Improving Maternal Health in Harris County: A Community Plan
Policy Agenda

1. **Create and fund a maternal mortality and morbidity data registry demonstration project for Harris County, Texas.** The goal of this initiative is to improve the quality of maternal data in Harris County by creating a centralized data registry to which hospitals report data on cases of severe maternal morbidity or mortality from their EHRs. The data will provide physicians with a more accurate understanding of the rates of maternal morbidity and mortality and the conditions or complications that underlie cases. This type of data registry will aid in building the capacity of hospitals to collect and report better quality data, identify areas of need, and facilitate the assessment of interventions to improve the overall quality of care being delivered to pregnant women.

2. **Simplify and expedite seamless enrollment across Medicaid, CHIP-Perinatal, and Healthy Texas Women.** The complexity of eligibility and confusion around the enrollment process allows pregnant women who would qualify for Medicaid or CHIP-P to fall through the cracks. These women are less likely to receive prenatal care, which leads to higher rates of morbidity and mortality. Enrollment in Healthy Texas Women is essential for women to maintain their health before and after pregnancy, as it covers disease screening, disease prevention, and access to contraception.

3. A. **Increase postpartum coverage through Medicaid up to one year.** According to the Texas Maternal Mortality and Morbidity Task Force, nearly 60% of maternal deaths occur after 60 days following birth. Currently, women qualifying for Medicaid due to pregnancy are covered for only 60 days after giving birth. The loss of coverage directly contributes to poor health outcomes for mothers, which negatively affects the health of babies. Prolonging coverage is essential to protect mothers and babies.

   B. **Sustain and enhance health coverage for all Texas women.** Sean Blackwell, Chair of Obstetrics, Gynecology, and Reproductive Sciences at McGovern Medical School, states, "If a woman enters pregnancy unhealthy, it is unlikely that she will be able to improve her health during pregnancy." Due to strict eligibility criteria in Texas, most women with low incomes do not qualify for public health programs until they become pregnant. This predisposes women to entering pregnancy with an untreated, detrimental health condition and having a high-risk pregnancy. Expanding coverage for all women prior to pregnancy will attenuate high risk cases, reducing mortality rates and high cost emergency room visits.

4. **Increase state Medicaid reimbursement rates to private physicians.** In Texas, the reimbursement rate for Medicaid is very low, which creates barriers to care for Medicaid patients seeking care with private physicians. Because women cannot see the physician of their choice, many do not receive the prenatal care they need. In addition, low reimbursement rates can shorten the length of patient visits, which affects the quality of care women receive from their physician. Increasing reimbursement rates will increase access to see the physician of their choice and preserve quality of care for all women.

5. **Encourage HHSC to seek Medicaid waivers and other funding sources for coverage for substance use disorder (SUD) and other behavioral health issues for Medicaid recipients and other women with low incomes.** Although opioid abuse is a growing problem nationally, in Harris County cocaine, methamphetamine, and heroin pose a very substantial threat to the health of residents as well. There is a need for Texas to pursue Medicaid waivers to cover opioid SUD as allowed by congressional statute. The State of Texas should also pursue other funding streams to increase access to additional SUD treatment.

6. **Modify Medicaid transportation policy/coverage to allow dependent children of a Medicaid recipient to accompany the recipient being transported to a Medicaid provider.** A barrier to receiving care for many Medicaid recipients is the inability to secure safe and reliable transportation. Although Medicaid provides transportation services, the inability for Medicaid recipients to bring their children with them deters recipients from utilizing the services. Modifying policy on transportation services is critical to increase access to care for those in need.

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7. **Cover doula services through Medicaid.** Currently, Texas Medicaid does not cover the use of doulas. Doulas are important supports for pregnant women with low incomes and their families during and after birth. Covering doulas can help to improve birth outcomes and post-partum maternal health.

8. **Improve access to long-acting reversible contraception (LARC) in order to prevent unintended pregnancy.** Unintended and adolescent pregnancy are associated with late entry into prenatal care, which can lead to poor birth outcomes. Access to a full range of contraceptive options, including LARCs, for all women of reproductive age is a fundamental step toward prevention of pregnancy. Effective prevention practices will significantly reduce the social and economic burden of unintended and adolescent pregnancy.

