Missing Babies: Best Practices for Ensuring Continuous Enrollment in Medicaid and Access to EPSDT

Executive Summary

For more than 25 years, federal law has guaranteed automatic and continuous enrollment, beginning at birth and continuing uninterrupted through the first year of life for most babies whose births are financed by Medicaid. The purpose of these provisions—passed with bipartisan Congressional support under the Deficit Reduction Act of 1984 (P.L. 98-369)—is to ensure that babies would not experience even a single day's break in coverage from the date of birth through the first year of life. Policy changes in 2009 further strengthened the law's protections and reach.

States have used various strategies for implementing this special automatic newborn and infant continuous enrollment protection; however, over the years, Medicaid's increasing operational and technical complexity resulting from changes in health care delivery such as managed care have made infant enrollment more challenging. As a result, states' approaches to implementation vary widely.

Federal law requires this so called "deemed" eligibility to infants born to mothers covered by Medicaid (i.e., those having a Medicaid financed birth), from the date of the child's birth and continuing through the first year of life. States are required to:

- Provide Medicaid coverage for newborns born to a woman covered by Medicaid for the child's birth.
- Not require separate eligibility application and determination.
- Eliminate rules requiring that infants must live with mother or mother remain eligible for Medicaid.
- Use the mother's Medicaid identification number for up to a year and/or issue a separate number/card to the baby for mothers who lack a Medicaid number.
- Not require proof of citizenship for the first year of an infant's life.
- Continue infant eligibility until the first birthday unless the child dies, moves out of state, or the family requests voluntary disenrollment.
- Conduct a redetermination of eligibility and notify the family prior to a baby's first birthday.

This project analysed state reported data on infants enrolled in Medicaid and entitled to EPSDT benefits. National and state trends indicate the following.

- In each year between Federal Fiscal Years (FFY) 2010-2018, more than 2.3 million infants were counted by states as enrolled in Medicaid and entitled to EPSDT benefits. This is more than half of the total 3.9 million U.S. births per year.
- On average, each year more than 500,000 babies in Medicaid were not counted as enrolled for least 90 days continuously in their first year.
- Most states show a gap between the number of infants counted as eligible and the number continuously enrolled. The percentage varies substantially by state, ranging from a low of 6% to a high of 41% in FFY 2018.
- The variations in data by state suggest that the gap is the result of state administration practices related to the actual enrollment process or data reporting, not simply variation attributable to the timing of births.

Executive summary from: Johnson K. Missing Babies: Best Practices for Ensuring Continuous Enrollment in Medicaid and Access to EPSDT. Johnson Group Consulting, Inc. January, 2021.
This work was funded by a grant from the David and Lucile Packard Foundation.

BEST PRACTICES FOR INFANT ENROLLMENT

Prenatal

- Inform during prenatal visits.
- Preassign number for baby.
- Give cards with preassigned numbers.
- Use outstationed eligibility workers, navigators, home visitors, and others to assist and inform families.

Birth

- Inform family.
- Set up simple methods for notice of birth.
- Use mother's number until infant number / card is received.
- Provide tools for families and providers to verify enrollment.
- Establish effective methods to auto-enroll whether birth financed by managed care or fee-for-service.

Infant

- Require no action by family before time of first birthday.
- Use mother's number until infant number / card is received.
- Continue enrollment throughout year.
- Use technology to flag when any infant is disenrolled.
- Develop a data dashboard for infant enrollment.

First birthday

- Inform and remind family prior to first birthday.
- Conduct re-determination process automatically.
- Offer no wrong door approach (e.g., in-person, online, or e-mail document submission).
- Conduct data quality reviews of CMS 416, T-MSIS, and other data.

Basic elements to support these approaches: policies and procedures aligned with federal law, trained eligibility staff, specific managed care contract provisions, clear communications materials, and effective data and IT systems.

RECOMMENDATIONS FOR STATE ACTION

Project findings from analysis of data, state procedures, contract language, and communications point to opportunities for states to improve their implementation of automatic newborn and continuous infant eligibility. These recommendations apply during and beyond the COVID-19 public health emergency.

