Baby Love and Budget Relief: Some Promising Practices in Prenatal Managed Care in Medicaid

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The provision of prenatal health care is one of the most important functions of Medicaid, as approximately three-quarters of program enrollees are poor women and children. A rapidly increasing number of states are seeking to address the dual crises of spiralling program costs and inadequate access to services through the use of managed care in Medicaid. Medicaid managed care is growing rapidly and now stands at more than 8 million enrollees, the overwhelming majority of whom are women and children. The focus on accessible preventive and primary care that is, in theory, the hallmark of managed care, should apply well to prenatal health services for Medicaid beneficiaries, though this is not always the case. The more successful managed prenatal care programs thus far have some common characteristics, which are examined here in the hope that they will be replicated by other states.

While consensus on health care reform remains elusive in the nation's capital, efforts to restructure the health system at the state level—particularly Medicaid—are surging forward. It appears to us that the future of the Medicaid program is in managed care. The joint federal-state program that provides health care to the poor, disabled, and chronically ill, Medicaid today serves more than 36 million people, more than half of whom are children, with expenditures in excess of $143 billion in fiscal year 1994. Even though only 29.6% of 1994 Medicaid expenditures are attributable to maternal and child health (the remainder was spent on low-income elderly and the disabled), women and children represent almost two-thirds of Medicaid beneficiaries, and more than one-quarter of the nation's births are financed by Medicaid.[1] Therefore, the provision of prenatal services is one of the most important functions of the Medicaid program. As more and more states pursue Medicaid managed care, there are a number of success stories that lead the way in the quality and cost effectiveness of prenatal managed care for at-risk pregnant women.

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The state-operated structure of Medicaid has always encouraged substantial variation and experimentation from state to state. The federal government has consistently cooperated with innovative states through waiver authorities granted to the Health Care Financing Administration (HCFA) in Sections 1115 and 1915(b) of the Social Security Act. Managed care is the approach pursued in almost all of the Medicaid waivers approved in the last few years. Medicaid managed care enrollment was up more than 60% in 1994, with most states planning to enroll almost all of their Medicaid beneficiaries in health maintenance organizations within the next two to three years. Today, about 8 million Medicaid beneficiaries, about 24% of the total, receive their health care through managed care plans.[2] HCFA expects even more growth in 1995.

Managed care in Medicaid is a recent phenomenon in most areas of the nation. Faced with limited numbers of providers available to serve Medicaid recipients and spiralling program costs, an increasing number of states have turned to managed care as an alternative to traditional fee-for-service delivery systems. To date, however, most managed care organizations have focused their business on reasonably affluent, healthy, well-educated suburban patient bases. Of the millions of Americans enrolled in managed care plans, the overwhelming majority are white, and a minuscule number are poor or low income. In contrast, more than 60% of Medicaid recipients are poor, and some 55% of Medicaid beneficiaries in poverty are minorities (unpublished data, HCFA-2082, Bureau of Data Management and Strategy, Information Processing Branch, July 1995). Therefore, in implementing Medicaid managed care programs, millions of impoverished children and cash-assisted adults—most of whom are racial or ethnic minorities—are entering health care delivery systems that, until now and for the most part, have had little experience in providing care to them. Thus, this examination of some of the most successful prenatal managed care practices for at-risk Medicaid recipients is particularly timely.

Proponents claim that with the right combination of system sensitivity and patient responsibility, managed care can improve results of Medicaid prenatal care services while saving substantial program dollars. In theory, managed care offers a dedicated primary care provider for every patient and a continuum of coordinated care in which the provider follows the patient. This construct can increase beneficiary access to care while reducing inappropriate use of health care services, such as seeking primary care services in emergency rooms.

The prepaid nature of managed care financing, supporters say, offers incentives to providers to ensure the good health of their patients, thereby avoiding costly specialists and hospitalization. This should lead to strategies that address unhealthy behaviors, such as smoking or substance abuse. It should also result in innovative outreach programs and other "enabling" services such as transportation, case management, health and nutrition education, that enhance the effectiveness of preventive care. Ideally, managed care provides a framework for the continuous delivery of quality services to the patient that can be monitored and consistently improved upon.

