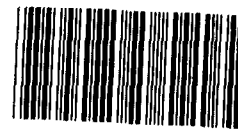
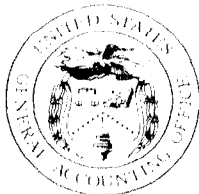


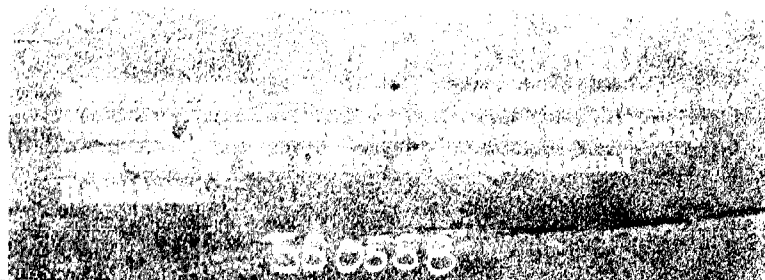
February 1991

PRENATAL CARE

Early Success in Enrolling Women Made Eligible by Medicaid Expansions



143346



**Program Evaluation and
Methodology Division**

B-242530

February 11, 1991

The Honorable Thomas Bliley, Jr.
Ranking Minority Member
Select Committee on Children, Youth, and Families
House of Representatives

The Honorable Dan Coats
Ranking Minority Member
Subcommittee on Children, Family, Drugs, and Alcoholism
Committee on Labor and Human Resources
United States Senate

In response to your May 1989 request, this report presents data on enrollment in Medicaid by newly eligible pregnant women following the expansion of the program in 1986 and 1987. We also report on program efforts of the states to provide larger numbers of pregnant women with prenatal care and other maternal health services.

Background

Medicaid coverage of health care for low-income families declined during the 1980's. The average state Medicaid program provided care for a larger share of families in poverty in the mid-1970's than in the mid-1980's. In addition, Medicaid application procedures were criticized as unnecessarily complex and burdensome, presenting additional barriers to access.

In response to these coverage and access problems, the Congress passed a number of laws in 1986 and 1987 that expanded eligibility for Medicaid prenatal care. The states were also intent on providing services to a larger number of women, and they used the opportunity of program expansion to introduce a variety of program elements to overcome problems encountered when trying to enroll clients in service programs.

**Objectives, Scope, and
Methodology**

One goal of the Congress was to increase the number of women receiving prenatal care through the Medicaid program. But in the past, participation among eligible populations has not always met expectations. Therefore, the objectives of our work in this project were to

- assess the degree to which newly eligible pregnant women have enrolled in the Medicaid expansions,
- describe the demographic characteristics of expansion enrollees,

- describe the eligibility and outreach activities that have been implemented by the states, and
- determine the activities that are the most common among the states with the most favorable enrollment trends.

We used case studies of 10 states that were early implementors of expansion programs. The report is limited to an examination of the enrollment of pregnant women after only 2 years of program experience. Therefore, we cannot generalize our findings to other states or make conclusions concerning either longer term effects or effects on prenatal care or birth outcomes. In addition, our report is confined to enrollment in state expansion programs that serve pregnant women previously ineligible for Medicaid assistance. That is, we did not examine participation in Medicaid maternity services by traditional recipients of Medicaid assistance.

After selecting 10 states for study based on variation in program implementation and state characteristics, we collected documentary and interview data through site visits. Data collection took place between September 1989 and March 1990 and the work was performed in accordance with generally accepted government auditing standards. Our conclusions are based on both qualitative data about expansion-related activities and quantitative data about enrollment by eligible pregnant women.

Findings

With regard to the first objective, we estimate that across the states we studied between two thirds and three quarters of potentially eligible women enrolled within 2 years of the implementation of expansion policies. However, because of variability, some states enrolled only a little more than a third of the eligible population and others enrolled almost all eligible women.

With regard to the second objective, we found some limited evidence that expansion participants are more likely than women previously eligible for Medicaid to come from two-parent, nonminority families and from families in which at least one of the parents is employed.

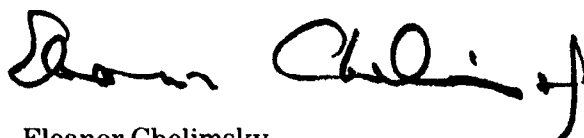
With regard to the third objective, we found that the states have made many efforts to enhance enrollment. Included among these efforts are media campaigns, active case-finding programs, the "outstationing" of eligibility workers in health care settings, and initiatives designed to

notify providers and patients about the eligibility expansions and the importance of early prenatal care.

Finally, among the states we studied, the states that have simultaneously implemented presumptive eligibility and dropped assets tests have experienced the most rapid growth in enrollment. Presumptive eligibility allows certain providers (such as local health departments, community health centers, and hospitals) to determine temporary eligibility and provide prenatal care during the formal processing period. The elimination of assets tests simplifies the complex and lengthy application process as well as the required documentation. We find that by providing more immediate feedback to applicants concerning their status, these program features help maintain participation in the Medicaid process.

These findings on enrollment reflect initial program effects. However, many questions, including the effects that enrolling more women in Medicaid have on prenatal care quality and perinatal outcomes, remain to be answered.

As we arranged with your office, unless you publicly announce the contents earlier, we plan no further distribution of this report until 30 days after its issue date. We will then send copies to other interested parties and make copies available to others upon request. If you have any questions or would like additional information, please call me (202-275-1854) or Robert York (202-275-5885), Acting Director of Program Evaluation in the Human Services Areas. Other major contributors are listed in appendix IV.



Eleanor Chelimsky
Assistant Comptroller General

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Abbreviations

AFDC	Aid to Families with Dependent Children
AGI	Alan Guttmacher Institute
NGA	National Governors Association
WIC	Special Supplemental Food Program for Women, Infants, and Children

Introduction

Responding to a decline in prenatal care coverage in the United States in the early 1980's, and to the likelihood that the Public Health Services' 1990 perinatal health goals would not be met, the Congress enacted several changes to the Medicaid program in 1986 and 1987.¹ These changes broadened eligibility to almost twice the poverty level and simplified Medicaid application procedures for prenatal care. Several state agencies have initiated projects to study these new programs.² Further, the National Governors Association has monitored program implementation.³ However, there has not yet been any multistate study of initial effects. As a result, we do not know the degree to which eligible pregnant women have availed themselves of the new services. This report addresses this issue.

The Problem

As we reported in September 1987, many factors influence obtaining prenatal care, including the availability of providers, the structural characteristics of the delivery system, and the lack of transportation and child care. The most important barrier, however, is financial—that is, lack of health insurance.⁴

Medicaid is a joint federal-state program that has a major role in financing care for the uninsured. Since the 1970's, however, Medicaid coverage overall has declined. In 1975, the average state Medicaid program provided care for families with incomes of up to 73 percent of the poverty level; by 1988, the level of coverage had dropped to 49 percent of the poverty level.⁵ In addition, whereas in 1978 almost all children from families with incomes below the poverty level received Medicaid assistance, by 1983 only 7 of 10 received it.⁶

¹Institute of Medicine, Prenatal Care: Reaching Mothers, Reaching Infants (Washington, D.C.: National Academy Press, 1988); U.S. Public Health Service, The 1990 Health Objectives for the Nation: A Midcourse Review (Washington, D.C.: U.S. Department of Health and Human Services, 1986).

²J. W. Senner and J. M. Eatmon, "An Evaluation of the SOBRA Modifications to Medicaid," paper presented at the American Public Health Association, Chicago, October 1989; Department of Social and Health Services, Interim Progress Report: First Steps (Olympia, Washington: February 15, 1990); J. Breyel, Improving State Programs for Pregnant Women and Children (Washington, D.C.: Center for Policy Research, National Governors Association, 1990).

³I. Hill, Reaching Women Who Need Prenatal Care (Washington, D.C.: Center for Policy Research, National Governors Association, 1988).

⁴U.S. General Accounting Office, Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care, GAO/HRD-87-137 (Washington, D.C.: 1987).

⁵Hill, Reaching Women Who Need Prenatal Care.

⁶J. Holahan, J. Bell, and G. S. Adler, Medicaid Program Evaluation: Final Report (Baltimore, Md.: Office of Research and Demonstrations, Health Care Financing Administration, 1987).

Aside from direct considerations of coverage, questions about Medicaid application procedures—as impediments to enrollment—had also been raised. A study in one region indicated that most pregnant women were denied eligibility for Medicaid because of insufficient documentation regarding income and assets and not because income or assets placed them above the eligibility threshold.⁷ Denials for noncompliance with procedures (63 percent) were much more common than denials for other reasons, such as excessive income (23 percent) or resources (3 percent). Complex and lengthy application forms are viewed as a major contributor to this problem. Not only does the lengthy lag between application and approval of eligibility delay the first prenatal care visit but some pregnant women have also lost Medicaid eligibility during pregnancy, causing disruption in the continuity of prenatal care.

Congressional Actions

In response to these coverage and access problems, the Congress enacted several changes to Medicaid in 1986 and 1987 designed to broaden eligibility for uninsured pregnant women and to simplify the application process. The 1986 legislative changes allowed states to

- raise eligibility to 100 percent of the poverty level,
- guarantee pregnant women coverage 60 days postpartum (continuous eligibility),
- permit pregnant women to be determined temporarily eligible at health care settings while full application processing is completed (presumptive eligibility), and
- eliminate the requirement to count personal assets in calculating applicants' financial status.

