The Role of Medicaid in Reducing Infant Mortality

Presentation by Kay A. Johnson

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MEDICAID ELIGIBILITY

Which women and infants are eligible for Medicaid?

Eligibility for Pregnant Women

- Medicaid reforms of the 1980s.
  - Congress and states de-linked Medicaid and welfare, through Medicaid expansions between 1984-1989.
  - Pregnancy/infancy as a distinct eligibility category.
- Four foci of Medicaid maternity care reforms
  1. Eligibility
  2. Streamlined enrollment,
  3. Enhanced benefits /content of care, and
  4. Increased reimbursement for obstetric services.

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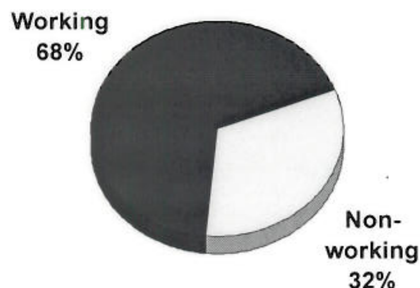
Medicaid Coverage for Infants by Work status of Family, US, 1994



Over 1.4 million infants had Medicaid as a source of health insurance.

Nearly 1 million (68%) of these infants lived in families whose head of household was working.

Source: Kay Johnson. ***Families, Babies, and Medicaid: Special Report for the Speaker of the House***. White Plains, NY: March of Dimes. 1995
(Based on EBRI analysis of CPS 1994 data.)

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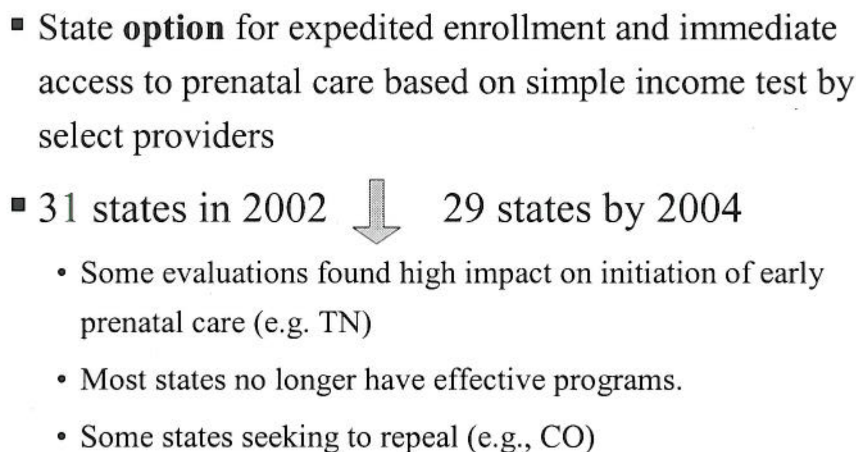
Special Eligibility and Enrollment Rules: Pregnant Women

- Presumptive eligibility



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Special Eligibility, Enrollment, & Benefit Rules : Pregnant Women (2)

- Continued coverage once enrolled
  - "Guaranteed" throughout pregnancy and 60 days after end of pregnancy (postpartum)
- "Pregnancy only" benefits
  - Only Medicaid-covered services related to:
    - "pregnancy (including prenatal, delivery, post partum, and family planning services); and
    - other conditions which may complicate pregnancy.
      - NOTE: Specific services are not listed. However, reasonable interpretation related to a successful pregnancy outcome is expected."

