

WWS 402c – Healthcare Reform: Organizing, Financing, and Delivering Care for Low-Income Americans

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**Access to Prenatal Care for Undocumented Immigrants Under Medicaid and CHIP:  
A Review of State Prenatal Care Programs**

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This paper represents my own work in accordance with University Regulations.

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## Executive Summary

### PROBLEM STATEMENT:

Prenatal care has been shown to improve birth outcomes. According to a study of pregnant undocumented women conducted in California, those without prenatal care were 3.8 times more likely to deliver low birth weight infants and 7.4 times more likely to enter labor prematurely. In terms of infant mortality, infants born to mothers lacking prenatal care are five times more likely to die. In order to ensure adequate health outcomes both for the infant and the mother, prenatal care must be provided and utilized. This viewpoint is evident in the Medicaid program's mission and goals. One of Medicaid's main functions is to provide maternity-related care for low-income women. However, the provision of prenatal care to undocumented immigrants is lacking throughout the United States. It is important to note that the infants of these undocumented immigrant mothers who are born in the United States will be American citizens, thus many will qualify for and utilize Medicaid upon birth or soon thereafter. Additionally, as seen in the table below, costs of prenatal care are much cheaper than costs for Neonatal Intensive Care Unit (NICU) admissions.

Average NICU Cost per infant	\$60,000
Average cost of prenatal care for women under Medicaid	\$2,142
Average delivery cost for women under Medicaid	\$4,577

Sources: (Kornhauser and Schneiderman 2010, 28-30) & (Anonymous 2007)

### STATE CASE STUDIES:

Many states recognize the need to provide prenatal care to this undocumented immigrant population in order to create a healthier state population. Currently, sixteen states and the District of Columbia utilize one of two methods to provide such prenatal care. These methods of provision are the Children's Health Insurance Program (CHIP) Unborn Child State Plan Amendments (SPAs) and state-only Medicaid funds. While the motives and services vary between states, each of these sixteen does provide adequate prenatal care in the hopes of improving birth outcomes.

#### Texas:

Texas utilizes the Unborn Child SPA to provide prenatal care to pregnant, undocumented immigrants 200 percent of the federal poverty line and below. With 1.5 million undocumented immigrants, Texas has the second largest such population, thus necessitating these services in order to ensure a healthier population. Texas utilizes CHIP Perinate Coverage to provide these services with the hopes of insuring children as quickly as possible. Additionally, with higher CHIP match rates, Texas wishes to gain these benefits by utilizing CHIP to cover these unborn children.

#### Washington:

Washington also uses the Unborn Child SPA to provide prenatal coverage to pregnant, undocumented immigrants 185 percent of the federal poverty line and below. Though it does not have a particularly large undocumented immigrant population, Washington provides this care through the First Steps program. The main goal of the

Washington program was to improve birth outcomes by providing prenatal care to low-income women. Another goal of the program was to lower NICU costs.

**New York:**

On the contrary, New York utilizes state-only Medicaid funds to provide prenatal care to this population. Through the Prenatal Care Assistance Program, New York is able to provide a plethora of services to all women who are 200 percent of the federal poverty line and below, regardless of immigration status. With the fourth largest undocumented immigrant population nationwide, New York aims to ensure a healthy state population. Additionally, many individuals in New York cite the concept that healthcare is a right, not a privilege as another main reason for this program.

**FINDINGS:**

All sixteen of these programs are still in place, attesting to their successes. With 75 percent of all newborn care costs allocated to NICU admissions and Medicaid covering 41 percent of births in the United States, prenatal care appears to be an adequate solution to the NICU admissions problem.

While it is true that only 4 percent of all births in America result in NICU admission, prenatal care remains a cheaper provision than does NICU costs. Providing prenatal care to all women utilizing Medicaid for birth coverage would amount to slightly over \$3.7 billion. On the contrary, providing twenty days of NICU care to the 4 percent of premature infants whose mothers utilize Medicaid for birth coverage would amount to slightly over \$4.2 billion.

**RECOMMENDATIONS:**

Since prenatal care is less expensive than NICU care, it may be beneficial for CMCS to further analyze the individual state programs to determine their efficacy and successes. Particularly, it may be beneficial for CMCS to analyze provider participation in the program to consider the actual accessibility of prenatal care to pregnant, undocumented immigrants. While outreach was a major component of each program at its inception, it is currently not a major factor. Thus, it may be advantageous for CMCS to consider the correlation between outreach efforts and program participation. Finally, with the “Hispanic paradox” of better birth outcomes within Hispanic populations, it may be useful for CMCS to perform a cost-benefit analysis considering the correlation between prenatal care and birth outcomes among the undocumented immigrant population.

## INTRODUCTION:

In order to ensure adequate health outcomes both for the infant and the mother, maternal care, and prenatal care in particular, must be provided and utilized. This viewpoint is evident in the Medicaid program's mission and goals. Not only is Medicaid's main purpose to provide access to equal and adequate care for all low-income, uninsured children and disabled individuals, but more significantly, one of Medicaid's main functions is to provide maternity-related care for low-income women.<sup>1</sup> Yet Medicaid is not the sole program underwriting services to low-income, uninsured populations. Through the latest Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, states are now able to utilize CHIP funds to cover prenatal care for low-income, uninsured mothers with incomes below 185 percent of the federal poverty line simply by utilizing CHIP with no waivers or state plan amendments. States receive greater federal matches through FMAP as incentive for providing these services.<sup>2</sup> In this paper, maternal care is meant to encompass physician visits, ultrasound screenings, prenatal vitamins, and other prenatal options in addition to delivery and in some cases, a certain level of postpartum care.

While Medicaid and CHIP provide prenatal care for all eligible American citizens and, after CHIPRA, for all eligible legal immigrants, states have never been permitted to provide coverage to undocumented immigrants utilizing federal funds either through basic Medicaid or basic CHIP.<sup>3</sup> Yet, if the infants of these undocumented immigrant

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<sup>1</sup> Usha Ranji and others, *State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings* (Washington, DC: The Kaiser Family Foundation and GWU School of Public Health and Health Services, 2009).

<sup>2</sup> Jackie Garner, "State Health Official - CHIPRA #2," (May 11, 2009).