The 1987 legislative changes gave the states the option to broaden eligibility to 185 percent of the poverty level.

These revisions in application and eligibility procedures represent major changes to traditional practices. Authorizing continuous eligibility for pregnant women for up to 60 days postpartum regardless of changes in income allows for continuity of care. This eliminates disruption in the prescribed sequence of prenatal and postpartum visits and avoids recertification visits.

⁷S. Shruptine and V. Grant, Study of the AFDC/Medicaid Eligibility Process in the Southern States (Washington, D.C.: Southern Governors Association, 1988).

Authorizing presumptive eligibility allowed for provision of prenatal care during the application processing period, enabling women to begin care without waiting up to 45 days to receive their Medicaid card. Additionally, it allowed certain provider sites (such as county health departments and hospital clinics) to make temporary eligibility determinations (while formal processing is completed), thereby enabling the place of care to assist in arranging for Medicaid financing.

Authorizing dropping assets tests allowed for simplification of the complex and lengthy application process and accompanying documentation. Besides reflecting further eligibility expansion, this measure allowed for a reduction in the the incidence of procedural denials and the number of return visits to Medicaid. Dropping assets tests also made possible the shortening of application forms, since information about house and automobile ownership, bank accounts, and so on became unnecessary.

Without increases in enrollment in Medicaid prenatal care, achievement of the primary goal of reducing rates of low birthweight and infant mortality among the disadvantaged is not likely. Accordingly, the question that must be answered first in evaluating Medicaid's changed eligibility requirements is the extent to which they have led to increased enrollment. The Alan Guttmacher Institute and the National Commission to Prevent Infant Mortality posed this issue as one of immediate importance and deserving further investigation.⁸

Along with a focus on enrollment, attention has been devoted to outreach—that is, methods aimed at increasing participation in early prenatal care. Some examples of these methods include media campaigns, maternity telephone hot lines, “outstationing” of front-line Medicaid eligibility workers in clinics, and community-based case finding and coalition-building. Concern with outreach is exemplified by the publication in 1988 of the report of the Institute of Medicine's Committee to Study Outreach for Prenatal Care, which summarized current knowledge about approaches to enhancing prenatal care participation.⁹

Hence, at the outset of the Medicaid expansions, and partly because of past experience in other programs, uncertainty existed as to whether

⁸A. Torres and A. M. Kenney, “Expanding Medicaid Coverage for Pregnant Women: Estimates of the Impact and Cost,” *Family Planning Perspectives*, 21:1 (1989), 19-24; National Commission to Prevent Infant Mortality, *Death Before Life: The Tragedy of Infant Mortality* (Washington, D.C.: 1988).

⁹Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants*.

eliminating financial barriers alone would be sufficient to engender substantial increases in participation. Questions concerning the most effective approaches for involving disadvantaged pregnant women in early prenatal care had also increased in prominence.

Objectives, Scope, and Methodology

The House Select Committee on Children, Youth, and Families and the Senate Subcommittee on Children, Family, Drugs and Alcoholism asked us to report on the following four questions:

1. Has participation in Medicaid by pregnant women increased as a result of expanded eligibility?
2. What groups of women are most likely to take advantage of expanded eligibility?
3. What eligibility and outreach activities currently exist?
4. Which activities are most common among the states that have the most favorable participation trends?

Our work involved case studies of 10 states: Arkansas, Florida, Kentucky, Maryland, Mississippi, New Jersey, New Mexico, Oregon, Washington, and West Virginia. Each of these states had expanded eligibility for at least 2 years by the time of our study. We studied only pregnant women, even though certain provisions of the legislative changes also applied to infants and children. Our methodology employed information from individual states about program processes and the number of enrollees. We did not independently verify the data. We were concerned with state activities resulting from the Medicaid expansions and the numbers of pregnant women enrolling in those services; we do not report on the quality, adequacy, or duration of services.

We selected the 10 states for study and collected documentary and interview data through site visits to each state. Our findings are based on both qualitative data about expansion-related activities and quantitative data about enrollment by eligible pregnant women.

Selection of States

We began by limiting the study to states that raised eligibility for Medicaid prenatal care on or before January 1988. With data collection taking place primarily in early 1990, this provided at least 2 years of program experience. This criterion reduced the potential pool to 21

**Appendix I
Introduction**

states. Next, we gathered information about state and program characteristics to guide selection from among these states. See table I.1.

Table I.1: State Selection Parameters

State	POV ^a	Date	PE ^b	Cont ^c	DAT ^d	LBW ^e	PCAP ^f	Metro ^g	Region ^h
Arizona	100	1/88	N	Y	Y	31-34	26	76.2	M
Arkansas	100	4/87	Y	Y	N	8-9	46	39.5	WSC
Delaware	100	1/88	N	Y	Y	13-16	13	66.0	SA
District of Columbia	100	4/87	N	Y	Y	NA	NA	100.0	SA
Florida	100	10/87	Y	Y	Y	11-12	17	90.8	SA
Kentucky	100	10/87	N	N	N	20-22	41	45.8	ESC
Maryland	100	7/87	Y	Y	Y	11-12	7	92.9	SA
Massachusetts	100	7/87	Y	Y	Y	35-37	3	90.7	NE
Michigan	100	1/88	N	Y	Y	20-22	20	80.2	ENC
Mississippi	100	10/87	N	Y	N	1-2	50	30.3	ESC
New Jersey	100	7/87	Y	Y	Y	23-24	2	100.0	MA
New Mexico	100	1/88	Y	Y	N	10	43	48.4	M
North Carolina	100	10/87	Y	Y	Y	7	36	55.3	SA
Oklahoma	100	1/88	N	Y	Y	29-30	44	58.8	WSC
Oregon	85	11/87	N	Y	Y	41-45	30	67.6	P
Rhode Island	100	4/87	N	Y	Y	31-34	14	92.6	NE
South Carolina	100	10/87	N	Y	Y	1-2	42	60.4	SA
Tennessee	100	7/87	Y	Y	Y	5	37	67.0	ESC
Vermont	100	10/87	N	N	N	31-34	28	23.1	NE
Washington	90	7/87	N	Y	N	41-45	12	81.2	P
West Virginia	100	7/87	N	Y	Y	23-24	49	36.3	SA

^aPoverty level adopted; I. Hill, *Reaching Women Who Need Prenatal Care* (Washington, D.C.: Center for Policy Research, National Governors Association, 1988).

^bPresumptive eligibility; Hill, *Reaching Women Who Need Prenatal Care*.

^cContinuous or protected eligibility; Hill, *Reaching Women Who Need Prenatal Care*.

^dDrop assets tests; Hill, *Reaching Women Who Need Prenatal Care*.

^eLow birthweight rank (smaller rank means greater LBW rate); Food Research and Action Center, *Poor Infants, Poor Chances* (Washington, D.C.: September 1987).

^fState rank on per capita disposable income, 1987; *Statistical Abstract of the United States* (1989).

^gPercent population in metropolitan areas, 1987; *Statistical Abstract of the United States* (1989).

^hNE = New England; MA = Middle Atlantic; ENC = East North Central; WNC = West North Central; SA = South Atlantic; ESC = East South Central; WSC = West South Central; M = Mountain; P = Pacific.

We abstracted data about specific Medicaid expansion components from National Governors Association publications, including presumptive and

continuous eligibility and the elimination of assets tests. Then we gathered published vital registration and census statistics about low birthweight, per capita income, and urbanization. We also documented the Bureau of the Census region in which each state was located. Finally, we conducted exploratory interviews with Medicaid and public health officials to review and verify application process, outreach, and data collection activities related to the expansions.

Using this information, we selected 10 states that varied in eligibility and outreach activities as well as in state characteristics related to maternal and child health. Presumptive eligibility and the removal of assets tests served as the foci for selection because these components seemed most likely to affect participation. Since little variation existed in the state-elected poverty level (19 of 21 chose 100 percent) and in continuous eligibility (19 of 21 had adopted this), these parameters did not have a major influence on our state selection effort. Hence, we selected 10 states of which 5 had adopted presumptive eligibility and 5 had eliminated assets tests. To provide variation in other state characteristics, we also included states at the extremes of the distribution of per capita income, urbanization, and low birthweight rate. Finally, we selected a geographically diverse set of states, with 7 of 10 regions represented in our sample.

Site Visits

During our site visits, we gathered information from multiple sources, including

- interviews with state and local Medicaid and public health officials;
- direct observation of eligibility determination sessions at hospitals, local health departments, and Medicaid agencies;
- program documents (for example, application and other program forms, annual reports, state legislation); and
- state data files (that is, number of expansion program enrollees by month).

Oregon and West Virginia served as pilot states and were visited in late August and mid-September 1989; the remaining states were visited between January and April 1990. The visits were 2 to 3 days each in duration.

Analysis Strategies

From the interview and field notes and agency documents, we abstracted summaries of each state's eligibility determination and outreach activities. We compiled monthly statistics on program enrollment provided by state officials. We supplemented these data with published estimates of need, which served as a baseline against which to judge progress in enrollment. Finally, we jointly considered data about implemented expansion components and enrollment to discern if any relation existed between states' activities and levels of expanded participation. That is, we sought to identify the program components or combinations of components that uniquely distinguished states with more rapid growth in enrollment. Table I.2 presents the link between the data sources and the four evaluation questions.

