

Achieving Healthy Outcomes for Moms and Babies

Testimony to the House Public Health Committee Interim Hearing on Birth Outcomes

The next generation of honor roll students, successful entrepreneurs, and community leaders starts with healthy mothers, healthy pregnancies, and healthy birth outcomes. Texas has made progress reducing infant death and preterm births, but far too many women experience barriers to care that negatively affect pregnancy and birth and the state continues to see high rates of premature and low-birth weight babies. Texas can take steps to ensure healthier, stronger babies are born across the state by improving access to preconception, prenatal, and postpartum care; continuing to invest in evidence-based home visiting programs that support moms and babies during and after pregnancy; and streamline Medicaid eligibility and enrollment and leverage existing outreach and education efforts to target eligible but uninsured pregnant women during their first trimester of pregnancy.

Thank you for the opportunity to provide testimony on this important issue. My name is Adriana Kohler and I am the Senior Health Policy Associate at Texans Care for Children, a statewide nonprofit organization that works to drive policy change to improve the lives of Texas children today for a stronger Texas tomorrow. We collaborate with community and health leaders around the state to identify health challenges for children and families, barriers to health care access, and potential policy solutions to improve the well-being of Texas children and families.

Background

Healthy birth outcomes today are key to ensuring that the next generation of Texas children and adults are healthy and successful. When babies are born too early (premature) or too small (low-birth weight), there are significant long-term consequences for kids, families, and communities. Prematurity can lead to lifelong health and development issues, including lung and breathing problems like asthma; hearing loss; intellectual and developmental disabilities, such as cerebral palsy, autism, and other neurological disorders; lower academic achievement; and behavior issues like attention deficit hyperactivity disorder.¹ Low-birth weight babies are more likely than normal-weight babies to have health conditions later in life, such as diabetes, high blood pressure, and heart disease.² Preventing prematurity and low birthweight is not just about the number of days a baby has to spend in a hospital's neonatal intensive care unit (NICU) – healthy

birth outcomes are essential to preventing long-term health and developmental issues and ensuring children can lead healthier lives and succeed in school and into adulthood.

Texas has made progress in recent years towards improving the health of mothers and babies.³ Our state's rate of infant mortality (5.9%) has been below the national average (6.0%) for about 10 years and has declined over the past five years.⁴ Texas has worked hard to improve birth outcomes and recognize the importance of preconception and prenatal care through various state programs, such as the Healthy Texas Babies (HTB) initiative, the "Someday Starts Now" life planning tool, and HTB Local Coalitions that implement evidence-based interventions around the state, many of which focus on increasing preconception care in provider settings.

Yet, Texas' rates of premature and low-birth weight births are still above national averages⁵ and there are significant racial disparities when it comes to health outcomes of moms and babies.⁶ In particular, African American babies die at twice the rate of White and Hispanic babies.⁷ Black women are much more likely to have preterm birth (14.0% of live births among Texas Black women are preterm, meaning before 37 weeks) compared to Texas women overall (10.3%) and U.S. women overall (9.6%). Both preterm birth and low birth weight births can be prevented and influenced by the health of a woman before and during pregnancy. Indeed, the Texas Department of Health and Human Services (DSHS) has estimated that 61% of deaths of African American infants are preventable.⁸

Ensuring access to care before, during, and between pregnancies not only helps prevent unplanned pregnancies and improve birth spacing, but also positively affects pregnancy outcomes and the baby's health and development. To address birth outcomes, there are three critical windows of opportunity: before, during, and after pregnancy. In particular, preventive care and interventions before pregnancy are one of the most effective ways to prevent preterm birth and low birth weight births and improve health outcomes for moms and babies.