1. Create and fund a maternal mortality and morbidity data registry demonstration project for Harris County, Texas.

Background

Accurate maternal health data is severely lacking across the United States with maternal health data and research lagging far behind other health issues. The quality of maternal mortality data in Texas is widely considered to be poor, as the data collection and reporting procedures vary across the state, bringing the true mortality rate into question. Morbidity data collected from hospital discharge records can also be unreliable, as inaccuracies may occur due to misclassification and inconsistent coding across hospital systems. The lack of high-quality maternal health data reflects a need for hospitals to build capacity around the collection and reporting of maternal health data. Healthcare stakeholders in Harris County have collaborated to address this challenge by designing a comprehensive and centralized data registry to improve the quality of maternal health data. Through this demonstration project, project partners will develop a mechanism to collect data from electronic health records on cases of severe maternal morbidity and mortality in hospitals that deliver babies in Harris County.

The demonstration project will provide stakeholders with a more accurate understanding of the rate of maternal morbidity and mortality in Harris County and the conditions and complications that underlie cases. Through this demonstration, hospitals will build capacity to collect and report high quality maternal data, which can be used to identify areas of need and translate findings into action to improve the overall quality of maternal care. In addition, this demonstration project is designed to provide data to inform possible future endeavors to develop a statewide data registry.

Demonstration Project Proposal

So as not to burden hospitals with significant amounts of data collection, the demonstration project proposes to track only cases of mortality and select severe morbidities. Of the approximately 70,000 births in Harris County each year, these cases are expected to represent 2 - 3% of hospital births in the county.

The demonstration project is designed to be relatively simple, with elements including a case review form that aligns with state quality requirements, a secure online database that is commonly used in hospital settings, training for participating hospital staff, and specific measures to ensure data integrity. Findings will be reported only at the aggregate level, with individual hospitals receiving their results for internal use.

Hospital participation in the demonstration project will be voluntary and, by aligning with state maternal levels of care reporting, will be incentivized with training to support basic reporting requirements and improving capacity to collect, report, and utilize high quality data.

Recommendation

Provide funding to support the demonstration of a data registry that will provide high-quality data on the frequency and characteristics of maternal mortality and select morbidities and will also provide valuable information to inform the development of a statewide data registry in the future.

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2. Simplify and expedite seamless enrollment across Medicaid, CHIP-Perinatal, and Healthy Texas Women.

Background

The State of Texas has the highest percentage of uninsured women of reproductive age at 24 percent, or 1.4 million women[i]. The complexity of eligibility guidelines, strict deadlines, and confusion about the enrollment process has likely widened the already expansive coverage gap in Texas by causing women eligible for public health benefits to remain uninsured. As part of a year-long research effort led by Houston Endowment to reduce maternal mortality and morbidity in Harris County, researchers conducting focus groups with women living in Harris County found that women with low incomes experienced confusion about the Medicaid and CHIP-Perinatal enrollment process and barriers to meeting form submission deadlines[ii]. This often delayed entry into prenatal care, predisposing women to adverse pregnancy-related health conditions.

Texas Medicaid covers prenatal care and delivery of the baby for women with low incomes at or below 198% of the federal poverty level, but the mother's Medicaid ends 60 days after delivery. Post-partum care can be difficult to obtain for those whose Medicaid coverage expires. Between 2015-2016, nearly 30 percent of new mothers in Texas were uninsured, the highest percentage in the country[iii]. The Texas Health and Human Services Commission automatically enrolls women coming off of the Medicaid for Pregnant Women coverage into the Healthy Texas Women Program when Medicaid benefits expire. However, research indicates that smooth transitions, in which providers inform patients of their new benefits and conduct warm handoffs to new providers, do not always happen.[ii]

To ensure healthy entry into pregnancy and reduce negative outcomes for post-partum mothers, enrollment in public insurance coverage and transitions from Children's Medicaid, Medicaid for Pregnant Women, CHIP, and CHIP-Perinatal to Healthy Texas Women should be seamless and consistently implemented throughout Texas.

