverage after being found ineligible for Medicaid. In its place, Louisiana developed systems for processing the standard LaMOMS application more quickly. With full-time staff in each region of the state dedicated to processing applications, Louisiana has been able to process regular

applications in five days or fewer, making presumptive eligibility no longer necessary. Similarly, Connecticut has an expedited eligibility process for pregnant women instead of presumptive eligibility, which grants coverage in one to five days from the date the application is received.

Currently across the country, more states have presumptive eligibility policies than in 1992, when 25 states and Washington, DC allowed the practice. However in 1992, 16 states expedited eligibility determinations for pregnant women, compared to only 10 states in 2007. Taken together, the number of states with presumptive eligibility or another expedited process is essentially unchanged since the early 1990s; however there has clearly been a shift towards presumptive eligibility.

Outstationed Eligibility Workers

States are required by federal law to outstation Medicaid eligibility workers at certain locations in the community—specifically, at all Federally Qualified Health Centers and hospitals that serve a disproportionate share of Medicaid eligibles.⁷⁹ By outstationing workers at such points of service, states have the potential to reach and enroll pregnant women who may not otherwise make a separate trip to a social services office to apply for coverage. However, this portion of the statute has been hard to enforce, and there has never been a time when all states complied with the requirement. The reasons for this are complex. For example, states with staffing shortages may be unwilling to outstation staff in the community because they are needed elsewhere. Also, some states simply choose not to comply, while others argue that they have other, more convenient avenues for women to apply for coverage.

⁷⁹ 42 CFR 435.904

Among those states that currently outstation eligibility workers:

- Twenty-six states outstation workers in hospitals;
- Nineteen states place eligibility workers in community health centers;
- Ten states have workers in health department clinics; and
- Fifteen states outstation eligibility workers at other locations.

Several states also place eligibility workers in non-traditional sites. For example, Georgia outstations workers in many different locations and events where pregnant women may be contacted, including daycare centers, community fairs, cultural festivals, and community recreation centers. Outstationed eligibility workers in Georgia work evenings and weekends across the state in an effort to maximize their effectiveness.

As a whole, states have not maintained their previous commitments to place eligibility workers in the community. Only 34 states and Washington, DC outstationed eligibility workers in 2007. In 1992, that number was 49 states and the District of Columbia.

B. Outreach Strategies

Improving enrollment policies and practices are essential to the effort to improve access to prenatal care. However, many pregnant women may not be aware that they are eligible for Medicaid. Strong outreach efforts help to ensure that eligible pregnant women are aware of and apply for coverage. Therefore, many states have developed aggressive outreach strategies aimed at reaching pregnant women and informing them of the importance of prenatal care and the availability of Medicaid coverage.

The survey collected data about a number of outreach issues, including:

- Whether states explicitly dedicate Medicaid funding to outreach;
- Whether states conduct social marketing campaigns using paid or unpaid media, including radio, television, and print media;
- Whether states invest in community-based outreach;
- Whether states provide direct incentives to women to influence their participation in prenatal care; and
- Whether states target specific high-risk populations through outreach.

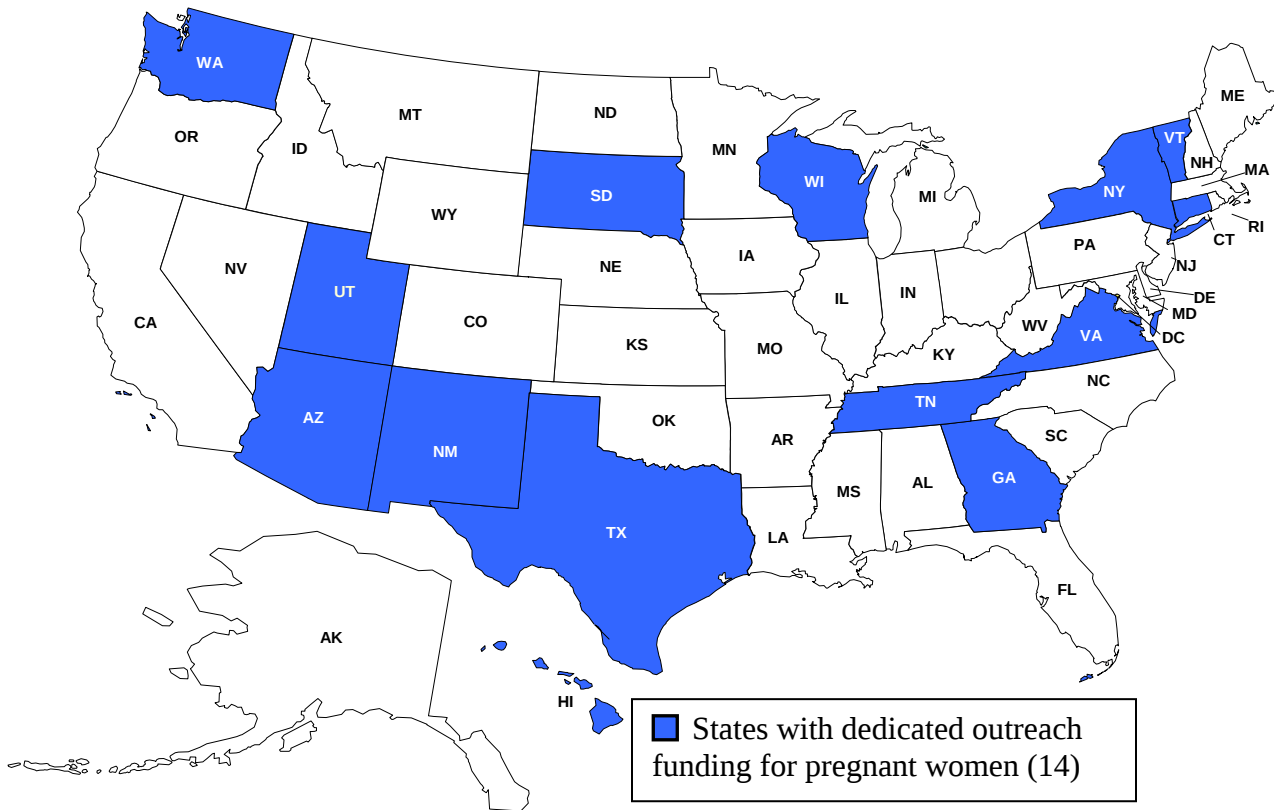
Survey findings from these queries are summarized below.

Dedicated Funding for Outreach to Pregnant Women

Adequate funding may improve the success of states' outreach efforts, allowing states to invest in longer term campaigns aimed at branding and raising public awareness of their programs. Our survey found that, to further their outreach efforts, 14 states have explicitly earmarked a portion of their Medicaid budgets to support outreach to pregnant women (see Figure 5).

However, our survey also revealed that states can directly support outreach under Medicaid without explicitly dedicating funding in their budgets. Many state officials indicated that they use portions of Medicaid administrative funds for outreach, or support outreach through the salaries of administrative staff who are responsible for designing and overseeing outreach initiatives. Many such states also work to maximize free or low-cost sources to support outreach, such as promoting their programs through press releases and inviting news media coverage of outreach events.

**Figure 5:
States with Dedicated Funding for Outreach to Pregnant Women, 2007**



Media Campaigns and Other Outreach Strategies

The survey asked states about a variety of strategies for educating the public about Medicaid coverage for pregnant women. Strategies explored included media outreach, the use of printed materials, whether or not outreach is conducted in multiple languages, and if a toll-free hotline is available for pregnant women to call for information about coverage programs.

Ten states reported that they conduct some type of media outreach.⁸⁰ For example, three states (New Mexico, New York, and Utah) conduct outreach using unpaid television and/or radio, and four states (New York, South Dakota, Utah, and Wisconsin) pay for television and/or radio outreach.

New York and Utah both use billboards as part of their outreach strategies. New York reported that they have found billboards to be among the best outreach media, particularly in rural areas, because they are viewed by a large number of people and are relatively inexpensive. These two states, along with Connecticut and Maine, also use posters displayed in public spaces (such as malls, bus stops, and on subways) to encourage pregnant women to enroll. Two states (Arkansas and Utah) provide incentives/coupons to encourage enrollment.

Seven states reported that they conduct other media outreach, including Connecticut which advertises in community newspapers, and Louisiana which sends out press releases to publicize their program. Colorado reported that they have found advertising in small community newspapers to be especially effective, because advertising in large papers is expensive and their target audience is more likely to read smaller publications.

The majority of states (26) produce printed materials specifically to encourage pregnant women to apply for coverage. These brochures and fact sheets are distributed at a variety of community locations. For example,

- Twenty-two states distribute printed materials at community, rural and migrant health centers, as well as free clinics;
- Printed materials are placed in hospitals and doctors' offices in 18 states;

⁸⁰ TV or Radio (paid), TV or Radio (unpaid), Billboards, Posters, Incentives/Coupons, Other Media Outreach

- In 21 states, pregnant women can find outreach materials at county welfare and social services offices, and 18 states place materials in public health departments;
- Eight states make materials available at schools and/or colleges; and
- Eighteen states distribute printed materials on their web sites or via e-mail and sixteen states mail materials to Medicaid recipients when their eligibility category changes, or upon request.

Additionally, the majority of states produce printed materials in languages other than English to encourage non-English speakers to apply for pregnancy coverage. Naturally, languages used vary based on the populations in the states. For example, New Mexico prints outreach materials in English, Spanish, and Navajo, and Florida prints materials in English, Spanish, and Creole. Of the 30 states with bilingual or multilingual outreach efforts, 29 states reported that materials are available in Spanish, five provide materials in Russian, four have materials in Chinese, and nine states reported that they have materials available in at least one other language.

Several states (19), offer incentive programs to encourage and reward participation in educational activities. For example, pregnant women in New Mexico receive rewards such as infant car seats and ice cream parties after completing pregnancy classes. In Washington, DC, the Healthy Start Project hosts an annual baby shower and the Department of Health sponsors the Safe Cribs Program that provides free cribs to women. In Nevada, pregnant women are given gift cards, movie tickets, and car seats for attendance at orientation classes.

Finally, 36 states have a toll-free hotline pregnant women can call to learn more about coverage and services.

Community-Based Outreach Efforts

Whereas mass media strategies aim to raise the public’s awareness of coverage, build “brand recognition,” and can encourage a population to change its behavior (in this case, to enroll in Medicaid and/or seek prenatal care), community-based outreach aims to accomplish a very different set of goals. For example, community-based outreach workers and agencies can provide more personal, hands-on information, assistance and counseling to persons who may need help with their pregnancy. As such, community-based outreach holds greater potential to reach “hard to reach” populations who may be reluctant to apply for public assistance, may not understand whether or not they are eligible for assistance, or who may have personal reasons for not seeking care. With regard to programs like Medicaid, many outreach experts believe that community-based outreach represents a critical complement to broader social marketing campaigns by providing a more direct means of assisting individuals and families with applying for coverage.

Our survey of state Medicaid programs found that, as part of their overall strategy for pregnant women, 22 states fund community-based outreach. These community-based outreach efforts may take several forms and utilize community partners and managed care organizations to assist in those efforts. For example,

- Nineteen states make grants to community-based organizations such as charity organizations and schools, to help them hire staff and support an outreach infrastructure;
- Fourteen states fund organizations to provide application assistance to pregnant women applying for Medicaid; and
- Six states enlist managed care organizations as community-based outreach partners and involve these entities in both marketing and application assistance.

Colorado employs “Regional Outreach Coordinators” who work in the same communities in which they live. Several of these coordinators are bi-lingual, and as community member themselves, they are better able to build trust and reach out to individuals who may otherwise be reluctant to apply for Medicaid. New York has also utilized outreach workers who are familiar with the communities in which they work, including the local resources and languages.

Targeted Outreach Efforts

Many states target their outreach efforts and resources towards women who are most vulnerable for high-risk pregnancies and negative birth outcomes. Across the country, 18 states focus a portion of their outreach efforts towards one or more target populations.

For example,

- Twelve states target outreach efforts towards adolescents;
- Fourteen states target refugees and/or immigrants mothers; and
- Thirteen states target high-risk populations for more intensive outreach in other ways, for example, by directing resources to low-income neighborhoods that consistently experience higher rates of poor birth outcomes.

Some states make specific efforts to identify high-risk populations. For example, Michigan identifies high-risk populations through WIC clinics, soup kitchens, and local public health departments. The Medicaid managed care plans in the state provide incentives such as gift cards to bring high-risk women in for prenatal and follow-up services, and utilize incentive baby showers and support sessions as opportunities to educate women about their pregnancies.

Louisiana, as another example, targets migrant workers for outreach through a school-based migrant education coordinator who distributes information about Medicaid.

The state also has a portion of one worker's time devoted to traveling across the state to large farms and nurseries in an effort to educate migrant workers about Medicaid coverage.

C. Enhanced Prenatal Benefits

As discussed in the literature review, by the early 1990s many states had taken steps to improve birth outcomes by expanding the content and delivery of care beyond the prenatal, delivery, and 60 days post-partum care requirements to include a wide variety of enhanced psychosocial support services. States' enhanced prenatal care benefits packages covered a number of additional services, including targeted case management and home visiting, health education and counseling, smoking and substance abuse treatment, psycho-social counseling, perinatal risk assessments, and transportation services. Our survey found that, for the most part, states have continued to support a broad range of prenatal benefits. Specifically:

- Thirty five states cover prenatal risk assessments;
- Thirty states offer home visiting to pregnant women;
- Twenty eight states offer health education as part of their enhanced benefits packages;
- Nutritional counseling is included as part of the pregnancy benefit in 27 states;
- Targeted case management is included as a benefit in 32 states; and
- Preconception counseling is offered in 19 states.

The survey also found that:

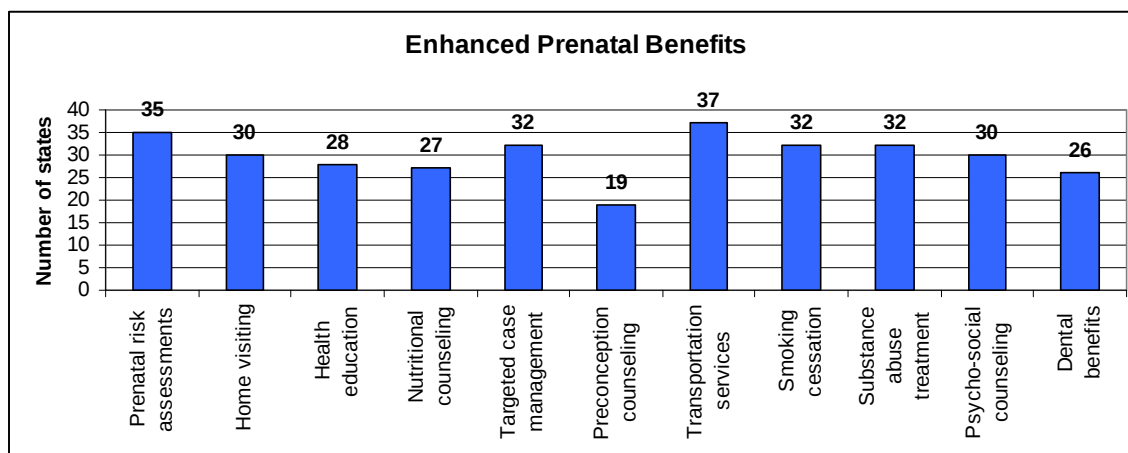
- Thirty seven states offer transportation services to pregnant women as part of their enhanced benefits packages;
- Smoking cessation programs are available to Medicaid enrolled pregnant women in 32 states;

- Similarly, 32 states offer substance abuse treatment for pregnant women;
- Psychosocial counseling is an available benefit in 30 states; and
- Twenty six states provided dental coverage to pregnant women, as a result of recent studies indicating evidence of a link between periodontal disease and preterm and low weight births.

These findings are summarized in Figure 6, below.

Thus, it appears that, for many enhanced benefits, coverage has remained constant or slightly decreased since the early 1990s. For example, prenatal risk assessments, nutritional counseling, home visiting programs, health education, targeted case management, and preconception counseling were all available in slightly fewer states in 2007 than in the 1990s. However, other pregnancy benefits were more prevalent in 2007 than in the 1990s, including smoking cessation, transportation services, psycho-social counseling, dental coverage, and substance abuse treatment. For the most part, states continue to make a wide variety of enhanced benefits available to pregnant women receiving Medicaid coverage.

Figure 6: State Medicaid Program Enhanced Prenatal Benefits, 2007



Several states have prioritized connecting pregnant women with specific enhanced benefits. For example, Utah's eligibility questionnaire includes a question about smoking. The state contacts women who report that they smoke, connects them with smoking cessation programs, and does additional follow-up as needed. Wisconsin works with public health departments and First Breath (the statewide stop-smoking program) to educate women about the dangers of smoking while pregnant. Pregnant enrollees get support, reminders, and phone calls. The state reported that when they weren't successful in getting pregnant women to quit smoking completely, they were successful in getting them to smoke less.

As another example, Connecticut conducts risk assessments to identify high-risk pregnant women and refers them to case management as needed. Case management includes providing the women with the information they need about other resources that are available to them, including food stamps, shelter, parenting classes, and treatment for post-partum depression.

IV. Pulling it All Together: Summaries of Five States' Models

Based on our in-depth follow-up telephone interviews with Medicaid officials in selected states, we learned more about how states design models that attempt to integrate outreach and enrollment efforts into a cohesive “whole.” The following program summaries provide brief overviews of innovative efforts in five states—Connecticut, Michigan, New Mexico, Utah, and Wisconsin.