Table I.2: Evaluation Questions and Data Sources

Evaluation question	Data source
1. Has participation in Medicaid by pregnant women increased as a result of expanded eligibility?	State Medicaid eligibility administrative data files; published estimates of need
2. What group of women are most likely to take advantage of expanded eligibility?	State Medicaid administrative data files; case-study field notes
3. What eligibility and outreach activities currently exist?	Case-study field notes and agency documents
4. What outreach activities and other initiatives characterize states with the most favorable participation trends?	State Medicaid administrative data files; published estimates of need; case-study field notes and agency documents

State Expansion Activities

In this appendix, we answer question 3 (What eligibility and outreach activities currently exist?). We present this question ahead of the others because implementation must be examined before participation outcomes can be ascertained. We profile expansion program activities related to eligibility determination and outreach. The objective of these activities is to increase enrollment by publicizing the availability of expanded eligibility, removing procedural barriers in the Medicaid application process, and creating greater awareness of the importance of early prenatal care.

Eligibility Determination

Besides broadening coverage for the uninsured, eligibility reforms have the goal of reducing application complexity by eliminating specific procedures that were perceived to be obstacles to the receipt of early prenatal care. Table II.1 on the next page summarizes the 10 states' implementation of eligibility determination components.

**Appendix II
State Expansion Activities**

Table II.1: Eligibility Determination

State	Poverty level	Presumptive eligibility	Drop assets tests	Continuous Eligibility	Reduced form and processing time
Arkansas	75% in 4/87; 100% in 2/88	Yes 4/87	Yes 11/88	Yes 4/87	1-page PE form and 3-page Medicaid application; patient document checklist
Florida	100% in 10/87; 150% in 7/89	Yes 10/87	Yes 10/87	Yes 10/87	1-page PE form 10/87; health-Medicaid referral form; 1-page Medicaid application in 11/86
Kentucky	100% in 10/87; 125% in 10/88	No	Yes 6/89	Yes 8/88	2-page pregnant women Medicaid application in 9/89; health-Medicaid referral form; patient responsibilities contract
Maryland	100% in 7/87; 185% in 7/89	Yes 7/87	Yes 7/87	Yes 7/87	1-page PE form; special 3-page pregnant women Medicaid application; patient document checklist and referral form
Mississippi	100% in 10/87; 185% in 10/88	No	Yes 10/88	Yes 10/88	Patient document checklist and referral form
New Jersey	100% in 7/87	Yes 8/88	Yes 7/87	Yes 7/87	1-page PE form; special 4-page pregnant women application; patient document checklist
New Mexico	100% in 1/88	Yes, phased in 4/89 to 1/90	Yes 12/88	Yes 7/89	2-page PE form; patient follow-through instructions; nonshortened bilingual application
Oregon	85% in 11/87; 100% in 9/88	No, but "expedited" in 7/88	Yes 11/87	Yes 11/87	1-page pregnant women application; 24-hour processing time (7/88) extended to 5 days in 7/89; referral form
Washington	90% in 7/87; 185% in 8/89	No	Reduced stringency of test in 7/87; dropped 8/89	Yes 7/87	5-page Medicaid application 1/90; 15-working-day requirement for final determination; mail-in planned
West Virginia	100% in 7/87; 150% in 7/88	No	Yes 7/87	Yes 7/87	3-page pregnant women application 7/87; 10 working day requirement; mail-in option

In some states, eligibility reforms were implemented all at once, while in others implementation was staggered over months or years. For example, Washington, which implemented 90 percent of poverty in July 1987, went to 185 percent of poverty and launched a major new maternity care initiative (the First Steps program) in August 1989 (more than 2 years later). New Mexico staggered its elimination of assets tests and implementation of continuous eligibility and presumptive eligibility across a 2-year period following the raising of eligibility to 100 percent of poverty in January 1988. Kentucky, which raised eligibility to 100 percent of poverty in October 1987, adopted continuous eligibility in August 1988, moved to 125 percent of poverty in October 1988, dropped assets tests in June 1989, and adopted a two-page application form in September 1989.

Alternatively, other states implemented a relatively full set of eligibility changes at one time. For example, Maryland moved to 100 percent poverty, adopted presumptive eligibility and continuous eligibility, and

eliminated assets tests all in July 1987. Florida adopted presumptive eligibility, dropped assets tests, shortened application forms, and instituted continuous eligibility all in October 1987.

Eight states further extended eligibility following initial expansion. The time between initial expansion and subsequent extension was about 26 months on the average. Most states initially moved to 100 percent of poverty or just below. Following their initial expansions, Kentucky moved to 125 percent, Florida and West Virginia to 150 percent, and Maryland, Mississippi, and Washington to 185 percent.

Five states implemented presumptive eligibility. Local health departments, community health centers, hospitals, and community-based clinics all served as presumptive eligibility locations. A one- or two-page presumptive eligibility application form was used by these providers in determining temporary eligibility.

Administrators in states that did not implement presumptive eligibility cited difficulties with client follow-through as reasons. However, in states that elected presumptive eligibility, we observed progress in overcoming this problem. In Arkansas, for example, following initially high rates of poor client follow-through, local health department staff began "coaching" clients about the importance of making Medicaid appointments and about required forms and procedures and also used a document checklist. With this approach, rates of successful client follow-through improved markedly. In other states, written instructions, document checklists, patient contracts, and referral forms were implemented that specified the documents presumptive eligibility patients needed to bring to Medicaid and that encouraged greater communication and problem-solving activity between health care and Medicaid agencies. For example, in Kentucky, applicants were asked to sign a contract in which they pledged to completely follow through with the process.

All 10 states eventually dropped assets tests, 5 of the 10 doing so concurrently with initial expansion. Washington made its assets test more lenient as a first step but eventually dropped consideration of assets completely in August 1989.

All 10 states eventually implemented continuous eligibility. Six states had done so at the time of the initial eligibility expansion, while the 4 others delayed an average of about 15 months following initial expansion.

Seven states shortened the length of Medicaid application forms for pregnant women and children (typically, to one to five pages). West Virginia allowed applications through the mail, and Washington was considering a mail-in option. Several states that instituted short applications limited their use to pregnant women and children. In addition, 3 states that did not implement presumptive eligibility (Oregon, Washington, and West Virginia) required shortened processing periods for pregnant women applicants. For example, Oregon initially set a policy that required processing to be completed within 24 hours, before extending the time to 5 days.

Outreach

Prenatal outreach has the goal of increasing awareness about the importance of early prenatal care. In addition, outreach efforts can assist women in obtaining financing and locating providers. Table II.2 summarizes the 10 states' prenatal outreach activities.

**Appendix II
State Expansion Activities**

Table II.2: State Outreach Activities

State	Outstationing	Telephone hotline	Public service announcements	Notification of patients and providers	Case finding
Arkansas	At 10 pilot local health departments 9/89 and 2 hospitals	No, but planned	No, but planned	WIC, food stamp, AFDC "stuffers"; governor letter; presentations to Medicaid physicians; brochures	Pilot effort in 4 counties
Florida	Universal outstationing at over 220 hospitals, local health depts, and community health centers	"Healthy Baby" line established 1986	At district initiative uneven across state	Medicaid newsletter announcement; "stuffers"; brochures and posters	Outreach workers in 12 counties with lowest rates of early prenatal care
Kentucky	At 3 hospitals	No	No	Letter campaign to OB Society; "stuffers"; brochures	Eight workers in 5 counties involving coalition community development effort; follow-up of positive pregnancy tests at local health departments
Maryland	None	No, but planned for 7/90	No, but planned for 7/90	Brochures at WIC and local Medicaid agencies	Pilot effort in 3 localities; neighborhood Medicaid workers placed in Baltimore
Mississippi	Since July 1985, 33 sites have outstationing including hospitals and local health and community health centers	Yes, staff added to Governor's Service Line in 1986	Yes, periodically since 1986, radio and TV	"Stuffers"; posters; brochures; newsletters; presentations	State and local coalition-building
New Jersey	None	Yes, 2/88	Radio and TV PSAs during initial implementation in 2/88	Stuffers; brochures and posters	Outreach workers placed in 9 urban localities
New Mexico	None	No	No	Brochures; presentations; newsletters	Activity at 5 sites, including outreach workers, local coalition building, and an incentive program
Oregon	None	No	Radio and TV PSAs during initial implementation in 9/88	Brochures; mailings to Medicaid providers	State and local coalition-building
Washington	Pilot effort involving 10 workers	No, but planned	No, but planned	Newsletter; mailings to Medicaid providers	Gradual phase-in of "First Steps" outreach workers at local Medicaid agencies 1/89
West Virginia	No	Yes, in 1983	No	Mailing to OB Society	Follow-up of positive pregnancy test by local health workers

Outstationing can eliminate the need for applicants to ever visit local Medicaid agencies by placing Medicaid eligibility workers directly in health care settings. It can also reduce the level of noncompliance with procedures and reduce inconvenience for patients. Local health departments, hospitals, and community health centers are typical sites for outstationing. This outreach approach was most widely implemented in Florida, with 4 other states experimenting with it on a pilot basis. Florida has almost universal outstationing with over 220 sites involved statewide. States that are currently piloting this approach plan more extensive implementation. Arkansas, Mississippi, and Washington plan broader implementation of outstationing following evaluation of initial experiences at a small number of locations.

Telephone hot lines for maternity patients have been implemented in 4 of the 10 study states and are planned in 3 others. Hot lines were sponsored by state government as well as nonprofit groups, such as Healthy Mothers, Healthy Babies Coalitions. For example, in Mississippi, the state's Coalition for Mothers and Babies supplied a perinatal specialist to help staff the Governor's Service Line, while in New Jersey the Department of Health established a hot line several months after expanding eligibility.