- Studies show that when women are able to plan or space their pregnancies, they are less likely to deliver early (preterm),⁹ more likely to receive prenatal care in the first trimester,¹⁰ and their babies are less likely to be low birthweight and have slow neonatal growth.¹¹ Yet, over half of pregnancies in Texas are unintended, and too many women miss out on the benefits of birth spacing.¹²
- In addition, identifying and treating diabetes before pregnancy can reduce the risk of pregnancy complications, including preeclampsia, premature birth, birth defects, and miscarriage.¹³ It is

essential that diabetes is identified early and is under control about three to six months before a woman becomes pregnant.¹⁴

- Likewise, treating hypertension before and during pregnancy helps reduce pregnancy complications, such as preeclampsia, placental abruption, and gestational diabetes,¹⁵ and decreases the risk of premature birth, low birth weight, and infant death.¹⁶
- Depression before and during pregnancy is a risk factor for postpartum depression, which affects about 69,000 to 79,000 Texas women each year.¹⁷ If untreated, postpartum depression may negatively affect infant health, the mother-child relationship (attachment and bonding), and a baby's brain development, including adverse effects on a child's behavior and cognitive and social-emotional development.¹⁸ Screening before, during, and after pregnancy and access to mental health treatment are key to improving health outcomes for moms and babies.

Early prenatal care is extremely important for the health of both the mother and baby.¹⁹ Yet, nearly 40% of Texas women receive prenatal care late or not at all. Early prenatal care enables women to work with their doctors to identify and manage health risks, such as hypertension, diabetes, and depression, and address behaviors that affect pregnancy, such as unhealthy diet, smoking, and alcohol use. But in 2013 only 61% of pregnant woman in Texas entered prenatal care in the first trimester (the recommended time to start prenatal care).²⁰ Late access to prenatal care is a statewide problem that disproportionately impacts African American and Hispanic women, with about 30% of White women in 2013 receiving late or no prenatal care, compared to about 39% of Hispanic women and 47% of African American women.

Too many women experience barriers to prenatal care access. In 2013 in Texas:

- 229,352 women received prenatal care starting in the first trimester;
- 95,194 women received prenatal care starting in the second trimester;
- 24,530 women received prenatal care starting in the third trimester; and
- 17,880 women received no prenatal care.²¹

Barriers to prenatal care range from transportation challenges, to difficulty getting time off work, to not being able to get an appointment.²² Notably, however, among women who could not access prenatal care as early as they wanted, the most common barriers reported were not having insurance or enough money to pay for prenatal care visits (52.2%) and not having a Medicaid card (51.2%).²³ These are issues that can be fixed through policy solutions. Some barriers require individual and community changes – such as increased

awareness of the importance of early prenatal care – which is harder to achieve. But improved access to early prenatal care through affordable coverage and timely enrollment in Medicaid can be addressed by the legislature. Reducing these barriers is essential for improving access to prenatal care in the first trimester in Texas and achieving healthy outcomes for moms and babies.

Improving birth outcomes saves the state money. Medicaid pays for 53% of births in Texas,²⁴ and about 70% of Medicaid costs for hospitalized newborns are related to prematurity.²⁵ Reducing premature and low-birth weight births would not only alleviate the suffering of newborns and families, but also potentially increase state cost savings. There is a *ten-fold* increase in average Medicaid costs for preterm births compared to full term births – and average Medicaid costs can be *over 150 times* higher for extremely premature births. Specifically, a healthy, full-term newborn birth costs an average of \$404 to Medicaid. But a premature baby without major problems costs Medicaid an average of \$4,019 and an extremely premature infant birth costs Medicaid an average of \$63,124.²⁶ In fact, the Texas Health and Human Services Commission (HHSC) estimated that a 1% reduction in neonatal intensive care unit (NICU) utilization results in \$3.1 million in savings to general revenue.²⁷

Recommendations

RECOMMENDATION 1: Improve access to preconception care, prenatal care, and postpartum care after the birth of a child so that women and their providers can address health conditions and risks that may impact pregnancy outcomes and a baby’s health and development.

