

STUDY COMMITTEE ON SERVICES TO PREGNANT WOMEN
FINAL REPORT

Presented to:

Governor Fife Symington
Senator Peter Rios, President of the Senate
Representative Jane Dee Hull, Speaker of the House

October 1, 1992

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TABLE OF CONTENTS

Letter from Chair and Vice-Chair.....	1
Executive Summary.....	2
Prenatal Health Care in the United States.....	9
Status of Prenatal Health Care in Arizona.....	17
Goals of the Study Committee.....	23
AHCCCS Eligibility and Enrollment.....	24
Introduction.....	24
Barriers to Medicaid Eligibility Nationally.....	24
Barriers to AHCCCS Eligibility.....	29
Recommendations.....	38
Justification.....	40
Availability of Providers.....	41
Statement of the Problem.....	41
Recommendations.....	46
Special Populations.....	49
Introduction.....	49
African-American Women.....	49
Hispanic Women.....	50
Native American Women.....	54
Teen Mothers.....	58
Homeless Women.....	60
Targeted Case Management.....	60
Health Start.....	62
Teen Express.....	62
Family Planning Services.....	64
Recommendations.....	65

Justification..... 66

Pregnant Women and Chemical Dependency..... 69

 Prenatal Substance Abuse and its Effects..... 69

 Availability of Treatment Services..... 72

 Residential Treatment..... 77

 Intensive Case Management..... 79

 Recommendations..... 80

 Justification..... 83

Education..... 85

 Recommendations..... 86

 Justification..... 88

Budget Implications..... 91

Conclusion..... 94

Addendum..... 96

Minority Report..... 98

Minority Response..... 98

Findings..... 99

Recommendations..... 99

Signatures..... 100



Arizona State Legislature

1700 West Washington

Phoenix, Arizona 85007

October 20, 1992

Speaker Jane Dee Hull
Arizona House of Representatives
1700 W. Washington
Phoenix, AZ 85007

Dear Speaker Hull:

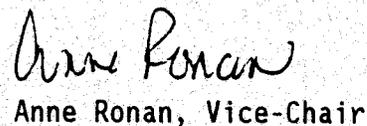
Attached is the report of the Study Committee on Services to Pregnant Women, established by Laws 1991, Chapter 193. This report, authored by us, represents the findings of the Committee and its recommendations for action by the Legislature, state administrative agencies, local communities and the private sector.

Copies of the minutes, the subcommittee reports and other handouts prepared by staff can be obtained from the Secretary of the Senate's office. The Office of Women's and Children's Health within the Department of Health Services has copies of the studies and other related reports compiled for the Committee.

The recommendations proposed in this report constitute a comprehensive scheme to improve the health status of women and children. It is our hope that the recommendations will be implemented incrementally by the appropriate entities as budgetary constraints allow.

Sincerely,


Dr. Tom Griffin, Chair


Anne Ronan, Vice-Chair

TG/AR/cmh

cc: Governor Fife Symington
President Peter Rios

EXECUTIVE SUMMARY

In June, 1991, Governor Fife Symington appointed this Committee to study barriers to prenatal care for women in Arizona. The Committee heard testimony and reviewed extensively the studies done nationally and in Arizona on the question. The following is a summary of the Committees findings and recommendations.

Arizona ranks among the worst in the percentage of infants born to women receiving late or no prenatal care. Only New Mexico, Texas, and the District of Columbia ranked lower.

A recent Arizona Department of Health Services' study showed a marked increase in women receiving inadequate prenatal care between 1982 and 1989. In Phoenix there was a 147% increase in the percentage of women who had less than 5 prenatal visits and a 277% increase in the percentage who entered care in the third trimester or who had no care at all.

The decline is more marked in the inner city area of Phoenix and other high poverty areas. The number of Hispanic women receiving inadequate care increased by 86%; the number of Black women increased by 124%; and the number of white women receiving inadequate care increased by 62%. Most alarming is the finding that AHCCCS women fared the worst at a time when AHCCCS eligibility was expanding.

A measure of the health status of women and children is the number of children born at low birth weight. The low birthweight

rate in Arizona had been steadily declining from 1970 to 1981. Since 1982 it has been on the increase. If Arizona had maintained the same level of prenatal care and the same low birthweight rate it had in 1981, at least 211 very low birthweight births would have been prevented in 1987 alone. Seventy infant deaths could have been prevented.

In addition to the cost in human life and health, the financial cost to the state is significant. The 211 very low birthweight babies born in 1987 as a result of deteriorating prenatal care cost the state approximately \$8,440,000. The total cost of healthy births would have been only \$1,293,000 for a net savings of \$7,147,000.

Dr. Patricia Nolan, the former Medical Director for AHCCCS, testified that the entire AHCCCS eligibility process is complicated and unfriendly, and has been designed to keep people off of AHCCCS. Robert Gomez, the Executive Director of El Rio Health Center, found that it took on the average 43 days for women seen at his clinic to complete the AHCCCS eligibility and enrollment process.

Public information about eligibility and enrollment is not well-targeted to the women who are in need of care.

Of Arizona's fifteen counties, ten had areas, both urban and rural, designated as primary care health personnel shortage areas. Within these ten counties, thirty-one communities were identified as shortage areas for primary care physicians. In 1987, twelve communities had no physicians within a thirty minute

travel zone who were willing to deliver babies. Additionally, the federal government has designated eleven Arizona counties as medically underserved areas.

60% fewer practitioners were providing obstetrical care in rural Arizona than in 1982. It is expected that many of the physicians serving rural areas will be retiring in the near future. The shortage of providers is not limited to doctors, and includes nurse practitioners, nurse midwives and physician assistants. The budget crisis in the state may result in the state-supported schools being inadequately funded to accept and educate the needed recruits to address these shortages.

Indian Health Services (IHS) provides care for Native American women, almost 7,000 of whom give birth each year in Arizona.

In 1989, approximately 25 obstetricians who provided care through IHS chose not to serve any longer.

Barriers to prenatal care exist for women of all racial, ethnic, and age groups, however, for some groups the barriers are greater.

African-American women consistently receive less care than women of all other races. The number of babies born at low birthweight among the African-American population is disproportionately high. Non-financial barriers are the main reasons black women receive inadequate care. Lack of awareness of the pregnancy and the need for prenatal care were found to be the most frequent reasons black women delayed care.

In Arizona, Hispanic women are 3.5 times more likely to receive no prenatal care than are white women. Even when Hispanic women are enrolled early and continuously with AHCCCS, they are less likely to receive adequate prenatal care than are white non-Hispanic AHCCCS enrolled women. Language and cultural differences are barriers to care for Hispanic women. There is often a wide socioeconomic, cultural, and educational gap between low-income pregnant women and their providers. Providers are not educated about cultural differences that affect prenatal care.

Native American women face cultural and language barriers to care as do Hispanic women. Only 60% of Native American women in Pima County received care during their first trimester, while 75% of white women in Pima County received early care. Native American women were 2.7 times more likely to receive no prenatal care than were white women.

Teenagers 15 to 17 years old are twice as likely to receive no prenatal care than are women between the ages of 20 to 34. The frequency of teen pregnancy in Arizona is increasing rapidly. Between 1985 and 1990 there was a 22% increase in the number of births to teenagers. Santa Cruz County saw an increase of 103% in births to teens. Most alarming is the increase in births to women younger than 15 years. Between 1985 and 1990 there was an increase of 67% (110 births to 184 births). 63% of these births were to teens in Maricopa County. The chance of a teen having a low birthweight baby is 25% greater than the chance of an adult having a low birthweight baby. Teens lack knowledge of the need

for prenatal care. Local school board policies and practices may also discourage teens from remaining in school during their pregnancy.

A targeted case management program designed around the unique needs of the high risk group is essential.

Unintended pregnancies are directly related to late entry into prenatal care. Family planning counseling and services play an integral part in reducing unintended pregnancies and the resultant low birth weight babies.

In 1987, the National Association for Perinatal Addiction Research and Education estimated that 11% of all babies born nationwide have been exposed to illicit drugs at the time of birth. A 1990 study issued by the U.S. General Accounting Office found that 16% of all newborns born nationwide are substance-exposed. Exposure to alcohol prenatally is also a serious problem. The Arizona Department of Health Services estimated that 1,343 women who delivered babies in 1991 in Arizona used alcohol during pregnancy.

With comprehensive treatment programs designed specifically for women and their families these women and their babies can be helped. Current ADHS statistics show that 29% of all drug abusers are female, yet only 11% of residential treatment center beds are taken by women and very few are available to pregnant women.

If a substance abuse problem is not dealt with during pregnancy, a woman may not be able to properly care for her

children. Many drug-exposed babies are developmentally delayed. Others have serious chronic medical problems.

Throughout all of the committee hearings and subcommittee meetings much concern was expressed about the lack of education regarding the necessity of prenatal care. Every subcommittee found educational deficits in the current system. Lack of knowledge of the need for prenatal care was found to be the most prevalent barrier to care. The Subcommittee on Education was charged with developing a plan to increase awareness of 1) the symptoms of pregnancy and the necessity for prenatal care, 2) how to access the AHCCCS system and 3) the availability of care.

Among the recommendations necessary to eliminate the barriers to prenatal care the Committee proposes the following:

Simplify the AHCCCS Eligibility and Enrollment Process.

Increase AHCCCS eligibility income level to 185% of the poverty level.

Establish a sliding scale program for women whose income is below 250% of the federal poverty level.

Increase output of primary care physicians, OB/GYNs, nurses and other maternity care providers.

Increase incentives to existing and future providers to support continued practice in rural/underserved areas.

Assure that women in special target populations receive case management services that are responsive to the women's individual needs.

Provide specialized education on the importance of receiving prenatal care to the various special population groups.

Require the Department of Education to develop policies that ensure that all barriers to continued education for pregnant teens are eliminated.

Require the state funded medical educational institutions to include in their curriculum courses on the cultural differences of the populations served.

Increase state funding for family planning services.

Increase funding for residential drug and alcohol treatment.

Fund an Intensive Case Management System .

Expanded Education in School Systems.

Establish a broad based Media Campaign to educate the public on the need for prenatal care.

Increased Accessibility to Pregnancy Testing.

Expand Hotline Services.

"The willingness to protect children is a moral litmus test of any decent and compassionate society. It is also a test of the common sense of any nation seeking to preserve itself and its future."

Marion Wright Edelman

In June 1991 Governor Symington signed into law House Bill 2424 which created this committee to study the barriers that prevent women from receiving prenatal care; the degree to which current prenatal care services are used; the underserved populations; and the problems women face in establishing eligibility for AHCCCS. This report represents the findings of the Committee and its recommendations for action by the legislature, state administrative agencies, local communities and the private sector.

Prenatal Health Care in the United States

Early, continuous, and adequate prenatal care can prevent low birthweight and can help to decrease infant and maternal mortality. The National Governors' Association report on prenatal care found that women who do not receive adequate prenatal care are twice as likely to have low birthweight babies than are women who do receive adequate prenatal care.¹ Further, a recent study conducted by the U.S. Department of Health and Human Services found that almost 80% of all women at risk of having a low birthweight baby can be identified during the first prenatal

¹I. Hill, Reaching Women Who Need Prenatal Care, Washington, D.C. : National Governor's Association, 1988, p. 2 citing Gold et al., 1987.

visit.² Once this risk is identified, action can be taken that will substantially improve the chances of a healthy birth.

The Children's Defense Fund's 1991 report entitled The Health of America's Children, found that the leading cause of infant mortality is low birthweight, meaning birthweight of less than 5.5 pounds. In 1988 over 270,000 newborn Americans were born either prematurely or at a low birthweight. In the same year, 38,910 babies died before they turned one year of age, and approximately 60% of those deaths were attributed to problems arising from low birthweight.³ The Southern Regional Task Force on Infant Mortality concluded that low birthweight babies are forty times more likely to die during their first month of life than are babies who weigh more. This is due in part to the fact that these babies are born with premature and underdeveloped lungs, livers, and immune systems. Low birthweight babies never entirely escape this higher risk. Those who do survive are twice as likely to suffer one or more disabilities during their lifetime than are normal birthweight babies.⁴

Despite advances in medical technology, the number of babies born at low birthweight is increasing. Between 1972 and 1984 the percentage of low birthweight babies born in the U.S. decreased,

²M. Clement, Speech on Prenatal Care: The Arizona Condition, December 1, 1988, p. 2.

³S. Rosenbaum, C. Layton, and J. Liu, The Health of America's Children, Washington, D.C.: Children's Defense Fund, 1988, p. 2.

⁴I. Hill, p.3.

but between 1984 and 1988 the rate increased.⁵ In 1988, 6.9% of all live births were low birthweight. UNICEF data shows that between 1980 and 1988 the United States ranked twenty-eighth in the world in percentage of infants born at low birthweight.⁶ The U.S. fell behind countries such as Egypt, Iran, Romania, and the former Soviet Union and tied with Albania and Paraguay.⁷

Adequate prenatal care must begin early and include a sufficient number of visits throughout the pregnancy. The standards set by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists provide that prenatal care entails 1) monitoring the health status of pregnant women, 2) providing information to foster optimal health and good dietary habits, and 3) providing appropriate psychological and social support.⁸ The Children's Defense Fund found that in 1988 less than 69% of all births were to women who received adequate prenatal care.⁹ Low income women fared the worst, and their children experience infant mortality rates twice as high as other children.¹⁰ In 1988 barely 50% of African-American mothers

⁵S. Rosenbaum et. al., The Health of America's Children, pp. 7-8.

⁶Id. at p. 9.

⁷Id. at p. 9.

⁸Id. at p. 1.

⁹Id. at p. 2.

¹⁰S. Rosenbaum, D. Hughes, E. Butler, D. Howard, Incantations in the Dark: Medicaid, Managed Care, and Maternity Care, The Milbank Quarterly, Vol. 66, No. 4, 1988, p. 663 citing Eguobuono

received minimally adequate care and 13% of African-American babies were born at low birthweight.¹¹ This is 2.32 times greater than the percentage of white babies born at low birthweight, 5.6%. Black babies are 2.99 times more likely to be born at a very low birthweight (less than 3.5 pounds) than are white children. The gap between black and white low birthweights in 1988 was the widest it had been since the National Center for Health Statistics began reporting the data by race in 1969. 12.9% of teen mothers, a disproportionate number of whom are minorities, received late or no prenatal care.¹²

In response to the need for greater access to and availability of prenatal care, Congress enacted several expansions to eligibility for the Medicaid program. States must extend coverage to all pregnant women and infants with family incomes below 133% of the federal poverty level. States, at their option, may extend coverage to all pregnant women and infants with family incomes below 185% of the federal poverty level.¹³ One study estimates that of the 9 million uninsured women of childbearing age, two-thirds have family incomes below 250% of

and Starfield, 1982.

¹¹S. Rosenbaum et. al., The Health of America's Children, pp. 7-8.

¹²Id. at pp. 7-8.

¹³Id. at pp. 7-8.

the federal poverty level.¹⁴ If all fifty states were to take full advantage of the Medicaid expansions, more than 500,000 additional pregnant women would be eligible for coverage each year.