<sup>3</sup> Kaiser Family Foundation, "CHIP Tips: New Federal Funding Available to Cover Immigrant Children and Pregnant Women," (July 2009).

mothers are born in the United States, they will be American citizens, thus many will qualify for and utilize Medicaid upon birth or soon thereafter. Nevertheless, coverage of undocumented immigrant maternal care is often lacking throughout the United States, particularly on a federal level. In fact, Nebraska's Medicaid-provided prenatal care program recently generated further inspection by the federal government. Nebraska had been providing prenatal care to undocumented immigrants under Medicaid. However, it had been utilizing federal and state funds in order to provide this prenatal care. This utilization of federal funds for these prenatal care services threatened its future receipt of FMAP funds, thus causing it to reorganize prenatal care provisions and eliminate prenatal care for undocumented immigrants.<sup>4</sup>

Since neither Medicaid nor CHIP provide prenatal care for undocumented immigrants directly, some states have chosen to request and receive waivers and state plan amendments in order to utilize Medicaid and CHIP funds to provide prenatal care to these pregnant undocumented aliens.<sup>5</sup> By gaining these waivers and state plan amendments, states wish to better these infants' health outcomes, thus decreasing their necessary medical care after birth.

Through various studies, researchers have shown that prenatal care greatly improves infant and maternal health outcomes during and after birth, a reason that one of Medicaid's main goals is the provision of prenatal care for all low-income individuals. According to a study of pregnant undocumented women conducted in California, those without prenatal care are 3.8 times more likely to deliver low birth weight infants and 7.4

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<sup>4</sup> Nancy Hicks, "Just One More Month," *Lincoln Journal Star*, Feb 20, 2010, <http://proquest.umi.com/pqdweb?did=1968070331&Fmt=7&clientId=17210&RQT=309&VName=POD>.

<sup>5</sup> Evelyne P. Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children* (CRS Report for Congress, 2008).

times more likely to enter labor prematurely.<sup>6</sup> In terms of infant mortality, infants born to mothers lacking prenatal care are five times more likely to die.<sup>7</sup> Without prenatal care, infants are more likely to have negative health outcomes upon birth. Furthermore, infants whose mothers lacked prenatal care were found likely to have neonatal hospital stays nearly twice as long as those infants whose mothers received prenatal care.<sup>8</sup> Low birth weight and prematurity may lead to severe, life-long diseases and complications that require tremendous amounts of future care. These disease and complications include neural damage, retinopathy of prematurity leading to blindness, chronic lung disease, and many others. Without prenatal care, risks of acquiring these diseases are increased, leading to more hospitalizations, physician visits, and overall medical care.<sup>9</sup>

While the health of these infants is in and of itself important, perhaps equally significant are the costs incurred due to this increased need for medical attention. If access to prenatal care throughout pregnancy can better the infant's health outcomes, providing prenatal care to all individuals appears to be beneficial in the long term. Since an infant born to a low-income, undocumented immigrant mother in the United States is considered an American citizen and is likely eligible for Medicaid, federal and state Medicaid or CHIP funding will pay for the child's health care after birth. Should the infant be permanently disabled due to prematurity or low-birth-weight, Medicaid could

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<sup>6</sup> Michael. C. Lu and others, "Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A cost/benefit Analysis," *American Journal of Obstetrics and Gynecology* 182, no. 1 (2000), 233-239,

<http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=10649184&site=ehost-live>.

<sup>7</sup> Maternal and Child Health Bureau, *A Health Start: Begin before Baby's Born* (Maryland: US Department of Health and Human Services: Health Resources and Services Administration, 2009), <http://mchb.hrsa.gov/programs/womeninfants/prenatal.htm> (accessed April 18, 2010).

<sup>8</sup> Lu and others, *Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A cost/benefit Analysis*, 233-239.

<sup>9</sup> AHRC New York City, "Frequently Asked Questions Intellectual Or Developmental Disabilities," AHRC New York City, <http://www.ahrcnyc.org/faqs/faqs.htm> (accessed May 3, 2010).

be responsible for this individual throughout his or her life. As illustrated in Table 1 on page 28, providing prenatal care to undocumented immigrant mothers may decrease costs of healthcare for the infant, lowering federal and state Medicaid and CHIP expenditures.

## **BACKGROUND:**

Congress passed CHIPRA in 2009, extending and expanding CHIP in order to ensure that states would be able to provide adequate healthcare for low-income uninsured children covered through the program. Not only did CHIPRA greatly increase federal funds for children's healthcare, but it also increased eligibility levels and increased enrollment, decreasing the rates of uninsured children. Regarding prenatal care, CHIPRA ensured states' ability to continue providing access to prenatal care through two previously existing routes in CHIP: section 1115 pregnant women demonstrations and the Unborn Child state plan amendments. CHIPRA also provided a new option for insuring eligible mothers under a new amendment to state CHIP plans. This option allows states to provide coverage and prenatal care for low-income uninsured mothers themselves, rather than their unborn children as is implied in the Unborn Child State Plan Amendments (SPAs).<sup>10</sup> Yet this new option for covering pregnant women under CHIP continues to exclude undocumented immigrants. Consequently, some states have received waivers and state plan amendments allowing them to utilize Medicaid and CHIP funds to provide prenatal care to these pregnant undocumented women.<sup>11</sup> These waivers allow improved infant health outcomes and potentially decrease necessary medical care after birth.

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<sup>10</sup> Garner, *State Health Official - CHIPRA #2*

<sup>11</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

## Section 1115 Waivers

Utilizing state and federal CHIP and Medicaid funds, section 1115 waivers allow states to provide a variety of services not normally covered under Medicaid or CHIP.

