Kay A. Johnson, MPH MEd

What Assures Good Outcomes in Medicaid-Financed Prenatal Care?

Medicaid's role in financing prenatal care has changed dramatically since the early 1980s. Hundreds of thousands more families now depend on Medicaid as a source of maternity and infant health insurance. A decade of research on infant mortality and low birth weight pointed to access barriers as a key problem, with the result that policy makers at the state and Federal level committed substantial resources to improving access—and, they hoped, outcomes—through Medicaid prenatal care eligibility and benefit expansions enacted during the 1980s. Policy makers now want to know if this investment has been a sound one. New and better research is needed to help us understand how Medicaid-financed prenatal care has improved pregnancy outcomes in the United States. Knowing how, when, and why these Medicaid expansions did or did not work is critical to understanding what to do next.

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Between 1984 and 1990, Congress, the Reagan and Bush administrations, and the states enacted a series of improvements to make the Medicaid program a better source of health insurance coverage for pregnant women and infants. These improvements focused on: (*a*) broadening eligibility criteria beyond the Aid to Families with Dependent Children, or AFDC, Program to include more uninsured, low-income pregnant women and children (the AFDC Program was, of course, eliminated in the welfare reform legislation of 1996), (*b*) making benefits more appropriate through enhanced prenatal services, and (*c*) expediting enrollment to improve use of early prenatal care.

As a result, Medicaid has become an important source of health coverage for a much larger and more diverse group of pregnant women and infants than in the past. By 1993, Medicaid covered 1.4 million infants, representing about one out of every three babies born in the United States. Approximately 1 million of these children lived in families that did not receive AFDC cash benefits and in which the head of household worked.[1] Among pregnant women and infants receiving Medicaid benefits, three population groups that differ in socioeconomic status can be defined: those linked to welfare programs, those who are living below the poverty level but do not receive cash assistance, and those living between 100% and 185% of the poverty level. (In 1996, 185% of the poverty level was approximately $28,000 per year for a family of four.)

A number of researchers have undertaken evaluations of Medicaid eligibility and benefit expansions by asking, "Did the expansion improve pregnancy outcomes?"[2–5] However, in light of the varying socioeconomic levels encompassed by the Medicaid-funded programs, this question is too simple to shed much light on the effectiveness and potential of a policy change. Important intermediate factors are left out. As the authors of the article "Outcomes in Public and Private Settings of Enhanced Prenatal Services for Medicaid-Eligible Women" point out, *which* women are served by *which* providers may make a significant difference in outcomes. For example, to understand the impact of an

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expansion one must know about women's enrollment patterns, the appropriateness of the benefit package, the availability of appropriate providers, and prenatal care utilization patterns.[6] The accompanying article is an important step toward answering such questions for women Medicaid recipients in California, a state in which eligibility and benefit expansions were well planned and implemented.[7–8]

What does this study tell us that is new? The results challenge a piece of conventional wisdom that says public health departments provide the most appropriate prenatal care to low-income pregnant women and achieve the best outcomes. Patients of private physicians who were certified to deliver enhanced prenatal care services had significantly better pregnancy outcomes than patients of public health department clinics, community clinics, and private hospital clinics (with public hospital clinic patients faring no better or worse). Of course, health departments vary in their capacity, and this group of private practices with multidisciplinary supports may be the exception to the rule. However, the findings here should reduce the tendency to overgeneralize about the competence of either the public or the private sector.

Since the Medicaid maternity expansions took effect, millions of beneficiaries have been mandatorily enrolled in managed care plans. Women and children are among those most likely to be moved into managed care. In this time of transition to private managed care plans, Simpson, Korenbrot, and Greene note some important lessons. Most important is that improving eligibility and benefits alone will not improve outcomes; there must be attention to the content of care, its quality, and its appropriateness. Other reports have made recommendations; this study shows how these factors work in practice to improve outcomes.

Pregnant women need prenatal care that includes early and continuous risk assessment, health promotion and counseling, and medical or psychosocial intervention;[9–11] they also need care that is provided in user-friendly settings by qualified providers.[12] If we want healthier mothers and babies, this is the package the stork should deliver.

More research is needed to help us understand how Medicaid-financed prenatal care has improved pregnancy outcomes in the United States.

Ms. Johnson is a Senior Research Staff Scientist at the Center for Health Policy Research, George Washington University Medical Center, Washington DC.

Address correspondence to Ms. Johnson, tel. 202-530-2311; fax 202-296-0025; e-mail <kayj@gwis2.circ.gwu.edu>.

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