Reducing financial barriers to care by expanding Medicaid coverage alone has not improved early entry into care and birth outcomes for low income women. Tennessee expanded Medicaid eligibility in 1985 to include married women. In comparing the statistic for the years prior to and subsequent to the expansion, researchers found no improvements in the rates of very low and moderately low birth weight babies and infant deaths.¹⁵ In both years, two thirds or more of the mothers enrolled after the first trimester.¹⁶

The National Governors' Association Report entitled Reaching Women Who Need Prenatal Care found that participation rates among women who are potentially eligible for Medicaid are significantly behind expected levels, and that the rates vary tremendously from state to state.¹⁷ The NGA survey showed that participation rates of pregnant women in Medicaid varied widely between 11% of

¹⁴S. Rosenbaum et. al., Incantations in the Dark, p. 663 citing the Alan Guttmacher Institute, 1988.

¹⁵J. Piper, W. Ray, M. Griffin, Effects of Medicaid Eligibility Expansion on Prenatal Care and Pregnancy Outcome in Tennessee, JAMA Vol 264, No. 17, November 7, 1990, p.2220.

¹⁶Id., p. 2221.

¹⁷I. Hill, p. 3.

the eligible population and 84%.¹⁸ In addition, a U.S. General Accounting Office study cited by the National Governor's Association found that only 36% of women participating in Medicaid received adequate prenatal care.¹⁹ Numerous organizations, including the National Governors' Association, the U.S. Conference of Mayors, the General Accounting Office, and others have conducted studies to identify what barriers exist to participation in prenatal care programs. They have all identified substantially the same problems. The lack of financial access to care is regarded as the primary barrier.²⁰ Other barriers listed by the National Governors' Association include difficulty in finding a provider, lack of information about Medicaid eligibility, lack of transportation to health care facilities, shortage of information on how and where to receive care, inconvenient clinic hours, inability to leave work, lack of child care for other children, lengthy delays in getting appointments, inability to speak English, and fear of consequences such as deportation. Improved outreach and education are an effective way to overcome these barriers. Outreach workers can help women who are unaware of their pregnancy, who fear doctors and/or medical procedures, who fear others learning of the pregnancy, who lack the knowledge of the

¹⁸Id. at p. 4.

¹⁹Id. at p. 3.

²⁰Id. at p. 4.

importance of prenatal care and who do not know how to obtain Medicaid services.²¹

Improved outreach can improve awareness but barriers exist in the eligibility system even for women who know they are eligible and who seek prenatal care. The National Governors' Association report identified the following barriers. Often women must visit several different sites to fill out the eligibility paperwork and these sites are almost never the same sites that actually provide medical care. Once women have reached the correct site they must negotiate very complex eligibility forms. The NGA report found that the average application form for Medicaid is 14 pages, but the applications can be up to 40 pages.²² The eligibility forms require extensive documentation and verification, most of which a woman is not likely to have with her when she applies. After the forms are completed, the determination of eligibility can take almost two months, and the most common reason for denial of eligibility to participate in public benefits programs is that the applicant "did not comply with required procedures." The Center on Welfare Policy and Law found that in 1984 one-third of the persons denied for procedural reasons were in fact eligible.²³

The United States Conference of Mayors conducted a survey to

²¹Id. at p. 4 citing U.S. G.A.O., 1987 and Hughes et. al., 1988.

²²Id. at p. 5 citing Gold et. al., 1987.

²³Id. at p. 7.

determine barriers to the use of Medicaid, and discovered similar problems. Difficulties with required documentation, lack of information about the program, complexity of the application process, excessive paperwork requirements, lack of outreach, lack of transportation, lack of permanent address, stigma, applications written at too high a literacy level, language barriers, and inadequate staffing and inaccessible locations of Medicaid offices were identified by the mayors as the most prevalent barriers to utilization of the program. Pregnant women were identified as the group most likely to face difficulties in receiving Medicaid benefits.²⁴

Congress addressed some of these barriers and gave the states authority to remove them. As of 1990, all states could opt to 1) eliminate a resources test for eligibility for prenatal care, 2) shorten the application forms, and 3) implement presumptive eligibility for pregnant women waiting for final determination of Medicaid eligibility. States must continue eligibility throughout the pregnancy and during the postpartum period and place eligibility workers in community health centers and hospitals that provide care to a high number of low income women.

The cost of caring for babies born with severe problems caused by low birthweight is extremely high. In 1986-1987, the average cost of a normal pregnancy and delivery was approximately

²⁴United States Conference of Mayors, Barriers to Participation in Benefit Programs, Washington, D.C.: 1988, p. 51.

\$2,900. If a child was born prematurely with major complications the cost skyrocketed to \$12,000 and if the child is born extremely prematurely the cost further escalated to \$27,000.²⁵ Arizona specific data (See BUDGET IMPLICATIONS) indicates that current costs are at least double the 1987 costs. Neonatal intensive care is required for 6% of all Medicaid births, but the cost of neonatal intensive care constitutes 30% of all state Medicaid maternity expenditures.²⁶ In 1986-87, the Office of Technology Assessment found that the U.S. health care system saves between \$14,000 and \$30,000 in neonatal and long term care costs for every low birthweight birth which is averted by prenatal care.²⁷ The Institute of Medicine of the National Academy of Sciences estimates that every dollar spent on comprehensive prenatal care saves \$3.38.²⁸ The Children's Defense Fund reported that the difference between the U.S. infant mortality rate and the Japanese infant mortality rate costs the U.S. \$7 billion annually in lost productivity.²⁹

The Status of Prenatal Health Care in Arizona

In 1988 in Arizona the percentage of infants born to women

²⁵I. Hill, p. 3 citing Gold et. al., 1987.

²⁶Id. at p. 3 citing Kenney et. al., 1986.

²⁷M. Clement, p. 3.

²⁸S. Rosenbaum et. al., The Health of America's Children, p. 9 citing Institute of Medicine, "Preventing Low Birthweight," National Academy Press, Washington, D.C.: 1985.

²⁹M. D'Antonio, "Dying Young," Los Angeles Times Magazine, July 12, 1992, p. 15.

receiving late or no prenatal care was among the worst of all states in the nation. 10.2% of Arizona women received late or no prenatal care. Only New Mexico, Texas, and the District of Columbia were worse.³⁰ In 1987, 66.8 of every 1000 women in the U.S. and 89.5 of every 1000 women in Arizona received fewer than five prenatal visits.³¹ In 1988, 31% of all pregnant women in Arizona did not receive care in the first trimester.³² 62.9 babies out of every 1000 live births were born at low birthweight.³³ The Arizona infant mortality rate was 9.7 deaths per 1000 live births.³⁴ Approximately 60% of all infants who died in Arizona in 1987 were low birthweight babies.³⁵

The Arizona Department of Health Services recently completed a study of prenatal care rates in Maricopa and Pima counties for 1982, 1986 and 1989. These two counties account for 77% of the Arizona births with Maricopa accounting for 60% and Pima for 17%. There was a marked increase in women receiving inadequate prenatal care between 1982 (the best year for prenatal care for which data is available) and 1989. In Phoenix there was a 147%

³⁰S. Rosenbaum, The Health of America's Children, p. 32.

³¹Babies and Business: A Healthy Bottom Line, Greater Phoenix Affordable Health Care Foundation, 1990, p. 6, citing Children's Defense Fund.

³²Id. at p. 5 citing Children's Defense Fund.

³³Pima County Community Health Committee, Pima County Community Health Plan for the Year 2000, 1991, p. 65.

³⁴Id. at p. 65.

³⁵Babies and Business: A Healthy Bottom Line, p. 6.

increase in the percentage of women who had less than 5 prenatal visits and a 277% increase in the percentage who entered care in the third trimester or who had no care at all. In Pima county there was a 25% increase in the number of women who received less than 5 visits and a 16% increase in the number beginning care in the third trimester. The prenatal care rates in Pima County in 1982, the base year, were much worse than Maricopa County and therefore the decline was not as dramatic.

Further analysis showed that the decline in prenatal care rates was not uniform throughout Maricopa County, but was much more marked in the inner city area of Phoenix and other high poverty areas. The number of Hispanic women receiving inadequate care increased by 86%; the number of Black women increased by 124%; and the number of white women receiving inadequate care increased by 62%.³⁶

In 1989 Arizona birth certificates for the first time included information on the payor of care. Jane Pearson, the program director for Maternal and Child Health for the Office of Women and Children's Health for the Arizona Department of Health Services, told the committee on November 19, 1991 that AHCCCS women on average received 3.5 fewer prenatal visits than privately insured women.³⁷ The strongest statistical

³⁶Arizona Department of Health Services, "Prenatal Care Report" DRAFT, Analysis of 1982, 1986, 1989 Birth Certificate Data for Maricopa and Pima Counties, July 24, 1991

³⁷Nationally babies born to Medicaid women are not as healthy as babies born to poor uninsured women. S. Rosenbaun, et.al., Incantations in the Dark: Medicaid, Managed Care, and Maternity

correlation for women who received less than 5 prenatal visits were AHCCCS enrolled, late entry into care, unmarried, Hispanic, and education below the 9th grade.³⁸

The Arizona Department of Health Services (ADHS) operates the Newborn Intensive Care Program (NICP) which provides care for high-risk babies. Currently, 4% of all Arizona births or 3000 infants, are enrolled in the ADHS program. 57% of all babies enrolled in NICP are low birthweight babies. Low birthweight is a more common reason for NICP admission among African-American infants. In fiscal year 1987, 76% of African-American NICP infants were low birthweight babies.³⁹

In 1990, one-third of all babies born in Pima County were born to mothers who received inadequate prenatal care.⁴⁰ Only 67% of mothers received prenatal care during their first trimester.⁴¹ Only 64% visited a provider at least nine times during pregnancy, which is considered to be the optimal number of visits necessary for adequate care.⁴²

The Pima County statistics confirmed what the Department of

Care, p 661 citing Utah Health Department 1987 and Oregon Health Dept. 1985 unpublished data.

³⁸ADHS, "Prenatal Care Report" DRAFT

³⁹Report of the High Risk Perinatal Task Force, Arizona Perinatal Trust and Arizona Department of Health Services, November, 1990, p. 4.

⁴⁰H. Strich, producer, Maternal & Infant Health Status, Pima County Health Department, 1992.

⁴¹Id.

⁴²Id.

Health Services Draft report showed, that the health status of mothers and children in Arizona is worsening. In 1987 Pima County had a low birthweight rate of 63.6 per 1000 births (6.4%). This rate was higher than any rate reported in the previous ten years.⁴³ Furthermore, the infant mortality rate in Pima County rose from 8.1 deaths per 1000 live births in 1980 to 9.3 deaths per 1000 live births in 1988 - an increase of almost 15%.⁴⁴

In October 1982 Arizona implemented on a demonstration basis a Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS). Prior to the implementation of AHCCCS, the individual Arizona counties provided medical care to indigents. There was no uniform definition of eligibility, and most counties did not recognize pregnancy as a condition rendering someone eligible. Some prenatal services were provided through various grant programs including Title V of the Maternal and Child Health Care Block Grant program. According to WIC and Title V statistics, in 1981 Arizona was the worst among all 50 states in the provision of prenatal care.⁴⁵

Although significantly more women are eligible for prenatal care services under AHCCCS than under the county programs, since 1982 the status of maternal and child health care in Arizona has worsened. The low birthweight rate had been steadily declining from 1970 to 1981. Since 1982 it has been on the increase. If

⁴³Pima County Prenatal Care Initiative Attachment 1 p 1.

⁴⁴Id. at p. 1.

⁴⁵M. Clement, p. 5.

Arizona had maintained the same level of prenatal care and the same low birthweight rate it had in 1981, at least 211 very low birthweight births would have been prevented in 1987 alone.⁴⁶ Seventy infant deaths could have been prevented.⁴⁷

In addition to the cost in human life and health, the financial cost to the state is significant. The 211 very low birthweight babies born in 1987 as a result of deteriorating prenatal care cost the state approximately \$8,440,000.⁴⁸ The total cost of healthy births would have been \$1,293,000 for a net savings of \$7,147,000.⁴⁹ Clearly, the provision of comprehensive prenatal care is very cost effective and the potential savings to the state is great.

The Pima County study found that the Pima County women who are least likely to receive adequate prenatal care are those using AHCCCS.⁵⁰ Women enrolled in AHCCCS were more likely to give birth to low birthweight babies and have more premature deliveries. Furthermore, AHCCCS enrolled women were more likely to smoke and drink during pregnancy than were privately insured women.⁵¹

The committee heard testimony from several of the major

⁴⁶Id. at p. 8.

⁴⁷Id. at p. 8.

⁴⁸Id. at p. 10.

⁴⁹Id. at p. 10.

⁵⁰Strich, Maternal & Infant Health Status, 1992.

⁵¹Id.

AHCCCS health plans. Joe Anderson of Arizona Physician's IPA stated that 30% of the women who delivered babies through AP/IPA enrolled in the plan for the first time at delivery. Kathy Byrne, CEO of Mercy Care reported similar statistics for her plan.

The infant mortality rate in Arizona has not risen at the same rate as the increase in low birthweight babies and the decline in prenatal care rates. This is due in large part to the advances in medical technology for the care of sick newborns. At significant expense doctors can now save very small and sick infants.⁵² The relatively steady infant mortality rate is not a reflection of improved public health, but of the availability of very expensive medical technology.

The Goals of this Committee

The importance and necessity of prenatal care has been studied extensively. It is incontrovertible that early and adequate prenatal health care is crucial for the health of our women and children. It saves lives and money.

The committee identified the particular problem areas for women needing care as 1) eligibility and enrollment in the AHCCCS program, 2) the needs of special populations / teens, minority groups, and substance abusing pregnant women, 3) the availability throughout the state of health care providers and 4) education of women and the entire community on the need for and availability of prenatal health care. A subcommittee was formed to address

⁵²M. Clement, p. 8.

each of these problems and each subcommittee reported its findings and recommendations back to the whole committee. The recommendations constitute a comprehensive scheme to improve the health status of women and children which the committee suggests be implemented incrementally as the state budget allows.

AHCCCS ELIGIBILITY AND ENROLLMENT

Introduction

AHCCCS is Arizona's indigent medical care program. It is a combined federal Medicaid and state/county funded program. It pays for approximately 40% of the births in Arizona.⁵³ Although Medicaid eligibility has expanded significantly over the past several years, more AHCCCS eligible women than ever are receiving inadequate prenatal care or no care at all. In studying the barriers to prenatal care in the eligibility system, the subcommittee found that the problems were not unlike the problems women face in other states.

Barriers to Medicaid Eligibility Nationally

Studies done nationally of the Medicaid application process found that the application and verification process is extremely complex.⁵⁴ Women are deterred from applying at the onset of pregnancy because of the bureaucratic and logistical hurdles.

⁵³Testimony of Patricia Nolan, former Medical Director of AHCCCS, before committee 11-19-91.

⁵⁴S. Shuptrine and V. Grant, Study of the AFDC / Medicaid Eligibility Process in the Southern States, Report for the Southern Regional Project on Infant Mortality, Sponsored by the Southern Governors' Association and the Southern Legislative Conference, April, 1988, p. 1.