A. Connecticut's Healthy Start Initiative

In Connecticut, outreach and enrollment of low-income pregnant women into Medicaid is primarily conducted through the Healthy Start program, a statewide public health insurance and direct service initiative. Established in 1989, Healthy Start is now run by the Connecticut Department of Social Services (DSS) with the mission of improving pregnancy outcomes and overall maternal and child health through home- and office-based case management. With the support of the Department of Public Health, the Healthy Start program utilizes Maternal Child Health Block Grant monies and federal Medicaid matching funds to administer contracts to 17 organizations that include hospitals, community health centers, local health departments, human service agencies and community-based organizations which assist pregnant women and their children in obtaining Medicaid coverage and provide case management. Specialized outreach materials are distributed at Healthy Start program contractor and subcontractor sites, as well as Women, Infant and Children program offices across the state. Healthy Start program efforts are especially focused in Connecticut communities that have disproportionately high rates of infant mortality and low birth weight. Within these

communities, program staff often address health emergencies for low-income pregnant women who are without health insurance coverage. Healthy Start program staff also conduct targeted outreach for several high-risk populations of pregnant women, including adolescents, refugees, migrants, and women in homeless shelters.

Upon coming in contact with eligible pregnant women, Healthy Start program staff perform program eligibility screening, application assistance and work as liaisons with Department of Social Services eligibility staff. To be eligible for Healthy Start services pregnant women must have a household income at or below 185 percent FPL. As of December 2007, the income level for pregnant women was increased to at or below 250 percent of FPL for Medicaid coverage. When calculating applicant income, there is no asset limit, certain employment and childcare expenses can be considered as income disregards, and a pregnant woman is counted as two family members—or if she is pregnant with twins, three family members, etc. Healthy Start program applications may be downloaded online and mailed in, and are available at both DSS regional offices and at community-level contractor sites—at the latter site, staff not only accept applications, but provide case management for eligible pregnant women and their children from birth to age 2. Healthy Start program staff perform risk assessments and health education, design tailored health and human services care plans, and provide information about available resources (e.g. food stamps, shelter, parenting classes, post-partum depression treatment).

The Connecticut Healthy Start program does not have presumptive eligibility, but instead employs an “expedited” eligibility process. Once Healthy Start staff complete applications, they fax them to one of three Regional Processing Units (RPUs). At the

RPUs, DSS eligibility staff make a eligibility determination for the program applicant within one day—typically if a case is deemed an emergency by Healthy Start staff—or up to five days, after which applicants are allowed 60 days to complete the remainder of program eligibility verification requirements. Connecticut DSS began the Regional Processing Unit system in December 2005, and since its implementation has increased Medicaid enrollment efficiency through monitoring of application submissions and timeliness. Nonetheless, officials also report that a limited state budget poses a significant barrier to continued outreach and enrollment efforts targeting pregnant women, noting an association between decreases in Medicaid application submissions and periods of tapered outreach efforts.

B. Michigan’s Healthy Kids, MiChild, and MOMS Initiatives

In the State of Michigan, coverage of prenatal care services is available through several programs administered by the Michigan Department of Human Services (MDHS) and the Michigan Department of Community Health (MDCH). The Department of Human Services administers the Healthy Kids program, which covers women with incomes up to 185 percent FPL during pregnancy and 60 days post-partum, infants up to one year after birth, and children under age 19. Women who do not meet Healthy Kids citizenship requirements can apply for prenatal care coverage under Medicaid emergency health care services, which covers only the cost of labor and delivery. Pregnant women whose household income exceeds the Healthy Kids 185 percent FPL limit can apply for the Medicaid Group 2 Pregnant Women program, and be assigned a deductible for medical expenses, beyond which services are covered by the state.

The Michigan Department of Community Healthy (MDCH) administers MICHild, Michigan's SCHIP program, which also covers pregnant women whose incomes are below 185 percent FPL. MDCH also manages the Maternity Outpatient Medical Services (MOMS) program as well, which provides immediate health coverage for pregnant women who have a pending Medicaid application. The MOMS program provides outpatient prenatal coverage only, and is also offered for adolescents who choose not to apply for Medicaid for confidentiality reasons, and/or non-citizens who are eligible only for emergency services. When Medicaid coverage becomes available for MOMS program enrollees, prenatal health care services are covered through MOMS and/or Medicaid for the entire pregnancy through 60 days post-partum.

Application to MDHS/MDCH programs is facilitated by a presumptive eligibility process, which is conducted at sites by outstationed state eligibility staff and trained providers. Pregnant women can apply for coverage with a "MICHild-Healthy Kids" application form that is available at either a shortened or regular length, and can be downloaded online and mailed in, or submitted online. MDCH officials share that applications are processed within 10 days. In response to new citizenship documentation requirements, MDCH/MDHS gave "authorized providers" the ability to verify citizenship documentation, redesigned application forms, and is currently in the process of implementing a statewide cross-match system of vital records.

With regard to outreach targeting pregnant women, MDCH/MDHS do not explicitly dedicate Medicaid funding, but use a recently implemented Women, Infant and Children (WIC) program screening initiative to identify pregnant women and perform targeted, community-based activities for high-risk populations. A significant amount of outreach

is conducted by Maximus, the Medicaid program's managed care enrollment contractor, which staffs a special hotline for pregnant women, prints specialized outreach materials, and conducts trainings for MDHS/MDCH community partners, such as faith-based organizations and Blue Cross/Blue Shield of Michigan. MDCH also recently began the Maternal Infant Health Program (MIHP), a strategic planning initiative to revise the state's Maternal and Infant Support Services program in effort to provide a standardized statewide system to identify, enroll and connect Medicaid-eligible pregnant women with health and human services.

Another service available to pregnant women is Plan First, the Michigan Family Planning Waiver program. Women ages 19 to 44 become eligible for Plan First two months postpartum, and are given basic family planning services, such as contraceptives (excluding abortion), and STD screening. Plan First is advertised statewide through an extensive marketing campaign including television, posters, and direct mailings. Plan First-eligible women are also identified through WIC screening. However, Plan First enrollees who become pregnant are not automatically enrolled into Medicaid's pregnancy coverage, but rather referred to the MOMS program. Through its MIHP redesign, MDCH is addressing this issue with the goal of coordinating efforts across and among state agencies.

C. New Mexico's Medicaid, SCHIP, and Premium Assistance for Maternity Programs

The New Mexico Human Services Department (NMHSD) offers Medicaid benefits for pregnant women through Pregnancy- Related Medicaid, SCHIP, and the Insure New Mexico Premium Assistance for Maternity (PAM) program. This broad scope of coverage reflects NMHSD's philosophy that "everyone is entitled to health care," and

department staff make significant effort to remove all stigma from the receipt of public health insurance in New Mexico. Through the Medicaid and SCHIP programs, the state offers coverage for pregnant women up to 235 percent of poverty through pregnancy, 60 days post-partum, and for 12 months of extended family planning. The recently implemented PAM program has no upper income limits, offers incentives for early prenatal care initiation, and provides full pregnancy benefits through two months postpartum, or until pregnancy termination, or until the woman moves out of state. Pregnant women who receive health coverage through PAM participate in its buy-in structure; deductibles, premiums and co-payments are set on a sliding scale based on family income. Undocumented immigrant pregnant women in New Mexico are not eligible for full health coverage, although NMHSD does pay for emergency delivery services for such pregnant women under the SCHIP unborn child option. Upon birth, the infant is then automatically enrolled into the New Mexico Medicaid program.

New Mexico enables pregnant women to apply for Medicaid coverage expeditiously through the Presumptive Eligibility/ Medicaid On-Site Application Assistance (PE/MOSAA) program. Under PE/MOSAA, pregnant women do not have to visit a NMHSD eligibility office to obtain coverage, but instead can complete a required face-to-face interview with a PE/MOSAA Determiner (e.g. school employees, public and private providers, or physician, hospital and clinic staff), who is trained and certified by NMHSD to enroll people in Medicaid and expedite the application process. As PE/MOSAA Determiners are located statewide, PE/MOSAA determination occurs nearly everywhere in New Mexico: from hospitals and rural clinics, to state fairs and shopping malls. The presumptive eligibility portion of the PE/MOSAA program allows pregnant

women to apply for and receive instant short-term Medicaid coverage for pregnancy services only. A PE/MOSAA determiner provides a Medicaid application to a pregnant woman, collects eligibility verification documents, conducts an eligibility interview, processes the PE, and forwards the completed PE/MOSAA application to the NMHSD Income Support Division, which reviews the application and makes a final eligibility decision within 60 days. The NMHSD Income Support Division also performs data cross-matches, has trained eligibility workers on new Medicaid citizenship documentation requirements, and coordinates pregnancy Medicaid enrollment with enrollment in the Medicaid Family Planning waiver program. The PE coverage is effective from the date of eligibility determination, until the last day of the following month. Pregnant women can apply for Medicaid benefits directly at the NMHSD Income Support Division Offices located in each county.

Although New Mexico offers universal prenatal care coverage, NMHSD does not have dedicated funding for Medicaid outreach targeting pregnant women, but does have three full-time staff that conducts outreach for all low-income programs with materials printed in Spanish, English and Navajo. The PAM program is advertised separately through radio, television, and websites, and on printed NMHSD Income Support Division materials. To target outreach to New Mexico's American Indian population, NMHSD coordinates efforts with Indian Health Services (IHS) to perform outreach and outstation caseworkers in IHS hospitals and rural clinics. These IHS-out stationed caseworkers aim to processing applicants for full Medicaid coverage, not just short-term presumptive eligibility in order to coordinate eligible women with services.

Since 1998, most of New Mexico's Medicaid recipients have joined one of four contracted managed care organizations (MCOs) through the NHMSD-administered Salud! Medicaid managed care program. The four MCOs are required by NMHSD to spend a certain amount of money for outreach and media materials targeting pregnant women, and offer incentive programs and enhanced benefits to pregnant women. One managed care organization, Lovelace, administers the Baby Love pregnancy program for its members. The Baby Love program distributes tailored education materials specific to an individual client's pregnancy, and provides a toll-free "BabyLine" which is staffed 24-hours-a-day by an obstetrical nurse to answer pregnancy-related questions.

D. Utah's Baby Your Baby Program

Since 1988, Utah Department of Health (UDOH) has conducted intensive outreach to and enrollment of pregnant women into Medicaid through the Baby Your Baby program. The mission of the Baby Your Baby program is to provide expanded prenatal health care services and outreach to pregnant women and their families through a statewide toll-free hotline. Once eligible pregnant women contact the Baby Your Baby program, staff provides answers to questions relating to prenatal and well-child care, and assist eligible pregnant women in applying for presumptive eligibility for Medicaid. UDOH officials use presumptive eligibility to ensure that every woman who contacts the Baby Your Baby hotline is connected with prenatal services, even if they are later found to be ineligible for ongoing Medicaid coverage.

Baby Your Baby messages are advertised in both English and Spanish via television, radio, and newspaper. Current Baby Your Baby messages include "Now is the time to Baby Your Baby" and "Thirteen is your lucky number," which raises awareness about the

importance of seeing a doctor before the 13th week of pregnancy and seeing a doctor at least 13 times during pregnancy. Baby Your Baby outreach campaigns deliberately do not mention Medicaid to avoid the stigma that is sometimes associated with receiving support through public programs. Pregnant women in Utah use a standard Medicaid application which can be obtained online or mailed in. The state also maintains a specialized Baby Your Baby website (www.babyyourbaby.org) where pregnant women may link to and complete an online application for presumptive eligibility for Medicaid and prenatal Medicaid.

The Baby Your Baby program also has dedicated funding for community-based initiatives, which are developed by an advisory board composed of advocate partners (e.g. March of Dimes, Planned Parenthood, and others) and business partners (e.g. Intermountain Healthcare and the local CBS television station). Each local health department has Baby Your Baby staff that has the flexibility to tailor the program to fit the needs of local community. The program also includes an educational component, and pregnant women are given a Baby Your Baby “Keepsake Book” which includes mother and baby health information, nutrition information, height and weight charts, a safety checklist, and a place to store immunization and well-child care visit records.

Since its implementation, the Baby Your Baby program has achieved extremely high “brand recognition;” a recent poll found that 95 percent of Utahans are familiar with the Baby Your Baby program. Other Utah outreach efforts targeting pregnant women include a March of Dimes billboard campaign and baby showers sponsored by March of Dimes-contracted health plans.

E. Wisconsin's BadgerCare Plus Program

In Wisconsin, Department of Health Services (WDHS) offers coverage for pregnant women through the state's SCHIP program, BadgerCare Plus. The WDHS places greater emphasis on the enrollment of pregnant women into health coverage than on outreach efforts. Pregnant women can enroll through an Express Enrollment (EE) process into temporary BadgerCare Plus and receive health coverage for pregnancy-related services from the day they apply and the subsequent two calendar months. Temporary BadgerCare Plus insurance for pregnant women covers outpatient pregnancy-related services (e.g. doctor visits, dental care), but not inpatient hospital services, such as labor and delivery. After the temporary BadgerCare Plus coverage has ended, pregnant women should be enrolled in the regular BadgerCare Plus program, which covers pregnant women with income up to 300 percent of the FPL. Once determined eligible, she remains enrolled regardless of income changes through the end of the second month following the end of pregnancy. Once enrolled in BadgerCare Plus, pregnant women have no premiums or co-payments, although pregnant women with incomes from 200 percent to 300 percent FPL who also have another form of insurance must keep the other coverage, and pregnant women with incomes above 300 percent FPL must meet a deductible before receiving BadgerCare Plus benefits. Pregnant women who are denied BadgerCare Plus coverage due to their citizenship status, or who are in prison or jail, can apply for the BadgerCare Plus Prenatal Services program to receive extensive prenatal care benefits (e.g. doctors visits, prescription drugs, labor and delivery). BadgerCare Plus Prenatal Services coverage begins within 30 days of applying for the program and ends at the end of the second month after the end of pregnancy. After 60 days post-

partum, eligibility for women in BadgerCare Plus is redetermined to see if she qualifies for coverage under BadgerCare Plus (as a parent) or the Family Planning waiver. For those pregnant women who are not eligible for the BadgerCare Plus Prenatal Services program, coverage is available through Medicaid Emergency Services, which covers costs of labor and delivery, and pregnancy-related emergencies. Women may apply for Emergency Services as early as one month before their due date, and as late as 60 days after their due date.

Pregnant women in Wisconsin are not required to have a face-to-face interview for Medicaid/SCHIP prenatal coverage, and can apply for prenatal care via mail, phone or online with an online application tool called ACCESS (<https://access.wisconsin.gov/>), a self-service system that enables pregnant applicants to screen for many public programs at once. ACCESS also allows certified providers to certify and establish EE for medical benefits for pregnant women. Upon starting an application, ACCESS will prompt an applicant to create a personalized online account. After an application is submitted, it will also display information about ‘next steps’, including verification items that may need to be submitted, and other available resources. Once BadgerCare Plus eligibility is established, an individual’s ACCESS “Check My Benefits” account is regularly updated to display benefits information, pending requests for information or verification and contact information for local agencies. When an online BadgerCare Plus application is submitted via ACCESS, it is sent electronically to CARES, the WDHS eligibility determination system, for workers to conduct the final eligibility determination. In response to recent citizenship documentation requirements, WDHS eligibility staff use CARES to perform cross-matches to other Wisconsin records, and trained EE-certified

providers and staff on new application protocols. WDHS officials share that as a result of their targeted efforts to address citizenship requirements, pregnant women have a lower eligibility-denial rate based on citizen documentation than other Medicaid/SCHIP applicants.

WDHS officials encourage medical providers to become familiar with ACCESS and certified to extend Express Enrollment (EE) to assist pregnant women in gaining coverage under BadgerCare Plus. To date, state officials report that health care providers have demonstrated excellent compliance with enrolling pregnant women into available programs. Officials also report that EE and ACCESS have made the overall Medicaid application process easy and quick for applicants, and that WDHS has hired a new outreach person to develop and implement future outreach and enrollment efforts to specifically target pregnant women.

Although WDHS places a lot of focus on the enrollment of pregnant women, the state does have dedicated Medicaid/SCHIP funds for outreach to pregnant women and provides outreach grants to community-based organizations, staffs a dedicated information hotline, performs targeted outreach to high risk populations, and prints materials in several languages, including English, Spanish, Hmong, and Russian. Moreover, numerous enhanced prenatal benefits are available to pregnant women through BadgerCare Plus, including First Breath, a WDHS-coordinated statewide smoking cessation program that is administered through local public health departments to educate women about the dangers of smoking while pregnant.

V. Different Approaches toward the Same Goals: In-Depth Case Studies of Louisiana and New York

As a final step in our research, we conducted multi-day site visits to two states that had very different histories and approaches to working to improve coverage and outcomes for pregnant women under Medicaid. Case studies of the LaMOMS program in Louisiana, and the Prenatal Care Assistance Program (and related efforts) in New York appear below.