When women are healthy before, during, and after their pregnancy, babies are less likely to be born too early or too small, and kids will have healthier outcomes. Texas has recognized the importance of these issues through various state programs, such as the Healthy Texas Babies (HTB) Local Coalitions and the “Someday Starts Now” life planning tool. Additionally, Texas has made strides on postpartum and interconception care by deciding to auto-enroll women who receive Medicaid for Pregnant Women into Healthy Texas Women (the state women’s health program, launching July 2016) after the 60-day postpartum Medicaid certification period ends. This helps reduce gaps in preventive care, especially during the critical time after delivery of a newborn. Yet, the Healthy Texas Women program only has the capacity to reach a fraction of the low-income women in need of access to affordable preventive care, and the program only provides a limited scope of services.

Access to comprehensive health coverage is limited in Texas. Most low-wage jobs do not provide insurance. Premiums for individual health insurance are unaffordable for low-wage workers. Subsidies on the Affordable Care Act (ACA) Marketplace are only available for individuals *above* the poverty line. Texas Medicaid is only available to working-age, able-bodied adults if they are pregnant or if they are a parent and the household income is below \$5,000 per year for a family of four. In other words, a mother in a family of four that earns between \$5,000 and \$24,000 per year is not eligible for affordable health coverage in Texas.

Moving forward, the state should develop a workable solution for the coverage gap in order to maximize federal funds and substantially increase the number of women able to access a medical home where they can receive care *before, during, and after* pregnancy. Continuity of coverage and care will enable women and their providers to address health conditions and risks before pregnancy and improve early access to prenatal care, thereby reducing the risk of prematurity and low birthweight and ensuring healthier outcomes for moms and babies.

RECOMMENDATION 2: Streamline Medicaid eligibility and enrollment processes and leverage existing outreach and education efforts to target eligible but uninsured pregnant women during their first trimester of pregnancy.

In recent years, Texas HHSC has made improvements to better streamline the Medicaid application and eligibility process for pregnant women. HHSC and Medicaid managed care plans are making efforts to reduce the time between submission of a Medicaid application, selection of a plan, and a woman's prenatal visit with her provider.

While progress has been made, many people are not aware of the availability of Medicaid coverage for low-income pregnant women – and for many others, the process takes too long to be able to get prenatal care in a timely manner. The perception of high costs to the consumer (i.e., not being able to afford prenatal care or a doctor's visit) often keeps women from critical prenatal visits. In particular, 2011 PRAMS data shows that, among Texas women who could not access prenatal care as early as they wanted, the most common barriers reported were not having insurance or enough money to pay for prenatal care visits (52.2%) and not having a Medicaid card (51.2%).²⁸

The state must increase investment in outreach and education efforts and promote clear, easy-to-read information about availability of Medicaid for pregnant women. The state must also continue to streamline the



application and enrollment process for pregnant women so they can easily select a health plan, get enrolled, and receive a Medicaid card. These steps are needed to ensure pregnant women enroll in Medicaid coverage and access prenatal care in their first trimester.

RECOMMENDATION 3: Continue investing in evidence-based home visiting programs that lead to healthier pregnancies and have a demonstrated effect on maternal and infant health.

Texas must continue supporting evidence-based home visiting programs that are proven to improve pregnancy outcomes and ensure moms and babies are healthier. Texas has a successful home visiting program that supports four evidence-based models in communities across the state. As an example, Nurse Family Partnership (NFP) pairs nurses with low-income, first-time mothers during and after pregnancy to provide one-on-one education and counseling on health, breastfeeding, infant diet and feeding practices, and child development issues. The program's expert guidance has been proven to lead to healthier pregnancies by working with women on healthy diets and smoking cessation and by helping women access health professionals for prenatal care.

The state should continue investing in these effective intervention programs to support pregnant women and new parents as they start down the path to raising happy and healthy kids.

Thank you for your consideration, and for your commitment to improving the lives of children and families in Texas. If you have any questions, please feel free to contact me at 512.473.2274.

