ISSUE BRIEF
February 2025

CLARK COUNTY WASHINGTON
PUBLIC HEALTH

Prenatal Care Access for Apple Health (Medicaid) Clients in Clark County

Clark County Public Health

In the fall of 2023, a community service provider notified Clark County Public Health (CCPH) that **Apple Health (Medicaid) clients seeking prenatal care in the community were unable to find available appointments**, sometimes waiting weeks or months to get care. Public Health outreached to local providers and documented that many were at capacity, not accepting Apple Health, and/or short on clinicians (e.g., OB/GYN, midwife, nurse practitioners) and scheduling fewer appointments.

Public Health worked with the Washington State Health Care Authority and local managed care organizations to communicate guidance for pregnant Apple Health clients struggling to access prenatal care. In the months since, CCPH has completed a **comprehensive analysis of birth certificate data to illuminate the adequacy of prenatal care among the birthing Medicaid population for the year 2023**. Working alongside community organization partners, the Southwest Washington Healthy Families Coalition, and CCPH Lifecourse program staff, these data were reviewed to understand inequities in care and birth outcomes.

Significant inequities exist in Clark County for the Medicaid population compared to private insurance and by race and ethnicity. This Issue Brief presents a review of the data and policy and system recommendations from various comprehensive state planning efforts aimed at improving outcomes for birthing parents and babies. It concludes with **recommended action steps for health systems and organizations serving pregnant and parenting families in Clark County**.

NATIONWIDE MATERNAL HEALTH CRISIS

Nationwide there is a crisis in maternal health, most visibly indicated by unacceptably high[1] maternal death rates. Before, during, and after childbirth, pregnant people in the United States are dying at a higher rate from pregnancy-related causes than in any other developed nation. For certain people, the risk is much higher. For most pregnancy-related deaths, the cause is considered preventable. Beyond mortality, severe maternal morbidity has a compounding impact for families during and after pregnancy, with significant short- or

long-term consequences for health and well-being. Systemic barriers and implicit and explicit bias within the health care system has meant that pregnant individuals of color – Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander – and rural individuals experience a greater share of these dire outcomes.[2]

THE IMPORTANCE OF EARLY AND REGULAR PRENATAL CARE

Prenatal care is the medical care a pregnant person receives throughout their pregnancy. Comprehensive prenatal care may be delivered by a family practice physician or nurse practitioner, midwife or certified nurse midwife, obstetrician (OB/GYN), and/or maternal fetal medicine specialist. Prenatal care is an essential service in the continuum of care the begins before pregnancy and is delivered throughout pregnancy, birth and an extended postpartum period.

Early and regular prenatal care promotes healthy pregnancies. Inadequate prenatal care increases risk for pregnancy complications and adverse birth outcomes for the pregnant individual and baby. Consistent prenatal care is associated with fewer preterm births, higher birthweight infants, and fewer maternal and infant deaths.[3,4]

MEDICAID COVERAGE OF PRENATAL CARE

Medicaid provides health coverage to millions of Americans, including low-income pregnant people. Medicaid is administered by states according to federal requirements and is jointly funded by states and the federal government. The Washington Medicaid plan is called Apple Health.

States have discretion to determine the scope and reimbursement of maternity care benefits, and states that have expanded Medicaid (like Washington) must cover preventive services recommended by the US Preventive Services Task Force (i.e., prenatal screenings, folic acid supplements and breastfeeding support).[5]

Apple Health provides comprehensive pregnancy and 12 months of postpartum coverage for individuals who qualify based on income, regardless of citizenship or immigration status. In addition to basic covered services, Apple Health covers regular office visits and associated services for prenatal care, mental health services, delivery in a hospital, birthing center or home birth, abortion care and pregnancy loss, substance use disorder services, additional preventive services covered through Maternity Support Services , Infant Case Management and Childbirth Education and more.[6] With the passage of ESSB 5950[7] into law during the 2024 legislative session, Apple Health will also include a doula benefit.