Louisiana’s LaMOMS Program

Louisiana’s history of innovation with regard to outreach and enrollment of pregnant women in Medicaid is a fairly recent one. The state, unlike most others, did not take great advantage of optional authority under OBRA-86 and OBRA-87⁸¹ and, as recently as 2000, only covered pregnant women at the minimum federal requirement—those with incomes up to 133 percent of the federal poverty level. Similarly, the state did not invest significant resources in outreach or enrollment simplification during the 1980s or 1990s; the extent of its efforts in these areas were the Office of Public Health’s management of a toll-free Maternal and Child Health “hotline,” and the Medicaid program’s adoption of Presumptive Eligibility, which reportedly did not work well because most obstetrical providers refused to serve women who only had presumptive coverage, as they would be left to serve uninsured women who failed to establish full-scope coverage. According to officials from the Department of Health and Hospitals (the state Medicaid agency), Louisiana’s eligibility system was still very wedded to its “welfare”/cash assistance programs, characterized by long and complex application forms, significant verification requirements, and rules that said women needed to complete their applications through

⁸¹ Hill, I. (1992) *ibid.*

face-to-face interviews at parish⁸² Medicaid eligibility offices or certified Medicaid Application Centers. “It was a system designed to minimize errors and keep people out,” according to one key informant.

The sea change for Louisiana actually occurred with the state’s adoption of Title XXI and its creation of a State Children’s Health Insurance Program. Under the leadership of DHH Secretary David Hood and Medicaid Deputy Director Ruth Kennedy, the DHH mission was recast—to conduct aggressive outreach, to make eligibility rules easier, and to enroll as many children as possible. The program, launched in 1998, was called “LaCHIP” and it raised income eligibility for children to 185 percent of poverty. The application of a 15 percent income disregard effectively raised program income eligibility to 200 percent of poverty. Bright and cheerful outreach materials were developed, outreach efforts were encouraged and organized at the local level across the state’s 64 parishes, and extensive networks of collaborative community-based agencies were forged. The LaCHIP application was reduced to a single page, verification requirements were minimized, and the culture of the agency—with regard to this program, at least—was transformed to become inclusive and welcoming, a facilitator of coverage rather than a barrier to it. The efforts succeeded, as Louisiana saw dramatic growth in enrollment of children into LaCHIP—the program enrolled nearly 60,000 children in its first three years and enrollment currently stands at over 125,000 children⁸³—and the state gained national recognition and praise for its efforts.⁸⁴

⁸² In Louisiana, counties are called “parishes.”

⁸³ Louisiana Department of Health and Hospitals. (2009) *LaCHIP Enrollment numbers—December 2008*. Retrieved on January 12, 2009 from: <http://www.louisiana.gov/offices/publications/pubs-119/454.pdf>

⁸⁴ Hill, I. Hawkes, C., Harrington, M. et al. (2003) *Congressionally Mandated Evaluation of the State Children’s Health Insurance Program: Final Cross-Cutting Report on the Findings from Ten State Site Visits*. Prepared for the U.S. Department of Health and Human Services. Washington, DC: The Urban Institute and Mathematica Policy Research, Inc.

Based on this success, DHH officials decided that it was time to focus attention on the needs of pregnant women in the state. Many of the lessons learned from LaCHIP were thus applied to policies and procedures for mothers, even in the creation of a new program identity—La MOMS. As will be described below, Louisiana raised the upper income limit for pregnant women to 200 percent of poverty, developed an extensive network of perinatal outreach entities, and dramatically reshaped enrollment procedures so that pregnant women could be enrolled into coverage quickly and efficiently and prenatal care would be more widely available to them.

A. Outreach Strategies under LaMOMS

The State of Louisiana is both innovative and assertive in its marketing for and enrollment of pregnant women into the LaMOMS program, which Louisiana officials modeled closely after the already successful LaCHIP initiative. LaMOMS outreach and enrollment are closely tied to one another, and are typically performed concomitantly by DHH regional staff located across 46 parish Medicaid offices. In January 2003, Louisiana officials officially launched LaMOMS in Baton Rouge with a kick-off event and issued a statewide press release, but stopped short of carrying out a large-scale, department-led media campaign. Instead, state officials opted for community-based, grassroots campaign and encouraged regional employees to develop and execute outreach strategies. Departmental leadership then implemented a system of providing resources (e.g. earned media and public relations training) to regional DHH staff, who then conducted LaMOMS activities in their respective communities. Regional DHH employees utilized many of the same local contacts and inroads developed during LaCHIP program implementation to successfully target their efforts and make the new

LaMOMS program known in their respective Louisiana communities. This coordination of state-level guidance with local-level execution has provided the framework for LaMOMS program outreach, and proven to be immensely effective.

The Louisiana Medicaid program does not have dedicated Medicaid outreach funding for the LaMOMS program, however, as DHH regional staff are Medicaid employees, Medicaid funds support outreach activities targeting low-income pregnant women. Through the state continuation of Robert Wood Johnson Covering Kids and Families project, DHH expanded its outreach network from four original contractors to 11 statewide sites where LaCHIP and LaMOMS program are jointly promoted. Furthermore, additional resources are available through the Louisiana Office for Public Health (OPH). The Office for Public Health acts in partnership with DHH in outreach targeting pregnant women, primarily by utilizing marketing resources from other initiatives to concurrently promote the LaMOMS program. The OPH “Healthy Babies” campaign is housed in all parish public health units, where OPH staff also educated eligible pregnant women about LaMOMS. As part of the Louisiana family planning waiver—*Take Charge*—which targets pregnant and post-partum women, OPH hired a small number of full-time workers to coordinate the program among state regions, and subsequently integrate LaMOMS outreach. Additionally, OPH makes use of a small media budget to staff a toll-free hotline for pregnant women, and produce public service announcements directing eligible pregnant women to LaMOMS.

DHH leadership provides the overall direction for LaMOMS outreach, and regional office staff employ their creativity and talents in outreach design and implementation. LaMOMS outreach efforts are often coordinated with local and community events.

Regional staff make contact with potential LaMOMS applicants at hospitals, clinics, physicians' offices, Mardi Gras/parish parades, schools, community festivals, casinos, churches, colleges, and salons/barbershops. At these events, outreach workers can set up portable enrollment “offices” with laptops, scanners and printers to perform program eligibility determination intake. DHH initially received funding through the state budget process for four LaMOMS staff dedicated to outreach and enrollment. With recent funding to hire five more employees, DHH currently has nine LaMOMS outreach and enrollment staff, each stationed in one of the nine DHH administrative regions across Louisiana. Medicaid officials maximize this opportunity and place these staff in clinics and health units across the state to approximate the practice of outstationing workers.

DHH officials and regional staff have carefully developed LaMOMS marketing materials to appeal to potential applicants and dispel the potential for public program stigma—as done by the LaCHIP program—in Louisiana communities. LaMOMS outreach materials are available in English, Spanish, and Vietnamese, and avoid terms like “Medicaid” and “free health care,” instead referring to “no cost health care coverage.” LaMOMS eligibility cards closely resemble those used by private insurance companies, with Louisiana officials overseeing a switch from large, monthly issued paper cards—which for many Louisianans signified public program participation—to small, wallet-sized plastic cards. To increase awareness of the LaMOMS program among Louisianans, DHH prints the program logo on a variety of household and personal products (e.g. Band-Aid holders, pens, mirrors, water bottles, medicine dispensers, etc.) that are distributed by staff at outreach events. This careful construction of the LaMOMS brand and materials enables parish workers to transcend barriers often associated with

Medicaid outreach, and contributes to a new perspective that receiving LaMOMS—and LaCHIP—eligibility does not equate with welfare or living in poverty.

LaMOMS outreach efforts are constantly reviewed and revised so as to best address the needs of pregnant women in Louisiana. In small, rural communities where one-on-one outreach is reportedly more effective, state employees knock door-to-door, make speeches at local church meetings, and leave LaMOMS applications at grocery stores, bus stations, and parish courthouses. In urban areas where outreach is more effective at large events, offices conduct multi-day outreach “blitzes” for LaMoms and other programs, where eligibility staff perform outreach and distribute materials at Wal-Mart, basketball tournaments, and concerts.

Following Hurricane Katrina, a large number of Hispanic immigrants came to Louisiana to aid in rebuilding efforts. Among this emergent population were a growing number of pregnant women with undocumented immigrant status and limited English proficiency, for whom there were very few prenatal services available. To address the needs of this growing population, the New Orleans Hispanic Apostolate partnered with DHH as a certified Medicaid Application Center and employed three, full-time Promotoras de Salud (Health Promoters) to conduct outreach among Spanish-speaking immigrant woman. The Promotoras play a critical role in linking pregnant immigrant women to prenatal health care—such as coverage of labor and delivery costs via the SCHIP Unborn Child Option and services available through the March of Dimes mobile unit van—and rely heavily on word-of-mouth and networking; often performing outreach in local stores and on street corners. (See Vignette #V-1).

Whether LaMOMS outreach is performed as part of an Office of Public Health initiative or parish/community event, it is generally regarded as a means through which eligible pregnant women are identified and enrolled into the program. Regional Medicaid outreach staff perform innovative and aggressive outreach in tandem with enrollment assistance, and work tirelessly—often during evening and weekends—to connect eligible pregnant women with prenatal care services.

Vignette # V-1: March of Dimes Mobile Health Centers

In 2005, Hurricanes Katrina and Rita devastated the Gulf Coast and overwhelmed the health services infrastructure in Southern Louisiana, rendering it unable to meet the health care needs of the region's population. For low-income and uninsured pregnant women, Hurricane Katrina's aftermath worsened the challenge of obtaining quality and timely prenatal care services. In years following the 2005 hurricanes, workers moved to the Gulf Coast region to aid in rebuilding efforts, and the Spanish-speaking population experienced a sizeable increase, revealing the region's dearth of health care resources to also serve individuals with limited English proficiency.

In 2007, the March of Dimes sought to bring needed prenatal care to the Greater New Orleans and Gulf Coast area and to aid new Spanish-speaking residents by launching four March of Dimes Mom & Baby Mobile Health Centers®. The Mobile Health Centers are made possible by a \$3 million gift from the people of Qatar as part of the Qatar Katrina Fund, which was established to provide direct assistance to people and affected by Hurricanes Katrina and Rita. The New Orleans Mobile Health Centers are stationed in the Jefferson and St. Bernard Parishes and the Lower 9th Ward areas that were devastated by Katrina, and each have bilingual staff consisting of an obstetrician, a nurse practitioner/midwife, a nurse, lab technician and an outreach worker, all employed by the Daughters of Charity Services of New Orleans and the Partnership for Access to Health Care. Each Mobile Health Center observes a fixed weekly schedule at specific locations throughout the New Orleans area, in order to bring women reliable prenatal care services.

The Mobile Health Centers resemble conventional healthcare provider offices with waiting areas, private exam areas and a phlebotomy station, and are equipped with state-of-the art medical equipment such as fetal monitors, electronic file systems, and ultrasounds. Staff also screen clients for domestic abuse, breast and cervical cancer and diabetes, and use the service-oriented, group-based Centering Pregnancy Care Model to connect clients with educational activities and support groups. Since their launch, the Mobile Health Centers are estimated to have provided about 15,000 visits, and have significantly contributed to improving the health of pregnant women and infants throughout the Gulf Coast region.

B. Enrollment Simplification and Facilitation

The Louisiana Department of Health and Hospitals began placing a higher priority on enrolling pregnant women into Medicaid during the late 1990s. Prior to this, the eligibility determination process was lengthy and complicated, shaped by conservative Medicaid income limits and onerous application and verification requirements. Eligibility determination and enrollment in the pre-welfare reform era was primarily conducted at parish welfare offices, where pregnant women were required to complete long application forms and participate in face-to-face interviews for initial enrollment and coverage renewal. According to state officials, the DHH organizational culture up until the late-1990s emphasized thorough case documentation and error reduction, and eligibility caseworkers viewed themselves as “keepers of the state’s till,” even though the Louisiana constitution has long declared a “right” to healthcare, regardless of income. State employees shared that applicants during this time would wait as long as eight weeks after applying for Medicaid coverage before receiving notification of their enrollment and benefits, and that some Louisianan physicians would not accept a pregnant Medicaid applicant as a patient until she received an official Medicaid card. When it came time for eligibility redetermination, Louisiana Medicaid cases were more often closed than renewed due to procedural challenges associated with the failure of enrollees to submit verification or renewal forms, and the inability of caseworkers to locate enrollees.

Although DHH did not focus great attention early on efforts to simplify Medicaid enrollment, by 1990 the state had implemented a presumptive eligibility process where qualified providers could determine eligibility, eliminated the assets test for pregnant women and children, developed a shortened application form for pregnant women, and

outstationed eligibility workers at the nine state-owned safety net “charity hospitals”. By 1992, DHH established Medicaid Application Centers in locations—in addition to charity hospitals—throughout Louisiana communities, where Medicaid applicants could go to have the required face-to-face interview.

A change in departmental leadership in the late 1990s initiated a shift in DHH organizational culture, and challenged employees to view themselves as conduits, not gatekeepers, between eligible Louisianans and available services. Pursuant to this paradigm shift, the state of Louisiana adopted several policies during the late 1990s and early 2000s to simplify the eligibility determination and enrollment process, including:

- Elimination of the face-to-face requirement for initial enrollment and renewal, allowing pregnant women to be submit their applications by mail (2000);
- Removal of citizenship, household composition, and Louisiana residence documentation requirements for pregnant women (2000);
- Implementation of *Ex Parte* renewal (passive renewals) when a renewal form is not received (2001); and
- Simplification of coverage renewal form (2001).

After years of covering pregnant women only up to income levels made mandatory by federal law, Louisiana officials raised the upper income eligibility threshold to, in effect, 200 percent FPL in 2003. Coupled with the 2003 launch of the LaMOMS program, the 200 percent FPL coverage expansion led to the passage of more enrollment simplification policies targeting pregnant women, many of which had been proven successful for the LaCHIP program, including:

- Telephone *ex parte* renewals to confirm enrollee’s current address and phone number when an applicant does not submit a renewal form (2003);

- Incremental conversion to electronic Medicaid case records (2005);
- “Reasonable certainty” income verification in lieu of self declaration of income, where in the instance that an applicant is within 75 percent of the FPL, assets verification is not requisite (2006);
- Elimination of medical verification of pregnancy, which state officials claim created a “catch 22” for pregnant women when required, since it assumed that women needing insurance had reliable resources to get a medical exam, and resulted in delays in prenatal care (2004); and
- Launch of online LaMOMS application (2007).

As DHH developed its eligibility infrastructure to expedite LaMOMS enrollment, enrollment policies evolved. Since its implementation, the practice of presumptive eligibility in Louisiana varied from parish to parish and difficulties in presumptive eligibility determination resulted in high rejection rates among applicants, with some physicians opting to no longer accept Medicaid patients. Consequently, DHH created an expedited eligibility process aided by an extensive statewide network of over 835 Medicaid eligibility workers are located at 45 local DHH eligibility offices and contract Medicaid application assistors are located at over 400 community-based application sites. According to state officials, public health clinics are currently the number one site of LaMOMS enrollment in Louisiana. Community-based application sites include Federally Qualified Health Centers, hospitals, public health clinics, and social service offices where staff complete a two-day DHH training and become “certified” to conduct Medicaid eligibility application assistance. Certified staff also request LaMOMS document verifications and forward completed applications electronically or through postal mail to the Medicaid Eligibility Division for eligibility determination and processing. (For an example of a community-based outreach and enrollment agency, see Vignette #V-2). For

each successful Medicaid application submitted from a community-based application site, DHH pays a \$14.00 reimbursement to the agency/organization. Additionally, DHH provides LaMOMS application assistance via a 24-hour, toll-free information hotline designed for eligible pregnant woman, which provides services in several languages (e.g. English, Spanish, Vietnamese) to best serve Louisiana's populations of pregnant women with limited English proficiency.

The statewide system of outstationed eligibility staff and trained community-based eligibility workers has contributed to steady increases in enrollment of pregnant women into Medicaid. Pregnant women can apply for the LaMOMS program in person at any DHH eligibility offices or community-based application sites, or by mail, or through the Internet. The paper LaMOMS application, fashioned after the LaCHIP application with a program brochure and a detachable form, can be obtained from Medicaid offices and application centers, downloaded from the DHH web site or requested via the toll-free state Medicaid hotline. Pregnant woman can also complete and submit the LaMOMS application online, where a virtual profile is created to indicate outstanding verifications required to complete the enrollment process and obtain coverage. Louisiana Medicaid eligibility staff report that they receive a similar volume of both online and mailed-in applications, and note that each application type has its own advantages; online applications for pregnant women tend to be processed more quickly, whereas paper applications tend to be more reliable with regard to paperwork and pregnancy due dates.

Vignette # V-2: Family Road of Greater Baton Rouge

Family Road of Greater Baton Rouge is a private, non-profit organization that coordinates and delivers the services of more than 104 private, public, and governmental programs to families in one, centralized location. This “one stop shop” center is designed to help build stronger, healthier families and communities through the leadership, collaboration and coordination of available community resources. Family Road opened in December 1998 through the Baton Rouge Women’s Hospital, and is modeled after the original Family Road that is located in Hutzel Hospital in Detroit, Michigan. Since its launch, Family Road has moved outside of the hospital and currently is in its own building where workshops, support groups, counseling, special events and classes take place. The center is conveniently located on three bus lines, and provides an incentive program for attendance and free child care for parents while they attend classes. Since 2006, Family Road has served over 23,000 Louisianan families who travel to the center from over 12 neighboring parishes.

