MEDICAID COVERAGE OF PERINATAL SERVICES:

Results of a National Survey

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Executive Summary

Introduction

In the late 1980s, the states and Federal government enacted a series of eligibility and program expansions to improve access to prenatal care for low-income women. Largely due to the success of these expansions, Medicaid has become one of the major funders of prenatal care and delivery services for women in the United States, paying for approximately one-third of all births in the nation. During the last decade, however, the Medicaid program has also changed considerably with the broad adoption of managed care arrangements for Medicaid enrollees. Today, over half of all Medicaid beneficiaries—mostly low-income women and children—are enrolled in managed care. This shift has changed the way states organize and finance care, and has implications for access to and the delivery of perinatal services under Medicaid.

Because Medicaid is both a state and Federal program, understanding what is happening at the state level is necessary if one is to gain a national picture of the program. To identify how perinatal services operate under Medicaid across the nation, The Henry J. Kaiser Family Foundation contracted with Health Systems Research, Inc. to conduct a national survey of state Medicaid programs to document state policies on coverage of perinatal care under a changing Medicaid system.

Methods

From August 1999 to March 2000, Health Systems Research, Inc. conducted a telephone survey of officials in Medicaid agencies in the 50 states and the District of Columbia; responses were received from 47 states and DC.[1] To complement this information with the perspective of providers, telephone interviews were conducted wherever possible with representatives from the American College of Obstetricians and Gynecologists (ACOG), the professional association of obstetrical providers, in each state; 14 state ACOG chairs or other representatives responded to the request for an interview.

In addition to these telephone interviews, background information was gathered from the states, including Medicaid managed care contracts, statutory or regulatory language, and statistical reports. The information collected from each informant was catalogued and analyzed in a database using Microsoft Access.

[1] Mississippi, New Mexico, and Wyoming did not respond to the survey.

Findings

I. Medicaid Eligibility and Services

States are using a range of eligibility streamlining techniques to encourage eligible women to enroll in Medicaid. Approaches that have been adopted include the:

- elimination of the asset test as part of the financial eligibility determination (a strategy used by 39 states and DC);
- implementation of a presumptive eligibility policy, which allows women to enroll temporarily in Medicaid and receive services while eligibility is formally determined (27 states and DC);
- use of a shortened application form (41 states and DC);
- acceptance of applications at sites other than welfare offices (36 states) and outstationing of eligibility workers in the community (34 states and DC);
- combination of the Medicaid application with that for other public assistance programs (31 states);
- elimination of the face-to-face interview requirement in favor of a mail-in application (35 states and DC); and
- preparation and distribution of applications in languages other than English (used by 30 states and DC).

Pregnancy-related services are used primarily by two major categories of Medicaid beneficiaries: 1) very poor women who are eligible under AFDC-related categories who become pregnant while enrolled in Medicaid, and 2) women who qualify under pregnancy-related "expansion" categories with higher income limits.

- The benefits package offered under these two categories is the usually the same; 38 states and DC offer the full spectrum of Medicaid benefits to both AFDC and expansion categories of Medicaid enrollees, while eight states limit coverage to only pregnancy-related services for expansion enrollees.
- Basic prenatal services, such as prenatal visits and laboratory tests are covered by all of the responding states, prenatal vitamins are covered by 43 states.
- Ultrasound is covered by all states that were surveyed (47 states and DC). Amniocentesis (46 states and DC), chorionic villus sampling (42 states and DC), and genetic counseling (36 states and DC) are also typically included in the benefits package. Coverage of medical and psychosocial risk assessments is common as well.

- Basic delivery services, including vaginal and cesarean delivery, anesthesia, and postpartum care, are covered by all states, although only 34 states and DC cover birth centers and home births.

Coverage of perinatal education and support services is less comprehensive than coverage of medical services.

- Prenatal care coordination is offered by 41 states and DC, and transportation for pregnant women is covered by 38 states.

- Nutrition counseling (34 states) and psychosocial counseling (37 states) are less commonly offered, as are educational services such as childbirth education (30 states), infant care education (27 states), and other health education services (21 states).

- Breastfeeding support coverage is similarly uncommon, with 22 states offering breastfeeding education, 29 covering rental of breast pumps, and only nine covering individual lactation consultation.

II. Perinatal Services and Medicaid Managed Care

State Medicaid agencies are increasingly turning to managed care programs, particularly capitated systems, to control program costs and improve access to services for their enrollees. Of the 48 Medicaid programs that responded to the survey, all but three use some type of managed care strategy to serve pregnant women.

- Capitated health maintenance organizations (HMOs) are offered to pregnant women in 41 states and DC. Under these programs, states' coverage of pregnancy-related services is generally fairly broad, but the inclusion of specific services in managed care contracts is limited in many states.

- Many states that cover specific perinatal services do not explicitly specify these services in managed care contracts; not even the most basic perinatal services, such as prenatal visits or delivery services, are mentioned by all 42 jurisdictions in their contracts.

- Prenatal visits and lab services are included in the managed care contracts of slightly more than half of the states and a similar proportion include language specifically related to coverage of delivery and anesthesia.

- Prenatal education and support services are included in the contracts of fewer than half of the states, although care coordination and home visiting are included in the contracts of a majority of states that cover these services.

Payment to providers and health plans is another critical aspect of managing care and has a significant impact on access to perinatal care. Medicaid has historically paid providers lower rates that the private sector or even Medicare. This has translated to long-standing problems with provider participation.

- Of the states that continue to cover some (or all) Medicaid pregnancies through traditional payment systems and/or primary care case management programs, more than half (28 states) pay global fees to physicians for perinatal care. These global fees typically include prenatal office visits, the delivery, and at least some postpartum care.

- Access to anesthesiologists is a particular problem in the Medicaid program. Medicaid officials in twelve states reported one or more instances of women's being asked for cash payments for anesthesia (typically epidurals) in the hospital because anesthesiologists refuse to accept the Medicaid fee as full payment. Despite strong federal guidance that these incidents should not be tolerated, many state officials reported that they are unable to stop these practices. However, two states reported success in increasing anesthesiologists' participation in Medicaid by increasing rates and changing billing policies.

- In capitated systems, establishing payment rates and structures that compensate plans adequately presents a challenge. Because many women do not become eligible for Medicaid until they are pregnant, and do not enroll in a managed care plan until Medicaid eligibility is determined, plans may not receive capitation payments for them for more than a few months before being faced with the expense of a delivery. Therefore, states may either exclude women in the pregnancy-related category from enrollment in capitated plans, or they may structure payments to plans to compensate them separately for delivery.

- The states with capitated Medicaid managed care programs reported several approaches to this problem. Two states entirely exclude women from participating in managed care programs if they are eligible for Medicaid because of pregnancy. Some states use alternative methods of paying plans for perinatal services instead of or in addition to their standard capitation rate structure. For example, two states pay plans a global fee instead of monthly capitation payments. In another nine states, the Medicaid program pays a separate lump sum, often called a "kick payment," for each delivery.

III. Monitoring Access and Availability

Although monitoring the quality of services provided under Medicaid managed care can be complex, pregnancy is a time-limited event with measurable outcomes, and data are often readily available to measure both the process of care—including the type and frequency of services used—as well as the outcome of those services, such as infant birth weight and gestational age. To monitor these indicators, however, state Medicaid agencies must be able to collect accurate encounter data from the managed care plans with which they contract.

- In general, most states reported that they did attempt to collect encounter data from plans, and many also reported that they monitor specific measures of the use and outcome of perinatal care.

- The proportion of women who enter prenatal care in the first trimester, the low birth weight rate, the adequacy of prenatal care, cesarean section rates, and abortion rates are the most popular measures used to monitor access.

- Other indicators included the number of sterilizations performed (including vasectomies, tubal ligations, and hysterectomies), the proportion of women who receive postpartum checkups soon after delivery, the availability of obstetricians in managed care plans, and the length of stay for maternity admissions.

- Only 15 states reported having formal mechanisms for monitoring access to obstetric or other perinatal providers under Medicaid, often doing so while monitoring their Medicaid managed care programs.

Conclusions

The findings of this survey paint a complex picture of how low-income women receive perinatal services. Most state Medicaid programs cover a comprehensive range of perinatal services, generally including prenatal medical services and testing, delivery (including anesthesia), and postpartum care. Many states also cover prenatal support and education services. However, relatively few states cover smoking cessation services or services to support women's decision to breastfeed, two services that can have a dramatic and immediate effect on infants' health.

The coverage of specific services, however, does not always guarantee that the services are accessible. States still experience difficulty recruiting providers and plans to participate in Medicaid. While many state officials report broader access to providers since the implementation of Medicaid managed care, others continue to struggle to maintain their provider networks.

States are also not always equipped to monitor and evaluate access to services under their Medicaid programs. Further complicating the problem of monitoring and evaluation is the fact that commonly-used payment mechanisms such as capitation and global fees make it difficult for state officials to monitor the specific services provided for these payments.

In conclusion, it appears from this survey that while many states have established an infrastructure for providing comprehensive perinatal care to low-income women, much ongoing work is needed to assure that these policies translate into practical access to care for the low-income women who rely on Medicaid to cover their care.

Chapter I: Introduction and Overview

I. Introduction and Overview

Since the mid-1980s, Medicaid—the joint Federal and state health program for the poor—has had an increasing role in coverage of services for low-income pregnant women. Today, Medicaid finances approximately one-third of all births in the United States. These births tend to be to women who are younger, lower-income, and in poorer overall health than the population generally; as a result, women on Medicaid experience higher risks in pregnancy.

Legislative concern about poor birth outcomes to low-income women, as well as the high cost of maternity care, prompted a series of efforts between 1986 and 1989 to expand Medicaid eligibility for pregnant women. First, Congress severed the link between Medicaid eligibility and receipt of cash benefits, allowing all women with family incomes below a given level to qualify. Later, all states were required to offer Medicaid coverage to pregnant women with family incomes below 133 percent of the Federal poverty level (FPL), although states have the option of setting higher income limits.

Legislation passed in 1986 also allowed states to simplify the Medicaid enrollment process for pregnant women. This legislation included such options as eliminating the asset test; offering presumptive eligibility, which allows providers to bill Medicaid for services to low-income women while a formal eligibility determination is being made; allowing clients to mail in their applications; and outstationing eligibility workers in hospitals and health centers (an option that was mandated by later legislation). Finally, as eligibility expanded, states began to offer (with support from the Federal government) a wider range of services for Medicaid-eligible pregnant women, adding such services as case management, risk assessment, nutritional counseling, health education, psychosocial support, and transportation to their benefit packages.

Despite this expansive policy environment, practical access to care for pregnant women has long been a problem in the Medicaid program. Provider participation in Medicaid, particularly among obstetrician/gynecologists and primary care providers, has consistently been a concern (Rowland and Salganicoff, 1994), and eligibility expansions were not necessarily accompanied by increased participation by obstetrical providers (Dubay et al., 1995). To address this issue, Congress included in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) a requirement that states assure that access to obstetric and pediatric providers was at least equal to that found in the private sector. To enforce this "equal access" requirement, states were required to report the proportion of these providers who participated in Medicaid each year.

The introduction and rapid expansion of Medicaid managed care in the 1990s was another attempt to improve access to care for Medicaid recipients, as well as an effort to contain the rapidly rising cost of the Medicaid program to the states. While managed care offers the prospect of improved access to primary care and coordination of services, it can also limit access to perinatal care. For example, the packages of enhanced services that states began offering in the

1980s were largely provided through local health departments, which may not be included in managed care networks. In addition, managed care organizations' provider networks may not include the range of hospitals needed by high-risk pregnant women (Hein, 1999).

