STATE HEALTH POLICY

Briefing

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Through their Medicaid programs, states may offer specialized pregnancy benefits to women that target risks contributing to poor pregnancy outcomes. Though such benefits are categorized as "optional" Medicaid services, they are seen by many as critical to optimizing maternal health and positive birth outcomes. These enhanced pregnancy benefits support women in having healthy pregnancies and contribute to improved infant and maternal health.

Congress gave states the option to offer enhanced pregnancy benefits to pregnant women on Medicaid in 1985, and many states quickly took advantage of this opportunity, adding comprehensive non-clinical and medical pregnancy services to their Medicaid benefit packages. The use of enhanced pregnancy benefits peaked in 1993 when forty-four states provided at least one enhanced pregnancy benefit through Medicaid. Since then, the number of states offering Medicaid enhanced pregnancy benefits appears to have dipped and then rebounded nearly to 1993 levels.

NATIONAL ACADEMY for STATE HEALTH POLICY

Enhanced Pregnancy Benefit Packages: Worth Another Look

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Recognizing the value of non-medical, psychosocial support services in promoting prenatal care, Congress, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, gave states the option to provide "enhanced pregnancy benefits" to pregnant women on Medicaid without also offering the same additional benefits to all Medicaid recipients. These enhanced pregnancy benefits support women to have healthy pregnancies and contribute to improved infant and maternal health. Many states quickly took advantage of this opportunity, and, as of July 1990, thirty-five states had implemented programs covering comprehensive non-clinical and medical pregnancy benefits.[1] The use of enhanced pregnancy benefits peaked in 1993 when forty-four states provided at least one enhanced pregnancy benefit through Medicaid.[2] Since then, the number of states offering Medicaid enhanced pregnancy benefits appears to have dipped and then rebounded nearly to 1993 levels.

In the last decade, the task of providing prenatal benefits to disadvantaged expectant mothers has grown more complex. More states now rely on managed care organizations to serve Medicaid beneficiaries, and new federal programs have diversified funding for prenatal benefits. In 2003, approximately 1.7 million births, or 41 percent of all U.S. births, were financed by Medicaid.[3] Such volume represents great potential to improve the health of mothers and infants by

offering enhanced pregnancy benefits to a larger population through Medicaid and other programs.

Though less prominent in current policy discussions, the benefits of appropriate prenatal care—including improved health outcomes and, in some cases, cost-savings to states—should not be overlooked. This Briefing examines the significant role enhanced pregnancy benefits play in achieving good health outcomes for mothers and infants, and provides an update on the number of states using specific enhanced pregnancy benefits to assist pregnant women on Medicaid. Though most states continue to offer these services, it is vital that the importance of prenatal health is not forgotten in this time of tightening state budgets.

Surveys Documenting Enhanced Pregnancy Benefits in Medicaid Programs

From 1990 - 1994, the National Governors Association (NGA) tracked the use of enhanced pregnancy benefits by state Medicaid programs.[i] These surveys reported on six enhanced pregnancy benefits: prenatal risk assessment, targeted case management, home visiting, psychosocial counseling, health education, and nutritional counseling. The NGA's 1993 survey found that forty-one states offered at least three enhanced pregnancy benefits, and thirty-six states offered at least five services, the apparent high-water mark in the number of states offering these services to pregnant women on Medicaid.[4] When NGA repeated the survey in1994, they found that the fewer states were offering enhanced pregnancy benefits in their Medicaid programs. In 1994, thirty-seven states offered at least three enhanced pregnancy benefits and only twenty-nine states offered at least five services.[5] After 1994, no further comprehensive surveys of state Medicaid programs' enhanced pregnancy benefits were published for nearly a decade.

The Current Status of Enhanced Pregnancy Benefits

In 2007, the March of Dimes contracted with the Urban Institute and NASHP to assess the current "state of the art" of state Medicaid program efforts to enroll and provide services to pregnant women. As part of this work, the Urban Institute and NASHP conducted a new survey of states' enhanced pregnancy benefits.[6] In addition to the six benefits included in the original surveys, the Urban Institute/NASHP survey sought information regarding three additional enhanced pregnancy benefits: smoking cessation, substance abuse treatment, and dental care.