Recommendation

Support modification of Healthy Texas Women automatic enrollment policy to identify and automatically enroll all women with low incomes of reproductive age in Healthy Texas Women, and ensuring that women who become pregnant are enrolled in Medicaid or CHIP-Perinatal.

Fiscal Impact

An interim report from Health and Human Services Commission released in July 2018, found that automatic enrollment of women aging out of Medicaid and CHIP in the Healthy Texas Women Program would result in an estimated $58.7 million savings in general revenue from 2020-2025[iv]. This savings is the result of an estimated 11,275 births averted by increasing access to contraceptive care, family planning services, and well woman visits through the Healthy Texas Women Program. This finding can logically be generalized to a slightly older population of women transitioning from Medicaid for Pregnant Women to the Healthy Texas Women Program. Furthermore, it can be inferred that the savings may be larger as this is a slightly older, likely more sexually active, population. The successful implementation of automatic enrollment in the Healthy Texas Women Program in this population may result in even more averted pregnancies.

[i] https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy
[ii] Houston Endowment, Inc. (2017). *Improving Maternal Health in Harris County: A Community Plan.*
[iii] https://www.healthaffairs.org/do/10.1377/hblog20180917.317923/full/
[iv] Texas Health and Human Services (2018). *Auto-Enrollment in the Healthy Texas Women Program*. Health and Human Services, Austin, TX.

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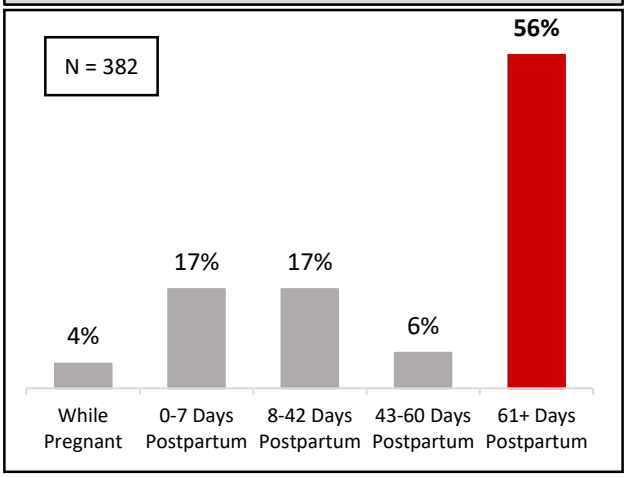
Improving Maternal Health in Harris County
A Community Plan

Texas's Maternal Health Crisis: *The Need to Extend Access to Medicaid*

The Problem

Maternal Deaths in Texas From 2012-2015[1]



In Texas,

- Maternal mortality and morbidity rates are **high** and **on the rise** with the majority of deaths occurring more than 60 days after giving birth.
- Rates of severe maternal morbidity have increased by **15%** from 2008 to 2015 and are **25%** higher than the national rate.
- Low-income and African American women are **disproportionately affected**.

What is Contributing to This Problem in Texas?

1.4 Million women of reproductive age are uninsured.[2]

30% of new mothers are uninsured.[3]

60 Women who give birth on Medicaid lose coverage **sixty** days after birth.

Uninsured are **4x** less likely to have a regular source for health care.[4]

How Can We Fix It?

Extend Medicaid coverage up to 1 year

Increase access to health care before, during and after pregnancy

Provide all women an equal chance for a healthy pregnancy

[1] Texas Department of State Health Services (2018). Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Retrieved on 1/7/19 from https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

[2] Guttmacher Institute (2018). Dramatic Gains in Insurance Coverage for Women of Reproductive Age are Now in Jeopardy. Retrieved on 1/7/19 from https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy

[3] McMorrow, S., Kenney, G. (2018). Despite Progress Under the ACA, Many New Mothers Lack Insurance Coverage. Retrieved from 3 https://www.healthaffairs.org/do/10.1377/hblog20180917.317923/full/