They wait to apply until delivery when they can delay care no longer. This defeats all efforts to provide adequate and preventive prenatal care designed to decrease the number of sick, low birthweight babies.⁵⁵

A comprehensive study performed by the Southern Regional Project on Infant Mortality in 1987 looked at eligibility in 17 states for a period of one year. It concluded that of the 1 million people denied AFDC / Medicaid assistance, sixty-three percent were denied due to the applicant's "failure to comply with procedural requirements."⁵⁶ The study also concluded that this result was not unique to the southern states. In the United States in the 1985-86 fiscal year, 60% of all AFDC / Medicaid eligibility denials were due to "failure to comply with procedural requirements."⁵⁷ In addition, since 1980 the number of applications denied for "failure to comply with procedural requirements" has increased by 75%.⁵⁸

In the past, the federal income and resource limitations for Medicaid were often the same as those for welfare assistance. The resource limitations had not been adjusted since 1979. The income limitations were often far below the federal poverty level.

In 1986 Congress enacted changes to Medicaid eligibility for

⁵⁵Id. at p. 1.

⁵⁶Id. at p. 1.

⁵⁷Id. at p. 2.

⁵⁸Id. at p. 2.

pregnant women which allowed states to 1) raise eligibility to 100 percent of the poverty level, 2) guarantee continuous eligibility 60 days postpartum, 3) allow for presumptive eligibility, and 4) eliminate the resources test.⁵⁹ In 1987 Congress further expanded Medicaid, giving states the option to extend eligibility for pregnant women to 185% of the poverty level.⁶⁰ In 1990, Congress mandated eligibility up to 133% of poverty, mandated continuous coverage for pregnant women throughout their pregnancy regardless of changes in income, expanded the presumptive eligibility provision, allowed for continuous eligibility for infants to age one, mandated expansion of coverage of poor children, and mandated outstationing of eligibility workers at specific locations that provide care to indigent pregnant women.⁶¹ States that have fully implemented the changes have seen improvement in the health status of mothers and children.

The Georgia Hospital Association commissioned a comprehensive study to assess the Medicaid eligibility process and provide recommendations for improvement. The report illustrates the complexity of the application process. The documentation and verification required is extensive, and the applicants usually receive little or no help filling out the

⁵⁹ Omnibus Budget Reconciliation Act of 1986 (OBRA-86)

⁶⁰ Omnibus Budget Reconciliation Act of 1987 (OBRA-87).

⁶¹ Omnibus Budget Reconciliation Act of 1990 (OBRA-90); 42 U.S.C. § 1396a(1).

forms.⁶² The Alan Guttmacher Institute found that applications are normally between 4 and 40 pages long, with an average length of 14 pages.⁶³ Arizona's application is 12 pages long. In order to successfully apply for benefits a person must a) be able to read, write, and understand complicated instructions, b) have transportation to the offices/agencies involved, c) have access to a telephone and copying machine, d) have money to pay for documents, copies, transportation and certain initial medical tests, and e) the ability to devote daytime hours to obtaining documents, filling out forms, and attending eligibility interviews.⁶⁴ These burdens are considerable when one realizes that the population seeking eligibility is not highly educated and of very low income.

The Georgia study found that three-fourths of those denied for procedural reasons had not yet reapplied for benefits at the time of the study interview. 31.6% stated they would not reapply because of discouragement with the application process. Among women who were denied for failing to return a verification document the reason most frequently cited was that they did not

⁶²S. Shuptrine and V. Grant, Assessment of the Medicaid Eligibility Process in Chatham County, Georgia, Report for the Memorial Medical Center, June 1991, p. 1

⁶³Brown, editor; Prenatal Care: Reaching Mothers, Reaching Infants; Committee to Study Outreach to Prenatal Care, Division of Health Promotion and Diseases Prevention, Institute of Medicine, Washington, D.C.: National Academy Press, 1988 p. 72.

⁶⁴S. Shuptrine, Assessment of the Medicaid Eligibility Process in Chatham County, Georgia, p. 7.

have enough time to obtain the information.⁶⁵

Another factor which contributes to the denial of so many applications for procedural failures is that the federal government monitors the states' eligibility errors and imposes sanctions when the errors are greater than the statutory tolerance levels.⁶⁶ These sanctions are imposed only when benefits are wrongfully provided to an ineligible person, not when benefits are wrongfully withheld from an eligible person.⁶⁷ This policy gives an incentive to states to wrongfully deny eligibility rather than risk approving someone who may turn out to be ineligible. Congress responded to this problem in OBRA'90 with a moratorium on financial sanctions for eligibility errors made on applications for pregnant women and children. The moratorium has been extended to March of 1993.⁶⁸ Removing the threat of sanctions has freed states to simplify their eligibility process.

Despite the elimination of sanctions for eligibility decisions for prenatal care coverage, the mindset of some eligibility workers has not changed. Eligibility workers still find it safest to err on the side of disqualifying someone from benefits.⁶⁹ Complicating the process further, the same

⁶⁵Id. at pp. 46-53.

⁶⁶Id. at p. 8.

⁶⁷Id. at p. 8.

⁶⁸Id. at p. 10.

⁶⁹Id. at p. 9.

eligibility workers who handle Medicaid applications process applications for the Aid to Families with Dependent Children (AFDC) and the Food Stamp programs for which sanctions still exist.

Eligibility for pregnant woman coverage is much simpler than the other federal benefits programs, but often women must needlessly fill out more complex forms because states including Arizona have not created applications for women who are seeking only pregnancy services.

Barriers to AHCCCS Eligibility

Dr. Patricia Nolan, the former Medical Director for AHCCCS, testified that the entire AHCCCS eligibility process is complicated and unfriendly, and has been designed to keep people off of AHCCCS.⁷⁰

There are three major AHCCCS eligibility categories that apply to pregnant women. About 38% of the AHCCCS eligible pregnant women receive Aid to Families with Dependent Children and are automatically eligible for AHCCCS as a result. Their care is funded 68% with federal dollars and 32% with state match. If an AFDC eligible woman loses AFDC eligibility during her pregnancy federal law requires that she be evaluated for eligibility under the other federally funded categories. The committee heard from advocates and providers that pregnant women are regularly being terminated from AFDC and AHCCCS even though they continued to qualify, causing disruption in their care. The

⁷⁰Testimony of Dr. Patricia Nolan, 11-19-91.

other major federally funded category is referred to as SOBRA, which stands for the Sixth Omnibus Budget Reconciliation Act of 1990. SOBRA expanded eligibility for Medicaid coverage for pregnant women and infants to 133% of poverty and allowed states to expand eligibility up to 185% of poverty. Arizona has opted to cover women up to 140% of poverty under this category. Approximately 52% of the AHCCCS births are in this category. The third category is the Medically Needy/Medically Indigent, which covers 9.7% of the AHCCCS births. This category is funded with state and county dollars only.

Both the Department of Economic Security (DES) and the 15 Arizona counties do AHCCCS eligibility determinations for pregnant women. DES does the eligibility for the federal categories. The counties do eligibility for the state only funded category (MN/MI). In addition, for the federal categories, the counties do the initial interviews, verify eligibility and refer the cases to DES for final determination. This system is not only confusing to the woman, but it is costly for the state. The Joint Legislative Budget Committee staff estimate that about 4% of the MN/MI eligible women are actually eligible for SOBRA and a greater percent might be eligible for AFDC if they were to apply. Shifting these women to the federal categories allows the state to seek federal reimbursement for 68% of the cost of their care. Secondly, there is duplication in the process. There are two eligibility workers processing each case and duplication of paper work.

Eligibility for the SOBRA category has been greatly simplified by federal law and can take from 1-15 days to complete. However, eligibility for the MN/MI state funded program and the AFDC program is very complicated and requires extensive documentation. Robert Gomez, the Executive Director of El Rio Health Center, studied the time it took for women seen at his clinic to complete the AHCCCS eligibility and enrollment process. For the first six months of 1991 the average time was 43 days. LeAnn Thrapp, a nurse with Indian Community Health Services, reported that even with the assistance of their advocates the average time it took for their clients to be enrolled was 34 days.

The subcommittee found that Arizona women face heavy verification requirements, as do women across the country. In addition to financial eligibility, women must prove they are pregnant before they can receive care and in some areas of the state it is difficult to obtain free pregnancy testing. Transportation to eligibility offices is a problem for women everywhere due to the limited public transportation system in urban areas and inaccessibility of eligibility offices in the rural areas.

In some areas of the state, bilingual staff are not available to interview non-English speaking women. It is difficult to recruit bilingual staff because of poor compensation rates. The Arizona Department of Administration does not yet recognize that being bilingual is a skill that requires

additional compensation. Written information is in formal textbook vocabulary and not the language understood by the women receiving the information.

Even English speaking women have difficulty understanding written eligibility material since it is written at such a high literacy level. The literacy level of the AHCCCS population is low, and the information is so complicated that even educated people have trouble understanding it.

In addition, some women fear the eligibility process because they know that DES will attempt to establish paternity and collect child support from the fathers of their babies. Many of the witnesses testified that their patients fear the consequences of identifying the fathers of their children. DES can waive this requirement in some cases, but most women are unaware of this possibility. One advocate testified that a pregnant teen who came to her clinic in the last month of her pregnancy thought that if she waited until late in the pregnancy, the father, who is also a teen, would have to pay less. Some women fear that the eligibility office will refer them to Child Protective Services because of their drug and alcohol use or because they are homeless.

Although the majority of the population lives in either the Phoenix metropolitan area or in the Tucson metropolitan area, the rural areas of the state tend to be very rural in nature. This is especially true of many of the Indian reservations. Mail service in some of these areas is unreliable. An applicant must

respond within ten days to a letter from the eligibility office or else her application will be denied. If she does not get her mail within ten days or she cannot read the letter, she will miss the deadline and will have to start all over again. Women who live in urban areas face similar problems, since they often do not have telephones and/or move frequently.⁷¹ This makes continuing contact with the eligibility offices very difficult. If the eligibility process cannot be completed in one visit to the eligibility office the chances of denial go up.

Once a women has been found eligible for AHCCCS she must enroll in one of the AHCCCS health plans to receive care. If she is eligible under the AFDC or SOBRA categories, she has a right to choose her health plan. AHCCCS allows 14 days to chose a plan. If she does not receive her enrollment notice or if she is unable to go into an AHCCCS enrollment office, she is auto-assigned to a health plan according to her zip code. Once she picks a plan or is assigned she is not actually enrolled with the plan for three more days. The entire enrollment process can take as long as three weeks.⁷² Although in theory a doctor will be paid for services provided during this period, as a practical matter most doctors will not treat a women unless she has been enrolled in the health plan the doctor contracts with.

Many witnesses testified about problems with the enrollment

⁷¹DES information confirmed that from 13-16% of the eligible population may move in a month.

⁷²Testimony of Dr. Nolan, 11-19-91.

process. Women are told they can not enroll until they receive their notice from AHCCCS. Some women do not receive the enrollment notice. Some reported that enrollment offices had limited hours or were no longer located at the address listed on the AHCCCS notice. Women lacked transportation and child care and as a result could not go into the offices to enroll. The fact that eligibility and enrollment offices are at different locations exacerbates the transportation problem.

Women currently receiving care from one AHCCCS provider may be auto assigned to a health plan that does not contract with that provider. When this occurs she must change doctors during her pregnancy, disrupting continuity of care and severing the doctor-patient relationship. Often the provider she is currently seeing is conveniently located near her home. AHCCCS policy, generally, will not permit a person to change health plans if the reason for the change is preference for a particular provider, convenience of the providers location or office hours, cultural or bilingual capabilities of the provider, or quality of care. The AHCCCS Administration recently changed its policy concerning plan changes for pregnant women. The policy will permit a women to remain with her current provider if she can convince the medical directors of both health plans that a change in providers will impact continuity of medical care. Quoting from the policy:

A plan change for medical continuity is not an automatic process. The member's physician must provide documentation to both health plans that supports the need for a health plan change. The health plan(s) must

be reasonable in the request for documentation. However, the burden of proof that a plan change is necessary rests with the member's physician.

Some health plans do not permit a woman to change primary care physicians within the same health plan in order to stay with a doctor of her choice.⁷³

If transportation is a problem and the location of the AHCCCS-assigned provider is not convenient to the patient, it is unclear whether the new policy will permit a woman to change to a more convenient provider. Although the health plans are responsible for providing transportation to medical appointments, the committee heard that compliance varied among the plans. Gloria Vaca, a nurse practitioner with Clinica Adelante, a community health center that serves migrant farmworkers, testified that her clients must often travel one to two hours to get to a health care appointment. She reported incidents where women were transported to their appointments one hour from their homes and no one returned to take them home. Her clients chose instead to wait for the nurse practitioner to come from Clinic Adelante once a month rather than rely on the health plans' transportation. Nationally, the U.S. Government Accounting Office (GAO) found that distance to providers and lack of adequate public transportation created barriers to prenatal care in many rural areas around the country.⁷⁴

⁷³Testimony of Sylvia Stock before committee, 11-19-91.

⁷⁴ Brown, editor; Prenatal Care: Reaching Mothers, Reaching Infants, p. 73

It is also unclear whether the new AHCCCS plan change policy will allow a woman to change providers if the assigned provider is not bilingual or culturally sensitive.

Just as a lack of available child care services affects women keeping their eligibility appointments, it also affects women keeping their health care appointments. If child care services are not available, women must bring their children to the provider's office or clinic. Additionally, many clinics and offices offer services during normal working hours only, when women are working or in school or when volunteer child care is not available. Many women cannot afford to lose the pay they forego in taking time off work to see a provider. Recently, Medicaid providers in the Washington, D.C. area expanded the hours of its prenatal care services into evenings and began providing care on Saturdays. This schedule is more accommodating for both work schedules and child care availability. The patient loads increased significantly at the provider sites that expanded hours. Other reforms were implemented at the same time, but the staff believed that the expansion of hours was the main reason for the increased program participation.⁷⁵

While AHCCCS eligibility is pending, public providers (county clinics and community health centers) provide care. These public providers are often conveniently located. If the patient is auto-assigned to another plan, the public provider is reimbursed on a fee-for-service basis, which some witnesses said

⁷⁵ Id. at p. 75 fn 80.

is not as attractive as the full AHCCCS prenatal care payment. Some health plans will pay conveniently located public providers to care for their pregnant patients, but some will not.

A number of the AHCCCS health plans reported on efforts to reach out to their members who are pregnant. The health plans know that SOBRA women are pregnant because she must be pregnant to qualify under SOBRA. They can identify these women and focus their outreach. There is no similar indicator for AFDC or MN/MI women. This makes it difficult for the health plans to identify pregnant women and get them into care early.

In addition, many of the low income women served by AHCCCS need a combination of health care and social services. Some of the health plans reported efforts to address the social as well as medical needs of their members, but as a practical matter, the AHCCCS HMO model is dependent on a private delivery system which does not contain the coordinated social services available from the public health delivery system.

Public information about eligibility and enrollment is not well-targeted to the women who are in need of care. Because the process is very complicated, it is difficult to simplify the public information for dissemination. Because of the lack of public information, women depend on word of mouth from their neighbors and often believe (wrongly) that they are not eligible for care.

The subcommittee also identified attitudinal problems within the system. Some eligibility staff have a "keep out" attitude

which discourages pregnant women from utilizing the program. This is demonstrated both by attitudes conveyed personally at the various offices and by telephone contact. For example, some women complain that they have trouble calling offices and getting through to their workers. Many of these problems with the eligibility and enrollment process can be solved by making adjustments to the current system. If eligibility and enrollment procedures are simplified and tailored to the needs of the women using the system, the increased access to prenatal care will result in healthier mothers and healthier babies and less money spent by the state on costly life-saving measures for ill, low birthweight infants.