Public service announcement campaigns about the expansions and the importance of early prenatal care have been implemented by 4 states, with 3 others currently planning campaigns. Most campaigns run for only a limited period, typically around the time of the expansion policy change. For example, New Jersey and Oregon launched major radio and television campaigns concurrently with an expansion of eligibility. In Mississippi, prenatal care awareness media campaigns have been aired intermittently since 1986.

Every state made at least some effort to notify existing patients and providers about the expansions. These efforts included "stuffers" in checks to food stamp, Medicaid, Aid to Families with Dependent Children (AFDC), or other human-service client groups; mailings to all Medicaid providers or members of state medical societies; distribution of brochures, posters, and newsletters; and in-person presentations to groups of health and human-service providers.

All 10 states have implemented some form of active case finding. However, in most instances, case-finding activities are restricted to a limited number of high-risk geographic areas within the state. Case-finding projects typically employ nurses or community health workers to locate

pregnant women in need of care or to develop local community organization and awareness efforts around issues of infant mortality and prenatal care. For example, West Virginia and Kentucky instituted programs in which local health workers followed up the women who tested positive for pregnancy at health department clinics. Arkansas, Florida, Maryland, and New Jersey instituted geographically limited programs of neighborhood workers who canvass communities, linking identified pregnant women with a source of care. Other states, including Kentucky, Mississippi, New Mexico, and Oregon, have developed programs of community development and coalition-building.

As can be seen from the activities described above, the Medicaid expansions served to invigorate and intensify state efforts to attract pregnant women into early prenatal care. Major new efforts at eligibility reform and outreach have followed the states' adoption of expansion options. The information presented here should be viewed as speaking to an ongoing and still evolving process. For example, Maryland, Mississippi, New Mexico, and Washington recently began major new maternity care initiatives that are not reflected in the data presented here. Additional policy changes and service reforms can be expected in the future.

Participation by Pregnant Women, Their Characteristics, and State Activities

In this appendix, we answer question 1 (Has participation in Medicaid by pregnant women increased as a result of expanded eligibility?). That is, we present findings concerning changes in enrollment following the expansion of eligibility for prenatal care under Medicaid. The appendix begins with data on the number of newly eligible enrollees. We then go on to answer question 2 (What groups of women are most likely to take advantage of expanded eligibility?) by presenting information on the demographic characteristics of these new enrollees. We also answer question 4 (Which activities are most common among the states that have the most favorable participation trends?). Here we identify the eligibility and outreach activities that distinguished states with more rapid growth in enrollment from states that exhibited slower growth.

Findings

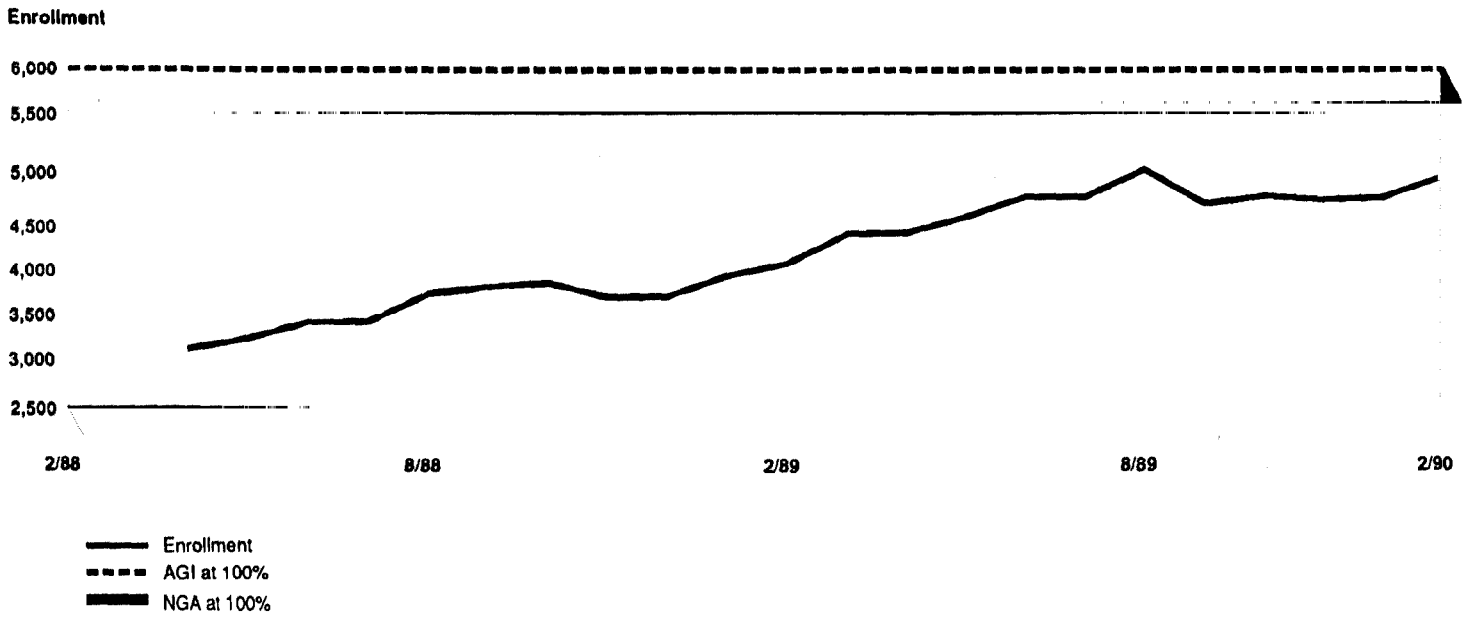
Enrollment

To address the first evaluation question, we combined monthly expansion program enrollment totals with two estimates of need for the program at 100 percent of the poverty level. These data reflect enrollment in the states' expansion programs that serve pregnant women previously ineligible for Medicaid assistance. Therefore, at the initiation of the expansions, no pregnant women in the expansion target group were receiving Medicaid maternity care. Figures III.1 through III.8 present participation trends for the 8 states for which usable enrollment data were obtained.¹

¹Although West Virginia and Washington have a method for identifying expansion patients, we did not include data from these states because only a brief time period was available.

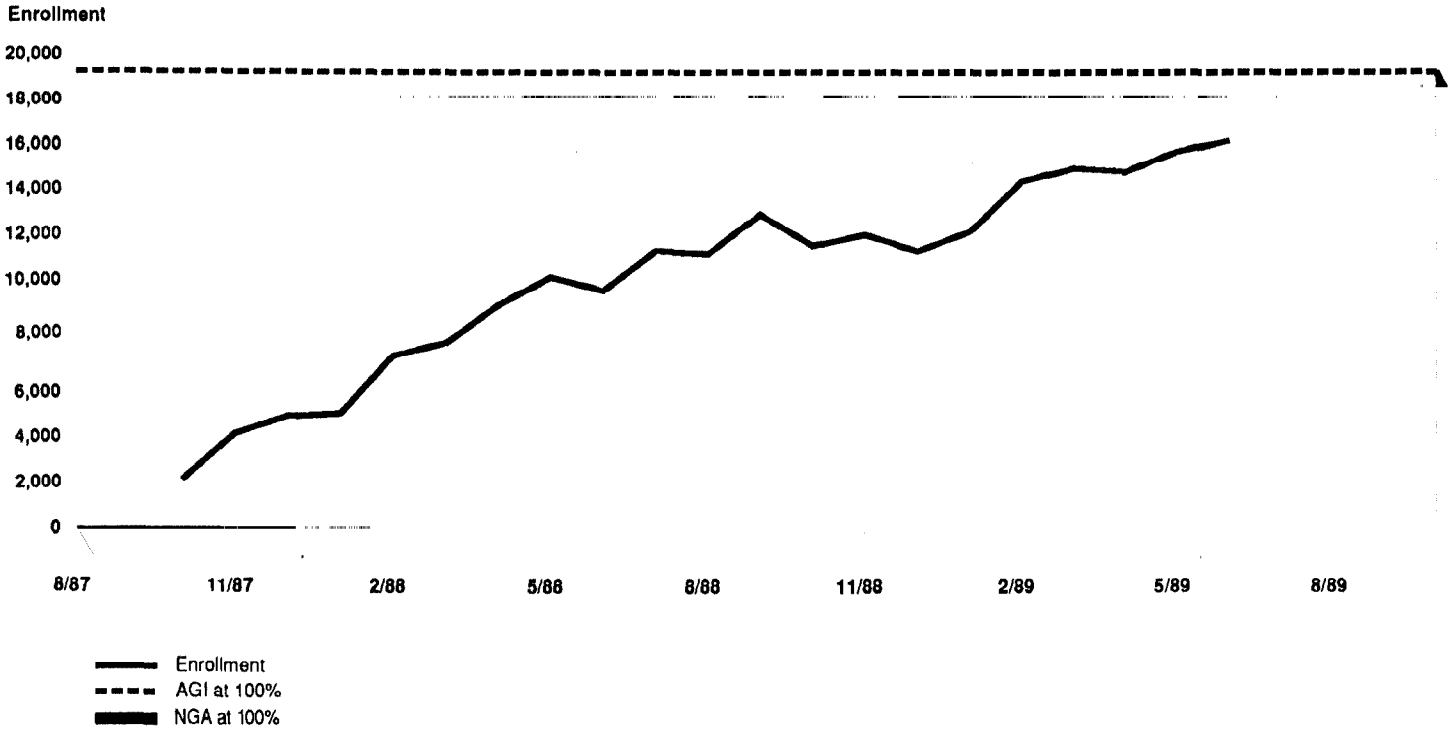
Appendix III
Participation by Pregnant Women, Their
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Figure III.1: Arkansas Enrollment