[4] Texas Medical Association (2018). The Uninsured in Texas. Retrieved on 1/7/19 from https://www.texmed.org/uninsured_in_texas/

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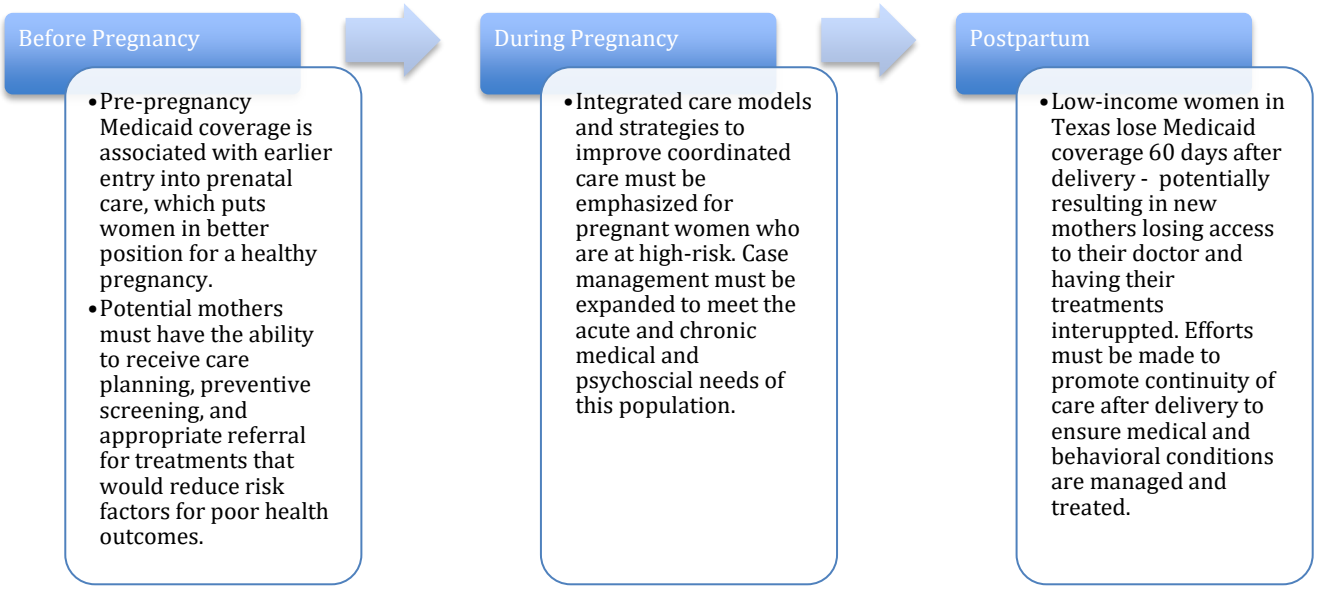
3B. Sustain and enhance health coverage for all Texas women.

Background
The State of Texas has the highest percentage of uninsured women of reproductive age at 24 percent, or 1.4 million women[i]. Many of these women have reduced access to care, receive treatment that does not align with standards of care, and forego more important preventive services than women who are insured. In addition, the characteristics of women who are more likely to be uninsured – minorities, less educated, and low-income – are similar to the characteristics of women at higher risk for poor maternal health outcomes.

The greatest opportunity to improve maternal and infant health occurs *before* and *after* a woman becomes pregnant. Unfortunately, in Texas, the lack of affordable options for health coverage and the state's limited Medicaid eligibility requirements have impeded the ability of low-income, childless women to find coverage, allowing potentially treatable conditions to worsen until pregnancy is already established. As a result, uninsured women enter pregnancy in poor health with chronic conditions (e.g., pre-pregnancy obesity, diabetes, and hypertension) that increase the risk of poor maternal health outcomes. After delivery of the baby, many women in Texas lose health coverage and are no longer able to receive care from their healthcare providers. Between 2015-2016, nearly 30 percent of new mothers in Texas were uninsured, the highest rate in the country[ii].

