



**Medicaid Outreach and Enrollment for Pregnant Women:  
What is the State of the Art?  
Draft Executive Summary**

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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 period, the level of attention that the federal and state governments have focused on publicly-sponsored health insurance care 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% of the federal poverty level (FPL). Thirty-six states cover pregnant women at 185% FPL or above.
- 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, rather than requiring the applicant to provide documentation.



- 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.
- Forty-five states have their applications available on their websites. 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 states, pregnant women can submit their applications over the internet, allowing for an entirely electronic application process.
- Twenty nine states have policies of presumptive eligibility for pregnant women—during which time pregnant women can receive vital 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 expedited processes.
- In 2007, 34 states and Washington, DC outstationed Medicaid eligibility workers in the community to facilitate the application process.

For the most part, the survey found that state Medicaid agencies have continued to focus on simplifying eligibility and enrollment for pregnant women, even during a period when children's coverage has been a more dominant policy focus. It was striking, for example, to see how many states were taking advantage of the internet to facilitate access to program applications. However, states have lost some ground in several areas. For example, in 2007, seven states required that pregnant women document their resources and denied eligibility for those whose resources were above a certain level. By comparison, 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 the community, compared to 34 states that placed eligibility staff in the community 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 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 of states' outreach efforts include:

- In 2007, 13 states had dedicated funding supporting outreach for pregnant women.
- Ten states conduct outreach through the media, including three that utilize unpaid television or radio and four states include 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 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.

### ***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**

### ***Louisiana***

As a historically poor state, Louisiana ranked very low among the states in terms of its low weight birth and infant mortality rates at the start of this decade. 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 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 funding for full-time outreach staff deployed to each of the state's nine public health regional offices. These staff focus particular effort on expeditiously processing Medicaid applications from pregnant women. To further reduce barriers to coverage, Louisiana also dropped its requirement for medical verification of pregnancy, and allows eligibility workers to exercise "reasonable certainty" in determining women income eligible when they are unable to produce verification documents. Working closely with the state Office of Public Health, Louisiana Medicaid emphasizes grassroots outreach and partnerships with faith- and community-based organizations and 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.

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 6<sup>th</sup> best in the rate of women who receive "adequate prenatal care" during their pregnancies.

### ***New York***

New York State has long been a pioneer in its 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 such 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 include PCAP providers in their networks. New York's Medicaid program also monitors the quality of care provided through health plans using several key perinatal outcome measures and has begun keying payment levels to plan performance on these measures. Growing from these efforts, New York Medicaid now finances over 40 percent of all deliveries in the state, and the state's infant mortality rate has fallen to 6 deaths per 1,000 live births, ranking it 6th best, nationally.

### **Preliminary 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 strong majority of states continue to enforce a series of policies that facilitate pregnant women's access to coverage, and states have made particular new 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 covering the full scope of nonmedical support services that were covered in earlier decades.

Given these trends, and given tremendous variation in policies from state to state, we conclude that while the overall picture with regard to outreach and enrollment of pregnant women is not dire, there is still considerable room for improvement. With vast new opportunities presented by the prospect of broad health care reform, we recommend that advocates and policymakers redouble their efforts to analyze available options and maximize use of existing federal optional authority to improve coverage and services for pregnant women. In particular, states should:

- Design multi-faceted outreach strategies that utilize both statewide campaigns to raise women's awareness of the availability of coverage, coupled with grass roots and community-based efforts to assist women with enrollment.



- Adopt a broad range of policies that simplify eligibility and enrollment, implementing cutting-edge systems for receiving applications (e.g., through the internet) and processing them as expeditiously as possible.
- Broaden the scope of prenatal care benefits coverage beyond traditional medical care to include a range of psychosocial support services that can address risks that are associated with poor birth outcomes, and through rigorous contract development and monitoring, ensure that these benefits are available and accessible under Medicaid managed care arrangements.