An analysis of the survey data found that the number of states offering enhanced pregnancy benefits through

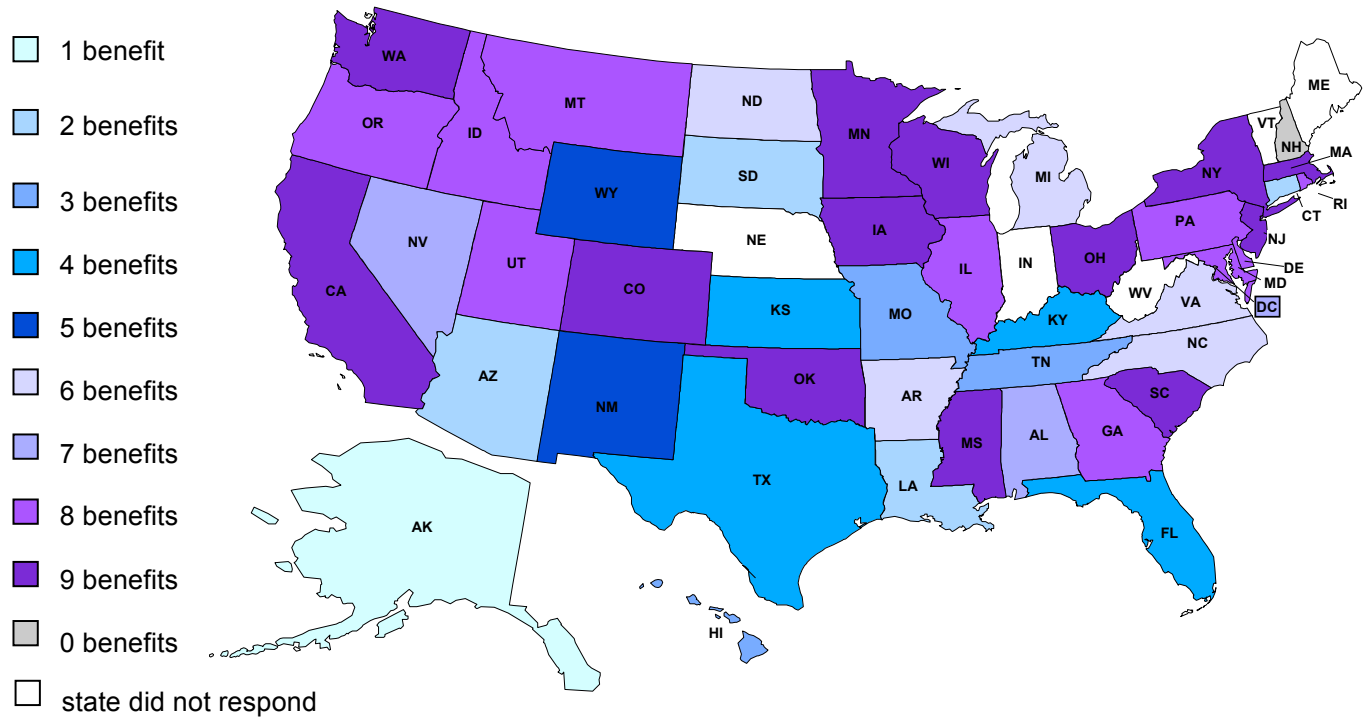
Table 1: Medicaid Enhanced Pregnancy Benefits

(-) indicates benefit not surveyed	Number of States Offering Each Benefit					
Enhanced Pregnancy Benefit	**1990**	**1991**	**1992**	**1993**	**1994**	**2007**
Prenatal risk assessment	27	33	39	43	39	37
Smoking cessation	-	-	-	-	-	32
Substance abuse treatment	-	-	-	-	-	32
Targeted case management	28	33	39	42	39	33
Home visiting	23	27	33	37	34	32
Psychosocial counseling	18	19	25	33	25	32
Health education	21	26	32	37	33	31
Nutritional counseling	22	25	31	36	32	31
Dental care	-	-	-	-	-	26

Data from 1990-1994 from the National Governors Association *MCH Update*.
Data from 2007 from the Urban Institute/NASHP survey.