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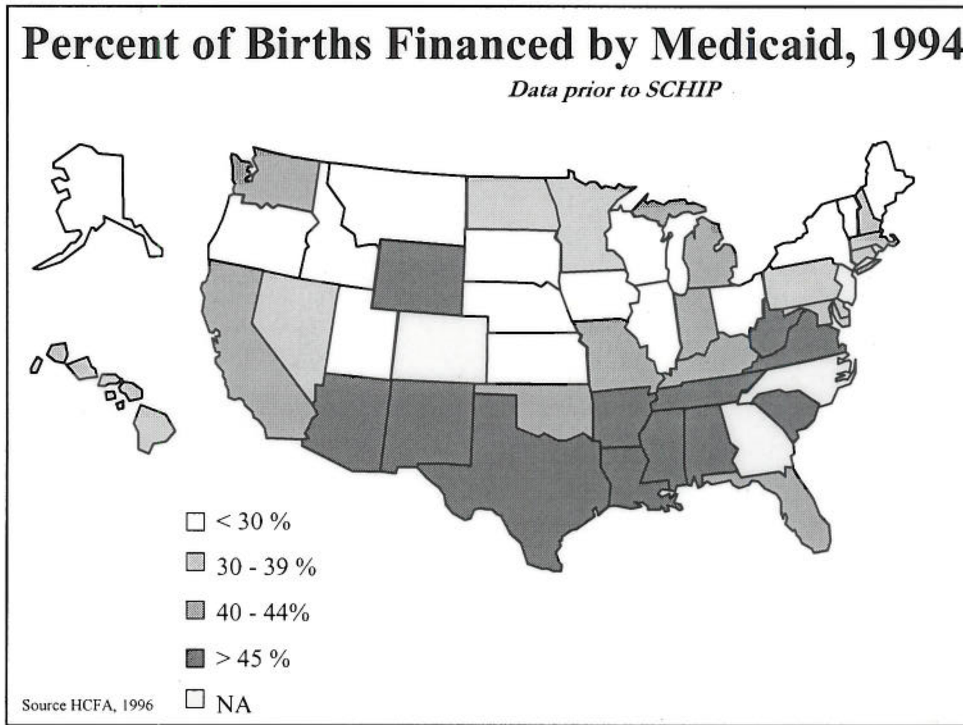
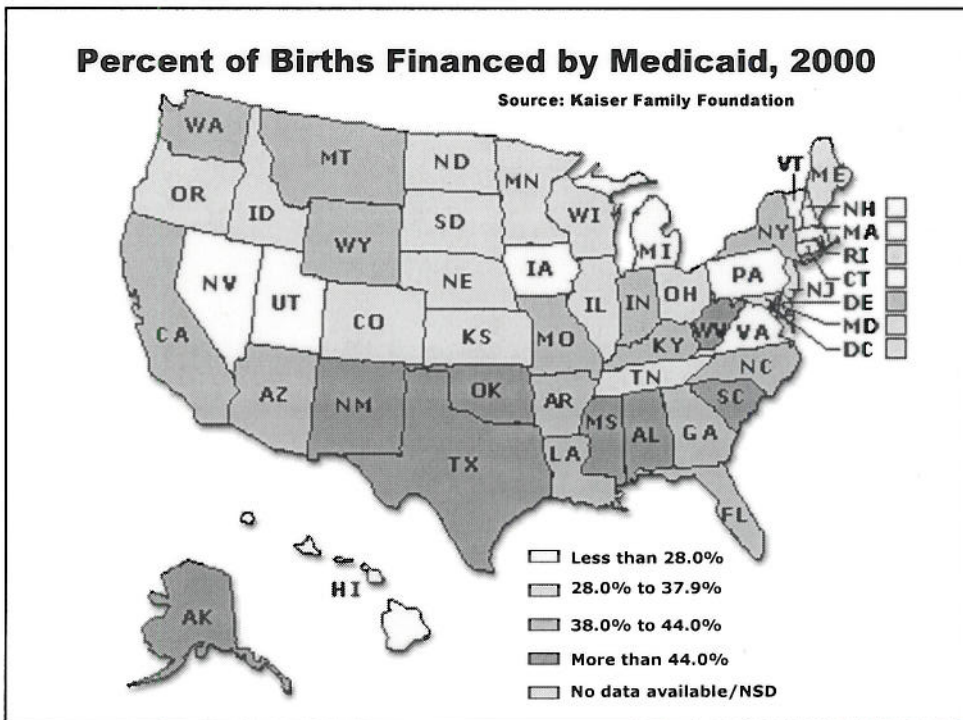

Percent of Births Financed by Medicaid, 1994
Data prior to SCHIP
< 30 %
30 - 39 %
40 - 44%
> 45 %
NA
Source HCFA, 1996