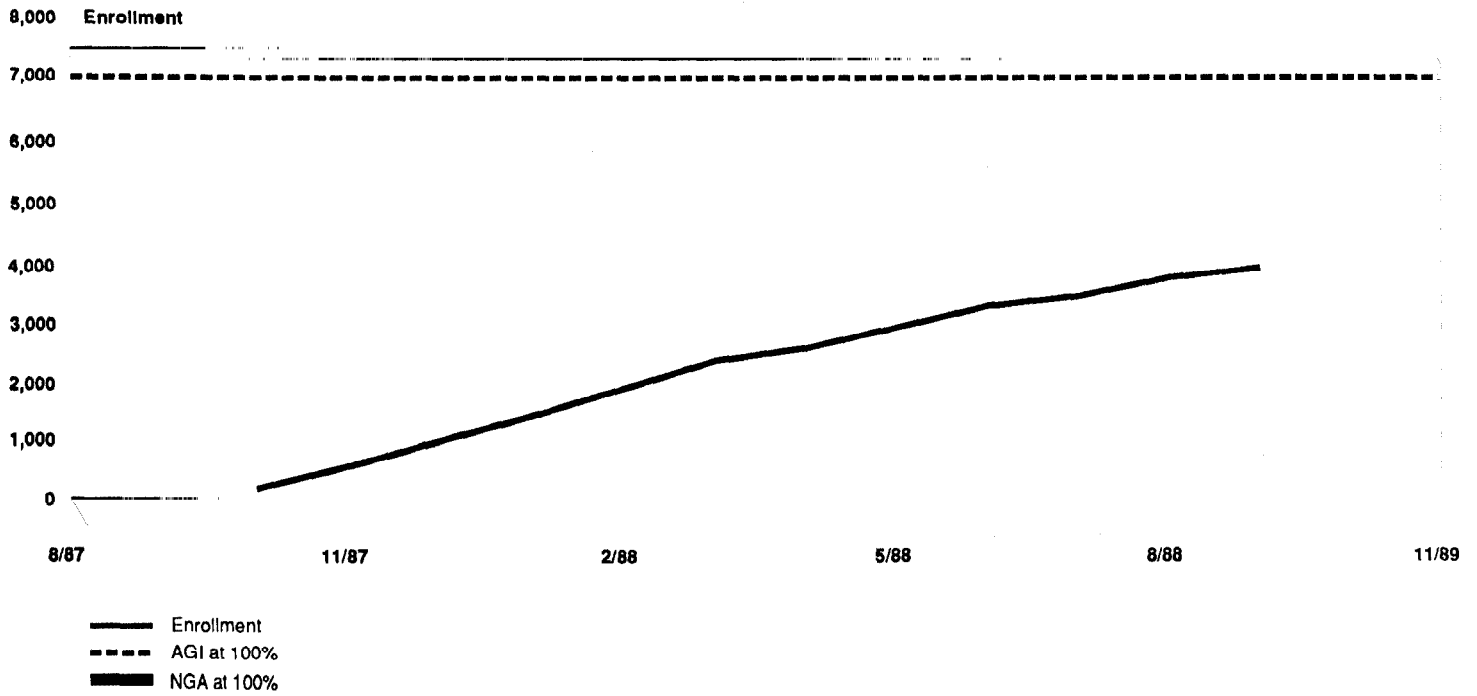
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Figure III.2: Florida Enrollment



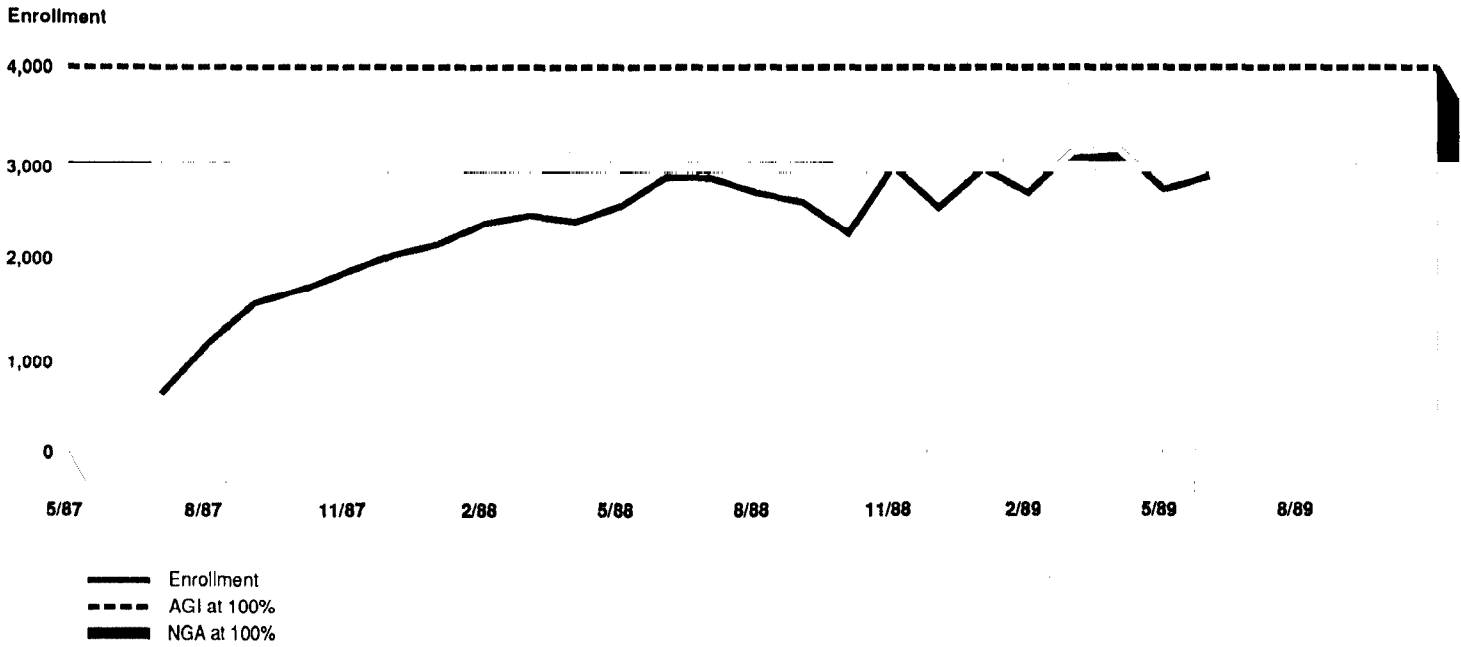
Appendix III
Participation by Pregnant Women, Their
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Figure III.3: Kentucky Enrollment



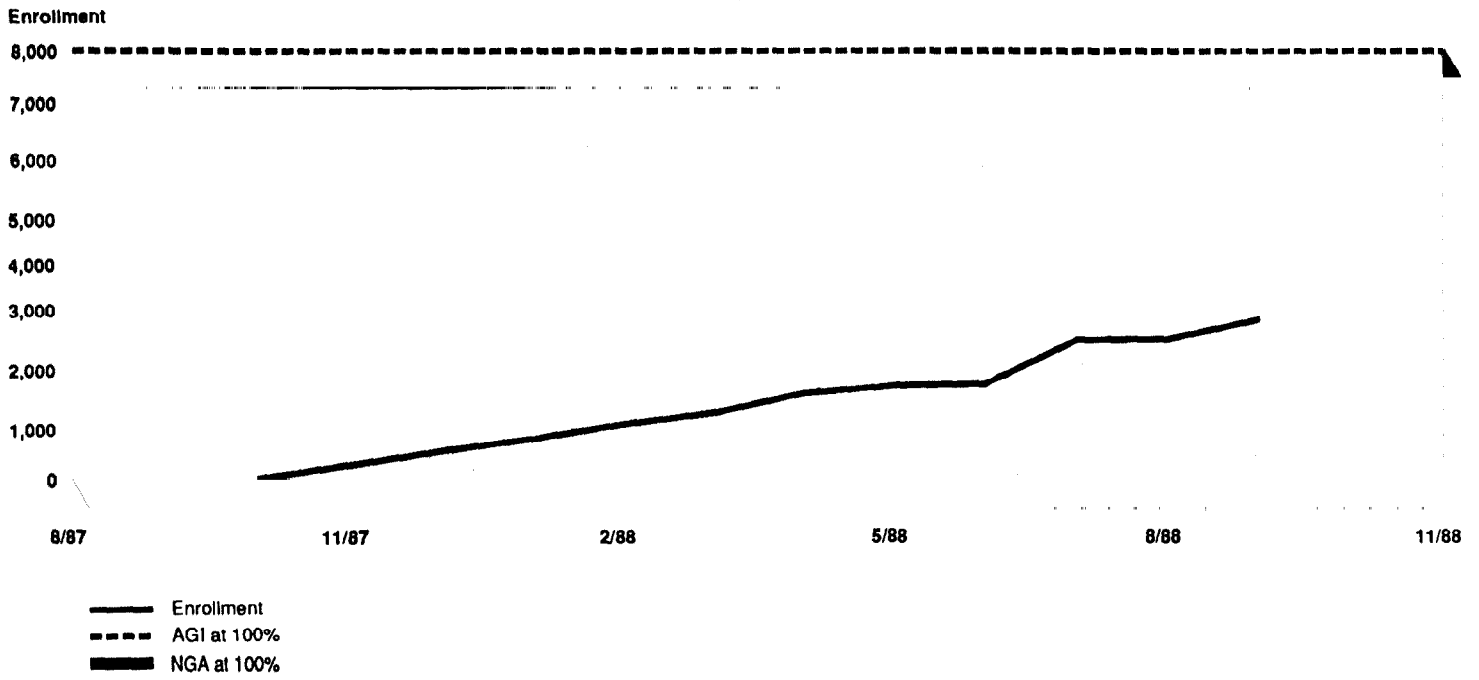
Appendix III
Participation by Pregnant Women, Their
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Figure III.4: Maryland Enrollment