HCFA is in the process of developing an assessment tool for Medicaid prenatal managed care programs, particularly those enacted under federal waivers. While we hope to conduct a systematic review of operational Medicaid waiver

programs for their effectiveness in the near future, there are some promising and positive examples that are immediately apparent and worth closer examination.

HCFA considers the best practices in managed prenatal care for Medicaid beneficiaries to be those that significantly increase access to care in appropriate settings, emphasize quality primary and preventive care and health promotion, and result in efficient management of health care resources, reduction in costly hospital stays, and improved obstetrical outcomes. Four programs employing these practices are described here.

South Carolina
High-Risk Channeling Project

In April 1986, the South Carolina Department of Health and Environmental Control and the State Health and Human Service Finance Commission initiated the High-Risk Channeling Project (HRCP) under a Section 1915(b) waiver granted by HCFA. The project, based on a comprehensive, provider team model, was developed to assure that all Medicaid-eligible pregnant women and their children received risk-appropriate care. The project identifies high-risk pregnant women and newborns and channels them to appropriate providers of specialty prenatal or pediatric services. Women and children in the program receive nutritional assessments, social work evaluations, health education, nursing follow-up, one-year postpartum examinations, and other counseling and referral services as required.

South Carolina maintains a long-running commitment to improving prenatal care for low-income women, and the HRCP builds on the strengths of that commitment, such as the state's close relationship to community health centers, county health departments, and social service providers. All pregnant Medicaid recipients in South Carolina are assessed for risk of obstetrical complications at the first prenatal visit, where a uniform risk assessment form is used to begin the care coordination process. Private physicians, county health department staff, community health centers, or hospital clinics can perform the assessment. The county health department receives assessment forms for all at-risk Medicaid recipients residing in its jurisdiction and assigns them case managers.

Case managers—all of whom are registered nurses—assure that the pregnant woman is enrolled with an obstetrician and coordinates referrals to a social worker and nutritionist. Case managers also assess the home environment, provide education, arrange for transportation, and in general work with the client's family or guardian to assist them in negotiating barriers to services. Social workers complete a comprehensive assessment and develop a plan of care based on identified psychosocial problems; issues of concern and follow-up range from financial problems to family violence and substance abuse. Nutritionists provide medical nutrition therapy and education based on their assessments. Counseling on obesity, feeding techniques and schedule is a routine practice. Case managers follow their at-risk clients through the pregnancy, and high-risk women are required to deliver in hospitals equipped to manage potentially compromised neonates.

South Carolina attributes HRCP with Medicaid savings of more than $1.5 million annually due to decreased use of neonatal intensive care and other specialized, high-cost services. Most importantly, at-risk pregnant women are receiving coordinated services from highly trained interdisciplinary teams of professionals, and outcomes continue to demonstrate improvement. The state reports that infant mortality has diminished from 14.6/1,000 in 1985 to 10.6/1,000 in 1993, and considers HRCP to have played a major role (Division of Women's and Children's Services, Department of Health and Environmental Control and Health and Human Service Finance Commission, unpublished data, April 1995).

Alabama Maternity Waiver Program

Alabama's Maternity Waiver Program began in September 1988, also under Section 1915(b) waiver authority granted by HCFA. Under Alabama's program, the State contracts with primary care providers to manage all pregnancy-related medical care for Medicaid eligibles in specified underserved counties at a pre-established global fee that covers virtually all prenatal, delivery, and postpartum services. The global fee amounts to 97% of the fee-for-service equivalent for these services, plus more than $70 for each patient's case management.

The State's goal in establishing the program was to provide a coordinated system of health care to pregnant women and, after delivery, to encourage the use of family planning and Early Periodic Screening, Diagnosis and Treatment services. By September 1996, the program will include 55 of Alabama's 67 counties, and the state reports that in the last two years it covered more than 75% of all Medicaid deliveries in the state.