[i] In 1992, a survey conducted for the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) by Health Systems Research, Inc. also documented states' rapid adoption of enhanced pregnancy benefits since they were added as a state option by Congress in the mid-1980s. (Hill, Ian T. *The Medicaid Expansions for Pregnant Women and Children: A State Program Characteristics Information Base*. Prepared for Office of Research, Health Care Financing Administration, U.S. Department of Health and Human Services. Washington: Health Systems Research, Inc., 1992.)

Figure 1: Number of Enhanced Pregnancy Benefits Offered in Each State, 2007



Medicaid has rebounded to levels close to the high-water mark of 1993. In 2007, forty-five states reported offering at least one enhanced pregnancy benefit. Thirty-eight states offered at least three benefits, and thirty-one of these offered at least six benefits.[ii] However, several states offered enhanced pregnancy benefits to narrow categories of pregnant women or offered them only in certain circumstances, such as only to women deemed to be "high risk."[iii] This may reflect a shift in emphasis away from providing care to pregnant women and towards the enrollment of vulnerable children, as well as changes accompanying the growth of Medicaid managed care.

Evidence for the Effectiveness of Enhanced Pregnancy Benefits

The following sections: (a) describe each enhanced pregnancy benefit included in the 2007 survey, (b) review evidence of each benefit's effectiveness at improving birth outcomes, and (c) provide an update on how many states currently offer that benefit.

Prenatal Risk Assessment

A prenatal risk assessment is used to identify medical and psychosocial factors that may put either the mother or the fetus, or both, at risk.[7] The prenatal risk assessment is often considered an integral part of care coordination and case management because it provides the mechanism by which states target high-risk mothers to receive additional services. Prenatal risk assessments are most effective when instituted in the first or second trimesters of pregnancy, which allows them to be better coupled with other enhanced benefits.

The number of states reporting they cover prenatal risk assessments for pregnant women on Medicaid decreased between 1993 and 2007. In 1993, 43 states reported offering prenatal risk assessments to expectant Medicaid mothers. In 2007, the number was 37. Additional states may conduct prenatal risk assessments as part of their targeted case management or home visit benefits instead of as a stand-alone benefit.

[ii] These figures reflect the number of enhanced pregnancy benefits offered out of nine benefits included in the survey.

[iii] For example, Arizona and Tennessee offer case management to women determined to be at high risk; Montana offers home visiting when medically necessary; and Missouri provides limited coverage of dental care and substance abuse treatment.

Smoking Cessation Programs[iv]

Smoking cessation programs are critical to addressing the substantial threat that maternal smoking poses to infant health. The Centers for Disease Control and Prevention has called smoking during pregnancy "the single most preventable cause of illness and death among mothers and infants."[8] Nationally, one third of Medicaid beneficiaries are smokers.[9] Smoking has been linked to increased risk for a host of adverse birth outcomes, including pre-term delivery, low birth weight, and perinatal mortality. Research favors beginning smoking cessation programs before pregnancy, but there is little consensus on the relative effectiveness of various smoking cessation treatments during pregnancy. Counseling-based smoking cessation treatments are less risky to a developing fetus and can be inexpensively supplemented with self-help materials.[10] These interventions reduce smoking rates by about six percent.[11] While several recent studies warn about the effects of nicotine replacement therapy during pregnancy, others suggest that the benefits of reducing maternal smoking may outweigh the risks of such interventions.[12,13,14,15]

