

Opportunities to Optimize Access to Prenatal Care through Health Transformation

Introduction

Although many factors influence birth and health outcomes for mothers and infants, access to timely, quality, affordable and adequate health care coverage during pregnancy ranks high among them. Despite the need for access to health care, one in six women of reproductive age is uninsured.¹ Moreover, among women with incomes below the Federal Poverty Level (FPL), one in four lack health insurance.²

Prenatal care, which is a national priority addressed in the Healthy People 2020 and other major health policy initiatives, is predicated on access to coverage for women of reproductive age. Healthy People 2020 objectives related to pregnancy include increasing the proportion of pregnant women who receive prenatal care beginning in their first trimester and increasing the proportion of pregnant women who receive early and adequate prenatal care.³ According to Healthy People 2020 baseline data, about 70 percent of women received early and adequate prenatal care starting in their first trimester.⁴ This indicates that there remain barriers to accessing timely prenatal care.

Prenatal care is critical to reducing the risk of pregnancy-related complications for mother and infant. Access to health care coverage and subsequent utilization of prenatal care allows health care practitioners to monitor the health of mothers and infants and detect and treat certain medical conditions, such as gestational diabetes and preeclampsia, in a timely manner. Women who do not receive prenatal care are also three to four times more likely to die from pregnancy-related complications than those who do receive care. The likelihood is even higher for women with high-risk pregnancies.⁵ Infants born to mothers who do not receive prenatal care are three times more likely to have a low birth weight (<2500g) and five times more likely to die in infancy than those born to mothers who receive care.⁶ Low birth weight in infants can contribute to additional complications including respiratory problems, increased risk of sudden infant death syndrome (SIDS) and gastrointestinal problems.⁷ In addition, lack of prenatal care can put women at risk for preterm birth. Preterm infants are at higher risk of death; those who survive may suffer from health complications throughout their lives.⁸

Pregnancy Coverage in an Era of Health Reform

Prior to passage of the Patient Protection and Affordable Care Act (ACA), women faced barriers to acquiring coverage. Insurance companies could deny coverage due to pregnancy status, which was legally considered a pre-existing condition. In addition, maternity care was often not included as a benefit in health care plans.⁹ Women could be charged higher premiums based solely on gender or on their pregnancy status. This situation left many women without affordable or adequate coverage.



Since the ACA became law, many issues tied to coverage and access have been addressed. The ACA eliminated discrimination or denial of coverage based on gender or pre-existing conditions, including pregnancy¹⁰ This protection is critical to improving access and affordability of health care for all women in their reproductive years before and during pregnancy.

Qualified health plans (QHPs) inside and outside the Health Insurance Marketplace (Marketplace) are now required to include maternity and newborn care as one of 10 essential health benefit (EHB) categories.¹¹ QHPs are required to cover health care services before and after the birth of a child, as well as labor and delivery. The other categories of EHBs include ambulatory patient services (outpatient care); emergency services; hospitalization; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive services and chronic disease management; and pediatric services, including oral and vision care. Thus, the EHB package offers women coverage for critical health services not only during their reproductive years but throughout the course of their lives. Additionally, the ACA requires individual health plans sold in and outside of the Marketplace to offer preventive health services without cost-sharing. Table 1 lists covered services for pregnant women or women who may become pregnant.

Table 1: Covered Services for Pregnant Women or Women Who May Become Pregnant

For pregnant women or women who may become pregnant:	For women overall:
<ul style="list-style-type: none"> Anemia screening 	<ul style="list-style-type: none"> Breast cancer genetic test counseling (for women at high risk)
<ul style="list-style-type: none"> Breastfeeding support and counseling 	<ul style="list-style-type: none"> Breast cancer mammography screenings (every one to two years after age 40)
<ul style="list-style-type: none"> FDA-approved contraceptive methods 	<ul style="list-style-type: none"> Breast cancer chemoprevention counseling (for women at high risk)
<ul style="list-style-type: none"> Folic acid supplements (for women who may become pregnant) 	<ul style="list-style-type: none"> Cervical cancer screening (for sexually active women)
<ul style="list-style-type: none"> Gestational diabetes screening (for women 24-28 weeks pregnant or those at high risk) 	<ul style="list-style-type: none"> Chlamydia infection screening (for younger women and other women at high risk)
<ul style="list-style-type: none"> Gonorrhea screening (for women at high risk) 	<ul style="list-style-type: none"> Domestic and interpersonal violence screening and counseling (for all women)
<ul style="list-style-type: none"> Hepatitis B screening (for pregnant women at first prenatal visit) 	<ul style="list-style-type: none"> Gonorrhea screening (for women at high risk)
<ul style="list-style-type: none"> Rh incompatibility screening (for all pregnant women and follow-up testing for women at high risk regardless of pregnancy status) 	<ul style="list-style-type: none"> Human Papillomavirus (HPV) DNA test (every three years for women 30 or older)
<ul style="list-style-type: none"> Syphilis screening (for pregnant women and women at increased risk regardless of pregnancy status) 	<ul style="list-style-type: none"> Sexually transmitted infections counseling (for sexually active women)
<ul style="list-style-type: none"> Tobacco intervention and counseling (for pregnant tobacco users) 	<ul style="list-style-type: none"> Tobacco use screening and interventions
<ul style="list-style-type: none"> Urinary tract or other infection screening 	<ul style="list-style-type: none"> Well-woman visit

Source and for more information: <https://www.healthcare.gov/preventive-care-women/>

Coverage Options for Pregnant Women

By expanding coverage and lowering cost barriers, the ACA has created pathways for women to receive prenatal care and services at little or no cost to them. However, gaps remain in this complex system. To address these gaps, a patchwork of coverage options is available for pregnant women through public, private and safety net programs. These programs are described below.