Nearly 29% of Clark County residents accessed Medicaid services in 2023 (151,691 individuals).[8] Just over 117,000 were enrolled in a fully integrated managed care plan in December 2023.[9] These plans pay for care and are responsible for organizing and delivering care by establishing accessible provider networks, developing and applying coverage and treatment standards, ensuring health care accessibility and quality, and coordinating clinical care and social services. Molina Healthcare of Washington, Wellpoint, Community Health Plan of Washington, and Coordinated Care are the plans in Clark County.

CLARK COUNTY BIRTH DATA

The Washington State Department of Health collects information on all births that occur in Washington state through the Washington State Birth Certificate Form. The CCPH Health Assessment and Evaluation team regularly reviews birth certificate data on pregnancies and deliveries in the county to understand birth trends, identify high risk populations, set prevention priorities, and plan health promotion strategies. The following data charts and tables represent all births among Clark County residents, including out of state births (e.g., in a Portland-area hospital).

Figure 1. On average, there are about 5,500 Clark County births every year.

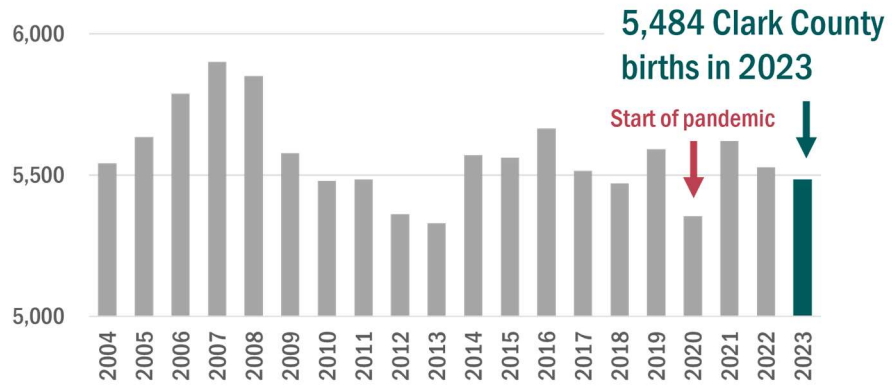
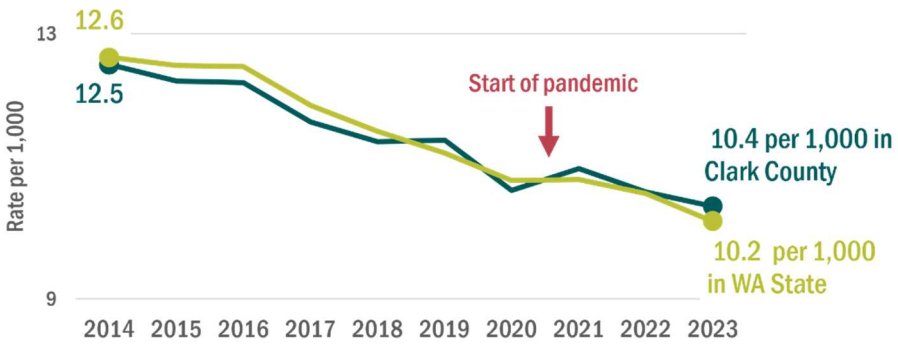


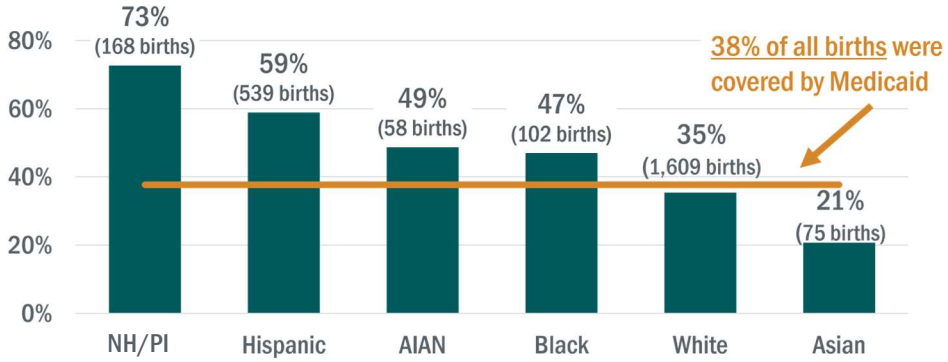
Figure 2. Between 2014-2023, the birth rate per 1,000 population in Clark County decreased by about 17% and decreased by 20% in Washington state.