Percent of Births Financed by Medicaid, 2000
Source: Kaiser Family Foundation
WA
OR
ID
MT
WY
ND
SD
NE
MN
WI
IA
MI
IL
IN
OH
PA
NY
VT
ME
NH
MA
RI
CT
NJ
DE
MD
DC
NV
UT
CO
KS
MO
KY
WV
VA
NC
SC
TN
CA
AZ
NM
OK
AR
MS
AL
GA
LA
TX
FL
AK
HI
Less than 28.0%
28.0% to 37.9%
38.0% to 44.0%
More than 44.0%
No data available/NSD

Eligibility for Non-pregnant Women

- Welfare reform limited eligibility.
  - Congress and states approved welfare reforms (reductions) between 1994-1996.
  - Since 1996, coverage outside of pregnancy for women of childbearing age has declined.
- Family planning waivers are an important exception.
- HIFA waivers are another source of coverage.

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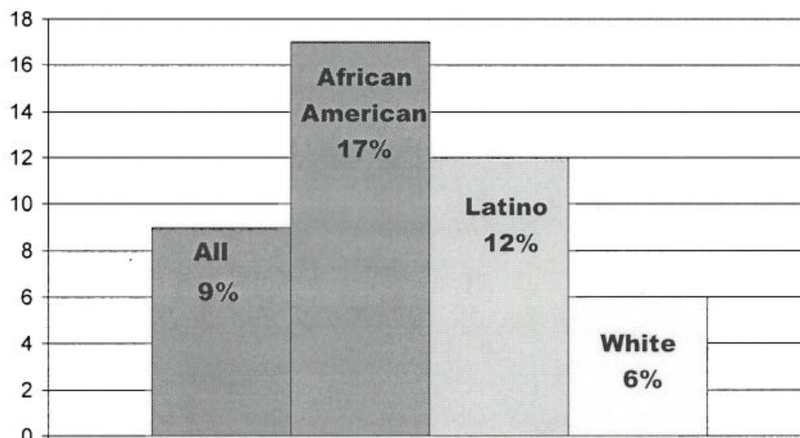
Percent of Low-income Women (<200%FPL) **Ages 18-64, Covered under Medicaid, By Race/Ethnicity, US, 2001**



Source: Kaiser Family Foundation. Kaiser Women's Health Survey, 2001.

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Did the characteristics of welfare-eligible pregnant women change from 1996 to 1999?

	1996 Pre-PRWORA	1999 Post-PRWORA
Eligibility characteristics		
Received some form of public aid	74%	58%
Reported some income from work	43%	57%
Had no medical risk	64%	60%
Insurance pre-pregnancy		
Private	15%	22%
Medicaid	53%	29%
Uninsured	32%	49%

Source: Adams EK, Gavin NI et al. Welfare Reform: Insurance Coverage and Use of Prenatal Care among Low-Income Women 1996 to 1999. RTI, 2004.

Special Eligibility and Enrollment Rules: Family planning waivers

- Family planning waivers in 22 states
  1. Intra-partum coverage built on post-partum 60 days
  2. Any woman losing Medicaid eligibility
  3. Any low-income women (and men)
- Coverage duration varies – average 2 years
- Large expansion
  - More than 1.4 million covered in California
  - Nearly one-half million in other states

