

## MAKING THE MOST OF MEDICAID Promoting the Health of Women and Infants With Preconception Care

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Received 3 June 2008; revised 22 July 2008; accepted 25 July 2008

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**This paper examines the evolution and current role of Medicaid in improving access to preconception care for low-income women. The authors review Medicaid's eligibility policy and benefits of relevance to women of reproductive age and discuss various approaches to promote preconception care in Medicaid. The challenges facing the program and potential opportunities to use the program to promote preconception care to low-income women are discussed.**

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When Medicaid was enacted in 1965 as the lowly stepsister to Medicare, no one could have imagined that more than 40 years later, it would be the largest financier of maternity services in the nation, paying for 41% of all births in the United States (National Governors Association, 2006). Although the importance of Medicaid in promoting prenatal care access and covering infants has been widely acknowledged, less understood is its potential to further promote maternal and infant health, particularly for the nation's poorest, most at-risk women before they become pregnant. This paper examines the evolution of Medicaid as a major national payer of maternity care and family planning services and reviews its long-standing role in improving maternal and infant birth outcomes for low-income women. It explains the program's eligibility policy for and benefits important to low-income women of reproductive age and discusses the opportunities that state and federal policy makers should explore to maximize Medicaid's role in promoting preconception care for low-income women.

### Medicaid's Evolution

As the successor to Kerr-Mills, Medicaid was created as a state and federal program that provided federal

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The authors have no direct financial interests that might pose a conflict of interest in connection with the submitted manuscript.

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matching funds to states for the care of the poor. At its inception, Medicaid was strictly a "welfare program," granting automatic eligibility to women and children receiving Aid to Families with Dependent Children and other cash assistance programs.

In the early 1980s, the program began to shift from a program essentially serving the welfare population to one that provided coverage to poor infants and children, and increasingly pregnant women (Rowland, 2005/2006). This latter group was assisted largely in response to a growing concern about the stagnation in infant mortality rates and the rise in the rate of low-birthweight newborns. Landmark reports on improving birth outcomes by the Institute of Medicine (1985, 1988), along with state-based efforts, paved the way for federal legislation that at first gave states the option to expand coverage to low-income pregnant women. By 1989, all states were required by law to offer eligibility to pregnant women with incomes up to 133% of the federal poverty level (FPL), with the option of going higher. These expansions were widely adopted so that today maternity costs comprise over a quarter of all Medicaid inpatient charges, and 6 of the top 10 hospital procedures billed to Medicaid relate to maternity care (Merrill & Elixhauser, 2006).

In the 1990s, there was growing interest at the state level to expand eligibility to "noncategorical groups," that is parents and adults without children, through §1115 Research and Demonstration Waivers. These waivers were also designed to foster innovation at the state level and were used to considerably broaden

the use of mandatory managed care enrollment. These waivers, however, were constrained by federal requirements that program changes be budget neutral, meaning that they would not cost the federal government more than they would have absent any policy changes.

Owing to rising program costs and the fiscal constraints of state budgets, states began to explore other options with §1115 waivers by restricting the scope of services to family planning and targeting those of reproductive age, mostly women, for these services. States have taken three eligibility approaches with these family planning waivers. Four states provide services to new mothers who lost Medicaid eligibility during the postpartum period, two states have broadened eligibility to women who lost Medicaid coverage for any reason, and most states take a broader approach extending eligibility to women (and sometimes men) who qualify based on low income alone, regardless of earlier eligibility for Medicaid or their categorical status (Gold & Alrich, 2008). Today, 26 states operate family planning waiver programs. These programs have been especially attractive to state policy makers because of the enhanced 90% federal matching rate paid to states for family planning services, which is considerably higher than the standard rates that states usually receive.<sup>1</sup> The services covered, however, are narrowly limited to those defined as family planning, despite efforts to broaden the scope to include more primary care.

