



## Births to Mothers in HUSKY A: Prenatal Care, 2004

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Efforts to improve maternal health and birth outcomes focus mainly on ensuring timely, high quality prenatal care for all women and risk-appropriate care for women at increased risk for adverse outcomes. In Connecticut, pregnant women in low-income families are eligible for Medicaid.<sup>1</sup> Access to prenatal care is better for low-income women with Medicaid coverage.<sup>2</sup>

Most pregnant women are enrolled in HUSKY A (Medicaid managed care). HUSKY A health plans are responsible for linking expectant mothers with prenatal care providers as early as possible in pregnancy, providing assistance with appointment scheduling, transportation, and other support services; and providing case management and specialized services for high risk mothers. Some pregnant women are covered with fee-for-service Medicaid, including eligible women who apply for coverage in the third trimester and whose prenatal care providers do not participate in one of the managed care provider networks. Fee-for-service coverage is also available to eligible US citizens and qualified legal immigrant women who failed to apply during pregnancy (retroactive coverage) and to undocumented immigrant women (emergency Medicaid to cover hospital charges for care during labor and delivery).

### Methods

This report is the fifth annual summary of data on births by town to mothers in Medicaid.<sup>3</sup>

Records of births in 2004 were linked with HUSKY A enrollment files and with Medicaid eligibility data in order to identify births to mothers who were enrolled in HUSKY A or Medicaid fee-for-service (FFS) at the time they gave birth.<sup>4</sup> Rates for early prenatal care (first visit before 13 weeks gestation) and adequate prenatal care (care that began in the first trimester with more than 80 percent of the recommended

number of prenatal visits for gestation; includes “intensive” and “adequate” categories of care) were determined and compared by payer source (HUSKY A, FFS, other payers) and by HUSKY A health plan (Blue Care Family Plan, Community Health Network [CHNCT], Health Net, Preferred One).

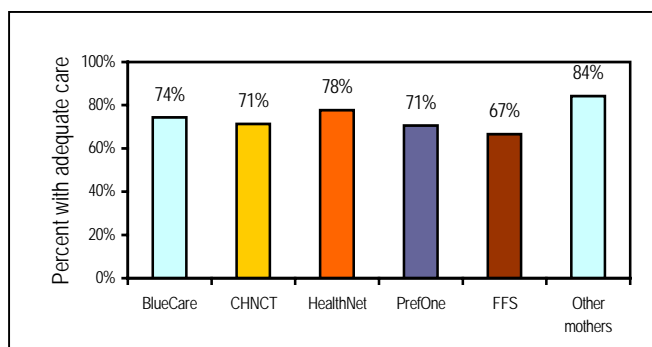
### Results

In 2004, there were 42,004 births to Connecticut residents, including 10,373 births (24.7%) to mothers enrolled in HUSKY A and 2,535 births (6.0%) to mothers whose births were covered by FFS Medicaid.

In 2004, mothers in HUSKY A were far less likely than other mothers to begin prenatal care early in the pregnancy (78% v. 93%) and less likely to have had adequate prenatal care (74% v. 84%). However, mothers in HUSKY A were more likely than those with FFS Medicaid to have had early care (78% v. 64%) and more likely to have had adequate prenatal care (74% v. 67%).

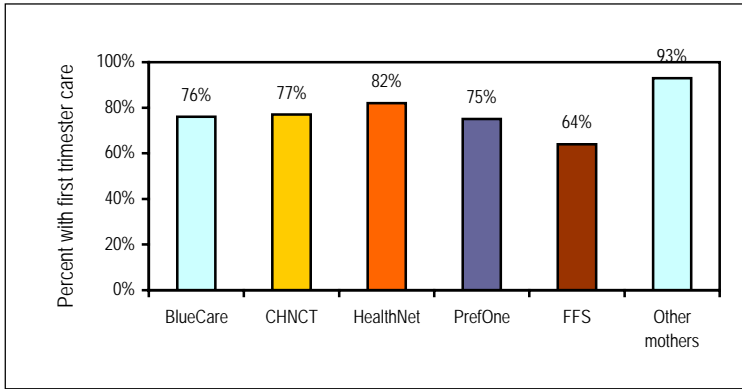
The timing and adequacy of prenatal care by the health plan in which the mother was enrolled in the month she gave birth are shown in Figures 1 and 2 and compared with rates for women with FFS coverage and other mothers.<sup>5</sup>

**Figure 1. Mothers with Early Prenatal Care by MCO and Payer Source: 2004**



Note: May include care prior to enrollment or coverage.