SPOTLIGHT ON DATA QUALITY

Despite comprehensive data collection forms, fields with missing data are regular in Washington birth certificate data sets. In 2023, 15% of Clark County birth records were missing information on prenatal care visits, and this varies by demographic group. For example, 13-14% of prenatal care data are missing for births to Asian, White, Hispanic, or Black mothers, while 20% are missing for Native American and 26% for Native Hawaiian/Pacific Islander (NH/PI) births. For all identities, the rate of missing data is higher for Medicaid financed births, up to 29% for NH/PI.

Figure 3. In 2023, 38% of all Clark County births were covered by Medicaid (representing 2,017 births). The highest rates of Medicaid births were among Native Hawaiian/Pacific Islander, Hispanic, and Native American birthing parents.



Note: Race/ethnicity categories are not mutually exclusive. Data include birthing parents who reported a single race as well as those who reported more than one race, therefore data will not add up to 100%.

MEASURING ADEQUACY OF PRENATAL CARE

Prenatal care is most effective when it starts early and continues throughout pregnancy. The Adequacy of Prenatal Care Utilization Index (APNCU) is a measure of whether pregnant people are using prenatal care. It is based on two factors: when prenatal care began and the number of prenatal visits during pregnancy.

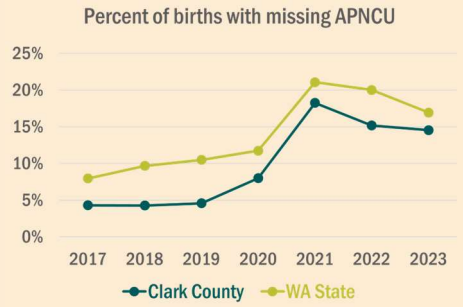
***Inadequate* prenatal care means:**

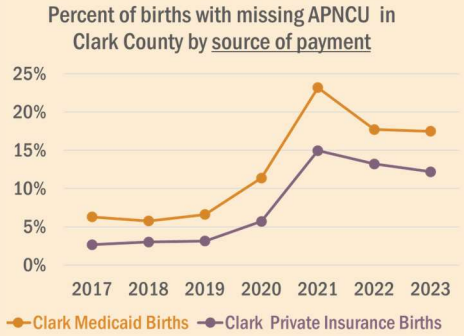
- **care started in month five or later**
- ***or* less than 80% of recommended visits were received**

Increasing the percent of pregnant individuals receiving early and adequate prenatal care is a Healthy People 2030 objective and is measured using the APNCU. Figures 4-6 utilize the APNCU to display inadequate prenatal care. Figures 7-9 break out the initiation component of the APNCU separately to view care initiation by trimester of pregnancy.

SPOTLIGHT ON DATA QUALITY

The percent of births with missing data to compute APNCU has increased post-pandemic.





CLARK COUNTY DATA - ADEQUACY OF PRENATAL CARE

The Washington State Birth Filing Form includes data entry fields for maternal race/ethnicity as well as payor type, allowing detailed analysis of prenatal care trends for Medicaid recipients, as well as by race and ethnicity. Disparities exist between Medicaid and private insurance for adequate prenatal care access, as well as among racial and ethnic groups in Clark County.

Figure 4. Trends in the percent of births with inadequate prenatal care are similar over time in Clark County and Washington state.