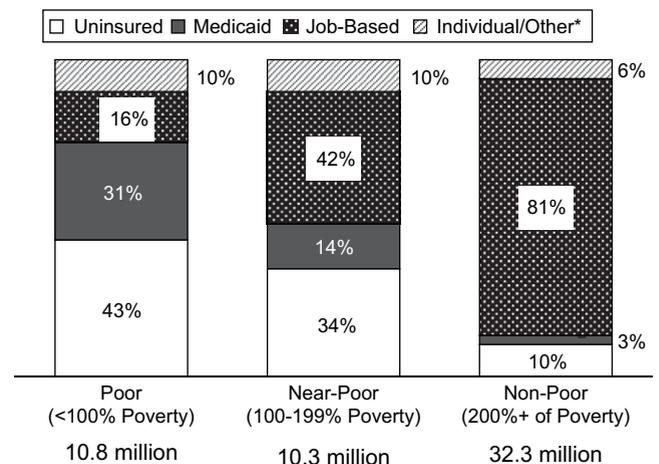
### Medicaid and Preconception Care

In 2006, the Centers for Disease Control and Prevention (CDC) issued a report containing a broad range of recommendations to improve the preconception health of women in the United States (Johnson et al., 2006). These recommendations emerged from many discussions with a wide range of national experts and a growing body of research that documented the importance of interventions, such as screenings, treatment, and educational tools for women before conception (Freda, Moos, & Curtis, 2006; Johnson et al., 2006). These recommendations covered many dimensions including consumer education and awareness, personal responsibility, clinical practice, research, and financing of health care services. Of the many recommendations that emerged from that effort, it encouraged policy makers to “increase public and private health insurance coverage for women with low incomes to improve access to preventive women’s health and preconception and interconception care” (Johnson et al., 2006, p. 13). Medicaid was identified as a potentially major avenue to address this recommendation, particularly given that employer-sponsored coverage and individually-

<sup>1</sup>Federal matching funds for Medicaid services are based on a formula that considers the per capita income in the state. Matching rates range between 50% and 76% of state contributions (*Federal Register*, 2006).

purchased insurance policies are beyond the reach of many low-income women. Today, employer-sponsored coverage only insures 16% of poor women (<100% FPL) and 42% of near-poor women (100%–199% FPL) ages 19–44 (Figure 1). Many low-income women either work in low-wage jobs that offer few benefits such as health insurance, or they work part time or part year because of their childrearing responsibilities and do not qualify for benefits offered to full-time workers (Kaiser Family Foundation, 2007b). Purchasing insurance through the individual insurance market is also not an option for many low-income women owing to costs. Furthermore, many of the benefits that women of reproductive age might need, such as maternity care, preventive services, family planning, and prescription drugs, are typically not included in basic benefit packages offered by many individual market insurers (Pollitz, Kofman, Salganicoff, & Ranji, 2007). Further complicating the affordability concerns of low-income women, the presence of any health problem may disqualify them for coverage even if they wished to purchase a policy (Pollitz, Sorian, & Thomas, 2001).

Because the private sector is not a viable option for so many low-income women, Medicaid is currently the primary mechanism for covering this population. Medicaid serves 1 in 10 women of reproductive age, largely due to eligibility policy that includes major pathways for women who are pregnant or those who have children (Kaiser Family Foundation, 2008). Nearly 7.3 million women between the ages of 15 and 44 were covered by Medicaid in 2006, which comprised nearly two thirds (64%) of adult women on Medicaid (Kaiser Family Foundation, 2007a). For women of color, this program can serve as a lifeline to a wide range of health care services, with 19% of African-American, 13% of Latina, and



**Figure 1.** Health insurance coverage of women ages 19–44, by income, 2006. *Note.* The FPL was \$16 600 for a family of 3 in 2006. \*Individual/other coverage includes individually purchased private coverage and other public insurance such as Medicare and TRI-CARE. (Source: Kaiser Family Foundation unpublished analysis of the March 2007 Current Population Survey.)

13% of Native-American women of reproductive age covered by Medicaid (Kaiser Family Foundation, 2008).

Low-income women served by Medicaid also face a disproportionate burden of illness stemming from poverty and are at greater risk for experiencing poor maternal and birth outcomes. Diabetes, obesity, and hypertension are all chronic health problems that are more likely to occur among low-income individuals (Lawrence, Contreras, Chen, & Sacks, 2008). The 2004 Kaiser Women's Health Survey, found that 45% of nonelderly women on Medicaid reported fair or poor health, 13% had diabetes, 28% had asthma, and 40% suffered from anxiety or depression, all higher rates than women with private coverage (Salganicoff, Ranji, & Wyn, 2005). In addition, women on Medicaid exhibit behavioral factors that can put them at risk: 35% of non-elderly adults on Medicaid (two-thirds of whom are women) reported being current smokers and 31% being current regular drinkers (Lethbridge-Cejku, Rose, & Vickerie, 2006; Kaiser Family Foundation, 2007a). These women also often lack the resources needed to manage their health problems; 59% of women ages 19–44 on Medicaid are living in poverty and 26% have not completed high school (Kaiser Family Foundation, 2008).