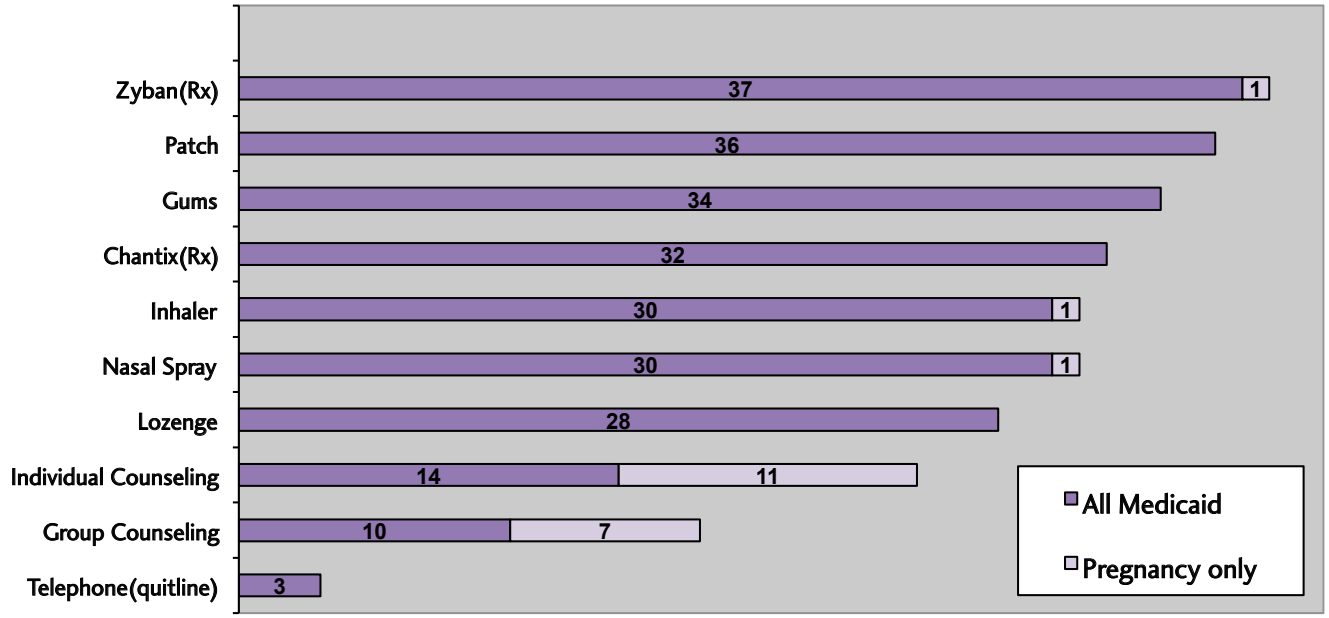
Smoking cessation is one of the more widely available benefits offered to women in Medicaid. In 2007, 32 states reported offering a smoking cessation benefit to pregnant women on Medicaid. However, additional states may offer smoking cessation as a benefit to all Medicaid beneficiaries, rather than just as an enhanced benefit for pregnant women. In a 2006 survey, 43 states reported covering smoking cessation benefits in their Medicaid programs.[16]

A state's Medicaid smoking cessation benefit may cover medication, counseling, or both. Smoking cessation nicotine replacement therapies provided by states vary widely and include gums, patches, nasal sprays, inhalers, lozenges, and oral medications. Counseling may be available in a group or individual setting or through a telephone "quit-line," and is the treatment most likely to be made available only to pregnant women by state Medicaid programs.

Substance Abuse Treatment[v]

Drug and alcohol abuse by an expectant mother poses a very serious risk to the health of the infant. Recreational drug and/or alcohol use during pregnancy not only increase the risk of birth defects, but may also hinder a child's psychological and behavioral development.[17] Despite these risks, some pregnant women continue to engage in these behaviors. National surveys estimate that approximately ten percent of pregnant women drink alco-

Figure 2: Numbers of State Medicaid Programs offering Particular Tobacco-Dependence Treatments, 2006



[iv] Neither the 1992 HCFA-funded survey nor the NGA surveys requested information regarding smoking cessation benefits.
[v] Neither the 1992 HCFA-funded survey nor the NGA surveys requested information regarding substance abuse treatment benefits.

hol, 2 percent engage in binge drinking (five or more drinks on one occasion) and 6 percent use an illicit drug.[18, 19]

As with many enhanced pregnancy benefits, substance abuse treatment appears to be more effective when provided in conjunction with other benefits. Studies have shown that integrating substance abuse treatment with patients' prenatal visits improves maternal and newborn health outcomes.[20, 21] Substance abuse treatment incorporated into an intensive case management program has also been shown to reduce substance abuse rates among low-income women.[22]

The number of state Medicaid programs offering a substance abuse treatment benefit to pregnant women does not appear consistent with the immediacy of dangers posed by substance use during pregnancy. In the 2007 Urban Institute/NASHP survey, 32 states reported offering some form of substance abuse treatment for Medicaid enrollee prospective mothers. Taking risks into account, more states should consider covering this benefit among pregnant women on Medicaid.

