

Planning for Healthy Babies Program Concept Paper

Overview

The Planning for Healthy Babies Program (P4HB) is an 1115 Demonstration Waiver Program borne out of Georgia's desire to reduce its low birth weight rate (birth weight less than 2500 grams).

In April of 2009, the Georgia Department of Community Health, in collaboration with numerous community and agency partners, initiated the Improving Birth Outcomes Workgroup and embarked on a bold initiative to reduce Georgia's low birth weight rate from 9.5% to 8.6% over a five year time span. The number of low birth weight babies in Georgia climbed between 2003 and 2007 from 12,205 to 14,351. The number of very low birth weight babies increased from 2,387 to 2,780 though this number as a percentage of total births remained unchanged at 1.8%.

Based on 2006 birth data (Georgia's low birth weight rate of 9.6%), the Kaiser Family Foundation ranked Georgia as 45th in the nation (out of 51 – DC was ranked equivalent to a state) in the number of births of low birth weight and 44th in the nation (out of 51) in the births of low birth weight as a percentage of total births. Several southwest Georgia counties have low birth weight percentages of total births ranging from 14.9% to 22.5%. Of additional concern is the persistence of racial disparities in Georgia's low birth weight (LBW) rates. African American (AA) women in Georgia have a low birth weight rate that is twice that of white women (in 2007 – AA = 14.0, White = 7.1; 2006 – AA = 14.4, White = 7.1) and a very low birth weight (birth weight less than 1500 grams) rate that is three to four times the very low birth weight (VLBW) rate of white women.

Drs. Alfred Brann of the Emory University Woodruff Health Sciences Center and Brian McCarthy of the Centers for Disease Control and Prevention presented results of their ongoing birth outcomes research in November 2009 to Georgia's Perinatal Center Directors. Their findings include:

- Georgia's infant mortality declined by 50% from 1975 to 1996, primarily due to improved survival of low birth weight infants.
- The largest contributor to Georgia's infant mortality rate is the birth of LBW and VLBW infants.
- Births of VLBW infants are approximately 2% of all births but account for 50% of all infant deaths.
- Survival of VLBW infants has significantly improved in the last 25 years, but the prevalence of cerebral palsy has not changed.
- No obstetrical or prenatal assessment or intervention has been successful in predicting or preventing a woman's first preterm/LBW delivery
- The single best predictor of a preterm/VLBW infant is a history of a previous preterm/VLBW delivery

- For women who have had a VLBW delivery:
 - There is a substantial prevalence of unrecognized and/or poorly managed chronic diseases
 - Reproductive tract infections, iron-deficiency anemia, and substance abuse are common following a VLBW delivery
 - The receipt of health care services for themselves is less of a priority than is securing income/employment, and this influences their health care seeking behaviors
- A review of the costs of initial (delivery) hospitalization for 10 live born infants less than 2500 grams conceived within 18 months of a VLBW delivery revealed:
 - Birth weight range: 730 – 2430 grams (mean weight of 1733 grams)
 - Initial hospitalization : 2 – 137 days (mean stay of 29.9 days)
 - Cost of initial (delivery) hospitalization per live born infant less than 2500 grams of \$55,576

The March of Dimes has identified two main reasons why a baby may be born with low birth weight:

1. Prematurity – babies born before 37 completed weeks of pregnancy. Preterm labor frequently results in the birth of a premature, low-birth weight baby and about 67% of low birth weight babies are premature.
2. Fetal growth restriction – babies may be full term, but underweight as a result of their parents being smaller than average or an intrauterine event or insult that halted their growth.

The following factors may contribute to premature births:

- Chronic health problems in the mother
- Smoking
- Inadequate weight gain during pregnancy
- Infections in the mother
- Socioeconomic factors such as low income, lack of education and race – black women, women under 17 and over 35 are at increased risk.

While there is no single solution to low birth weights, research has shown that the following recommendations may reduce the incidence of low birth weight. These recommendations include:

- Preconception health services that allow screening for health problems including infections, control of chronic health conditions, and discussions on health habits and nutrition. Pregnancy is often too late to initiate preventive care for a mother who has previously delivered a very low birth weight infant.
- Family Planning
 - In February 2009, a Guttmacher Institute Study report contained the following statement, “Six in 10 women who get care at a family planning center, including three out of four who are poor, consider the center to be

their usual source of health care.” Rachel Benson Gold, the study’s lead author further stated “many low-income women get their basic health care for the year during an annual visit to a family planning center. The package of services they receive not only includes contraceptive counseling and the provision of a contraceptive method. It also includes pelvic and breast exams, tests for HIV and other sexually transmitted infections (STIs), screenings for reproductive cancers, high blood pressure and diabetes, and referrals to other health providers when necessary. This is essential, preventive health care for disadvantaged women.”