Section 1115 waivers are utilized for research and demonstration projects attempting to further the goals of the Medicaid or CHIP program. Using these waivers, the Secretary is able to waive any Medicaid requirements contained in section 1902 of the Social Security Act, or certain CHIP sections and requirements, though these are not specified.<sup>12</sup> In 2001, the Bush Administration created the Health Insurance Flexibility and Accountability (HIFA) Initiative, encouraging states to provide CHIP and Medicaid services to the uninsured who were 200 percent of the federal poverty line and below.<sup>13</sup> The HIFA initiative builds upon section 1115 waivers in an attempt to increase their flexibility and increase cost sharing for optional and expansion populations.<sup>14</sup>

Currently, six states utilize CHIP §1115 waivers to provide maternal care to low-income pregnant women aged nineteen and older who are not normally covered under CHIP and Medicaid: Colorado, Idaho, Nevada, New Jersey, Rhode Island, and Virginia.<sup>15</sup> Five of these states also utilize HIFA's authority to secure these waivers. The services provided vary between states.<sup>16</sup> CHIP §1115 waivers lack a provision of services to pregnant undocumented immigrants. Rather, CHIP §1115 waivers provide services for mothers who are between 133 percent and 185 percent or 200 percent of the federal poverty line and below, variable by state.

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<sup>12</sup> Evelyne P. Baumrucker, *Status of SCHIP Adult Coverage Waivers (as of August, 2008)* (Washington, DC: CRS Report for Congress, 2008).

<sup>13</sup> Elicia J. Herz, Bernadette Fernandez and Chris L. Peterson, *SCHIP Insurance Program: A Brief Overview* (Washington, DC: CRS Report for Congress, 2005).

<sup>14</sup> Gretchen Engquist and Peter Burns, "Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States," *State Coverage Initiatives III*, no. 2 (August 2002).

<sup>15</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

<sup>16</sup> Ibid.

## Unborn Child State Plan Amendments

The Unborn Child SPA allows states to cover maternity care on the premise that it will aid in improving infants' health outcomes. While it effectively allows for the mother's treatment, all services are to be administered for the unborn child.<sup>17</sup> Ultimately, care is being provided not for the mother, but rather for her infant. Regardless of the manner in which they are able to do so, this provision allows states the ability to provide care to individuals who are otherwise ineligible for Medicaid or CHIP due to income levels, immigration status, or incarceration. However, since all treatments must be specifically geared towards the health of the fetus, events that may endanger the mother, including broken limbs or other similar incidents, are not covered under the SPA.<sup>18</sup> Nevertheless, according to Jackie Garner, the Acting Director of the Center for Medicaid, CHIP, and Survey & Certification (CMCS) in a May 2009 letter to State Health Officials, the express purpose of the Unborn Child SPA is to provide health services in order to ensure healthy pregnancies, regardless of the mother's eligibility status.<sup>19</sup> In short, the state plan amendments attempt to increase access to prenatal care, though the explicit format is through providing care to the unborn child.

Though they vary by state, generally, the services provided include prenatal care and labor and delivery services. Postpartum care is covered in some states, but most do not provide this service under the premise that it no longer directly impacts the child. Furthermore, a federal provision of the Unborn Child SPA states that postpartum care is

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<sup>17</sup> National Immigration Law Center, "Prenatal Coverage for Immigrants through the State Children's Health Insurance Program," (June 2003).

<sup>18</sup> Texas Health and Human Services Commission, "CHIP Perinatal Coverage Information for Clients," Texas Health and Human Services Commission,

<http://www.hhsc.state.tx.us/chip/perinatal/ClientInformation.htm#CoveredServices> (accessed 4/18, 2010).

<sup>19</sup> Garner, *State Health Official - CHIPRA #2*

not considered an acceptable service for CHIP federal matching funds, further discouraging states from providing such a service.<sup>20</sup> This mode of coverage is sanctioned by CMCS through its SPA process.<sup>21</sup> Currently, fifteen states utilize the Unborn Child SPA: Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Washington, and Wisconsin. Fourteen of these states utilize the Unborn Child SPA to provide prenatal care to undocumented immigrants who are at least 185 percent of the federal poverty line and below and are not covered by Medicaid. Since most states do not cover undocumented immigrants under Medicaid, if individuals within this population obtain Medicaid income eligibility levels, they are eligible for care through the CHIP Unborn Child SPA.

Contrary to these fourteen states, Tennessee does not provide this same coverage to undocumented immigrants. Rather, Tennessee utilizes the Unborn Child SPA to provide care to citizens or legal residents who are 185 percent to 250 percent of the federal poverty line and below and would otherwise be ineligible for Medicaid or CHIP benefits.<sup>22</sup>

### **Medicaid Provisions for Undocumented Immigrant Prenatal Care**

Until recently, the state of Nebraska provided prenatal care to undocumented immigrant mothers through Medicaid, under the premise that their unborn children will become American citizens who qualify for Medicaid, very similar to the premises utilized in the Unborn Child SPA. However, in late 2009 DHHS informed Nebraska that covering these undocumented women based on their unborn children was not valid under

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<sup>20</sup> Texas CHIP Coalition, *Children's Health Insurance Program Perinate Policy* (Austin: Texas CHIP Coalition, 2005).

<sup>21</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

<sup>22</sup> Ibid.

Medicaid, threatening to remove federal matching should the state continue to provide such unsanctioned coverage. In order to maintain its federal funding, Nebraska was required to immediately halt coverage of undocumented immigrant mothers under the auspices of Medicaid, thus decreasing the number of women receiving prenatal care under Medicaid by over one thousand undocumented immigrants.<sup>23</sup>

However, it appears that a major reason for Nebraska's need to halt coverage for undocumented immigrants was due to unauthorized utilization of federal funds to provide such care. Some states opt to utilize state Medicaid funds in order to provide such coverage. These states include New York, New Jersey, and the District of Columbia.<sup>24</sup> While the services provided by each state differ, some provision of prenatal care and labor and delivery services is provided. Though it may be disadvantageous for states to utilize state-only Medicaid funds since they will be unable to receive a federal match as they would with the Unborn Child SPA, each state does have a particular, distinct motive for their decision.

## **STATE CASE STUDIES**

Though most states do not cover maternal care for undocumented immigrants, of those that do provide such care, each state utilizes a different method and approach. While some opt to utilize a combination of state and federal CHIP funds by using an Unborn Child SPA, others choose to utilize solely state funds to provide such services. Even within states utilizing the same mode of providing prenatal care to undocumented immigrants, the approach utilized in terms of services provided, funding methods, and

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<sup>23</sup> Cindy Gonzalez and Martha Stoddard, "6,000 Women in State Face Loss of Prenatal Care," *Omaha World – Herald*, Jan 30, 2010,

<http://proquest.umi.com/pqdweb?did=1953659771&Fmt=7&clientId=17210&RQT=309&VName=PQD>.