RECOMMENDATIONS

The committee recommends that the following measures be taken to simplify the eligibility and enrollment process. The committee is very aware of the current financial situation of the state, and suggests that the steps which require additional state dollars be implemented incrementally as the state budget allows.

AHCCCS Eligibility and Enrollment

1. Simplify the Eligibility Process

Use a short, simple application.

Simplify the MN/MI eligibility rules to follow the federal rules. (except for citizenship).

Require all notices and information about eligibility to be written at a fifth grade reading level. ⁷⁶

⁷⁶ Project SLIM made similar recommendations for the Department of Economic Security processing of all assistance applications.

Allow women to apply for AHCCCS at WIC sites, hospitals, doctors' offices, county clinics, family planning clinics, Head Start offices, and IHS and tribal sites. Allow the staff of the sites to assist with the application, conduct the interview, and collect the documentation necessary to verify eligibility.

Allow mail-in applications and interviews by telephone.

Eliminate the requirement of face to face interviews.

Require applications to be processed within five days.

Combine eligibility for WIC and AHCCCS.

Implement incentives that encourage eligibility workers to assist applicants with the documentation and verification process.

Colocate county and DES eligibility offices.
DEFER TO LEGISLATIVE COMMITTEE STUDYING
ELIGIBILITY

2. Simplify the Enrollment Process

Allow women to enroll at eligibility.

Allow all women to choose their providers.

Allow for automatic plan changes for pregnant women.

Allow enrollment by mail or by telephone.

Allow enrollment at doctors' offices, WIC sites, community health centers, and tribal health clinics.

3. Increase eligibility income level to 185% of the poverty level.⁷⁷

⁷⁷(Twenty-four states have increased eligibility levels to 185% of poverty and California, Massachusetts and Vermont cover pregnant women with incomes up to 200% of the federal poverty level, using state funds to cover those above Medicaid eligibility thresholds.) National Governors' Association, Gaining Ground: State Initiatives for Pregnant Women and Children, Washington D.C., 1992, p. 3.

4. Advertise aggressively the availability of prenatal care through AHCCCS. Target high risk areas for outreach and education.
5. Study why 30% of women enroll for the first time at delivery.
6. Provide funding for transportation and child care during the eligibility process.
7. Establish a sliding scale program for women whose income is below 250% of the federal poverty level.

Justification

The Maryland Program

The state of Maryland has incrementally elevated the eligibility level to 185% of the poverty level, dropped the assets test, adopted continuous eligibility, and implemented presumptive eligibility in all health departments and community health centers. The state has also made efforts to get women onto WIC. It made it possible for women to become presumptively eligible in hospital outpatient departments where many women were going to receive care. Maryland's program is comprehensive in that it provides case management, health education, nutritional counseling, psychological counseling, home visits, and outpatient drug treatment, all of which are now covered by Medicaid. Maryland incorporated fee increases into the Medicaid fee structure, hired public health nurses to do one-on-one physician recruitment, and initiated an aggressive public information campaign which was coordinated with Blue Cross/Blue Shield.⁷⁸

⁷⁸Id. at p. 6.

The Maryland program has had very successful results. A U.S. Government Accounting Office study concluded that Maryland has succeeded in enrolling nearly 100% of the low income pregnant women estimated to be eligible for Medicaid.

The Vermont Program

Vermont has also increased the eligibility limit to 185% of poverty and has taken several other actions to simplify the eligibility and enrollment process. The Department of Social Welfare (which administers Medicaid) has collaborated with the Department of Health (which administers WIC) to develop a unified approach to increasing the enrollment in both programs. The agencies developed a three pronged strategy in which they 1) developed a single page joint application form which can be accepted at either a WIC or a Medicaid eligibility site, 2) required an eligibility determination within ten days, and 3) initiated a mass media outreach program which especially targeted to teenagers.⁷⁹

The Vermont approach has also been quite successful. The number of low income women receiving prenatal care has increased from 1,245 in 1988 to 1,420 in 1990 to 1,704 in 1991.⁸⁰ State officials believe that these statistics are indicative of the success of their policies.

AVAILABILITY OF PROVIDERS

Statement of the Problem

⁷⁹Id. at p. 7.

⁸⁰Id. at p. 7.

Initial testimony before the committee established that a significant barrier to receiving adequate prenatal care is the inability of women to locate health care practitioners in their community. As with eligibility and enrollment, the problems in Arizona mirror the problems of the entire nation. A report issued in March, 1991 by the Center on Budget and Policy Priorities stated that in 1988, 62% of nonmetropolitan counties nationwide did not have an obstetrician/gynecologist serving the area. The report also cited the American College of Obstetricians and Gynecologists, stating that in 1988, 22 states had large regions with no practicing obstetrician.⁸¹ The American College of Obstetricians and Gynecologists and the American Academy of Family Physicians report that many physician members of their organizations are decreasing the obstetrical services they provide.⁸² Other common factors are adversely affecting the availability of prenatal health care providers in nonmetropolitan and metropolitan areas as well, including increased premiums for malpractice insurance, low reimbursement rates from insurers, and growing numbers of women who cannot pay for maternity care.⁸³

The subcommittee reviewed the research done by the Rural

⁸¹L. Summer, Limited Access: Health Care for the Rural Poor, Washington, D.C.: Center on Budget and Policy Priorities, March 1991, p. 16.

⁸²Id. at p. 17.

⁸³Id. at p. 17.

Health Office at the University of Arizona.⁸⁴ Of Arizona's fifteen counties, ten had areas, both urban and rural, designated as primary care health personnel shortage areas. Within these ten counties, thirty-one communities were identified as shortage areas for primary care physicians.⁸⁵ In 1987, twelve communities had no physicians within a thirty minute travel zone who were willing to deliver babies. Additionally, the federal government has designated eleven Arizona counties as medically underserved areas. According to Dr. Michael Clement, the OB/GYN who used to visit Page to consult on obstetrical care no longer does so. At one time in 1990 all the OB/GYN practitioners in Casa Grande had stopped providing care.⁸⁶ Demonstrating the effect of the shortage, the very low birthweight, low birthweight, and inadequate prenatal care rates at Casa Grande hospital at that time were consistently higher than state averages.⁸⁷ Problems in other areas are apparent as well. As of December, 1991, there were 7-8 OB/GYNs providing care to the Yuma community, where

⁸⁴The most recent information available to the committee is from 1987. At that time in rural and underserved areas of Arizona there were 82 licensed physicians, 477 registered nurses, 12 certified nurse practitioners, and eight licensed physician assistants per 100,000 population. R. Gordon; Arizona Rural Health Provider Atlas, Rural Health Office, Id.

⁸⁵Id.

⁸⁶At the present time two obstetricians and two general practice physicians provide care in Pinal County, although some women must travel 40 minutes one way to a provider.

⁸⁷Report of the High Risk Perinatal Task Force, Phoenix: Arizona Perinatal Trust and Arizona Department of Health Services, November 1990, p. 10.

there are 2400 births a year.⁸⁸ In the Globe/Miami area, only three doctors were providing obstetrical care for 450-500 yearly births.⁸⁹ Mohave County has noticeable problems as well. Kingman experiences 650 annual births, and many of these mothers must be referred to Lake Havasu or to Flagstaff for delivery.⁹⁰ In 1988, Dr. Clement cited preliminary figures from a study being conducted by the University of Arizona Rural Health Office that indicated that 60% fewer practitioners were providing obstetrical care in rural Arizona than in 1982. The shortage of providers is not limited to doctors, and includes nurse practitioners, nurse midwives and physician assistants. The State Board of Nursing reports there are three to five open positions for every nurse practitioner certified by the state.⁹¹

The subcommittee found that these existing shortages will be exacerbated by additional factors. It is projected that many of the physicians serving rural areas will be retiring in the near future, and without a satisfactory number of new doctors replacing them the problem in the rural underserved areas will only worsen. The subcommittee further cited the high cost of malpractice insurance and the lack of professional support for

⁸⁸B. Attico and D. Meyer, Prenatal Care Services to Indian Women in Arizona, Presentation by the Phoenix Area Indian Health Service to the Arizona Legislature Study Committee on Services to Pregnant Women, December 1991, p. 12.

⁸⁹Id. at p. 13.

⁹⁰Id. at p. 13.

⁹¹M. Clement, Speech on Prenatal Care: The Arizona Condition, December 1, 1988, p. 11.

leave of absence as deterring providers from serving the underserved areas. In addition, the budget crisis in the state may result in the state-supported schools being inadequately funded to accept and educate the needed recruits to address these shortages.

Indian Health Services (IHS) provides care for Native American women, almost 7,000 of whom give birth each year in Arizona. IHS uses certified nurse midwives and obstetricians to provide prenatal care. IHS also uses a comprehensive system of community health nurses, whose job it is to make sure that pregnant women go to their appointments and are referred to other providers as is needed. In 1989, approximately 25 obstetricians who provided care through IHS chose not to serve any longer. The general nursing shortage is also affecting IHS. IHS is facing great difficulty recruiting obstetricians and nurses to replace those leaving. This is partially because many assignments are in very isolated areas and the pay is lower than in private practice, which makes IHS jobs less appealing.⁹²

All three Arizona areas served by IHS have lower low birthweight rates than the national average. In addition, the Navajo area has one of the lowest infant mortality rates in the nation.⁹³ This progress and success is in danger of being reversed if the shortage of health care providers is not

⁹²Report of the High Risk Perinatal Task Force, at p. 8.

⁹³B. Attico, Prenatal Care Services to Indian Women in Arizona, p. 3.

addressed. These shortages come at a time when IHS has been making progress in improving maternal and child health for their population.

RECOMMENDATIONS

Availability of Providers

Improving the distribution of primary care providers in underserved areas will require a systematic, community-based approach to recruitment, training, retention and utilization of providers.

Recruitment and Training

1. Increase output of primary care physicians, OB/GYNS, nurses and other maternity care providers by one of the following two legislative proposals:

A.

Develop an advisory council consisting of representatives from Arizona Colleges and Universities, the Arizona Health Education Centers (AHECS) and other interested parties. The Advisory Council will work together to develop implementation strategies and evaluation criteria for the following changes:

- 1) Direct state-funded schools to increase recruitment of students from rural and underserved areas.
- 2) Require schools to increase the percentage of students whose training will focus on community/rural based care rather than the traditional hospital/urban based care to 30% of each medical student class, undergraduate and graduate nursing class, and social work class. Approximately 30% of the community/rural-based curriculum will be devoted to experience in multi-disciplinary community centers or with other community based providers.
- 3) Enhance existing community-based health facility and rural hospital rotation programs

for Arizona and out-of-state medical students, residents and non-physician practitioner students.

- 4) Expand preceptor programs in underserved areas.
- 5) Increase accessibility to training programs that offer upgrading from associate degree to baccalaureate degree nurses and programs which enhance skills and knowledge for all types of providers of prenatal and obstetrical care.
- 6) Either expand and develop non-physician practitioner community based education programs within Arizona or develop a commission similar to the Western Interstate Commission on Higher Education (WICHE) that allows interested Arizona students to receive this training in other states.
- 7) Restructure and increase the value of related scholarships and educational loan repayment programs.⁹⁴

OR

B.

Direct the Boards that oversee post-secondary education to increase the number of graduates who practice primary care by 20% over an eight-year period. The initiative must be designed to encourage newly graduated primary care providers to establish or join practices in areas of Arizona that are medically underserved.

2. Increase student enrollment in current publicly-funded educational programs by modifying curriculum delivery to include:
 - a) local faculty throughout the state;
 - b) the use of telecommunications to teach

⁹⁴The "Community Partnerships" initiative sponsored by the W.K. Kellogg Foundation provides good models of successful programs which implement the above recommendations.

classes (videotapes, cable or the state's new fiber optic system);

- c) increased satellite sites; and
- d) increased number of night and weekend classes to accommodate older and/or working students.

Retention and Utilization

1. Increase incentives to existing and future providers to support continued practice in rural/underserved areas. Allow communities to decide for themselves what programs best address their specific needs.
 - a) Continue the state-funded program which subsidizes malpractice insurance for primary care providers in underserved areas. Expanded the program to include nurse practitioners.
 - b) Offer an additional subsidy to Family Practitioners and General Practitioners which covers the difference between the "50 babies delivered" price and the "100 babies delivered" price, so that rural doctors who can only afford malpractice for 50 deliveries a year may expand their practice.
 - c) Direct the Department of Insurance to evaluate cost control measures that will increase the number of providers in rural/underserved areas who can afford to purchase malpractice insurance.
 - d) Coordinate a locum tenens program within the licensing boards and appropriate agencies to allow for leave of absence coverage and to provide continuation of care by qualified providers.
 - e) Establish a countywide or regional benefit program for private practicing primary care providers including:
 - i) supply and equipment procurement system.
 - ii) group employee benefit program.
 - f) Establish a countywide or regional program that would allow employee sharing from private/public agencies.
2. Coordinate existing services to develop community based health care plans including multi-disciplinary team members:

Non-physician providers: NP, CNM, PA
Physician
Social Worker

Nurse (RN)
Eligibility worker
Health Educator
Nutritionist
Lay outreach worker

3. Utilize a case management model to strengthen and streamline coordination of community based services.
4. Utilize existing and developing mobile health care teams which provide services to rural/underserved areas in Arizona (i.e. Blue Cross/Blue Shield, DHS, March of Dimes).

SPECIAL POPULATIONS

Introduction

Barriers to prenatal care exist for women of all racial, ethnic, and age groups, however, testimony before the committee established that for some groups the barriers are greater. A subcommittee studied these special populations to identify their special barriers and to develop targeted solutions. The committee found that minority women, teens, homeless women, and women who used drugs and alcohol confronted unique barriers to receiving prenatal care.

African-American Women

Numerous studies reviewed by the Committee established that African-American women consistently receive less care than women of all other races. The number of babies born at low birthweight among the African-American population is disproportionately high.⁹⁵ The studies conclude that non-financial barriers are

⁹⁵J. Burks, "Factors in the Utilization of Prenatal Services by Low-Income Black Women," Nurse Practitioner, Vol. 17 No. 4, April 1992, p. 34.

the main reasons black women receive inadequate care. Lack of awareness of the pregnancy and the need for prenatal care were found to be the most frequent reasons women delayed care.⁹⁶

African-American women in Arizona are 2.3 times more likely to receive no prenatal care than are white women.⁹⁷ The low birthweight rate among African-Americans in Arizona in 1988 was 139 infants per 1000 births.⁹⁸ This is nearly 2.5 times the low birthweight rate for white infants. (59 per 1000 births.) The infant mortality rate among African-Americans is 17.9 infant deaths per 1000 live births.⁹⁹ This is approximately two times the white infant mortality rate.

Low birthweight rates for children born to black middle class women who received adequate prenatal care are greater than the rates of similarly situated white children. Researchers are unsure of the cause. Clearly, the disparate health outcomes for black children require that special attention be paid to this population.

A further risk factor affecting African-American women is that they are more likely than other racial groups to give birth as teenagers.

