Women's Policy Education Fund Issue Paper

Is Georgia's Commitment to Healthy Childbearing Flagging?
Enhanced Family Planning Services May Be an Answer

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Introduction

Four essential elements of healthy childbearing are: family planning, to avoid unintended pregnancy and maintain good reproductive health; preconception care to assure optimal health for pregnancy; timely prenatal care; and early identification of potential issues and linkage to services for infants. Ideally, these elements would form a continuum of care throughout one's reproductive years. This paper will focus on the importance of preconception health, the role family planning services can play in providing an early entree into this continuum of care, and how Georgia can expand the availability of family planning services to improve maternal and infant health.

In the year 2007, it is dismaying to realize how little progress this nation has made toward improving pregnancy outcomes. Here in Georgia, while infant mortality is itself down from 1990, little progress has been made since the 1999, when the rate reached a low of 8.2 per thousand live births. It has since stagnated, and even crept back up to 8.5. Other measures of infant health show similar trends: improvement in the 1990's, but stagnation or even worsening since then. The percentage of babies born at low birth weight stayed steady through the 1990's at around 8.7%, but has risen since 2000 so that by 2004, it stood at 9.3%. Likewise, the percentage of preterm births was 12.8% in 1990. It decreased to as low as 11.4% in 1996, but has risen slowly but steadily back to 12.8% in 2004.[1]

Of great concern as well is the persistence of racial disparities in all of these numbers, underscored by the fact that black infant mortality is twice the rate of white infants.[2] This overall lack of progress is in spite of the positive trend in the number of women receiving prenatal care, although after improving throughout the 1990's that number has fallen again since 2001. Even so, only 4% of women in Georgia receive late or no prenatal care during pregnancy.[3] Further, findings of the Georgia Mortality Surveillance System show that the maternal mortality

[1] KIDS COUNT State Level Data On Line, Georgia Profile, 2006, Annie E. Casey Foundation. Found at www.kidscount.org.

[2] Kahn, EB; Thompson, DL; Alexander, NT and Carter, JT, *Reproductive Health Indicators Report, 1994-2004*, Georgia Department of Human Resources, Division of Public Health, Division of Public Health, Epidemiology Branch, Maternal and Child Health Section, February, 2006.

[3] KIDS COUNT State Level Data On Line, Georgia Profile, 2006.

rate in Georgia remains twice as high as the national average, at 21 deaths per 100,000. The findings also show that black women are three times more likely to die from a pregnancy-related death as white women.

The benefits of prenatal care and its impact on pregnancy outcomes are undisputed. Much attention has been paid to ensuring greater access to prenatal care for all women through private insurance, raising income eligibility for pregnancy care under Medicaid, and other programs for women who are not Medicaid eligible. While in recent years the percentage of pregnant women receiving late or no prenatal care has inched up[4], there is little argument as to the wisdom of providing such access, and nationally and locally, much has been accomplished toward making prenatal care the norm.[5] Improvements should still be made, of course, by expanding Medicaid access to higher income eligibility[6] and expanding programs aimed at those ineligible for Medicaid, to allow the ever-growing number of uninsured women to receive prenatal care as early as possible.

On the other hand, for a long time, preconception health care was not sufficiently promoted as a component of maternal and infant health. And family planning services as a context in which to provide preconception health care even less so. As will be discussed below, even the best prenatal care generally starts too late into pregnancy to provide the tools to prevent some of the most common, and preventable, risks to maternal and infant health. Unless we make a concerted effort to emphasize preconception health care, the opportunity to address many of these risks and thereby improve pregnancy outcomes, will continue to be lost.

Family Planning and its Potential Role in Improving Pregnancy Outcomes

Much more than simply birth control, the term "family planning services" refers to a cluster of services which includes contraception counseling and supplies, sexually transmitted disease and cancer screenings, blood pressure and diabetes screening, all aimed at ensuring overall health.

For generally healthy women of reproductive age, regardless of economic status, their family planning visit is often their only contact with the health care system. That being the case, it provides an enormously important and possibly the only opportunity to educate about healthy lifestyles counsel the benefits of planning for pregnancy, and screen for chronic conditions which may negatively impact the woman's own health and that of future children.