Targeted Case Management

Targeted case management (also referred to in some settings as care coordination) is the keystone of many states' enhanced prenatal benefits programs. Case management and care coordination services typically involve four central functions:

- determining a client's needs by assessing risk factors,
- developing a plan of care to address those needs,
- coordinating referrals to appropriate service providers,
- ensuring the client receives services.[23]

Case management is especially critical to the health of expecting mothers with chronic health problems, such as diabetes, obesity, and hypertension, which are conditions more likely to occur among low-income individuals. Poor diabetes management during pregnancy can cause serious complications for the mother during delivery and raise the risk of birth defects and other problems for the infant. Maternal obesity has been linked with a significantly increased risk of maternal and infant mortality. Hypertension can be pre-existing or develop during pregnancy, but both forms can cause low birth-weight and premature delivery, as well as damage the mother's kidneys and raise her risk of developing preeclampsia, a condition that can lead to fatal complications for mother or baby.

The number of states offering targeted case management or care coordination as an enhanced pregnancy benefit has decreased since 1993. In 1993, 42 states reported offering the benefit. In 2007, that number had dropped to 33. A large number of the states offering this benefit provide it only to those women deemed "at-risk," which generally means women who have exhibited certain risk factors for an adverse pregnancy outcome during a prenatal risk assessment. Some states that use Medicaid managed care to serve pregnant women 'carve out' the targeted case management benefit from the services covered by the managed care organization, providing case management through other means.

Home Visits

Home visits are viewed by many states as a way to focus delivery and increase effectiveness of the provision of additional benefits. In other words, home visiting is viewed not simply as an intervention in and of itself, but as a delivery system for other interventions.[24] Visiting clients' homes to deliver services ensures that beneficiaries receive services on schedule and remain connected to their prenatal care programs. The visits also provide a picture of the client's home environment and any risk factors therein. These qualities make home visiting an optimal delivery system for mothers exhibiting numerous adverse pregnancy risk factors.

Home visit programs vary widely from state to state in both scope and intensity. They may be conducted by registered nurses, paraprofessionals, or volunteers. They may end at delivery or continue postpartum. Some programs are

The *Nurse-Family Partnership* program is one example of what is possible through a well-designed and highly structured home visit program. Registered nurses visit mothers periodically from the second trimester of pregnancy until the child reaches two years of age. The visits cover a wide variety of topics, including parenting skills, personal health, risk assessment, case management, environmental health, and maintaining a social support network. Positive outcomes of the program include decreases in substance abuse, reduced child abuse and neglect, lower smoking rates in mothers, and improved birth outcomes. Colorado, Oklahoma, Louisiana, and Pennsylvania have implemented the Nurse-Family Partnership statewide, funding it through a variety of sources, including Medicaid.

Nurse Family Partnership www.nursefamilypartnership.org accessed 10/15/2009.

restricted to first-time mothers while others are open to all mothers deemed at-risk. In some states, pregnant women on Medicaid must request to participate while in others, predetermined criteria are used to select participants. The broad variability of home visiting programs makes evaluation difficult, but a growing number of studies have concluded that nurse home visiting programs in particular are both effective and cost-effective.[25, 26]

Despite building evidence of cost-effectiveness, there has been a noticeable decrease in the number of states offering home visits as an enhanced pregnancy benefit through Medicaid since 1993. Then, 37 states reported offering a home visits benefit. In 2007, only 32 states reported offering a home visits benefit. Because some states use braided funding streams that weave together Medicaid funds with other sources of financial support or funding sources entirely independent of Medicaid to support home visit programs, the reported decrease may be a result of states funding home visits through programs other than Medicaid. States may also be providing home visits as part of another benefit category, such as Louisiana using a home visit model for its targeted case management benefit.

Psychosocial Counseling

Psychosocial counseling is a way for states to address non-medical determinants of maternal and infant health—such as inadequate income, unsafe housing, and insufficient nutrition—as well as maternal mental health or substance abuse issues. Most states provide this benefit through one-on-one counseling in a variety of settings, including through a telephone hotline, during home visits, or at office check-ups.