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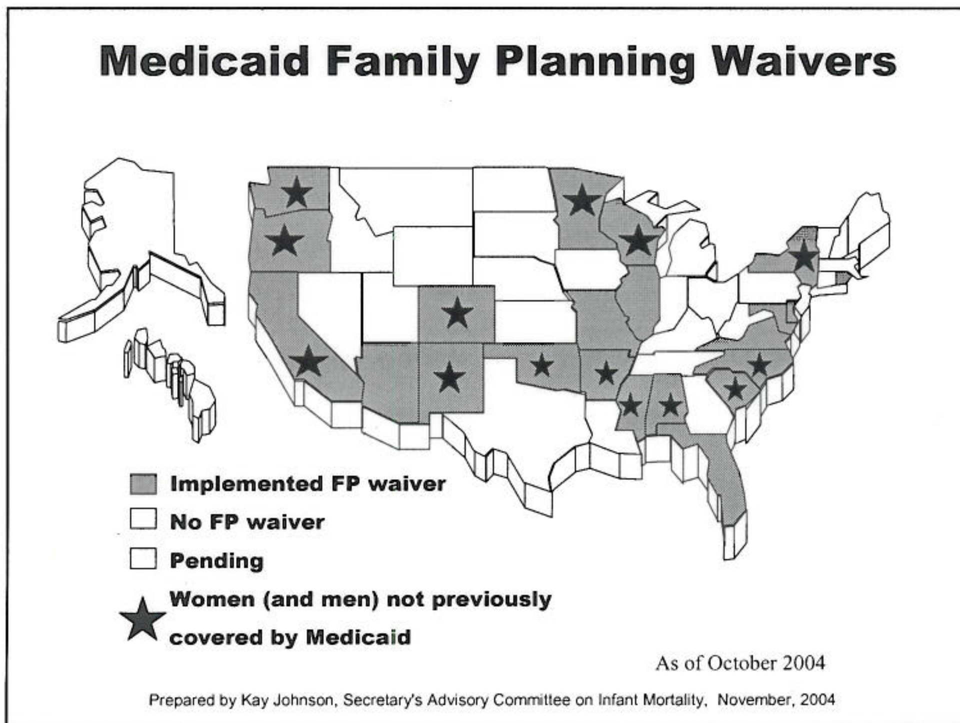
Medicaid Family Planning Waivers
Implemented FP waiver
No FP waiver
Pending
Women (and men) not previously covered by Medicaid
As of October 2004
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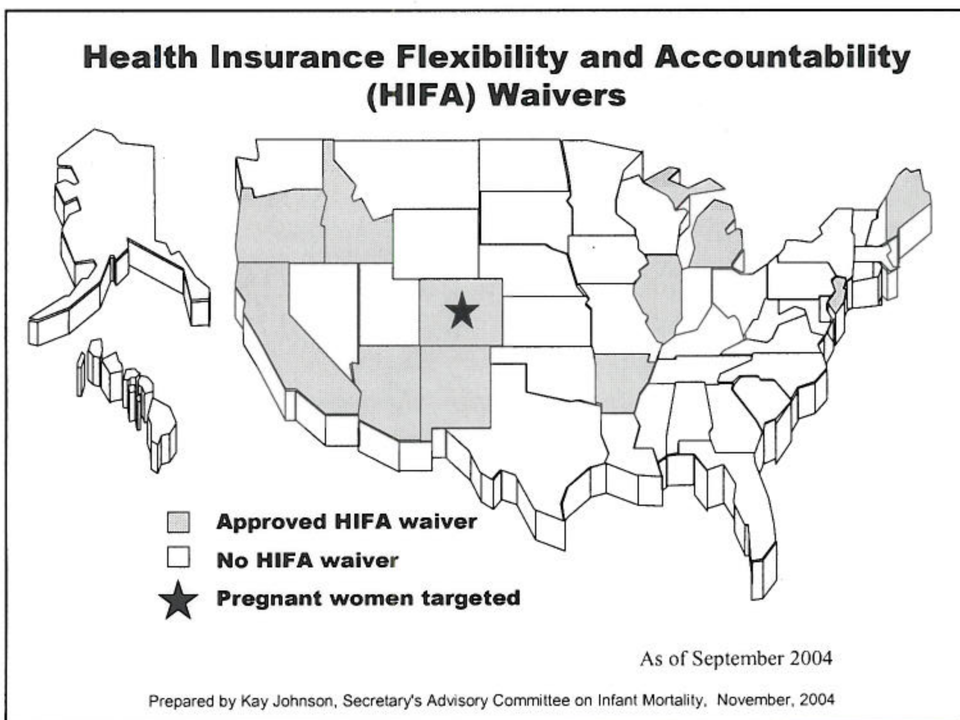
Health Insurance Flexibility and Accountability (HIFA) Waivers
Approved HIFA waiver
No HIFA waiver
Pregnant women targeted
As of September 2004
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Eligibility for Infants