Other recent policy changes at the Federal level may affect access to perinatal services as well. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, known as "welfare reform," completed the de-linking of Medicaid from cash benefits. The Aid to Families with Dependent Children (AFDC) program, which had provided the basis for Medicaid eligibility for most low-income families, was eliminated, and the Temporary Assistance to Needy Families (TANF) program was established in its place. This program provides block grants to states to provide income support and other programs to help low-income people enter and stay in the work force. Although Medicaid eligibility standards were not affected, the decline in the use of cash benefits has been accompanied by a decline in Medicaid enrollment, possibly due to confusion about eligibility rules (Ku and Garrett, 2000), which may affect pregnant women's access to timely prenatal care. In addition, the Balanced Budget Act of 1997 contained a provision repealing the "equal access" requirement included in OBRA-89. Thus, states are no longer required to monitor the participation of obstetricians and pediatricians in Medicaid or to assure access to these providers.

To further explore the status of state policies on coverage of and access to perinatal services and providers under a changing Medicaid system, The Henry J. Kaiser Family Foundation commissioned a national survey of state Medicaid agencies. From August 1999 through March 2000, Health Systems Research, Inc. conducted a telephone survey of officials in Medicaid agencies in the 50 states and the District of Columbia; responses were received from 47 states and the District of Columbia (all but Mississippi, New Mexico, and Wyoming). The survey instrument included questions about Medicaid eligibility standards and processes for pregnant women, services covered under state Medicaid programs and Medicaid managed care contracts, access to providers and services, payment systems, and the lessons state officials had learned from their experiences providing perinatal care to low-income women. In many states, this required interviews with several Medicaid officials, as no single informant was fully aware of all of Medicaid's provisions for serving pregnant women under both managed care and fee-for-service systems. To complement this information with the perspective of providers, telephone interviews were conducted wherever possible with representatives from the American College of Obstetricians and Gynecologists (ACOG), the professional association of obstetrical providers, in each state; 14 state ACOG chairs or other representatives responded to the request for an interview.

This report presents the results of the study. The next chapter presents findings on Medicaid eligibility standards for pregnant women and the perinatal services covered under state Medicaid programs. The following chapters discuss, in turn, perinatal services under Medicaid managed care programs (Chapter III), mechanisms for paying perinatal providers under both fee-for-service and managed care arrangements (Chapter IV), and systems for monitoring and assuring access to services (Chapter V). The final chapters present the perspectives of state officials (Chapter VI) and HSR's conclusions about access to perinatal care (Chapter VII).

Chapter II: Medicaid Services and Eligibility

II. Medicaid Services and Eligibility

Medicaid reforms, particularly eligibility expansions and implementation of Medicaid managed care programs, have been a cornerstone of state efforts to improve perinatal health among low-income pregnant women. States have dramatically increased the income eligibility levels for Medicaid coverage for pregnant women and, consequently, state Medicaid programs finance a substantial proportion of births. In addition, states have expanded the range of benefits offered to pregnant women to include a number of non-medical support services. State Medicaid programs can therefore provide a continuum of services, including prenatal medical care, support services, education, delivery, and postpartum care, to meet the unique medical and psychosocial needs of individual women.

A. Eligibility

In 1986, Congress first gave states the option to extend Medicaid coverage to pregnant women who were not eligible for cash assistance. Since that time, Congress has continued to expand state options, some of which were later mandated, to provide Medicaid coverage to pregnant women based upon family income alone. Since 1987, states have had the option to expand eligibility for pregnant women with incomes up to 185 percent of the Federal poverty level (FPL). At a minimum, however, states have been required since 1989 to provide Medicaid coverage to pregnant women with incomes up to 133 percent of FPL. States may also take advantage of the 1902(r)(2) option of the Social Security Act to more broadly expand Medicaid coverage for pregnant women above the 185 percent threshold. Under this option, states may choose to disregard a certain amount of an applicant's income, thus raising the effective income eligibility level above the 185 percent limit.

Despite states' expansions of Medicaid coverage to pregnant women, the 1990s witnessed a surprising increase in the number and percent of pregnant women without health insurance. According to a recent study, nearly 14 percent of pregnant women were uninsured in 1997, although three-quarters of them were actually eligible for Medicaid coverage. The percentage of pregnant women who were uninsured rose steadily throughout the 1990s, despite the increases in Medicaid eligibility levels implemented during the past decade (Thorpe, 1999).

Table II-1 shows the income threshold for Medicaid eligibility for pregnant women in each jurisdiction studied (48, including the District of Columbia). Of the states that were interviewed, 11 cover pregnant women at the mandated level of 133 percent of the federal poverty level (FPL), and 21 extend coverage to pregnant women up to 185 percent FPL. Six states have income thresholds between 133 and 185 percent, ranging from 140 percent in Arizona to 170 percent in Oregon. In addition, nine states and DC extend coverage above the 185 percent limit: seven states and DC cover women up to 200 percent FPL, Rhode Island covers women up to 250 percent, and Minnesota covers women up to 275 percent of FPL.

Table II-1

State Medicaid Eligibility Levels and Enrollment Policies for Pregnant Women

State	Income Eligibility Limit for Pregnant Women	No Asset Test	Continuous Coverage Through 60 Days Postpartum	Presumptive Eligibility
United States Total		**40**	**44**	**28**
Alabama	133% FPL	●	●	
Alaska	200% FPL	●	●	
Arizona	140% FPL		●	●
Arkansas	133% FPL		●	●
California	200% FPL*	●	●	●
Colorado	133% FPL	●	●	●
Connecticut	185% FPL	●	●	●
Delaware	185% FPL	●	●	●
District of Columbia	200% FPL	●		●
Florida	185% FPL	●	●	●
Georgia	200% FPL	●	●	●
Hawaii	185% FPL	●	●(to 30 days pptum)	
Idaho	133% FPL		●	●
Illinois	200% FPL	●	●	●
Indiana	150% FPL	●	●	
Iowa	185% FPL		●	●
Kansas	150% FPL	●	●	
Kentucky	185% FPL	●	●	
Louisiana	133% FPL	●	●	●
Maine	185% FPL	●	●	●
Maryland	200% FPL	●	●	
Massachusetts	200% FPL	●	●	●
Michigan	185% FPL	●	●	
Minnesota	275% FPL	●	●	
Mississippi	- - -	- - -	- - -	- - -
Missouri	185% FPL	●	●	●
Montana	133% FPL			
Nebraska	185% FPL	●	●	●
Nevada	133% FPL		●	
New Hampshire	185% FPL	●	●	●
New Jersey	185% FPL	●	●	●
New Mexico	- - -	- - -	- - -	- - -
New York	185% FPL	●	●	●
North Carolina	185% FPL	●	●	●
North Dakota	133% FPL		●	
Ohio	150% FPL	●	●	
Oklahoma	185% FPL	●	●	●
Oregon	170% FPL	●	●	
Pennsylvania	185% FPL	●	●	●
Rhode Island	250% FPL	●	●	
South Carolina	185% FPL	●	●	●
South Dakota	133% FPL		●	
Tennessee	185% FPL	●	●(to 45 days pptum)	
Texas	185% FPL	●	●	●
Utah	133% FPL	●	●	●
Vermont	200% FPL	●	●	●
Virginia	133% FPL	●	●	
Washington	185% FPL	●	●	
West Virginia	150% FPL	●	●	
Wisconsin	185% FPL	●	●	●
Wyoming	- - -	- - -	- - -	- - -

Notes: - - - =States did not respond to survey

The 1999 Federal Poverty Level was 13,880 for a family of three.

*California's state-funded Access for Infants and Mothers program covers pregnant women up to 300% FPL

Data as of March 2000

In most states, expansions to the current eligibility levels have been in place for several years. However, the survey revealed recent expansions among a few states. Between 1998 and 2000, a total of six states increased eligibility levels for pregnant women. Three of these states—Alaska, Ohio, and Oregon—increased the threshold above the 133 percent minimum FPL to 200, 150,

and 170 percent, respectively. The other three states—Georgia, Maryland, and Massachusetts—all went from a threshold of 185 percent to 200 percent of FPL.

In addition to increasing income eligibility levels, states may also take steps to simplify the process pregnant women must go through to enroll in Medicaid (Table II-1). First, OBRA-86 gave states the option of disregarding assets (or resources) when determining eligibility for pregnant women. Thirty-nine states and DC have dropped the asset test. They may also institute presumptive eligibility, which allows providers to grant immediate, temporary Medicaid coverage to women who meet certain criteria while a formal eligibility determination is being made, giving them access to health services right away. Twenty-seven states and DC have implemented presumptive eligibility policies. The sites that are permitted to do presumptive eligibility determinations include Federally Qualified Health Centers (FQHCs), physicians' offices, and, in two states, WIC clinics.

Another eligibility simplification strategy is continuous eligibility, which eliminates the need for eligibility re-determination during the course of pregnancy. To do this, states may provide continuous coverage to women during pregnancy and through 60 days postpartum, regardless of changes in income. Of the 48 jurisdictions that responded to the survey, 44 indicated that they provide such coverage. Three states—Hawaii, Montana, and Tennessee—and DC do not provide such continuous coverage to pregnant women. In Hawaii, women are covered throughout pregnancy and for 30 days of postpartum care and Tennessee provides coverage for 45 days postpartum. Montana noted that due to recent welfare reform legislation that mandates that eligibility be determined on a monthly basis, pregnant women can lose Medicaid coverage if there is a change in income above the threshold level.

Other methods for facilitating access to Medicaid are important as well. This study explored states' use of six specific eligibility streamlining techniques: use of a shortened application form, acceptance of applications at sites other than welfare offices, outstationing of eligibility workers in the community, combining the Medicaid application with that for other public assistance programs, elimination of the face-to-face interview requirement in favor of a mail-in application, and availability of applications in languages other than English (Table II-2). Finally, states were given the opportunity explain other techniques they employ to streamline the eligibility process.

Of these six strategies, states employ an average of about four methods, and half of the states indicated that they have instituted five or six of these methods to simplify the Medicaid application process; this trend reflects the significant effort that has taken place in many states to facilitate access to Medicaid for this population:

- **Shortened Application Forms.** Medicaid applications, like applications for other public assistance programs, are often long and cumbersome. To reduce this barrier to enrollment, 41 states and DC have shortened their Medicaid forms.

- **Submitting applications at other sites.** Thirty-six states reported that they allow applicants to submit applications at sites other than the state Medicaid office. Hospitals, clinics, and doctors' offices were most frequently cited as examples of alternative locations. Other states accept applications through enrollment brokers, FQHCs, mental health centers, and at job fairs.