The number of states making psychosocial counseling available to pregnant women on Medicaid has remained relatively unchanged since 1993. In 1993, 33 states reported offering such a benefit to prospective Medicaid mothers; in 2007, 32 states reported offering it. Additional states may be offering psychosocial counseling as a component of other enhanced pregnancy benefits, such as home visiting or targeted case management.

Health Education

Health education provides new and expectant mothers with critical information to ensure a healthy pregnancy and infant. Though aspects of health education may overlap with other enhanced pregnancy benefits, it generally involves either group or individual guidance on subjects such as the physiology of pregnancy, healthful behaviors during pregnancy, pregnancy risk signs, dangers of smoking and drug use, stress management, family planning, labor and delivery, basic infant care, and parenting.

Health education has been recognized as a way to increase expectant mothers' appropriate utilization of health services. In particular, educating expectant mothers on when, why, and how to seek health services may increase the appropriate use of prenatal services among pregnant women on Medicaid.[27] Emphasizing health education as part of a prenatal benefits package may also significantly increase expectant Medicaid mothers' knowledge of pregnancy risk factors, satisfaction with the care they receive, smoking cessation rates, and time spent with their providers.[28, 29, 30]

In 1993, 37 states offered health education as an enhanced pregnancy benefit. In 2007, 31 states reported making a health education benefit available to pregnant women on Medicaid.

Nutritional Counseling

Proper nutrition during pregnancy is a proven way to improve birth outcomes. For example, numerous studies have confirmed the importance of folic acid in preventing neural tube defects in newborns.[31] Research suggests that most low-income women fail to meet the nutritional requirements of pregnancy, which may contribute to an increased risk of having a low birth weight infant.[32] Studies also suggest that maternal obesity significantly increases the chance of complications during birth and of numerous birth defects. In an effort to address these health concerns, states' nutritional counseling protocols generally instruct clients on the relationship between proper nutrition and health, special dietary needs during pregnancy, and understanding weight gain and exercise. Some programs also address infant nutrition, including how to both breast and bottle feed an infant.

The Urban Institute/NASHP 2007 survey showed a marked drop in the number of states offering a stand-alone nutritional counseling benefit. In 2007, 31 states reported offering nutritional counseling to pregnant women on Medicaid, compared to 36 states in 1993.

Dental Care[vi]

The services covered under adult Medicaid dental benefits vary widely among the states. Some states cover only emergency dental services while other states also cover routine dental exams, fluoride application, dental cleanings, crowns, fillings, root canals, and periodontal surgery. Emerging evidence suggests that periodontal disease may be a risk factor for a host of adverse maternal and child health outcomes. Periodontal treatment is safe in pregnant women and may reduce the risk of preterm birth, low birth-weight infants, and small-for-gestational-age infants.[33]

In 2007, only 26 states reported that they offer dental care services to pregnant women on Medicaid. However, coverage of dental care for adult Medicaid beneficiaries, including pregnant women, may be increasing. A more recent NASHP survey reported that as of early 2008, 33 states provide dental benefits beyond emergency services to pregnant women on Medicaid. This survey also reported that 25 states provide coverage to expectant Medicaid mothers for periodontal services.[34]

Advantages of Providing Enhanced Pregnancy Benefits

The health and cost benefits of proper prenatal care are widely documented. Studies assessing statewide Medicaid enhanced pregnancy benefits programs have shown disparate but positive effects on birth outcomes. The findings of such studies include the following: improvement in infant mortality and low birth weight rates statewide, for women on cash assistance only, for African American women only, or no impact on low-birth weight rates.[35, 36, 37, 38] The enhanced pregnancy benefits programs in the above studies differed widely in content and implementation. Additional evaluations of such programs are needed to adequately assess statewide program effectiveness. Nevertheless, an abundance of literature describes the success of enhanced pregnancy benefits in improving the health of women and children.

The cost of caring for low birth-weight infants alone can be a significant expense to state Medicaid programs. Hospital delivery costs for low birth-weight infants average approximately $15,000, compared to only $600 for normal-weight infants.[39] Proper prenatal care can help to reduce low birth-weight births, helping to improve infant health and thereby lowering state Medicaid expenditures.[40]

Below are three examples of state enhanced pregnancy benefit programs demonstrating positive health results for women and infants. Some of these programs also explicitly document cost-savings to the state.

