

The Role of North Carolina Medicaid in Women's Health and Wellness

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There are numerous opportunities for public policy to improve women's health care. Programs that promote access to comprehensive health care and support services deliver long-term cost benefits and enhance quality of life. North Carolina Medicaid collaborates with several partners across the state to address the physical, mental, and perinatal health care needs of eligible women. According to the Henry J. Kaiser Family Foundation, three-quarters of the adult Medicaid population are women. Medicaid finances 41% of all births in the US and accounts for 71% of all publicly-funded family planning services. However, in their words: "childless women without disabilities typically are never eligible no matter how poor."¹ Over the years, North Carolina Medicaid has been proactive in seeking ways to expand eligibility to low-income women while delivering cost benefits to the state.

In October 2005, North Carolina Medicaid implemented the Be Smart Program, a five-year demonstration waiver project for family planning services to reduce unintended pregnancies and improve the well-being of children and families. Though only in its fourth year, this Family Planning Waiver has provided services to thousands of women across the state. During its first year, 9,819 women received services, 15,858 the second year, and the number of women receiving services continues to increase annually. The program has drastically reduced Medicaid-covered costs

associated with unintended pregnancies. According to the January 2009 Interim Annual Report for the program, 1,139 pregnancies were averted by pregnancy prevention during the second year of the waiver due to the existence of the program. This resulted in a Medicaid cost savings of \$11,735,000. Preliminary findings show that the subsequent waiver year resulted in an even greater Medicaid cost savings of between \$13,862,000 and \$14,219,000.²

North Carolina has taken advantage of federal options to expand Medicaid eligibility criteria to allow greater coverage for pregnant women. The Baby Love Program was launched in 1987 as a joint effort between the Division of Medical Assistance and the Division of Public Health. This Medicaid-funded program was designed to offer pregnant women and their infants early, continuous, and comprehensive health care and other needed support services with the goals of improving health and reducing infant mortality. Services include case management, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutrition therapy, and health and behavioral interventions.³ Since the beginning of this program, the infant mortality rate has decreased from 14.9 deaths per 1,000 live births (1987) to 8.2 infant deaths per 1,000 (2008).

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and end of life care; (4) *coordination and integration of care* across all elements of the health system (e.g., hospital, subspecialty care, skilled nursing care) and the patient's community (family and community-based services); (5) *optimal quality and safety of care* through evidence-based medicine and continuous quality improvement techniques and with patient participation; (6) *enhanced access* to care; and (7) *just and appropriate payment structures* that support the provision of the above services and values improved outcomes.⁵ There is growing evidence to support this model of care as a viable system to improve quality outcomes.⁴ Many aspects of the PCMH focus on improving access, communication, and integration of care. Women's health, including prenatal care, family planning, and chronic disease management, provide excellent opportunities for collaboration among family physicians and other specialists.

The World Health Organization's key indicators for overall community health are infant mortality and birth weight.⁶ Unfortunately, North Carolina is currently 43rd in the nation with regards to infant mortality.⁷ In 2007, there were 1.8 million women of childbearing age in North Carolina with 130,886 births, of which 12,100 were classified as low birth weight

(< 2,500 grams).⁸ There were 1,568 perinatal deaths (< one month of age) and 1,107 infant deaths (> one month but < one year of age).⁸ Communities with an increased supply of primary care practitioners (family physicians, general internists, and pediatricians) per capita have lower infant mortality rates and higher birth weights, especially in areas with high levels of disparities.⁹ Although there are a small but significant portion of family physicians who provide prenatal care (in North Carolina, 5% of family physicians provide both maternity care and deliveries and 11% provide prenatal care only, though in some counties family physicians are the only maternity care provider),¹⁰ the improvements in infant birth weight and lower infant mortality rates are not necessarily the result of the care patients receive during the narrow prenatal timeframe. Evidence suggests these improvements are more the result of a continuity of health care provided across the reproductive lifespan, beginning with preconception family planning, chronic disease management, and risk reduction aimed at improving overall maternal and neonatal health.⁹

North Carolina Pregnancy Risk Assessment Monitoring System (PRAMS)¹¹ data showed that approximately 45% of all

In spite of this improvement, North Carolina continues to have an infant mortality rate higher than the national average. In an effort to improve neonatal outcomes in the state, the Division of Medical Assistance was awarded a grant by the US Centers for Medicare and Medicaid Services to address this challenge. The project is in partnership with the Perinatal Quality Collaborative of North Carolina and builds upon the collaborative success that North Carolina has demonstrated in primary care. In the recent legislative session, the General Assembly directed the Division of Medical Assistance to research and report on the feasibility and efficacy of a Medicaid waiver allowing two years of interconceptional coverage to low-income women who have given birth to high-risk infants. The report will address whether estimated cost savings from improved birth outcomes will offset the cost of providing Medicaid coverage to additional eligible women.⁴

Aside from family planning and reproductive health issues, North Carolina also covers mammograms and preventive

care to eligible women. Chronic disease management through the Community Care of North Carolina network provides valuable services to recipients while delivering cost savings to the state. Low-income adults with disabilities may be eligible for a broad array of services under the Community Alternatives Program for Adults. Medicaid coverage is extended to uninsured women under the age of 65 with breast or cervical cancer that has been detected through North Carolina's Breast and Cervical Cancer Control Program. The common theme in all of these programs is the partnership and collaboration between Medicaid and other entities across the state. In moving forward with health care reform, these partnerships will be vital in improving access to quality health care for all North Carolina citizens.

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pregnancies in North Carolina were unintended. Mothers with unintended pregnancies are more likely to have low birth weight infants and infants who die before their first birthday.¹¹ The causes of unintended pregnancy are multifactorial, including, but not limited to, the availability of birth control, the timing of postpartum follow-up, and the messages given to patients regarding health priorities and life choices. Because of the associated risks with unintentional pregnancies, Healthy People 2010 has set a goal of achieving 70% of pregnancies as intentional.¹² Family physicians, because they are the primary care practitioner for so many women in North Carolina are vital to the success of reducing unintended pregnancies.

When women interact with multiple providers in our fragmented health care system, the historical details of their total health care "picture" can easily become disconnected. Family physicians in a PCMH can reconnect those disparate fragments. They have the ability to affect family planning and pregnancy intendedness for these women as they seek care with their family physician for preconception care or, if now pregnant, for their immediate pregnancy. They may also affect pregnancy intendedness after patients return from receiving

care from their obstetricians, midwives, or maternal-fetal medicine specialists. Also, by providing care for children, family physicians have the opportunity to interact with mothers during well-child checkups and vaccinations and can partner with pediatrician colleagues to encourage all health care providers to take an active role in family planning.¹³

The 2007 PRAMS report also states that mothers with unintended pregnancies are less likely to adopt healthy behaviors during pregnancy, such as avoiding tobacco, illegal drugs, or alcohol.¹¹ In 2006, the Center for Disease Control and Prevention's (CDC) Preconception Care Work Group and Panel on Preconception Care recommended that elements of preconception care be integrated into every primary care visit, including screening for risks, identifying and treating chronic diseases, and reviewing reproductive health during the interconception period.¹⁴ The North Carolina Department of Public Health's Preconception Health Strategic Plan mirrors the CDC Preconception Care Work Group with six priority areas: (1) pregnancy intendedness, (2) obesity and related conditions, (3) substance abuse, (4) mental health, (5) collaborative research and policy development, and (6) access to care.