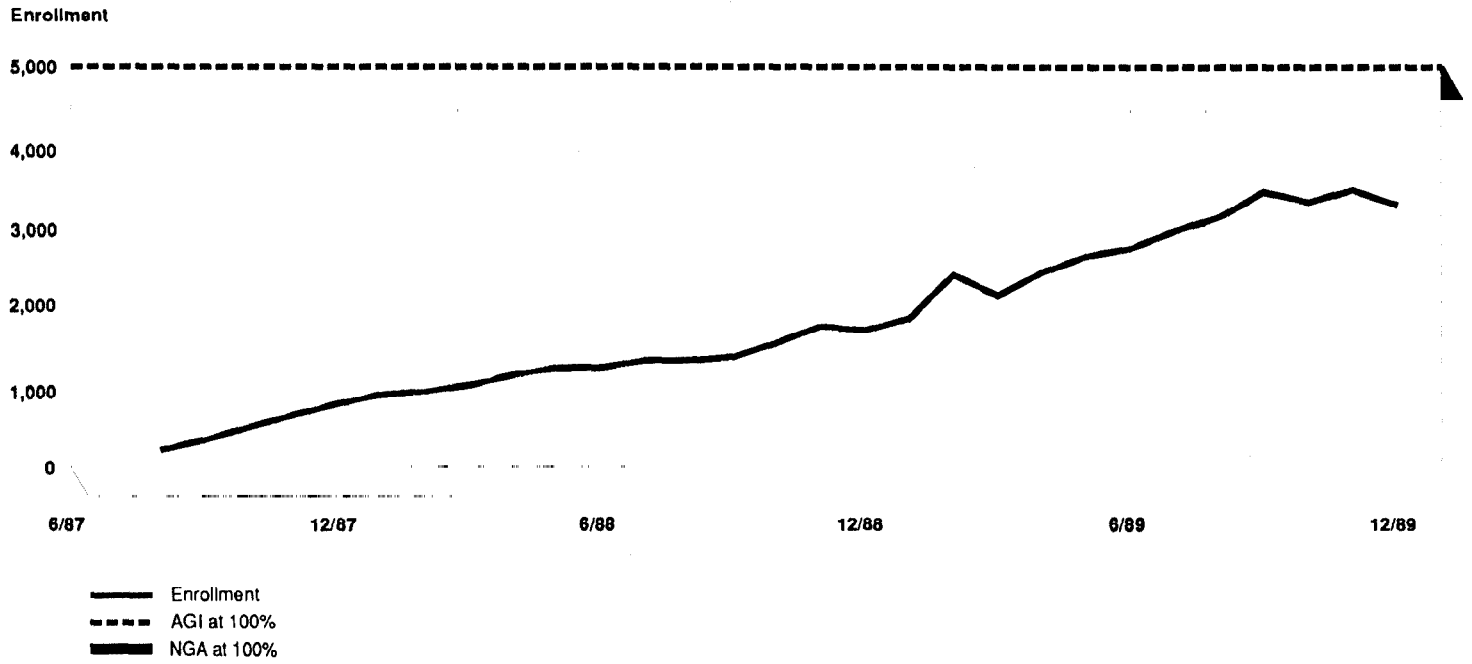
**Appendix III
Participation by Pregnant Women, Their
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Figure III.5: Mississippi Enrollment



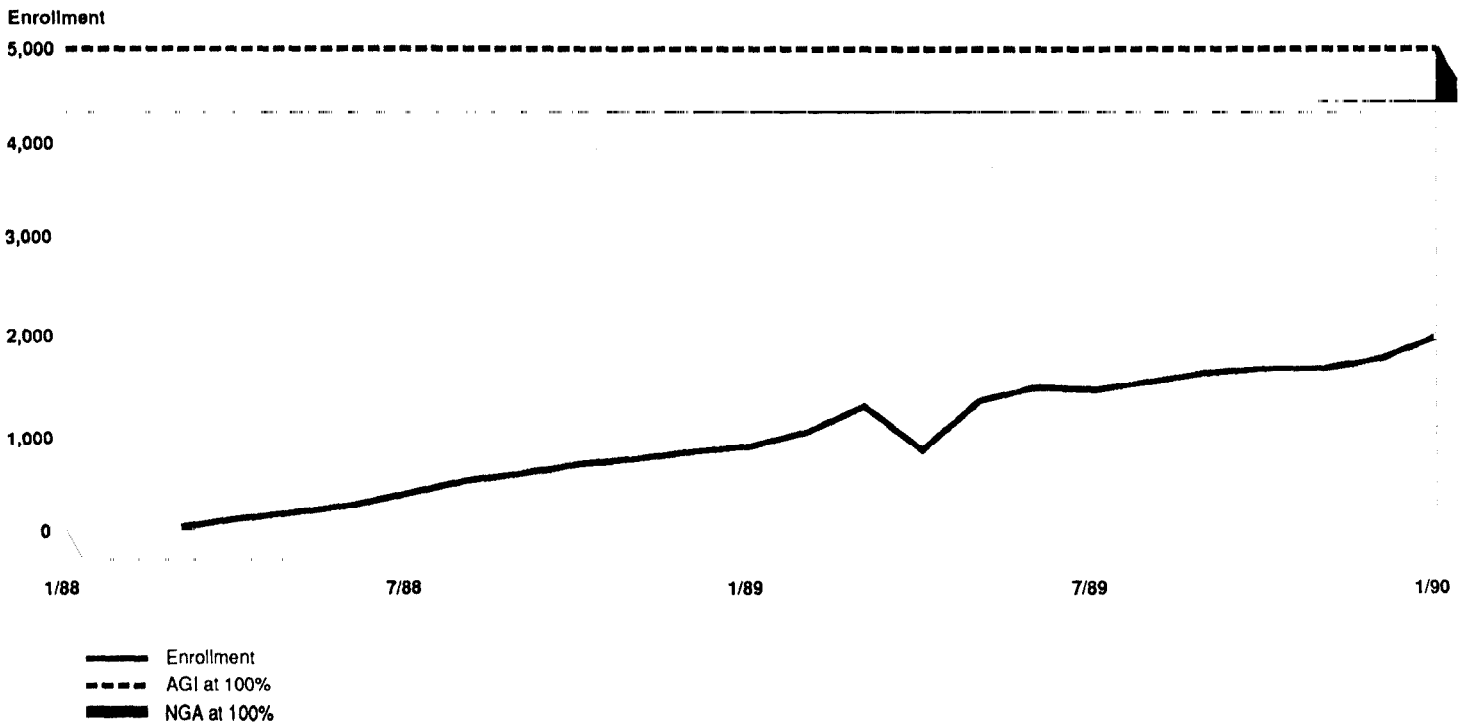
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Figure III.6: New Jersey Enrollment



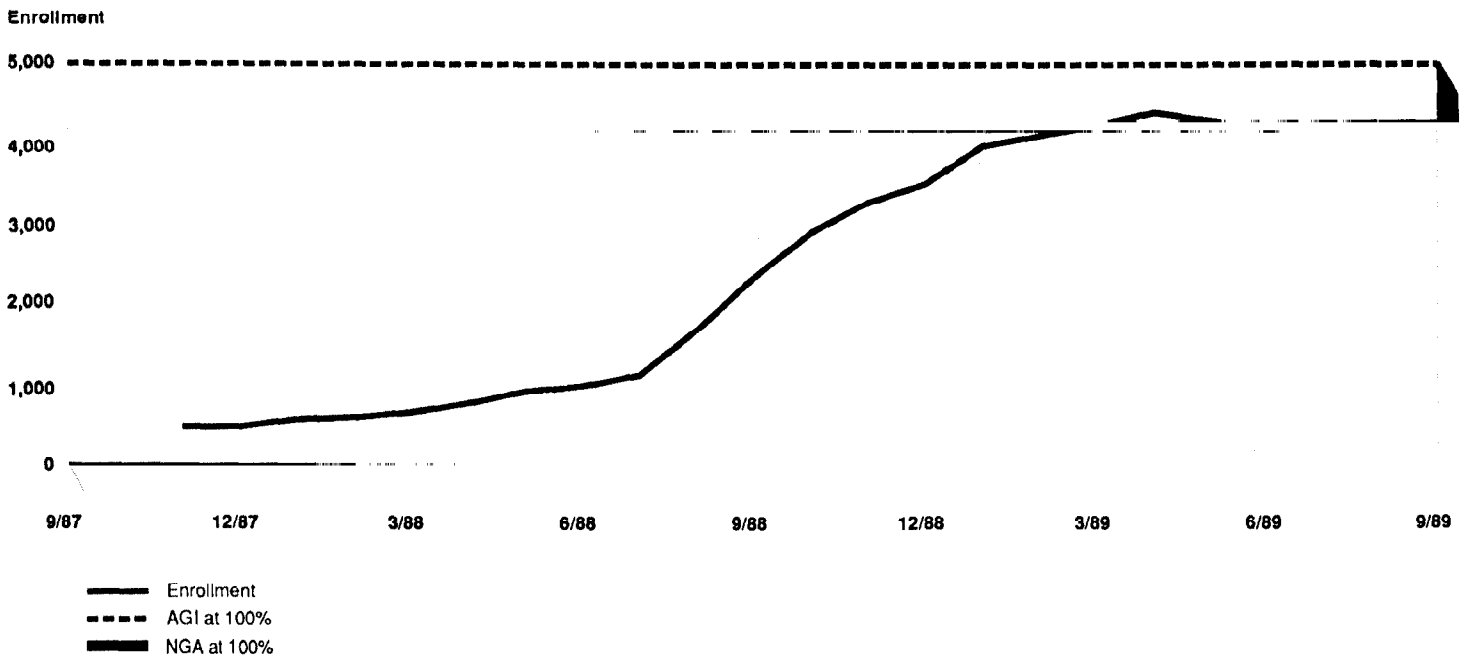
Appendix III
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Figure III.7: New Mexico Enrollment