Louisiana

The *Nurse Family Partnership Program for First Time Parents* in Louisiana follows the home visiting model of targeted case management. First time mothers with an income below 200 percent of the federal poverty level may opt into the program. The *Partnership* serves beneficiaries through teams of public health nurses located throughout Louisiana.[41] It uses MCH Block Grant funds to start new sites and operate them for their first few years. The *Partnership* then uses a 'braided funding source' that combines funds from Medicaid targeted case management reimbursements, the state's MCH Block Grant, Temporary Assistance for Needy Families (TANF), private foundations, state funds, and local funds to continue and expand services. Provider reimbursements for services rendered through the *Partnership* are made independently from the state's Medicaid program. Researchers estimate the *Partnership* has resulted in a 52 percent reduction in premature births, 50 percent reduction in emergency room visits by the time a child is 15 months old, 33 percent reduction in pregnancies by 14 months postpartum, and 43 percent reduction in prenatal depression.[42]

Wisconsin

Wisconsin's *First Breath* program is an effective and cost-effective smoking cessation program. The *First Breath* program provides counseling-based smoking cessation services to low-income pregnant smokers statewide. *First Breath* is funded through a series of public and private grants. An estimated 90 percent of *First Breath* enrollees are Medicaid recipients. An analysis of the program showed average savings to Medicaid of $1,274 per woman who quit smoking and a return on investment of $9 for every $1 invested.[43] The prenatal quit rate for enrollees in 2007 was 35.4 percent, and 30 percent of those who did not quit were able to reduce their smoking.[44]

[vi] Neither the 1992 HCFA-funded survey nor the NGA surveys requested information regarding dental services.

Oregon

Oregon's *Early Childhood Cavities Prevention* is an innovative pilot program that treats dental disease in pregnant women and new mothers to reduce transmission of disease to children. Mothers are recruited for participation by a county-funded program coordinator who is stationed at the Klamath County Women, Infants, and Children (WIC) agency. Women are initially provided with educational materials, a toothbrush, toothpaste, and dental floss. Dental hygiene students at a local college then make home visits to the women and schedule them for clinic visits, where open cavities and severely decayed teeth are treated. These clinic visits are paid for with Medicaid funding. Preliminary data shows pregnant women in the pilot county accessing dental services at higher rates (47% vs. 9%) than other pregnant women on Medicaid statewide.[45]

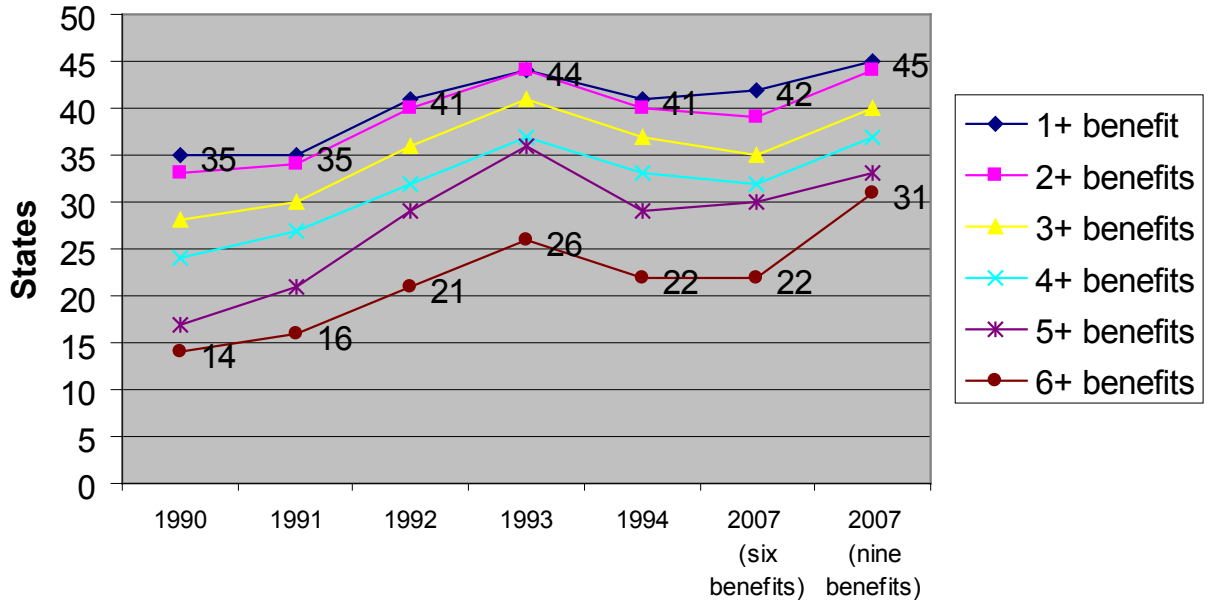
Additional Funding Opportunities for Enhanced Pregnancy Benefits