Women served by Medicaid have potentially much to gain from screening, assessment, and counseling services associated with improved preconception health care and better birth outcomes, as do their infants. Like other insurers, Medicaid does not typically reimburse for a "well-woman" visit or a "preconception visit," which can be used to do initial screening and counseling. However, many of the services that are recommended for women can be offered and covered as part of routine care that many women already receive through their primary care providers and obstetricians/gynecologists. The challenge is that care financed by Medicaid, like private plans, tends to be fragmented and falls short of the comprehensive continuum of services suggested by the CDC recommendations.

### **Making the Most of Medicaid Preconception Care**

The Medicaid program offers many opportunities to improve the health of reproductive-age women, which could be done by strengthening the existing program and potentially expanding both eligibility and scope of coverage to maximize its potential to assist this population. Simplifying the eligibility process, broadening categorical and income eligibility requirements, extending the scope of benefits, and building on family planning programs, as well as state efforts to develop integrated preconception programs, are all measures that state officials should consider in their efforts to improve preconception and interconception care.

#### *Eligibility*

Medicaid eligibility is based on both meeting a categorical test, that is, fitting in a certain "category" such as

being a mother of dependent children or a pregnant woman, and meeting the very low-income threshold. For nonpregnant adults, income eligibility levels are largely state-determined and generally based on eligibility for Aid to Families with Dependent Children, a welfare program that was replaced by Temporary Assistance to Needy Families. There is tremendous variation from state to state, but the national average is 41% of the FPL, roughly \$7,000 for a family of 3 for nonworking parents (Ross, Horn, & Marks, 2008). State variation in income thresholds for nonworking parents is sizable; Minnesota utilizes the most expansive income policy at 275% of poverty and Alabama has the most restrictive, at 11% of poverty.

Income eligibility levels for women who qualify based on eligibility as parents are much lower than those used for pregnant women. Most states currently exceed the minimum federal eligibility threshold of 133% FPL for pregnant women. Eligibility currently ranges from 133% FPL in 6 states to 300% FPL in the District of Columbia, with most states' threshold at 185% or 200% FPL (Ross et al., 2008). States have also adopted policies to make enrollment easier by waiving restrictive assets tests, adopting presumptive eligibility policies that allow women who commence prenatal care to get covered for visits if they are "presumed" to be eligible, and by deploying enrollment workers at hospitals and clinics rather than exclusively at welfare offices. For pregnant women who qualify, eligibility is guaranteed throughout the pregnancy and through 60 days postpartum. To enroll for regular Medicaid coverage after the postpartum period, however, women must requalify for eligibility based on the much lower income eligibility levels set for parents.

Although pregnant women are almost always guaranteed coverage for their entire pregnancy, women who qualify based on their categorical status as parents do not have the same guarantee of coverage for a preset time period. Arcane eligibility requirements and administrative complexities involved in maintaining and reenrolling in Medicaid result in many women on Medicaid going off the program, causing instability in health insurance and gaps in continuity of care. This is often due to state policies that require that beneficiaries requalify periodically by filling out complex forms and paperwork (Ross et al., 2008). During a 4-year period, an average of nearly 1 million people left Medicaid/State Children's Health Insurance Program (SCHIP) every month, with the majority (65%) becoming uninsured (Short, Graefe, & Schoen, 2003). Forty percent of the people who had Medicaid/SCHIP coverage anytime in the 4-year period left and later reenrolled. Women are particularly vulnerable to insurance churning through Medicaid owing to circumstances such as pregnancy and changes in income and employment status.