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Figure III.8: Oregon Enrollment



The monthly enrollment totals are “snapshots” of all pregnant women enrolled in the expansion program for that month. Each patient is counted each month during which she is eligible, from the time of successful application through the end of postpartum services. The first enrollment data presented are for the month in which eligibility was first broadened (with the exception of Arkansas, where specific codes identifying expansion pregnant women were not incorporated until a year following initial expansion). We present only data for enrollees under the expansion to 100 percent of the poverty level.

The horizontal lines at the top of figures III.1 through III.8 represent two distinct estimates of need, with need defined as the number of pregnant women potentially eligible for services under the expansions. One of the estimates was developed by the Alan Guttmacher Institute (AGI), the other by the National Governors Association (NGA).² Consistent with

²P. W. Newachek, *Estimating Medicaid-Eligible Pregnant Women and Children Living Below 185% of Poverty* (Washington, D.C.: Center for Policy Research, National Governors Association, 1988); A. Torres and A. M. Kenney, “Expanding Medicaid Coverage for Pregnant Women: Estimates of the Impact and Cost,” *Family Planning Perspectives*, 21:1 (1989), 19-24.

the enrollment data, they represent need at 100 percent of the poverty level. The two need estimates were made from the same initial census data set, although somewhat different assumptions were employed for each estimate.³ Briefly, the estimation procedure involved calculating the number of uninsured women of child-bearing age for several income groups (less than 100 percent poverty, between 100 percent and 125 percent poverty, and so on) and applying a fertility rate to calculate the number of pregnancies expected for each poverty subgroup. The AGI estimates are higher because AGI used a poverty-adjusted fertility rate that accounted for higher fertility among lower-income groups and also included women with private insurance that did not cover maternity care.

In general, the trends depicted in the figures reflect our expectations for enrollment trends. That is, most show gradual growth that levels off at or somewhat below estimated need. In some states, however, growth toward achieving need is not as great as in others. Some states, such as Florida, Kentucky, and Maryland, experienced a rapid acceleration in caseload, whereas in others, such as New Jersey and New Mexico, enrollment growth was steady but at a slower rate. Some states, such as Oregon and Maryland, leveled off close to need, while in others, such as Arkansas and Mississippi, enrollment continued to approach need levels.

Using final monthly enrollments as numerators and needs estimates as denominators, we computed the percentage of need captured by enrollment. On the average, across the 8 states, after 22 months of program activity (the range is 12 to 33 months), 65 percent of need was captured using the AGI estimate as the denominator and 73 percent using the NGA estimate. For the AGI and NGA denominators, the state-level estimates ranged from 37 to 85 percent and 40 to 98 percent, respectively (we attempt to explain this variation below).

Enrollee Characteristics

To answer the second question, we needed to know more about the demographic characteristics of pregnant women enrolled in the expansion programs. Unfortunately, we found that the data do not exist. In order to learn about the characteristics of expansion enrollees, we need to match Medicaid eligibility and claims data and to link them with data from birth certificates. Birth certificates contain demographic data as

³Data from the March supplement of the Current Population Survey pooled across 3 years (1984-86 for NGA and 1985-87 for AGI). The data were pooled because of small sample size at the state level for any single year.

well as data about prenatal care and birth outcomes. By linking birth certificate and Medicaid data, the subset of all births that are Medicaid births can be identified (as well as those within particular Medicaid eligibility categories), and statistics concerning their characteristics and outcomes can be developed. Arkansas was the one state we visited that had completed matching and linking Medicaid and birth certificate data.⁴ Table III.1 shows selected demographic characteristics for Arkansas's expansion program enrollees.

Table III.1: Racial and Marital Status of Arkansas Births by Medicaid Status July 1987 to July 1988

	Expansion births	Medicaid cash-recipient births	Non-Medicaid births
Marital status			
Married	69.2%	31.2%	87.1%
Unmarried	30.8	68.8	12.9
Race			
Nonwhite	25.4	55.6	15.1
White	74.6	44.4	84.9

As indicated in table III.1, the Arkansas expansion program patients were more likely to be married and to come from nonminority backgrounds than traditional Medicaid mothers. Given that the Medicaid expansions were directed to women with incomes higher than very poor traditional Medicaid patients, we expected that expansion program patients would possess characteristics more typical of higher-income women.

Although further quantitative data were not available, frontline eligibility workers from several states other than Arkansas indicated during site visit interviews that expansion program patients seemed more likely to come from employed and married households. However, given the paucity of quantitative data, we are not able to draw firm conclusions about the characteristics of pregnant women enrolling in the expansions.

Activities Associated With More Rapid Enrollment

The final (fourth) evaluation question concerns the state activities that are associated with better enrollment success. To address this question, we examined data on eligibility determination and outreach activities as well as the enrollment data. We focused on rates of enrollment growth during the early stages of expansion and compared these rates in states

⁴Some other states had initiated linking of data.

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that implemented certain eligibility and outreach activities to rates in states that did not. This was possible because one factor that influenced our selection of states was variation in these activities.

To control for varying length of programs, we limited examination of enrollment to approximately the first year of program activity. Table III.2 lists the time periods we used and illustrates the computation of an enrollment growth rate.

Table III.2: Computation of Enrollment Growth Rate in 8 States

State	Program initiation	End point	Months	Percent need at end point		Enrollment growth rate ^a
				AGI	NGA	
Arkansas	4/87	4/88	13 ^b	54	57	4.2
Florida	10/87	9/88	12	69	72	5.8
Kentucky	10/87	9/88	12	55	52	4.6
Maryland	7/87	6/88	12	72	96	6.0
Mississippi	10/87	9/88	12	37	40	3.1
New Jersey	7/87	6/88	12	25	28	2.1
New Mexico	1/88	11/88	11 ^c	15	17	1.4
Oregon	11/87	6/88	8 ^d	20	23	2.5

^aBased on AGI denominator.

^bUsed 13 months because March 1988 data were unavailable.

^cUsed 11 months because at month 12 assets tests were dropped.

^dUsed 8 months because at month 9 an expedited process was implemented involving a shortened form and reduced processing time.

For example, for Oregon we used the first 8 months of program experience (from November 1987 to June 1988). We stopped at June 1988 because Oregon instituted a 24-hour application processing policy and reduced application length in the following month. By the eighth month, Oregon had enrolled 20 percent of estimated need. This reflects an enrollment growth rate of 2.5 percent per month. Similar computations were performed for the 7 other states.

Table III.3 combines the enrollment growth rates with information concerning eligibility determination and outreach activities. Each state is placed horizontally according to its performance on the enrollment rate. The table lists five program components.⁵ The activities implemented by

⁵We did not include outstationing because only 1 state had broadly implemented this approach. We did not include provider and patient notification efforts because all states had implemented this approach. We did not include case finding because this approach was limited to small geographic areas.

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each state during the time period on which the enrollment rate is based are indicated in the body of the table.

Table III.3: Frequency of Eligibility Determination and Outreach Activities by Enrollment Growth Rate

	Enrollment growth rate							
	MD 6.0	FL 5.8	KY 4.6	AR 4.2	MS 3.1	OR 2.5	NJ 2.1	NM 1.4
Short form	X	X						X
Media campaign		X			X	X		
Hot line		X			X			X
Drop assets	X	X				X		X
Presumptive eligibility	X	X		X				

Table III.3 suggests a joint effect of presumptive eligibility and the elimination of assets tests. The 2 states with the highest enrollment rates implemented both components. The remaining states had implemented either only one or none of these components. With respect to the other components (short form, hot line, media campaigns, and so on), they were implemented by both high- and low-enrollment states and therefore cannot explain differences in enrollment success. For example, although both high-participation states adopted shortened forms, a state that did relatively poorly on enrollment growth also adopted this component. Also, although both high participation states removed assets tests, 2 other states with relatively slower enrollment growth also dropped these tests.

Limitations

The AGI and NGA need estimates possess limitations of sampling error and inability to reflect temporal changes in the underlying demographic distribution. As with many new programs, it is also possible that the enrollment data contain some misidentification of cases, particularly during early stages of program implementation.⁶ However, the enrollment data presented here are the only available information about participation in the expansions, and the AGI and NGA estimates are the only estimates of need that employ a consistent methodology across states.