<sup>24</sup> National Immigration Law Center, "State-Funded Medical Assistance Programs," (July 2005).

motives differ tremendously. Being in various geographic regions with differing populations of undocumented immigrants, Texas, Washington, and New York are three interesting case studies to consider when discussing the provision of prenatal care to undocumented immigrants. While Texas and New York have large populations of undocumented immigrants, Washington has a smaller population. Nevertheless, all three states provide prenatal care to this population, though by differing methods.

## **Texas**

As a border state, Texas has the second largest population of undocumented immigrants according to a study conducted by the Pew Hispanic Center in 2009.<sup>25</sup> Texas provides prenatal care to these individuals to ensure a healthier population. This care is provided under the assumption that these infants will become American citizens, thus potentially falling under the auspices of Medicaid or CHIP. In 2006, Texas began utilizing the Unborn Child SPA to offer coverage to pregnant, undocumented immigrants 200 percent of the federal poverty line and below. Texas utilizes a CHIP Separate State Program to provide prenatal care, labor and delivery, and two postpartum visits. This program is known as CHIP Perinatal Coverage and was estimated to cover nearly 48,000 perinates in 2007.<sup>26</sup> While two postpartum visits are provided, care for the mother is terminated at the end of the month in which she gives birth.<sup>27</sup>

One of the main goals for the Texas program is to ensure the unborn child is enrolled in CHIP as quickly as possible until Medicaid can be filed for and granted, thus

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<sup>25</sup> Jeffrey S. Passel and D'vera Cohn, *A Portrait of Unauthorized Immigrants in the United States* (Washington, DC: Pew Hispanic Center, 2009).

<sup>26</sup> Task Force for Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas* (Texas: Task Force for Access to Health Care in Texas, 2008), <http://www.coderedtexas.org/> (accessed April 24, 2010).

<sup>27</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

allowing exemption from the ninety day waiting period and the CHIP asset test.<sup>28</sup> While this may detract from the mother as the individual receiving care throughout her pregnancy, it remains an adequate way to approach the provision of prenatal care to all women. For Texas, the consideration is that the earlier the child is enrolled in an insurance program, particularly if he or she is insured prior to birth, the better the child's health outcomes, as opposed to situations in which no prenatal care is provided or those in which the child is required to wait ninety days for an asset test to be completed. With over 1.5 million undocumented immigrants currently residing in Texas, leaders there may see an advantage to providing prenatal care to these individuals.

As a result of its desire to provide immediate coverage for all American born children who may be eligible for CHIP or Medicaid, Texas provides prenatal services through CHIP Perinatal Coverage. CHIP Perinatal Coverage began in January 2007 and in February 2010, there were over twenty-eight thousand individuals enrolled.<sup>29</sup> This form of coverage is available for the unborn children of pregnant women who are either 185 percent to 200 percent of the federal poverty line and below or are 200 percent of the federal poverty line and below and are not otherwise eligible for Medicaid benefits. CHIP Perinatal Coverage varies from traditional CHIP in that there is no waiting period, and the asset test normally utilized for higher income CHIP cases is not utilized in CHIP Perinatal Coverage cases. Additionally, under CHIP Perinatal Coverage, there are no fees for the patients.<sup>30</sup> These services are provided to low-income women regardless of

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<sup>28</sup> Texas CHIP Coalition, *Children's Health Insurance Program Perinatal Policy*

<sup>29</sup> Texas Health and Human Services Commission, "Children Enrolled in Medicaid, CHIP and CHIP Perinatal Coverage by Month," Texas Health and Human Services Commission,

[http://www.hhsc.state.tx.us/research/Medicaid\\_Chip\\_ChipPerinatal\\_Counts.html#3](http://www.hhsc.state.tx.us/research/Medicaid_Chip_ChipPerinatal_Counts.html#3) (accessed 3/17, 2010).

<sup>30</sup> Texas Health and Human Services Commission, "CHIP Perinatal Coverage Provider Fact Sheet," Texas Health and Human Services Commission,

<http://www.hhsc.state.tx.us/chip/perinatal/InfoForProvidersAndCBOs.htm#b1> (accessed 3/17, 2010).

immigration status. Since this coverage allows children to remain insured for the normal twelve-month coverage period after initial enrollment, these services are in line with Texas's goal of ensuring continuing care and coverage for children immediately upon birth.<sup>31</sup> In terms of specific services, Texas's CHIP Perinatal Coverage provides up to twenty prenatal visits. These visits include one visit every four weeks for the first twenty-eight weeks of pregnancy, one visit every two or three weeks for twenty-eight to thirty-six weeks gestation, and one visit every week for thirty-six weeks gestation until delivery. The program also covers some laboratory testing, education and planning services, some prescription drug costs, and hospital facility and professional service charges associated with delivery.<sup>32</sup>

All services provided are meant to cater to the needs of the unborn child, ensuring a healthy outcome and minimal risk. This point is underscored by analyzing those services excluded from Texas's CHIP Perinatal Coverage, namely inpatient hospital care for the mother not directly related to labor or delivery, false labor, and most outpatient services.<sup>33</sup> Nevertheless, after the child is born, the mother receives two postpartum visits and the child receives normal CHIP coverage for up to twelve months from the date of enrollment.

In Texas, women who are American citizens and are 185 percent of the federal poverty line and below receive prenatal care through Medicaid, rather than CHIP Perinatal Coverage. Thus, demographers studying the program conclude that most individuals enrolled are either legal permanent residents (LPR) or undocumented immigrants. According to personal communication with the Texas Medicaid office,

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<sup>31</sup> Ibid.

<sup>32</sup> Texas Health and Human Services Commission, *CHIP Perinatal Coverage Information for Clients*, 1.