- Child Spacing
 - Multiple influences impact low birth weight including the needs for early identification and management of high risk conditions in women before pregnancy and reproductive planning to increase wanted and adequately spaced pregnancies. Research shows that the lowest risks for adverse perinatal outcomes are infants conceived 19 – 23 months after a previous live birth. Numerous sources affirm that reducing unintended pregnancy begins by increasing access to family planning services.
- Early prenatal care that allows the health care provider to identify and treat problems early. Unfortunately, even the best prenatal care starts too late into pregnancy to provide the tools to prevent some of the most common and preventable risks to women and infants.
 - A March/April 1997 *Family Planning Perspectives* article reported that ambivalence toward pregnancy is a barrier to early and continuous prenatal care. Women with a mistimed or unwanted pregnancy are less likely than those with a wanted pregnancy to initiate early prenatal care and to make an adequate number of visits.
- Nutrition programs that encourage a healthy diet and folic acid supplementation. When 400 micrograms of folic acid are taken daily before and early in pregnancy, serious birth defects involving the brain and spine are prevented. When taken throughout pregnancy, folic acid may help reduce the risk of prematurity and low birth weight.
- Health education on the needs of pregnant women.

Implementation of the Planning for Healthy Babies (P4HB) program will impact Georgia in a number of areas. First, it will provide pre-conception health care and family planning to low-income women thereby influencing Georgia’s low birth weight rate. Second, by providing contraceptive services to women who would become eligible for Medicaid if they experienced an unintended pregnancy, the P4HB program will generate substantial cost savings for Georgia. A February 2009 Guttmacher Institute news release stated that “avoiding the significant costs associated with these unintended births saves taxpayers \$4 for every \$1 spent on family planning.” Guttmacher Institute researchers have determined that the most cost-effective approach for family planning is to establish parity between the income ceiling a state uses to determine eligibility for Medicaid-funded pregnancy-

related care and the state's income ceiling for family planning. In 2006, the Institute concluded that if this approach was instituted nationwide, it would save \$1.5 billion in federal and state dollars annually by the third year, while reducing unintended pregnancy rates in the US by 15%.

Program Goals

- Primary: Reduce Georgia's low birth weight and very low birth weight rates
- Secondary: Reduce the number of unintended pregnancies in Georgia
- Tertiary: Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Program Objectives

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the five year term of the demonstration.
- Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women
- Decrease late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the project, thereby reducing annual pregnancy-related expenditures.
- Increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women
- Increase consistent use of contraceptive methods by incorporating care coordination and patient-directed counseling into family planning visits
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them.
- Estimate the overall savings in Medicaid spending attributable to this project.

Current Situation

Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200 percent of the FPL. These women are eligible for family planning services through the end of the month in which the 60th postpartum day falls. After 60 days, women whose incomes exceed the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning.

Proposed Program

The Georgia Department of Community Health Division of Medicaid is requesting a waiver from the Health Care Financing Administration to: extend eligibility for family planning services to women aged 18 - 44 years who are at or below 200 % of the most current FPL; and provide inter-pregnancy care to women at or below 200% of poverty who have previously delivered a very low birth weight baby. If approved, this waiver would begin in January 2011 and end in December 31, 2015.

Family Planning Services include medically necessary services and supplies related to birth control and pregnancy prevention. Services include contraceptive management with a variety of methods, patient education, counseling and referral as needed to other social services and health care providers. Inter-pregnancy care includes primary care and primary care case management (including Resource Mother's outreach) from delivery of a very low birth weight infant until conception of the next infant (as long as the woman remains eligible for waiver services) with the goal of delaying conception for 18 to 23 months from conception of the index very low birth weight infant.

Women enrolled in the demonstration project would be eligible for all family planning services covered by the Georgia Medicaid Program (See attached Table for a description of services and costs). This expanded eligibility will: increase access to family planning services by permitting women to use private health care providers as well as county health departments and community health centers; and reinforce the medical home concept by allowing women to choose their delivering physician or prenatal care provider as their family planning provider.

Enrollment

Georgia women who meet the eligibility requirements for the P4HB program will be enrolled through the DCH Enrollment Process administered by the Georgia Department of Human Services. Point of service enrollment will not be utilized. Pregnant women enrolled in the Right from the Start (RSM) Medicaid Program will have facilitated enrollment into the P4HB program upon termination of their RSM eligibility. They must provide proof of continued income eligibility to DCH's enrollment broker. Eligible members will be provided with a membership card that identifies their affiliation with the P4HB program.