Family planning can positively influence birth outcomes in several ways. First, it helps women increase the interval between births, which has been shown to reduce the risk of low birth weight. Second, by reducing unintended pregnancy in favor of planned pregnancy, there is a greater likelihood of early prenatal care, and with it, an early introduction of health promoting

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[4]Ibid.

[5] Preconception Health and Care, 2006, CDC AT A GLANCE, found at http://www.cdc.gov/ncbddd/preconception/documents/At-a-glance-4-11-06.pdf .

[6] California, Minnesota, and Maryland have raised the income eligibility for pregnancy care to 300%, 275%, and 250%, respectively.

behaviors (good nutrition), and avoidance of risky ones (use of alcohol, cigarettes and drugs). Finally, family planning can improve maternal and infant health by "reducing the rate of births among high risk women or delaying conceptions until risks are reduced." [7] Thus, women with chronic diseases, or who engage in behaviors known to have adverse effects on fetal development, can delay pregnancy until such condition is properly managed or the behavior is changed.

The Growing Appreciation of the Importance of Preconception Health Care

Beginning in the 1980's, researchers began looking at preconception health – pregnancy planning – as a critical component of maternal and infant health. An Institute of Medicine report noted that planning for healthy pregnancies *before* becoming pregnant would positively impact birth outcomes.[8] The early opportunity to screen for chronic conditions likely to have an impact on fetal health, as well as to educate about healthy pregnancy behaviors, has been shown to improve pregnancy outcomes.[9]

Some preventable anomalies occur within days of the first missed period, before a woman even realizes she's pregnant. The conventional timing of the first prenatal visit (11th or twelfth week) is weeks past the critical period in which many serious anomalies occur. As noted by the Centers for Disease Control and Prevention (CDC),

> Risks factors for poor pregnancy outcomes remain prevalent among women of reproductive age. For example, 11% smoke during pregnancy, and 10% consume alcohol. Of women who could get pregnant, 69% do not take folic acid supplements, 31% are obese, and about 3% take prescription or over the counter drugs that are known teratogens. In addition, about 4% of women have preexisting medical conditions, such as diabetes, that can negatively affect pregnancy if unmanaged. All of these factors pose risk to pregnancies, but could be addressed with proper health interventions.[10]

Thus, it is when a woman *begins to think* about becoming pregnant that her attention should be focused on more specific health screenings, good nutrition and vitamin supplements, and behavioral changes such as smoking cessation. And for women who are already mothers, the benefits of adequate birth spacing may be addressed.

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[7] Klerman, Lorraine V., DrPH, Phelan, Sharon T., MD, Poole, Victoria L, RN, DSN, Goldenberg, Robert L., MD, Family Planning: An Essential Component of Prenatal Care, *Journal of American Women's Medical Association,* Vol. 50, No. 5, at 147, 149-151.

[8] Institute of Medicine, *Preventing Low Birth Weight,* Washington, DC, National Academy Press, 1985.

[9] Merry-K Moos, MPH, RN, FNP, FAAN, Preconceptional Health Promotion: Progress in Changing a Prevention Paradigm, *Journal of Perinatal and Neonatal Nursing*, Jan-March 2004.

[10] Preconception Health and Care, 2006, CDC AT A GLANCE, found at http://www.cdc.gov/ncbddd/preconception/documents/At-a-glance-4-11-06.pdf

Preconception health care can easily be incorporated into traditional family planning services, and sometimes, it is. If such was more often the case, making family planning more accessible to more women would mean more effective pregnancy prevention and better, healthier pregnancy planning. Which raises the next issue: How do we ensure more women receive preconception health care as part of their family planning services when a large number of women are not effectively planning their pregnancies?

The Problem of Unintended Pregnancy

The long-term "epidemic" of unintended pregnancy in Georgia and the nation presents a clear obstacle to increasing preconceptional health care through family planning services. The overall percentage of unintended pregnancies did not change between 1994 and 2001; 49% of pregnancies remain unintended.[11] According to data collected by the Georgia Pregnancy Risk Assessment Management System (PRAMS) Georgia's unintended pregnancy rate has been even higher, remaining over 50%.