Family Road utilizes a modular format for services, which are divided into categories called “roads,” ranging from prenatal and parenting, to banking and technology, to wellness, nutrition and fitness. The staff at Family Road provide resources and services to pregnant women through several of these “roads.” The Better Beginnings program addresses gaps in services and resources available to pregnant women by connecting expectant mothers with social workers and physicians. The Building Strong Families program provides social services to couples who are expecting a baby or who have an infant less than three months of age. The WIC Supplemental Food program serves women enrolled in Family Road programs who are identified by risk specific risk categories. Also, the Healthy Start program provides case managers who link and coordinate pregnant women with community resources, such as medical appointments, pregnancy and parenting information, transportation, housing, medical insurance, and employment. The Healthy Start Nurse Family Partnership provides special case management performed by registered nurses to teenage mothers in the greater Baton Rouge area. Through Family Road, the Healthy Start program has provided case management and home visitation to approximately 250 clients and provided outreach to approximately 9,600 Baton Rouge community participants. Additionally, Family Road provides relief and recovery services to pregnant women affected by Hurricane Katrina with staff members conducting outreach and ongoing case management in FEMA trailer parks.

Family Road generates a considerable number of Medicaid applications, and three certified Medicaid application assisters are part of the center’s staff. At Family Road, LaMOMS and LaCHIP applications are accepted on Mondays and Tuesdays, and WIC applications are accepted on Wednesdays. Family Road Medicaid eligibility staff share that they are able to complete a LaMOMS application in 30 minutes to one hour using the online DHH system. When a pregnant applicant does not have all required verification documents with her at the time of application, Family Road staff provide her with print out that details needed verification and continue to provide her with application assistance. If a pregnant women is found to be ineligible for LaMOMS, Family Road staff work with her to identify and enroll her in those state programs for which she is eligible. From 2006-2007, Family Road staff assisted in over 1,100 Medicaid and presumptive eligibility applications and continue to work to improve the quality of application assistance that they provide to pregnant women.

Once a LaMOMS application is received by DHH (either electronically or through the mail), an eligibility staff member is assigned the case immediately as pregnant women applications receive priority processing. After being assigned a LaMOMS application, DHH eligibility staff utilize a variety of state databases (i.e. Louisiana Department of Social Services, Louisiana Workforce Commission, Louisiana Vital Records Registry) to conduct eligibility verification. Staff can verify income, employment and residency/citizenship requirements within a very short amount of time, and often do not need to contact applicants to request additional eligibility verification documentation. Once eligibility is confirmed, a letter detailing LaMOMS coverage and a Medicaid identification number is automatically generated from a centralized DHH office in Baton Rouge and sent via postal mail to the new program enrollee. Enrollee information is also sent to a DHH contractor, Unisys, for the production of a Medicaid insurance card, which typically arrives within a week of eligibility verification. In the advent that LaMOMS eligibility is denied, the applicant is also notified through telephone, e-mail, or mail of the reason for denial and/or of missing documentation needed to complete the determination process.

The LaMOMS eligibility redetermination process also employs reduced administrative barriers to ensure that coverage is renewed seamlessly. The redetermination process was first transformed beginning in 2000, when DHH officials embraced the new perspective that it was more costly to process new and churning applications, than to complete eligibility redetermination, and therefore more administratively efficient to “maintain enrollment gains.” Reflective of this change in perspective, departmental leadership replaced the term “redetermination” with the new

term “renewal,” simplified verification requirements and renewal forms, and implemented aggressive administrative follow up when renewal forms are not received. *Ex parte* renewals rely heavily on other databases and computer systems (e.g. Food Stamps, TANF, child support, etc.) to determine eligibility renewals. Telephone renewals have largely replaced paper renewal forms for those cases in which an *ex parte* renewal is now possible. In the event that a renewal form is mailed, DHH now requires that eligibility staff attempt to contact an enrollee via phone before closing a case and document all attempted and successful calls. Most recently, DHH has offered automated voice response renewal for enrollee convenience. The automated voice response renewal option is available through the toll-free hotlines, where enrollees can select the prompt, “To renew by phone now, Press 3,” after which enrollee data is retrieved and electronically sent to local eligibility offices. DHH leadership has also supported local parish office initiatives to improve Medicaid retention, such as adding a “drop box” outside the office building for after hours convenience, and enclosing another renewal form with advance notice of coverage ending for failure to renew. If a pregnant woman is found to no longer be eligible for LaMOMS, eligibility caseworkers are required to check her eligibility for all Louisiana state public programs so that other forms of health coverage and assistance are explored and/or identified. As one eligibility caseworker remarked, “it is easier to certify people for programs than to reject them.”

Expedited Medicaid enrollment and coverage renewal is now part of the DHH organizational culture. Since the late 1990s, departmental officials have implemented a series of eligibility simplification policies and procedures and challenged local parish staff to reduce processing time and improve retention of enrollees using these

simplifications. As a result, DHH employees have developed an administratively efficient Medicaid enrollment process, and now DHH officials state that majority of Louisiana eligibility processing offices parishes can currently process LaMOMS applications on the same day of application, with the average statewide processing time for LaMOMS applications at three calendar days, including those which need follow-up verification.

DHH officials continue to encourage employees to raise the bar for Medicaid eligibility determination through the *WorkSmart!* eligibility process improvement initiative that identifies workflow challenges, areas needing improvement and solutions at the state, local, and caseworker level in order to eliminate unnecessary work and improve efficiency. Parish office administrators encourage staff accountability and set processing goals by making monthly enrollment reports available to employees. State officials say that the sharing of monthly enrollment data among eligibility caseworkers—a practice begun in 2001—has shifted the focus from closing cases to connecting eligible individuals to services. Additionally, eligibility offices are involved with the “Plan, Study, Do, Act” program, wherein employees participate in regional workgroups that meet monthly via conference calls, and the DHH intranet to perform small-scale testing of eligibility process improvement strategies. State officials state that the *WorkSmart!* and “Plan, Study, Do, Act” programs have not only contributed to increased administrative efficiency, but also empowered eligibility managers and caseworkers with regard to their work.

From a history marked by onerous verification requirements and lengthy application procedures, to a present-day highlighted by efficient and seamless administrative

practices, DHH officials offer several key lessons regarding their efforts to transform the enrollment and retention of pregnant women in Louisiana Medicaid. Officials share that organizational change can be achieved through widespread communication of departmental goals, increased expectations of staff, and empowerment of employees. These efforts shaped the evolution of state eligibility caseworkers from “keepers of the state’s till” to “conduits who open the door” to Medicaid coverage, and produced a culture of application processing efficiency and innovation. Participation of local parish offices in improving eligibility processing also has resulted in greater awareness of challenges and opportunities, as locally based staff have unique insights about the enrollment and renewal process that, when communicated to managers and leadership, can inform departmental policies and procedures. Moreover, the use of electronic records and eligibility verification simplifications has proven to reduce administrative costs. The movement towards paperless Medicaid eligibility determination has not only decreased costs associated with postage, paper usages, and staff time, but has made it easier for eligibility caseworkers to implement simplification strategies. Moreover, DHH leadership share that ongoing evaluation of department policies and procedures is essential to increasing administrative efficiency. The collection and distribution of data is important in monitoring staff workflow and performance, and identifying areas of improvement as well as solutions. DHH works continuously to recognize and share best practices for eligibility verification and renewal in order to institutionalize successful policies.

C. Enhanced Prenatal Care

Consistent with its actions in the areas of outreach and eligibility simplification, Louisiana also did not take significant steps to enhance the scope of its prenatal benefits

coverage under Medicaid in the late 1980s or early 1990s. COBRA authority was used to adopt “care coordination” under Medicaid, but the service was only provided in New Orleans and was phased out in the mid-1990s.

The major historical change that occurred in Louisiana with regard to prenatal care was the dramatic shift in the locus of service delivery from the public, to private, sector in the early 1990s. Up to 1990, virtually all Medicaid-enrolled pregnant women received their prenatal care at public health units and delivered their babies in charity hospitals; there were virtually no other options for these women, as chronically low Medicaid reimbursement rates had led to a very low rate of private obstetrical provider participation in Medicaid. Following a federal statutory change in 1990 that required Medicaid programs to pay “competitive” rates to obstetrical and pediatric providers, however, Louisiana significantly raised its fees and the private sector soon realized that Medicaid represented a viable line of business. Over the course of several years, nearly all of Medicaid-financed prenatal care shifted to private obstetricians, and public health units became less involved in the direct delivery of prenatal care, and more involved in the provision of support and enabling services, like care coordination. This is still true today.

More recently, Louisiana took some important steps to enhance its perinatal services. Beginning in 2000, after closely following OPH’s pilot projects in two parishes, Medicaid became interested in covering the intensive support services provided to high-risk pregnant women under the Nurse Family Partnership (NFP) model. The NFP model, described in detail in Vignette #V-3, represented a rigorously evaluated, evidence-based

Vignette # V-3: Nurse-Family Partnership

The Louisiana State Office of Public Health Nurse-Family Partnership (NFP) is a program in which nurse home visitors work intensively with first-time, low-income mothers and families to improve maternal health, birth outcomes, and parental life course. The NFP™ program is a well-regarded early intervention model developed by David Olds of the University of Colorado, and has been demonstrated in studies across the United States to improve child health, prevent child abuse and neglect, decrease the length of time before women receive public assistance, and reduce violence and criminal behavior among young adults. The University of Colorado National Center for Children, Families and Communities currently assists 23 states, including Louisiana, in successfully replicating the Olds home visiting model and meeting program objectives. In Louisiana, NFP is available in all of the state's regions and is funded through a combination of Medicaid and state funds. Although all first-time mothers in Louisiana Medicaid are eligible to participate in NFP, only a small fraction of those participate due to the specific nature of the program.

The NFP program focuses on low-income, first-time mothers, who have been found to benefit most from the model, and is performed by nurses, who have been determined to possess the necessary combination of skills and knowledge to successfully work with high-risk mothers and families. Nurses start making home visits during an enrollee's pregnancy—ideally between the 12th and 20th week, but no later than the 28th week—and continue to make visits through the first two years of the child's life. If an enrolled woman drops out of NFP, she can re-engage and become active again in the program at any time before the child turns two. For each visit, nurse home visitors follow standard protocols and program curricula that focus on the mother's health, quality care giving for the child, and the mother's own life-course development. Nurses also involve the mother's support system (e.g. family, father of the child, friends) and utilize a clinical information system designed for the NFP model to monitor family characteristics, needs, provided services and progress towards accomplishing objectives. Given the intense structure of the NFP program, each nurse home visitor is allowed a caseload of no more than 25 mothers.

The New Orleans NFP program currently consists of four nurses, and one supervisor who together oversee about one hundred cases through the parish. Nearly 59 percent of women served by the New Orleans NFP program are African American, and the program also serves women of wide variety of racial/ethnic backgrounds, including Arab, Hispanic, and Caucasian. . The Louisiana Office of Public Health is working to expand the program to include another team of four nurses in more regions of the state, including the East Bank area of New Orleans parish, and to address the increasing number of NFP enrollees speak Spanish by recruiting more bilingual nurses. Studies of the Louisiana NFP program performed by Tulane University School of Public Health and Tropical Medicine indicate excellent outcomes, and demonstrate that the program is making a positive difference in the lives of the women and babies it serves.

approach to improving outcomes for high-risk mothers and, as such, Medicaid officials thought it would be an ideal strategy to both improve quality and avoid the high costs of poor birth outcomes. Medicaid adopted coverage of NFP services under the “targeted case management” option and NFP services are now available statewide, provided primarily by public health and public human services nurses working out of parish units.

Medicaid also adopted dental coverage for pregnant women in 2003 based on compelling evidence that periodontal disease was highly correlated with increased rates of low birth weight and premature births. Louisiana had never covered adult dental under Medicaid, so this marked a significant departure from past policy. The coverage is available statewide, yet access is reportedly challenging in some parts of the state, due to shortages of dentists that accept Medicaid.

Finally, Louisiana has also implemented a Medicaid Family Planning Waiver Program—called *Take Charge*—and has taken various steps to integrate it with Medicaid’s broader perinatal coverage. For example, women transitioning off of LaMOMS coverage as they reach their 60th day post partum are automatically enrolled in *Take Charge* if they are not eligible for more comprehensive Medicaid coverage so that they can continue to receive family planning services and intraconceptional care. Similarly, if a woman who is already enrolled in *Take Charge* becomes pregnant, she is automatically enrolled in LaMOMS so that she can receive full-scope Medicaid coverage for her pregnancy.

D. Conclusions, Lessons Learned, and Future Directions

Based on several indicators, it appears that Louisiana’s outreach and enrollment strategies are achieving their objectives. First, the state has enrolled a steadily growing number of

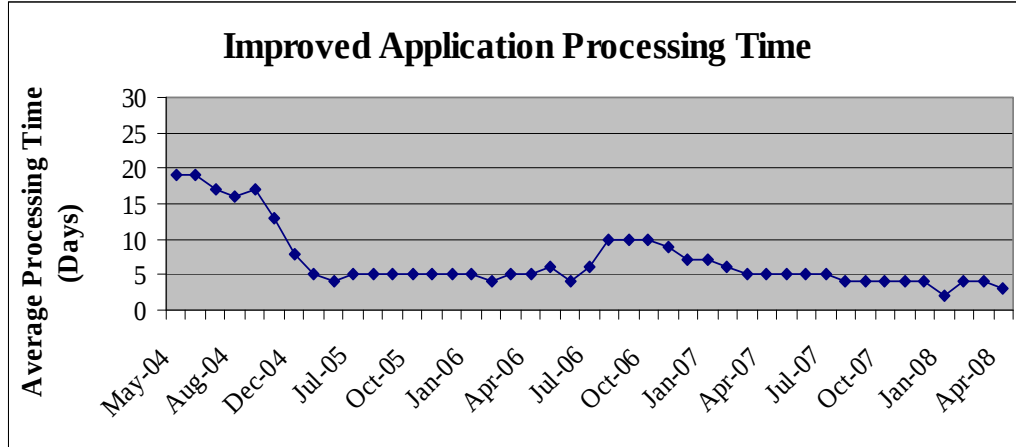
pregnant women over the last several years into LaMOMS (from approximately 56,000 women in 2003 to nearly 63,000 in 2007⁸⁵ and Medicaid now pays for roughly two-thirds of all deliveries in Louisiana.⁸⁶ Second, the Medicaid program's emphasis on expediting the processing of applications, especially for pregnant women, has resulted in dramatic reductions in turn-around time. As seen in Figure 7, the average processing time for Medicaid pregnant women applications has dropped from almost 20 days in June 2004, to roughly 3 days in December 2008. According to state officials, turn-around time is even quicker in the most populous areas of New Orleans and Baton Rouge. DHH officials note that the observed spike in application time between July 2006 and December 2006 in Figure 7 is related to implementation of federal requirements to verify citizenship and identity. Due to these delays in processing time, Louisiana officials made the decision to "assume the risk" of accepting photocopies of documents to verify identity (citizenship for women born in Louisiana is verified online through state Vital Records), which once again bought the processing time back down. Finally, quicker enrollment appears to have had a direct impact on the proportion of pregnant women who are able to receive "adequate" prenatal care, as defined by trimester of entry into care and number of visits before birth. Since 1990, Louisiana's national ranking on this indicator has risen from 34th (67 percent of pregnant women receiving adequate prenatal care) to 6th (82.8 percent with adequate prenatal care) in 2007.⁸⁷ Each of these indicators provides state officials with strong proof that their policies are moving the state in the right direction.

⁸⁵ Kyle C. Viator, Louisiana Department of Health and Hospitals. Personal communication 20 March 2008.

⁸⁶ J. Ruth Kennedy. Louisiana Department of Health and Hospitals. Personal communication 12 March 2008.

⁸⁷ United Health Foundation. (2007) America's Health Rankings 2007: Louisiana snapshot. Retrieved January 12, 2009 from: <http://www.unitedhealthfoudation.org/ahr2007/pdf/Louisian.pdf>.

Figure 7: Louisiana Medicaid Program Application Processing Time, 2004-2008



In discussing how and why the state designed and implemented its perinatal policies,

Louisiana officials at the state and local level share the following lessons:

- ***Building on a successful brand is smart and efficient.*** Medicaid and public health officials described how the initial revolutionary changes to state policy were made with the launch of LaCHIP, the state’s SCHIP program. Through positive outreach and dramatically simplified eligibility procedures, that program proved widely popular, grew quickly, and received considerable national attention for its success in getting children covered. The decision to apply these lessons to a revamping of the program rules for pregnant women was easy—right down to its name, LaMOMS built on the LaCHIP brand and mimicked many of the same outreach and enrollment strategies with positive results.
- ***Changing organizational culture, to reflect openness and a desire to help, laid the critical foundation for success.*** For decades, Medicaid eligibility policy and procedures were intimately linked to those of cash assistance, and the culture for that program focused on tight control, minimizing errors, and protecting state coffers so that only “truly deserving” individuals gained eligibility. With LaCHIP and, subsequently, LaMOMS, state leadership worked hard to shift this paradigm to one that shed its “welfare stigma,” that existed as a service to help families, and that was oriented to remove (rather than erect) barriers to coverage. By changing that perspective, DHH was poised to transform its way of doing business.
- ***Empowering regional and local staff made a huge difference.*** With its cultural change, DHH also delegated significant responsibility for outreach and enrollment to its regional and local levels. Indeed, central office officials intentionally worked to give these staff incentives to be creative and innovative in their development of outreach and enrollment strategies. As discussed above, a contest was held to allow regional staff to suggest how the pregnant woman expansion

should be branded. After LaMOMS was selected, a regional outreach coordinator position was designated in each of the state's nine regional offices and was encouraged to develop strategies that were uniquely tailored to suit the needs of their particular communities. What resulted was not only a broad range of reportedly successful strategies, but enormous "buy in" from these staff. In interviews, regional key informants described how proud they were of their efforts and how it felt like they "owned" their programs.