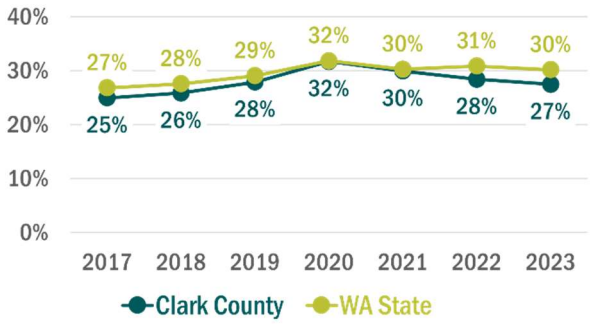


Figure 5. The percent of births with inadequate prenatal care have diverged sharply in recent years by payor type, with Medicaid births having higher rates of inadequate care than private insurance births.

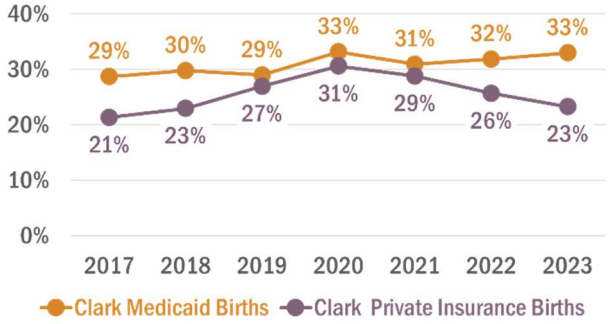
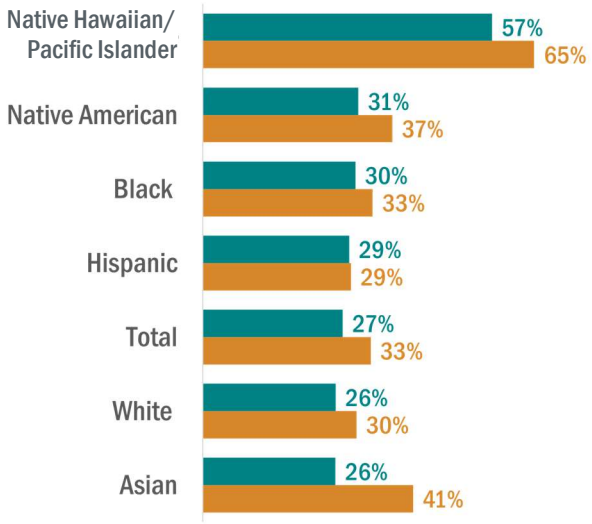


Figure 6. In 2023, Native Hawaiian/Pacific Islander birthing parents experienced the highest rates of inadequate prenatal care across births financed by Medicaid (65%) and overall (57%).



Note: Race/ethnicity categories are not mutually exclusive. Data include birthing parents who reported a single race as well as those who reported more than one race.

CLARK COUNTY DATA - INITIATION OF PRENATAL CARE

The health care received during pregnancy should start as early as possible, and ideally within the first trimester or first 12 weeks of pregnancy. Disparities exist between Medicaid and private insurance for initiation of prenatal care in the first trimester, as well as among racial and ethnic groups in Clark County.

Figure 7. Trends in the percent of births with first trimester prenatal care initiation are similar over time in Clark County and Washington state.

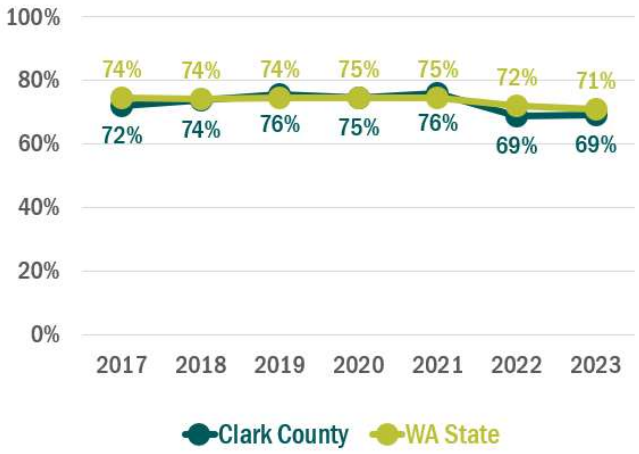


Figure 8. The percent of births with first trimester prenatal care initiation have persistent gaps over time by payor type, with lower early initiation among Medicaid births compared to private insurance births.