Family Planning Provider Network

P4HB program participants will be allowed to select a care management organization (CMO) with its affiliated provider network to provide the family planning and inter-pregnancy care services. Specifically, women enrolled in the Inter-pregnancy care program will have access to the CMO's primary care and family planning providers. Women enrolled in family planning services only will have access to the family planning

providers only. Primary care needs will be provided through referrals to federally qualified health centers, community health centers, rural health centers and public health departments.

Funding

The Georgia State Legislature appropriated \$225,000 in state funds for SFY 10 to support the start up of a Family Planning Waiver program. Sustainable funding will be sought in the 2010 Legislative Session for program implementation in January 2011 should this Demonstration Project be approved by CMS and HCFA.

Benefits and Costs

As calculated by the Georgia Health Policy Center at Georgia State University, by the fifth year following implementation of this project, it is anticipated that over 165,900 women will be enrolled in the program (out of an eligible population of 276,548) and of those enrolled, nearly eighty-three thousand (83,000) will utilize the family planning and inter-pregnancy services. This assumption is based upon the enrollment of 50% of the women losing their Medicaid eligibility after pregnancy and the implementation of an effective outreach campaign with a provider and public awareness component. Participation in the program would result in 23,994 births averted over the five years of the project. Cost savings would begin ten (10) months after project implementation and accrue over the project period, with the assumption of even distribution over each 12-month period. In Georgia, the average total cost of prenatal, delivery, newborn and first year infant costs for a term normal weight infant is approximately \$8,400 per pregnancy. The average costs for the delivery and hospital stay alone for low birth weight babies (currently 9.5% of total births in Georgia) is \$55,576 per baby.

Data

As previously stated, the estimated women eligible (18 – 44 years, uninsured, <200 FPL) to participate in the waiver program is 276,548 based on data from the Georgia Health Policy Center 2008 Georgia Population Survey.

Using information from the South Carolina Family Planning Waiver Program, it is estimated that at best, 50% of eligible women will enroll, and of those 50% that enroll, 50% will actually use services. Experience shows the first year use of services seems to vary, but is typically low – 1.5% to 20%. The program is expected to mature in three years. Dr. Dave Goodman, Maternal and Child Epidemiologist with the Georgia Division of Public Health provided estimates of the enrollment for the P4HB program. For year 1, he suggested 40% of eligible women would enroll, and 30% would use waiver services. In year 2, 45% of eligible women would enroll, and 40% would use services (18% of the total estimated.) He used 50% enrolled and 50% using services for year 3. In year 4, 55% of eligible women would enroll, and 50% would use services. By year 5, it is expected

that 60% of eligible women would enroll, and 50% would use services. These estimates assume the eligible population remains constant over time (those gaining eligibility equals those losing eligibility).

<u>Year</u>	<u>Enrolled</u>	<u>Projected to Use Services</u>	<u>% of total eligible population</u>
1	110,620	33,186	12%
2	124,447	49,779	18%
3	138,274	69,137	25%
4	152,102	76,051	27%
5	165,929	82,965	30%

The estimated number of births averted was calculated using Pregnancy Risk Assessment and Monitoring System data that defined women 18 – 44, <200% FPL who had an unwanted or mistimed pregnancy (wanted later) but were not using birth control at the time they became pregnant (n = 21,421). Using the percent of the eligible population who would use services (from the information above), the number of births potentially averted was calculated based on the percentage of births among women 18 – 44, < 200% FPL who had an unwanted or mistimed pregnancy (wanted later) but were not using birth control at the time they became pregnant.

<u>Year</u>	<u>Projected Births Averted</u>
1	2,571
2	3,856
3	5,356
4	5,784
5	6,427

The projected Fertility Rate during the project was calculated using: the number of women eligible to participate in the program; the number of estimated women who would give birth that were 18 – 44, < 200% FPL and uninsured prior to pregnancy (n = 50,503); and the potential births averted.

<u>Year</u>	<u>Projected Fertility Rate</u>
0	183 per 1,000 women (18 – 44, < 200% FPL, uninsured)
1	174 per 1,000 women (18 – 44, < 200% FPL, uninsured)
2	169 per 1,000 women (18 – 44, < 200% FPL, uninsured)
3	164 per 1,000 women (18 – 44, < 200% FPL, uninsured)
4	162 per 1,000 women (18 – 44, < 200% FPL, uninsured)
5	160 per 1,000 women (18 – 44, < 200% FPL, uninsured)

Budget Neutrality

The required CMS methodology for estimating cost effectiveness begins with calculating the base year fertility rate of women. A spreadsheet projecting annual savings following

implementation of the Planning for Healthy Babies Program is attached to this concept paper.