- ***Grassroots outreach is critical.*** Part and parcel to empowering regional and local officials was the belief that community- and grass roots-level outreach would be critical for success, as opposed to state-level investments in media marketing. DHH officials in Baton Rouge set broad goals and objectives, and identified policies that would facilitate the achievement of those goals and objectives. But they left the specifics of how to conduct outreach to the regional staff and their networks of community-based agencies.
- ***Search for simplicity wherever possible, and be pragmatic.*** Louisiana adopted many of the "tried and true" strategies for simplifying enrollment that were adopted by states across the nation, including shortening its application form for pregnant women, doing away with the assets test, and allowing women to mail in their applications without having to complete a face-to-face interview in a county social services office. But the state also developed its own variations on some of the traditional themes, variations that were driven by the need to be practical and applicable to the circumstances in the state. For example, rather than allowing completely open "self declaration" of income, Louisiana permitted workers to apply "reasonable certainty" when assessing a woman's income. That is, if a woman said she worked at Wal-Mart as a clerk, that worker could conclude that she likely earned income well below the state's upper limit and, therefore, would not require her to produce pay stubs. Similarly, when it became clear that the typical rule of producing a "medical verification of pregnancy" was, itself, creating a barrier to enrollment, Louisiana dropped the requirement. Officials note that the policy change has been in place since November 2004, and based on their experience, fears that applicants would "fake a pregnancy" in order to receive Medicaid have proven to be unfounded. Finally, moving away from Presumptive Eligibility when it was clearly not working pushed state officials to, instead, devise a different strategy for expediting the processing of applications for pregnant women.
- ***Incrementalism is OK.*** Louisiana did not adopt its policies and procedures under a single, sweeping package. Rather, it added and refined its policies over time, making incremental changes as the need for such changes became apparent. Rather than being viewed negatively, this approach was viewed by state officials as a reflection of continuous quality improvement.
- ***Capitalizing on technology is critical.*** Technological advances made it possible for Louisiana to effectively implement many of its strategies. For example,

equipping regional and local eligibility staff with laptops and portable scanners allowed them to set up shop virtually anywhere and help women to complete program applications. Wireless internet capabilities permitted these workers to submit applications to central processing units immediately. And sophisticated state data networks in these processing units allowed DHH Medicaid eligibility staff to cross-check applicant information against multiple state databases—such as those of the departments of labor and public health/vital records—to verify income and citizenship/residency information and allow for faster processing of applications.

- ***Having a centralized, state-run eligibility system is very helpful.*** State officials attribute much of their success to the fact that their eligibility system is state administered and implemented under uniform policy across Louisiana’s nine regions and 64 parishes. This fundamental characteristic allowed DHH to set goals and policies, and shift the agency’s philosophy on coverage, and then have these changes filter down to localities in a relatively consistent manner. In many states across the United States, Medicaid and cash assistance eligibility are determined by autonomous county authorities, each possessing the flexibility to set tone and implement rules on their own. This design introduces the potential for tremendous variation across counties and, in the opinion of Louisiana officials, to undermine a state’s desire to make broad and sweeping improvements to the way an agency does business.

Louisiana provides an interesting case study of how a southern, traditionally conservative state took steps to expand, open up and streamline its publicly-sponsored health coverage programs for pregnant women. In the next case study, we analyze the efforts of a northeastern, traditionally liberal state to achieve similar goals.

New York's Prenatal Care Assistance Program and Related Efforts

New York State has had a longstanding commitment to improving birth outcomes and has been a leader in efforts to improve pregnant women's coverage and access to care under Medicaid. Its current programs have their roots in the mid-1980s when the state took full advantage of optional authority contained in the Omnibus Budget Reconciliation Acts of 1986 and 1987 (OBRA-86 and OBRA-87) to expand Medicaid eligibility for pregnant women with incomes up to 185 percent of the federal poverty level (FPL) and, subsequently in 2000, to 200 percent FPL. State officials adopted a host of policies designed to simplify eligibility rules and streamline enrollment for pregnant women and also launched a statewide social marketing campaign—*Growing Up Healthy*—to raise public awareness of the new expanded coverage that was available, a campaign that continues to this day.

Understanding that health insurance was only the first step in improving birth outcomes, officials from New York's Medicaid and Maternal and Child Health programs collaborated to design and launch the Prenatal Care Assistance Program (PCAP) which certified providers with the capacity to deliver a comprehensive scope of medical prenatal care and psychosocial support services to address the nonmedical needs of pregnant women, as well as the ability to grant Presumptive Eligibility to pregnant women who appear to be eligible so that they can immediately receive Medicaid-financed prenatal care. Over the ensuing years, the state's Department of Health invested significant resources into a broad range of community-based outreach and home visiting programs, all designed to improve early access to care and outcomes for high risk women and infants. And as New York's Medicaid program transitioned to prepaid managed care as

its primary financing and delivery system model, it worked hard to ensure that PCAP standards of care were integrated into contracts with health plans while also enlisting health plans as partners in the state's ongoing outreach efforts.

As will be described below, New York continues to adapt and improve its public perinatal programs by enforcing rigorous quality standards and tying provider and health plan reimbursement to performance.

A. Outreach Strategies

New York State takes a broad view of “outreach” and considers all women of childbearing age, not solely pregnant women, as potential beneficiaries. To this end, outreach seeks to not only raise women's awareness of available health care coverage and encourage enrollment, but also to identify and serve women who need help in accessing prenatal, postpartum, and women's health services. In many instances, this latter form of outreach is provided through community-based home visiting programs. Thus, outreach is multi-faceted in New York, having developed over many decades, across multiple boroughs and counties, and therefore encompasses many different strategies.

Social Marketing

Social marketing has been a core tenet of the state's outreach strategies since the mid-1980s. The state conducts multiple social marketing campaigns to increase public awareness of Medicaid and other programs for pregnant women, but the *Growing Up Healthy* “brand” has been employed throughout. In addition, a toll-free 24/7 *Growing up Healthy* hotline is staffed by English and Spanish-speaking counselors who assist callers with information and referrals to needed health and human services. (There is also access to an AT&T language line, and a TTY number.) The hotline receives 60,000 calls a year

and specializes in providing information regarding resources for prenatal care, family planning, WIC, and Family Health Plus and a range of other health and human services.⁸⁸ New York City also has its own hotline and its Department of Health occasionally has monies to fund a dedicated prenatal care hotline (roughly every two years).

Stakeholders believe these hotlines are well known brands throughout the state in part because of aggressive social marketing campaigns. These campaigns target a wide area (using zip codes corresponding to poor health status indicators) relying on radio, television, and print advertisements all featuring the hotline number(s). Following social marketing campaigns, the hotlines typically see a large increase in call volume. For example, the last time the state ran a prenatal care campaign, it saw a 62 percent increase in calls to the hotline. To help design the ad campaigns, the Department of Health drew on research conducted by the Community Action for Prenatal Care (CAPC) program (an initiative to find high-risk pregnant women and connect them with services) which held focus groups with pregnant women to identify those images and messages to which they would best respond. NYC social marketing campaigns consist only of radio and print advertisements as television advertising is reportedly too expensive.

While the State Department of Health oversees and implements the social marketing campaigns, they also partner and contract with multiple agencies and community-based organizations (CBOs) to conduct targeted program-specific outreach. This is due to the large size and diversity of New York's population and the Department's belief that outreach and public awareness campaigns can better reach hard-to-engage populations when they are coordinated with local partners. To help ensure consistency of message,

⁸⁸ Medicaid has its own hotline for Child Health Plus

the Department of Health provides media packets to local partners to support their campaigns and activities at the local level.

Community-Based Outreach

Throughout New York State, there are multiple community-based health and social service initiatives targeted at low-income pregnant women that contribute heavily to state outreach efforts as well as care coordination. Examples of outreach activities include health fairs, outreach workers visiting laundromats and churches, public service announcements, and advertisements on billboards in whatever languages are needed.

Specific examples of community-based outreach initiatives include:

- ***Healthy Start*** focuses its outreach efforts in 5 urban neighborhoods with high infant mortality rates and where TANF-eligible families live. Healthy Start outreach workers conduct street outreach in a 20 block radius and have a designated contact total. Workers typically conduct outreach either for a Healthy Start project or may refer to other home visiting programs available in their target area such as Healthy Families New York (a home visiting program targeting children at risk of abuse). According to Healthy Start officials, their outreach mission is to “reach pregnant women to provide information about and access to maternal and child health services, as well as other consumer needs.” Outreach workers connect families with services based on their needs.
- ***Baby Steps*** is a preventive home visiting program available in limited areas of the state, which targets pregnant women or those with children under three months old. Street outreach is conducted by culturally competent staff who reflect the populations they serve. Outreach workers may go door-to-door in housing projects or seek places in the community where they are likely to find pregnant or new mothers.
- ***Community Action for Prenatal Care (CAPC)*** is an initiative to find high-risk women (particularly women with HIV, but also those w/ substance abuse addiction, immigrants, adolescents, and the homeless) not in prenatal care targeted to the three highest risk areas of the state. CAPC develops coalitions in high risk areas and assists local organizations in effectively reaching out to and linking target women to prenatal care and other services. Outreach workers for the program undergo an enhanced outreach training program to develop the skills needed to engage these high risk populations.

- ***Community Health Worker Programs*** have been funded by the state’s Bureau of Women’s Health since 1987. Currently, there are 24 CHW programs across state, each targeting neighborhoods (by zip code) that have high rates of poor birth outcomes. The programs employ a paraprofessional home visiting model whereby indigenous community workers conduct “street” outreach to find uninsured women, as well as home visits to at-risk enrolled women and their infants. The CHW protocol involves workers conducting monthly home visits to teach their clients proper nutrition during pregnancy, provide breast feeding support, conduct home assessments for safety and lead exposure, and share information on the importance of family planning, immunizations for newborns, and screening for developmental delays. Community Health Workers receive training in these skills, but work under the supervisions of registered nurses or social workers.

Alongside these community-based, local outreach efforts, New York State has several umbrella entities which seek to provide coordination of care and outreach initiatives. The next section discusses these forums in detail.

System-Level/ Regionalization

Due to the size, geography and diversity of New York, the State Health Department recognized the need to coordinate with regional and local partners to improve birth outcomes. In this section, three examples of ways in which the Department has forged local partnerships to improve outcomes by working with regional systems of care for pregnant women and new mothers are discussed.

Comprehensive Prenatal Perinatal Service Networks have existed in New York State for about twenty years and were developed at a time of public health crisis in the state. The Networks—16 are currently funded—are charged with addressing systems issues that hamper high risk women from successfully accessing perinatal health services. The Northern Manhattan Perinatal Network (NMPN) is one such network based in New York City (specifically Harlem and surrounding neighborhoods). There are 19 different funded initiatives under the umbrella of NMPN including Healthy Start, CAPC, Community

Health Worker Program, and Baby Steps. While its mission over the majority of the last 18 years has been to reduce the area's infant mortality rate (which has declined—although gentrification of the neighborhood may also be contributing to the reduction), NMPN are now shifting to an interconception care focus. Outreach is a large component of their *modus operandi*. In 1997 NMPN established its own social marketing firm and they define outreach as “health communication.” However, the various programs housed within NMPN draw on a full range of outreach strategies including door-to-door and street outreach.

Regional Perinatal Forums were created approximately five years ago as part of the state's system of regionalized perinatal care in order to expand the ability of hospitals and other providers to reach consumers in their regions. These Regional Perinatal Forums are generally co-led by a representative of the tertiary level hospital in the region selected by the Department of Health to serve as the Regional Perinatal Center and by the Perinatal Networks. As part of their mission, the Forums are charged with coordinating outreach and enrollment. The main focus of outreach is raising public awareness on an agreed upon health topic. Each Regional Perinatal Forum sets its own agenda according to local needs and priorities. An example of one such focus is raising awareness of the importance of preconception care and smooth transition to prenatal care.

The Infant Mortality Reduction Initiative (IMRI) is a third example of a cross-cutting coalition to coordinate systems of care. IMRI convenes and facilitates a coalition of agencies to increase efficiency and coordination of infant mortality reduction activities in Central Brooklyn where infant mortality rates are high. IMRI's focus is on inter-conception care, believing that appropriate use and access to care before, during, and

after pregnancy will result in healthier families. IMRI define two kinds of outreach—general awareness raising regarding the services available in the area, and targeted outreach to get particular groups into care. Their outreach consists of media campaigns to increase community awareness about infant mortality and education regarding the risk factors leading to infant deaths and encouraging timely preconception as well as prenatal care. A final outreach component is to health care providers to educate them on the socio-cultural risk factors for infant mortality and to promote pre-conception health care.

Health Plans as Outreach Partners

Over the years, managed care health plans have become increasingly important outreach partners, not only for pregnant women but for all Medicaid recipients. State officials have worked to balance concerns over inappropriate marketing by plans—whereby staff are precluded from steering clients to sign up for their plan or services—with the recognition that these entities can be effective agents for getting the word out about available services and benefits to persons already enrolled into coverage. Generally speaking, health plans outreach focuses on educating members about what services are offered and how to access them. All health plans maintain their own toll-free 1/800 phone lines that are widely advertised on billboards, bus and subway placards, brochures, and handbooks and other materials that members receive when they enroll with a plan. Many of these advertisements and print materials specifically focus on the importance of prenatal care, and health plan operators staffing phone lines are trained to refer pregnant women to appropriate and accessible PCAP and other prenatal care providers in their network. As will be described in the next section, health plan staff also are available to help pregnant women (and other populations) to apply for Medicaid.

B. Enrollment Simplification and Facilitation

New York’s strategies to simplify and facilitate enrollment in Medicaid are built around presumptive eligibility, a policy that enables pregnant women who appear to be Medicaid eligible to access prenatal care services immediately. Presumptive eligibility can only be granted by “qualified providers,” many of which are PCAPs, but that also include other medical providers and facilities, and WIC sites. Indeed, as mentioned above, all PCAPs are required to have the capacity to determine and grant Presumptive Eligibility, and then are enabled to immediately provide Medicaid-financed prenatal care.

Women apply for presumptive eligibility using the simplified *Growing Up Healthy* application form. Approval is based on a cursory assessment of income, self-attestation of New York residence, and verification of pregnancy (including an “expected date of confinement,” or EDC); no documents are required to verify income, residence, or household structure. If a woman wants to be considered for ongoing Medicaid coverage, the same *Growing Up Health* application is used (no additional application form is filled out). However, she will need to provide income and residency documentation.

Applications for full Medicaid coverage are forwarded to the appropriate county Department of Social Services, and these agencies have 30 days to make their determination. While New York officially requires women to have a face-to-face interview when enrolling for Medicaid, the presumptive eligibility interview suffices. (See Vignette #V-4 for a detailed summary of how applications are processed in the boroughs of New York City).

Vignette # V-4: Application Processing in New York City

The Human Resources Administration (HRA) is local authority responsible for processing Medicaid (and other social services) applications across New York City's five boroughs. They are also the centralized processing location for Presumptive and other applications forwarded from PCAPs in the New York City area.

HRA has roughly 15-20 workers processing an average of 20 applications each per day, processing roughly 400-500 applications on an average day.

Providers can submit applications to HRA either electronically or manually. While electronic applications are significantly easier for HRA to process, they do not encourage electronic submission because of the cost to providers, and some providers do not have the electronic capacity.

HRA requires that applications be processed in 30 days or less. On average, however, they turn applications around in 20 days or less.

Manually and electronically submitted applications are processed in generally the same manner, as follows:

- Applications are first checked for accuracy and completeness (ie, to ensure that all necessary fields are complete, including names of each household member, home address, income, EDC, and applicant's signature.
- Applications are then registered in the system and submitted for data-match (to verify income, residency, etc.) Data-matching "takes a few days."
- The application then goes to an eligibility specialist for processing. A data entry sheet is created with an authorization date (based on EDC letter).
- All paperwork is then sent to a supervisor for review.
- Once approved, the application is returned to the worker and typed into the system.
- Approved application notices are transmitted overnight to the client and the provider that assisted the client the next day.

In addition to Presumptive Eligibility, and to make the formal application process easier, New York implemented a large number of eligibility simplifications when it first expanded Medicaid coverage in January of 1990. To facilitate enrollment of pregnant women into Medicaid, the state adopted:

- A special shortened application form (available in English and Spanish);
- No testing of assets as part of the eligibility determination;

- Continuous eligibility throughout pregnancy and 60 days postpartum, regardless of fluctuations in income;
- No requirement for citizenship documentation (in spite of new federal requirements under the Deficit Reduction Act of 2004, since the state covers all pregnant women up to 200 percent FPL regardless of immigration status), and
- Outstationing county social services eligibility workers at Federally Qualified Health Center and Disproportionate Share Hospitals (though the presence of PE at most of these facilities negates the requirement to post county eligibility staff).

A final avenue through which pregnant women can apply for Medicaid is through the “facilitated enrollment” system. Facilitated enrollment was originally created to assist parents in signing their children up for Child Health Plus—New York’s State Children’s Health Insurance Program—and facilitated enrollers are typically based in a broad range of community-based organizations. However, facilitated enrollers are rarely health care providers and, thus, cannot issue presumptive eligibility or render prenatal care.