Medicaid

Historically, Medicaid has been instrumental in providing coverage to low-income women, especially pregnant women. Medicaid is administered by states and funded jointly by states and the federal government.¹² Federal law dictates minimum standards and eligible populations, but states have the option to expand coverage to more populations and at more generous eligibility levels.

Traditional Medicaid: Several population groups fall into mandatory eligibility categories for Medicaid, including low-income pregnant women, low-income infants and children and individuals with disabilities.¹³ In providing Medicaid coverage to pregnant women, states must comply with federal guidelines that specify services that must be offered to pregnant women, including tobacco cessation, nurse midwife services and inpatient and outpatient hospital services.¹⁴ The type, amount, duration and scope of these services are determined by the states but must comply with federal guidelines.¹⁵

Medicaid Expansion: The ACA sought to expand Medicaid to cover all individuals under age 65 whose household income was at or below 138 percent of the FPL. This would mean that previously ineligible populations, including adults without dependent children and adults who were not disabled, could qualify for Medicaid. However, as a result of the 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius, Medicaid expansion was made optional for states. As of July 7, 2016, 32 states including the District of Columbia have chosen to expand

Medicaid, and 19 states are not adopting at this time; the current status of Medicaid expansion decisions can be found at the [Kaiser Family Foundation](#).¹⁶

Pregnancy-Related Medicaid: States have the option to provide coverage to pregnant women beyond 138 percent of the FPL through either Medicaid or the Children's Health Insurance Program (CHIP). Benefits for pregnant women include care related to pregnancy (and related complications), labor, delivery and postpartum care through the end of the calendar month in which the 60th day after the end of pregnancy falls.¹⁷ States have the option to provide these higher income pregnant women with full-scope Medicaid coverage or limit coverage to pregnancy-related services. A majority of states offer full-scope benefits to pregnant women.¹⁸

The Centers for Medicare & Medicaid Services (CMS) recently reviewed the pregnancy-related Medicaid services in states that do not provide full-scope Medicaid benefits to women in their pregnancy-related program to determine if the services were sufficient to meet the requirement for minimum essential coverage (MEC). Seven states were reviewed; of those, four states met the requirements for MEC and three did not. Low-income pregnant women residing in these three states may qualify for subsidies through the Marketplace, or they may qualify for a hardship exemption.¹⁹ Providing this assistance helps ensure that these women are not penalized financially by the Internal Revenue Service for failure to comply with the individual shared responsibility provision.

Minimum Essential Coverage

The ACA requires that most individuals and families purchase qualifying health coverage known as minimum essential coverage (MEC) or pay a penalty. This is called the ACA's individual shared responsibility requirement and is sometimes referred to as the individual mandate. MEC is qualifying health coverage that satisfies the ACA's individual shared responsibility provision. With MEC, an individual does not have to pay the penalty associated with failing to comply with the individual mandate.

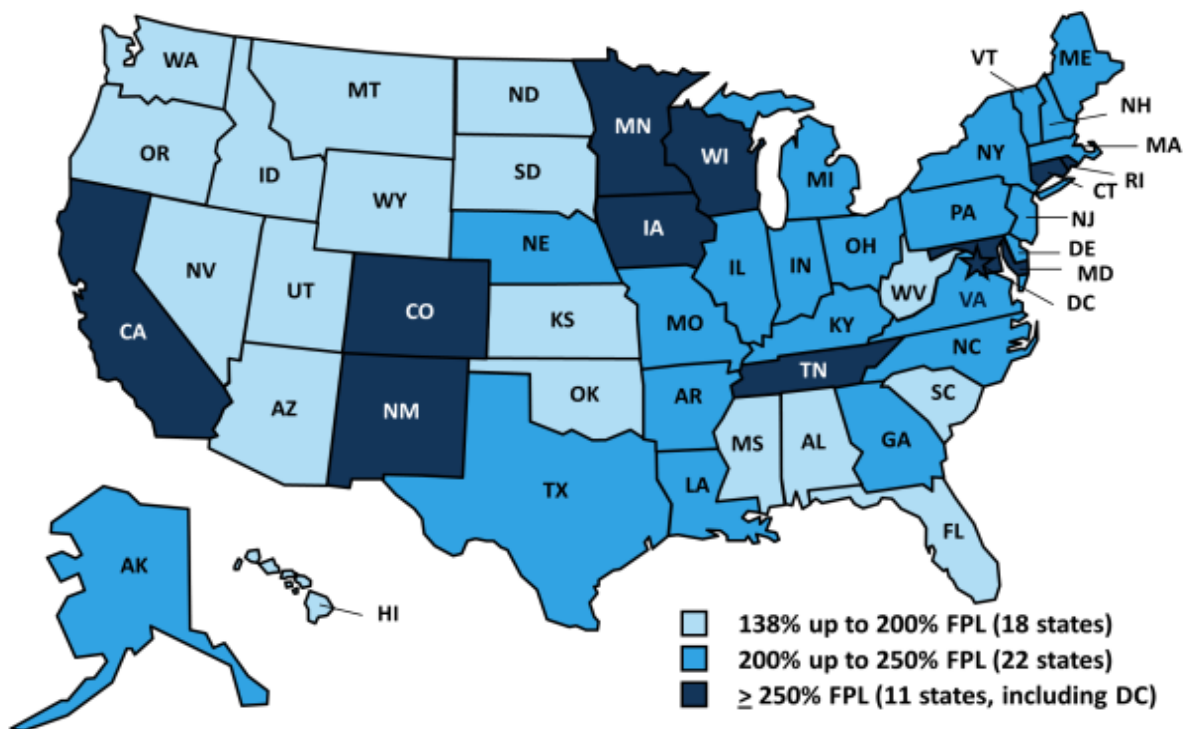
Children's Health Insurance Program (CHIP): CHIP provides health care coverage through Medicaid or separate CHIP programs within states. In some states, pregnant women receive health care through CHIP.