Table II-2
Eligibility Streamlining Techniques

State	Short Application	Forms Submitted at Other Sites	Oustationed Eligibility Workers	Combined Application Form	Mail-in Application	Multi-lingual Forms	Total
United States Total	**42**	**36**	**35**	**31**	**36**	**31**	**Average = 4.4**
Alabama	●	●	●	●	●	●	6
Alaska	●	●	●		●		4
Arizona	●	●				●	3
Arkansas	●	●	●	●			4
California	●	●	●	●	●	●	6
Colorado	●	●	●	●	●	●	6
Connecticut	●	●	●	●	●	●	6
Delaware	●	●	●	●	●	●	6
District of Columbia	●		●		●	●	4
Florida	●		●		●	●	4
Georgia	●	●	●		●	●	5
Hawaii		●	●		●		3
Idaho	●			●		●	3
Illinois	●	●		●	●	●	5
Indiana	●	●	●		●		4
Iowa	●	●	●	●		●	5
Kansas	●						1
Kentucky	●	●		●			3
Louisiana	●	●					2
Maine	●			●	●		3
Maryland	●	●	●		●	●	5
Massachusetts	●	●	●		●	●	5
Michigan	●	●	●	●	●	●	6
Minnesota		●	●	●	●	●	5
Mississippi	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Missouri	●	●	●	●	●	●	6
Montana							0
Nebraska	●		●	●	●	●	5
Nevada		●	●	●		●	4
New Hampshire	●	●			●		3
New Jersey	●	●	●		●	●	5
New Mexico	- - -	- - -	- - -	- - -	- - -	- - -	- - -
New York	●	●	●	●		●	5
North Carolina	●	●	●	●	●	●	6
North Dakota					●	●	2
Ohio	●		●	●	●	●	5
Oklahoma	●	●	●	●	●	●	6
Oregon		●	●	●	●	●	5
Pennsylvania	●			●	●		3
Rhode Island	●	●		●	●	●	5
South Carolina	●	●	●	●	●		5
South Dakota	●	●	●	●	●		5
Tennessee	●	●	●		●		4
Texas	●	●	●	●		●	5
Utah	●	●	●	●	●	●	6
Vermont	●	●		●	●		4
Virginia	●	●	●	●	●		5
Washington	●		●		●	●	4
West Virginia	●		●	●	●		4
Wisconsin	●	●	●	●		●	5
Wyoming	- - -	- - -	- - -	- - -	- - -	- - -	- - -

Notes: - - - =States did not respond to survey
Data as of March 2000

- **Outstationed eligibility workers.** Another strategy for facilitating Medicaid enrollment is to station eligibility workers at places other than the welfare office such as hospitals or clinics where people receive health services. This approach, used by 34 states and DC, makes it more convenient for people to complete the eligibility and enrollment process and also allows them to avoid going to a welfare office to enroll for health care coverage. Another strategy for making enrollment more accessible is to pay "application assistors" in provider agencies a fee for each completed application submitted; this is the approach used by Illinois.

- **Combined application forms.** To reduce the need for people who are likely to be eligible for multiple public assistance programs from completing several similar forms, many states have combined application forms for Medicaid with those for other programs such as Food Stamps, WIC, and Temporary Assistance for Needy Families (TANF). Thirty-one states have implemented this streamlining strategy.

- **Mail-in applications.** Allowing pregnant women to apply for Medicaid by mailing in their applications and eliminating the requirement for a face-to-face interview is another important way to reduce barriers to Medicaid enrollment. Thirty-five states and DC have implemented this strategy.

- **Multilingual application materials.** Thirty states and DC provide application materials in languages other than English. Spanish was overwhelmingly the most popular choice, with 21 states and DC providing materials in Spanish. In addition, translators are available for client assistance in Iowa, Kentucky, Oregon, and Vermont. In Oregon and Georgia, applications are furnished in a variety of Asian languages. Oregon and North Dakota also offer application materials in several Eastern European languages.

- **Other streamlining strategies.** Several state officials noted additional strategies that have been implemented for simplifying the enrollment process. Five respondent states indicated that they not only accept applications at multiple sites, but they also allow clients to obtain applications at sites throughout the community. Hospitals, community health centers, legal aid centers, and Planned Parenthood clinics were given as examples of locations in the community that supply applications. In an attempt to simplify the enrollment process, California no longer requires pregnancy verification, while Oklahoma does not require income verification. Alaska, with its large rural population, required more innovative and far-reaching solutions to reach the targeted audience, so the state posts the Medicaid application on-line.

ACOG members were also asked about their roles in prenatal care outreach efforts. ACOG representatives in seven states (Hawaii, Illinois, Maryland, Michigan, Nevada, Tennessee, and Washington) indicated that their members are involved in outreach efforts, especially collaborative efforts involving health departments, Medicaid offices, churches, housing groups, community groups, and hospitals. While the major goal of these initiatives is the promotion of prenatal care, states also hope to promote access to and utilization of services, Medicaid enrollment, and good nutrition habits.

B. Percent of Births Covered by Medicaid

Given the importance of Medicaid eligibility expansions in states' perinatal reform efforts, this study sought to assess the role of the Medicaid program in financing perinatal care. Using 1996 as a baseline, Medicaid representatives reported the percentage of births in their states that were paid for by Medicaid in that year (Table II-3). A small group of states (Massachusetts, New Hampshire, Nevada, North Dakota, Pennsylvania, and Utah) indicated that fewer than 30 percent of all births were covered by Medicaid. The plurality of states (17) said that Medicaid covered 30 to 39 percent of all births in 1996. Another sizable group of states (16) indicated that Medicaid births accounted for 40 to 49 percent of total births. In another two states (Alabama and Louisiana), Medicaid paid for between 50 and 59 percent of births in that year.

States were also asked for figures on 1998 Medicaid-covered births when they were surveyed. While more than half of the states and DC were not able to provide data, 23 states furnished the requested information. More than half of these states (14) indicated that the share of births financed by Medicaid had decreased between 1996 and 1998. Four states reported an increase in Medicaid-covered births, while three indicated that the rate remained unchanged. Thus, while Medicaid is a critical source of financing for deliveries, it is covering a declining percentage of births in many states.

C. Services Covered for AFDC and Expansion Categories

Pregnancy-related services are used primarily by two major categories of Medicaid beneficiaries: those who are eligible under AFDC-related categories, who may become pregnant while enrolled in Medicaid, and those who qualify under pregnancy-related "expansion" categories with higher income limits. Often, the package of benefits offered under these two categories is the same; 38 states and DC offer the full spectrum of Medicaid benefits to both AFDC and expansion categories of Medicaid enrollees, while eight states (Alabama, Arkansas, California, Idaho, Indiana, North Carolina, South Dakota, and Utah) cover only pregnancy-related services for expansion enrollees. (In Florida, expansion enrollees are technically eligible only for outpatient services, but Medicaid representatives indicated that there is nothing in the system to prevent providers from billing for services for these patients, so they may receive the full range of services.)

There is little difference among states between the perinatal services covered for AFDC and expansion categories, although coverage for expansion categories was slightly less comprehensive for some types of services. Tables II-4 through II-10 diplay the pregnancy-related services covered by each state:

- **Prenatal Services.** All of the participating states cover basic prenatal services such as prenatal visits (Table II-4) and prenatal laboratory tests (Table II-5) for both AFDC and expansion categories, with the exception of Kansas, which does not cover prenatal lab services for expansion category enrollees. Forty-three states cover prenatal vitamins.

  Coverage of prenatal medical and psychosocial risk assessments is common as well. Only four states (Colorado, Connecticut, Georgia, and Michigan) do not cover medical

Table II-3

Percent of Births Covered by Medicaid

State	Percent of Births Covered by Medicaid 1996	1997	1998
Alabama	55%	47%	N/A
Alaska	46%	42%	43%
Arizona	45%	44%	42%
Arkansas	46%	45%	42%
California	43%	40%	40%
Colorado	31%	31%	N/A
Connecticut	N/A	24%	24%
Delaware	32%	32%	N/A
District of Columbia	N/A	N/A	N/A
Florida	46%	45%	N/A
Georgia	N/A	N/A	51%
Hawaii	N/A	N/A	N/A
Idaho	36%	32%	28%
Illinois	41%	39%	39%
Indiana	36%	N/A	N/A
Iowa	34%	30%	N/A
Kansas	31%	25%	31%
Kentucky	42%	N/A	N/A
Louisiana	50%	N/A	42%
Maine	41%	34%	N/A
Maryland	34%	27%	25%
Massachusetts	21%	21%	21%
Michigan	39%	30%	N/A
Minnesota	33%	31%	31%
Mississippi	- - -	- - -	- - -
Missouri	43%	42%	42%
Montana	N/A	N/A	N/A
Nebraska	30%	30%	35%
Nevada	28%	26%	N/A
New Hampshire	23%	20%	N/A
New Jersey	33%	N/A	N/A
New Mexico	- - -	- - -	- - -
New York	40%	46%	42%
North Carolina	44%	42%	42%
North Dakota	23%	N/A	N/A
Ohio	35%	35%	N/A
Oklahoma	41%	N/A	50%
Oregon	34%	31%	N/A
Pennsylvania	21%	26%	N/A
Rhode Island	33%	30%	30%
South Carolina	46%	47%	N/A
South Dakota	34%	33%	N/A
Tennessee	48%	42%	N/A
Texas	47%	49%	47%
Utah	29%	30%	27%
Vermont	32%	N/A	N/A
Virginia	N/A	N/A	N/A
Washington	43%	N/A	42%
West Virginia	N/A	N/A	N/A
Wisconsin	32%	34%	34%
Wyoming	- - -	- - -	- - -

Notes: N/A=Information not available
- - - =States did not respond to survey
Data as of March 2000

assessments, and nine states (Colorado, Connecticut, Georgia, Louisiana, Montana, North Carolina, South Carolina, Tennessee, and Washington) and DC do not cover psychosocial risk assessments for either category. Two states, Illinois and Nebraska, indicated that prenatal risk assessments (both psychosocial and medical) are covered as part of the prenatal office visit but do not have a separate billing code.

States vary in their coverage of prenatal testing and counseling services, although the states provide the same benefits to AFDC-related and expansion categories. All responding states cover ultrasound, although only 46 states and DC cover amniocentesis and 42 states and DC cover chorionic villus sampling (CVS). Genetic counseling is covered by 36 states and DC.

- **Counseling Services.** States are much less likely to cover counseling services, such as preconception counseling, nutrition counseling, psychosocial counseling, and smoking cessation interventions, distinct from an office visit with a physician (Table II-6). Of these services, the most widely covered is psychosocial counseling, which is available to all enrollees in 37 states, followed by nutrition counseling, covered in 34 states. Preconception counseling is explicitly covered by 21 states, and six additional states—Delaware, Illinois, Iowa, Virginia, Vermont, and West Virginia—indicated that they cover this service as part of an office visit, but not as a separate billing code.

  Eighteen states indicated coverage of smoking cessation services for both AFDC and expansion categories and at the time of the survey, the Iowa legislature was in the process of approving coverage of nicotine replacement products for all Medicaid populations. Until recently, the Connecticut legislature prohibited Medicaid coverage of smoking cessation services; these services may now be covered, with an annual limit of $400, yet they have not been funded. Two states, California and Nevada, pointed out that educational interventions are not always covered as part of the smoking cessation services. In these states, 'smoking cessation services' consist only of products such as the nicotine patch.

- **Support Services.** Overall, states' coverage of perinatal support services is less comprehensive than coverage of perinatal medical services. Forty-one states and DC cover prenatal care coordination/case management, and 38 states cover transportation for both AFDC-related and expansion categories (Table II-7).

  More than two-thirds of the states cover prenatal and postpartum home visiting for both eligibility categories; however, several states restrict the circumstances under which home visits are covered. Colorado, Iowa and Tennessee cover prenatal and postpartum home visits only for high-risk or medically necessary cases, and Florida covers visits only for enrollees who are homebound for medical reasons. While California covers both prenatal and postpartum home visits, prenatal home visits are covered only when conducted by a physician, certified nurse-midwife, RN, licensed visiting nurse, registered nurse practitioner, physician's assistant or licensed social worker. Arkansas and California cover postpartum home visiting only in cases of high risk, early discharge or special medical reasons. Home visiting services are carved out in Maryland; the state pays local health departments to provide this service. In Massachusetts, the Medicaid

Table II-4

Medicaid Coverage of Prenatal Services for AFDC and Expansion Categories

State	Prenatal Care Visits	Vitamins	Social Risk	Medical Risk	Ultrasound
United States Total	**48**	**43**	**38**	**44**	**48**
Alabama	●	●	●	●	●
Alaska	●	●	●	●	●
Arizona	●	●	●	●	●
Arkansas	●	●	●	●	●
California	●	●	●	●	●
Colorado	●	●			●
Connecticut	●	●			●
Delaware	●	●	●	●	●
District of Columbia	●			●	●
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	- - -	- - -	- - -	- - -	- - -

Notes: ●=Covered for all eligibles
- - - =States did not respond to survey
Data as of March 2000

program does not pay for these services although some managed care plans provide them to high-risk enrollees.