Therefore, the Department of Health encourages facilitated enrollers to refer any pregnant women they meet to the nearest PCAP providers so that they can obtain Presumptive Eligibility.

Health Plan Enrollment

All Medicaid managed care plans are required to contract with providers who determine Presumptive Eligibility. To meet this requirement, most plans subcontract with PCAP providers to be part of their networks. Health plans are typically also certified as “facilitated enrollers” and thus can assist a broad range of populations with their initial applications for Medicaid. (Once again, however, they are encouraged to refer uninsured pregnant women to PCAP providers so that they might qualify for Presumptive Eligibility and immediately receive prenatal care.)

Once pregnant women (or any other enrollees, for that matter) are determined eligible for coverage, they are asked to select a health plan in which to enroll for their primary care. Pregnant women, in particular, are urged to make their selection immediately; however, they have 60 days to make their decision. Health plans, themselves, are permitted to assist with this decision making as long as they adhere to requirements that they present information about *all* available plans (not just their own) and do not attempt to steer the enrollee to their own plan. New York’s managed care “enrollment broker”—Maximus—also forwards to every new enrollee a packet of information containing descriptions of available health plans and instructions regarding how they are to choose a plan. If individuals do not select a plan within 60 days, they are assigned by Maximus to a plan based on an algorithm that considers the individual’s location, past relationships with providers, and other factors.

An important issue raised by state officials is the need to minimize the time period between a pregnant woman’s eligibility and her choice of a health plan. To the extent that a woman uses the entire 60 days available to her to make this decision, critical time is lost, limiting the health plan’s ability to serve women from early in their pregnancy and provide additional services to those at risk of poor birth outcomes. Thus, beginning in January 2009, state officials encourage PCAP presumptive eligibility staff to counsel women on their health plan selection right away, after the PE determination has been made. Once again, these staff cannot express a preference for one plan over another, or otherwise “steer” women to a particular plan. Rather, they are required to objectively discuss all available plans and the services they offer. During our interviews with state, health plan, and PCAP officials, we learned that most PCAPs contract with multiple

plans in their county or borough, so they do not possess any direct incentive to refer women to one health plan over another.

C. Enhanced prenatal care

To complement its efforts to insure pregnant women and facilitate their enrollment into coverage, New York has also invested in the development of perinatal systems of care for pregnant women, once they are enrolled. Once again, PCAP is the cornerstone of this effort but other specialized programs, as well as the state's Family Planning Waiver program, also work to improve access and outcomes. Finally, managed care health plans are, once again, partners in the state's efforts.

Prenatal Care Assistance Program

There are currently 134 PCAPs in New York State, managing service delivery in over 400 clinic sites. Many different provider types have been certified as PCAPs, including local health departments, Federally Qualified Health Centers, family planning providers and, most often, hospital outpatient departments. To qualify for PCAP Medicaid reimbursement, providers must demonstrate the capacity to provide a comprehensive package of prenatal care services, including:

- Risk assessment (of both maternal and fetal risk, including conducting screening of genetic, nutrition, psychosocial, and personal risk factors and referring those identified as at risk to services);
- Plan of care development (to ensure the coordinated delivery of all services required by a woman);
- Care coordination (to assist with making referrals, scheduling appointments, monitoring visits, following up with women to assist with the receipt of care; and arranging for appropriate home visitation support);
- Nutrition services (including assessment and counseling);

- Health education (including signs of complications of pregnancy, activity and exercise during pregnancy, sexuality and risks during pregnancy, signs of labor, labor and delivery process, preparing for parenting, newborn screening, and family planning);
- Psychosocial assessment and counseling (on such issues as social, economic, psychological, and emotional problems);
- Prenatal diagnosis and treatment (by qualified physicians, licensed midwives, and qualified nurse practitioners); and
- HIV services (including testing, education, counseling, and management).

Throughout, PCAP providers are also required to adhere to standards for recordkeeping and recording, and conduct regular internal quality assurance activities.

PCAPs are also required to conduct outreach in their communities by engaging with community-based agencies and resources and disseminating information about their services through these linkages. Finally, as described in the previous section, all PCAPs must be certified as capable of conducting Presumptive Eligibility reviews.

The PCAP model is most readily available in urban settings; in fact, 100 of the state's PCAPs are in the New York City boroughs. But state officials have adapted the model to rural settings as well, where it is called the MOMS Program. Essentially, under MOMS, physicians or midwives (and their staffs) serve as primary caregivers, but develop formal contractual relationships with local health departments and home health agencies to provide assistance in Presumptive Eligibility determinations, enrollment in Medicaid, nutrition screening and referrals, psychosocial support and home visitation services.

Home Visiting Programs

As discussed in previous sections, New York has developed a large number of home visiting programs, including its Community Health Worker Program, Healthy Families, the Prenatal Care Initiative, and CAPC (among others). While these are typically

referred to as “outreach” efforts by state and local officials, they also represent interventions that serve to enhance the delivery of prenatal, postpartum, and early childhood care.

One particularly intensive home visiting program is the Nurse Family Partnership (NFP). New York is one of 23 states that operates NFP programs. NFP programs exist in New York City and Monroe (Rochester), Onondaga (Syracuse), and Broome (Binghamton) Counties. As was described in detail in the Louisiana case study, NFPs follow the evidence-based model developed by David Olds and provide intensive home visiting support to first time pregnant women throughout their pregnancy and up to the child’s second birthday. New York has not yet succeeded in obtaining Medicaid reimbursement for NFP services, but is working toward that end. In the meantime, it is supported by local and state (matching) funds from the Department of Health.

Family Planning Waiver

New York also operates a Section 1115 Medicaid Family Planning Waiver. Fifty-three agencies oversee service delivery in 197 sites, and each provides a full scope of clinical and educational family planning services, as well as community-level outreach and education. When women complete their perinatal coverage under Medicaid/PCAP, they are referred and may be enrolled into the waiver program. Similarly, women in the waiver program who become pregnant are referred to the nearest PCAP provider so that they can be reviewed for Presumptive Eligibility and enrolled into prenatal care.

Managed Care Plans

As discussed above, all managed care plans participating in Medicaid must adhere to PCAP standards of care. As such, most health plans include PCAP providers in their

networks and build outreach and referral systems to ensure that enrollees who become pregnant are referred to PCAPs for their care. These requirements are viewed by state officials as critical quality assurance strategies, since Medicaid’s role in financing perinatal care has steadily grown over the last two decades. Indeed, as of the time of this writing, Medicaid paid for approximately 42 percent of all births in New York State, and 70 percent of these women were enrolled in managed systems of care.

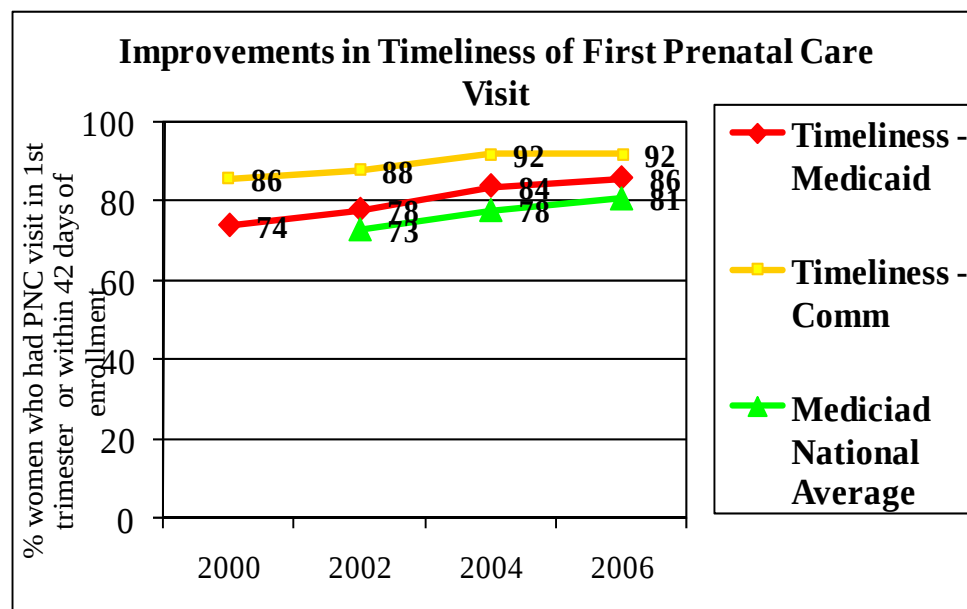
The state’s other major tool for quality assurance under managed care is QARR—the Quality Assurance Reporting Requirements. QARR represents a subset of NCQA’s HEDIS (Healthcare Effectiveness Data and Information Set) measurement system and, with regard to perinatal care, routinely tracks health plan performance on a core set of indicators, including (among others) rates and trends in:

- Women receiving first trimester prenatal care;
- Timeliness of prenatal care (visit within 45 days of enrollment);
- Postpartum care (visit within 60 days of delivery);
- Delivery in appropriate hospital setting (based on woman’s risk level); and
- Rates of Caesarian delivery.

Over nearly two decades of monitoring, New York has typically seen consistent improvement in QARR performance, especially when viewing rates for Medicaid recipients in comparison to women in commercial managed care. For example, as seen in Figure 8, the gap between Medicaid enrolled and commercially insured pregnant women on the rate of women who received “timely prenatal care” narrowed from 12 percentage points (74 percent vs. 86 points) in 2000 to 6 percentage points (86 percent vs. 92 percent) in 2006. Furthermore, in a study published in the *Journal of the American*

Medical Association, performance of Medicaid and commercial health plans were compared in both 2003 and 2006. In 2003, there was an overall 6 percent difference between Medicaid and commercial insurance on 10 measures of quality; by 2006,⁸⁹ this gap had shrunk to 3 percent.⁹⁰ However, the state’s analysis had also found persistent racial/ethnic disparities on most measures, disparities that have been slow to improve.

Figure 8: Initiation of Prenatal Care After Enrollment in New York State Medicaid Program, 2000-2004



(For a description of one health plan’s efforts to improve outcomes for pregnant women, see Vignette #V-5.)

In recent years, New York has begun basing payment on performance. Specifically, the state has developed a schedule of incentive payments for health plans that “bump” per

⁸⁹ QARR, 2008.

⁹⁰ Bruce E. Landon, MD, MBA; Eric C. Schneider, MD, MSc; Sharon-Lise T. Normand, PhD; Sarah Hudson Scholle, MPH, DrPH; L. Gregory Pawlson, MD, MPH; Arnold M. Epstein, MD, MA, “Quality of Care in Medicaid Managed Care and Commercial Health Plans,” JAMA. 2007;298:1674-1681.

capita payment rates when plans demonstrate significant improvement on key quality measures. To develop competition across health plans, the state also developed a “matrix” that annually presents each plan’s performance on key indicators against its performance in prior years, and against the statewide average for each measure. Plans performing significantly below the state average are required to conduct a “root cause analysis” and present a corrective action plan.

Vignette # V-5: Affinity Health Plan and its Healthy Beginnings Program

Affinity Health Plan is an independent, not-for-profit managed care organization designed specifically to serve low-income New York residents. Founded in 1986 and headquartered in the Bronx, Affinity was the first health plan licensed in New York State to serve publicly insured populations and served as a model for New York’s Medicaid managed care program as it was rolled out across the state. The health plan grew from a collaboration of several Federally Qualified Health Centers in the Bronx that were interested in using a managed care model to enhance the role of primary care in service delivery, improve quality of care, and design systems to meet the particular needs of low-income and vulnerable populations in the New York City metro area. Affinity, in 2008, had approximately 212,000 enrollees—nearly 70 percent of whom are Medicaid recipients—and delivered over 5,000 babies to Medicaid-enrolled pregnant women.

Building on its commitment to primary care, Affinity Health Plan has focused considerable attention on improving birth outcomes and access to timely prenatal and post-partum care. In 2000, Affinity was one of 10 health plans, nationally, to participate in the Center for Health Care Strategies’ *Best Clinical and Administrative Practices (BCAP)* program, funded by the Robert Wood Johnson Foundation. Under BCAP, Affinity designed and implemented its Healthy Beginnings Program, whose objective is “to promote early identification of all pregnancies and ensure that the appropriate level of care is rendered.” The program is, essentially, a case management/care coordination model that utilizes a seven-person team to assess all pregnant women for risk, assists with scheduling appointments, reminds clients of appointments, and provides education materials related to prenatal and post-partum care and behavior. Case managers closely collaborate with women and their health care interdisciplinary team to maintain pregnancies for as long as possible and to improve birth outcomes.

While Healthy Beginnings has been in place, Affinity’s QARR rates for prenatal and postpartum care have steadily improved. Specifically, between 2001 and 2006, the proportion of women with a “timely” initial prenatal visit improved from 81 percent to 92 percent, while the rate of women who receive postpartum care three to eight weeks after delivery improved from 66 percent to 74 percent.

D. Conclusions, Lessons learned, challenges, and future directions

New York State has a long history of working to improve the health and wellbeing of pregnant women and their newborns. The state viewed the OBRA expansions as a critical opportunity to extend their efforts to reach out to and cover pregnant women with health insurance while improving the quality of the care they received through Medicaid. Moving forward, New York officials realize that their numerous efforts to improve access to care for pregnant women have resulted in a complex system, but one that is generally well coordinated by the State Department of Health. The centerpiece of New York's future efforts will be to focus on the development of a more holistic approach to inter-conception care, one that will aim to reach women *before* they are pregnant so that they can be linked into the health system and be provided education that will improve their knowledge and behaviors so that birth outcomes improve.

During the case study process, state officials identified a large number of challenges as well as promising best practices related to outreach, enrollment, and providing enhanced prenatal care. Some of the highlights follow.

Outreach

Many stakeholders felt there was a need to better understand what strategies work in outreach and to share these lessons and train staff accordingly. To this end, stakeholders recommended a systematic effort to document strategies, protocols, and policies on how to do outreach so they can train their workers more effectively. For example, at the time of our visit, Healthy Start was planning an "Outreach Expo." Collecting data on outreach efforts and effects (contacts made and number of contacts resulting in enrollment) would

also help organizations demonstrate the effectiveness of their work, which in turn assists with future funding.

For some key informants, there is a worry that the state has too many outreach and home visiting models and that there may be duplication of effort. (“With 40 outreach agencies doing it in 50 different ways, it can lead to confusion for consumers,” said one stakeholder.) Indeed, separate categorical funding streams for outreach can result in there being “a lot of different messages out there.” Looking forward, the Department of Health will be working to develop the most cost-effective mix of services in all areas of the state with poor birth outcomes and high-risk populations.

Stakeholders mentioned other challenges in conducting outreach including gaining the trust of women, high staff turnover rates, and labor-intensive work (recommending staff receive incentives and recognition for their efforts). Stakeholders also told us a big outreach challenge was “how to access the higher hanging fruit”—those women and families who are the hardest to reach but often the most in need.

In terms of what works best, we were told that word-of-mouth is the most powerful outreach tool and stakeholders felt getting clients to be the outreach workers is an effective method. Other suggestions for useful methods included articles about the programs in free local newspapers, since mass media advertising can be expensive. Effective partnerships between agencies were also felt to be powerful in both conducting outreach and being able to refer women to appropriate services. Stakeholders also suggested faith-based organizations can be key to reaching some people. Stakeholders advised tailoring outreach efforts to the specific population being targeted, for example, urban vs. rural, and being sensitive to the different populations within an urban area. In

addition, officials shared that “one size doesn’t fit all” when it comes to outreach; that individual programs must work hard to understand their unique communities and residents and design strategies that work best in those communities. Conducting client focus groups can be an effective approach for making such assessments. Finally, the Department of Health views the 24/7 hotline as indispensable to provide information to families about services available to them. Importantly, the hotline is staffed by people, so a client can call at any time.

On a systems-level, and within the context of New York State, regional and local-level networks and coalitions may be useful in directing and coordinating the varied and many outreach efforts. This will prevent confusion among women but also create a seamless system of referral between programs, for example by connecting women with the initiative that best meets their needs.

Enrollment Simplification and Facilitation

Presumptive eligibility is the cornerstone of the State’s enrollment efforts, simultaneously facilitating entry into prenatal care and application for Medicaid. By relying, for the most part, on application assistors based in PCAP facilities, the State enables women to take care of their health insurance and health care needs at the same time. Smaller changes to the application process are aimed at simplifying enrollment, such as reducing the need for documentation of citizenship. However, while the State does not require assets tests for presumptive eligibility, thereby assisting with a fast authorization, the full Medicaid applications are often slowed down by missing or delayed income and household structure documentation.

Access to and Coordination of Care

Many different stakeholders commented on the untimely termination of PCAP services at six weeks postpartum that sometimes occurs when the date of delivery is not updated in the record (PCAP benefits are terminated on the last day of the month in which the 60th day postpartum falls), calling it “really problematic” when trying to impact women’s health and birth outcomes *between* pregnancies. Additionally, while mental health services are part of the required PCAP menu, stakeholders reported great difficulty in linking women to mental health services, especially in the relatively short postpartum coverage period, and called mental health a “gaping hole” in PCAP services. As mentioned, stakeholders also worry that too many women are not entering managed care early enough and part of the problem seems to be getting women to choose a health plan.

Categorical funding has made it challenging for New York to streamline and coordinate its various outreach and home visiting programs since every program has different eligibility rules, target populations, and funding support. The challenge is to coordinate the different programs and target women in a systematic way across all programs. Additionally, the State is looking at computer referral systems that will enable the smooth transfer of women from one program to another based on their needs assessments.