People tend to think of unintended pregnancy as a problem among teens, however, the numbers tell a different story. Teens do indeed have among the highest rates of unintended pregnancy, but the highest numbers by far are among adult women. Over these years, the rates of unintended pregnancy fell among adolescents, college graduates, and higher income women, but rose among poor and less educated adult women.[12]

The majority of unintended pregnancies occur in women who are either not contracepting or are doing so inconsistently, making it clear that many women are not regularly accessing family planning services.[13] Unless we can provide and encourage more women to regularly use these services, we will remain unable to fully realize the benefits of including preconceptional care into family planning services.

Family Planning in Georgia

Georgia delivers most of its publicly funded family planning services through an extensive network of public health clinics, which have a presence in all of Georgia's 159 counties. These clinics provide a variety of services in addition to family planning services, and are supported with several sources of state, federal and county funds. A major source of funds for the family planning services provided is a federal program established under Title X of the Public Health Service Act, a federal program devoted to ensuring family planning services to low income women. Clinics funded with Title X dollars provide the full panoply of family planning services

[11] Finer, Lawrence B. and Henshaw, Stanley K., Disparities in Rates of Unintended Pregnancies in the United States, 1994 and 2001, *Perspectives on Reproductive and Sexual Health*, 2006 38(2): 90—96

[12] Ibid.

[13] Guttmacher Institute, *Contraception Counts: Ranking State Efforts*, February, 2006.

to women for free to women up to 100% of the federal poverty level, and on a sliding fee scale to women between 101% and 250%.[14]

According to the last full report published by the Alan Guttmacher Institute (AGI), there were 490,900 women in need of publicly funded family planning services in Georgia.[15] AGI defines "women in need" as those who are fertile, sexually active and not seeking to become pregnant, and have incomes below 250% of the federal poverty level, or are sexually active teenagers. Of these 490,900, 199,840 received services at one of Georgia's 338 publicly funded family planning clinics, resulting in only 41% of the women in need being served in 2001.[16]

Recent data from AGI show an even greater number (522,940) of women in need.[17] The Department of Human Resources (DHR) reports a lower number of women served in recent years, reducing even further the percentage of women in need receiving publicly funded services.[18] Thus the problem of unintended pregnancy is unlikely to improve without employing new strategies aimed at increasing the number of women served. And unless we increase the number of women served by family planning providers, we will not likely see a great improvement in pregnancy outcomes.

Previous Initiatives to Expand Access to Family Planning in Georgia

In the mid-late 90's, there was an increased commitment to making the use of family planning and prenatal care more prevalent, both to reduce unintended pregnancy and to improve birth outcomes. In making policy around welfare reform, in addition to what many felt were punitive policies, then-Governor Zell Miller proposed initiatives to reduce unintended pregnancy among adults and teens. Using a mix of federal Title X and Temporary Assistance to Needy Families (TANF) and state funds, he proposed and the state established a youth development program model called Teen Plus. Through Teen Plus, the Department of Human Resources (DHR) set up 39 teen clinics which provided comprehensive youth development and health services, including contraceptive counseling and supplies.

Additionally for TANF recipients, family planning counseling became mandatory, and the family cap was introduced. But at the same time, the state sought to make family planning services more accessible to adults, both TANF recipients and potential TANF recipients, by increasing funding for services at public health clinics (thus addressing a chronic shortage of

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[14] National Family Planning and Reproductive Health Association, Title X Fact Sheet, May 2007, found at http://www.nfprha.org/site/c.ggLRIWODKtF/b.944085/k.720A/Reproductive_Health_Info.htm

[15] Guttmacher Institute, *Contraception Counts: Georgia,* Guttmacher Institute, 3/2006, found at http://www.guttmacher.org/pubs/state_data/states/georgia.html.

[16] Ibid.