- Infants are population group most likely to be eligible.
  - An estimated 36-40% of US births are Medicaid financed.
  - Since 1996, SCHIP covered additional infants and children.
    - 21 states adopted Medicaid (M) - SCHIP

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Special Enrollment Rules: Newborns and Other Infants

- Automatic newborn enrollment
  - Federal law requires that states have mechanisms for automatic enrollment.
- Continuous coverage "guaranteed" for infants through first year
  - Among those with birth financed by Medicaid most remain eligible throughout full 12 months.
  - **Most states' procedures need improvement.**

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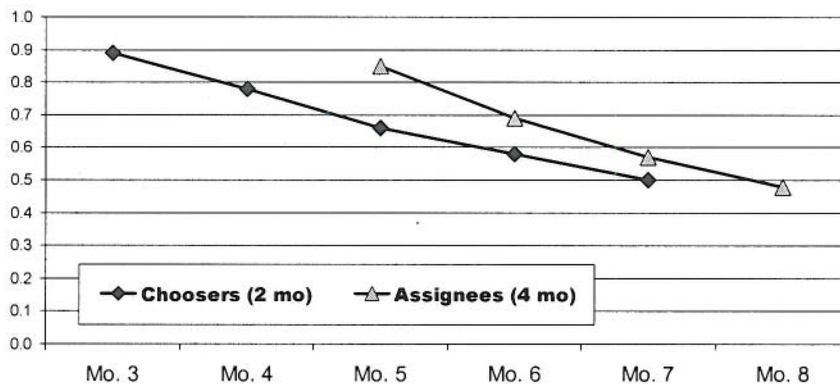
Infant Enrollment in Managed Care



Longer time to provider designation = lower odds of preventive care

- Likelihood of completing AAP 7 month recommended visit by age 12 months.
- Neither choosers in PCCM or assignees in HMO got timely care

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MEDICAID BENEFITS

What services are covered?
What benefits are available to infants under EPSDT?

EPSDT Framework

- Follow the letters:

Early - starting before problems worsen

Periodic - at regular intervals & as needed

Screening - comprehensive well child exams

with developmental, physical, and mental, plus separate vision, hearing, dental

Diagnosis - as appropriate

Treatment - all services (covered under federal law) needed for diagnosed conditions

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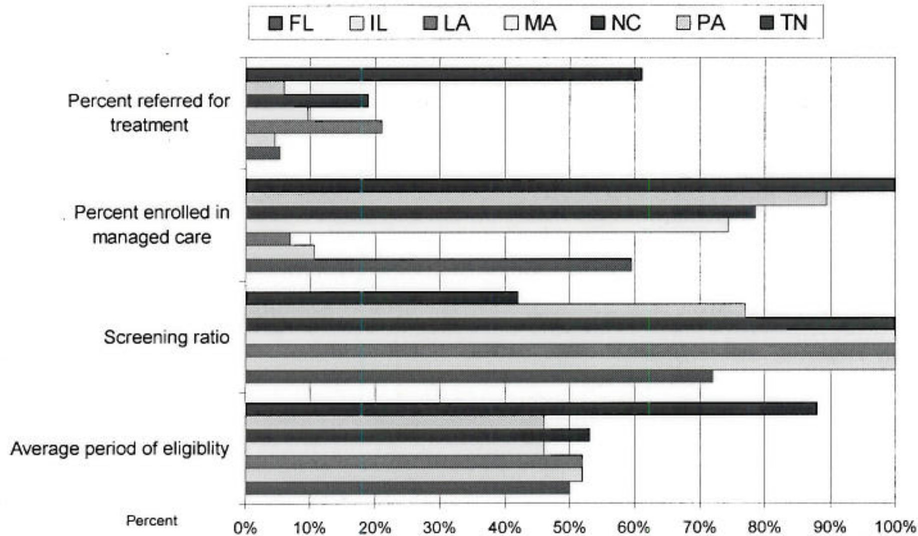