Respectfully,

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- ² Saigal, S., & Doyle, L.W. "An Overview of mortality and sequelae of preterm birth from infancy to adulthood." *Lancet*. 371: 261–69 (2008). March of Dimes. "Low Birthweight." <http://www.marchofdimes.org/complications/low-birthweight.aspx>.
- ³ Mandell, D.J., & Kormondy, M. *Healthy Texas Babies: Data Book*. Austin, TX: Division for Family and Community Health Services, Texas Department of State Health Services (2015). Available at <http://www.childhealthtx.org/wp-content/uploads/2012/12/2015-Healthy-Texas-Babies-Data-Book.pdf>.
- ⁴ *2015 Healthy Texas Babies Data Book*, at p. 6.
- ⁵ Texas has a higher rate of premature births (10.4%) and low-birth weight babies (8.2%) compared to the U.S. overall (9.6% and 8.0% respectively). *2015 Healthy Texas Babies Data Book*, at p. 10.
- ⁶ *2015 Healthy Texas Babies Data Book*, at p. 6-12.
- ⁷ Infant mortality rate for African American babies is 12 deaths per 1,000 live births; Texas' overall infant mortality rate is 6 deaths per 1,000 live births. *2015 Healthy Texas Babies Data Book*, at p. 6 (Figure 8).
- ⁸ Texas Department of State Health Services. *Feto-Infant Mortality in Texas*. Texas Department of State Health Services, Office of Program Decision Support (July 2011). Available at <https://.dshs.state.tx.us%2Fhealthytexasbabies%2Fdocuments%2Ftexas-ppor-analysis>.
- ⁹ Orr, S.T., Miller, A., James, S.A., Babones, S. Unintended pregnancy and preterm birth. *Pediatric and Perinatal Epidemiology* 2000, 14, 309-313 (finding that unplanned or unintended pregnancies were twice as likely to result in a preterm birth as planned pregnancies).
- ¹⁰ Mosher, W.D., Jones, J., & Abma, J.C. "Intended and Unintended Births in the United States: 1982-2010." *National Health Statistics Reports*, 55, 2012 (noting that 19% of women whose pregnancies were unplanned did not receive prenatal care in the first trimester; this number fell to 8% for women whose pregnancy was planned).
- ¹¹ Gemmill, A., & Lindberg, L.D. "Short Interpregnancy Intervals in the United States." *Obstetrics and Gynecology*, 122(1), 64–71 (2013). Conde-Agudelo, A., Rosas-Bermudez, A., & Kafury-Goeta, A.C. "Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis." *JAMA*, 295(15) (2006).
- ¹² Frost J. et. al. "Contraceptive Needs and Services, 2013 Update," Guttmacher Institute (2015). Nearly 1.8 million low-income women in Texas are in need of publicly-funded preventive services. Yet less than a quarter of these women currently receive the services they need.
- ¹³ Centers for Disease Control and Prevention. *Type 1 and Type 2 Diabetes and Pregnancy*. <http://www.cdc.gov/pregnancy/diabetes-types.html>. See *2015 Healthy Texas Babies Data Book*, p. 20.
- ¹⁴ See March of Dimes. "Preexisting Diabetes." <http://www.marchofdimes.org/complications/preexisting-diabetes.aspx>. American Diabetes Association. *Preconceptional care of women with diabetes*. *Diabetes Care*. 27, Suppl 1:S76-S78 (2004). Johnson, Kay. et. al., *Recommendations to Improve Preconception Health and Health Care: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*. Centers for Disease Control and Prevention. 55 (RR06); 1-23 (Apr. 21, 2006). Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm> (finding that pre-pregnancy diabetes is a risk factor for adverse pregnancy outcomes and noting that "the three-fold increase in the prevalence of birth defects among infants of women with type 1 and type 2 diabetes is substantially reduced through proper management of diabetes."). Roland JM,

et. al. *The pregnancies of women with Type 2 diabetes: poor outcomes but opportunities for improvement*. *Diabet Med* 22:1774-7 (2005).