Quality Assurance

Quality Assurance Goals

- Family planning services are accessible and available
- Family planning care meets nationally recognized standards
- Family planning services are evaluated and revised through ongoing monitoring

Metrics

- Percent of Eligible Population Enrolled – monthly, quarterly, annually
- Number of Family Planning Providers – quarterly, annually
- Percent of Eligible Population Seen for any Waiver Service – monthly, quarterly, annually
- Percent of Enrolled Population Seen for any Waiver Service – monthly, quarterly, annually
- Percent of VLBW Waiver clients seen for any Waiver Service – monthly, quarterly, annually
- Percent of VLBW Waiver clients engaged with primary care providers and Outreach workers
- Percent of Waiver Clients Seen Primarily at County Health Departments – monthly, quarterly, annually
- Percent of Title X/Health Department Clients Covered by the Waiver - annually
- Number of Births Averted per Program participants - annually
- Percent of Expected Births Estimated to be Averted – annually
- Member and provider satisfaction surveys
- Ease of ability to collect data

Evaluation

The project's metrics will be collected and analyzed as identified above by DCH program and Performance, Quality and Outcomes staff members. Areas of strength and areas needing improvement will be identified through data review and appropriate interventions and follow up will occur with members, providers and systems as appropriate. Monitoring of interventions will occur on an ongoing basis by state office program staff. Annual reports of the results of this analysis will be disseminated to federal and state officials and shared with providers and clients as the annual report card for this project.

Budget Neutrality Calculation for the Planning for Healthy Babies Program – GA DCH

Year	Group	Pop	Births	Fertility Rates	Members enrolled	Participants	Births	Fertility Rate
0	18 - 44 yo women	276,548	21,421	0.183				
1	18 - 44 yo women				110,620	33,186	18850	0.174
2	18 - 44 yo women				124,447	49,779	17565	0.169
3	18 - 44 yo women				138,274	69,137	16065	0.164
4	18 - 44 yo women				152,102	76,051	15637	0.162
5	18 - 44 yo women				165,929	82,965	14994	0.16

	Births Averted (BA)	Proj LBW rates	LBW BA	NI wt BA	Birth Cost NI Wt	Birth Cost LBW
1	2571	9.50%	244	2327	\$8,400.00	\$55,576.00
2	3856	9.30%	359	3497	Hospital and	Hospital costs only
3	5356	9.10%	487	4869	first yr of life	Long term costs
4	5784	8.90%	515	5269		will be higher
5	6427	8.60%	553	5874		

Yearly Savings from BA	NI Births	LBW births	BA Total Savings
1	\$19,544,742.00	\$13,574,160.12	\$33,118,902.12
2	\$29,378,092.80	\$19,929,998.21	\$49,308,091.01
3	\$40,896,273.60	\$27,087,520.10	\$67,983,793.70
4	\$44,261,481.60	\$28,609,190.98	\$72,870,672.58
5	\$49,343,935.20	\$30,718,077.87	\$80,062,013.07

Yearly Budget Neutrality	90/10 Program Costs	65/35 Program Costs	Total Costs	90/10 as % of total	65/35 as % of total
1	\$26,334,881.62	\$1,509,130.03	\$27,844,011.65	95%	5%
2	\$36,826,547.86	\$2,263,695.05	\$39,090,242.91	94%	6%
3	\$49,066,508.65	\$3,143,998.16	\$52,210,506.81	94%	6%

4	\$53,438,194.50	\$3,458,411.62	\$56,896,606.12	94%	6%
5	\$57,809,247.35	\$3,772,779.60	\$61,582,026.95	94%	6%

	BA Total Savings	Total Costs	Program Savings	90/10 Savings	65/35 Savings
1	\$33,118,902.12	\$27,844,011.65	\$5,274,890.47	\$5,011,145.95	\$263,744.52
2	\$49,308,091.01	\$39,090,242.91	\$10,217,848.10	\$9,604,777.21	\$613,070.89
3	\$67,983,793.70	\$52,210,506.81	\$15,773,286.89	\$14,826,889.67	\$946,397.21
4	\$72,870,672.58	\$56,896,606.12	\$15,974,066.46	\$15,015,622.47	\$958,443.99
5	\$80,062,013.07	\$61,582,026.95	\$18,479,986.12	\$17,371,186.95	\$1,108,799.17