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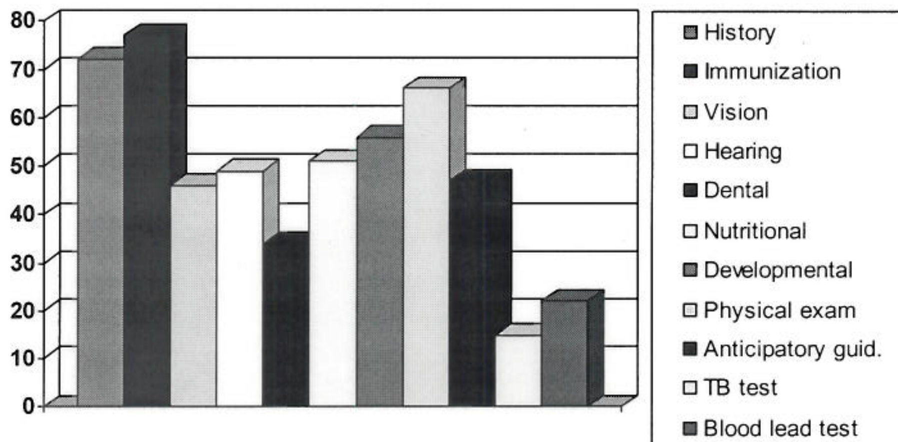
Michigan EPSDT Quality Study

Percentage of Michigan children enrolled in Medicaid managed care plans who received EPSDT, by service component and age. (Ages 0-6 years)



Source: Michigan Council on MCH. 2001

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EPSDT mandates more benefits

- Examples of services and items states have covered for infants and children, even if not included in state plan for adults
  - Case management for care coordination
  - Home visits/intensive home-based services
  - Prescriptions following newborn screening
  - Maternal-infant therapy in cases of abuse
  - High-risk newborn follow up
  - Physical therapy

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EPSDT "Medical Necessity"

"Medically necessary" services covered

- EPSDT definition is broader than most private insurance plans
- EPSDT purpose includes prevention & early intervention --
  - if service will prevention condition
  - if service will improve health or ameliorate condition
  - if service will cure or restore health

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MEDICAID PROVIDERS

Who can be a provider and bill for Medicaid services?

Medicaid Providers

- A provider may be an individual or be an institution or facility.
  - Facilities may be reimbursed cover time of staff team, including some individuals who would not qualify as providers otherwise.
    - Hospital - physicians, nurses, nurses aides
    - Federally qualified health center – outreach staff
    - Managed care plans - medical & administrative staff

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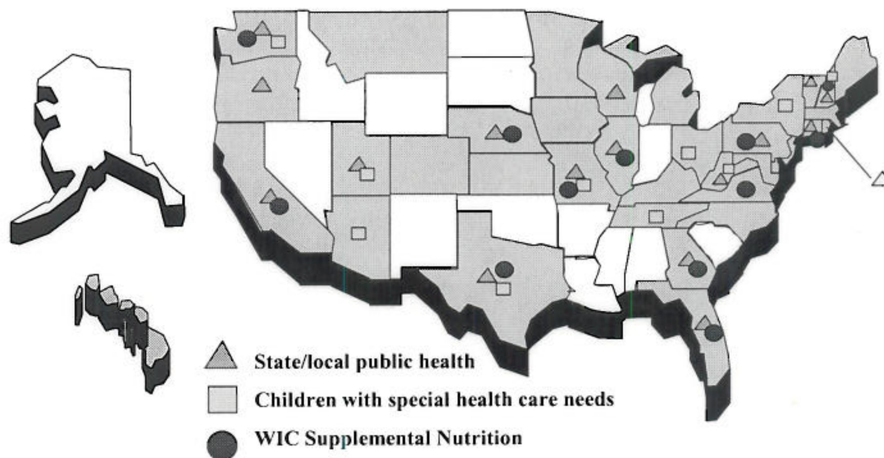
Relationships with Other Public Agencies



Source: Rosenbaum et. al. *Negotiating the New Health System*. George Washington University. 2002.

MEDICAID FINANCING

How are Medicaid services financed?