CHIP can provide care through four mechanisms:

- A Section 1115 waiver to cover uninsured women
- State plan option to cover the unborn child
- State plan option to cover low-income pregnant women
- State plan option to cover lawfully-residing immigrant pregnant women.²⁰

Figure 1, produced by the Kaiser Family Foundation, identifies income eligibility levels by state for pregnancy-related coverage in Medicaid/CHIP.²¹

Figure 1: Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2016



source: Kaiser Family Foundation

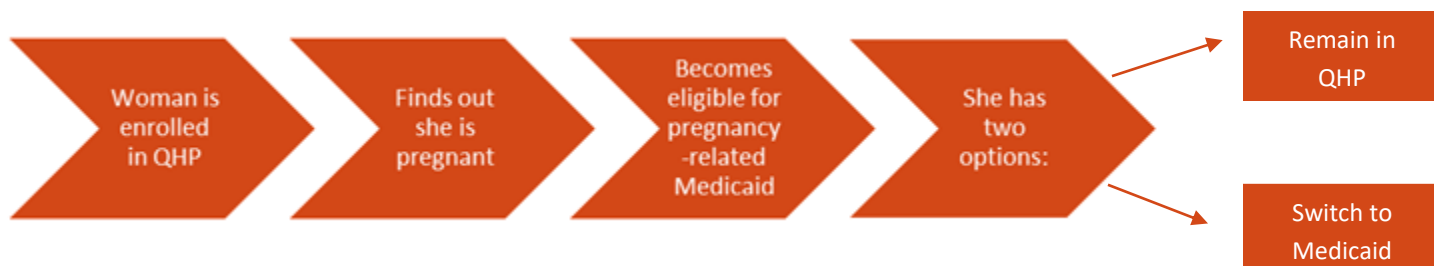
Health Insurance Marketplaces

Health Insurance Marketplaces (sometimes called Exchanges) facilitate the purchase of health insurance by individuals and families and play a central role in ACA implementation. Subsidies are available as Advanced Premium Tax Credits (APTC) to individuals with incomes between 100 percent and 400 percent of the FPL; in addition, cost-sharing reductions (CSR) are available for individuals with incomes between 100 and 250 percent of the FPL who purchase a silver plan.²² Marketplaces also screen individuals to determine whether they are eligible for Medicaid and CHIP coverage, ensuring that people experience “no wrong door” to health coverage.

All plans sold on the Marketplace must cover maternity care and newborn care, and they must offer the aforementioned preventive services for pregnant women without cost sharing. Marketplace plans provide another option for health care access and coverage for low- to moderate-income pregnant women to receive the prenatal care they need. Regardless of a woman’s pregnancy status at the time of enrollment in the

Marketplace, her pregnancy and related care will be covered by the plan if she becomes pregnant. All QHPs meet this minimum essential coverage requirement.

At the time of enrollment, women who are pregnant and eligible for Medicaid based on pregnancy status will be enrolled in that program for coverage. Women enrolled in a QHP prior to becoming pregnant, who then become pregnant and eligible for Medicaid based on their pregnancy status, may choose to remain in the QHP or may switch to coverage under Medicaid.



However, if a state offers CHIP benefits for an unborn child, a pregnant woman may enroll the unborn child in CHIP and enroll herself in a QHP with APTCs – provided the state does not limit CHIP eligibility for an unborn child based on a pregnant woman’s other coverage.²³

Community Health Centers

Community health centers (CHCs) serve populations that are medically underserved by providing health services, either through the staff and supporting resources of the center or through contracts or cooperative arrangements. The CHC program was established in 1965 by the Office of Economic Opportunity. Under Section 330 of the Public Health Service Act, CHCs must satisfy key requirements in order to receive federal funding. One requirement is to provide primary health care, which includes pregnancy and prenatal care, including health services related to obstetrics or gynecology.²⁴ A full list of required primary health benefits can be found in the resources.

Some CHCs are designated as federally qualified health centers (FQHCs). FQHCs include organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for reimbursement through Medicaid and Medicare and must serve an underserved population or area and provide comprehensive services and meet other requirements.²⁵ Within the scope of comprehensive services, FQHCs provide prenatal care without regard to income, insurance or immigration status.²⁶

Other Public Sources of Care

Some local health departments provide health care services to women, children and their families. The extent and scope of services vary by jurisdiction and are determined by local needs, capacity and resources. These services are supported by a range of funding sources including Title V in some states.