[17] Guttmacher Institute, *Contraceptive Needs and Services*, found at http://www.guttmacher.org/pubs/win/index.html.

[18] The Department of Human Resources Family Planning Program Fact Sheet shows that in FY 2006, 167,949 women were served by Georgia's family planning clinics.

supplies midway through the year) and through the establishment of non-traditional clinics at more accessible locations and hours.

Similarly, access to pregnancy care was expanded when income eligibility for Medicaid was increased to match PeachCare eligibility levels (235% of the Federal Poverty Level, or FPL), thus allowing continuity of care throughout pregnancy and childbirth and then health care for the child. This expansion supplemented other prenatal care programs such as Babies Born Healthy and High Risk Pregnancy care.

Georgia's Earlier Attempt at a Family Planning Waiver

In 2000, Georgia attempted to enhance its Medicaid program with interconceptional family planning at the increased income eligibility, providing services for two years following a Medicaid birth. Standard Medicaid pregnancy care includes family planning services for 60 days following a Medicaid birth. In order to encourage greater use of such services, the Medicaid matching rate has been set very high, at 90%, rather than the usual 50-77% match for other health services. In the last 10-15 years, states began seeking and obtaining research and demonstration waivers from the federal Medicaid agency (Center for Medicaid Services, or CMS) to allow them to provide family planning services to women based on a higher income eligibility than their standard programs would allow, and to do so at the enhanced match rate.[19]

These Medicaid family planning waivers had been successfully implemented in several states, proving to be not only budget neutral, as required, but showing a sizable savings, even with the enhanced matching rate.[20] Georgia (reasonably) anticipated approval for its waiver application, added the 10% match into the FY 2001 budget, and implemented the services in July, 2000.

Timing proved to be against the state, however. When President Bush took office, administration officials adopted a policy against family planning waivers. In the summer of 2001, CMS told DCH that its 1115 waiver proposal would not be approved. Publicly, the administration claimed that they were against the notion of "single service waivers." Many suspected that the new administration did not want to be seen as funding expanded access to family planning.[21] CMS told Georgia officials that a condition of the family planning waiver would be a commitment to provide primary care to all waiver clients. The verbal denial prompted the state to discontinue family planning services to over 43,000 women who had been eligible for waiver services following a Medicaid birth.

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[19] Henry J. Kaiser Foundation and Alan Guttmacher Institute, ISSUE BRIEF, Medicaid*: A Critical Source of Support for Family Planning in the United State*s, found at http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf.

[20]Guttmacher Institute, *.Medicaid Family Planning Expansions Hit Stride*, Issues in Brief, 2004 Series, No.1.

[21] Administration's New Medicaid Rules Could Limit Family Planning**,** *Guttmacher Report on Public Policy*, August, 2001, Vol. 4, No. 4.

Over the next few months, CMS amended its position stating instead that family planning waiver programs must ensure primary care services to waiver clients by establishing "formal arrangements with community health centers to provide primary care services."[22] Nevertheless, Georgia withdrew its application in early 2002, stating that the new requirement of facilitating access to primary care services for waiver clients was not feasible.

Since this time, however, several states have successfully obtained family planning waivers so that as of September, 2007, 26 states are functioning under a waiver. Nineteen states have income-based waivers, meaning that women are eligible solely on the basis of an elevated income level, often matching the higher level used to determine pregnancy care. Seven states have waivers similar to that applied for by Georgia, providing services to women following a Medicaid birth at the same income level as that which qualified them for pregnancy care.[23]

As the body of research into the efficacy of waiver programs grows, there is no question but that these programs are a resounding success both in lowering birth rates and saving public funds which would have been spent on the averted pregnancies. The broad, income based programs appeared to be having the most significant impact.

A Changing Emphasis on the State Level: Georgia's Flagging Commitment

In the last few years, publicly funded family planning has struggled in Georgia. Political support has waned; some of the Teen Centers have closed or no longer provide clinical services as they did early on, and the rise of abstinence education has modified the focus of many teen pregnancy prevention programs. Beginning in FY 2004, after years of modest increases, less state money was appropriated for family planning services. State family planning clinics are serving less women, not because the need is not there, but because of funding shortages, and a shortage of nurses to staff the clinics (related to the funding shortages).