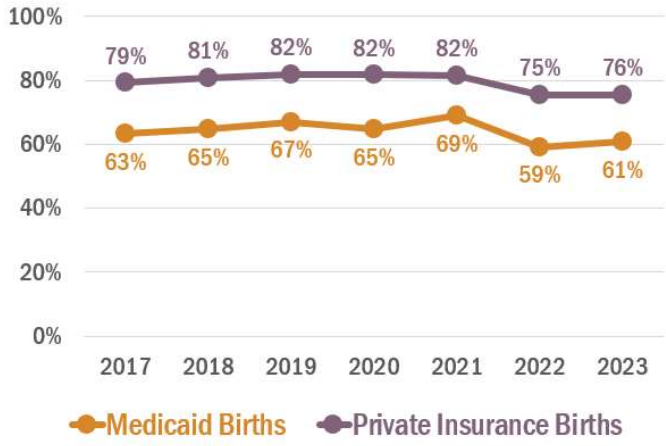


Figure 9. Among Clark County residents in 2023, prenatal care was initiated in the first trimester in 69% of births and varied by payor type – private insurance (76%) vs. Medicaid (61%). Among Medicaid births in 2023, Native Hawaiian/Pacific Islander (40%) and American Indian/Alaskan Native (49%) birth parents have the lowest rates of early prenatal care initiation (first trimester).

		1st trimester		2nd trimester		3rd trimester		No prenatal care	
Private insurance births		2,099	76%	609	22%	58	2%	12	0.4%
All births in Clark County		3,297	69%	1,223	26%	171	4%	67	1%
Medicaid births		1,064	61%	551	31%	97	6%	38	2%
Medicaid births by race/ethnicity	Asian	47	73%	12	19%	<10	--	<10	--
	White	869	63%	418	30%	65	5%	25	2%
	Black	55	63%	25	29%	<10	--	<10	--
	Hispanic	283	63%	144	32%	17	4%	<10	--
	AIAN	23	49%	16	34%	<10	--	<10	--
	NH/PI	51	40%	49	38%	20	16%	<10	--

Note: Race/ethnicity categories are not mutually exclusive. Data include birthing parents who reported a single race as well as those who reported more than one race.

POLICY AND SYSTEM ACTIONS

The challenges pregnant individuals experience accessing prenatal care in Clark County are one indicator of a broader and long-standing crisis, which was officially and most recently recognized in 2022 at the federal level in the White House Blueprint for Addressing the Maternal Health Crisis.

In Washington state, several foundational plans include goals and recommended actions to address the crisis, including addressing barriers to access along a spectrum of the social and political factors that influence the opportunities for retaining high-quality, culturally congruent and affordable prenatal care. These documents include the 10-Year Plan to Dismantle Poverty in Washington, the Washington State Board of Health 2024 State Health Report, and findings of the statewide maternal mortality review panel (MMRP) published in the 2023 MMRP report.

The following tables outline recommended activities by key actors in Clark County. Each activity is matched to state and federal priorities as recommended in the above-mentioned documents/plans.

- **Public Health** (local government)
- **Legislators and Policymakers** (local, state, and federal elected officials)
- **Health care providers and facilities** (e.g., hospitals, clinics, managed care organizations, physicians, nurses, etc.)
- **Community-based organizations** and other community-serving agencies (nonprofits, social services, other local government, workforce and education, academia)

State/Federal Alignment Key:

WA-MMRP =	Washington State Maternal Mortality Review Panel Report
WA-BP =	Dismantling Poverty in Washington Blueprint
SBOH =	Washington State Board of Health State Health Report
US-BP =	White House Blueprint for Addressing the Maternal Health Crisis

Table 1: Clark County Public Health

Local health jurisdictions provide core services, known as foundational public health services (FPHS), as part of the broader governmental public health system in Washington state. The following recommended activities align with foundational capabilities and programs local health jurisdictions maintain or, in some instances, are additional important services provided by local public health in many communities. All activities align with state and/or federal goals and recommendations to improve access to prenatal care.