Issues and Gaps in Coverage

Between 2013 and 2014, the rate of uninsured women of reproductive age declined from 17.9 to 13.9 percent. The rate of uninsured women of reproductive age with incomes below the FPL decreased from 32.1 to 25.6 percent.²⁷ Improvements in coverage among all women of reproductive age are largely attributable to coverage expansions through the ACA, such as implementation of the Medicaid expansion and the creation of the

Marketplace. Yet, while the uninsured rate for women of reproductive age has declined, pregnant women continue to face barriers when accessing health care.

Coverage Churn

Due to changes in eligibility for Medicaid and federal subsidies throughout a woman's pregnancy and the postpartum period, pregnant women and new mothers often find themselves transitioning from one health care plan to another, or they transition on and off of coverage. This process, also known as "churning," can disrupt the continuity of care, because it often shifts women to different health care networks with different providers. Recognizing that churn has numerous adverse effects for pregnant women, CMS released guidance clarifying that women should have a choice in the type of coverage they receive during their pregnancy and immediate postpartum period.²⁸ The guidance states that women receiving federal subsidies who become pregnant and at that time are income-eligible for pregnancy-related Medicaid that is recognized as MEC, can choose either to stay in the QHP and continue to receive tax credits, or they may elect to switch to pregnancy-related Medicaid.²⁹

No Special Enrollment Period for Pregnancy

Pregnancy is not a qualifying life event that triggers a special enrollment period (SEP) in the Marketplace. An SEP allows an individual to enroll in Marketplace coverage outside of the open enrollment period. Qualifying life events that do trigger an SEP include change in marital status, birth or adoption of a child, loss of health care coverage and change of residence. Although Marketplaces are bound by the SEP categories outlined by HHS, there is flexibility in identifying which situations or scenarios qualify for the "exceptional circumstances" SEP.³⁰

In 2015, several organizations and members of Congress urged HHS Secretary Burwell to create an SEP for pregnancy in the following letter (excerpted):

If a woman becomes pregnant while uninsured at a time outside of the annual open enrollment period or is enrolled in a

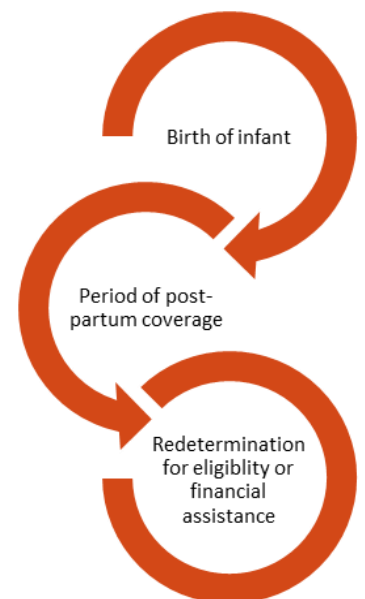
grandfathered plan that does not cover maternity services, she will not be able to access coverage for maternity care. These women are forced to either forgo critical prenatal care or face significant out-of-pocket costs. Special enrollment periods currently exist for qualifying life events like the birth of a child or the adoption of a child. We believe pregnancy should trigger a similar special enrollment period.

While the 2017 Notice of Benefit and Payment Parameters Final Rule³¹ did not specify a final rule to include pregnancy as an SEP, many organizations (including AMCHP) and members of Congress are still encouraging HHS to adopt this.

New York and Vermont have passed legislation that makes pregnancy a qualifying life event for an SEP in the health insurance Marketplaces in their respective state.^{32,33}

Re-Determination for Coverage Upon End of Postpartum Period

Upon the birth of an infant, a woman's eligibility for certain insurance programs is redetermined. Medicaid pregnancy coverage lasts through the postpartum period, defined as the end of the calendar month in which the 60th day following the end of the pregnancy falls.³⁴ Following the postpartum period, the woman will be redetermined for eligibility in Medicaid. If she is no longer eligible for Medicaid, she may be able to enroll in Marketplace coverage, since the birth of a child triggers an SEP. A woman who is already enrolled in Marketplace coverage can, upon birth of the child, retain her coverage or take advantage of the SEP to choose a different QHP. Regardless of what she chooses, it is important that she report the birth, as the family addition could affect her eligibility for and/or levels of financial assistance.³⁵



The “Family Glitch”

In the current health reform landscape, moderate- to low-income pregnant women may experience the “family glitch,” a situation in which low- to moderate-income families are not eligible to receive financial assistance in the Marketplace. The family glitch arises because eligibility for Marketplace subsidies is determined not only by income but also access to other sources of coverage, such as employer-sponsored coverage. If the employer-sponsored coverage is considered “affordable”—defined as costing less than 9.66 percent of household income—then the individual is not eligible for federal subsidies. This determination of affordability is based on *individual coverage* rather than family coverage, which is often more expensive.³⁶ Thus, employer-sponsored coverage for an individual and his/her family may be considered “affordable” in this sense, rendering them ineligible for federal subsidies, even though the same individual and family could actually receive less expensive coverage through the Marketplace if they were eligible for subsidies. It is important for MCH programs to be aware of this issue and understand what types of coverage can fill gaps for pregnant women.