Recommendation
Expand Medicaid eligibility in the State of Texas to remove the barriers to coverage that low-income women face so that they may have access to continuous care before pregnancy, during pregnancy, and after delivery.

Continuous coverage across the continuum of care[iii]:



Fiscal Impact
Providing health insurance for women of childbearing age is not only beneficial for Texas families, but it is fiscally wise as well. For every dollar invested in preconception care (e.g., vaccinations, enriched nutrition, disease management), $1.60-$5.10 is saved in maternal and fetal care costs, with most of the savings coming from the reduced rate of neonatal intensive care unit hospitalizations among infants[iv]. Other research shows for every dollar spent on prenatal care, it saves $3.33 in postnatal care and $4.63 in long-

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term morbidity costs[v]. Investing taxpayer dollars to cover women of childbearing age not only significantly reduces medical spending and bankruptcies, it ensures that mothers are more likely to have healthier pregnancies and deliver healthier babies.

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[i] https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy
[ii] https://www.healthaffairs.org/do/10.1377/hblog20180917.317923/full/
[iii] https://www.liebertpub.com/doi/abs/10.1089/jwh.2017.6871
[iv] https://www.ncbi.nlm.nih.gov/pubmed/16786418
[v] http://ipp.jsi.com/Docs/SOHC_2006.pdf

4. Increase state Medicaid reimbursement rates to private physicians.

Background

Medicaid reimbursement rates in Texas are significantly lower than the national average. Compared to the average Medicaid fees across the U.S., Texas's rates are 12% lower for all healthcare services.[i] In addition, Texas Medicaid reimbursement for primary care services and obstetric care services is 14% and 25% lower than the national average, respectively. Overall, based on Medicaid fee data from 2016, Texas has the 7th lowest Medicaid reimbursement rate for obstetric care services in the U.S.[i]

Low Medicaid reimbursement rates, to private physicians in particular, creates substantial barriers for pregnant women with low incomes to receive high quality prenatal care. Because of low reimbursement rates, many private physicians limit the number of Medicaid patients they will accept or do not accept any new Medicaid patients at all, reducing access to care for women with low incomes.[ii] This can lead to late entry into prenatal care, which places women at higher risk for birth complications and negative health conditions. In addition, anecdotal reports from physicians in the Houston area indicate that providers may shorten the length of visits by half for women with Medicaid due to low reimbursement rates. This affects the woman's perception of the care quality and may result in decreased compliance with physician recommendations.[iii]

Recommendation

Increase Medicaid reimbursement rates to private physicians to increase access to high quality health care for women with low incomes. As most adults that qualify for Medicaid in Texas are pregnant women with low incomes, reducing barriers to care created by low reimbursement rates has the potential to improve women's health and prevent maternal mortality and morbidity.

[i] Zuckerman, S., Skopec, L., and Epstein, M. (2017). Medicaid Physician Fees after the ACA Primary Care Fee Bump. Urban Institute, March 2017.
[ii] Decker, S. (2012). In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs* 31 (8): 1673–79.
[iii] Houston Endowment, Inc. (2018). *Improving Maternal Health in Harris County: A Community Plan.* [Online] https://www.houstonendowment.org/resources/reports/

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5. Encourage HHSC to seek Medicaid waivers and other funding sources for coverage for substance use disorders (SUD) and other behavioral health issues for Medicaid recipients and other women with low incomes.

The recent significant rise in incidences of substance use disorder (SUD) has alarmed the nation and garnered bi-partisan support at the federal level for legislation to address treatment, prevention, recovery and enforcement efforts concerning SUD.[i] Texas is experiencing a significant substance abuse epidemic as well. In order to have the resources and funding to effectively address this public health crisis, Texas should apply for a Medicaid waiver as provided by Section 1115 of the Social Security Act. A section 1115 waiver would provide Texas with the authority and funding to improve access to and quality of SUD treatment.[ii] Texas should also pursue additional funding streams to increase access to SUD treatment.