⁶The largest potential source of inaccuracy is that some patients might have been eligible for the Medically Needy program had the expansion not occurred. However, eligibility for the Medically Needy program usually requires "spend-down" of assets. This typically would not occur until large delivery bills arose at the end of pregnancy. Hence, prenatal services were rarely provided by Medically Needy programs. All the states in our sample except Mississippi and New Mexico have Medically Needy programs.

Conclusions

Enrollment

We conclude that implementation of expansion policies has resulted in substantial increases in Medicaid participation by pregnant women. Indeed, the general finding is that between two thirds and three quarters of the target population was enrolled in less than 2 years. From our analysis, we conclude that several factors are likely contributors to this high degree of success.⁷

First, the eligibility determination reforms may have successfully removed procedural and application process barriers. During site visits, eligibility workers frequently commented about the simplicity and ease of procedures employed in the expansion reforms compared to traditional Medicaid application procedures.

Second, the outreach and public information campaigns initiated by states may have been successful in informing eligible pregnant women about the expansions. This possibility is reinforced if the demographic characteristics of the expansion population are similar to those of Arkansas, since outreach and education programs tend to succeed better with persons of higher socioeconomic status. In addition, strong "word of mouth" referral patterns in communities may have contributed to broad knowledge of the expansions.

Third, other maternal health programs are likely to have played an important role in creating rapid expansion enrollment. Shifts of patients served by local health department and community health center maternity programs into Medicaid may have occurred. Also, the Special Supplemental Food Program for Women, Infants, and Children (WIC) serves pregnant women with incomes of up to 185 percent of the poverty level in most states. Therefore, pregnant women WIC clients are very likely to be eligible for Medicaid under the expansion programs. By bringing these women into public sector health services networks, WIC increases

⁷One review of 23 studies of participation in entitlement programs reported that the average enrollment was only 45 percent. In addition, we reported that about 44 percent of those eligible for the food stamp program actually participated. This was for programs that had been operating for lengthy periods of time and is still well below our finding of between 65 and 73 percent enrollment after only about 2 years of program activity. See R. Prottas, "Cost of Free Services: Organizational Impediments to Access to Public Services," *Public Administration Review*, September-October 1981, pp. 526-34; U.S. General Accounting Office, *Food Stamp Program: A Demographic Analysis of Participation and Nonparticipation*, GAO/PEMD-90-8 (Washington, D.C.: 1990).

the chance that eligible pregnant women would learn about the expansions.

As already noted, our results do not address whether prenatal care adequacy or birth outcomes have improved. The data also do not reflect expansion program activities that occurred proximate to, or following, our site visits. What we report on is a cross section, after about 2 years of activity, of an on-going process. Until July 1989, when coverage to 75 percent poverty was mandated, expansion was at state option. Congressionally mandated coverage for pregnant women is likely to create further acceleration in state program activity.

Enrollee Characteristics

The Arkansas data on enrollee characteristics closely correspond to the findings of a Michigan study. They indicate that, compared to women in Michigan's cash assistance Medicaid group, membership in the 185-percent poverty expansion group was associated with greater employment, greater age, more education, and marriage.⁸

Given confirmatory evidence from field interviews and from a separate empirical study, and given the reasonableness of the proposition, it seems probable that expansion program patients are more likely to be married, nonminority, and more highly educated and to come from families in which the major breadwinner is employed. However, the data are insufficient to make firm conclusions.

Activities Associated With More Rapid Enrollment

Those of the 10 states we studied that jointly implemented presumptive eligibility and dropped assets tests experienced the most rapid initial growth in enrollment. Because of our case study design, we cannot establish that these activities are causes of rapid enrollment. However, among the states we studied, implementing both these activities uniquely distinguished states with the most rapid increases in expansion program enrollment from all other states.

Qualitative data from interviews and observations at local Medicaid and health agencies provide a rationale as to why presumptive eligibility and dropping assets tests made a difference. Presumptive eligibility allows applicants to apply for medical assistance at the health care setting with minimal documentation. This enables them to be determined

⁸J. P. Mayer et al., "Pregnant Women Eligible Under Medicaid Expansion of Maternity Services: Implications for Outreach," *Evaluation and the Health Professions*, 12:4 (1989), 424-36.

(at least temporarily) eligible “on the spot” and this conveys a message of inclusion rather than exclusion early in the application process. Although applicants must visit the local Medicaid agency within 2 weeks of being determined presumptively eligible, they make this visit with the understanding that it is highly probable that they will be eligible throughout their pregnancy and into the postpartum period. Hence, the visit becomes one of confirming their status rather than one of initial application.

Eliminating assets tests greatly reduces the burden of providing documentation. Typically, applicants need to provide information only concerning income, pregnancy status, and residence; with assets testing, the process is more akin to completing a mortgage application (it requires detailed information about bank accounts, car ownership, house ownership, and the like). According to frontline eligibility workers, this relief from burdensome documentation also is likely to reduce the number of return visits by applicants for reasons of insufficient documentation.

Media campaigns and maternity telephone hot lines did not distinguish states with more rapid enrollment. These approaches to outreach may play a role in increasing awareness about the importance of early prenatal care but may perform less well in increasing awareness about specific changes in Medicaid policy. In addition, media campaigns were aired only intermittently, weakening potential effects. Preliminary research in Utah and Washington, D.C., has demonstrated a relationship between public service announcement airings, frequency of hot-line calls, and increases in maternity clinic activity and positive attitudes about prenatal care.⁹ Given methodological limitations of the studies, however, further study will be needed.

Outstationing avoids all visits to Medicaid agencies by applicants: the entire process is completed at the health care setting, typically during the first and second prenatal visits. Although it seems reasonable that this approach increases convenience and facilitates enrollment, we were unable to test it because its use was confined largely to a single state. Case finding and patient and provider notification efforts were implemented in all states and therefore could not possibly distinguish states with rapid enrollment growth. In addition, case finding was limited to

⁹P. Van Dyck and M. A. Smith, “Baby Your Baby Program,” Utah Department of Health, Family Health Services Division, March 1989; National Research, Inc., “An analysis of a Survey of D.C. Metro Area Residents’ Attitudes Toward Health-Related Issues,” report submitted to The Beautiful Babies Campaign, September 1987.

small geographic areas, making statewide effect unlikely. Research concerning the effectiveness and efficiency of local prenatal case-finding is limited; we located only one empirical study.¹⁰

Summary and Future Evaluation Research Needs

Given uncertainty concerning the extent to which expanded eligibility for prenatal care would actually increase participation by pregnant women in Medicaid, the main objective of the present study was to present data on enrollment trends. These data show that after less than 2 years of program experience, between 65 percent and 73 percent of the pregnant women who were made eligible by the expansions enrolled in Medicaid.

This finding reflects participation effects. As noted previously, the enrollment data do not indicate that more intensive or higher-quality prenatal care has been provided. Nor do the data signify improvement in low birthweight or other perinatal outcomes. Hence, many challenges remain for evaluation studies of the Medicaid maternity expansions. Included among process and outcome questions remaining unanswered are the following.

Who Participates in the Expansions?

We were unable to gather sufficient data to make firm conclusions concerning the characteristics of expansion participants. Additional descriptive studies about the characteristics of women enrolling in the expansions are important to discern what segments of the uninsured population are actually participating. In addition, more comprehensive information concerning levels of participation will be needed as the program matures. Is the increase we found national? Will that increase continue? If so, at similar or slower rates? Which states will end up with the highest and lowest ceilings on enrollment? Besides financial barriers, other barriers, such as transportation problems, lack of child care, lack of providers, fragmented delivery systems, and excessive appointment delays will remain as obstacles and will continue to exert influence on participation.

Where Is Care Received?

The expansions may cause changes in the types of providers from whom low-income pregnant women seek maternity care. Shifts may occur in the kinds of hospitals in which low-income pregnant women deliver

¹⁰M. C. McCormick et al., "Outreach as Case Finding: Its Effect on Enrollment in Prenatal Care," *Medical Care*, 27:2 (1989), 103-11.

from university and charity hospitals to a more diverse mix of institutions. Besides potentially decreasing levels of uncompensated care, this may have the effect of allowing women to receive care in local hospitals and therefore diminish transportation problems. Additionally, shifts in the prenatal care provider base from the public sector to the private sector may occur. Some analysts are concerned that if this shift occurs, comprehensiveness of care may be “diluted” as low-income pregnant women choose private physicians over clinic providers. Clinics typically have nutritionists, social workers, and public health nurses available to provide enhanced services, while private physicians’ offices typically do not. In either case, a major problem is locating a sufficient number of obstetrical providers willing to participate in Medicaid. Although states have initiated efforts to recruit and retain providers (including increasing fees and simplifying paperwork), lack of providers is viewed by many state and local officials as a significant barrier.

What Kind of Care Is Received?

The expansions may result in improvements in the adequacy and comprehensiveness of maternity care. Simplification of application procedures may result in more frequent initiation of care during the first trimester. Case management programs and continuous eligibility may improve continuity of care by avoiding switching among multiple providers during pregnancy and maintaining adherence to the prescribed sequence of prenatal visits. Comprehensive maternity care policies, especially those directed toward high-risk women, may result in more frequent risk assessments, home visits, nutritional and psychosocial counseling, and other health promotion components.

What Are the Effects on Health Outcomes?

The “bottom line” of all activities discussed in this report is to improve health outcomes, such as low birthweight and infant mortality rates. As mentioned above, whether any policy changes to date have affected these outcomes remains to be determined. By improving the earliness and comprehensiveness of care, and eliminating financial barriers for the uninsured, the expansions may result in improvements in health outcomes.

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