It should be noted that most legal immigrant women<sup>2</sup> are typically barred from enrolling in Medicaid for their first 5 years in the United States. Some states use their own funds to cover legal immigrants and in some cases even those who are undocumented as well (Schwartz & Artiga, 2007). In the case of pregnant women, some states cover women through “emergency Medicaid” programs that cover a more limited range of prenatal or delivery services. Twelve states have utilized the “fetal” coverage option through an SCHIP state plan amendment where a pregnant woman is covered because her fetus qualifies for SCHIP (Baumrucker, 2008). Eligibility levels for SCHIP vary across states, with California with the highest income eligibility threshold at 300% of the FPL. Eleven of these states extend coverage to undocumented pregnant women. After the child is born, the woman is no longer eligible, although 9 states do offer 60 days of postpartum care. The infant, as a citizen, qualifies for a minimum of 1 year of Medicaid coverage.

#### Scope of coverage

The range of mandatory services covered by Medicaid is quite broad. States must cover inpatient and outpatient services, physician and nurse-practitioner services, care in rural health clinics and federally qualified health centers, laboratory tests and x-rays, as well as family planning. States may, at their option, cover other services that are important to preconception health and still receive federal matching funds. Although defined as “optional” under Federal law, many of these services are often considered essential and include prescription drugs, dental care, diagnostic screening, preventive and rehabilitative services, clinic services, and primary care case management services (Kaiser Commission on Medicaid and the Uninsured, 2002).

Whereas Medicaid offers coverage of many services that are central to preconception care, the scope of a woman’s coverage depends largely on what state she resides. Because many of the services recommended as elements of preconception care are considered optional under Medicaid, there are considerable gaps in coverage for many recommended services, with limited state coverage of core preconception services such as adult immunizations, tobacco cessation services, dental care, and preconception counseling (Table 1).

Even if a state covers a service, access is not always guaranteed. Medicaid typically only pays a fraction of what private insurers or Medicare pay. This lower payment, complicated by a patient base that often has very complex medical and social needs, made many health providers historically reluctant to participate in the program (Rowland, Salganicoff, & Keenan, 1999; Zuckerman, McFeeters, Cunningham, & Nichols, 2004).

<sup>2</sup>Refugees and other humanitarian immigrants, as well as active duty members and veterans of the US Armed Forces and their families are exempt from the 5-year ban.

**Table 1.** States’ Medicaid Coverage of Selected Benefits Associated With Preconception Care

	Number of States That Offer Following Benefits
Immunizations (Rosenbaum et al., 2003)*	
Advisory Committee on Immunization Practices (ACIP)-recommended	32
Limited	16
Substance abuse-related outpatient testing and treatment services (Robinson et al., 2004)	
Extensive	25
Limited	18
Tobacco-dependence treatment services (CDC, 2008)	38
Dental services (Medicaid/SCHIP Dental Association, 2001)	
Full	7
Limited	18
Perinatal services (Schwalberg et al., 2001a)†	
Prenatal genetic testing	37
Nutrition counseling	34
Preconception counseling (Schwalberg et al., 2001b)	23

\* The District of Columbia did not respond to the survey.

† Mississippi, New Mexico, and Wyoming did not respond to the survey.

Areas like obstetric services, specialty care, and dental care have been historically prone to having poor provider participation (Health Resources and Services Administration, 2000; Rowland & Salganicoff, 1994).

Finally, a sizeable share of women on Medicaid receives their care through managed care arrangements. Although this structure has the potential to help coordinate the fragmented care that many women receive, access to specialty services or providers can be problematic if the benefits are not specifically addressed in the plan’s contract or participating providers are not in network, even if they participate in Medicaid.

#### Waivers and integration with other public programs

Over the years, states have used waivers to extend coverage to certain populations for a specific set of benefits; in particular, this has been done for family planning, but a handful of states extend eligibility to HIV-positive patients before they qualify for disability with an AIDS diagnosis and also cover home- and community-based care to those at risk of institutionalization. The most popular in terms of number of enrollees, however, has been the family planning waivers, which are detailed in the article by Gold and Alrich (2008 [this issue]). Some have suggested that the family planning waivers could be broadened in scope to offer women who are enrolled in the program (generally low-income women who do not qualify for Medicaid under one of its traditional eligibility pathways) an expanded range of benefits that includes some or all of the services that are recommended as part of preconception or interconception care (Johnson et al., 2006).