Background

The city of Houston had more drug overdose deaths in 2017 than 21 states.[iii] While opioids are the leading cause of overdose-related deaths in Harris County (48% in 2017), other commonly abused substances include alcohol, methamphetamines, marijuana, synthetic cannabinoids and cocaine.[iv] The number of fatal overdoses in Harris County is increasing. In 2013, there were 445 fatal overdoses from heroin, fentanyl, opioids or cocaine; in 2017, there were 759 fatal overdoses.[v]

Moreover, drug overdose is the leading cause of death of new mothers in Texas.[vi] A mother struggling with SUD negatively affects the health and well-being of her children. The rate of infants affected by drugs in utero has doubled to 9.4% between 2009 and 2016 in Texas.[vii] This has widespread, long-term effects on the child's growth, behavior, cognition and achievement.[viii] Furthermore, in 2016, 38.5% of Child Protective Services' (CPS) completed investigations were drug-related, and in 2017, 52% of child fatalities resulting from abuse or neglect involved a parent or caregiver actively using a substance.[ix]

Currently, Medicaid provides minimal support for those with a SUD. This support is inadequate, however. Current Medicaid guidelines have resulted in inefficient treatment programs that do not integrate physical and behavioral treatment. On November 1, 2017, the federal Department of Health and Human Services announced its interest in receiving waiver applications aimed at providing "a full continuum of care for people struggling with addiction."[x] While Section 1115 waivers typically must be budget neutral, DHHS has made residential treatment services for SUDs eligible for federal Medicaid reimbursement for states who have received waivers.[xi]

Recommendation

HHSC should seek Medicaid waivers and other funding sources to improve SUD coverage among Medicaid recipients and other women with low incomes. The Medicaid waivers would allow for the infusion of federal dollars to support Texas priorities and innovations in delivery of SUD treatment.

Examples of section 1115 demonstration projects in other states:[xii]

- Using 1115 waivers, **Maryland** is redesigning its SUD delivery system to cover the full continuum of care, report specific quality measures, and integrate physical and behavioral health services to improve health outcomes.
- **Massachusetts** is using Medicaid waivers to cover a more comprehensive array of outpatient, residential inpatient and community SUD services.

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- **Virginia** is expanding its SUD delivery system to cover a full continuum of care and improve the quality of care so it is consistent with national treatment guidelines established in the American Society of Addiction Medicine criteria.
- **West Virginia** is expanding coverage to include methadone treatment, peer recovery supports, and withdrawal management. The state is also implementing an extensive quality and performance measurement plan and new care coordination features.
- **California** is expanding coverage to include a full continuum of care, providing coordination across systems of care, and reporting specific quality measures.

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[i] **Musumeci, M and Tolbert, J.** Crisis: Medicaid Provisions in the SUPPORT Act. *Kaiser Family Foundation.* [Online] Oct 05, 2018. https://www.kff.org/medicaid/issue-brief/federal-legislation-to-address-the-opioid-crisis-medicaid-provisions-in-the-support-act/.

[ii] 1115 Substance Use Disorder Demonstrations. Medicaid. [Online] [Cited: Jan 16, 2019.] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/1115-sud-demonstrations/index.html.

[iii] **Beth Van Horne, DrPH.** *Houston's Hidden Opioid Problem.* Baylor College of Medicine : Texas Children's Hospital Public Health Pediatrics, July 27, 2018.

[iv] ibid

[v] **Houston Police Department.** *Introduction to Houston's Opioid Epidemic.* 2018.

[vi] **Beth Van Horne, DrPH.** *Houston's Hidden Opioid Problem.* Baylor College of Medicine : Texas Children's Hospital Public Health Pediatrics, July 27, 2018.

[vii] ibid

[viii] ibid

[ix] ibid

[x] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[xi] ibid

[xii] 1115 Substance Use Disorder Demonstrations. *Medicaid.* [Online] [Cited: Jan 06, 2019.] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/1115-sud-demonstrations/index.html.

6. Modify Medicaid transportation policy/coverage to allow dependent children of a Medicaid recipient to accompany the recipient being transported to a Medicaid provider.