Recommendation #1: Improve data collection, quality and use in order to provide timely, locally relevant, and accurate information.	
• Provide guidance and training to individuals responsible for birth certificate registration in local hospitals and birthing centers. (FPHS) • Produce timely and locally relevant information and data reports on adequacy of prenatal care access and maternal health trends. (FPHS) • Explore new data sources, identify new uses of data, develop data sharing agreements to produce a fuller picture of prenatal care access (e.g., health care claims data sets). (FPHS) • Gather pregnant and birthing individuals' stories to center their voices in decision making, and to elevate experiences of racism, discrimination, bias and stigma to address them in the prenatal care setting. (US-BP #2) • Inform decision makers of potential and actual impacts to maternal, child and family health and contributing factors based on data and published reports, and discuss improvement recommendations including policy, system and environmental change initiatives to protect and improve health equity. (FPHS) • Measure and evaluate lessons and application of trainings about undoing racism, discrimination and bias in perinatal (before and after birth) care. (WA-MMRP 1.12) • Analyze access to paid family medical leave and local disparities in its usage. (WA-MMRP 5.14)	**State/Federal Alignment*** US-BP Goal #2, 3 WA-MMRP #1, 3, 5
Recommendation #2: Develop culturally and linguistically appropriate health care support services before, during and after pregnancy.	
• Expand access to and increase awareness of home visiting programs for pregnant persons. (WA-MMRP 2.18, 3.1)	**State/Federal Alignment*** US-BP #1

• Engage and support diverse community members and other partners to develop and implement prioritized plans for addressing prenatal care access barriers. (FPHS) • Work with partners to advocate for high priority policy, system and environmental change initiatives to improve prenatal care access and seek funding to implement and evaluate innovations. (FPHS) • Increase awareness about Medicaid eligibility, terms, types of health services available, and provider options during pregnancy. (WA-MMRP 3.12)	SBOH #3 WA-BP #4b WA-MMRP #2, 3

Table 2: Legislators and Policymakers

Legislators and policymakers play a key role in maternal health by creating law and regulations as well as funding initiatives that aim to improve access, quality and cultural congruency of prenatal care. It is critical that elected officials collaborate with impacted pregnant individuals, public health, health care providers and regulators, and community organizations to create a policy environment that is supportive, rather than burdensome, for pregnant individuals in Clark County.

Recommendation #3: Fund workforce expansion and perinatal quality efforts.	
• Fund training, education pathways, scholarships, grants, low-interest education loans, and reimbursement to train new perinatal care providers and patient advocates to expand and diversify the perinatal workforce. (WA-MMRP 1.1) • Fund culturally competent care, including community health workforce and value-based payment models that focus more on outcomes than on number of services delivered; fund increased access to out-of-hospital birthing care such as midwifery and doula services (e.g., funding for free-standing birth centers, rate increases for midwives, etc.); fund interpreter services, including services in a wider variety of languages. (WA-MMRP 1.2) • Expand access to home visiting services for pregnant and postpartum families through funding culturally relevant programs and long-term case management, exploring expansion of Medicaid reimbursement for home visiting (WA-MMRP 3.1) and fairly compensated reimbursement for the community-based workforce, such as community health workers. (SBOH #3) • Legislate perinatal quality improvement (QI) incentive programs (WA-MMRP 4.1) and support funding to implement QI initiatives, programs and organizations. (WA-MMRP 4.2)	**State/Federal Alignment*** WA-MMRP #1, 3, 4 US-BP #1, 4 SBOH #3 WA-BP 4b
Recommendation #4: Fund efforts to improve data collection, quality and use.	