Substance abuse treatment services for drugs and alcohol are covered for pregnant women in both the AFDC and expansion categories in 22 states; most states indicated no

Table II-5

Medicaid Coverage of Lab and Genetic Services During Prenatal Visits for AFDC and Expansion Categories

State	Lab	Genetics	CVS	Amniocentesis
United States Total	**47**	**37**	**43**	**47**
Alabama	●	●	●	●
Alaska	●	●	●	●
Arizona	●	●	●	●
Arkansas	●	●	●	●
California	●	●		●
Colorado	●			
Connecticut	●		●	●
Delaware	●	●	●	●
District of Columbia	●	●	●	●
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	- - -	- - -	- - -	- - -

Notes: ♦=Covered for AFDC-related eligibles only
●=Covered for all eligibles
CVS=Chorionic Villus Sampling
- - - =States did not respond to survey
Data as of March 2000

Table II-6

Medicaid Coverage of Counseling Support Services for AFDC and Expansion Categories

State	Preconception Counseling	Nutrition Counseling	Psychosocial Counseling	Smoking Cessation
United States Total	**21**	**34**	**37**	**18**
Alabama	●	●	●	●
Alaska		●	●	
Arizona	●	●	●	●
Arkansas	●	●	●	
California	●	●	●	●
Colorado	●			
Connecticut			●	
Delaware		●	●	●
District of Columbia				
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	- - -	- - -	- - -	- - -

Notes: ◆=Covered for AFDC-related eligibles only
●=Covered for all eligibles
- - - =States did not respond to survey
Data as of March 2000

Table II-7

Medicaid Coverage of Other Support Services for AFDC and Expansion Categories

State	Case Management	Transportation	Home Visits	Substance Abuse Treatment
United States Total	**42**	**38**	**37**	**22**
Alabama	●	●	●	●
Alaska	●	●		●
Arizona	●	●	●	●
Arkansas	●	●	●[1]	
California	●	●	●[1]	
Colorado			●[1]	♦
Connecticut	●	●	●	●
Delaware	●	●	●	
District of Columbia	●			
Florida		●	●[1]	
Georgia	●	●	●[2]	
Hawaii	●	●		
Idaho	●	●	●	
Illinois	●	●	●	●
Indiana	●	●	●	
Iowa	●	●	●[1]	
Kansas	●	●	●	
Kentucky	●			●
Louisiana		●		
Maine	●	●		
Maryland	●	●	●[4]	●
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		●	●[1]	●
Texas	●	●		
Utah	●	●	●[3]	
Vermont	●		●	●
Virginia	●	●	●	●
Washington	●			
West Virginia	●	●	●	
Wisconsin	●	●	●	●
Wyoming	- - -	- - -	- - -	- - -

Notes: ♦=Covered for AFDC-related eligibles only
●=Covered for all eligibles
1=Home visits covered for high-risk, medically necessary, or homebound cases only.
2=Postpartum home visits only
3=Prenatal home visits covered for expansion population only
4=Provided by local health department
- - - =States did not respond to survey
Data as of March 2000

special programs for pregnant substance abusers. Two states, Colorado and North Carolina, cover substance abuse services for the AFDC category only. Kansas representatives indicated that pregnant women are eligible for substance abuse services, but there are no programs specifically for pregnant women. Louisiana, New Hampshire, Nevada and Missouri also indicated that they only refer pregnant women to substance abuse programs, although in Nevada, pregnant women do have priority for these programs. In California, Medicaid contracts with the Alcohol and Drug Prevention Department for coverage of residential care specifically for pregnant women.

- **Delivery and Postpartum Care.** All of the participating states cover basic delivery services such as vaginal and cesarean delivery, anesthesia, and postpartum care for both AFDC and expansion categories. In West Virginia, although anesthesia is covered, epidural coverage is limited to two hours (Table II-8).

  In comparison to states' coverage of hospital deliveries, fewer states cover alternative delivery options such as birth centers and home births for either AFDC or expansion categories. Ten states do not cover the home birth or birth center option for either category. Twenty-five states and DC cover both birth centers and home births for AFDC and expansion categories and three states (Minnesota, South Carolina, and Texas) cover these services for AFDC-related enrollees only. Eight states cover one of the two alternative delivery options: Oklahoma covers birth centers but not home births, and Arkansas, Colorado, Georgia, Iowa, Indiana, Nebraska, and Utah cover home births only. Finally, Illinois does not cover birth centers, but will pay providers for delivering in these settings.

  A Missouri representative indicated that although both birth center and home births are covered in the state, some managed care organizations (MCOs) are having trouble enlisting home delivery providers and in response, Medicaid has authorized disenrollment from the MCO for some enrollees as a last resort to provide coverage for the home birth providers available. Nebraska's coverage of home births is also restricted; Nebraska Medicaid only allows physicians, not midwives, to attend home births. While birth centers are not excluded from coverage in Minnesota and Nebraska, there are no birth centers in these states.

  Alaska, which covers both home births and birth centers, also provides the option of "prematernal homes." These are facilities in the urban centers where women from remote areas can stay until delivery in order to provide them with the opportunity to deliver in a hospital. Coverage is provided for up to one month and transportation to the hospital is also covered for women in prematernal homes. For those women who do not have access to a prematernal home facility, hotel stays are also covered up to one week prior to delivery.

  Tubal ligation was covered by all responding states for both AFDC and expansion categories, with the exception of Texas, which only covers the service for the AFDC category. Access to tubal ligation does not appear to be limited even in states that contract with faith-based plans or providers. In the 11 states that contract with faith-based plans, including four states that contract with plans that do not provide tubal

Table II-8

Medicaid Coverage of Delivery and Postpartum Care for AFDC and Expansion Categories

State	Vaginal Delivery	C-Section	Anesthesia	Birth Centers	Childbirth Support	Postpartum Care	Tubal Ligation
United States Total	**48**	**48**	**48**	**35**	**7**	**48**	**47**
Alabama	●	●	●			●	●
Alaska	●	●	●	●		●	●
Arizona	●	●	●	●		●	●
Arkansas	●	●	●	●[3]		●	●
California	●	●	●	●	●	●	●
Colorado	●	●	●	●[2]		●	●
Connecticut	●	●	●	●		●	●
Delaware	●	●	●	●		●	●
District of Columbia	●	●	●	●		●	●
Florida	●	●	●	●		●	●
Georgia	●	●	●	●[2]		●	●
Hawaii	●	●	●			●	●
Idaho	●	●	●	●		●	●
Illinois	●	●	●	●[4]		●	●
Indiana	●	●	●	●[2]		●	●
Iowa	●	●	●	●[2]		●	●
Kansas	●	●	●	●		●	●
Kentucky	●	●	●			●	●
Louisiana	●	●	●			●	●
Maine	●	●	●	●		●	●
Maryland	●	●	●	●		●	●
Massachusetts	●	●	●	●		●	●
Michigan	●	●	●			●	●
Minnesota	●	●	●	♦		●	●
Mississippi	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Missouri	●	●	●	●		●	●
Montana	●	●	●			●	●
Nebraska	●	●	●	●[3]		●	●
Nevada	●	●	●			●	●
New Hampshire	●	●	●			●	●
New Jersey	●	●	●	●		●	●
New Mexico	- - -	- - -	- - -	- - -	- - -	- - -	- - -
New York	●	●	●	●		●	●
North Carolina	●	●	●	●		●	●
North Dakota	●	●	●	●		●	●
Ohio	●	●	●	●	●	●	●
Oklahoma	●	●	●	●[1]		●	●
Oregon	●	●	●	●	●	●	●
Pennsylvania	●	●	●	●	●	●	●
Rhode Island	●	●	●	●	●	●	●
South Carolina	●	●	●	♦		●	●
South Dakota	●	●	●	●	●	●	●
Tennessee	●	●	●	●		●	●
Texas	●	●	●	♦		●	♦
Utah	●	●	●	●[2]		●	●
Vermont	●	●	●	●		●	●
Virginia	●	●	●			●	●
Washington	●	●	●	●	●	●	●
West Virginia	●	●	●*	●		●	●
Wisconsin	●	●	●			●	●
Wyoming	- - -	- - -	- - -	- - -	- - -	- - -	- - -

Notes: ♦=Covered for AFDC-related eligibles only
●=Covered for all eligibles
*epidurals limited to two hours
1=birth centers only
2=home births only
3=home births only with MD provider
4=provider paid but center not covered
- - - =States did not respond to survey
Data as of March 2000

ligation (Illinois, New York, South Carolina, and Washington), all plans are required to refer enrollees to other providers to assure access to this service.

Finally, only seven states (California, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, and Washington) cover support services during childbirth, such as a doula or labor coach.

- **Education Services.** Educational services such as childbirth education, infant care education and other health education services are covered by still fewer states. Thirty states cover childbirth education, 27 cover infant care education, and 21 cover other health education services (Table II-9).

  In at least 11 states, educational and support services, including childbirth education, psychosocial counseling, and nutritional counseling are covered as part of a perinatal office visit but are not billed as separate services. For example, Florida and South Carolina use enhanced billing codes to cover perinatal support and education services. In Florida, care coordination and nutritional, genetic, and psychosocial counseling as well as infant care education and other health education services are billed as part of "evaluation and management" codes that are added on to office visits. Similarly, in Illinois, counseling services are assumed to be part of a prenatal physician visit under ACOG's guidelines for perinatal care; however, nutritionists, geneticists, or other counselors are not paid to provide these services. In Wisconsin, Medicaid will reimburse for psychosocial counseling, smoking cessation, and education services as part of a physician visit.

- **Breastfeeding Support Services.** Lactation support services for both AFDC and expansion categories are covered by somewhat fewer states than other perinatal support services. Breastfeeding education is covered by 22 states, breastfeeding equipment rental (such as breast pumps) is covered by 29 states, and individual lactation consultation is covered by only nine states (Table II-10). Seven states (Georgia, Illinois, Indiana, Kansas, Missouri, Ohio, and South Carolina) reported that breastfeeding education is covered as part of an office visit or postpartum visit, not as a separate service; likewise, in Massachusetts and Wisconsin, these services may be provided through hospitals but are not separately billable. Iowa's Medicaid program does not cover breastfeeding education because it is provided through the WIC program. In Indiana, breastfeeding equipment is often available free so it is not covered by Medicaid.

  California is the only state in which Medicaid covers the purchase of human milk. Medi-Cal, California's Medicaid program, covers the purchase of milk from the Human Milk Bank, which is one of only seven such organizations in the nation. The Bank collects, screens, processes, and distributes milk from volunteer breastfeeding mothers for distribution to families of infants for whom it has been prescribed. Common reasons for prescribing donor milk include formula allergies, failure to thrive, immunological deficiencies, and prematurity.