ELIGIBILITY RULEs AND PROTOCOLS

- Aim to have every baby with a Medicaid/CHIP financed birth leave the birth facility (e.g., hospital, birthing center) with a card or written document that shows the eligibility/identification number to be used for infant care.
- Assure that state rules and regulations are aligned with federal law requirements.
- Set up enrollment procedures and protocols that are streamlined, clear, and have administrative check points around both the time of birth and the time of the first birthday.
- Include clear and specific language regarding automatic newborn and continuous infant enrollment in Medicaid contracts with MCOs, ACOs, and similar entities.
- Develop specific procedures for automatic newborn enrollment of infants born to a mother who has emergency labor and delivery coverage only.
- In states that rely on managed care plans to facilitate reports of birth and automatic enrollment, develop specific procedures for women who are not enrolled in MCOs.
- Use a State Plan Amendment (SPA) to adopt all options for coverage for infants with a CHIP financed birth, and thereby expand automatic newborn coverage.
- Under the Families First Coronavirus Response Act maintenance of effort provisions, do not disenroll children who reach their first birthday who were enrolled as infants as of March 18, 2020 or thereafter during the COVID-19 public health emergency (unless they move out of state or voluntarily disenroll).

COMMUNICATIONS AND OUTREACH

- Update and clarify communications regarding Medicaid eligibility for infants in materials designed for use with providers and health plans (e.g., rules, guidance, provider manuals, websites, reporting forms, billing procedures, etc.).
- Improve and update communications aimed at informing families about Medicaid eligibility for infants (websites, brochures, benefits booklets, letters, etc.).
- Include information about deemed infants in both communications related to pregnancy and communications related to children, giving the topic of infant coverage its own subheading or section.
- Train and involve health navigators, outstationed eligibility workers, home visitors, staff in WIC programs, and others in the process for automatic and newborn eligibility.

DATA AND ANALYSIS

- Review CMS Form 416 data annually with the aim of improving data quality, particularly analyzing trends in infant continuous enrollment.
- Use electronic systems for matching data (e.g., vital statistics and Medicaid pregnancy or infant enrollment).

- Link birth data and Medicaid data to assess the percentage of covered births, maternal and infant outcomes, and automatic and continuous infant enrollment.
- Take advantage of opportunities in the Transformed Medicaid Statistical Information System (T-MSIS) to support automatic newborn and continuous infant eligibility and utilization of care by the youngest children in Medicaid and CHIP.

ALIGNING MATERNAL AND INFANT ELIGIBILITY

- Develop prenatal approaches for designating a Medicaid identification number to the infant (e.g., special cards with preassigned numbers), which can be quickly validated at the time the state agency receives notice of the birth.
- Increase prenatal focus on informing parents about the automatic newborn coverage rules and on designation of a pediatric primary care provider.
- Adopt Medicaid policies to extend Medicaid postpartum coverage for 12 months following the end of pregnancy.

CONCLUSION

More than one half million babies per year are not counted by states as continuously eligible for Medicaid and therefore are not entitled to EPSDT well-baby visits and other needed care, reflecting at least data issues and perhaps a much larger and troubling concern about gaps in infant enrollment.

The nation cannot afford to miss the opportunity to provide preventive and other needed health services for so many babies. The first year of life sets a foundation for future well-being; a time when both preventive care and early identification and treatment of special health needs are critical for ensuring optimal health and development. Automatic and continuous enrollment is particularly important given that the Bright Futures Guidelines call for six visits in the first year after an infant leaves the hospital as a newborn. Immunizations are due at five of those well-baby visits. Developmental screening is due at the 9-month well-baby visit. Maternal depression screening is also recommended during well-baby visits. Moreover, infants are more likely to suffer life threatening conditions than older children. For example, without infant coverage, a child's developmental delays may not be detected at the 9-month visit, a respiratory infection may be left unattended to become critical and life threatening, and services for conditions identified by newborn screening may not be provided. Such serious and life-threatening conditions were one factor that stimulated Congressional adoption of the automatic newborn and continuous infant eligibility requirements.

Medicaid and CHIP are key sources of health coverage for approximately half of all births, and the programs are particularly important for families of color having babies. The Kaiser Family Foundation reports that approximately two-thirds of Black, American Indian/Alaska Native, and Hispanic infants have coverage through Medicaid and CHIP public coverage. We cannot achieve health equity for infants and young children without effective state policies and administrative procedures.

Every state can do much better in implementation of this policy. Improved policy is needed to ensure that our babies get the coverage to which they are entitled and that they have access to services that will optimize their health and development. In tandem, Congressional and state action to provide one year of postpartum coverage for new mothers is needed to align maternal and infant coverage in Medicaid and CHIP. Having both maternal and infant coverage under Medicaid be continuous for one year following a birth is a major step toward ending disparities in maternal and infant mortality and giving our children an equitable start.