Application Processing Delays

Pregnant women who apply for coverage through Medicaid or CHIP may have to wait to gain coverage while their applications are being processed. Small errors on the application or missing information can result in lengthy delays in obtaining coverage. While a woman waits for coverage, she may be forced to go without prenatal care or pay out-of-pocket for her care.

Scaling Back of Medicaid for Pregnant Women

Some states have scaled back Medicaid eligibility for pregnant women in an effort to reduce state spending. This change could greatly impact access, affordability and essential coverage for pregnant women. While states are considering or have considered this measure, it is important to note that federal law requires states to provide coverage to pregnant women based on a minimum income standard; states are required to provide the higher income standard of either 1) 138 percent of FPL for respective family size or 2) such higher income standard up to 185 percent FPL, if any, as the State

had established as of December 19, 1989, for determining eligibility for pregnant women or, as of July 1, 1989, had authorizing legislation to do so.³⁷ At the minimum, states must provide health care coverage through Medicaid at the higher of the income standards indicated, meaning that states cannot scale back Medicaid for pregnant women beyond a certain point.

Immigration Status

Traditional Medicaid and CHIP eligibility rules require lawfully residing immigrants to wait five years before applying to Medicaid or CHIP (often called the “five-year bar”). The Children’s Health Insurance Program Reauthorization Act (CHIPRA) included a new option to allow states to provide Medicaid or CHIP coverage to lawfully-residing pregnant women who have not completed the waiting period.³⁸

As of March 2014, 24 states have adopted this provision either through their Medicaid or CHIP programs.³⁹ In more than half of the states, lawfully-residing pregnant women within the five-year window must still wait for Medicaid or CHIP coverage, and often, they are not able to afford coverage through the Marketplace. This can cause a woman to forgo care altogether during the critical prenatal period.

Undocumented women may have access to prenatal care through CHCs or FQHCs at the local level. Such coverage varies by region. In addition, some undocumented women receive emergency Medicaid coverage during their pregnancies or for the birth of the child. Emergency Medicaid, however, does not typically include access to routine prenatal care.⁴⁰

The Title V Role in Improving Coverage and Access to Care for Pregnant Women

The Title V Maternal and Child Health Services Block Grant of the Social Security Act (Title V) program has a rich, 80-year history of building comprehensive, integrated systems to ensure the health and well-being of women and children, including children with special health care needs

and their families. Title V can provide a foundation to ensure access to comprehensive prenatal and postnatal care to women, especially low-income and at-risk pregnant women. State Title V programs are well-positioned to engage with stakeholders at every level — including providers, patients, payers and consumers — to increase the number of women who receive timely and adequate prenatal care.

With the transformation of the Title V Block Grant, the new framework includes National Outcome Measures (NOMs) that represent desired results of an activity or intervention and National Performance Measures (NPMs) that are intended to improve outcomes relative to indicators of health status (i.e. NOMs). The NPM framework focuses on elements of access to prenatal care. Specifically, the NPMs include well-woman visits, low-risk cesarean deliveries, adolescent well-visits and the percentage of women who smoke during pregnancy. Through the framework, these NPMs are intended to impact NOMs related to maternal mortality, low birth weight, infant mortality, preterm birth or a combination of these.⁴¹

State Title V programs administer or partner with public programs that are natural access points for educating and assisting women on access and the importance of prenatal care. These include prenatal care clinics, home visiting programs, and the Special Supplemental Food and Nutrition Program for Women, Infants and Children (WIC). Title V programs are also required by statute to coordinate with their state Medicaid program in order to provide expertise on access issues faced by women. Examples of specific services include providing toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

Policy Options and State Strategies for Title V Programs

Access to timely, affordable and continuous coverage for pregnant women is complex. State policies related to coverage for pregnant women vary, as do the challenges faced in each state. The options and strategies outlined in this section, while

not exhaustive, serve as examples to help Title V agencies consider their role in addressing some of the challenges pregnant women face.

Partnerships

Successful strategies to improve access to care often involve partnerships between and across agencies that provide direct services such as Medicaid, the Marketplace or other community-based organizations. Title V can serve as a convener to bring together these agencies. Examples of successful partnerships within three states are described below.

Florida

MomCare is a Medicaid-funded program authorized by a special waiver from the federal government. MomCare was developed as a partnership between the Florida Association of Healthy Start Coalitions, Florida Department of Health (where the Title V program resides), Florida Agency for Health Care Administration and the Florida Department of Children and Families. The program is managed at the community level by 32 local Healthy Start coalitions and identifies at-risk women through the Florida Department of Health universal prenatal risk screening process. Clients receive guidance on how to select a prenatal care provider, assistance with scheduling initial prenatal visits and information about state programs for which they may be eligible. Case management is an ongoing process to track client progress, identify client needs and assist women in accessing services.

Arizona

Health Start, which was created in 1994, utilizes community health workers or “promotoras” to address the needs of rural, minority pregnant women in Arizona. The community health workers identify women early in their pregnancies and link them to prenatal care. The program focuses on women and families who meet at least one medical risk and one social risk at the time of enrollment. Health Start contracts with 13 community-based agencies, including county health departments. The program identifies, screens and enrolls women in their first trimester of pregnancy and postpartum women and families and assists women in obtaining early and consistent prenatal care. Community health workers provide prenatal and

postpartum education; parenting education; depression, alcohol, tobacco and other drug screening, brief intervention and education; domestic violence screening and education; Healthy @ Home Assessments, advocacy and case management services; and information and referral services. Although the Health Start Program resides within the Bureau of Women and Children's Health, the program coordinates services across several programs and agencies.