Table II-9

Medicaid Coverage of Education Services for AFDC and Expansion Categories

State	Childbirth Education	Health Education	Infant Care Education
United States Total	**30**	**21**	**27**
Alabama	●	●	●
Alaska			
Arizona	●	●	●
Arkansas	●	●	●
California	●	●	●
Colorado			
Connecticut			
Delaware	●	●	●
District of Columbia			
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	- - -	- - -	- - -

Notes: ●=Covered for all eligibles
- - - =States did not respond to survey
Data as of March 2000

Table II-10

Medicaid Coverage of Breastfeeding Support Services for AFDC and Expansion Categories

State	Breastfeeding	Lactation	Equipment Rental
United States Total	**22**	**9**	**29**
Alabama	●		
Alaska			●
Arizona	●		●
Arkansas	●	⋆	
California	●	●	●
Colorado			
Connecticut			●
Delaware	●		
District of Columbia			
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	- - -	- - -	- - -

Notes: ⋆=Covered for AFDC-related eligibles only
●=Covered for all eligibles
*Purchase of kit covered
- - - =States did not respond to survey
Data as of March 2000

Chapter III: Perinatal Services and Medicaid Managed Care

III. Perinatal Services and Medicaid Managed Care

A. Medicaid Managed Care Programs

Since the early 1990s, state Medicaid agencies have increasingly used managed care strategies to control the costs of their programs and improve access to care. These strategies take two general forms: primary care case management (PCCM) approaches, in which primary care providers are responsible for managing and authorizing the care their patients receive, for which they are paid a monthly fee (although clinical services are still reimbursed on a fee-for-service basis), and capitation, in which managed care organizations are paid a capitated rate to cover all of the care their members receive. Of the states that responded to the survey, only Alaska reported having no Medicaid managed care programs at all (Table III-1). Of the 42 jurisdictions that offer capitated programs, 31 require Medicaid eligibles to enroll in managed care plans, and 13 make enrollment voluntary (in New York and North Carolina, enrollment in HMOs is mandatory in some counties and voluntary in others). Five states reported using PCCM models of managed care exclusively, 30 and DC use capitation alone, and 11 use both.

B. Inclusion of Pregnant Women in Medicaid Managed Care

Of the 42 jurisdictions that have capitated Medicaid managed care programs in place, 29 states and DC require pregnant women to enroll in capitated managed care arrangements. In 12 states, capitated managed care enrollment is offered to pregnant women on a voluntary basis (again, New York and North Carolina fall into both categories). The remaining two respondent states (Georgia and Montana) have capitated managed care systems, but exempt pregnant women from mandatory or voluntary enrollment in them.

Of the 39 and DC jurisdictions in which pregnant women are required or allowed to participate in capitated managed care programs, all reported that enrollment includes women eligible through AFDC/TANF programs, and 37 states and the District of Columbia indicated that pregnant women eligible through income-related expansions may participate in managed care plans.

To build on this information about state managed care policies, the survey asked what percentage of a state's Medicaid-eligible pregnant women are enrolled in capitated managed care arrangements. The majority of states (23) indicated that this information is not available. Of the 19 states that were able to provide an estimate, seven states (Arizona, Connecticut, Hawaii, Rhode Island, Oregon, South Dakota, and Tennessee) and DC reported that more than 75 percent of Medicaid-eligible pregnant women in the state participate in capitated managed care plans (these tend to be states in which all Medicaid enrollees are required to join capitated plans). Five states (North Carolina, Nevada, Utah, Vermont, and Washington) indicated that 50 to 75 percent of Medicaid-eligible pregnant women are in HMOs. Between 25 and 50 percent of pregnant

Table III-1

Managed Care for Pregnant Women

State	None	Capitated Mandatory	Capitated Voluntary	PCCM Mandatory	AFDC Population in Managed Care	SOBRA Expansion
United States Total	**1**	**31**	**13**	**16**	**42**	**39**
Alabama				●		
Alaska	●					
Arizona		●			●	●
Arkansas				●	●	●
California		●*			●	
Colorado			●*	●	●	●
Connecticut		●			●	●
Delaware		●			●	●
District of Columbia		●			●	●
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		●*	●*	●	●	●(voluntary)
North Dakota			●*	●	●	●
Ohio		●*			●	●
Oklahoma		●*		●	●	
Oregon		●			●	●
Pennsylvania		●*			●	●
Rhode Island		●			●	●
South Carolina			●		●	●
South Dakota				●		
Tennessee		●			●	●
Texas		●*		●	●	●
Utah		●*			●	●
Vermont		●			●	●
Virginia		●*			●	●
Washington		●			●	●
West Virginia		●*		●	●	●
Wisconsin		●			●**	●**
Wyoming	- - -	- - -	- - -	- - -	- - -	- - -

Notes: *Capitated managed care in certain counties only

**Capitated managed care voluntary in certain counties only

- - - =States did not respond to survey

Georgia and Montana exempt pregnant women from enrollment in their managed care systems.

Data as of March 2000

women are in capitated managed care arrangements in two respondent states (Indiana and New York). Three states (California, Maine, and Texas) said that fewer than 25 percent of the indicated population participates in capitated managed care plans.

Finally, states reported on their plans to expand their Medicaid managed care programs, a move which would likely increase the number of pregnant women enrolled in managed care arrangements. Eleven states noted plans to expand their managed care programs geographically; these states, including Minnesota, Missouri, Pennsylvania, and Virginia, were those in which managed care programs were piloted in urban areas and are gradually expanding into additional counties as managed care plans become available. However, officials in several states, including Nebraska and Illinois, reported that they have had difficulty enrolling plans and providers to new counties, particularly in rural areas. In addition, two states—Maine and New York—reported plans to expand their Medicaid managed care programs by requiring enrollment in counties in which it is currently voluntary.

C. Services Included in Managed Care Contracts

The Federal definition of pregnancy-related services is inclusive, but not specific. It includes "...services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy." Similarly, the extent to which states cover pregnancy-related services and procedures is fairly broad, but the inclusion of specific services in managed care contracts is limited in many states. Thirty-nine states and DC include pregnant women in their capitated managed care programs and therefore must indicate, either directly or by reference, managed care plans' responsibilities for coverage of pregnancy-related services. Many states indicated that they cover specific perinatal services, however, they do not include specifications for coverage of these services in managed care contracts; not even the most basic perinatal services, such as prenatal visits or delivery services, were mentioned by all 42 jurisdictions in their managed care contracts. Georgia, for example, indicated that specific services are not listed in the contract explicitly, but the categories of services that must be covered are listed in their Policy and Procedures Manual. North Dakota also indicated their contract language is somewhat general and does not list specific services that must be covered. States' inclusion of perinatal services in managed care contracts is discussed in more detail below.[1]

- **Prenatal Services.** Slightly more than half of the states include prenatal care visits and prenatal lab services in managed care contracts. However, less than half of the states that cover other prenatal services specify these services in managed care contracts. For example, although chorionic villus sampling (CVS), a form of prenatal testing for genetic or chromosomal disorders, was covered by 36 and DC states that operate capitated managed care programs, it was explicitly included in the contracts of only 20 states.

[1] Quotations from contracts are taken both from the original sources and from Rosenbaum, Sara, Smith, Barbara M., and Shin, Peter, et al. Negotiating the New Heath System: A Nationwide Study of Medicaid Managed Care Contracts, Second Edition. Washington, DC: The George Washington University Center for Health Policy Research, February 1998.

There is significant variation in contract language among states that do include these services in the contracts. California, for example, is very specific in its description of how 'risk assessment' services are to be provided. They require the plan to *"ensure that an obstetrical record and a comprehensive initial risk assessment tool is completed on all pregnant women at the initiation of pregnancy related services"* and that the assessment will include specific components such as obstetrical, nutritional, psychosocial and health education assessments. Other states, such as Maryland, use more general language, indicating only that *"enrollees seeking prenatal care shall be assessed for medical, behavioral, environmental, and social risk factors."*

- **Delivery and Postpartum Care.** Although all of the states cover vaginal and cesarean delivery, anesthesia and postpartum care, only slightly more than half of the states include language specifically related to coverage of these services in their managed care contracts. Other delivery options such as home births, birth centers, and childbirth support were included in contracts by half the states that cover these services.

  Tubal ligation is included in managed care contracts in just over half of the states that cover it. Although the service is covered in Tennessee and included in the contracts *("The Contractor shall cover sterilizations, abortions and hysterectomies...")*, a state ACOG representative indicated that tubal ligation has been frequently denied by the plans in the past.

- **Education and Support Services.** Similarly, fewer than half of the states that indicated coverage of most educational and support services included them in managed care contracts. Case coordination/case management and home visiting, however, were included by the majority of states covering these services. Smoking cessation was included in managed care contracts in less than one quarter of the states in which it is covered. Interestingly, one state that indicated it does not cover smoking cessation services mentions in its managed care contract that *"the case manager is responsible for assuring that the patient receives all appropriate services available [and]...such services* may include...smoking cessation services, etc."

  Some states use general contract language related to education and support service requirements for the plans. Delaware, for instance, mandates, as a minimum requirement, that *"Enhanced Care Services for pregnant women include assessment, counseling and education by a nutritionist, social worker, and/or nurse....in addition to the basic medical care of the physician...,"* but does not delineate which services are included in these categories. Other states, such as Michigan, Massachusetts, Florida and California, define service requirements in their contracts more specifically. Massachusetts' managed care contracts, for example, stipulate that health care counseling provided during the course of pregnancy *"must include, but are not limited to the following: PGH screening for teenage pregnant women; smoking and substance abuse; hygiene and nutrition during pregnancy; care of breasts and plans for infant feeding; obstetrical anesthesia and analgesia; the psychosociology of labor and the delivery process...and family planning."* Although the contract language is not as specific, Michigan also includes a list of conditions and situations (e.g., *"abuse of alcohol or drugs or smoking; nutrition problem")* in the managed care contract and

mandates that *"support services should be provided if any of the listed conditions are likely to affect the pregnancy."*

Many states include case management or care coordination in managed care contracts; however, few states detail what activities or mechanisms these 'continuity of care and case management services' should include. Massachusetts, South Carolina, and Nebraska are among those states that provide richer descriptions of the case management and care coordination activities to be provided. In contrast, other states, such as Montana, included more general language in the contract regarding case management: *"The contractor shall offer Medicaid-enrolled targeted case managers for high-risk pregnant women..."*

- **Breastfeeding Support Services.** Most states included breastfeeding related services in managed care contracts by reference rather than direct specification. Individual lactation consultation, which is covered by just ten states, is included in contracts in only three of those states (California, New Hampshire, and Rhode Island). Similarly, only 13 of the 29 states that indicate coverage of breastfeeding equipment include it in their contracts. Several of the states that cover breastfeeding equipment indicate that it is covered under provisions which mandate the inclusion of other 'medically necessary' pregnancy-related services or treatment, but it is not specified directly in the contracts.

  Less than 40 percent of the states that indicated coverage of breastfeeding education include it in managed care contracts at all. The states that do include it tend to do so by reference, often suggesting it as a topic of health education that should be made available to pregnant or new parent enrollees. North Carolina's and Rhode Island's contracts, for example, mention that *"educational efforts should include topics such as: ...feeding (including breastfeeding)..."* and Massachusetts specifies that health care counseling made available to women during the course of pregnancy should include *"care of breasts and plans for infant feeding."*

Chapter IV: Payment and Financial Issues

IV. Payment and Financial Issues

Access to perinatal care can be significantly influenced by the level and structure of payment to providers and health plans. This section examines how providers are reimbursed under traditional Medicaid and Primary Care Case Management (PCCM) programs, as well as the structure of payments to health plans for pregnant enrollees.