How do fee levels affect care?

Medicaid Provider Payments

- Provider fee levels set by each state.
  - Medicaid may pay fee-for-service or capitated.
  - Typically below commercial rates in either case.
  - Repeal of law requiring "adequate" rates for obstetric and pediatric care
- Trend in obstetric fees 1993-1998 (Urban Institute)
  - Overall 7.5 percent increase
  - Did not keep pace with inflation, real dollar terms
  - Variation $1,500 in Alaska to $296 in New Jersey

Impact of OB fee increases

- Debates about the impact of Medicaid fee increases on access to maternity care
  - Threshold effect
  - Managed care impact
  - Attitudes about race and class
  - Large liability context
- Study with NMIHS data
  - 10% increase resulted in 1% increase in early PNC
  - Some increases but lagging in real dollar terms

Source: Grey, Health Affairs, 2001

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MANAGED CARE

What is happening in Medicaid managed care?

Case Studies on the Impact of MMC on MCH Care in 8 Cities

- Mechanisms to improve maternal and infant health had to be redesigned by MCOs.
- Enrollment process a challenge
  - Identified by providers, plans, and families
  - Initial, transitions, birth/newborn, churning
- Former welfare recipients and working, two-parent families had very different views.

Source: Johnson and Rosenbaum. Starting Points, Carnegie Corporation, 2000

Study of the Impact of MMC on Maternal and Infant Outcomes

- Mixed evidence regarding effects of mandatory MCO enrollment on:
  - Timing of initiation of prenatal care timing and
  - Adequacy of prenatal care utilization
- Lower rates of repeat C-sections
  - Effects varied by county and state
- No evidence that mandatory MCO enrollment resulted in reductions in LBW rates.

Source: Kenney et al. Urban Institute. 2004

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MMC Improvement Projects

- Best Clinical and Admin Practices (BCAP)
  - MCO in ten states focused on improving birth outcomes for Medicaid beneficiaries
- Strategies and opportunities
  - Modify plan/provider processes (forms, etc.)
  - Provider incentives (bonuses, etc.)
  - Quality improvement projects (PDSA, HEDIS)
  - Outreach projects (home visiting, etc.)
  - Content of care projects
    - e.g., Folic acid, Smoking cessation, Risk assessment

Source: Center for Health Care Strategies. Toward Improving Birth Outcomes.

MMC - Performance Measures related to Maternal and Infant Health

HEDIS MEASURES

- Births and discharges,
- LOS for infants and women
- Postpartum services and enrollment
- Prenatal care rates
- Weeks gestation at time of plan enrollment

OTHER MEASURES

- Trimester pregnant woman identified
- Contact rate
- Risk assessment
- Postpartum checkups
- LBW rates
- Prenatal care visit average
- Gestational age at birth (average)

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MEASURING SUCCESS

What do we know about Medicaid's role in reducing infant mortality?

Does the literature support conclusion that expanding Medicaid for prenatal/maternity care coverage has had a positive impact?

- Goals of Medicaid expansions for pregnant women:
  - To reduce financial barriers to prenatal care for low-income women, thus improving pregnancy outcomes and reducing spending for high-risk newborn care.

  4 foci: 1) eligibility, 2) streamlined enrollment, 3) enhanced benefits, and 4) increased reimbursement.
- States with a multifaceted strategy to Medicaid prenatal expansions were more successful in **improving**:
  - Early, continuous prenatal care among low-income women, and
  - Outcomes of pregnancy among women with higher risk factors.

National study of the Impact of Medicaid Expansions on Prenatal Care and Birth Outcomes

- Medicaid expansions were associated with an increase in early initiation of prenatal care
- No evidence of significant, large-scale improvements in birth outcomes.
- Large remaining differences in prenatal care timing and LBW
  - Correlated with mother's race, educational attainment, and marital status. (Also probably income, if known.)

Investigators: Genevieve Kenney, Lisa Dubay, Embry Howell, and Anna Sommers
The Urban Institute; Theodore Joyce and Robert Kaestner, National Bureau of Economic Research.