¹⁵ Centers for Disease Control and Prevention. "Pregnancy Complications." Available at <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm>.

¹⁶ *Ibid.*

¹⁷ Van Horne B, Correa N, Mclver S, Vardy H. Opportunities to break barriers & build bridges: results of the 2014 postpartum depression needs assessment Houston, Texas. *Children at Risk*. (Oct. 2014).

¹⁸ Earls, M. The Committee on Psychosocial Aspects of Child and Family Health. American Academy of Pediatrics. "Clinical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice." *Pediatrics*. 126(5):1032–1039 (2010). Reaffirmed December 2014. Additionally, while some research has found that about 5 to 25 percent of new moms develop postpartum depression, studies of low-income mothers and parenting teens have reported rates of depressive symptoms at 40 to 60 percent – showing that access to mental health treatment is particularly important for low-income mothers. *Ibid.* Also, a recent study found that postpartum depression's impact on interactions between depressed mothers and their infants appear to be universal across different cultures and socioeconomic status groups. This study found that many caregiving activities are compromised by postpartum depression, including feeding practices, particularly breastfeeding, sleep routines, the child's receipt of health care (well-child visits and vaccinations), and safety practices. Field T. "Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review." *Infant Behavior and Development*. 33(1): 1 (Feb. 2010). Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2819576/>.

¹⁹ Compared to mothers who receive prenatal care, a mother who does not receive prenatal care is three times more likely to have a baby that is low birth weight and the baby is five times more likely to die. U.S. Department of Health and Human Services, Office on Women's Health. *Prenatal Care Fact Sheet*. Studies show that prenatal care can improve maternal and infant health outcomes by reducing the risk of still birth, premature birth, neonatal death, and infant death. Partridge, S. et. al. "Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries Over 8 Years." *American Journal of Perinatology*, 29(10) (2012).

²⁰ Texas Department of State Health Service. Vital Statistics. (2013). <http://healthdata.dshs.texas.gov/VitalStatistics/Birth>

²¹ *Ibid.*

²² See January 2016 San Antonio Express-News three-part series examining the challenges to receiving early prenatal care. Available at <http://www.centerforhealthjournalism.org/fellowships/projects/behind-start-prenatal-care-crisis-puts-bexar-county-babies-risk>. Texas Department of State Health Services. Texas Pregnancy Risk Assessment Monitoring System (PRAMS): 20011 Annual Report. Page 29 (2011).

²³ Texas Department of State Health Services. Texas Pregnancy Risk Assessment Monitoring System (PRAMS): 20011 Annual Report. Page 29 (2011).

²⁴ David Lakey, MD. "Healthy Babies Initiatives." Presentation to Health Resources and Services Administration Infant Mortality Summit (Jan. 12, 2012). Available at <http://mchb.hrsa.gov/infantmortalitysummit/presentations/lakey.ppt>.

²⁵ *Ibid.*

²⁶ Data based on Medicaid diagnosis-related group billing codes. *Ibid.* Slide 11. Cost estimates based on Medicaid claims data by diagnosis related group (DRG), a normal newborn costs \$410 per claim; a neonate with other significant problems costs \$1,295 per claim, a full-term neonate with major problems costs \$5,962 per claim; a premature baby without major problems costs \$4,019 per claim; a premature baby with major problems costs \$19,059 per claim; and an extreme premature baby costs \$63,245 per claim.

²⁷ Texas State Committee on Health and Human Services, *Interim Report to the 83rd Legislature*. p. 17 (Dec. 2012). Available at <http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/c610.InterimReport82.pdf>.

²⁸ Texas Department of State Health Services. Texas Pregnancy Risk Assessment Monitoring System (PRAMS): 20011 Annual Report. Page 29 (2011).