<sup>33</sup> Ibid.

approximately five hundred citizen women are enrolled in the program annually due to their economic status of being between 185 percent and 200 percent of the federal poverty line, a minimal number as compared to the program as a whole. It appears that of those enrolled in the program, about 40 percent are undocumented immigrants while nearly 60 percent are LPRs.<sup>34</sup>

CHIP Perinate Coverage essentially serves as a replacement for the title V Maternal and Child Health Block Grant being utilized in Texas prior to the introduction of CHIP Unborn Child SPAs. While Texas is still able to distribute prenatal care through this grant, with flat funding, its ability to cover a wide proportion of the population is declining.<sup>35</sup> Utilizing this block grant, Texas is technically able to provide prenatal care to all women who are residents of Texas, not necessarily citizens, thus bypassing the question of immigration status.<sup>36</sup> The Maternal and Child Health Block Grant is Title V of the Social Security Act and is the only federal program that strives solely to improve the health of all mothers and children.<sup>37</sup> Texas utilizes these funds to provide prenatal care to many pregnant individuals within the state, including undocumented immigrants. Yet, with the declining funds for this Title V program and a higher federal match rate through CHIP, Texas has moved towards utilizing CHIP Perinate Coverage as the primary method of providing prenatal care to this population.

When discussing birth outcomes, Texas considers the concept known as the “Hispanic Paradox.” This term describes an occurrence seen in many southern states,

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<sup>34</sup> Texas Medicaid Office, phone conversation with author, March 30, 2010.

<sup>35</sup> Jennifer Eldridge, *Health Care Access for Immigrants in Texas* (Austin: Lyndon B. Johnson School of Public Affairs, University of Texas at Austin, 2002).

<sup>36</sup> *Ibid.*

<sup>37</sup> US Department of Health and Human Services, "Maternal and Child Health Bureau: Maternal and Child Health Services Title V Block Grant," US Department of Health and Human Services: Health Resources and Services Administration, <http://mchb.hrsa.gov/programs/blockgrant/overview.htm> (accessed 3/17, 2010).

namely that while Hispanic populations seek prenatal care at a much later stage of pregnancy, if at all, this population tends to have better birth outcomes in terms of low birth weight and preterm birth. There seems to be no difference between the Hispanic populations and white American populations in terms of these birth outcomes and Hispanic populations tend to have even lower rates of infant mortality than do white Americans.<sup>38</sup> While experts are as of yet unsure of the precise reasons for these improved birth outcomes, there have been many speculations. Some cite the Hispanic cultural practices of increased breast-feeding and decreased smoking, while others point to immigration itself. According to Kelaher and Jessop in their article discussing differences in instances of low birth weight between different populations, some official health screening is performed during migration. More importantly, the movement of Hispanics into America promotes “migration of the fittest,” thus decreasing poor health outcomes.<sup>39</sup>

## **Washington**

While Washington had only 180,000 undocumented immigrants as of April 2009, it still provides prenatal care to its undocumented immigrant population utilizing the Unborn Child SPA.<sup>40</sup> Washington applied for and received the Unborn Child SPA in 2003. This raised its eligibility to cover unborn children and provide prenatal care to their mothers who had incomes below 185 percent of the federal poverty line. According to Washington’s initial request for the Unborn Child SPA, its estimated one-year cost of adding prenatal care in 2003 was \$23.5 billion. The state estimated it would provide

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<sup>38</sup> Texas Medicaid Office, phone conversation with author, March 30, 2010.

<sup>39</sup> Margaret Kelaher and Dorothy Jones Jessop, "Differences in Low-Birthweight among Documented and Undocumented Foreign-Born and US-Born Latinas," *Social Science & Medicine* (1982) 55, no. 12 (December, 2002), 2171-2175.

<sup>40</sup> <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=12409130&site=ehost-live>.

<sup>40</sup> Passel and Cohn, *A Portrait of Unauthorized Immigrants in the United States*

coverage to nearly six thousand unborn children.<sup>41</sup> As of January 2008, Washington utilized the CHIP Separate State Program to provide prenatal care and associated health services for mothers from conception and through the start of labor and delivery. These services were funded through CHIP, utilizing the First Steps Program, while labor and delivery were provided and funded by Emergency Medicaid.<sup>42</sup> In 2006, non-citizen births accounted for 21 percent of all Medicaid deliveries in Washington.<sup>43</sup>

Though the provision of prenatal care through CHIP began in 2003, Washington has been providing such care, initially through Medicaid, since 1989 utilizing the First Steps Program. The Department of Social and Health Services (DSHS) and the Washington State Department of Health (DOH) jointly administer the First Steps Program. As stated by the Washington State DOH, the goal of First Steps is to reduce infant mortality and premature birth by utilizing education, early intervention, and other services to support families in making positive healthcare choices.<sup>44</sup> First Steps began in 1989 in response to Washington's poor birth outcomes and low national rankings in terms of prematurity and low birth weight infants. This nationally low birth outcome ranking was cited to be the result of a lack of access to health care for low-income women. In an attempt to improve birth outcomes and lower NICU costs, Washington chose to create First Steps to provide prenatal care to low-income pregnant women.<sup>45</sup>

The program is comprised of three services, Maternity Support Services (MSS), Childbirth Education (CBE), and Infant Case Management (ICM). MSS provides prenatal

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<sup>41</sup> Letter from Dennis Braddock, Secretary of DHS in Washington to CMS

<sup>42</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

<sup>43</sup> Laurie Cawthon, Peter Woodcox and Dorothy Lyons, *County Profiles: Birth and Unintended Pregnancy Statistics 1990 to 2006* (Olympia: Department of Social and Health Services, Planning, Performance, and Accountability Research and Data Analysis Division, 2008).

<sup>44</sup> Office of Maternal and Child Health, "Maternity Support Services," Washington State Department of Health, [http://www.doh.wa.gov/cfh/mch/maternity\\_support\\_services.htm](http://www.doh.wa.gov/cfh/mch/maternity_support_services.htm) (accessed 4/18, 2010).