Expansion in Rhode Island

- Multiple strategies
  - Increased eligibility levels
  - Streamlined enrollment process
  - Provided care coordination
  - Used public education / health promotion campaigns
  - Maximized managed care arrangements
  - Focused on provider participation and pay-for-performance
  - Expanded eligibility for family planning
- Results
  - Increased prenatal care utilization and initiation
  - Decreased infant mortality
  - Virtually eliminated gap in short inter-birth intervals

Source: JF Griffin, JW Hogan, JS Buechner and TM Leddy, "The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health*, 1999: 89.

Medicaid Prenatal Expansions

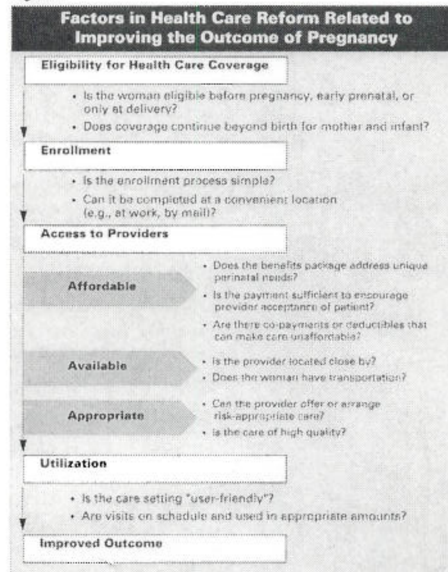
- One study of Massachusetts, including all Medicaid-eligible women (enrolled and not enrolled), concluded that state's Medicaid expansions for pregnant women did not improve birth outcomes.
  - Among pregnant women who did enroll in Medicaid for prenatal care, low birth weight and infant mortality rates were reduced.
    - Did not investigate why half of women did not enroll.
    - No data about the quality or quantity of prenatal care.

Source: Haas JS, Udavarhelyi IS, Norris CN, Epstein Am. The effect of providing health coverage to poor uninsured pregnant women in Massachusetts. *JAMA*. 1993;269:87-91.

Does the literature support conclusion that expanding Medicaid for prenatal/maternity care coverage has had a positive impact?

- Studies also suggest that barriers to care continued to limit the potential impact of Medicaid prenatal expansions.
  - Women who became eligible only after a confirmed pregnancy test experienced delays in enrollment and in linkage to their providers.
  - All areas did not assure access to providers who delivered appropriate and quality care.
  - Provider payments were not adequate in many states and the regulations requiring adequate reimbursement were repealed.
  - The content of prenatal care generally did not conform to recommendations (whether publicly or privately financed).
  - In managed care, few states continued to emphasize psychosocial interventions, effective care coordination, presumptive eligibility, and other approaches that had shown results.

It is critical that we monitor and study system dimensions & barriers - include the process, not just



Source: *Toward Improving the Outcome of Pregnancy: The 90s and beyond. 1993.*

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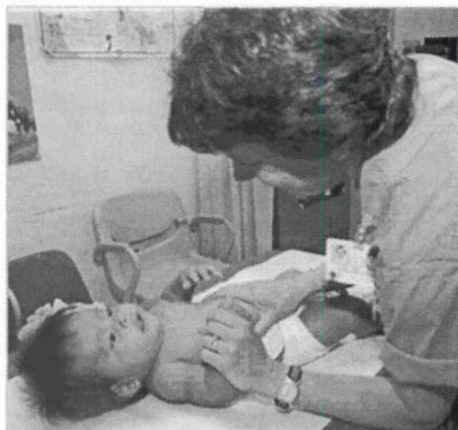

Despite many weaknesses,

the strength of Medicaid is that is provides a framework for improvement of financing, care, and outcomes for poor and underinsured women and infants.

Threats to Current Policy

- Arguments for Medicaid "block grant"
  - Kids are doing fine in SCHIP stand-alone plans
  - Medicaid prenatal expansions not effective
  - HIFA and similar waivers are working
  - Families should have more cost sharing
  - Runaway costs in Medicaid
- Ending family planning waivers
  - Temporary demonstration projects only
  - What evidence to support effectiveness?