The real challenge in designing such a program under a §1115 Research and Demonstration Waiver will be demonstrating budget neutrality, considering that services such as vaccines, dental care, and genetic testing will not be federally matched at such a high rate as family planning services. Intuitively, it may seem that the provision of these key services to women would promote more optimal birth outcomes and reduce neonatal intensive care and other health care costs. Although these investments for women could offset the costs of these services to infants, it may be very difficult to demonstrate from a budgetary perspective and remains a significant challenge.

States have also been moving toward integrating Medicaid and other programs to improve interconception and preconception care. For example, the Illinois Department of Public Aid has been using the Medicaid family planning waiver to implement the *Illinois Healthy Women* initiative, providing pre- and interconception care to women, who would otherwise lose maternity-related coverage after 60 days postpartum, along with all women ages 19–44, who were previously enrolled in Medicaid but lost their benefits. This initiative has improved the range of services offered to those eligible, including coverage for preventive and reproductive care, and has implemented statewide genetic counseling programs, folic acid campaigns, and perinatal depression screening programs (Boulet, Johnson, Parker, Posner, & Atrash, 2006).

## Discussion

Medicaid plays a central role in financing a broad range of care for the nation's poorest women, particularly in paying for their maternity and infant care. Many of the core services in preconception care are already covered under the basic Medicaid program, but more can be done to assure that at-risk, low-income women receive the optimal level of care before they become pregnant, so they can have the healthiest birth outcomes possible. This makes sense from both a health equity and fiscal standpoint.

The current Medicaid program focuses on providing coverage to low-income mothers—expectant and of dependent children—and not for women who have not yet had or choose not to have children. For pregnant women, state and federal policies have gone far in expanding the reach of the program to most low-income pregnant women in the United States. There are few women who are uninsured by the time they deliver, but many are uninsured at onset of pregnancy or before they conceive (Adams, Gavin, Handler, Manning, & Raskind-Hood, 2003; Egerter, Braveman, & Marchi, 2003). Coverage, however, ends abruptly 60 days postpartum unless the new mother can meet the more restrictive Medicaid eligibility levels set for parents. Although states have the option to raise eligi-

bility levels, many have been reluctant to raise the thresholds for these groups, many with the concern that covering more low-income families will further stress state budgets, particularly during economic downturns when unemployment is higher and state coffers are low. Easing categorical requirements to include single women and raising eligibility levels to a federal floor could go far in opening a pathway to Medicaid for many women who do not currently qualify.

Proponents of expanding access to preconception care have also looked to the family planning waivers as a possible foundation to expand services to include basic preconception care, including screening, education, and/or interventions (Gold & Alrich, 2008; Johnson, 2006). The women enrolled in the family planning programs are exactly the population that could benefit the most from the umbrella of recommended preconception services, which could do much to identify and reduce high-risk pregnancies (Johnson et al., 2006). These services would be supported by access to family planning services and counseling to increase the odds that pregnancies are intended and further increasing the likelihood of healthy maternal and infant birth outcomes. Family planning programs hold great promise in improving preconception care, but would need to be broadened to include a wider range of services than what they currently offer.

For those who are on Medicaid, the program offers a wide range of “medically necessary” services. Screening and treatment for alcohol and other substance abuse, smoking cessation treatment, dental services, nutritional counseling, and adult vaccinations are all core elements of a package of services that could enhance birth outcomes for women before they get pregnant. Yet these are defined as “optional” services under Medicaid, and a sizable share of states does not cover these services for adults enrolled in their Medicaid programs. Even in states that offer coverage for these services, access can be further compromised by low provider payment rates compared with private insurance, making many health care providers reluctant to participate in the program. This can make it difficult for enrollees to find providers, which can cause women to delay or forgo care. State variations in scope of coverage and payment rates have been challenges to the program and have resulted in uneven coverage and access in programs across the nation. Although this is a critical issue, it may be among the most difficult to resolve without additional resources.

As the leading payer of maternity-related care and neonatal services, covering more than 1.6 million of the 4.0 million births that occur in the United States each year, the Medicaid program could yield significant savings if birth outcomes and maternal outcomes were improved across the nation (National Governors Association, 2006; Rosenbaum, Markus, & Sonosky, 2004). In its preconception recommendations, the

CDC has laid out a blueprint for how we can start this effort. Clearly, Medicaid will need to be a key element of this initiative's future success.

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