CONNECTICUT VOICES FOR CHILDREN

Births to Mothers in HUSKY A: Prenatal Care, 2002

June 2005

Increasing access to prenatal care is one of the central features of policies and programs aimed at improving birth outcomes in the United States. In the mid-late 1980s, Congress expanded Medicaid coverage for pregnant women in order to help them obtain early and adequate prenatal care.

In Connecticut, pregnant women in families with income below 185% of the federal level are eligible for Medicaid and enroll in HUSKY A (Medicaid managed care) during pregnancy and for 60 days postpartum.[1] Some low-income women, including those with children, are already enrolled in HUSKY A when they became pregnant. Other women become eligible for HUSKY A coverage when they become pregnant. HUSKY A health plans are responsible for identifying pregnant women as early as possible; conducting risk assessment; providing needed assistance with appointment scheduling, transportation, and other support services; making referrals to the WIC program; providing care coordination and specialized services for high risk women; and offering prenatal health education aimed at promoting healthy birth outcomes.

This report is the third annual summary of data on births to mothers in HUSKY A (Medicaid managed care), previously issued by the Children's Health Council, and now issued by Connecticut Voices for Children in 2005.[2]

Methods

Records of births in 2002 were linked with HUSKY A enrollment data files in order to identify births to mothers who were enrolled in HUSKY A at the time they gave birth.[3] Prenatal care timing and adequacy for births to mothers enrolled in HUSKY A was compared with prenatal care for all other births in Connecticut in 2002. Results are summarized and compared to birth outcomes in HUSKY A for 2000 and 2001.

Results

In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born.[4]

Compared with other mothers, mothers who gave birth while enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% v. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v. 7%) or Hispanic (32% v. 12%).

Table 1. 2002 Births: Prenatal care

	Births to mothers in HUSKY A	Births to other mothers
When prenatal care began:		
1st trimester	**79%**	**97%**
Late or no care	**3%**	**2%**
Had adequate prenatal care	**73%**	**87%**

Timing of prenatal care: Mothers who gave birth while enrolled in HUSKY A were significantly less likely than other mothers to begin care in the first trimester (13 weeks gestation or less) and more likely to have begun care late in pregnancy or not at all (Table 1). They were also less likely to have had adequate care, that is care that began early followed by at least 80% of the recommended number of visits, adjusted for gestational age. In each racial/ethnic group, those in HUSKY A were more likely than other mothers to have delayed prenatal care or had no care at all.

The timing and adequacy of prenatal care by the health plan in which the mother was enrolled in the month she gave birth are shown in Figures 1 and 2. The variation between plans is attributable at least in part to when women began care even before enrolling in HUSKY A.

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Figure 1. Early Prenatal Care by Health Plan

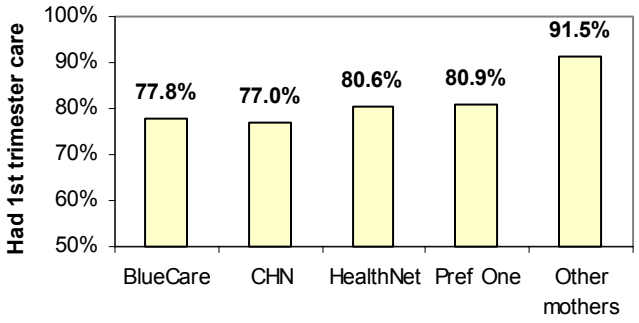
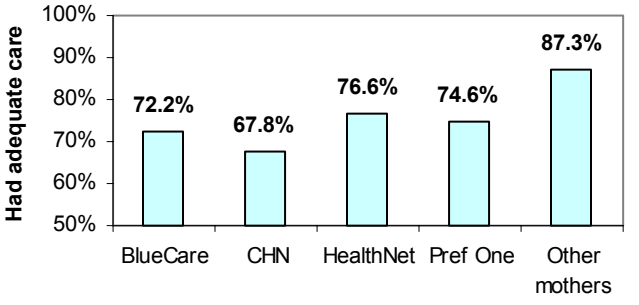


Figure 2. Prenatal Care Adequacy by Health Plan



HUSKY A health plans: BlueCare Family Plan, Community Health Network, HealthNet, Preferred One.

Trends: The total percentage of all births covered by Medicaid (managed care and fee-for-service) increased to 29 percent in 2002, up from with 27 percent in 2000 and 28 percent in 2001).

Compared with prenatal care in 2000, the proportion of births to HUSKY A mothers who began care in the first trimester was essentially unchanged, as was the proportion who had late or no prenatal care. The proportion of births to HUSKY A mothers who had adequate care (73%) was down slightly from 76 percent in 2000.

Comparison with national data: In 2002, the proportion of US women who began prenatal care in the first trimester was 84 percent, up from 76 percent in 1990. Connecticut and other New England states were among states reporting the highest proportion of mothers with first trimester prenatal care in 2002. The proportion of women with adequate or better-than-adequate prenatal care was 75 percent, up from 67 percent in 1990.[5]

National data show that women who delay or forgo prenatal care are more likely those who are under age 20, Black women, women with less than a high school education, and women on Medicaid.[6]

Discussion

Prenatal care has been shown to improve pregnancy outcomes for many women who are at risk for adverse birth outcomes, mainly by providing support and advice and by managing chronic and pregnancy-related health conditions. The Center for Health Care Strategies has identified effective strategies and best practices for improving birth outcomes in Medicaid managed care programs, including early identification of pregnant members, systematic assessment of health risks, outreach to those who do not seek care, and management of health risks like smoking and maternal depression. [7]

Recommendation

In the upcoming contract period, a quality improvement project in HUSKY A should focus on improving access to prenatal care and quality.

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[1] Pregnant women are eligible if family income is less than $23,736 for family of 2, $29,767 for family of 3, and $35,798 for family of 4. For eligibility determination, a pregnant woman is counted as two persons.

[2] Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on births was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant to Connecticut Voices from the Hartford Foundation. Performance monitoring in HUSKY A builds on work begun by the Children's Health Council which was created by the Connecticut General Assembly in 1995 and charged with evaluating the impact of Medicaid managed care on children's health services. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow. This report is also available at www.ctkidslink.org.

[3] Data sources: Connecticut Department of Public Health (2002 birth records, released to Connecticut Voices with the approval of DPH Human Investigations Committee) and Connecticut Department of Social Services (HUSKY A enrollment data). For a detailed description of the data elements, data linkage and evaluation, see technical notes in: Children's Health Council. Births to mothers in HUSKY A: 2000. Hartford, CT: CHC, February 2003. (Available at www.ctkidslink.org.)

[4] Birth certificates in Connecticut do not identify source of payment for prenatal care or birth, so births to women whose care was covered by fee-for-service Medicaid (n=2,153) are counted among births to other mothers.

[5] Martin JA et al. Births: final data for 2002. National Vital Statistics Reports, 2003; 52(10): 1-116.

[6] Beck LF et al. Prevalence of selected maternal behaviors and experiences, Pregnancy Risk Assessment Monitoring System (PRAMS), 1999. Morbidity and Mortality Weekly Report, 2002; 51(SS02): 1-26.

[7] Oehlmann ML. Toward improving birth outcomes: a best clinical and administrative practices toolkit for Medicaid health plans. Lawrenceville, NJ: Center for Health Care Strategies, Inc., 2001.