• Fund efforts to help smaller perinatal care facilities and practices share records with other health care systems through electronic health record systems. (WA-MMRP 3.5) • Address issues with significantly delayed identification of pregnant people on Apple Health through increased reimbursement for initiative obstetric visit, and un-bundling pregnancy care. (2024 HCA Budget Request)	**State/Federal Alignment*** US-BP Goal #3 WA-MMRP #3
Recommendation #5: Fund efforts to meet the basic needs of pregnant people.	
• Streamline processes so that pregnant and parenting people can easily access social programs and supportive services for health care, housing, transportation, nutrition, employment, child care and education by funding programs like Help Me Grow and care navigators. (WA-MMRP 5.3) • Pilot a guaranteed basic income program for the perinatal period. (WA-MMRP 5.4)	**State/Federal Alignment*** WA-MMRP #5 US-BP #5 WA-BP 6d
Recommendation #6: Restructure and modernize the perinatal health care reimbursement system, remove barriers to care.	
• Fund value-based payment models that focus more on outcomes than on number of services delivered. (WA-MMRP 1.2) • Explore expansion of Medicaid reimbursement for home visiting. (WA-MMRP 3.1) • Enhance reimbursement rates for mental health and substance use disorder screening in pregnancy. (WA-MMRP 2.1) • Ensure compliance with network adequacy contracted requirements for perinatal care. • Enhance language accessibility in Washington by establishing a specialized Office of Language Access and a permanent public advisory body to increase language access in health care at the state level. (SBOH #3 – references State Language Access Workgroup recommendations)	**State/Federal Alignment*** US-BP #1 SBOH #2, 3 WA-BP 4b WA-BP 5g

Table 3: Health care providers and facilities

According to the Washington State Maternal Mortality Review Panel analysis of pregnancy related deaths between 2017-2020 in the state, "**80% might have been prevented by 'increased clinical skill and quality of care'"**.[10] It is incumbent on all actors in the health care system to ensure

high-quality, culturally congruent care is provided, regardless of payor source and complexity of client need.

Recommendation #7: Improve quality of care for pregnant individuals.	
• Co-locate services for prenatal, primary, obstetric, substance use, behavioral health, and well-child care, for example by offering prenatal care at substance use treatment clinics. Ensure care navigation and coordination is available for co-located services. Integrate services if needed using telehealth. (WA-MMRP 2.16) • Reduce barriers to care by offering telehealth, extended hours, and walk-in appointments for prenatal care. (WA-MMRP 3.9) • Ensure patients are aware of the full spectrum of benefits under Medicaid, including transportation, care coordination, and doula services. (WA-MMRP 3.10) • Ensure pregnant patients of all body sizes and weights get appropriate and respectful care, including access to adequate equipment and consultations as needed. (WA-MMRP 4.13) • Fund services to provide patients child care during appointments and transportation to appointments. (WA-MMRP 5.6) • Increase availability of care coordination to screen patients for social determinants of health and connect them with appropriate social services, such as transportation, housing, child care, etc. (WA-MMRP 5.7) • Implement perinatal quality improvement initiatives with a focus on health equity and culturally competent care (see Recommendation #8 for examples). (WA-MMRP 1.4) • Monitor, ensure and enforce network adequacy for perinatal care for the Medicaid population.	**State/Federal Alignment*** WA-MMRP #1-5 US-BP #1 SBOH #2 WA-BP #4
Recommendation #8: Address health inequities through provision of culturally competent (congruent) care.	
• Track data on racial disparities in all maternal outcomes as part of quality improvement initiatives. (WA-MMRP 1.5) • Ensure access to certified medical interpreters proficient in medical technology. (WA-MMRP 1.7 and Title VI of the Civil Rights Act and the Americans with Disabilities Act) • Offer evidence-based training to providers and staff around bias in care, stigma, racism, social determinants of health, trauma-informed care, and cultural needs, norms and preferences of communities served. (WA-MMRP 1.6) prioritize CEU/CMEs on these topics (1.9) • Ensure that doulas are available to all birthing people who would like doula services, offered by culturally appropriate providers from the same community as the birthing person, and integrated into the entire perinatal period and related care. (WA-MMRP 3.8)	**State/Federal Alignment*** WA-MMRP #1, 3 US-BP #3, 4 SBOH #3

Table 4: Local community-based organizations

Community-based organizations and social service agencies are on the front lines, working with families and witnessing the strengths and opportunities within systems intended to support pregnant individuals in Clark County. Their partnership and continued efforts to address systemic barriers through policy advocacy, client education, and funding are critical to addressing the maternal health crisis.