<sup>45</sup> June Hershey and Rebecca Peters, phone conversation with author, April 13, 2010.

care in order to ensure a healthy pregnancy for all women. There are many prenatal services included within MSS, including assessment, education, intervention, and counseling during pregnancy. Women are permitted to receive up to sixty “units” of service, one unit being the equivalent of fifteen minutes of service.<sup>46</sup> Utilizing state-only funds, First Steps continues to provide two months of postpartum care for all women in addition to family planning services for ten months after First Steps coverage ends.<sup>47</sup> This provision of postpartum care attests to the state’s desire to improve maternal health as well as infant health. Perhaps by improving maternal health and providing family planning services, Washington hopes to improve infant health as well.

In order to ensure the highest quality of care, Washington has adopted a team approach, requiring an interdisciplinary group of various professions and occupations to work together when providing prenatal care. In addition to community health nurses, the team includes registered dieticians, behavioral health specialists, and community health workers.<sup>48</sup> These individuals aid in services that may not be adequately provided by community health nurses. By maintaining a team approach, Washington attempts to create a greater trust between the patient and the healthcare providers. This creation of a relationship and trust between the patient and the provider serves as a form of outreach by fostering a sense of responsibility, thus encouraging women to continue seeking care from their trusted providers.

Yet, Washington employs several methods that encourage individuals to seek and receive prenatal care. In addition to creating a trusting relationship between the provider

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<sup>46</sup> Washington State Department of Social and Health Services and Washington State Department of Health, *First Steps Manual* (Washington: Washington State, 2007).

<sup>47</sup> Baumrucker, *SCHIP Coverage for Pregnant Women and Unborn Children*

<sup>48</sup> Washington State Department of Social and Health Services and Washington State Department of Health, *First Steps Manual*, 1-162.

team and the patient, First Steps provides childcare during prenatal care appointments for women with children. This provision allows these women to pursue the necessary prenatal care without the concern of finding childcare arrangements. First Steps also provides transportation to prenatal care appointments, allowing women to seek care regardless of their location.<sup>49</sup> This provision is particularly important as women are given the opportunity to seek the care of any provider participating in First Steps.<sup>50</sup> With providers located in the various counties of the state, women have access to the prenatal care guaranteed to them. This access to adequate prenatal care has greatly improved birth outcomes in Washington since the program's inception. With such a high proportion of births funded by Medicaid (47 percent in 2008), providers must participate in the program.<sup>51</sup>

## **New York**

As of 2008, New York had the fourth largest unauthorized immigrant population of all fifty states, with 925,000 such individuals. Similar to Texas, New York may have found it necessary to provide prenatal care to pregnant undocumented immigrants in order to ensure a healthier state population. New York's method of covering this population is quite different than the states encountered thus far. Rather than utilizing the Unborn Child SPA under CHIP, thus allowing for a federal match, New York utilizes state only Medicaid funds. The downside of this approach is that it is more costly to the state. Not only is New York unable to utilize federal funds to cover this maternal care,

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<sup>49</sup> Washington State Department of Social and Health Services, "First Steps General Information and how to Apply," Washington State Department of Social and Health Services, <http://hrsa.dshs.wa.gov/firststeps/FS.Client%20Page/FS.Client.index.08.06.htm#How%20do%20I%20qualify%20for%20First%20Steps> (accessed 4/18, 2010).

<sup>50</sup> June Hershey and Rebecca Peters, phone conversation with author, April 13, 2010.

<sup>51</sup> Laurie Cawthon, Peter Woodcox and Dorothy Lyons, *County Profiles: Birth and Unintended Pregnancy Statistics 1990 to 2006* (Olympia, Washington: Department of Social and Health Services, Planning, Performance, and Accountability Research and Data Analysis Division, 2008) (accessed April 25, 2010).

but it is also unable to gain any federal match on the state funds utilized for this provision. One reason cited for the lack of utilization of the CHIP Unborn Child SPA is an ideological one in terms of disagreeing with the premise of providing care to the unborn child rather than the mother.<sup>52</sup> Regardless of the reason, New York does lose these potential federal funds.

The specific program New York utilizes to provide prenatal care to all Medicaid-eligible, pregnant women is the Prenatal Care Assistance Program (PCAP). According to the New York Immigration Coalition, all pregnant immigrants in New York State, regardless of legal status, are eligible for PCAP, so long as their incomes are in accordance with eligibility requirements.<sup>53</sup> In order to be eligible for Medicaid, a pregnant woman must be 200 percent of the federal poverty line or below.<sup>54</sup> Contrary to the Unborn Child SPA, PCAP provides care directly to the mother, not to the unborn child. In an attempt to improve prenatal care standards for all women in New York State, the New York State Department of Health developed Medicaid Prenatal Care Standards in November 2009.<sup>55</sup> While certain quality standards have been in place since the program's inception in 1989, updates to the quality standards were made and implemented in 2009. These standards detail not only the patient and provider requirements, but also the precise list of services provided for Medicaid eligible pregnant

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<sup>52</sup> Alice Berger, phone conversation with author, April 16, 2010.

<sup>53</sup> New York Immigration Coalition, *Access to Health Care for Uninsured Immigrants* (New York: New York Immigration Coalition, 2009).

<sup>54</sup> New York State Department of Health Office of Medicaid Management, *Prenatal Care Assistance Program: Medicaid Policy Guidelines Manual* (New York: New York State Department of Health Office of Medicaid Management, 2007).

<sup>55</sup> New York State Department of Health, "Prenatal Care Standards," *New York State Medicaid Update* 26, no. 2 (February 2010), [http://www.health.state.ny.us/health\\_care/medicaid/program/update/2010/2010-02\\_special\\_edition.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-02_special_edition.htm) (accessed March 18, 2010).

women, including undocumented immigrant women who qualify for the same services as all others.

While there are many provider and staff requirements delineated by the New York Medicaid Prenatal Care Standards of November 2009, the two most significant of these are the requirement to participate in quality improvement initiatives as seen fit by the Commissioner of Health and the requirement to promote a culturally sensitive environment for the delivery of prenatal care. The latter of these requirements includes situations in which the recipient of care has a limited proficiency in English. Providers are required to provide translation services to these individuals in order to ensure the client is made aware of her health situation and is able to give consent to any and all provider procedures and services.<sup>56</sup> Since many undocumented immigrants may decline to seek medical attention for fear of being deported due to their immigration status, the requirement to create a culturally sensitive environment is particularly pertinent.