Background

Federal statute states that Medicaid funds for medical transportation can only be used for the transport of the recipient and a care giver. In response, Texas has created the Texas Medicaid Transportation Program. Under this program, vendors, family members, and others can sign up to receive reimbursement for the transport of the recipient and their care giver. The program can also fund other transportation modes but will only cover the recipient and care giver, excluding dependent children. This creates significant barriers for mothers with low incomes to access health care. As part of the Frew settlement, the state sought general revenue from the legislature to provide medical transportation, but the funds were ultimately moved to other programs within Medicaid due to budget constraints.

At the local level, transportation remains a significant barrier to care for mothers receiving Medicaid. In Mandell's "Understanding Characteristics of Women Accessing Care Late" (Mandell, 2016), researchers found that 17% of the women surveyed found transportation to be an issue. The Fetal Infant Morbidity Review of Congenital Syphilis & Perinatal HIV conducted 30 case reviews of sentinel events that occurred in Houston/Harris County, region 6/5 S, and Galveston, which identified barriers to transportation as a contributor to the health event. Attached are 3 case studies where transportation barriers were identified and contributed to a sentinel health care event (Appendix A).

United Way of Texas and others are taking the lead on this initiative with several legislative offices in the 86th Legislative Session.

Recommendation

Support of the United Way of Texas and others seeking modification of Medicaid transportation policy to include coverage of dependent children accompanying their mother. The coverage of dependent children under the Texas Medicaid Transportation Program is necessary at both the state and local level, and will significantly reduce barriers to proper medical care for mothers with low incomes.

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Appendix A[i]

- Case #1
  - Mom living with HIV who accessed prenatal care late. She had a previous child who could not ride with her to these appointments. HIV was transmitted to the infant perinatally.

- Case #2
  - Mom living with HIV and with 1 child. She does not access healthcare in her small town due to concern about the stigma associated with people discovering her HIV-positive status, while accessing care at an HIV-specific clinic. When she had transportation, mom accessed care in a larger nearby town. Mom now has very limited transportation. Around the time of the case pregnancy, she did not attempt to enter into prenatal care or into HIV-related care for herself. HIV was transmitted to the infant perinatally. Infant later died after a few weeks postpartum. Mom was recently pregnant and repeated same pattern of not accessing prenatal care or HIV-related care for herself.

- Case #3
  - Mom living with 2 children. Around the time of the case pregnancy she had minimal prenatal care; citing lack of childcare as a contributing factor since her children could not accompany her to prenatal care appointments. Mom was diagnosed with syphilis during her 2nd trimester entry into prenatal care. Mom suffered a syphilis-related stillbirth a few weeks later. Mom had another child after that and discussed the challenges of taking care of her own health while caring for her 3 children, during a FIMRSH maternal interview.

[i] The Fetal and Infant Mortality Review of Congenital Syphilis and Perinatal HIV (2016).

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7. Cover doula services through Medicaid.

Background

A doula, sometimes referred to as birth coach or birth companion, is a trained professional who provides continuous support for women before, during, and after childbirth, offering education, physical support, and emotional support to mothers. There is a growing body of evidence that suggests continuous support during pregnancy reduces the likelihood of adverse birth outcomes for mother and baby. Women receiving doula services throughout their pregnancy are less likely to have a caesarean birth (28% reduction in caesarean births on average), lower odds of preterm birth, require less pharmaceutical care during delivery, and spend less time in labor.[i,ii] The negative birth outcomes and procedures that are averted as a result of doula services add up to significant cost savings for hospitals, insurers, and state health programs.

Maternal mortality and morbidity rates are on the rise in Texas. Women with low incomes and African American women experience the highest burden of mortality and morbidity. While women with low incomes who gave birth on Medicaid were 14% more likely to desire the support of a doula, these services are not covered by Medicaid in Texas, effectively denying these women access to services proven to reduce the likelihood of adverse birth outcomes.[iii]

Two states, Minnesota and Oregon, have approved legislation to mandate coverage for doula services through Medicaid and have documented positive health and financial outcomes. Another three states, Vermont, New Jersey, and New York, introduced bills in 2018 to cover doula services through Medicaid. New York's effort to cover doulas through Medicaid is one part of a pilot to reduce disparities in maternal mortality.[ii]

Recommendation

Mandate the coverage of doula services through Medicaid to provide an avenue for women with low incomes to access the support they need and desire throughout pregnancy.