Recommendation #9: Advocate, fund, and/or implement efforts to diversify the perinatal workforce, and train the existing one.	
• Support and fund initiatives that lead to the diversification of the perinatal provider workforce to be representative of the demographics of the Clark County Medicaid population, including mentorship programs, student loan repayments and stipends, incentives to midwifery students, coverage of licensing exam fees, etc. (WA-MMRP 1.11) • Provide education and resources about undoing racism, discrimination and bias in perinatal care, measure and evaluate lessons and application of trainings. (WA-MMRP 1.12)	**State/Federal Alignment*** WA-MMRP - #1 SBOH #3
Recommendation #10: Connect pregnant people to supportive services and programs.	
• Increase awareness about Medicaid eligibility, terms, types of health services available, and provider options during pregnancy. (WA-MMRP 3.12) • Strengthen care coordination systems that connect pregnant patients to appropriate, culturally relevant social supports, navigators and other services options; increase availability and funding for social supports for pregnant persons in the community. (WA-MMRP 5.11) • Promote access for pregnant people to publicly available resources including housing, food, transportation and economic opportunity. Within housing programs, ensure the needs of pregnant and postpartum individuals are prioritized. (WA-MMRP 5.13) • Promote access to Washington's Paid Family Medical Leave among populations who disparately under-utilize the program in Clark County. (WA-MMRP 5.14)	**State/Federal Alignment*** WA-MMRP 3, 5 WA-BP 5c

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Clark County Public Health *collaborates with partners to protect and improve the health of and the environment for all people in Clark County. Together we prevent disease and injury, promote healthier choices, protect food, water, soil and air, and prepare for and respond to emergencies. Visit us here: https://clark.wa.gov/public-health*

The ***Health Assessment and Evaluation Team (HAE****) at Clark County Public Health works to develop a comprehensive understanding of health in our community and to translate data into action. Visit us here: https://clark.wa.gov/public-health/health-assessment-and-evaluation*

The ***Lifecourse Team*** *at Clark County Public Health works to identify policies and implement systems change to improve community health and wellbeing. Lifecourse Theory suggests that each life stage influences the next, and together the social, economic, and physical environments in which we live have a profound influence on our health and the health of our community. Visit us here: https://clark.wa.gov/public-health/raising-clark-county*

Contact us: *RaisingClarkCounty@clark.wa.gov*

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APPENDIX – FACILITY & MISSING DATA

Table 1: Births by Facility and payor, Clark County 2023

Facility	All Births	Medicaid Births	Private Insurance Births
Legacy Salmon Creek	53%	56%	54%
PeaceHealth Southwest	30%	34%	28%
Out of State	11%	6%	15%
Home	3%	2%	1%
Birth Center	1%	1%	1%
PeaceHealth St John	<1%	<1%	<1%

Table 2: Percent of births missing prenatal care data by hospital facility and payor, Clark County 2023

	All Births	Medicaid Births	Private Insurance Births
Legacy Salmon Creek	16%	19%	14%
PeaceHealth Southwest	11%	11%	10%

Table 3: Percent of births missing prenatal care data by race/ethnicity and payor, Clark County 2023

Maternal race/ethnicity	All Births	Medicaid Births	Private Insurance Births
NH/PI	26%	29%	12%
Native American	20%	26%	15%
Black	14%	18%	11%
Hispanic	14%	18%	8%
White	14%	16%	12%
Asian	13%	16%	13%