The New York Medicaid Prenatal Care Standards of 2009 outline the services provided to all pregnant women covered by Medicaid. These services include prenatal risk assessment, screening, and referral for care; psychosocial risk assessment, screening, and counseling; nutritional screening and counseling; health education; development of a care plan and care coordination; prenatal care services; and postpartum service.<sup>57</sup> As is evident by this myriad of services offered under New York's Medicaid program, services are meant specifically for mothers, contrary to those provided under Unborn Child SPAs. Many of the categories of services overlap, but the most important category for this paper is that of prenatal care services. In New York, prenatal care includes comprehensive

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<sup>56</sup> Ibid.

<sup>57</sup> Ibid.

assessments, standard and special laboratory tests, HIV services, dental care, immunizations, lead poisoning prevention, testing, ultrasound utilization, genetic disorders screening, and one postpartum visit.<sup>58</sup> While provision of these services attempts to ensure the best birth outcomes, many are primarily concerned with the mother's health as well.

The services provided by Medicaid for pregnant women are somewhat comparable to those provided by Texas under the Unborn Child SPA. Just as in Texas, a physician is meant to see the patient every four weeks for the first twenty-eight weeks of gestation, every two weeks between twenty-eight and thirty-six weeks gestation, and weekly between thirty-six weeks gestation and birth.<sup>59</sup> Since the American Congress of Obstetricians and Gynecologists recommends this schedule, it appears to be the ideal prenatal care schedule, thus causing its utilization in both Texas and New York.<sup>60</sup>

PCAP operates under a premise of presumptive eligibility. In other words, health care providers are able to conduct a preliminary financial screen for a pregnant woman and, if she is found initially eligible, they are required to provide her with prenatal care, even before her Medicaid eligibility is officially confirmed.<sup>61</sup> This may further aid in providing prenatal care for undocumented immigrants. If these pregnant undocumented women are made aware of the fact that providers are required to treat all pregnant women under 200 percent of the federal poverty line should they be found eligible under

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<sup>58</sup> New York State Department of Health, "New Prenatal Care Legislation Enacted," *New York State Medicaid Update* 26, no. 2 (February 2010), [http://www.health.state.ny.us/health\\_care/medicaid/program/update/2010/2010-02\\_special\\_edition.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-02_special_edition.htm) (accessed March 18, 2010).

<sup>59</sup> New York State Medicaid Program, *Information for all Providers: General Policy* (New York: New York State Medicaid Program, 2010).

<sup>60</sup> Texas Medicaid Office, phone conversation with author, March 30, 2010.

<sup>61</sup> New York State Department of Health Office of Medicaid Management, *Prenatal Care Assistance Program: Medicaid Policy Guidelines Manual*, 1-18.

presumptive eligibility, perhaps they will be more likely to seek at least initial prenatal care knowing that it will not be denied. Upon this first utilization of prenatal care, these women will realize that they are, in fact, eligible for PCAP, thus further ensuring their natal health and that of their child.

Though it does not utilize any federal funds and does not have an Unborn Child SPA, New York provides a wide array of prenatal care services to pregnant, undocumented immigrants. These prenatal care services provided under the auspice of state-funded Medicaid are comprehensive, inclusive, and even quality insured, thus more likely to lead to good health outcomes for both mother and child. The purpose of these services is to improve overall state health with the ideology that healthcare is a right, not a privilege.<sup>62</sup>

## CONCLUSION

As is evident from much prior research, providing prenatal care for mothers greatly improves their infants' health outcomes.<sup>63</sup> Prenatal care can also aid in decreasing NICU use and costs. As of 2008, Medicaid covered approximately 41 percent of all births in America.<sup>64</sup> While only about 4 percent of these births result in infant admission to the NICU, these infants account for nearly 75 percent of the total sum spent on newborn care.<sup>65</sup> According to a study conducted by Kornhauser and Schneiderman in early 2010 concerning NICU costs, NICU patients account for about 0.15 percent of the total

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<sup>62</sup> Alice Berger, phone conversation with author, April 16, 2010.

<sup>63</sup> Lu and others, *Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A cost/benefit Analysis*, 233-239.

<sup>64</sup> Melanie Bella, *Quality Improvement in Medicaid: Opportunities for States* (New Jersey: Center for Health Care Strategies, Inc., 2008).

<sup>65</sup> Edward F. Bell, "What to Look for in a Neonatal Intensive Care Unit," University of Iowa Children's Hospital, <http://www.uihealthcare.com/topics/medicaldepartments/pediatrics/neonatalintensivecareunit/index.html> (accessed 4/25, 2010).

population in America, but for about 0.45 percent of its entire health care costs.<sup>66</sup> The fact that a disproportionate amount of funds go towards NICU costs exemplifies the high costs for NICU infants. Additionally, in 2007, perinatal hospital stays accounted for over 25 percent of all hospital stays covered by Medicaid, a value second only to pregnancy and childbirth related stays.<sup>67</sup>

Since prenatal care can aid in decreasing NICU use, it is beneficial to assess the limited access to prenatal care for undocumented immigrants throughout the United States. While undocumented immigrants' health care is not itself a major concern of the United States, their children who are born in the United States will become American citizens and may qualify for Medicaid or CHIP. It appears to be cheaper to provide prenatal care to pregnant undocumented women than to care for their children who may be admitted to the NICU. As seen in table 1, providing prenatal care to women utilizing Medicaid amounts to approximately \$2,142. With an average length of stay of twenty days in the NICU, the costs amount to nearly \$60,000. While it is fair to claim that the majority of infants are not admitted to the NICU, as evidenced above in that only 13 percent of all births in America result in NICU admission, prenatal care remains a cheaper provision than does NICU care. Providing prenatal care to all women utilizing Medicaid for birth coverage would amount to slightly over \$3.7 billion. On the contrary, providing twenty days of NICU care to the 4 percent of premature infants whose mothers

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<sup>66</sup> Michael Kornhauser and Roy Schneiderman, "How Plans can Improve Outcomes and Cut Costs for Preterm Infant Care," *Managed Care Magazine*, January 2010, 2010, 28,

[http://www.nxtbook.com/nxtbooks/mediimedia/managedcare\\_201001/#/34](http://www.nxtbook.com/nxtbooks/mediimedia/managedcare_201001/#/34) (accessed April 20, 2010).