Hispanic Women

⁹⁶Id. at p 49.

⁹⁷Babies and Business: A Healthy Bottom Line, p. 6 citing Children's Defense Fund.

⁹⁸Id. at p. 6 citing Arizona Department of Health Services statistics of September 10, 1990.

⁹⁹Id. at p. 7 citing Arizona Department of Health Services.

In Arizona, Hispanic women are 3.5 times more likely to receive no prenatal care than are white women.¹⁰⁰ In Pima County, only 57% of Hispanic women received care during their first trimester.¹⁰¹ The low birthweight rate among Hispanic women in Arizona is 83 infants per 1000 live births compared to 59 infants per 1000 live births for white children¹⁰² The Hispanic infant mortality rate is 9.9 infant deaths per 1000 live births compared to 9.4 for white infants.¹⁰³ Nationally only 60% of Hispanic Women began prenatal care in the first trimester compared to 82% of white women.¹⁰⁴

Testimony before the committee identified language and cultural differences as a barriers to care for Hispanic women. There are an inadequate number of Spanish speaking personnel at all points in the health care system. This includes the eligibility offices, the AHCCCS enrollment sites, the health plans, and hospitals and doctors' offices.¹⁰⁵ Most of the published material received by Spanish-speaking women is written

¹⁰⁰Id. at p. 6 citing Children's Defense Fund.

¹⁰¹Strich, Maternal & Infant Health Status, 1992

¹⁰²Babies and Business: A Healthy Bottom Line, p. 6 citing Arizona Department of Health Services.

¹⁰³Id. at p. 7 citing Arizona Department of Health Services.

¹⁰⁴S. Rosenbaum, et. al., The Health of America's Children, p. 7.

¹⁰⁵Nationally, provider sites do not have a sufficient number of bilingual providers or interpreters. Brown, editor: Prenatal Care: Reaching Mothers, Reaching Infants, p. 76

in textbook Spanish that differs greatly from the language the women use and understand.

Dr. Patricia Moore of the ASU College of Nursing studied the use of prenatal health services by Hispanic women enrolled in AHCCCS.¹⁰⁶ Although previous studies have indicated that lack of health insurance and lack of a regular source of medical care are barriers, these factors account for only a small part of the variance.¹⁰⁷ Hispanics comprise 18% of the state's population, and account for 42.8% of all births financed by AHCCCS representing the largest single ethnic group served by AHCCCS.¹⁰⁸ 43% of all births to Hispanic women were financed by AHCCCS.¹⁰⁹

The women studied were young, less educated and more likely to be single. They were more likely to have been enrolled in AHCCCS when they became pregnant than non-Hispanic women. The women were generally satisfied with the care they received. The major problems expressed were transportation, child care, waits for appointments, and excessive waits in the doctor's office.

¹⁰⁶Dr. Moore's testimony was based on a study entitled Use of Perinatal Health Services by Mexican-American Women Enrolled in AHCCCS: Implications for Public Health Practice, presented to the American Public Health Association, November 11-15, 1991 in Atlanta, Georgia.

¹⁰⁷P. Moore, Use of Perinatal Health Services by Mexican-American Women Enrolled in AHCCCS: Implications for Public Health Practice, presented to the American Public Health Association, November 11-15, 1991 in Atlanta, Georgia, p. 1.

¹⁰⁸Id. at p.2.

¹⁰⁹Id. at pp.1,2.

The study found that only 41% of Hispanic mothers enrolled in AHCCCS received adequate prenatal care compared to 53% of the white non-Hispanic AHCCCS population; and twice as many received inadequate care.¹¹⁰

Dr. Moore found that the level of education of the mother had a direct bearing on the level of prenatal care. The higher the education, the more likely it is that the mother will utilize prenatal care services.¹¹¹ Additionally, there was a correlation between what the Hispanic culture taught women to believe about the need for care and the level of care they received.

The study conclusively found that even when Hispanic women are enrolled early and continuously with AHCCCS, they are less likely to receive adequate prenatal care than are white non-Hispanic AHCCCS enrolled women.¹¹²

There is often a wide socioeconomic, cultural, and educational gap between low-income pregnant women and their health care providers. This gap can lead to miscommunication and misunderstanding, and result in lower quality care.

Providers are not educated about cultural differences that affect prenatal care. For example, it is unacceptable among some Hispanic populations to have a pelvic examination conducted by a

¹¹⁰Id. at p.7.

¹¹¹Id. at p. 7.

¹¹²Id. at p.9.

man.¹¹³ Although pelvic examinations are a vital component of adequate prenatal care, insensitivity to the cultural differences can result in women not attending later appointments.

Native American Women

Native American women face cultural and language barriers to care as do Hispanic women. Michael Slattery an administrator with the Department of Economic Security, the agency responsible for eligibility, told the committee that his staff report that some Native American women will not discuss their pregnancy publicly, making it difficult to confirm eligibility.

The Indian Health Service (IHS), a federally funded program, provides culturally sensitive care to many Native American women. On some reservations IHS is the only health care provider. Women living on the reservations must travel great distances to eligibility offices as well as provider sites. There are approximately 6,500 Indian births in Arizona each year, comprising almost 10% of all Arizona births.¹¹⁴ The Phoenix Area of IHS (which encompasses more than the metropolitan Phoenix area) has a particularly high birth rate of 37.2 per 1000 population. This rate is more than twice the national rate, and to some extent is explained by the youth of the Phoenix Area IHS population (median age is 20 years).¹¹⁵

¹¹³Brown, editor; Prenatal Care: Reaching Mothers, Reaching Infants, p. 76.

¹¹⁴B. Attico, Prenatal Care Services to Indian Women in Arizona, p. 2.

¹¹⁵Id. at p. 3.

IHS has been successful in reducing the incidents of low birthweight. The low birthweight rates for all three IHS Areas are lower than the national average. The Phoenix Area has a rate of 6.1%, the Tucson Area a rate of 4.8%, and the Navajo Area has a rate of 5.5%. The U.S. average is 6.9%.¹¹⁶

Low birthweight is not the exclusive indicator of adequate prenatal care. Native American women have other significant health problems, including diabetes and high blood pressure, which adversely affect the health of their babies.¹¹⁷ Despite the relatively low rate of low birthweight babies statistics indicate that Native American women do not receive adequate prenatal care. A study conducted by the Pima County Health Department indicated that only 60% of Native American women in Pima County received care during their first trimester, while 75% of white women in Pima County received early care.¹¹⁸ The Children's Defense Fund found that in Arizona, Native American women were 2.7 times more likely to receive no prenatal care than were white women.¹¹⁹ The infant mortality rate for Arizona's Native American population is 9.9 deaths per 1000 live births, compared to the infant mortality rate for white children of 9.0

¹¹⁶Id. at p. 3.

¹¹⁷Babies and Business: A Healthy Bottom Line, p. 6 citing Arizona Department of Health Services.

¹¹⁸Strich, Maternal & Infant Health Status, 1992.

¹¹⁹Babies and Business: A Healthy Bottom Line, p. 6 citing Children's Defense Fund.

deaths per 1000 births.¹²⁰ It is not known why the birthweight of Native American babies is not impacted as directly by prenatal care as the rest of the population.

The Indian health care system is now facing challenges which jeopardize its ability to provide adequate prenatal care to the Native American population. An increasing number of Native Americans are moving to urban areas and IHS is only funded to provide care for Indians who live on or near a reservation¹²¹ Although funding is available for services to non reservation Indians, it is limited. The Phoenix Indian Medical Center (PIMC) continues to be overloaded with patients.¹²² The facilities and staff are in such short supply that PIMC must refer 1/3 to 1/2 of its obstetrical patients to other facilities in the Phoenix area.¹²³ PIMC facilities are sufficient to handle 800-900 births per year, but the actual workload is closer to 1500-2000 births per year.¹²⁴

Further compounding the problem, recent information received by the committee from the Health Care Financing Administration indicates that IHS may lose 30 to 40% of its OB providers within the next year. Given the remote location of IHS facilities and

¹²⁰Id. at p. 7 citing Arizona Department of Health Services.

¹²¹B. Attico, Prenatal Care Services to Indian Women in Arizona, p. 4.

¹²²Id. at p. 4.

¹²³Id. at p. 6.

¹²⁴Id. at p. 7.

the lower pay it will be difficult to replace these providers.

Problems have existed in the past and continue to exist with integrating the IHS system into the AHCCCS managed care system. Under federal law the IHS providers must be allowed to participate in the AHCCCS system. IHS is reimbursed on a fee for service basis for its cost with 100% federal dollars. The other AHCCCS plans are reimbursed on a capitated basis with 65% federal dollars and 35% state dollars.¹²⁵ Dr. Burton Attico of IHS reported to the committee that Native American women are not advised that they can chose IHS as their AHCCCS health plan and, as with most AHCCCS women, they are assigned to one of the other capitated health plans. The women continue to come to IHS facilities for care and IHS does not turn them away, but it is not reimbursed by AHCCCS for the care. This situation further exacerbates the IHS financial crisis and limits its ability to provide care to non-AHCCCS eligible women.

Conflicts between IHS and AHCCCS regarding AHCCCS eligibility have also posed problems. Since IHS has a limited budget, it has always asked indigent Indians to apply for state and county services and those who have insurance to seek private care. Native Americans continue to have problems with eligibility for the state funded portion of AHCCCS because, in Dr. Attico's opinion, the AHCCCS eligibility offices operated by the counties continue to refuse to allow the Native Americans to

¹²⁵Id. at pp. 9-10.

apply and enroll.¹²⁶

Teen Mothers

An increasing number of Arizona adolescents are becoming pregnant and teens as a group do not receive adequate prenatal care. Many teens cite fear as a primary reason they don't seek early care.¹²⁷ They fear doctors, medical procedures, the pregnancy itself and telling their parents about the pregnancy.¹²⁸ Teens also have a greater tendency to deny their pregnancy. Once they admit to themselves the fact that they are pregnant, they still often conceal it from their parents.¹²⁹ Out of 404 pregnant teens studied, one-half did not tell their parents they were pregnant for several months.¹³⁰ The fear of admitting the pregnancy necessarily leads to late or no prenatal care. Teenagers 15 to 17 years old are twice as likely to receive no prenatal care than are women between the ages of 20 to 34.¹³¹ The chance of a teen having a low birthweight baby is 25% greater than the chance of an adult having a low birthweight baby.¹³²

¹²⁶Id. at pp. 9-10.

¹²⁷S. Brown, editor Prenatal Care: Reaching Mothers, Reaching Infants, p.78.

¹²⁸Id. at p. 78.

¹²⁹Id. at p. 78.

¹³⁰Id. at p. 80.

¹³¹Babies and Business: A Healthy Bottom Line, p. 6 citing Children's Defense Fund.

¹³²Id. at p. 7.

In addition, teens lack knowledge of the need for prenatal care and the availability of family planning services. Local school board policies may restrict what the schools can do to educate teens about the benefits of prenatal care.

Local school board policies and practices may also discourage teens from remaining in school during their pregnancy. Some witnesses testified that these policies encourage teens to deny they are pregnant until late in the pregnancy in order to stay in school.

Another significant reason teens don't receive adequate care is that it is very likely that they are unmarried and therefore have less support throughout the pregnancy. Between 1980 and 1988 the number of unmarried women giving birth in Arizona increased almost 100%. Unmarried women are three times more likely than married women to attend fewer than five prenatal visits.¹³³

The frequency of teen pregnancy in Arizona is increasing rapidly. Between 1985 and 1990 there was a 22% increase in the number of births to teenagers.¹³⁴ Santa Cruz County saw an increase of 103% in births to teens.¹³⁵ Most alarming is the increase in births to women younger than 15 years. Between 1985 and 1990 there was an increase of 67% (110 births to 184 births).

¹³³Id. at p. 6 citing Children's Defense Fund.

¹³⁴Kids Count Factbook: Arizona's Children 1992, Phoenix: The Morrison Institute for Public Policy, 1992, p. ix.

¹³⁵Id. at p.ix

63% of these births were to teens in Maricopa County.¹³⁶

Homeless Women

Homeless women comprise another group that receives inadequate prenatal care. It is difficult for health plans and outreach workers to find these women because they don't have permanent addresses and telephone numbers. Homeless women often don't seek care because they fear that they might be referred to Child Protective Services and their other children might be taken away from them.

The Committee reviewed a study of homeless women in New York City and found that of those who gave birth between 1982 and 1984, 40% of the city's homeless residents received no prenatal care at all compared to 9% of the overall population.¹³⁷ Only 30% of the homeless women made 7 or more visits to providers of prenatal care.

A separate portion of this report addresses the concerns of women who use alcohol and drugs during pregnancy.

Targeted Case Management

A targeted case management program designed around the unique needs of the high risk group is the central theme of the committee's recommendations. There is growing evidence that for women living in poverty simply expanding eligibility is not

¹³⁶Id. at p. ix.

¹³⁷ S. Brown, editor; Prenatal Care: Reaching Mothers, Reaching Infants p. 79 citing Chavkin, et al. study.

enough.¹³⁸ Low income women must be supported in their efforts to meet basic needs such as housing, transportation, food, education, and health care.¹³⁹ Throughout the country the success of case management has been proven among high risk pregnant women. See Justification: The North Carolina Targeted Case Management Program. Case management entails the assessment of medical, social, educational, and emotional needs and the coordination of service delivery. One case manager is responsible for the assessment and coordination of all of the client's needs. This case manager must develop a trusting relationship with the client for optimal effectiveness. This relationship must be based on a sensitivity to and a knowledge of the unique cultural, medical, and emotional needs of the population. Linda Parson, Director of the Phoenix Birthing Project, explained that "[h]ealth behaviors are culture bound, [and] primary prevention efforts that address preventable disease and illness must emerge from a knowledge of and a respect for the culture of the target community to ensure that both the community organization and development effort and any interventions that emerge are culturally sensitive and linguistically appropriate."

The Department of Health Services operates two very successful case management programs, Health Start and Teen

¹³⁸ B.Guyer, Medicaid and Prenatal Care: Necessary But Not Sufficient. JAMA, 1990; 264:2264-2265. Editorial.

¹³⁹ P. Buescher, M. Roth, D. Williams, and C. Goforth, An Evaluation of the Impact of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina, American Journal of Public Health, Vol. 81, No.12, December 1991, p.1629

Express.

Health Start

Health Start uses lay health workers from the community to promote prenatal care among low income pregnant women and their families. The workers reflect the ethnic, cultural and socio-economic makeup of the communities they serve. Because they are from the community they are readily accepted into the women's home and confidence. The lay worker is in a good position to evaluate the woman's needs and to advise her of available resources. The woman is often more open to advice coming from someone who she knows and trusts and who is familiar with her culture and speaks her language. The lay health workers identify women in their neighborhoods who are pregnant; educate them of the importance of prenatal care; make home visits; assist them through the AHCCCS eligibility process; connect them with community resources and promote primary health care for their children.

Teen Express

The Teen Express program was funded by the legislature in 1989 to provide intensive outreach, early intervention and case management to increase the number of teens receiving early prenatal care. When a teen is identified she is enrolled in prenatal care immediately. If potentially AHCCCS eligible she is assisted with eligibility. If she is not AHCCCS eligible, and has income below 185% of poverty the program pays for her prenatal care.