The Health Start program also serves as a lead member of the Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs. The Task Force is designed to increase awareness of substance use among pregnant women; increase screening for alcohol and other drugs, including prescription drugs; and increase awareness of treatment options. Health Start also serves on the intra-agency Zero to Five Task Force and the interagency Home Visiting Task Force, both of which are supported administratively in part by Title V. Finally, Health Start also coordinates with the Department of Child Safety and Medicaid health plans, among other partnerships.

Pennsylvania

While the rates of early and adequate prenatal care in Pennsylvania have been improving, ethnic and racial disparities continue to persist. The Bureau of Family Health (BFH) recognized this issue and sought to address it creatively by implementing a Centering Pregnancy program. In 2013, the BFH partnered with Lancaster General Health (LGH) Healthy Beginnings Plus Program to offer Centering Pregnancy. Prior to 2013, the program did not work effectively, and the partners realized that for the program to be successful, they needed a coordinator and an organized delivery system. In addition, they found that patients needed participation incentives, which were not available initially, leading to significant no-show rates.

In 2013, the BFH and the LGH Healthy Beginnings Plus Program reintroduced Centering Pregnancy. The current program includes racially and ethnically diverse patients: 51 percent are Hispanic; 16 percent are African American; 7 percent are Asian; 64 percent are White and 13 percent are of mixed race. The comprehensive program includes

dietitians, breastfeeding consultants and social workers; and registered nurses, family practice residents and midwives. All providers have completed the required training to participate in Centering Pregnancy. Additionally, LGH offers various support services including a breastfeeding baby weigh station, cooking class, yoga class, walking club and pregnancy water aerobics. LGH recently received its second credentialing through the Centering Healthcare Institute this year. Program outcomes indicate a preterm birth rate of 8.5 percent, a breastfeeding initiation rate of 93 percent and a postpartum visit completion rate of 96 percent. The total prenatal visit completion rate is 95 percent. Qualitative data indicate that the program is greatly appreciated by both providers and patients.

Outreach and Education

Many pregnant women are unaware of coverage opportunities available in their state. In situations where women are at risk for disruptions in care during pregnancy or the postpartum period, health care navigators, assistants and community health workers could be trained to provide education and appropriate planning to alleviate some of the stress that comes with disruptions in care for these women. In addition, staff at qualified entities — such as WIC programs, Head Start or other public programs geared toward promoting the health of MCH populations — could also provide education and support.

Title V can play a role in ensuring that professionals who interact with these women have accurate and up-to-date information regarding coverage and access during pregnancy in their respective state. In addition, Title V programs can provide assistance and education to women through their toll-free hotlines. In providing these services, it is critical for MCH professionals in each state to know and understand the unique coverage landscape in their state or territory.

Presumptive Medicaid Eligibility

Presumptive eligibility is an optional Medicaid coverage policy that provides temporary access to Medicaid coverage for pregnant women and children who are likely eligible under a state's Medicaid eligibility guidelines. Presumptive

eligibility eliminates the waiting period for determination of eligibility and provides women immediate access to prenatal care. States have the option of authorizing qualified entities to enroll individuals through presumptive eligibility. Examples of qualified entities include community-based organizations, WIC programs, public housing programs and hospitals.⁴²

Basic Health Program

The ACA gives states the option of creating a Basic Health Program (BHP) for low-income individuals who would be eligible to gain coverage through the Marketplace. A BHP allows states to provide more affordable coverage for low-income individuals and improve continuity of care, especially for those whose eligibility for public insurance programs fluctuates. The BHP provides states another channel for coverage of pregnant women and may be especially effective for women who stand to lose their current coverage in the postpartum period.

As of January 1, 2015, states can provide coverage benefits to two categories of individuals:

- Those who are citizens or lawfully present non-citizens who do not qualify for Medicaid, CHIP or other MEC coverage and have incomes between 138 and 200 percent of FPL and
- Those who are lawfully present non-citizens with incomes equal to or less than 138 percent of FPL but who are ineligible to qualify for Medicaid due to immigration status, i.e. those lawfully present in the U.S. for fewer than five years.⁴³

Title V Program Considerations

As Title V leaders and staff, one place to start in policy advocacy and strategy is to carefully assess your own region's landscape of coverage for pregnant women. The information gleaned will provide a better understanding of the barriers and issues pregnant women may face while navigating coverage and prenatal care in your state, which can in turn inform strategies to address the unique issues in your state. Questions to consider when assessing the landscape include:

- What is the income eligibility to obtain Medicaid for pregnant women in your state?
- Does your state have pregnancy-related Medicaid, and if so, does it satisfy MEC requirements?
- Does your state have Medicaid presumptive eligibility? If so, what entities can enroll pregnant women?
- Is there an unborn child coverage option in your state's CHIP program?
- Does your state's Medicaid or CHIP program provide prenatal coverage to lawfully-residing pregnant women who are within the five-year window of immigration?
- Has your state scaled back or considered scaling back Medicaid eligibility for pregnant women?
- What type of Health Insurance Marketplace is operating in your state?
- Are there local or state efforts focusing on increasing access to prenatal care? Is Title V involved in those efforts?