And despite the success in recent family planning waiver programs, there has been thus far little interest on the part of state leaders to again seek a waiver. It is time for that to change. The potential benefits to be gained through implementation of a broad family planning expansion are too great to be ignored.

Why Georgia Should Renew its Effort to Obtain a Family Planning Waiver

- It makes financial sense. Even with the enhanced 90% match, all waiver programs have lowered birth rates and saved federal and state dollars.[24] This is of course not surprising. For women who would be eligible for Medicaid prenatal and delivery care and whose children would be covered by Medicaid, the cost of family planning services is certainly

[22] Gold, R., Administration Softens Its Stance on Medicaid Family Planning Waivers, *Guttmacher Report on Public Policy,* October, 2001, Vol. 4, No. 5.

[23] Guttmacher Institute, *State Policies in Brief,* State Medicaid Family Planning Expansions, Sept. 2007 found at http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

[24] Gold, Rachel Benson, Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort, *Guttmacher Policy Review*, Vol. 10, Num. 2, Spring, 2007, P. 13-14.

less than the cost of an unintended pregnancy. Every dollar spent on publicly funded family planning saves $3 in Medicaid funds for prenatal and newborn care.[25]

- Increasing the amount of Medicaid dollars used for family planning would "free up" funds currently used for direct services. While Medicaid family planning dollars must be used strictly for direct services to Medicaid eligible women, other funds such as Title X family planning dollars are more flexible. Other funds could be used to supplement staffing, for upgrading clinic sites and other infrastructure needs, and enlarging the array of birth control methods offered. Perhaps most importantly, funds could be used to enhance outreach efforts to increase the number of women seeking services. Efforts could be tailored to reach traditionally underserved communities, and more effectively address the persistent racial disparities in pregnancy outcomes, and in overall health. With additional funds for outreach, Georgia could reverse the downward trend in the number of women seen at the public health clinics. This, combined with the number of women receiving waiver services, could eventually vastly increase the percentage of women in need served. Of course, the success of this approach is dependent upon the state *maintaining* the current spending on family planning, and not supplanting such funds with Medicaid dollars upon approval of a waiver.[26]

- For every additional woman receiving family planning services, there is an opportunity to provide preconceptional care, allowing counseling about healthy choices that will positively impact her if and when she becomes pregnant, and throughout her life. Regular family planning visits provide an unparalleled platform for promoting good health practices and for early detection of potential problems for both mother and infant. This in turn will reduce both the financial and human cost of complications in pregnancy and childbirth.

Conclusion

As noted above, in looking at various indicators of infant health, one can see that by some significant measures, disturbingly little progress has been made. It is time for a change of course. Family planning services, with an emphasis on pre/interconceptional care, may provide a way to see real improvement in these indicators, as well as the overall health of women.

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[25] Guttmacher Institute, *Contraceptive Services*, Facts In Brief, , March, 2005, citing earlier research.

[26] For an excellent discussion of the opportunities to leverage Title X and Medicaid dollars to boost states' family planning programs, *see* Gold, Rachel Benson, Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort, *Guttmacher Policy Review,* Spring, 2007, Vol. 10, No. 2.

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There is an excellent body of work which makes the case for changing the way we look at women's reproductive health care; to move from a compartmentalized system that changes with each phase of women's lives, to a continuum beginning with family planning, and including preconception health care, prenatal care and interconceptional health care for those who choose parenthood. The CDC, the Georgia Division of Public Health, and non-governmental agencies such as the March of Dimes have all developed comprehensive, research based materials on the value of preconception health care, and recommendations both to providers and to the public about achieving good preconception health.

The challenge that remains is to dramatically expand access to family planning services, and to promote the understanding that is far more than contraception; that it is our best opportunity to bring women into a web of services that will serve them throughout their reproductive lives, helping them prevent unwanted pregnancy, plan for healthy pregnancy and their own long term health, and allow them to provide their babies with the best possible start in life.