All teens receive comprehensive case management services which include assessment, case planning, services coordination, advocacy, monitoring, home visits and prenatal education. The case manager acts as a link with the health care and social services delivery system. She assists the teen in talking with her parents if necessary and helps her plan for the challenges of parenting or adoption.

Case management is the central tool used by the Phoenix Birthing Project (black women), Indian Community Health Services (Native Americans), CODAMA (substance abusers), community health centers (Hispanics and migrants), and private employers such as Honeywell and Woodstuff.

The case managers make sure that high risk pregnant women attend prenatal care appointments. They are involved in educating pregnant women about the importance of good nutrition during pregnancy and the importance of abstaining from cigarettes, alcohol, and drugs. Case managers assure that the clients have access to necessary social services (such as WIC or AFDC) and that any special needs (such as mental health services) are provided. They coordinate access to educational programs, including parenting skills training, financial management training, vocational training, and literacy training. Birth control and family planning are also discussed.

Case management does not end when the baby is delivered. Staff of the Phoenix Birthing Project have discovered the importance of ongoing case management for these women during the

first year of the baby's life. New mothers often need assistance in learning parenting skills and learning how to cope with the stresses of motherhood. The goal of the case management approach is to provide the support and training necessary for the client to become self-reliant and a good parent.

A vital component of case management is patient advocacy. These women are often uneducated. The lengthy and complex application forms are difficult to manage without assistance. Case managers assist women in completing the necessary paperwork and also with arrangements for transportation to eligibility appointments and securing necessary documents to verify eligibility. Patient advocacy services benefit the women, the state agencies, and health care providers since they help assure that eligibility is properly established early on, which ensures early and ongoing care.¹⁴⁰

Family Planning Services

Unintended pregnancies are directly related to late entry into prenatal care.¹⁴¹ It is estimated over half of the pregnancies in the United States are unintended.¹⁴² Family planning counseling and services play an integral part in reducing unintended pregnancies and the resultant low birth

¹⁴⁰B. Attico, Prenatal Care Services to Indian Women in Arizona, pp. 16-17.

¹⁴¹J. Kotch, C. Blakely, S. Brown, F. Wong, editors; A Pound of Prevention: The Case for Universal Maternity Care in the U.S., American Public Health Association, 1992, p.132 citing Brown, et al; Prenatal Care: Reaching Mother, Reaching Infants, 1988.

¹⁴² Id. at p. 132.

weight babies.

RECOMMENDATIONS

Services to Special Populations

1. Assure that women in special target populations receive case management services that are responsive to the women's individual needs.
2. Provide incentives to the private sector to support and coordinate their efforts with the organizations already providing services to high risk women.
3. Expand funding for case management services provided by DHS and AHCCCS such as Health Start and Teen Express.
4. Require that AHCCCS health plans contract with case management organizations to provide services for their members.
5. Implement the "one-stop shopping" approach by locating eligibility offices, enrollment offices, social service agencies and health care agencies in close proximity to one another.
6. Provide specialized education on the importance of receiving prenatal care to the various special population groups. Education programs must address special linguistic and cultural considerations, and education planners must be cognizant of each group's special needs. Increase public funding for the ADHS public awareness campaign which does target special population groups.
7. Advise Native American women that Indian Health Services is a choice of AHCCCS provider.
8. Fund transportation as a necessary component of health care.
9. Require the Department of Education to develop policies that ensure that all barriers to continued education for pregnant teens are eliminated. In cooperation with DHS, the Department of Education should develop model programs for use by interested local school districts which encourage pregnant teens to stay in school.

10. Require the state funded medical educational institutions to include in their curriculum courses on the cultural differences of the populations served.
11. Requires AHCCCS and DHS to explore all federal sources of funding for family planning services.
12. Increases state funding for family planning services.

Justification

The North Carolina Targeted Case Management Program

The state of North Carolina has embarked on the most wide-reaching and ambitious prenatal program in the United States. Not only has the state expanded programming, but it has implemented the measures necessary to critically evaluate the success of the program. The state calls its program "Baby Love," and the results are impressive.

North Carolina has broadened Medicaid eligibility, made access to services easier, improved outreach, and mandated Medicaid coverage of support services. The cornerstone of the North Carolina program is a maternity care coordination program which follows case management principles. Simultaneously, the state initiated a program to evaluate the success of the expansions and to track the quality of the services delivered. This was done by making changes to the reporting system to allow for collection of information on maternity care coordination, the receipt of WIC, and the receipt of child care and family planning services. The State Center for Health Statistics now has the capability to match and analyze vital statistics and program data

files. Finally, the state implemented a maternity problem documentation log which quantifies data gathered by maternity care coordinators and developed a survey to identify the most effective outreach methods. The improved evaluation tools identified that 75% of clients learned about the Baby Love program from the staff at various agencies. In addition, 60% of the women participating in the Baby Love program had not been enrolled on Medicaid prior to the expansion. This statistic demonstrates that the Medicaid expansions are reaching the target population.¹⁴³

The key aspect of the Baby Love program is the emphasis on a system of care coordination. The statistics show that this approach is successful. The following statistics are from 1990. The preliminary data shows for women who received no care coordination:

- the low birth weight rate was 21% higher
- the very low birth weight rate was 62% higher.
- the infant mortality rate was 23% higher.¹⁴⁴

Of the women receiving care coordination;

-- 66% had nine or more prenatal provider visits compared to 54% for women who had no care coordination.

-- 88% participated in the WIC program compared to 72% of women without care coordination.

¹⁴³National Governors' Association, *Gaining Ground: State Initiatives for Pregnant Women and Children*, Washington, D.C., 1992, p. 23.

¹⁴⁴Id. at p. 25.

-- 68% received a postpartum examination compared to 43% for women without care coordination. Family planning services are often instituted at this postpartum visit.

-- 66% of the infants born to women receiving care coordination received a well-child visit compared to 25% of the infants born to women not receiving care coordination.

-- 82% of the infants born to women receiving care coordination participated in WIC compared to only 40% of infants born to women not receiving care coordination.¹⁴⁵

Clearly, the women receiving care coordination have better access to services. In analyzing the preliminary data, the evaluators were careful to control for factors such as maternal characteristics and location of care services provided. The results strongly show that women receiving care coordination delivered healthier babies.¹⁴⁶

Evaluators also analyzed the effect of the length of time of care coordination. They determined that women receiving care coordination for a longer duration had better birth outcomes. Care was taken to ensure that preterm delivery resulting in shortened program participation did not bias the results. To do this, evaluators compared birth outcomes with the percentage of the pregnancy for which care coordination was provided. The results showed that women who received care coordination for more than 50% of their pregnancy had substantially lower rates of low

¹⁴⁵Id. at p. 24.

¹⁴⁶Id. at p. 25.

birthweight, very low birthweight, and infant mortality.¹⁴⁷

North Carolina data also shows that care coordination is cost effective and quick to show results. Data shows that for every dollar spent on maternal care coordination, Medicaid has saved \$2.02 in newborn medical costs. Officials estimate that they have saved \$2,174,000 in just the first two years of the Baby Love program.¹⁴⁸

The early successes of the program impressed the North Carolina legislators enough to convince them to broaden Medicaid eligibility to 185% of the federal poverty level, provide up-front funding to expand the maternity care coordination system, and to continue to support efforts to reduce the infant mortality rate.¹⁴⁹ The early successes should also convince other states to initiate similar programs.

PREGNANT WOMEN AND CHEMICAL DEPENDENCY

Prenatal Substance Abuse and its Effects

In 1987, the National Association for Perinatal Addiction Research and Education estimated that 11% of all babies born nationwide have been exposed to illicit drugs at the time of birth. A 1990 study issued by the U.S. General Accounting Office found that 16% of all newborns born nationwide are substance-

¹⁴⁷Id. at p. 25.

¹⁴⁸Id. at p. 25.

¹⁴⁹Id. at p. 25.

exposed.¹⁵⁰ Exposure to alcohol prenatally is also a serious problem. The Arizona Department of Health Services estimated that 1,343 women who delivered babies in 1991 in Arizona used alcohol during pregnancy.¹⁵¹

The specific effect on the baby varies with the type of substance used by the mother. For example, cocaine has been found to have addictive effects (which cause 60-90% of infants exposed shortly before birth to go through withdrawal), toxic effects, and teratogenic effects (which disable organ development).¹⁵² The teratogenic effects are very serious, in that cocaine use inhibits development of the brain and other vital organs, especially during the first trimester.¹⁵³ Cocaine is also an appetite suppressant, which means the mother might not gain enough weight and the fetus will be deprived of essential nutrition.¹⁵⁴

¹⁵⁰This figure is from a study conducted in 1987 by the National Association for Perinatal Addiction Research and Education. In this study, 36 hospitals nationwide (primarily urban hospitals) were surveyed. This amounted to a study of 150,000 births. The substances covered by the study included cocaine, heroin, methadone, amphetamines, PCP, and marijuana. Alcohol was not included.

¹⁵¹Arizona Department of Health Services 1992 Arizona Health Status and Vital Statistics report.

¹⁵²J. Fink, "Reported Effects of Crack Cocaine Upon Infants," Youth Law News, Special Issue, 1990, p. 38.

¹⁵³Id. at p. 38.

¹⁵⁴N. Halfon, "Born Hooked: Confronting the Impact of Prenatal Substance Abuse," Testimony Before the U.S. House Select committee on Children, Youth, and Families, Washington, D.C., April 27, 1989, p. 6.

The effects of prenatal cocaine use can include placenta abruptio, spontaneous abortion, premature delivery, growth retardation, reduced brain growth, malformations of the heart and urinary tract, and strokes and cerebral infarctions.¹⁵⁵ After birth, a cocaine exposed infant can have problems such as irritability and hypersensitivity, movement disorders, altered state regulation (involving sleeping cycles), fine motor deficits, and increased occurrence of Sudden Infant Death Syndrome.¹⁵⁶

The effects of alcohol use during pregnancy are gaining more recognition. Fetal Alcohol Syndrome (FAS) is the third most common cause of mental retardation in the United States.¹⁵⁷ The National Institute on Alcohol Abuse and Alcoholism (NIAAA) describes FAS as "a well defined clinical entity comprising physical, mental, and behavioral abnormalities; low birthweight; abnormally small head; specific facial abnormalities; heart defects; joint and limb malformation; and mental retardation in most cases. FAS can be diagnosed on the basis of clinical examination of the infant; it does not require examination of the mother or knowledge of her drinking habits."¹⁵⁸ Prenatal

¹⁵⁵Id. at p. 6.

¹⁵⁶Id. at pp. 7-8.

¹⁵⁷National Institute on Alcohol Abuse and Alcoholism, United States Department of Health and Human Services, Program Strategies for Preventing Fetal Alcohol Syndrome and Alcohol-Related Birth Defects, Washington, D.C., p 1.

¹⁵⁸Id. at p. 1.

exposure to alcohol has been associated with spontaneous abortion, physical congenital anomalies, low birthweight, and abnormal neurobehavioral and neural development.¹⁵⁹

A baby born exposed and/or addicted to substances may go through painful withdrawal process. The withdrawal varies depending on the substance used and other factors. They can include high-pitched crying, sweating, excoriation of the extremities and gastrointestinal upset.¹⁶⁰ Additional effects of withdrawal are sleep disturbances, irritability, restlessness, crying, jitteriness, tremors, spasms, respiratory distress, abnormal eye movements, convulsions, poor feeding, vomiting, diarrhea, weight loss, and impaired neurobehavioral abilities.¹⁶¹ Although it is suspected that these children will be plagued by adversities and maladies throughout their lives, the extent of the setbacks are not yet fully known.

Availability of Treatment Services

With comprehensive treatment programs designed specifically for women and their families these women and their babies can be helped. Current statistics presented to the committee by the

¹⁵⁹Id. at pp. 6-7.

¹⁶⁰I. Chasnoff, Congressional Testimony to the U.S. Senate Subcommittee on Children, Family, Drugs and Alcoholism, "Falling through the Crack: The Impact of Drug Exposed Children on the Child Welfare System," Washington, D.C., March 8, 1990, p. 6.

¹⁶¹Department of Health Services, Newborns with Diagnosed Drug Withdrawal Syndrome in California, Sacramento, California, November, 1989, p. 2.

staff at CODAMA show that 29% of all drug abusers are female, yet only 11% of residential treatment center beds are taken by women and very few are available to pregnant women.¹⁶² Many residential and outpatient programs will not admit pregnant women because the staff do not have obstetrical expertise or because the woman is considered high risk and in need of more treatment resources. Additionally, some clinics and treatment centers are concerned about potential malpractice problems. Many residential treatment centers will not take women with other children. Since most women cannot or do not want to leave their children in order to go into residential care, the only option they have is to seek outpatient treatment. Outpatient treatment is less effective with pregnant women (discussed below) and also requires arrangement for transportation and child care.

The traditional program design for drug and alcohol treatment is premised on the profile of a male drug user and treatment proven effective for men. These perceptions are frequently reinforced by sexually discriminatory attitudes of staff members. Male-oriented philosophies are less effective for women. Traditionally, drug treatment programs take the approach that "if you use, you're out." Witnesses before the committee agreed that with a pregnant woman that approach is contraindicated. The program must also be concerned about the health of the unborn baby and therefore must encourage women to

¹⁶²Testimony of Elaine Smelkinson of CODAMA at subcommittee meeting 6-25-92.

stay in treatment even if they occasionally do revert to drug or alcohol use. Occasional relapse is considered by some experts to be a natural part of recovery.

Treatment centers often have to utilize waiting lists due to their limited resources. If the woman receives no treatment until she reaches the top of the list, she quite likely has either delivered the baby or is far enough into the pregnancy for damage to have been done to the baby.

The state funding formula for drug and alcohol services to pregnant women complicates the situation and makes it difficult to develop appropriate programs. AHCCCS provides drug and alcohol treatment only for federally funded women up to age 21. Women in the MN/MI population, and women over age 21 are not eligible for drug and alcohol treatment through AHCCCS. The AHCCCS health plans receive funds to provide services to women between age 18 and age 21 and Department of Health Services receives funds to provide services to those under 18. The Regional Behavioral Health Authorities receive federal funds from the Alcohol, Drug Abuse and Mental Health Block Grant, a percentage of which much go to services designed for women.

Some health plan representatives stated AHCCCS will only pay for care in residential treatment centers accredited by the Joint Commission on Accreditation of Health Care Organizations. These beds are scarce and so the plans must use very costly inpatient hospital care. Other health plan staff reported that their plan will only approve residential treatment if there is a medical

problem in addition to the drug or alcohol problem.

Additionally, some health plans do not feel transportation to drug and alcohol treatment is "medically necessary" and will not provide it.

The Arizona Department of Health Services through its Regional Behavioral Health Authorities provide Medicaid funded drug and alcohol treatment services to women under age 18. However CODAMA staff stated that, teens can not receive drug and alcohol treatment without their parents permission, and in some cases the teen is not willing to involve the parent in the situation.

Because of the complexity of the eligibility system AHCCCS eligibility may be disrupted during the pregnancy, thereby interfering with drug and alcohol treatment.