**Figure 2. Mothers with Adequate Prenatal Care by MCO and Payer Source: 2004**



Note: May include care prior to enrollment or coverage.

## Comparison with national data

**Initiation of prenatal care:** In the US in 2004, 84 percent of all mothers began prenatal care in the first 13 weeks of pregnancy. This rate is essentially unchanged from 2003, marking the end of a steady increase in early initiation of prenatal care since 1990.<sup>18</sup> The first trimester prenatal care rate for Connecticut was higher overall (88%), but lower for mothers in HUSKY A (78%) and lower still for mothers with FFS Medicaid coverage (64%).

**Adequacy of prenatal care:** No national data are available for comparison with Connecticut experience.

## Conclusions

- Nearly one in three babies born in Connecticut in 2004 was born to a mother whose care was covered by Medicaid.** Expanded Medicaid has been shown elsewhere to increase access to early and adequate prenatal care, thereby offsetting some of the social and health differences that contribute to greater risks for low-income mothers and babies who are otherwise likely to be uninsured.
- Connecticut can do even more to improve maternal and infant health.** Other states cover pregnant women at higher income levels,<sup>6</sup> cover undocumented pregnant women,<sup>7</sup> and provide coverage for new mothers beyond 60 days postpartum.<sup>8</sup> In addition, Connecticut can improve care with increased access to family planning, risk-appropriate preconception care, prenatal care, and prenatal care case management for mothers in HUSKY A and FFS Medicaid.

<sup>1</sup> Pregnant women are eligible for Medicaid coverage during pregnancy and for 60 days postpartum if living in households with family income less than 185 percent of the federal poverty level (FPL) (about \$29,000 for a family of three in 2004; a pregnant woman is counted as 2 persons for purpose of determining her eligibility).

<sup>2</sup> Hessol NA et al. Reduced risk of inadequate prenatal care in the era after Medicaid expansions in California. *Med Care*, 2004; 42(5): 416-22. Rittenhouse DR et al. Improvements in prenatal insurance coverage and utilization of care in California: an unsung public health victory. *Matern Child Health J*, 2003; 7(2): 75-86.

<sup>3</sup> Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report was prepared under a contract between the CT Department of Social Services and the Hartford Foundation for Public Giving, with a grant to CT Voices from the Hartford Foundation. CT Voices contracts with MAXIMUS, Inc. for data management and data analysis. This report and earlier reports were prepared under the direction of Mary Alice Lee, PhD, Senior Policy Fellow, and are available at [www.ctkidslink.org](http://www.ctkidslink.org).

<sup>4</sup> Birth data were obtained from the CT Department of Public Health with approval of the Human Investigations Committee. Matching methods and evaluation of the match are described in a detailed report on 2003 and 2004 births to mothers in HUSKY A, available at [www.ctkidslink.org](http://www.ctkidslink.org).

<sup>5</sup> These unadjusted plan-specific rates include prenatal care that may have occurred in the weeks or months prior to enrollment, and do not take into account differences in age, race/ethnicity or other factors that may have affected prenatal care utilization. Therefore, the rates are likely to be more indicative of differences in maternal risk than differences in plan-specific practices or provider networks.

<sup>6</sup> Most other states in the Northeast cover women at higher income levels than Connecticut does (200% FPL in Maine, Massachusetts, and Vermont; 250% FPL in Rhode Island with state-funded coverage for pregnant women with income 251 to 350% FPL; 200% FPL in New York and New Jersey).

<sup>7</sup> Four states (California, Nebraska, New Jersey, and New York) use state funds to provide Medicaid coverage during pregnancy for undocumented women. States that provide state-funded coverage during pregnancy can provide emergency Medicaid for labor and delivery with federal matching funds.

<sup>8</sup> Six states extend Medicaid coverage beyond 60 days postpartum (up to 1 year in Maryland; 2 years in Arizona, Florida, Rhode Island and Virginia; 5 years in Maryland).