<sup>67</sup> Healthcare Cost and Utilization Project, *HCUP Facts and Figures: Statistics on Hospital-Based Care in the United States, 2007* (Maryland: Agency for Healthcare Research and Quality, 2007) (accessed April 25, 2010).

utilize Medicaid for birth coverage would amount to around \$4.2 billion.<sup>68</sup> In addition to decreasing NICU utilization, prenatal care can reduce the risk of low birth weight and premature infants, thus decreasing the chances that these infants will develop life-long disabilities that may grant them Medicaid for life.

Many states, particularly those with large immigrant populations, have realized that providing prenatal care will decrease NICU and future costs and will create a healthier population. While Texas and Washington, along with twelve other states, utilize the Unborn Child SPA, granting them the ability to utilize some federal funds for their provisions of care, New York, along with one other state, chooses to utilize state-only Medicaid funds, providing the same services to its pregnant, undocumented immigrant population as to all other pregnant women qualifying for Medicaid. All the programs provide some form of adequate prenatal care, though by differing means and for differing reasons. Nevertheless, the underlying, perhaps unstated goal remains the same: ensuring a healthier population throughout the state.

## **RECOMMENDATIONS**

Since the provision of prenatal care for undocumented immigrants is not federal, it may be beneficial to further analyze individual state programs. To begin with, CMCS may wish to further investigate provider participation in the various programs in an attempt to delineate the actual accessibility of prenatal care in these various states. In an attempt to discover the true cost-benefit analysis of providing prenatal care to these populations, it may be useful for CMCS to consider the correlation between prenatal care and birth outcomes particularly as they apply to the undocumented immigrant population.

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<sup>68</sup> Calculations by author using birth rate figures from CIA World Factbook and cost figures from Kornhauser et al.

Finally, while each state employed certain outreach efforts upon the program's inception, many of them have halted these efforts. It may be advantageous for CMCS to consider the correlation between outreach efforts and program participation in order to assess the benefits of outreach.

## APPENDIX

**Table 1: Costs Comparison: NICU vs. Prenatal Care**

Average NICU Cost per infant	\$60,000
Average cost of prenatal care for women under Medicaid	\$2,142
Average delivery cost for women under Medicaid	\$4,577
Approximate cost of providing prenatal care to all Medicaid-birth women	\$3.7 billion
Approximate cost of providing NICU care to all Medicaid born infants admitted to NICU	\$4.2 billion

Sources: Kornhauser and Schneiderman, 2010; Anonymous, 2007; & CIA website

**Table 2: Summary of State Programs**

	<b>Texas</b>	<b>Washington</b>	<b>New York</b>
Number of Undocumented Immigrants in State (rank)	1,450,000 (2)	180,000 (15)	925,000 (4)
Upper-Income Threshold (% FPL)	200% FPL	185% FPL	200% FPL
Method of Coverage	CHIP Unborn Child SPA – CHIP Perinatal Coverage	CHIP Unborn Child SPA – First Steps Program	Medicaid State-only funds – PCAP
Characteristics of coverage program	<ul style="list-style-type: none"> <li>• No asset test</li> <li>• No waiting period</li> <li>• Services provided regardless of immigration status</li> </ul>	<ul style="list-style-type: none"> <li>• No asset test</li> <li>• Team approach to care</li> <li>• Services provided regardless of immigration status</li> </ul>	<ul style="list-style-type: none"> <li>• No asset test</li> <li>• Care directly to the mother</li> <li>• Presumptive eligibility</li> <li>• Services provided regardless of immigration status</li> </ul>
Description of prenatal care	<ul style="list-style-type: none"> <li>• Up to 20 prenatal visits: <ul style="list-style-type: none"> <li>◦ 1 visit every 4 weeks for first 28 weeks gestation</li> <li>◦ 1 visit every 2 weeks 28-36 weeks gestation</li> <li>◦ 1 visit every week 36 weeks to birth</li> </ul> </li> <li>• Lab testing, education, and family planning</li> </ul>	<ul style="list-style-type: none"> <li>• Services include: <ul style="list-style-type: none"> <li>◦ Screening</li> <li>◦ Education</li> <li>◦ Family planning</li> <li>◦ Transportation to appointments</li> <li>◦ Child care during appointments</li> <li>◦ Drug education and assistance</li> </ul> </li> <li>• Up to 60 “units” of care – one unit is 15 minutes</li> </ul>	<ul style="list-style-type: none"> <li>• Services include: <ul style="list-style-type: none"> <li>◦ Comprehensive assessments</li> <li>◦ Standard and special lab tests</li> <li>◦ HIV services</li> <li>◦ Dental care</li> <li>◦ Immunizations</li> <li>◦ Lead poisoning prevention</li> <li>◦ Testing</li> <li>◦ Ultrasounds</li> <li>◦ Genetic disorders screening</li> </ul> </li> <li>• Same schedule as Texas</li> </ul>
Description of labor/delivery care	<ul style="list-style-type: none"> <li>• Provided through CHIP Perinatal Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Provided through Emergency Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Provided through PCAP</li> </ul>
Description of postnatal care	<ul style="list-style-type: none"> <li>• Two postpartum visits</li> <li>• Allows children coverage for 12 months post enrollment</li> </ul>	<ul style="list-style-type: none"> <li>• 60 days through state-only funds</li> <li>• Family Planning Services for 10 months after First Steps ends</li> </ul>	<ul style="list-style-type: none"> <li>• One postpartum visit, but includes many services including depression screening</li> </ul>
Motives	<ul style="list-style-type: none"> <li>• Higher CHIP match</li> <li>• Large number of Undocumentededs</li> <li>• Insure children as quickly as possible</li> </ul>	<ul style="list-style-type: none"> <li>• Improve birth, pregnancy, and parenting outcomes</li> <li>• Coverage to low-income women</li> <li>• Lower NICU costs</li> </ul>	<ul style="list-style-type: none"> <li>• Large number of undocumented immigrants</li> <li>• Improve birth outcomes</li> <li>• Healthcare as a right, not a privilege</li> </ul>

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