Quality of services is monitored by a Quality Assurance Committee within each primary care provider's parent organization, which is responsible for performing medical chart audits and for developing programmatic improvement plans based on these audits. Data collected by the state indicate that access to care and quality of services have been greatly enhanced for Alabama's pregnant Medicaid population covered under the waiver. Prior to implementation of the waiver, 50% of Alabama's Medicaid population received no prenatal care. While in counties not covered by the program this situation has continued, virtually all pregnant Medicaid recipients in waiver counties are obtaining prenatal care—and beginning much earlier in their pregnancies.

In the two most recent years of operation, the median number of prenatal visits in waiver counties has increased from 3 before the program began to 12 for those beginning care in the first trimester, 10 for those beginning care in the second trimester, and 6 for those beginning in the third. The state and its primary providers have implemented a variety of outreach programs to bring women into the system earlier in their pregnancies. Alabama claims results have included a substantial decrease in the average length of neonatal intensive care unit stay, a reduction in the percentage of Caesarean births, and a reduction in the likelihood of low birthweight infants.

In unpublished data (Office of Managed Care memorandum, August 1994), Alabama estimates savings of almost $5,800,000 under the last two years of the waiver and projects savings of almost $10.5 million for the next two years of the program. These savings are attributed to the global fee methodology and reductions in diagnostic testing, genetic counseling, and hospital readmissions.

The Wellness Plan's Bentley Prenatal Center

The Wellness Plan, a Medicaid HMO operated by Comprehensive Health Services of Detroit, has been recognized nationally as one of the foremost managed care plans serving poor women and children. The Wellness Plan's William Bentley Prenatal Center, funded and certified by the State of Michigan, is one of the reasons for its success in serving pregnant Medicaid recipients and reducing their rates of neonate and infant morbidity and mortality.

The Bentley Center, like The Wellness Plan's other comprehensive health care centers, is located in one of Detroit's most severely underserved and high-risk communities in an effort to increase access to the Plan's successful prenatal program, which is intensively managed by provider staff. The managed care services provided at the Bentley Center are complimented and coordinated by sophisticated information systems and data reporting capabilities to maintain accurate membership rolls, manage a high-risk membership base, deliver comprehensive medical care, and assess and respond to the patient marketplace, all in the context of high-quality standards.

The Bentley Center's pregnancy management team is directed by obstetrician/gynecologists and maternal/fetal medicine specialists, assisted by a team of registered nurses and physician's assistants. State-of-the-art obstetrical equipment such as ultrasound and at-home intrauterine monitoring devices is available for those at high risk. All new patients are given a maternal medical risk assessment survey; after risk levels have been determined, the appropriate management protocols are selected by the obstetrician/gynecologist or, in the case of high-risk pregnancies, by the maternal/fetal medicine specialist for continued monitoring and care throughout the pregnancy. The risk management protocols typically include an aggressive schedule of prenatal visits and other services, such as incentives for prenatal education, home care visits, nutritional counseling, and on-site processing for the Women, Infants and Children (WIC) feeding program, psychosocial counseling, and transportation services.

As a condition of grant support from the state, the Bentley Center undergoes continuous process and outcome evaluation by an independent assessor, who files monthly reports with the Michigan Department of Social Services' Medical Services Administration. According to The Wellness Center, as of July 1, 1994, the pregnant women served at Bentley included 120 open cases with 49 deliveries, consisting of 42 normal births (86% of deliveries), 2 problem deliveries (one substance abuse-related, one preterm delivery at eight months, mother first seen at end of second trimester) and 5 terminations (4 early term miscarriages and one voluntary).

Projects like the Bentley Center's enable The Wellness Plan to defy the odds in Detroit. Citywide, the African-American infant mortality rate per 1,000 live births is 23.8; for Wellness Plan enrollees—98% of whom are African-American—delivering at Hutzel Hospital, where the vast majority of Plan deliveries occur, the rate was 12.6 (T. H. Gardin, PhD, unpublished data, April 1995).