In addition to enhanced pregnancy benefits offered through Medicaid programs, some states offer similar benefits through other state and federal programs. Healthy Start grants and other Title V Maternal and Child Health (MCH) Services Block Grant funds have been the two primary federal funding alternatives to Medicaid.[vii]

Both MCH block grants and the Healthy Start program offer states greater flexibility to determine eligible populations and benefits provided than does the Medicaid program. These programs generally target pregnant women who are deemed at-risk. However, because of their small size relative to Medicaid, these two programs are not currently viable alternatives for states to provide the amount of enhanced pregnancy-related benefits that they can through Medicaid. They are more suitable for filling service gaps in state Medicaid enhanced benefit programs than supplanting them entirely. To further this goal, the federal government requires coordination among these programs.

The $87 billion temporary increase in the federal medical assistance percentage (FMAP) for Medicaid, which was signed into law in early 2009 as part of the American Recovery and Reinvestment Act (ARRA), provides states with additional federal funds for Medicaid. Through the ARRA, states receive a 6.2 percent increase in their FMAP rate from October 2008 through December 2010 with the possibility of a further 5.5 percent, 8.5 percent, or 11.5 percent increase for those states experiencing a significant rise in

Figure 3: States Offering Enhanced Pregnancy Benefits



[vii] The Healthy Start program provides grantees with funds to improve maternal and infant health in at-risk communities. The Title V MCH block grant program provides federal money to states to alleviate barriers to heath care and improve health outcomes for women, children, and families.

unemployment. The increased FMAP rates may provide an added incentive for states with below average birth outcomes to strengthen their Medicaid enhanced pregnancy benefits packages. States providing prenatal care through programs other than Medicaid may also want to consider strengthening their Medicaid enhanced pregnancy benefits packages in light of the increased FMAP rates.

Finally, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) may make it easier for states to offer enhanced pregnancy benefits to women above the Medicaid income eligibility ceiling. CHIPRA provides states with the option to cover targeted low-income pregnant women under the Children's Health Insurance Program (CHIP) through a state plan amendment, a waiver, or an "unborn children" option. Though CMS has not yet determined which pregnancy benefits may be covered by states through this option, it appears that many and possibly all of the enhanced pregnancy benefits discussed here may be covered by states through CHIP.

Conclusion

Through their Medicaid programs, states may offer specialized pregnancy benefits that target risks contributing to poor pregnancy outcomes. Though such benefits are categorized as "optional" Medicaid services, they are seen by many as critical to optimizing maternal health and positive birth outcomes. These enhanced pregnancy benefits help women have healthy pregnancies and contribute to improved infant and maternal health.

Academic literature points to improved health outcomes for mothers and children when pregnant women receive these enhanced pregnancy benefits, and the number of states offering such benefits through their Medicaid programs—after dropping in the last decade—appears to have rebounded nearly to the levels of the early 1990's. While a majority of states do offer enhanced pregnancy benefits in their Medicaid programs, other states may wish to look again at the opportunities to improve health outcomes that these benefits can provide. The current FMAP increase, CHIPRA-authorized service expansions, and federal grant programs such as the Title V MCH block grant and Healthy Start provide states with an opportunity to improve maternal and infant birth outcomes using federal financial contributions. Improved birth outcomes save health care resources and protect children at the most vulnerable point of their lives. It is vital that the importance of prenatal health is not forgotten in this time of tightening state budgets.

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