Some of this information can be found on your state's Medicaid or CHIP website, [Medicaid Enrollment Strategies](#), [Medicaid MEC](#) or on Kaiser Family Foundation's State Health Facts: [Medicaid & CHIP](#), [Health Reform](#), [Women's Health](#).

Conclusion

Access to timely and adequate prenatal care is an essential step to improving health outcomes for women and infants. It can reduce the risk of low birth weight, preterm birth and several other pregnancy-related complications. Many Title V programs readily acknowledge the importance of prenatal health care and are leading efforts to develop new ways of improving access to prenatal care. As such, Title V programs are well positioned to act as a conduit, expert advisor and educator on these issues faced by women during pregnancy. Health reforms, including the ACA, provide Title V programs with new opportunities to develop and improve access to prenatal care and ultimately improve health and birth outcomes for women and infants in their states and communities.

Acknowledgment

AMCHP greatly appreciates and thanks the staff from state departments of health in Florida, Arizona and Pennsylvania for their valuable input. Lastly, AMCHP thanks Amy Chen and Marisa Spalding from the National Health Law Program (NHELP) for their review of the content.

This issue brief was made possible with funding support provided by the W.K. Kellogg Foundation. Its contents are the sole responsibility of the authors and do not necessarily represent the official view of the W.K. Kellogg Foundation.

Resources

AMCHP: [Who will be covered for what in 2015 and beyond?](#)

Centers for Medicare & Medicaid Services (CMS): [Special Populations: Pregnant Women Fast Facts for Assisters](#)

Healthcare.gov: [Health coverage if you're pregnant or plan to get pregnant](#)

Kaiser Family Foundation: [Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level](#)

Medicaid.gov: [Medicaid Program Information for Pregnant Women](#)

AMCHP Contact Information

This issue brief is part of a series of AMCHP tools, documents and resources on implementation of the Affordable Care Act and its impact on maternal and child health populations. For more information, please visit the [National Center for Health Reform Implementation](#). All AMCHP staff can be reached via phone at (202) 775-0436.

Endnotes

¹ Health Resources and Services Administration. Prenatal First Trimester Care Access. Accessed August 22, 2016. Available at: <http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/>.

² Guttmacher Institute. Fewer U.S. Women of Reproductive Age Were Uninsured in 2014 (September 2015). Accessed August 22, 2016. Available at:

[http://www.guttmacher.org/media/inthenews/2015/09/22/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+\(New+from+the+Guttmacher+Institute\)](http://www.guttmacher.org/media/inthenews/2015/09/22/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute))

³ Healthy People 2020. Maternal, Infant and Child Health Objectives. Accessed August 22, 2016. Available at: <http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives>

⁴ Ibid.

⁵ Coeytaux, F., Bingham, D., & Strauss, N. "Maternal Mortality in the United States: A Human Rights Failure" (March 2011). *Association of Reproductive Health Professionals*. Accessed August 22, 2016. Available at: <https://www.arhp.org/publications-and-resources/contraception-journal/march-2011>

⁶ Office on Women's Health. Prenatal Care Fact Sheet (July 2012). Accessed August 22, 2016. Available at: <http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html>

⁷ Lucile Packard Stanford Children's Hospital. Low Birthweight. Accessed August 22, 2016. Available at: <http://www.stanfordchildrens.org/en/topic/default?id=low-birthweight-90-P02382>

⁸ American Congress of Obstetricians and Gynecologists. Facts are Important (February 2012). Accessed August 22, 2016. Available at: <https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/20120221FactsareImportant.pdf?la=en>

⁹ U.S. Department of Health & Human Services. Women and the Affordable Care Act (June 2013). Accessed August 22, 2016. Available at: <https://www.hhs.gov/healthcare/facts-and-features/fact-sheets/women-and-aca/index.html>

¹⁰ National Women's Law Center. Nondiscrimination Protection in the Affordable Care Act: Section 1557 (May 2016). Accessed August 22, 2016. Available at: <http://nwlc.org/wp-content/uploads/2015/11/General-1557-Factsheet-May-2016.pdf>

¹¹ U.S. Department of Health & Human Services. Women and the Affordable Care Act. Accessed August 22, 2016. Available at: <https://www.hhs.gov/healthcare/facts-and-features/fact-sheets/women-and-aca/index.html>

¹² Medicaid.gov. Program History. Accessed August 22, 2016. Available at: <https://www.medicaid.gov/about-us/program-history/program-history.html>

¹³ Medicaid.gov. List of Medicaid Eligibility Groups. Accessed August 22, 2016. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf>. Accessed on March 30, 2016.

¹⁴ Medicaid.gov. Benefits. Accessed August 22, 2016. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>

¹⁵ Medicaid.gov. Financing and Reimbursement. Accessed August 22, 2016. Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html>

¹⁶ Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision (July 7, 2016). Accessed August 22, 2016. Available at: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

¹⁷ Kaiser Family Foundation. Health Reform: Implications for Women's Access to Coverage and Care (August 2013). Accessed August 22, 2016. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2012/03/7987-03-health-reform-implications-for-women-s-access-to-coverage-and-care.pdf>

¹⁸ Centers for Medicare & Medicaid Services. Letter to State Health Officials & Medicaid Directors, Re: Minimum Essential Coverage (November 2014). Accessed August 22, 2016. Available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>

¹⁹ Ibid.