Vermont Healthy Babies Program

Vermont's Healthy Babies Program is a comprehensive, managed and family-centered health initiative for pregnant women and children on Medicaid. Healthy Babies is an outgrowth of the Vermont Department of Health's prenatal initiative of 1987 and the State's Agency of Human Services more recent Success by Six project. The program, which is voluntary, offers comprehensive medical, nursing, nutritional, educational, and psychosocial services based on identified risks for poor obstetrical outcomes. The cornerstone of Healthy Babies is the provision of services in the home as well as in a medical setting, and family participation is a key element. Twenty program objectives have been established, based on the national goals of the US Public Health Service initiative, *Healthy People 2000*.[3]

Entry into the Healthy Babies program can occur through physician referral, WIC clinics, home health agencies, social service organizations, community health centers, and other entities. The program is designed as a coalition among obstetrical and pediatric care providers, public health and visiting nurses, parent-child centers, and participating families. Case management, counseling and health education, risk reduction intervention, home-based care, and other supportive and medical services are bundled together in a "Healthy Babies Package," as the risk protocols are called, and are tailored to meet the health needs of each individual expectant mother. All services are provided under a care plan that is regularly reviewed by a team of service providers working together with the pregnant woman and her family.

The state provides $25 per patient for a medical assessment to all participating obstetrician/gynecologists, family practitioners, nurse midwives, and nurse practitioners. A lump sum payment of $65 per visit is paid to maternal nursing services agencies. This financing strategy has allowed the state to double its home visiting capacity through contracts with private agencies. Standards for service providers and service delivery are developed by the state Healthy Babies Coalition, approved by the Medicaid Division of the Agency of Human Services, and administered by the Vermont Department of Health.

Prior to implementation of the program, pregnant women on Medicaid averaged about 3.5 prenatal visits during the course of their pregnancies. In an unpublished April 1995 memorandum to HCFA, the state projects that the average number of visits will increase to eight by July 1996, when the program is fully implemented statewide. The state plans to incorporate the Healthy Babies program into a statewide health care reform demonstration, pending approval of a Section 1115 waiver request it has submitted to HCFA.

Conclusion

From an enrollment viewpoint, Medicaid is predominately a maternal and child health program and finances more than one-quarter of the nation's births; the provision of prenatal health care services, therefore, is one of its most important functions. As a rapidly increasing number of states seeks to address the dual crises of inadequate access to care for Medicaid recipients and spiralling program costs through managed care arrangements, there are clearly good and bad approaches.

The more successful practices in Medicaid prenatal managed care programs—such as those demonstrated in South Carolina, Alabama, Vermont, and

The Wellness Plan in Detroit—have some common characteristics:

1) Local governments and participating managed care plans invested in adequate provider reimbursements, infrastructure, staff, and other resources necessary to address the prenatal care needs of their enrolled populations. Furthermore, they enhanced reimbursements or offered other incentives to participating providers to guarantee the provision of key "enabling" and other services. Across the board, these investments paid off several times over in savings from reduced hospital stays and other costly services.

2) Local governments formed partnerships with providers to plan and structure their Medicaid prenatal managed care programs. These systems were well thought out in advance, comprehensive in nature, overwhelmingly community-based, and incorporated referral systems or similar arrangements for behavioral and other essential services, such as translation.

3) Traditional Medicaid providers such as local health department clinics, community health centers, and other safety net entities with experience in serving these demanding populations had a substantial role in the delivery of services. (Indeed, in many innercity, underserved communities and impoverished rural areas, these traditional providers of care may be the only ones available to at-risk expectant mothers receiving Medicaid.)

4) Risk assessment and risk management were the central functions of these prenatal managed care systems. These programs used surveys, examinations, and interviews to individually evaluate pregnant women for factors and conditions associated with poor obstetrical outcomes. Once the patient's risk level was established, teams of providers went about delivering the appropriate regimen of risk management services. Each patient's prenatal services were tailored to her unique needs, thereby increasing the effectiveness of these services.

By replicating some of these practices, states may find that substantial savings and more favorable outcomes can result from improving the quality, sensitivity, and accessibility of prenatal services through Medicaid managed care arrangements.

References

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