Data shows that 83% of women who abuse alcohol and drugs had parents who were addicted to drugs or alcohol.¹⁶³ Many of these women are coping with poverty, are relatively uneducated, are single parents, and experience emotional problems. Many, if not most, have been victims of violence as an adult.¹⁶⁴ Studies of addicted women have shown that 40 to 80% of these women were

¹⁶³ C. Tracy, D. Talbert, J. Steinschneider, "Women, Babies and Drugs: Family-Centered Treatment Options," Network Brief, Center for Policy Alternatives: National Conference of State Legislatures, July 1990, p.9 citing the Prevention and Applied Research Laboratory of Human Behavior Genetics, Emory University School of Medicine.

¹⁶⁴Id. at p.9

victims of childhood physical and sexual abuse, including incest.¹⁶⁵ Studies show that addicted women are more likely than non-addicted women to have been victims of physical or sexual abuse, and some studies have found this likelihood to be almost five times greater.¹⁶⁶ One study in particular showed that 70% of addicted women reported being beaten as adults. 86% of these women were beaten by their husbands or partners.¹⁶⁷ Individuals trying to help these women must also be sensitive to the fact that many of them are afraid of law enforcement and Child Protective Services (CPS). Project Thrive is a program funded through the Department of Economic Security which provides services to families with drug and alcohol problems that are at risk for child abuse. However, some mothers fear using the program because of its connection with Child Protective Services.

If a substance abuse problem is not dealt with during pregnancy, a woman may not be able to properly care for her children. Many drug-exposed babies are developmentally delayed. Others have serious chronic medical problems. Testing being conducted by Memorial Hospital in Phoenix indicates up to one-third of all drug-exposed babies may have hearing loss. Witnesses testified that even for those who are familiar with services it is difficult to obtain comprehensive services for these children through AHCCCS, the Regional Behavioral Health Authorities and the schools. Many of the parents of these

¹⁶⁵Id. at p.9 citing Benward, 1975.

¹⁶⁶Id. at p.9

¹⁶⁷Id. at p.9 citing Regan et al., 1987

children don't bring them in for follow-up care. The health plans have difficulty locating them because of the lack of up-to-date addresses and phone numbers. A nurse working in an intensive care nursery explained that she attempts to schedule the first pediatrician's appointment for these babies before they leave the hospital. She found it difficult to schedule appointments, because the pediatricians who provide care for AHCCCS patients are severely overloaded.

Pregnant Women and Chemical Dependency

Residential Treatment

A primary problem facing the state is the lack of beds in short and long term residential treatment centers that will take pregnant women. Women, especially pregnant women, fare better in residential treatment centers than they do in outpatient treatment. Many women in the target population live in areas where drugs are plentiful, and therefore it is best to remove them from the community during treatment. As was discussed above, these women have many other stresses in their lives, including domestic violence and job strains. Those who testified before the committee generally agreed that the best treatment plan for women consists of 30 to 45 days of intensive inpatient treatment followed by transitional residential services and then by outpatient treatment of less intensity. A comprehensive program must be able to provide crisis intervention, detox programs, and mental health services when necessary.

Additionally, it is crucial that residential treatment centers allow children to stay with their mothers while they are being treated.

The cost per woman for providing residential treatment is difficult to assess. Currently the Department of Health Services pays residential providers \$72 per day. Although a few treatment programs allow women to bring their children to the treatment center, DHS does not reimburse the program for the cost of caring for the child. For most programs this makes it financially difficult to offer residential services to women with children. It is important to note that the State of Arizona does pay the cost of foster care for these children while their mothers are in residential treatment. DHS pays for the mother and DES pays for the child. If the two programs could be coordinated it should be possible for the children to accompany their mothers to residential services. A comprehensive program in Chicago reviewed by the committee costs approximately \$250 per day for the mother and \$180 per child. The director of that program felt cost in Arizona could be 20% lower. With the limited information available to the committee it is estimated that the cost of residential treatment is between \$72 and \$160 a day for the mother and \$50 to \$144 a day for the child.

Given the cost involved, the committee recommends that priorities be set to begin serving those at greatest risk of delivering a child who is disabled due to drug and or alcohol exposure. The only consensus on priority was that services

should go to the poorest women, those who face geographic barriers, IV drug users, and women who abuse alcohol. Other considerations discussed were whether there were other children in the family who were drug exposed, whether the mother was a serious abuser, and what type of substance was being abused. The general sense of the discussion was that it was very difficult to prioritize because the risks to the babies are equally great.

Intensive Case Management

Intensive case management entails one person being responsible for assessing the care needs of a patient and coordinating all the care that is necessary. It is multi-faceted in that medical and social services, counseling, emotional and educational needs are coordinated. When the client is a pregnant substance abuser, intensive case management is most effective when a nurse acts as the case manager since nurses have the medical and technical knowledge to deal with the complex problems of the pregnancy as well as the other non-medical needs. For maximum effectiveness, the case manager must be sensitive to the cultural and linguistic characteristics of the woman she is helping.

Ideally, a case manager should be involved with a mother and child for two years to really make a difference. The success of intensive case management has been demonstrated by both CODAMA and the Phoenix Birthing Project. In seven months, 22 out of 25 babies born in the CODAMA program were drug free. A very high percentage of those born drug free were born to mothers who

received residential treatment. In the ten months of operation of the Phoenix Birthing Project (a private organization that serves the African American community), 160 pregnant teens/women entered the program. Fifteen percent of these women were substance abusers. Out of 105 babies born so far, only one was positive for drugs. The Phoenix Birthing Project has shown that intensive case management must continue after delivery to help mothers maintain sobriety and cope with the stresses of recovery and parenting.

RECOMMENDATIONS

1. Proposed Continuum of Services for Chemically Dependent Women and Their Families
 - A. Identification and Referral
 - a. Outreach must be improved to encourage high risk women to undergo treatment.
 - b. Public awareness must be improved so that family and friends are better able to recognize the need for treatment and so self-referral occurs more frequently.
 - c. Provider education must be improved so that all health care personnel are better able to recognize high risk patients and refer them into treatment.
 - d. All potential referral sources must be able to identify high risk women and refer them to treatment and intensive case management. Referral sources include Behavioral Health authorities, high-risk clinics, hospitals, health plans, providers, detox centers, treatment centers, probation officers, CPS, schools, churches, and family members.
 - e. Case managers must be able to assess and coordinate the service needs of the high-risk pregnant women who are identified.

B. Services During Pregnancy

- a. Intake and assessment with the ability to arrange for immediate prenatal care, prior to screening for eligibility.
- b. Assistance in applying for other entitlement programs.
- c. Crisis intervention programs.
- d. Detox programs.
- e. Mental health treatment services.
- f. Short-term (30 to 45 days) intensive residential care centers where children can stay with their mothers.
- g. Daycare in residential treatment centers.
- h. Long-term transitional living programs after primary treatment.
- i. Expanded funding for DES daycare for women while they are receiving treatment.
- j. Weekly contact by case managers with the women. Face to face contact at least twice monthly to build trust and rapport.
- k. Support services including assistance in securing housing, DES daycare, arrangement of appointments for other medical needs and assistance in transportation.
- l. Education on the importance of good nutrition during pregnancy, the impact of drugs and alcohol and birth control.
- m. Prepare mother for both childbirth and parenting responsibilities.
- n. Literacy training and financial management skills.

C. Ongoing Services

- a. Follow-up medical care for mothers and babies.
- b. Follow-up social services for the entire

family for one year.

- c. Coordination between all providers to ensure comprehensive treatment and eliminate duplication.
- d. Parenting skills education. Special attention should be paid to teaching mothers about the unique needs of medically fragile infants who have been prenatally exposed to substances.
- e. Vocational training and preparation.

D. Services to Substance-Exposed Babies

- a. Assess the developmental needs of the babies
- b. Ensure that comprehensive early intervention strategies are used to prevent life-long disabilities.
- c. Home visits 3 to 5 times per week during the first month of the infants' lives by qualified case managers.
- d. Monitor the babies' development, the frequency and results of the babies' check-ups, and the babies' immunizations.

2. Target outreach to women of child bearing age who abuse substances to encourage the prevention of pregnancy.

3. Direct the Department of Health Services to coordinate all services to this population at the Director's level. Office of Women's and Children's Health, the Division of Behavioral Health, the Office of Children's Mental Health, and the Office of Substance Abuse Services should develop and fund a comprehensive program for services to this population. One office within DHS must be ultimately responsible for policy development, program design, and payment for services to this population.

Include in DHS authority the responsibility for establishing comprehensive policy for how services to this population will be provided with Medicaid dollars.

4. Require that AHCCCS amend the Medicaid State Plan to include drug and alcohol treatment as part of the package of services available to all Medicaid eligible pregnant women to maximize federal reimbursement for

this population.

5. Provide reimbursement to residential providers for caring for children who come with their mothers to treatment.

6. Require AHCCCS submit an amendment to the State Medicaid Plan to include coverage for the full array of Medicaid reimbursable services so that Medicaid coverage is available in residential treatment centers.

7. Develop goals for reduction of the number of children born exposed to drugs in response to the information developed by the upcoming DHS prevalence study. Require the Regional Behavioral Health Entities set goals for the reduction of drug use during pregnancy in their service areas.

8. Pass legislation to permit teens to receive drug and alcohol treatment without parental consent.

Justification

The Washington Program

In 1989 the state of Washington began implementing a comprehensive treatment program for substance abusers. The program encompassed much more than just pregnant women, but the legislation did identify pregnant women as a priority population. In the same year changes were made to the state's prenatal care program. These efforts were coordinated with the substance abuse treatment program so that the needs of pregnant substance abusers were specifically addressed.¹⁶⁸

The Omnibus Drug Act of 1989 is a wide-reaching piece of drug treatment legislation. Among its provisions was a \$5.5 million appropriation for treatment services for low-income,

¹⁶⁸National Governors' Association, Gaining Ground: State Initiatives for Pregnant Women and Children, Washington, D.C., 1992, p.60.

chemically dependent, pregnant and postpartum women; a \$12.5 million appropriation for youth assessment and treatment programs; and a \$3 million appropriation to assist communities in developing collaborative programming.¹⁶⁹ At the same time as the above legislation was enacted, the state passed other legislation that improved services. The Alcoholism and Drug Addiction Treatment and Support Act was revised to prioritize treatment of low-income, chemically dependent pregnant women and parents.¹⁷⁰ The Maternity Care Access Act expanded Medicaid eligibility for pregnant women to 185% of the poverty level and expanded Medicaid coverage to support services such as psychosocial assessment, nutritional services, health education, transportation, and case management.¹⁷¹ In 1990, Medicaid coverage was expanded to medical stabilization and detoxification of pregnant women and teens and child care services were expanded in order to ensure that lack of child care would not operate as a barrier to women receiving treatment.¹⁷²

The Department of Social and Health Services was charged with coordinating all of these efforts and it formed an interagency group to develop and implement a care continuum for pregnant substance abusers. Included in the interagency group

¹⁶⁹Id. at p. 60.

¹⁷⁰Id. at p. 60.

¹⁷¹Id. at p. 60.

¹⁷²Id. at p.61.

were representatives from Income Assistance, Medicaid, Maternal and Child Health, Substance Abuse, Child Protective Services, and the Office of Research Data Analysis.¹⁷³ The group reviewed agency policies to find conflicts and resolved these conflicts in the care continuum plan. The cornerstone of the care continuum was targeted case management.¹⁷⁴ To assure implementation of the continuum, the interagency group trained eligibility workers on the needs of pregnant women and worked with the legal community to educate them on the advantages of the new program as an alternative to prosecution.¹⁷⁵

The program has been very successful. In 1982, only 17% of those being treated in the alcohol and drug abuse system were female. None were pregnant. Now, 33% of those being treated in the drug and alcohol abuse system are female and 10% of those women are pregnant.¹⁷⁶ This represents a significant improvement in a very short time.

EDUCATION

Throughout all of the committee hearings and subcommittee meetings much concern was expressed about the lack of education regarding the necessity of prenatal care. Every subcommittee found educational deficits in the current system. Lack of knowledge of the need for prenatal care was found to be the most

¹⁷³Id. at p. 61.

¹⁷⁴Id. at p. 61.

¹⁷⁵Id. at p. 61.

¹⁷⁶Id. at p. 61-62.

prevalent barrier to care.¹⁷⁷ The Subcommittee on Education was charged with developing a plan to increase awareness of 1) the symptoms of pregnancy and the necessity for prenatal care, 2) how to access the AHCCCS system and 3) the availability of care.

The Subcommittee developed recommendations for 1) improving outreach, and 2) better educating the public and in particular the women of child bearing age about the importance of prenatal care and the need to begin their prenatal care early.

RECOMMENDATIONS

Education

1. Expanded Education in School Systems

Encourage school districts to expand their curriculum to include sex education, family planning, thorough health education, nutrition education and special programs for pregnant teens and parents. Establish a program within Office of Women's and Children's Health (OWCH), Department of Health Services (DHS) and the Department of Education to develop model education programs and to consult with school districts and provide interested districts with information about successful programs and implementation strategies in other districts and on the community college level.

2. Media Campaign

Encourage businesses and non-profit organizations that do not have their own prenatal/child health media campaign to contribute to the DHS campaign, "The Greatest Love," Encourage sponsors of the campaigns to include the DHS pregnancy hotline number to their spots, and publications.

Require DHS develop a method for measuring the current educational level of the public on the need for prenatal care and the effect of any media campaign on improving the knowledge of the community.

¹⁷⁷Louise H. Warrick, Use of Birth Registration Data for Prenatal Health Care Planning in Maricopa County, Columbia University, August 1986, p. 150

3. Lay Health Worker Programs

Expand one-on-one support systems for pregnant women and adolescents in the form of additional lay health worker programs. Successful existing programs include Comienzo Sano, Phoenix Birthing Project and Concimiento.

4. Continuing Medical Education

Survey OB/GYNs, physicians, nurses and non-physician providers through their professional associations to assess those areas relating to maternal health (nutrition, pharmacology, psychosocial risk assessment, procedure for enrolling women in WIC, etc.) about which they need to learn more. Follow up the survey with either continuing medical education classes or articles through the association's newsletter.

5. Patient Education Material

Develop patient education pamphlets covering basic prenatal care information such as the effects of smoking and drinking, and the need for good nutrition during pregnancy. The pamphlets would be distributed everywhere possible. They would include reference numbers for each of the problems (alcoholics anonymous, pregnancy hotline, etc.) and would be written in a low literacy level and style.

6. Increased Accessibility to Pregnancy Testing

Increase funding to publicly subsidized health facilities so free pregnancy tests can be offered at these locations.

Encourage clinics, primary care centers, and hospitals to implement a "fast track" system so that individuals requiring pregnancy testing can be helped quickly.

Direct the Department of Health Services Office of Women's and Children's Health to further investigate the feasibility of providing pregnancy testing at non-traditional sites, such as stores and pharmacies which offer periodic lab services through Health Waves Laboratories or schools after hours.

All pregnancy testing sites should provide immediate follow-up information on the necessity of prenatal care, the procedure for obtaining care if the woman

does not have a doctor or insurance, and the basic information the pregnant woman needs to know until she can see a doctor, as well as information on family planning if the test is negative. This will require incorporating new individuals, such as pharmacists, into the group of prenatal education providers.