²⁰ March of Dimes. CHIP Coverage for Pregnant Women (October 2013). Accessed August 22, 2016. Available at: <http://www.marchofdimes.org/materials/chip-coverage-for-pregnant-women-may-2014.pdf>

²¹ Kaiser Family Foundation. Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children and Pregnant Women (March 2016). Accessed August 22, 2016. Available at: <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>

²² National MCH Workforce Development Center. The Health Insurance Marketplace (2014). Accessed August 22, 2016. Available at: <http://www.amchp.org/Transformation-Station/Documents/ACA5-Marketplaces.pdf>

²³ Centers for Medicare & Medicaid Services. Letter to State Health Officials & Medicaid Directors, Re: Minimum Essential Coverage (November 2014). Accessed August 22, 2016. Available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>

²⁴ U.S. Code §254b. Health Centers. Accessed August 22, 2016. Available at: <http://uscode.house.gov/view.xhtml?edition=prelim&req=42+usc+254b&f=treesort&fq=true&num=20&hl=true>

²⁵ Rural Health Information Hub. Federally Qualified Health Centers. Accessed August 22, 2016. Available at: <https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers>

²⁶ American Congress of Obstetricians and Gynecologists. Health Care for Unauthorized Immigrants (March 2015). Accessed August 22, 2016. Available at: <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Unauthorized-Immigrants>

²⁷ Guttmacher Institute. Fewer U.S. Women of Reproductive Age Were Uninsured in 2014 (September 2015). Accessed August 22, 2016. Available at: [http://www.guttmacher.org/media/inthenews/2015/09/22/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+\(New+from+the+Guttmacher+Institute\)](http://www.guttmacher.org/media/inthenews/2015/09/22/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute))

²⁸ Centers for Medicare & Medicaid Services. Letter to State Health Officials & Medicaid Directors, Re: Minimum Essential Coverage (November 2014). Accessed August 22, 2016. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>

²⁹ Internal Revenue Service. Eligibility for Minimum Essential Coverage Under Pregnancy-Based Medicaid and CHIP Programs (2014). Accessed August 22, 2016. Available at: <https://www.irs.gov/pub/irs-drop/n-14-71.pdf>

³⁰ Urban Institute. Special Enrollment Periods in 2014: A Study of Select States (February 2015). Accessed August 22, 2016. Available at: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000122-Special-Enrollment-Periods-in-2014.pdf>

³¹ Federal Register. Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017 (March 2016). Accessed August 22, 2016. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>

³² New York State Press Release. Governor Cuomo Signs Legislation to Make New York the First State in the Nation to Allow Pregnant Women to Enroll in the State Health Insurance Exchange at Any Time (December 23, 2015). Accessed August 22, 2016. Available at: <https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-make-new-york-first-state-nation-allow-pregnant-women-enroll>

³³ Vermont health Connect. Qualifying Events. Accessed August 29, 2016. Available at: <http://info.healthconnect.vermont.gov/QualifyingEvents>

³⁴ National Partnership for Women and Families. Frequently Asked Questions: Health Insurance Coverage for Low and Moderate-Income Pregnant Women (November 2013). Accessed August 22, 2016. Available at: <http://www.nationalpartnership.org/research-library/frequently-asked-questions-coverage-pregnant.pdf>

³⁵ Centers for Medicare & Medicaid Services. Special Populations: Pregnant Women Fast Facts for Assistants. Accessed August 22, 2016. Available at: <https://Marketplace.cms.gov/technical-assistance-resources/special-populations-pregnant-women.pdf>

³⁶ Healthcare.gov. Affordable Coverage. Accessed August 22, 2016. Available at: <https://www.healthcare.gov/glossary/affordable-coverage/>

³⁷ U.S. Government Publishing Office. Electronic Code of Federal Regulations §435.116 Pregnant Women. Accessed August 22, 2016. Available at: [http://www.ecfr.gov/cgi-bin/text-](http://www.ecfr.gov/cgi-bin/text-idx?SID=b43826e7a5b6020fe17dc34e6ca016fd&node=se42.4.435_116&rgn=div8)

[idx?SID=b43826e7a5b6020fe17dc34e6ca016fd&node=se42.4.435_116&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=b43826e7a5b6020fe17dc34e6ca016fd&node=se42.4.435_116&rgn=div8)

³⁸ Medicaid.gov. Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women. Accessed August 22, 2016. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html>

³⁹ Ibid.

⁴⁰ C. Annette DuBard, Mark W. Massing, et al. "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants" (March 14, 2007). *Journal of the American Medical Association*. Accessed August 22, 2016. Available at: <http://jama.amanetwork.com/article.aspx?articleid=206014#REF-JOC60180-7>

⁴¹ Health Resources and Services Administration. Title V Maternal and Child Health Services Block Grant to States Program. Accessed August 22, 2016. Available at: <http://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/TitleV/blockgrantguidanceappendix.pdf>

⁴² Brooks, Tricia. "Hospital Presumptive Eligibility" (January 9, 2014). *Health Affairs*. Accessed August 22, 2016. Available at: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_106.pdf

⁴³ Centers for Medicare & Medicaid Services. Basic Health Program. Accessed August 22, 2016. Available at: <http://www.medicaid.gov/basic-health-program/basic-health-program.html>