A. Traditional Medicaid and PCCM

In total, 34 states continue to cover some (or all) Medicaid pregnancies through traditional payment systems and/or PCCM programs. (In addition, six states that operate statewide, mandatory capitated programs—Arizona, Connecticut, Hawaii, Oregon, and Vermont—also serve pregnant women on a fee-for-service basis in special circumstances, such as when they enroll in Medicaid late in pregnancy and enrollment in an MCO is impractical, or when the client has an established relationship with a provider who does not participate in a Medicaid managed care plan.) Of these states, more than half (28) pay physicians global fees for perinatal care. These global fees typically include prenatal office visits, the delivery, and at least some postpartum care. They do not typically cover hospital charges or anesthesia. For example, California's global payment includes four prenatal visits, all hospital visits, a postpartum office visit, all post-operative care, urinalysis, and educational services. For cases where the physician does not provide "global" care (e.g., fewer than four prenatal visits), separate per-visit (fee-for-service) billing rates are used.

States' global fee rates are provided in Table IV-1. Many states pay higher rates for cesarean deliveries than vaginal deliveries, reflecting the greater complexity of cesarean delivery. However, other states have chosen to establish a single rate for all deliveries, so as not to provide an incentive to recommend cesarean delivery unnecessarily. States may use other distinctions as well: in New York, enhanced rates are offered to providers who participate in the MOMS program, which requires private obstetricians to coordinate with local health departments for the provision of non-clinical support services. Florida offers separate rates for high-risk and low-risk pregnancies; a woman's level of risk is determined using a standard perinatal screening instrument that physicians are required to use for both private- and public-sector patients. The instrument assesses medical, environmental and social risk factors. In at least 12 states, separate rates are used for certified nurse midwives (CNMs); these rates range from 70 percent to 90 percent of the physician rate.

Provider participation can be strongly influenced by the level of payments and whether rates are adjusted to reflect inflation and increases in the cost of services. Anecdotally, physicians in some states (including Illinois, Maine, Michigan, and Oklahoma) report that payment levels affect providers' willingness to participate in Medicaid for perinatal services. Nevertheless, only 19 states reported increasing payment rates in the past five years. Four of these states (Alaska,

Table IV-1

Payment to Physicians in FFS/PCCM Systems

State	Global Fees to MDs (vaginal/cesarean)	Global Fees to CNMs	Services Included in Global fee
Alabama	$1,300	$1,040	All prenatal visits, delivery and postpartum visit. Excludes lab and ultrasound.
Alaska	-	-	
Arizona	$1,834	$1,651	All prenatal visits, delivery and postpartum visit
Arkansas	$595/$900	$476/$720	Antepartum, delivery, postpartum care
California	$961	-	At least 4 prenatal visits, postpartum office visit, postoperative care, all hospital visits, urinalysis, educational services; bonus for 10th visit.
Colorado	NA	NA	All prenatal visits, delivery and postpartum visit
Connecticut	$2638/$3012	$2374/$2711	Prenatal visits (at least 8), delivery, postpartum visit
Florida	$800 (low risk) $1100	$640/$880	Prenatal visits, risk assessment, delivery, postpartum care
Georgia	$1205/$1605	-	All prenatal visits (except initial visit), delivery, postnatal care.
Hawaii	$900/$1400	$675/$1050	Prenatal visits, risk assessment, delivery, postpartum care
Idaho	$1239/$1500	NA	Prenatal care, delivery, labs if done within MD office, postpartum visits
Illinois			
Iowa	$1254	1,066.0	Prenatal visits, blood tests, urinalysis, delivery, postpartum visits
Kansas	$1326/$1496	$995/$1122	Office visits, urinalysis, internal fetal monitoring
Kentucky	-	-	
Louisiana	-	-	
Maine	-	-	
Massachusetts	$1316/$1361/ $1350	-	At least 6 prenatal visits, delivery, postpartum visit.
Minnesota	$982/$1451 (higher for health centers)	-	Prenatal visits, urinalysis, delivery, at least one postpartum visit
Missouri	$1075/$1125	-	Prenatal visits, ultrasounds, risk appraisal, delivery, 30-day postpartum care.
Montana	$1408/$1572	$1267/$1399	Services specified in CPT4 book related to antepartum care and delivery.
Nebraska	$1093/$1554	-	Prenatal visits, urinalysis, delivery, postpartum visit
Nevada	$1306/$1663	NA	Prenatal care (beginning more than 60 days before delivery), urinalysis, delivery, postpartum care
New Hampshire	$1200	-	All obstetrical care; prenatal, delivery, care for complications, postpartum
New Jersey	$867	$607	14 prenatal visits, vaginal delivery, one postpartum visit
New York	$1037/ $1440 (MOMS)*	-	Prenatal care, delivery, postpartum care.
North Carolina	$1303/$1421	-	Physician services, hematocrit, urinalysis
North Dakota	-	-	
Ohio	$636/$683	-	Prenatal care, urinalysis, delivery, and postpartum visits
Oklahoma	$1000/$1100	-	determination of gestation, lab services including hematocrit, STF/RPR, Rh, GC culture, Hepatitis B and sickle cell
Oregon	$1200/$1500	-	Prenatal care, delivery, postpartum care
Pennsylvania	-	-	
South Carolina	-	-	
South Dakota	-	-	
Texas	-	-	
Utah	$952	$714	Office visits, routine lab work and treatment of all complaints common to pregnancy.
Vermont	$1100/$1300	-	Prenatal care and delivery.
Virginia	$1110/$1257	-	Prenatal visits, labor and delivery, postpartum care
West Virginia	-	-	
Wisconsin	$1002/$1313	$902/$1182	All prenatal visits, delivery and postpartum visit

Notes: States with managed care systems for pregnant women not included; only includes states in FFS/PCCM systems
NA=Information not available. - = No global fee.
*The MOMS project provides enhanced fees for OBs who coordinate with local health departments for support services.
MD=physician. CNM=certified nurse midwife. VBAC=vaginal birth after cesarean.
MS, NM, WY, did not respond to survey.
Data as of March 2000.

Nebraska, North Carolina, and North Dakota) make annual adjustments. In contrast, many other states have not changed rate levels since the early 1990s, and in some cases not since 1989. Reported rate increases were generally in the range of 1.6 percent to 3 percent.

B. Payment to Plans under Capitated Managed Care

In capitated systems, establishing payment rates and structures that compensate plans adequately presents a challenge. Because many women do not become eligible for Medicaid until they become pregnant, and do not enroll in a managed care plan until Medicaid eligibility is determined, plans may not receive capitation payments for them for more than a few months before being faced with the expense of a delivery. Therefore, states may either exclude women in the pregnancy-related category from enrollment in capitated plans, or they may structure payments to plans to compensate them separately for delivery.

The 42 jurisdictions with capitated Medicaid managed care programs reported several approaches to this problem. As noted earlier, Georgia and Montana exclude women eligible for Medicaid because of pregnancy from participating in managed care programs. Eleven states have structured their payment systems to compensate plans for the cost of delivery, while the remaining states and DC require plans to cover most pregnancy-related care through their capitation payments.

Some states use alternative methods for paying plans for perinatal services instead of or addition to their standard capitation rate structure (Table IV-2). For example, two states (New Hampshire and West Virginia) pay plans a global fee instead of monthly capitation payments. In another nine states, the Medicaid program pays a separate lump sum, often called a "kick payment," for each delivery. In Missouri, for example, plans receive $3,000 upon delivery of an infant to a woman in the expansion categories. In New York, a kick payment is made for each newborn; this payment varies by region and by plan, although the average payment is $2,736. In Vermont, plans receive a kick payment of $3,500, and the plans' capitation rate may also be adjusted. Maryland pays plans $4,403 for residents of Baltimore and $3,803 for Medicaid enrollees in less urban areas.

Table IV-2

Alternative Payment Methods for Perinatal Services in Capitated Programs

State	Kick Payment + Capitation	Single Payment, No Captitation	Fee-For-Service Reimbursement
United States Total	**9**	**2**	**5**
Delaware	NA	NA	Prescription drugs, vitamins, transportation
Maine	$4,342	NA	NA
Maryland	$4,403 urban/$3,803 other	NA	NA
Missouri	$3000	NA	NA
New Hampshire	NA	$1200	NA
New York	$2,736 (average)	NA	NA
North Carolina	Amount not available	NA	Case management, prescription drugs
North Dakota	NA	NA	Case management
Rhode Island	$5000	NA	NA
Texas	$3,000-$3,500, by area	NA	NA
Vermont	$3500	NA	Transportation, pharmacy, smoking cessation
Washington	$3500	NA	NA
West Virginia	NA	$1500	NA
Wisconsin	NA	NA	Case management

Notes: NA=Not applicable
Data as of March 2000

In five states, plans cover most perinatal care through the capitation payment, but cover some services through additional fee-for-service payments. For example, in North Carolina, North Dakota, and Wisconsin, separate rates are paid for prenatal case management or care coordination. In Delaware, pharmaceuticals, vitamins and transportation may be billed separately outside of the capitation rate; in Vermont, this is the case for transportation, pharmacy, and smoking cessation services.

States' approaches to and levels of payments to providers and plans are important elements in determining access to and use of care. Some states have sought to assure care through mechanisms such as global fee payments to physicians, additional fee-for-service payments for selected services such as case management, lump-sum "kick payments" to plans for deliveries in addition to, or instead of, capitation, and periodic increases in provider payment rates. Nevertheless, many states have not increased rates in many years, and most do not provide additional reimbursement to plans for deliveries. There remains significant diversity across states in the degree to which access to perinatal services is supported through Medicaid payment systems.

Chapter V: Monitoring Access and Availability

V. Monitoring Access and Availability

A. Monitoring Perinatal Services

Monitoring the quality of services provided under Medicaid managed care can be complex. The effectiveness of many services cannot be ascertained in the short term, and data are not always available to measure the outcome of many procedures. Perinatal care, however, is an exception. Pregnancy is a time-limited event with measurable outcomes, and data are often readily available to measure both the process of care—including the type and frequency of services used—as well as the outcome of those services, such as infant birth weight and gestational age. To monitor these indicators, however, state Medicaid agencies must be able to collect accurate encounter data from the managed care plans with which they contract.

In general, most states reported that they attempted to collect encounter data from plans. Thirty states said that they required plans to submit encounter data (Table V-1), although several reported that they were not convinced of the quality of the data submitted by plans, and others noted that they had just begun to collect these data. New York officials noted that, although they did require that plans provide encounter data, they had little information about the number of prenatal visits used by enrollees, as most plans pay their providers a global fee for all prenatal and delivery services and therefore did not have information on the individual services provided.

Three states (Illinois, North Carolina, and Pennsylvania) reported that, instead of gathering data on individual encounters, they required plans to submit data on the indicators included in the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS). The 1999 version of HEDIS included nine indicators related to perinatal care:

- Prenatal care in the first trimester;
- Low birth weight babies;
- Check-ups after delivery;
- Availability of obstetrical and prenatal care providers;
- Initiation of prenatal care;
- Low birth weight deliveries at facilities for high-risk deliveries and neonates;
- Discharge and average length of stay—maternity care;
- Cesarean section rate; and
- Vaginal birth after cesarean (VBAC) rate.