Yearly Budget Neutrality	Fed'I 90/10 savings	State 90/10 Savings	Fed'I 65/35 savings	State 65/35 savings
1	\$4,510,031.35	\$501,114.59	\$171,433.94	\$92,310.58
2	\$8,644,299.49	\$960,477.72	\$398,496.08	\$214,574.81
3	\$13,344,200.71	\$1,482,688.97	\$615,158.19	\$331,239.02
4	\$13,514,060.22	\$1,501,562.25	\$622,988.59	\$335,455.40
5	\$15,634,068.26	\$1,737,118.70	\$720,719.46	\$388,079.71

	Total Fed'I Savings	Total State Savings
1	\$4,681,465.29	\$593,425.18
2	\$9,042,795.57	\$1,175,052.53
3	\$13,959,358.89	\$1,813,927.99
4	\$14,137,048.81	\$1,837,017.64
5	\$16,354,787.72	\$2,125,198.40

updated 12.7.09

Year 1 Budget

Services Provided - 90/10 Match Qualified for 18 - 44 year olds YEAR 1 Budget

	Unit Costs	Number Served	Total	Federal Share	State Share
Office Visits					
Annual Comprehensive (99204)	\$110.51	33186	\$3,667,384.86		
Includes history, physical exam, pap, education and counseling					
Follow up visits (99213)	\$40.70				
Up to 4 per year	\$162.80	33186	\$5,402,680.80		
Lab Work					
Urine Pregnancy Tests (81025)	\$7.96	33186	\$264,160.56		
STD Diagnostic Tests					
Chlamydia (87491)	\$24.67	33186	\$818,698.62		
Herpes (87274)	\$15.08	33186	\$500,444.88		
Syphilis (86592) sent to state lab					
Gonorrhea (87590, 87591) sent to state lab					
HIV (86689) sent to state lab					
Contraceptives					
Male Condoms - one box of 40 x 12.5 boxes/client	\$2.88				
	\$36.00	16593	\$597,348.00		
Depo Provera Injection (J1055) x 4 annually	\$41.16				
Project 11% will use	\$164.64	3650	\$601,011.73		
IUD Insertion annually - Project 18% will use	\$62.48	5973	\$373,223.03		
IUD removal annually - Project 18% will use	\$72.99	5973	\$436,004.31		

Contraceptive Cap Insertion - Project 1% will use	\$78.21	332	\$25,954.77
Contraceptive Cap Removal - Project 1% will use	\$106.11	332	\$35,213.66
Oral Contraceptives - Project 59% will use annually	\$104.12	19580	\$2,038,642.53
Tubal Ligations (58671), plus Anesthesia (00851) \$337.15 + \$1100 estimated hospital costs			
Project 7.5% will use	\$1,437.15	2489	\$3,576,994.49

Services Provided - 90/10 Match Qualified for 18 - 44 year olds YEAR 1 Budget

	Unit Costs	Number Served	Total	Federal Share	State Share
Essure - Fallopian Tube Cannulation (58565), Medication (J1885) and 3 month post confirmation (74740) - Project 4% will use	\$1,988.83	1327	\$2,640,052.50		
Levonorgestrel - two pills Project 2.5% of 19 - 21 year olds will use	\$35.00	158	\$5,516.88		
Interpregnancy Care					
1 Office Visits for primary care, new pt (99205)	\$137.12	2500	\$342,800.00		
5 Office /outpatient visit, established pt (99213)	\$203.50	2500	\$508,750.00		
Resource Mother Outreach	\$1,800.00	2500	\$4,500,000.00		
Total Costs for services eligible for 90/10 match			\$26,334,881.62	\$23,701,393.46	\$2,633,488.16

Services Provided- 65/35 Match Qualified - for 18 - 44 year olds YEAR 1 Budget

Immunizations for women 19 - 21

Td/TdAP for 6200 women	\$10.00	6305	\$63,053.40		
HepB series for 6200 women	\$59.71	6305	\$376,491.85		
Folic Acid - annual supply	\$7.72	33186	\$256,195.92		
Complete Multivitamin with Folic Acid - annual	\$12.05	33186	\$399,891.30		
STD Treatments	\$12.46	33186	\$413,497.56		
Antibiotics including Ceftriaxone, Azithromycin, Benzathine Penicillin G, Erythromycin, Doxycycline, Metronidazole, etc					
Total Costs for services eligible for 65/35 match			\$1,509,130.03	\$980,934.52	\$528,195.51
TOTAL COSTS			\$27,844,011.65	\$24,682,327.98	\$3,161,683.67

updated 11.30.09