Managed Care

New York believes strongly that managed care plans can be effective partners in efforts to improve birth outcomes, as long as state programs actively oversee and monitor their behavior, and provide appropriate incentives for the provision of high quality care.

Under Medicaid, health plans have become increasingly involved in outreach and enrollment, and are required to deliver perinatal services according to PCAP standards. These standards, enforced through contracts and monitored under QARR, have helped Medicaid women to close the gap in their ability to receive care that is increasingly comparable to the care women receive under commercial insurance.

VI. Conclusions and Recommendations for Future Policy

The results of this study paint a mixed picture. In some areas, it is encouraging to see that state Medicaid programs continue to place a high priority on facilitating access to coverage for pregnant women. In other areas, slippage has occurred and it does not seem that states have maintained the same level of emphasis on this population as they had in the past. And as is always the case with Medicaid, tremendous variation exists from state to state.

Our findings as they relate to eligibility and enrollment are perhaps most encouraging. To summarize, compared to the late 1980s and early 1990s when pregnant women were targeted by state Medicaid programs as a high-priority group, states have continued to place strong emphasis on expanded coverage and simplified enrollment for this population. A strong majority of states continue to enforce a series of policies that facilitate pregnant women's access to coverage, and recently states have made impressive progress in the area of online application availability and submission.

However, in the areas of outreach and content of covered prenatal care benefits, our findings suggest that states have generally slipped. Fewer states are conducting multiple and diverse outreach efforts compared to 20 years ago, and in an environment that has become increasingly dominated by managed care, somewhat fewer states are explicitly covering the full scope of nonmedical support services that were covered in earlier decades.

Given these trends, we conclude that while the overall picture with regard to outreach and enrollment of pregnant women is relatively good, there is still considerable room for improvement. With vast new opportunities presented by the prospect of broad health

care reform under the Obama Administration, we recommend that advocates and policymakers redouble their efforts to analyze available options and maximize use of existing federal authority to improve coverage and services for pregnant women through public health insurance programs.

Unfortunately, given variation from state to state, it is also clear that no single set of recommendations can apply to all states. Rather, our analysis of alternative state models illustrates that the options for reaching and enrolling pregnant women are numerous and (to a large degree) interchangeable, that every state (and localities within those states) present somewhat unique environments and face different challenges, and that the “right” combination of outreach and enrollment policies and procedures may in fact be very different in one state than they are in another. Therefore, our recommendations offered for consideration below present guiding principles rather than specific prescriptions for action.

Facilitating Coverage and Enrollment of Pregnant Women

Generally, states should assess the broad range of eligibility and enrollment options available, and adopt a collection of policies that simplify rules and procedures to the maximum extent possible and that maximize the use of cutting-edge technology for receiving applications (e.g., through the Internet) and processing them as expeditiously as possible. Specifically, we urge policymakers to consider:

- ***Making upper income limits for pregnant women and children uniform***, so that eligibility rules for mothers and their offspring are simple, easy to understand and explain, and so that applications for coverage are integrated and easier to process.
- ***Designing application forms that are short, clear, simple, and written at easy-to-read literacy levels (whether they are specific to pregnant women, or are intended for the entire Medicaid population)***, so that women or families are not

intimidated by the prospect of seeking help and so that forms, themselves, do not present a barrier to enrollment.

- ***Not requiring a face-to-face interview as part of the application process under any circumstances***, so that the initial step toward applying for coverage can be simple and convenient and not require the extra time and/or effort of meeting with an eligibility worker.
- ***Allowing applications to be submitted online***, so that application processing can begin immediately. If such Internet-based systems are not yet ready in a given state, then allowing applications to be submitted by mail should be the starting point.
- ***Minimizing requirements for submitting physical verification of such items as income, residency, citizenship, and pregnancy***, so that application processing is not delayed while awaiting the submission of paperwork. Instead, states should invest in systems that permit ex parte review of such requirements through cross-checking applicant information across state databases.
- ***Adopting some form of expedited eligibility determination (whether or not that represents formal “presumptive eligibility”)***, so that women and families learn of the outcome of their applications quickly and so that prenatal care can be received as quickly as possible.
- ***Making application assistors widely available at the community level***, so that women and families that need help in completing their applications can get it. This can take the form of outstationing eligibility workers at community clinics and hospitals or, as is more often the case in SCHIP programs, can be accomplished by funding staff at community-based organizations and provider sites to provide outreach and application assistance.
- ***Building strong links between Medicaid pregnancy and family planning coverage***, so that women who lose their maternity benefits 60 days post-partum can continue to receive women’s health and family planning services, thereby improving the chances that their next pregnancy is healthy and intended. Similarly, links should flow the other way as well, so that women enrolled in family planning coverage can quickly transition to maternity coverage if they become pregnant.

Raising Public Awareness of Available Coverage and Encouraging Enrollment

Generally, it seems that the most successful outreach models combine some form of broad social marketing, with more grass-roots, community-based interventions.

Therefore, we recommend that policymakers strive to design multi-faceted outreach strategies that both raise women's awareness of the availability of coverage, and have the capacity to provide hands-on, one-on-one assistance to individuals who may be interested in applying for coverage, but have questions about what is entailed or whether they might be eligible. Specifically, we urge policymakers to consider:

- ***Supporting ongoing outreach in the form of social marketing, utilizing both electronic (radio and television) and print (posters, billboards, brochures, newspaper advertisements) media to build “brand identity” for the coverage program***, so that the general population is consistently reminded of, for example, the availability of health insurance coverage and/or the importance of prenatal care. Model state programs illustrate that such outreach cannot be a “one time” event; rather, periodic campaigns are required to keep the messages fresh and in the public eye. As one state official said, “There is a reason why we all see ads for (Cola) every night on TV!”
- ***Complementing broader media campaigns with funding that supports community-based outreach***, to foster the development of agencies that can provide hands-on assistance and advise potential enrollees and to improve the chances that a state can connect with “hard to reach” populations who might otherwise ignore broad marketing messages.
- ***Maintaining a toll-free hotline for interested parties to call for information and advice***, maintained 24/7/365 and advertised on *all* promotional materials so that women and families can *always* contact someone with questions about available programs.
- ***Developing outreach materials in multiple languages***, tailored to the specific cultural and ethnic mix in a given state or community, so that all populations can be reached and informed of the benefits that might be available.
- ***Building partnerships with managed care organizations***, so that states can tap into the business and marketing expertise of health plan staff, piggy-back on their resources for promoting coverage and preventive care, and broaden the overall reach of a state outreach effort. In the last decade, states have made considerable progress in partnering with managed care organizations even while strengthening and enforcing rules surrounding inappropriate marketing practices.

Broadening the Scope of Prenatal Care to Include both Medical and Nonmedical Services

State officials learned long ago that low-income, high-risk, and vulnerable populations often require benefits that go beyond traditional medical care and include a range of psychosocial support services that can address risks associated with poor birth outcomes. In an environment increasingly dominated by prepaid managed care arrangements, the challenge of extending such “enhanced prenatal care” is amplified, and requires rigorous contract development and monitoring to ensure that these benefits are available and accessible. Generally, we recommend that policymakers consider the range of services that might benefit the populations of pregnant women in their states and communities, and adopt coverage of the package or combination of benefits that offers the best chance of improving maternal and child health outcomes. Specifically, we urge policymakers to consider:

- ***Ensuring that some form of case management or “care coordination” is included in package***, so that women requiring a complex set of benefits receive help in planning, arranging, and receiving necessary care. Often described by state officials as the “glue” that holds services together, such assistance can be very intensive, requiring the skills of a professional nurse or social worker, and thus should not be confused with the telephone-based case management that is routinely available through managed care organizations. Telephone-based management may be sufficient for some lower-risk women, but should not be assumed to be sufficient for women experiencing multiple and complex challenges.
- ***Allowing for home visiting as part of the enhanced benefit package***, so that high risk pregnant women and mothers can receive intensive, hands-on education, assistance, and support during the pregnancy and post-partum period. Much debate surrounds the relative merits of nurse home visiting models, such as the David Olds/Nurse Family Partnership approach versus models that utilize “lay” community health workers. Different solutions may work well for different populations or communities; we simply urge policymakers to consider inclusion of one or more home visiting intervention models.

- ***Developing explicit contract language with managed care organizations surrounding the delivery of enhanced care***, so that there is no ambiguity surrounding the question of what services should be made available to women presenting various risks. Of course, policymakers should also consider the necessity of adjusting rates for health plans to reflect the cost of delivering enhanced services that will be required by a subset of the pregnant and post-partum enrollee population.

Integrating Perinatal and Child Health Coverage Initiatives.

The recent history of Medicaid maternal and child health policy witnessed innovations occurring in two stages, with outreach and enrollment initiatives directed toward pregnant women occurring first (in the late 1980s/early 1990s) and those directed toward children occurring coincident with the creation of SCHIP (beginning in 1998 and building over the last decade). As described in some of our state model summaries, it appears that there may be wisdom in the goal of working to integrate these two efforts to the maximum extent possible. Doing so creates the potential for more uniform and consistent marketing and messaging (targeting both mothers and their children), more consistent and integrated eligibility and enrollment procedures, and more holistic services (such as home visiting) that can address the needs of both populations. We therefore urge policymakers to explore the potential and feasibility for integration of maternal and child health initiatives.

Fostering Medicaid and Maternal and Child Health Collaboration

As was the case 20 years ago, states with the most promising models today tend to exist in an environment where Medicaid and public health/maternal and child health officials work collaboratively. The two state agencies often possess markedly different perspectives and expertise, yet also often work to achieve similar goals and objectives.

By working together, Medicaid and MCH officials can develop policies and systems of care that work in concert and have the potential for meeting goals related to quality, fiscal integrity, access, and efficiency. We therefore encourage policymakers to consider the strengths of both agencies and what they can each bring to system development efforts, and foster an atmosphere of cooperation and collaboration.

In conclusion, our study finds that with regard to outreach and enrollment strategies for pregnant women under Medicaid, the “glass” is either half-full, or half-empty, depending on your perspective. Priorities placed on easy access to broad prenatal coverage have not completely eroded in the last 20 years, by any means. But they have not dramatically advanced either. Thus, considerable potential for improvement remains, and we hope that the policies, practices, and models described in this paper provide advocates and policymakers at the federal, state, and local levels with ideas and inspiration for moving systems of care for pregnant women and children forward in the future.

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Appendix 1:

Survey of Medicaid Program Outreach and Enrollment of Pregnant Women



**March of Dimes Project
Survey of Medicaid Program
Outreach and Enrollment of Pregnant Women**

PLEASE RETURN THIS SURVEY BY: April 19, 2007

**TO: Ann Cullen (acullen@nashp.org)
National Academy for State Health Policy
50 Monument Square, 5th Floor
Portland, ME 04101
Ph: 207-874-6524
Fax: 207-874-6527**

Questions? Please call Andy Snyder at 202-903-2788

With funding from the March of Dimes, the Urban Institute and the National Academy for State Health Policy are partnering on a study of states' efforts to reach out to and enroll pregnant women into Medicaid. In recent years, much of the policy spotlight has been focused on children, as states have expanded coverage under the State Children's Health Insurance Program (SCHIP) and Medicaid, and focused on outreach and enrollment simplification in an effort to facilitate children's coverage. During the late 1980s, however, states tackled infant mortality reduction and worked to expand coverage, refine outreach, and streamline eligibility rules for pregnant women and their infants. This study will revisit this critical policy area and explore current state strategies to improve birth outcomes for newborns through outreach and coverage initiatives for vulnerable mothers.

This brief survey, which is being distributed to Medicaid programs in all 50 states and the District of Columbia, is the first step in our study. The information you provide will also help us identify several states with particularly innovative programs, and in-depth case studies will be conducted. We will combine the results of the survey and site visits in a report that will summarize the current state of the art, as well as describe best practices.

Thank you, in advance, for helping us by completing this survey. If you have any questions, please do not hesitate to call Andy Snyder at 202-903-2788, or e-mail Ann Cullen at acullen@nashp.org.

Name of respondent:

State:

Title:

Agency:

E-mail:

Phone:

Mailing address:

Contact information for state contact for publication, if other than respondent:

Name of respondent:

State:

Title:

Agency:

E-mail:

Phone:

Mailing address:

Survey Topics

A. Eligibility Criteria

The table below presents Medicaid eligibility policies and criteria for pregnant women and infants in your state. Please check, verify, or correct the information in the table, and fill in any areas where cells are blank.

A1. Please verify the following information is correct:

Eligibility Characteristic	Value	Changes/Corrections
Upper income eligibility threshold for pregnant women under Medicaid		
Upper income eligibility threshold for pregnant women under SCHIP		
Upper income eligibility threshold for infants (ages 0-1) under Medicaid		
Upper income eligibility threshold for infants (ages 0-1) under SCHIP		
Is self-declaration of income accepted?		
Does your state have an asset test for pregnant women?		
In Medicaid, how long after delivery do you cover the mother?		
In SCHIP, How long after delivery do you cover the mother?		

A2. For Medicaid, do you calculate a family's income based on gross income, or net income after disregards?

☐ Gross income ☐ Net income after disregards

A2a. If net, what income disregards are used? (*please specify*)

A2b. What documentation of income do you require? (*please specify*)

A3. If the Medicaid program has an asset test for pregnant women, what is the upper limit on assets (by type of asset)?

(<i>please specify</i>) \$	% of FPL	Asset type
\$	% of FPL	Asset type

A4. If the state covers prenatal care for pregnant women under SCHIP, what legal authority is used?

☐ SCHIP 1115 waiver

- ☐ HIFA 1115 waiver
- ☐ CMS regulatory guidance on coverage of prenatal care for unborn children who are presumed eligible for SCHIP at birth
- ☐ Other (*please specify*)

A5. If the state covers prenatal care for pregnant women under SCHIP, what income and asset rules are used?

- ☐ Same as Medicaid
- ☐ Different from Medicaid. Please specify differences:

B. Outreach

The following questions explore state Medicaid outreach initiatives. By outreach, we mean efforts designed to publicize, or market, the availability of Medicaid coverage for pregnant women, or the importance of timely prenatal care. Outreach campaigns can be broad in scope, involving mass media, or targeted, involving more community-based efforts to connect with "hard-to-reach" families. Except where indicated, we are interested in identifying Medicaid-funded (and, where applicable, SCHIP-funded) outreach initiatives.

Medicaid-conducted Outreach

B1. Has your state Medicaid program set aside dedicated funds for outreach to pregnant women eligible for Medicaid?

- ☐ Yes ☐ No

B2. Does your state Medicaid program have a toll-free hotline for pregnant women to call for information about coverage and services?

- ☐ Yes ☐ No

B3. Does your state Medicaid program conduct outreach to pregnant women through the media?

- ☐ Yes ☐ No

B3a. If yes, how? (Please check all that apply)

- ☐ Television or radio public service announcements (PSAs)
- ☐ Paid advertisements on television or radio
- ☐ Billboards
- ☐ Posters
- ☐ Incentives/coupon books
- ☐ Other (*please specify*)

B4. Does your state Medicaid program have printed outreach materials specific to Medicaid coverage and benefits for pregnant women?

- ☐ Yes ☐ No

(Please note: this question refers to outreach materials such as brochures or fact sheets, and not materials like recipient handbooks that a person would receive upon enrollment. If possible, please send us or e-mail us a copy of any such brochures, fact sheets, or other print materials.)

B4a. If yes, where are these materials made available? (Please check all that apply)

- ☐ Community/Rural/Migrant health centers/Free clinics

- ☐ Hospitals, physicians' offices
- ☐ Public libraries
- ☐ Grocery stores
- ☐ County welfare, social services offices
- ☐ Public health departments
- ☐ Schools/Colleges
- ☐ Medicaid web site/e-mail
- ☐ Web site/e-mail from other state agencies
- ☐ Mailed to Medicaid recipients changing categories; mailed on request
- ☐ Other places (*please specify*)

B5. In what languages besides English are outreach materials available?
(*Please check as many as apply*)

- ☐ Spanish
- ☐ Russian
- ☐ Chinese
- ☐ Other (*please list the other languages you make available*)

B6. Does your state have any outreach efforts targeted at specific groups of pregnant women?

☐ Yes ☐ No

B6a. If yes, what groups? (Please check all that apply)

- ☐ Adolescents
- ☐ High risk populations (e.g. smokers, women with HIV, addiction or mental health problems, women at risk of preterm birth, other)
- ☐ Refugees, immigrant groups (potential follow up area)
- ☐ Other (*please specify*)

Outreach at the Community Level

B7. Does your state fund any community-based outreach initiatives?

☐ Yes ☐ No

If yes:

B7a. Does this funding take the form of grants (or contracts) with community-based organizations, schools, or other entities to support outreach to pregnant women?

☐ Yes ☐ No

B7b. Do these funds support community-based efforts across your entire state?

☐ Yes ☐ No

B7c. Do any managed care organizations receive these grants/contracts and, thus, participate in your state's Medicaid outreach effort?

☐ Yes ☐ No

B7d. Do these funds support the provision of direct "application assistance" whereby community-based workers help families to complete and submit Medicaid applications and documentation?