The 2000 version of HEDIS includes six of these measures (all but the availability of obstetrical and prenatal care providers, low birth weight babies, and low birth weight babies born at facilities for high-risk deliveries). While these indicators are useful in monitoring the process

Table V-1

Data Collected to Monitor Access to and Utilization of Pregnancy-Related Services

State	Encounter Data	Low Birth Weight	C-Section Rates	Early PNC	Adequacy of PNC	Abortion Rates	Other Indicators
United States Total	**30**	**27**	**19**	**29**	**22**	**16**	**16**
Alabama		●	●	●	●		Birth complications
Alaska		●	●	●	●	●	Substance abuse
Arizona	●	●	●	●	●	●	
Arkansas	NA	NA	NA	NA	NA	NA	
California					●		Plans to use HEDIS indicators
Colorado	●		●	●	●	●	Sterilization rates; Postpartum check-ups;
Connecticut	●	●		●	●		
Delaware	●						
District of Columbia		●	●	●			
Florida	●	●					
Georgia		●	●	●		●	
Hawaii	●	●	●	●	●		
Idaho		●	●	●		●	
Illinois	●	●	●	●	●		WIC and case management enrollment
Indiana	●			●			Types of providers and types of delivery
Iowa	●	●					
Kansas	●	●		●			
Kentucky			●	●	●		Postpartum check-ups
Louisiana	NA	NA	NA	NA	NA	NA	
Maine							
Maryland	●	●		●	●	●	Prenatal risk assessments
Massachusetts	●		●	●	●		Postpartum check-ups; average length of
Michigan							
Minnesota	●	●					
Mississippi	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Missouri	●	●	●	●	●		
Montana	●						
Nebraska	●						
Nevada		●	●	●	●	●	Tubal ligation; vasectomies
New Hampshire	●	●		●	●		
New Jersey	●			●	●		
New Mexico	- - -	- - -	- - -	- - -	- - -	- - -	- - -
New York	●	●	●	●	●	●	Postpartum check-ups; access to facilities
North Carolina	●	●					
North Dakota	●	●		●		●	
Ohio	●			●			
Oklahoma							Plans to use HEDIS indicators
Oregon	●	●					
Pennsylvania	●		●	●	●	●	
Rhode Island	●	●	●	●	●		Maternal health status; cigarette and
South Carolina	NA	NA	NA	NA	NA	NA	
South Dakota							
Tennessee	●	●	●	●			Birth rates, fertility rates, interpregnancy
Texas						●	
Utah	●						
Vermont						●	
Virginia		●		●	●	●	
Washington	●	●		●	●	●	Unintended pregnancy
West Virginia	●	●	●	●	●	●	
Wisconsin	●	●	●	●	●	●	Sterilizations; Hysterectomies
Wyoming	- - -	- - -	- - -	- - -	- - -	- - -	- - -

Notes: NA = montoring data not available.
- - - = states did not respond to survey.
Data as of March 2000

and outcomes of perinatal care, they do not provide information about other access measures, provider participation in Medicaid, or the effect of payment levels on access to care.

Whether or not they require plans to report HEDIS measures, many states reported that they monitor specific measures of the use and outcome of perinatal care. The most popular measures

were the proportion of women who enter prenatal care in the first trimester, monitored by 28 states and DC, and the low birth weight rate, monitored by 26 states and DC (Table V-1). In addition, 22 states reported monitoring the adequacy of prenatal care, 18 states and DC monitor cesarean section rates, and 16 track abortion rates. Other indicators state officials mentioned included the number of sterilizations performed (including vasectomies, tubal ligations, and hysterectomies), the proportion of women who receive postpartum checkups soon after delivery, the availability of obstetricians in managed care plans, and the length of stay for maternity admissions.

B. Access to Providers

Medicaid coverage of specific perinatal services is only the first step in assuring that pregnant women receive the services they need. In practical terms, access to care requires that service providers be available who accept Medicaid and who are geographically, linguistically, and culturally accessible to Medicaid enrollees.

As discussed previously, the Balanced Budget Act of 1997 repealed the requirement that state Medicaid programs assure access to obstetric and pediatric providers that is equal to that found in the private sector. The survey explored the extent to which states are continuing to monitor access to perinatal providers despite this change in national policy. In addition, Medicaid officials and obstetric providers offered their opinions regarding Medicaid enrollees' access to obstetricians, nurse-midwives, and anesthesiologists in their states.

1. Access to Obstetricians

Most states (31) and DC have not continued to monitor access to obstetricians systematically since the repeal of the equal access provision. However, 15 states (Arizona, Idaho, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Missouri, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, Virginia, and Washington) have maintained some level of oversight, often doing so in concert with monitoring of their Medicaid managed care programs. For example:

- Kansas and Arizona require managed care plans to report the number and types of providers in their networks;
- Pennsylvania requires plans to demonstrate that all provider types are available in each county;
- In Missouri, for the counties in which capitated managed care plans operate, access is monitored through reports from the plans of the number of participating providers. In the remaining counties, a sample of enrollees in fee-for-service Medicaid are sent a brief questionnaire that uses specific data taken from their claim histories to inquire about the quality of care and access to providers; and
- Massachusetts monitors the number of open slots available in its primary care case management program.

Although many states do not conduct systematic monitoring of access to obstetric providers, Medicaid officials did offer anecdotal comments on the level of access available in their states. More than half (26) said access was good, and two (Alaska and Arizona) noted that a remarkably high proportion of obstetric providers participate in the Medicaid program. Many had the impression that access to providers has remained stable or improved since the repeal of the equal access provision. However, physicians were likely to report limited access to providers: in eight states (Hawaii, Illinois, Massachusetts, Michigan, New York, Oklahoma, Tennessee, and Wyoming[2]) ACOG representatives reported that a significant number of providers refuse Medicaid clients; and in four states (Georgia, Maryland, Missouri, and North Carolina), representatives noted a shortage of obstetric providers participating in the Medicaid program. Medicaid officials and ACOG representatives attributed the lack of provider participation to the following barriers:

- **Shortages of providers in rural areas.** Geographic availability of providers, the most frequently mentioned barrier, was reported by Medicaid officials in 22 states. Women may travel long distances to access a provider; for example, women may have to travel up to 160 miles to see an obstetrician in Nevada and up to 200 miles in Montana.
- **Low Medicaid rates.** Medicaid officials in six states (Alaska, Arkansas, California, Colorado, Idaho, and Missouri) and ACOG representatives in eight states (Hawaii, Illinois, Mississippi, North Carolina, Oklahoma, South Dakota, Tennessee, and Wyoming) reported that low Medicaid reimbursement rates discouraged providers from participating in Medicaid. For example, in urban counties in North Carolina, private plans' rates are higher than Medicaid's, and many obstetricians accept only a limited number of Medicaid patients. In smaller, rural counties, Medicaid's rates are higher than those of commercial managed care plans, and obstetricians are more likely to accept Medicaid patients. Another example is Tennessee, where an increasing number of obstetricians refuse to participate in TennCare, while others limit their participation in Medicaid to two deliveries per month or limit their practice to gynecological but not obstetrical services.
- **Problems with managed care plans.** ACOG representatives in several states (including New York, Maryland, Tennessee, and South Dakota) described delays in authorizations, claims processing, and payments as discouraging providers from participating in Medicaid managed care programs.

Several states have taken steps to improve access to perinatal providers, using a variety of strategies. One approach is to increase reimbursement rates; for example, Connecticut noted an increase in provider participation after reimbursement rates were increased. Similarly, in Alabama, reimbursement for care coordination was reported to increase provider participation while also enabling providers to manage their patients more effectively and increase providers' satisfaction with their participation in Medicaid. Another approach is to require physicians to participate: Rhode Island assures access to providers by requiring physicians in managed care plans that participate in RIteCare, the state's Medicaid managed care program, to accept RIteCare patients.

[2] Although the state of Wyoming did not respond to the survey, an ACOG representative in the state did.

2. Access to Anesthesiologists

In general, Federal law prohibits Medicaid providers from balance billing; that is, they may not charge their patients a fee in addition to the Medicaid reimbursement rate. However, when anesthesiologists do not participate in the Medicaid program, women may be asked for cash payments for anesthesia services when they come to the hospital to deliver. The issue of inappropriate requests for cash payments from Medicaid enrollees received significant attention in recent years due to some highly publicized cases where pregnant enrollees were asked to pay cash for epidural anesthesia. This issue was addressed by HCFA in a letter to Medicaid Directors in January 1999, which stated that "treatment of a Medicaid patient in this matter is not just a concern, it is alarming." The letter went on to explain that hospitals serving Medicaid patients are obligated to assure that these patients receive all medically necessary care. However, state Medicaid officials have not found effective ways of enforcing this requirement, so this continues to be a problem in some areas.

Most Medicaid representatives interviewed were not aware of any cases in their states where women enrolled in Medicaid were asked to pay out of pocket for pregnancy-related services. However, representatives in twelve states (Alabama, California, Connecticut, Florida, Georgia, Missouri, Montana, Louisiana, North Carolina, Oklahoma, South Carolina, and Utah) did acknowledge one or more instances of requests for out-of-pocket payments in the past several years. Such cases often involved payment for anesthesia services, specifically epidural anesthesia. For example:

- Officials in Utah cited "two or three" known cases where a client was asked to pay for an epidural;
- In North Carolina, some anesthesiology groups do not accept Medicaid for routine vaginal deliveries and request a cash payment of $800 from all clients before delivery (Medicaid's payment rate for epidurals is $120);
- In Louisiana, there have been reports of anesthesiologists not accepting Medicaid rates as payment in full. Alternative pain relief (general anesthesia or oral narcotics) may be offered instead of epidurals; and
- In California, there have been several highly publicized cases of anesthesiologists demanding cash payment before administering epidurals to women enrolled in Medicaid.

Medicaid officials in these states report that they are largely unable to stop these practices. In California, Medi-Cal officials explained that they cannot sanction the hospitals in which these events occur, as the anesthesiologists are not hospital employees. In North Carolina, officials explain that as long as providers treat all of their patients equally, they cannot intervene. In Colorado, however, officials have attempted to increase anesthesiologists' participation in Medicaid by increasing their reimbursement rates. Similarly, in South Carolina, where access to anesthesiologists has been limited because anesthesiologists object to both the Medicaid rate structure and the program's definition of anesthesiology services, one county allows physicians to bill for both surgery and anesthesia.

3. Access to Nurse Midwives and Other Perinatal Providers

Certified nurse midwives (CNMs) are registered nurses who have completed post-graduate training in nurse-midwifery and work in association with a board-certified obstetrician/gynecologist. As an alternative to obstetricians, and as a replacement for obstetricians in areas of limited availability, CNMs and direct-entry midwives can be an essential link to low-income women's access to perinatal services. For example, in Arkansas, the shortage of obstetricians in rural areas was alleviated by an increase in the number of midwives in these areas. Medicaid officials in 16 states and DC report good or adequate access to nurse midwives, while five (Colorado, Maryland, Missouri, Virginia, and Vermont) report limited access due to an inadequate supply or under-utilization.

Certified midwives or direct-entry midwives practice in a home or birth center setting and are not required to have a nursing background. According to the North American Registry of Midwives, seven states (Alaska, Arizona, Florida, New Mexico, Oregon, South Carolina, and Washington) allow direct-entry midwives to receive reimbursement under Medicaid; of these, Medicaid officials in Alaska and Oregon reported particularly good access to their services. Medicaid officials in New York also reported adequate participation by nurse practitioners and Colorado officials reported good access to birthing centers.

C. Encouraging the Use of Prenatal Services

To encourage pregnant women to take advantage of the prenatal services available to them, and to help improve access to services, state Medicaid agencies may offer incentives to clients or to plans to promote the use of prenatal care. Medicaid officials in 11 states report that they make an effort to promote prenatal care to the public or to the plans. These efforts include the following:

- **Outreach campaigns.** Alaska conducts a departmental public awareness campaign and places TV ads promoting prenatal care, and Utah's "Baby Your Baby" campaign includes mugs and T-shirts as well as pervasive media messages;
- **Medicaid policies.** Iowa officials consider their policy of enrolling newborns in the same plan as their mothers to be an incentive for plans to provide good prenatal care, as plans will want to increase the likelihood of good birth outcomes if they are responsible for the newborn's medical costs; and
- **Financial incentives.** Massachusetts uses plans' results on perinatal monitoring indicators as a factor in determining capitation rates as well as the algorithm used for auto-assignment of enrollees who do not choose a plan. In Ohio, capitation rates are adjusted based on the percentage of pregnant women who begin prenatal care early. Rhode Island also offers financial rewards to plans that meet performance goals. New York reported that their Medicaid program does the reverse, sanctioning plans that do not meet the goals stated in their contracts.