Develop a distribution program for the March of Dimes' pamphlet which contains a coupon for Early Pregnancy Test. The March of Dimes and ADHS will work together to increase the distribution and availability of home pregnancy tests. After the initial pilot program period, the pamphlet will be slightly restructured toward a larger population and will include the Arizona pregnancy hotline number rather than the toll number currently on the pamphlet.

7. Expand Hotline Services

DHS must expand the hotline so that it can meet the increased need generated by increased education and publicity of the Hotline services.

8. Private-Public Partnership

Hold a "summit" inviting private and public source who may be interested in funding the recommendations adopted by the Committee. The summit would be sponsored by the Governor office, Chairs of the appropriate Governor's Councils, Legislators and the Directors of DHS, AHCCCS and DES. Participants would include those in the private sector that contribute to philanthropies (i.e. the Valley Givers Association, non-profit organizations, etc). The private sector participants would be presented with an explanation of the need for improving accessibility to prenatal care, the recommendations from the Study Committee and an analysis of the cost effectiveness of adequate prenatal care.

Justification

The Utah Program

The state of Utah implemented reforms which removed eligibility barriers to prenatal care, provided for prenatal care coordination, and expanded services. One of the main components of the reform package was an expansive media campaign meant to

educate women on the importance and availability of prenatal care. The campaign was entitled "Baby Your Baby", and included public service announcements on television and radio, documentaries, brochures and other printed materials, a coupon book for women who entered care early and continued throughout the pregnancy, and a toll-free hotline.¹⁷⁸

The state closely monitored the program to determine its effect on birth outcomes. The increase in the use of the hotline demonstrates that the impact of the campaign was broad. In 1988 the hotline received an average of 155 calls per month, in 1989 the average was 856 calls per month, in 1990 the average was 965 calls per month¹⁷⁹ Further study showed that 65% of all hotline calls were made after a woman viewed a televised public service announcement.¹⁸⁰ There was an increase in the amount of calls received at the hotline for 15 minutes after spots were aired.¹⁸¹

It also appears that the campaign is successful in reaching the target population. Nearly 50% of all hotline calls were placed by women in their first trimester of pregnancy, indicating that the campaign helped get women into care earlier.¹⁸²

¹⁷⁸National Governor's Association, *Gaining Ground: State Initiatives for Pregnant Women and Children*, Washington, D.C., 1992, p. 21.

¹⁷⁹Id. at p.21.

¹⁸⁰Id. at p. 22

¹⁸¹Id. at P.22.

¹⁸²Id. at p. 22.

Although only 9% of births in Utah are to teenagers, 25% of the calls to the hotline were made by teenagers.¹⁸³ This is significant because teens are such a high-risk group. Another indication of the program's success is the fact that nearly all women with incomes less than 133% of poverty are enrolled in Medicaid.¹⁸⁴

The state of Utah also conducted a study to compare birth outcomes of women who used the hotline and women who didn't use the hotline and to compare the average cost of babies born to women who used the hotline and women who did not use the hotline. The findings were as follows:

-- 86% of hotline users initiated care in the first trimester, while 81% of non-hotline users initiated care in the first trimester.

-- The average cost of delivery to hotline users was \$2,016, while the average cost of delivery to non-hotline users was \$2,300.

-- 78% of pregnant teenagers who called the hotline received prenatal care in the first trimester, while only 64% of teenagers who did not call the hotline began care in the first trimester.

-- 7.1% of babies born to teenage hotline users were born at a low birth weight, while 9% of babies born to teenage non-hotline users were born at a low birth weight.¹⁸⁵

The proven success of the Baby Your Baby program has prompted Utah to expand similar programming.

¹⁸³Id. at p. 22.

¹⁸⁴Id. at p. 22.

¹⁸⁵Id. at p.22.

BUDGET IMPLICATIONS

The Committee attempted to establish cost estimates for the recommendations of the various subcommittees. The Committee requested specific information from the AHCCCS Administration, the Department of Health Services, Office of Women's and Children's Health, the Joint Legislative Budget Committee, and the Department of Economic Security on some but not all of the recommendations. The various agencies were not able to provide cost estimates for a number of the Committee's recommendations. However, the following information is presented as part of the Committee's report with the full knowledge that a more detailed budget analysis must be completed.

The total number of women in Arizona who have no apparent source of payment for prenatal/maternity services is unknown. Various studies have placed the figure anywhere from 5,000 to 18,000 per year.¹⁸⁶ Some women are uninsured and others have insurance but it does not cover maternity care. The Committee is recommending an incremental approach to making prenatal care financially accessible to all Arizona women. The first step is to raise AHCCCS eligibility to 185% of the Federal Poverty Level, the current maximum that the Federal government will reimburse. According to an analysis by the Joint Legislative Budget

¹⁸⁶J. Kotch, et. al., A Pound of Prevention: The Case for Universal Maternity Care in the U.S., pp. 87-107, 1992.

Committee (JLBC), this would make an additional 4,154 women per year eligible for care through AHCCCS at an estimated cost to the state general fund of \$11,697,500. These figures are estimates only and may vary with economic conditions, and the actual cost of care at the time of implementation. They do take into account women in this range who have insurance.

The Committee is also recommending coverage on a sliding scale for women whose income is above 185% and below 250% of the poverty level. The Committee had no information on the cost of implementing this recommendation.

The balance of the Budget Subcommittee information reflects the cost estimates for various recommendations and cost avoidance due to the intervention where known. Cost figures were provided by the Arizona Department of Health Services, Office of Women's and Children's Health and the Joint Legislative Budget Committee

I. Cost Analysis for SOBRA expansion to 185%

Estimated Cost (State)	Cost Avoidance (State)
11,697,500	3,953,625

Cost avoidance figures were calculated using the following formula. The JLBC told the Committee that 4154 more women would receive prenatal care if eligibility were increased to 185% of poverty. It assumed that those women would not have received minimally adequate care otherwise. The Committee used the Department of Health Services figures for the number of preventable very low birthweight babies (under 1500 gms) and preventable low birth weight babies (under 2500 gms). This number

was multiplied by the average hospital and physician charges reported to DHS for the Newborn Intensive Care Program and the medical costs for the first year of life for a low birth weight child. This figure represents the cost savings in total dollars of providing prenatal care to the additional 4154 women and thereby avoiding expensive low birth weight babies. The final state cost avoidance is 35% of the total figure since the federal government would reimburse approximately 65% of the new born costs. See Addendum for the complete calculation.

II. Cost Analysis for Selected Recommendations

INTERVENTION	STATE COST	STATE COST AVOIDANCE
Malpractice premium subsidy+NPs	467,403.8	---
Malpractice subsidy <50 deliveries	644,903.8	---
Mobile Care	630,024.0	---
Integration/One-Stop	167,200.4	---
Case Management	1,203,251.7	2,406,503*
In-School Ed	---	---
Media Campaign	---	---
Lay Worker Outreach	510,514.4	1,021,029*
Patient Ed Material	7,000.0	---
Hotline Expansion	43,044.7	---
Free Pregnancy Test	152,355.0	----***
Drug Treatment	1,503,902.0	----***
Community Outreach	55,467.3	---
Behav/Social Risk Ed	5,000.0	---
Family Planning	1,003,902.0	4,015,608**
Transportation	54,689.9	---
Mental Health	244,556.1	---
Housing Shelter	14,556.1	---
Teen Outreach	282,079.7	564,159*
OB/GYN NP Training	92,902.2	---
TOTAL	7,066,656.0	8,007,300

*For every dollar spent on case management, outreach and care coordination two dollars are saved in post delivery neonatal care.

** For every dollar spent on family planning services two to 6.6 dollars are saved on prenatal, maternity and neonatal costs. For this report a 1:4 ratio was used.

*** The cost avoidance associated with drug and alcohol treatment programs could not be estimated at this time due to lack of prevalence statistics for Arizona and reliable figures for cost avoidance from published studies.

III. SUMMARY OF COST ANALYSIS

INTERVENTION/RECOMMENDATION	COST	COST AVOIDANCE
Outreach/Case Management	1,995,846	3,991,692
Family Planning	1,003,092	4,015,608
SOBRA Eligibility to 185%	11,697,500	3,953,625
All Other Interventions	4,067,718	---
TOTAL	18,764,236	11,960,925
NET COST TO STATE	6,803,311	

CONCLUSION

The recommendations contained in this report provide a comprehensive plan for improving the health status of pregnant women and children in Arizona by 1) educating the public and women of child bearing age of the need for prenatal care and how to obtain it; 2) removing financial barriers to care; 3) creating an eligibility and enrollment system that facilitates early entry into care; 4) ensure that culturally sensitive providers are available in our communities; 5) make pregnancy testing and family planning services readily available and, 6) target special high risk populations for coordination of medical, social and educational services. The Committee realizes that the goals of accessible, affordable quality prenatal care for all Arizona women cannot be achieved overnight. The Committee urges Arizona's leaders both in the public and private sector to

embrace the recommendations contained in this report and to work toward their implementation.

ADDENDUM

Cost Avoidance Calculation:

COST AVOIDANCE = (#VLBW prevented x average NICU cost) + (#VLBW prevented x average physician costs in hospital) + (#VLBW prevented x average first year medical costs) + (#LBW prevented x average NICU costs) + (#LBW prevented x average physician costs).

State general fund cost avoidance: 35% of the total cost avoidance.

Average physician costs in hospital = 17% of hospital charges.

VLBW = Very low birth weight=<1500 gms

LBW = Low birth weight=<2500 gms

NICU = Neonatal intensive care unit

Costs estimates are from 1989 charges reported to Arizona State Newborn Intensive Care Program

Specialty Hospital Care at Birth: Cost Avoidance

	No.	Average NICU Costs	Total NICU Costs	Physician Costs
VLBW	98	58,160	5,669,680	968,946
LBW	152	18,581	2,824,312	480,133
		Total	8,523,992	1,449,079

First Year Medical Costs: Cost Avoidance*

	No.	Average Costs	Total
VLBW	98	13,500	1,323,000

Summary: Cost Avoidance

NICU Costs	8,523,992
Physician Costs	1,449,079
Medical Costs-First Year, Post Initial Hospital	1,323,000

TOTAL	11,296,071
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State Share 35%	3,953,6225
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*Pediatrics 1991;88:533-541.

Minority Report

STUDY COMMITTEE ON SERVICES TO PREGNANT WOMEN

Laws 1991, Chapter 193 established the Study Committee on Services to Pregnant Women. The Committee was charged with investigating:

1. the barriers which prevent pregnant women from receiving services,
2. the degree to which available services are being used,
3. the definition and description of the underserved population in Arizona, and
4. the problems that women encounter while establishing eligibility for state services.

The full Committee met nine times. The first four meetings were spent clarifying the scope of the problem. At the conclusion of the fourth meeting, the Committee broke into five work groups: Availability of Providers, Budget Implications, Education, Eligibility and Enrollment and Special Populations. The findings and proposed recommendations of the work groups were discussed at the remaining four Committee meetings. At the final meeting, the Recommendations were proposed in the Committee report and they were adopted by the members present.

Minority Response

As members and active participants of this Study Committee, we oppose the vast recommendations approved by the Committee. We acknowledge and appreciate the extensive hours consumed studying this important issue. However, throughout this process this committee has lost perspective, focus and most importantly identified extensive barriers but provides no prioritization to their solutions. Instead, the report provides an unrealistic broad "plan" without adequate direction. We believe the community will be better served by a targeted approach, which includes such features as high priority issues and a focused application of funding. This minority report provides specific findings as a result of the committee's research and endorses realistic and pragmatic recommendations.

Findings

Reports and testimony received by the Committee indicate that in 1990, of the nearly 69,000 babies that were born in Arizona, 602 families experienced the death of their babies before the child's first birthday and another 410 parents experienced a fetal loss. Additionally, 4,451 babies were born weighing less than 5.5 pounds. Although most of these babies survived, approximately half required newborn intensive care (NICU). Total NICU costs in 1989 were approximately \$75 million.

Additionally, study after study has concluded that comprehensive prenatal care begun early in pregnancy drastically improves birth outcomes. In comparison to other states, Arizona ranks 47th for getting women into prenatal care. In 1989, 82.8% of all women who were pregnant in the previous five years had their first prenatal care visits during the first trimester; 11.9% started prenatal care in the second trimester and 4.2% did not seek care until the third trimester or until delivery. The Committee received testimony about what barriers cause these delays. The most prevalent ones were: poverty, cultural differences, age, fear, lack of transportation, shortage of providers, lack of education concerning the importance of prenatal care, the complexity of the AHCCCS eligibility process, inability to receive child care for other children, substance abuse, language barriers, illiteracy, domestic violence and lack of home telephones.

Eliminating all these barriers would be the ideal situation. However, this is impossible during difficult financial times. Therefore, it is important to identify the barriers which can be both realistically addressed and which will produce immediate and long-term improvements. In keeping with the focus of the charges of this committee, we believe the following two recommendations signify the most effective and responsible policy recommendations:

Recommendations

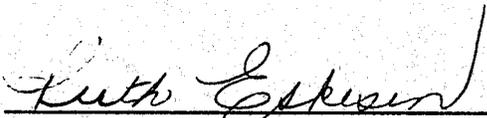
- 1. Increase public awareness of the importance of early and comprehensive prenatal care through a multi-media publicity campaign jointly sponsored by the state and a variety of private sector sponsors, similar to the successful Baby Your Baby program in Utah.**

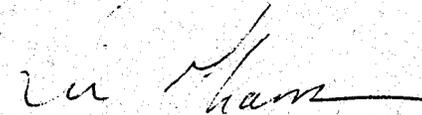
The benefit of a major media campaign is that it informs women of the importance and availability of early and continuous prenatal care. Utah has closely monitored its media campaign program to determine its effectiveness in raising public awareness of the infant mortality problem and to assess whether birth outcomes have been impacted. A steady increase in the number of calls has been seen during the first four years: in 1988 there were approximately 155 calls monthly, in 1991 there were approximately 1,333 calls monthly. Surveys of hotline callers revealed that nearly 50% of the calls were made by the women in their first trimester; 27% made the call within the first eight weeks of their pregnancy. Additionally, the average cost of delivery is lower for women who called the hotline. Deliveries for hotline callers averaged \$2,016 compared with \$2,300 for non-hotline callers.

2. **Establish presumptive eligibility for pregnant women by rendering immediate provider access to any pregnant woman at the time of application combined with a statewide educational component informing providers and pregnant women of the presumptive eligibility opportunity.**

Presumptive eligibility allows a woman to receive prenatal care before her eligibility for Medicaid is determined. Early prenatal care often improves the health of the mother and improves birth outcomes. Maricopa County already provides prenatal care to any pregnant woman with an income under 185% of the federal poverty limit (FPL). An average of 1,200 women are seen each month who are not enrolled in AHCCCS. The County estimates that up to 80% of these women could qualify for AHCCCS, i.e., would meet the 140% FPL income limit and other eligibility factors.

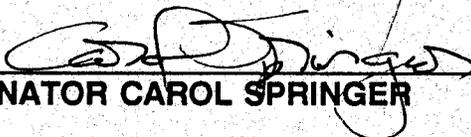
Implementation of a statewide presumptive eligibility program will require careful organization and planning. Outcomes and associated costs must be periodically reviewed to determine the feasibility of program continuation.


REPRESENTATIVE RUTH ESKESEN


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SENATOR CAROL SPRINGER