☐ Yes ☐ No

Outreach by Other Partners

B8. Are outreach efforts conducted by any of the following: *(Please all that apply)*

- ☐ Separate SCHIP program
- ☐ State maternal and child health and/or Title V
- ☐ County health departments
- ☐ Schools, School-based clinics
- ☐ Federally Qualified Health Centers
- ☐ Private organizations, such as the March of Dimes, or Healthy Mothers, Healthy Babies, *(please describe briefly)*
- ☐ Other *(please specify)*

B9. Are incentive programs for pregnant women conducted by other organizations? (e.g. gift giveaways, baby showers)

- ☐ Yes ☐ No

B9a. If yes, which organizations? (please specify)

B10. Are there any outreach practices you are particularly proud of or have found to be particularly effective?

- ☐ Yes ☐ No

B10a. If yes, Please describe your outreach practices:

Would you like to have us call you to describe these practices in more detail?

- ☐ Yes ☐ No

If yes, Please indicate the name and phone number of the appropriate person to call:

Name:

Phone #:

C. Application and Enrollment

In this section we explore states' efforts to simplify eligibility rules and streamline enrollment for pregnant women.

C1. Does your state have presumptive eligibility for pregnant women? *(please verify our information)*

- ☐ Yes ☐ No

Correction (if needed):

If yes...

C1a. which providers are authorized to grant PE?

(please specify)

C1b. how does the state follow up on PE applications to finish eligibility determination?

(please specify)

If no,

C1c. is there a DIFFERENT expedited enrollment process for pregnant women?

- ☐ Yes ☐ No

If yes, please describe the process briefly:

C2. If your state doesn't have presumptive eligibility or another expedited process, why not?
(Please check all that apply)

- ☐ Too expensive
- ☐ Too cumbersome
- ☐ Difficulties paying providers
- ☐ Too many pregnant women served who turned out not to be eligible
- ☐ Other (please specify)

C3. Do pregnant women in your state use a **standard** Medicaid application?

- ☐ Yes ☐ No

C3a. If yes, is this application available on-line?

- ☐ Yes ☐ No

C3b. Can the application be filled out and submitted on-line?

- ☐ Yes ☐ No

C3c. Can the application be mailed in?

- ☐ Yes ☐ No

C4. Does your state have a **shortened** Medicaid application for pregnant women?

- ☐ Yes ☐ No

C4a. If yes, is this application available on-line?

- ☐ Yes ☐ No

C4b. Can the application be filled out and submitted on-line?

- ☐ Yes ☐ No

C4c. Can the application be mailed in?

- ☐ Yes ☐ No

C5. Are women required to complete a face-to-face interview when applying for pregnancy-related coverage?

- ☐ Yes ☐ No

C6. At what physical locations can applications be submitted?

(Please check all that apply)

- ☐ County government office
- ☐ Community health center
- ☐ Hospital
- ☐ Physician's office
- ☐ Other Medicaid provider (please specify)

C7. In what languages besides English are applications available?

(Please check as many as apply)

- ☐ Spanish
- ☐ Russian
- ☐ Chinese
- ☐ Other (please list the other languages you make available)

C8. Does your state out-station eligibility workers? (yes/no)

☐ Yes ☐ No

C8a. If yes, where? (Please check all that apply)

- ☐ Hospitals
☐ Community health centers
☐ Health department clinics
☐ Other (please specify)

Citizenship Verification

C9. Has your state implemented the new proof of citizenship rules enacted in 2006?

☐ Yes ☐ No

C10. Does your state authorize agents (e.g. providers) to verify citizenship documentation?

☐ Yes ☐ No

C10a. If yes, what entities are authorized to verify citizenship? (please specify)

C11. Does your state conduct electronic cross-matches with databases such as vital records, Social Security, and the state motor vehicles department?

☐ Yes ☐ No

C12. Has your state done any of the following in response to the new citizenship documentation requirement? (check all that apply)

- ☐ Redesign application forms
☐ Train eligibility workers on new requirements
☐ Other (please specify)

D. Family Planning Waivers

A growing number of states have received Section 1115 waiver authority to extend coverage of family planning services to post-partum and low income women. These programs might offer another opportunity for Medicaid programs to conduct outreach, and we explore this in the questions below.

D1. Does your state have a 1115 family planning demonstration waiver? (please verify our information)

☐ Yes ☐ No

Correction (if needed):

If your state has an 1115 family planning demonstration waiver,

D1a. Are waiver participants who become pregnant automatically screened for and enrolled in Medicaid pregnancy coverage?

☐ Yes ☐ No

D1b. Are women eligible for Medicaid during their pregnancy automatically rolled over into the 1115 family planning waiver after 60 days postpartum? (please verify our information)

☐ Yes ☐ No

Correction (if needed):

E. Benefits and service delivery

In the late 1980s, most Medicaid programs did more than expand eligibility for pregnant women; they also enhanced the scope of their benefits to include an array of support services designed to improve birth outcomes. The questions below explore whether such coverage is still in place.

E1. Does your state provide any of the following enhanced prenatal care benefits for pregnant women? *(Please check all that apply)*

- ☐ Targeted case management (or “care coordination”) for pregnant women
- ☐ Prenatal risk assessment(s)
- ☐ Preconception counseling
- ☐ Nutritional counseling
- ☐ Psycho-social counseling
- ☐ Health education
- ☐ Smoking cessation
- ☐ Home visiting
- ☐ Transportation
- ☐ Dental care
- ☐ Substance abuse treatment
- ☐ Other *(please specify)*

E2. Are the above services reimbursed on a fee-for-service basis?

- ☐ Yes ☐ No

E2a. If yes, are any fee-for-service payment incentives linked to delivery of these services?

- ☐ Yes ☐ No

E3. Are managed care organizations that participate in Medicaid required to offer some or all of these services to pregnant women?

- ☐ Yes ☐ No

E3a. If yes, please summarize briefly:

Thanks very much for your time!

Appendix 2:

Selected Survey Results/State Program Characteristics, by State, 2007

Table 1: How Women Can Apply for Pregnancy-Related Coverage, 2007

States	Shortened application	Application available online	Application can be submitted online	Applications can be mailed in
Alabama		✓	✓	✓
Alaska		✓		✓
Arizona	✓	✓		✓
Arkansas		✓		✓
California	✓	✓		
Colorado		✓		✓
Connecticut	✓	✓		✓
Delaware	✓	✓	✓	✓
DC		✓		✓
Florida	✓	✓	✓	✓
Georgia				✓
Hawaii	✓	✓		✓
Idaho		✓		✓
Illinois		✓	✓	✓
Indiana	✓	✓		✓
Iowa		✓		✓
Kansas		✓	✓	✓
Kentucky				✓
Louisiana	✓	✓		✓
Maine	✓	✓		✓
Maryland	✓	✓		✓
Massachusetts		✓	✓	✓
Michigan	✓	✓	✓	✓
Minnesota		✓		✓
Mississippi		✓		✓
Missouri	✓	✓		✓
Montana		✓		✓
Nebraska	✓	✓		✓
Nevada		✓		✓
New Hampshire	✓			✓
New Jersey	✓			✓
New Mexico		✓		✓
New York	✓			
North Carolina		✓		✓
North Dakota	✓	✓	✓	✓
Ohio	✓	✓		✓
Oklahoma		✓		✓
Oregon		✓		✓
Pennsylvania	✓	✓	✓	✓
Rhode Island		✓		✓
South Carolina		✓		✓
South Dakota				✓
Tennessee		✓		✓
Texas		✓	✓	✓
Utah		✓	✓	✓
Vermont	✓	✓		✓
Virginia	✓	✓	✓	✓
Washington	✓	✓	✓	✓
West Virginia	✓	✓	✓	✓
Wisconsin	✓	✓	✓	✓
Wyoming	✓	✓		✓
TOTAL	25	45	15	49

Table 2: Asset Test and Self Declaration of Income for Pregnant Women, 2007

States	Asset test for pregnant women?	Self Declaration of Income?
Alabama		Other ¹
Alaska		
Arizona		
Arkansas	✓	✓
California		
Colorado		Presumptive Eligibility Only
Connecticut		✓
Delaware		Presumptive Eligibility Only
DC		Other ²
Florida		
Georgia		
Hawaii		Other ³
Idaho	✓	✓
Illinois		
Indiana		
Iowa	✓	Other ⁴
Kansas		
Kentucky		
Louisiana		Other ⁵
Maine		
Maryland		✓
Massachusetts		Presumptive Eligibility Only
Michigan		Other ⁶
Minnesota		
Mississippi		Other ⁷
Missouri		
Montana	✓	
Nebraska		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota		
Ohio		
Oklahoma		✓
Oregon		
Pennsylvania		
Rhode Island		
South Carolina	✓	
South Dakota	✓	
Tennessee		
Texas		
Utah	✓	
Vermont		✓
Virginia		
Washington		
West Virginia		
Wisconsin		✓
Wyoming		✓
TOTAL	7	18 (any form)

¹Self declaration accepted for SCHIP and in certain situations for Medicaid

²Unearned income is self-declared for SCHIP only. All other income must be verified

³Hawaii allows self-declaration of income only at the point of application and eligibility renewal

⁴Iowa has self-declaration for pregnant women who are eligible for presumptive and IowaCare (1115 waiver)

⁵If income reported is <75 percent of limit

⁶In some programs but not in all

⁷For the Family Planning Waiver participant ONLY

Table 3: Outstationing Eligibility Workers, 2007

State	Does state outstation eligibility workers?	Outstationed Eligibility Worker Locations			
		Hospitals	Community Health Centers	Health Department Clinics	Other
Alabama	✓	✓	✓	✓	✓
Alaska	✓				✓
Arizona	✓	✓			
Arkansas	✓	✓			
California	✓	✓	✓		
Colorado	✓	✓			
Connecticut	✓	✓	✓		
Delaware					
DC	✓	✓	✓		
Florida	✓				✓
Georgia	✓	✓	✓		✓
Hawaii	✓	✓	✓		
Idaho	✓		✓		
Illinois					
Indiana					
Iowa	✓		✓		
Kansas					
Kentucky					
Louisiana					
Maine					
Maryland	✓	✓		✓	
Massachusetts					
Michigan	✓	✓			
Minnesota					
Mississippi	✓	✓		✓	
Missouri	✓	✓			✓
Montana	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓
Nevada					
New Hampshire					
New Jersey	✓	✓	✓		
New Mexico	✓				✓
New York	✓	✓	✓	✓	
North Carolina	✓	✓	✓		✓
North Dakota	✓		✓		✓
Ohio	✓	✓	✓		
Oklahoma	✓	✓			
Oregon	✓				✓
Pennsylvania					
Rhode Island					
South Carolina	✓	✓	✓	✓	
South Dakota	✓				✓
Tennessee	✓	✓			
Texas	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	
Vermont					
Virginia	✓	✓	✓	✓	
Washington					
West Virginia	✓	✓			✓
Wisconsin	✓				✓
Wyoming					
TOTAL	35	26	19	10	15

Table 4: Media Campaigns/Outreach Strategies, 2007

States	TV or Radio (Paid)	TV or Radio (Unpaid)	Bill- boards	Posters	Incentives/ Coupons	Other Media Outreach	Printed Materials	Outreach in Multiple Languages	Toll-Free Hotline
Alabama							✓		✓
Alaska							✓	✓	✓
Arizona							✓	✓	✓
Arkansas					✓		✓	✓	✓
California								✓	
Colorado									✓
Connecticut				✓		✓	✓	✓	✓
Delaware									
DC							✓	✓	
Florida							✓	✓	✓
Georgia								✓	✓
Hawaii							✓		✓
Idaho									
Illinois							✓	✓	✓
Indiana									✓
Iowa									✓
Kansas							✓	✓	✓
Kentucky									✓
Louisiana						✓	✓	✓	✓
Maine				✓			✓	✓	
Maryland							✓	✓	✓
Massachusetts						✓	✓	✓	✓
Michigan							✓	✓	✓
Minnesota									
Mississippi									✓
Missouri									✓
Montana									✓
Nebraska							✓	✓	✓
Nevada							✓	✓	
N. Hampshire									
New Jersey									
New Mexico		✓				✓	✓	✓	✓
New York	✓	✓	✓	✓		✓			✓
North Carolina								✓	✓
North Dakota								✓	
Ohio							✓	✓	✓
Oklahoma									
Oregon									
Pennsylvania							✓	✓	✓
Rhode Island								✓	✓
South Carolina									✓
South Dakota	✓						✓	✓	✓
Tennessee								✓	✓
Texas							✓	✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vermont							✓	✓	✓
Virginia									
Washington							✓	✓	✓
West Virginia									
Wisconsin	✓					✓	✓	✓	✓
Wyoming									
TOTAL	4	3	2	4	2	7	26	30	36

Table 5: Community-Based Outreach Efforts, 2007

State	State Funds community-based outreach?	Makes grants to community- based orgs/ schools	Outreach is Statewide	Involves Managed Care Orgs	Provides application assistance
Alabama	✓	✓	✓	✓	
Alaska					
Arizona					
Arkansas					
California					
Colorado	✓		✓		✓
Connecticut	✓	✓	✓		✓
Delaware					
DC					
Florida					
Georgia	✓			✓	
Hawaii	✓	✓	✓		✓
Idaho	✓	✓	✓		
Illinois	✓	✓	✓		✓
Indiana					
Iowa	✓	✓	✓	✓	✓
Kansas	✓	✓	✓		
Kentucky					
Louisiana	✓	✓			
Maine					
Maryland					
Massachusetts	✓	✓	✓		✓
Michigan					
Minnesota					
Mississippi					
Missouri					
Montana					
Nebraska	✓	✓	✓	✓	✓
Nevada					
New Hampshire					
New Jersey					
New Mexico	✓	✓	✓	✓	✓
New York	✓	✓			✓
North Carolina					
North Dakota					
Ohio					
Oklahoma	✓	✓	✓		✓
Oregon					
Pennsylvania	✓	✓			✓
Rhode Island	✓	✓	✓		✓
South Carolina					
South Dakota	✓				
Tennessee					
Texas	✓	✓	✓	✓	✓
Utah	✓	✓	✓		✓
Vermont	✓	✓	✓		
Virginia					
Washington					
West Virginia					
Wisconsin	✓	✓			
Wyoming					
TOTAL	22	19	16	6	14

Table 6: Specific Populations Targeted for Outreach, 2007

State	Adolescents	High-Risk Populations	Refugees/ Immigrants	Other	No targeted outreach
Alabama					✓
Alaska					✓
Arizona					✓
Arkansas	✓				
California					✓
Colorado	✓	✓	✓		
Connecticut	✓	✓	✓	✓	
Delaware					✓
DC					✓
Florida					✓
Georgia					✓
Hawaii	✓				
Idaho					✓
Illinois					✓
Indiana					✓
Iowa					✓
Kansas					✓
Kentucky					✓
Louisiana			✓		
Maine					✓
Maryland					✓
Massachusetts		✓			
Michigan		✓			
Minnesota					✓
Mississippi	✓	✓			
Missouri					✓
Montana					✓
Nebraska					✓
Nevada	✓	✓			
New Hampshire					✓
New Jersey					✓
New Mexico	✓			✓	
New York		✓		✓	
North Carolina					✓
North Dakota					✓
Ohio					✓
Oklahoma					✓
Oregon	✓	✓			
Pennsylvania		✓			
Rhode Island					✓
South Carolina					
South Dakota	✓	✓		✓	
Tennessee					✓
Texas					✓
Utah		✓			
Vermont	✓	✓	✓		
Virginia					✓
Washington	✓				
West Virginia					✓
Wisconsin	✓	✓			
Wyoming					✓
TOTAL	12	13	4	4	32

Table 7: Expanded Benefits for Pregnant Women, 2007

State	Targeted case management	Prenatal risk assessment	Preconception counseling	Nutritional counseling	Psycho-social counseling	Health education	Smoking cessation	Home visiting	Transportation	Dental Care	Substance abuse treatment	Other
Alabama	✓	✓			✓	✓	✓	✓			✓	
Alaska												✓
Arizona	✓	✓	✓						✓			
Arkansas	✓	✓		✓	✓	✓		✓				
California	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Connecticut									✓	✓	✓	
Delaware	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
DC		✓		✓		✓	✓	✓	✓	✓	✓	
Florida	✓	✓					✓		✓		✓	
Georgia	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Hawaii			✓				✓		✓	✓	✓	
Idaho		✓		✓	✓	✓	✓	✓	✓	✓	✓	
Illinois	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
Indiana												
Iowa	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Kansas		✓				✓						
Kentucky							✓		✓		✓	✓
Louisiana	✓								✓	✓		
Maine												
Maryland		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Michigan	✓	✓		✓		✓	✓	✓	✓			
Minnesota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Mississippi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Missouri	✓								✓	✓	✓	
Montana	✓	✓	✓		✓	✓	✓	✓	✓	✓		
Nebraska												
Nevada					✓				✓		✓	
N. Hampshire												
New Jersey	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
New Mexico	✓	✓		✓	✓			✓	✓			✓
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina	✓	✓		✓	✓	✓		✓				
North Dakota	✓											
Ohio	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Oklahoma	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oregon	✓	✓		✓	✓		✓	✓			✓	
Pennsylvania	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Rhode Island		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
South Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Dakota							✓		✓		✓	
Tennessee	✓	✓						✓				✓
Texas	✓	✓			✓	✓		✓	✓			
Utah	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Vermont												
Virginia	✓	✓		✓			✓		✓	✓	✓	
Washington		✓	✓		✓		✓	✓	✓	✓	✓	
West Virginia												
Wisconsin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wyoming			✓		✓		✓	✓	✓	✓	✓	
Total	32	35	19	27	30	28	32	30	37	26	32	11