More often, however, Medicaid agencies leave it to plans to entice their members into prenatal care. Fifteen states reported that managed care plans may offer incentives to members to use prenatal care; these often include gift certificates, coupons, lottery tickets, diapers, and car seats.

In some states, these efforts may conflict with restrictions on marketing; for example, Colorado officials noted that although plans do give McDonald's coupons and other incentives for using prenatal services, they have to be careful, as they are prohibited from offering anything of "significant financial value" to members.

In two states, Medicaid officials report that it is the state health department's responsibility to promote prenatal care. Arkansas' public health department provides coupon books to prenatal clients that are redeemable for products and services in the community. Louisiana officials reported that the state's Maternal and Child Health program probably offered such incentives, but they were not familiar with them.

Chapter VI: Respondent's Perspectives

VI. Respondents' Perspectives

Although their impressions of access to care under Medicaid are largely anecdotal, nearly all Medicaid officials interviewed reported that access to perinatal care had improved in their states, and many felt that these improvements had been reflected in earlier and more consistent use of prenatal care by Medicaid-eligible women (although data are not always available to confirm this impression). However, the specific policy changes mentioned as having spurred these improvements varied across the states:

- **Increased reimbursement rates.** Medicaid officials in seven states (Arkansas, California, Georgia, Idaho, Indiana, Missouri, and Montana) noted that increases in Medicaid reimbursement rates had motivated more physicians, particularly ob/gyns, to participate in Medicaid, thus improving access to care for clients. A specific incentive used successfully in Georgia is the addition of a $100 payment to the global fee paid to providers for patients who enter prenatal care in the first trimester. Medicaid officials noted that approximately half of the providers who bill for the global fee are eligible for the additional payment, indicating an improvement in the proportion of women who enter prenatal care early;
- **Eligibility expansions.** Medicaid officials in three states (Alaska, Minnesota, and Washington) pointed to expansions in income eligibility levels as the main source of increased access to care for pregnant women;
- **Eligibility simplification.** In addition to the expansion of eligibility levels, Medicaid officials in California and Nebraska reported that efforts to streamline the Medicaid enrollment process, such as presumptive eligibility, continuous eligibility, and the waiver of asset limits, had greatly improved access to care. For example, California officials had seen a positive effect on the number of women who begin prenatal care in the first trimester since the state implemented presumptive eligibility and the asset waiver; in addition, the state's low birth weight rate declined in the mid-1990s, an effect that may be partly attributable to increased access to Medicaid coverage. However, as mentioned earlier, many low-income women do not participate in Medicaid during pregnancy and are therefore uninsured; and
- **Managed care.** Finally, Medicaid officials in 21 states report that Medicaid managed care has resulted in increased access to perinatal care. Several of these officials attributed this effect to increased participation in Medicaid among private-sector physicians, many of whom had never participated in fee-for-service Medicaid. Others noted that managed care plans emphasized health education, home visiting, care coordination, and support services, making them better able to meet the needs of low-income pregnant women. For example, Colorado officials told of one plan that had used their capitation payment to help a patient move out of an unsafe building, and Oklahoma officials noted that their managed care plans are required to hire Maternal and Child Coordinators who contact pregnant enrollees and encourage them to come in for care.

Medicaid officials in one state, North Carolina, reported negative effects of their policy changes. Since the implementation of managed care (using a PCCM system in most counties), a decrease has been noted in the number of women using local health departments for prenatal care. Thus, pregnant women have become less likely to receive the health education, nutrition, and care coordination services that are available from health departments but are not provided by private physicians.

Medicaid officials in six states (Arizona, Kansas, Louisiana, North Dakota, Utah, and Wisconsin) reported that their states' policy changes had no effect on access, and officials in three states (Hawaii, Massachusetts, and New Jersey) and DC did not know what the effect of these changes had been. In Massachusetts, for example, Medicaid officials pointed out that they had no baseline with which to compare utilization under their Medicaid managed care program, as indicators of access were never monitored in the fee-for-service system.

The physicians interviewed tended to be less optimistic about the effects of their states' policy changes. While several felt that increased reimbursement rates and the implementation of Medicaid managed care had improved physician participation and access to care, many had reservations about these changes. In Illinois, for example, the ACOG representative interviewed noted that while access had increased due to an enhancement of reimbursement rates for low-risk care, the rates paid for high-risk women were still inadequate and hospitals were losing money. In Tennessee, a physician reported that TennCare had improved access to care; however, that effect may not last, as many physicians and several plans are withdrawing from the program. In Maryland, an obstetrician raised an issue similar to the one that concerned Medicaid officials in North Carolina: he reported that MCOs in the state were not consistently providing risk assessment and case management to pregnant women, as local health departments had in the past. Thus, he felt that managed care had reduced women's access to support services. In addition, physicians in three states (Maryland, Michigan, and Oklahoma) reported that access to care had deteriorated, due to such factors as low reimbursement rates, insufficient MCO participation in Medicaid managed care, and stringent Medicaid eligibility requirements.

State officials and physicians also reported the major barriers to access to perinatal care that they observed. The barrier most frequently reported by Medicaid officials was simply the supply of available providers, particularly in geographically isolated areas; this was reported by officials in six rural states (Alaska, Idaho, Nebraska, North Carolina, North Dakota, and Texas). Medicaid officials in four states (California, Missouri, Oregon, and Utah) mentioned that provider participation in Medicaid, often related to low reimbursement rates, was a barrier, as did four ACOG representatives (in Illinois, Michigan, Tennessee, and Wyoming). Three Medicaid officials (in Indiana, Kansas, and New Jersey) and two physicians (in Maine and Nevada) also noted that lack of patient education about the need for prenatal care and the workings of the Medicaid system prevented women from using services. Finally, several physicians felt that restrictive Medicaid eligibility standards, transportation, child care, and language presented barriers to care.

Both Medicaid officials and physicians suggested a variety of policy changes to address these access barriers. These recommendations covered a wide range of issues, from the details of program implementation to suggested changes in state and Federal statutes:

- **Medicaid implementation.** Medicaid officials suggested a number of specific improvements they would like to see made in their programs, including expanding the package of services covered; allowing physicians who employ nurse practitioners to serve a larger number of patients; expanding community-based outreach efforts; making a particular effort to target pregnant substance abusers with outreach; educating providers about the workings of the Medicaid program; and helping women choose a provider quickly, in order to reduce auto-assignment rates. In addition, one ACOG representative recommended that the Medicaid program provide better outreach and case management for pregnant women;
- **State policy changes.** While only one Medicaid official suggested that her state institute presumptive eligibility, recommendations for policy changes within the Medicaid program were common among physician respondents. These included simplifying eligibility processes and instituting presumptive eligibility; simplifying or eliminating Medicaid managed care; and expanding income eligibility standards;
- **Funding issues.** Not surprisingly, increasing Medicaid rates was suggested by ACOG respondents from six states, and two others noted that more funds were needed in the Medicaid system as a whole. Two Medicaid officials made similar suggestions, one noting that rates were always a problem, and another suggesting that the overall Medicaid budget needed to be increased; and
- **Changes in state and Federal laws and regulations.** Two ACOG representatives and one Medicaid official recommended statutory or regulatory changes. One Medicaid official felt that the upper payment limits that govern Medicaid's capitation rates (which are based on historical fee-for-service expenditures) were unduly restrictive and prevented his program from paying plans adequately. He stated that these payment restrictions discouraged plans from participating in the program and should therefore be eliminated. One ACOG representative recommended that the State Child Health Insurance Program be expanded to cover pregnant women, and another suggested that physicians be legally required to serve people receiving public aid.

Thus, while the state Medicaid officials and physicians interviewed generally felt that care for low-income pregnant women had become more accessible in recent years, they also saw considerable room for improvement in the systems that serve these women. While eligibility expansions and Medicaid managed care programs are widely seen to have improved access to perinatal services, low reimbursement rates, physician shortages in the Medicaid program, and the complexity of Medicaid rules continue to constrain women's access to perinatal care.

Chapter VII: Conclusions

VII. Conclusions

Access to health care services for low-income pregnant women has been a vital concern of state and Federal policymakers for more than a decade. Eligibility expansions beginning in the late 1980s, and to some degree the introduction of Medicaid managed care programs in the mid-1990s, were intended to improve access to perinatal services. As these systems continue to evolve, this survey provided an opportunity to review the eligibility policies, benefit packages, access provisions, monitoring strategies, and payment mechanisms used by state Medicaid programs to provide services to pregnant women. A number of general conclusions can be drawn from the findings of this study.

First, most state Medicaid programs cover a comprehensive range of perinatal services, generally including prenatal medical services and testing, delivery (including anesthesia), and postpartum care. Many states cover prenatal support and education services as well; however, relatively few states cover smoking cessation services or services to support women's decision to breastfeed, two provisions of care that can have a dramatic and immediate effect on both women's and infants' health. In addition, many state officials reported that while they did not use separate billing codes for education and counseling services, these services were assumed to be included as part of a standard prenatal office visit. The lack of billing codes for these services makes it impossible for state officials to assure that these important prenatal services are being provided to Medicaid enrollees.

Moreover, coverage of specific services does not always guarantee that the services are accessible. For example, managed care contracts vary significantly in their specificity regarding the perinatal services to be provided to pregnant enrollees in Medicaid managed care plans, raising some question about the accessibility of services to managed care enrollees. In addition, provider shortages—particularly in rural areas—threaten the accessibility of obstetric and anesthesiology services for pregnant women. Even in urban areas, problems with access to anesthesiologists persist, and the publicity surrounding these incidents does not contribute to a positive image for the Medicaid program.

To address these issues, states have an obligation to monitor and evaluate access to services under their Medicaid programs. However, they are not always well-equipped to do so. While approximately half of states reported that they require managed care plans to submit encounter data, fewer are monitoring specific indicators of the use or outcomes of perinatal care such as low birth weight rates and adequacy of prenatal care. Further complicating the problem of monitoring and evaluation is the fact that commonly-used payment mechanisms such as capitation and global fees make it difficult for state officials to monitor the specific services provided for these payments.

Payment rates themselves, in both fee-for-service and capitated programs, can also present a significant barrier to access. Few states regularly adjust provider payment rates, and physicians

in states across the country report that low rates can discourage providers from participating in Medicaid. Moreover, fee-for-service payment rates form the basis for the calculation of capitation rates under managed care programs, preserving inequities in payment rates and limiting plans' ability to provide comprehensive perinatal care. This presents a particular challenge when women enter the Medicaid program late in their pregnancies, without early and adequate prenatal care, requiring expensive delivery and neonatal services with few months of capitation payments. While some states have developed mechanisms for financing deliveries outside of the standard capitation rate, most include all perinatal services in their base rate.

Overall, it appears that managed care alone has not solved the access barriers and policy issues related to perinatal care for low-income women. Making perinatal care accessible in a managed care environment involves, continuing to educate women about the importance of prenatal care and the availability of Medicaid coverage for pregnancy-related services, to help assure that women enroll in Medicaid and begin receiving care early in pregnancy. In addition, it is evident that the use of managed care does not necessarily resolve the problem of provider participation; while many state officials report broader access to providers since the implementation of Medicaid managed care, others, such as Tennessee, continue to struggle to maintain their provider networks. Therefore, it appears from this survey that while many states have established an infrastructure for providing comprehensive perinatal care to low-income women, much ongoing work is needed to assure that these policies translate into practical access to care.

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