Fiscal Impact

A decrease in cesarean births would result in large savings for Medicaid programs in the U.S. Based on data from 2013[ii]:

- Hospitals billed $126 billion for maternal and newborn care.
- Cesarean births cost 50% more than vaginal births.
- Decreasing cesarean births by 28% would result in a $659 million savings per year for Medicaid in the U.S.

Medicaid coverage of doulas is cost effective.

- It is estimated that doula services reimbursed at an average of $986 (average across U.S.) has the potential to result in overall Medicaid cost savings as doula supports decrease the rates of preterm and cesarean births.[iv]

[i] Association of State and Territorial Health Officials. (2018). State Policy Approaches to Incorporating Doula Services into Maternal Care. [Online] http://www.astho.org/StatePublicHealth/State-Policy-Approaches-to-Incorporating-Doula-Services-into-Maternal-Care/08-09-18/

[ii] Carol Sakala PhD, M. S. P. H., & Corry, M. P. (2016). Overdue: Medicaid and private insurance coverage of doula care to strengthen maternal and infant health. *The Journal of Perinatal Education*, 25(3), 145.

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[iii] Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2014). Major Survey Findings of Listening to MothersSM III: Pregnancy and Birth: Report of the Third National US Survey of Women's Childbearing Experiences. *The Journal of perinatal education*, *23*(1), 9.

[iv] Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth*, *43*(1), 20-27.

8. Improve access to long-acting reversible contraception (LARC) in order to prevent unintended pregnancy

Background

Unintended and adolescent pregnancy are associated with late entry into prenatal care, which increases the risk of poor health outcomes for both the mother and the baby. Unintended and adolescent pregnancy are a significant problem in Harris County and across the Houston region. The Pregnancy Risk Assessment Monitoring System survey (2012-2014) found that, among women reporting in Harris County, 33% reported their most recent pregnancy was unintended. In addition, in 2014, there were 5,610 teen births (up to 19 years of age) in Harris County, accounting for 7.9% of the total births.[1] The use of contraceptives greatly reduces the likelihood of becoming pregnant unintentionally, and LARCs are the most effective form of contraception. LARCs have been proven to be 99% effective in preventing pregnancy, are continuously effective for years, minimize the chance of human error, and can be removed whenever the user is ready to become pregnant.

Women with low incomes are at disproportionately high risk for adolescent and unintended pregnancy. The high cost of LARCs remains a barrier for low income women and contributes to this disparity. Although Medicaid covers the cost of contraceptives, most women with low incomes in Texas are not eligible for Medicaid until they become pregnant. As a result, most women in Texas are uninsured or using private insurance, which may not cover all forms of contraception. In addition, the current federal administration's changes to Title X have effectively removed the requirement for family planning grantees to offer all contraceptive options to their patients.[2,3] The new policy is detrimental to patients' access to LARCs for those that rely on Title X supported health centers for family planning, namely young women with low incomes.

Access to a full range of contraceptive options, including LARCs, for all women of reproductive age is a fundamental step toward preventing unintended pregnancy. Implementing effective pregnancy prevention strategies will significantly reduce the social and economic burden of unintended and adolescent pregnancy.

Fiscal Impact

In 2010, federal and state governments spent $2.9 billion on unintended pregnancies.[4] The state of Texas paid $1.1 billion for services related to teen pregnancy in 2010, the majority of which are unintended pregnancies.[5] The cost of unintended pregnancy and the elevated incidence of pregnancy complications in this population is exorbitant. In contrast, public spending for family planning services totaled $148 million ($92M Medicaid, $14M Title X) in Texas. The resulting reduction of unintended pregnancy and negative reproductive outcomes saved $749 million in federal and state dollars.[4] An investment in better family planning services, including access to LARCs, would be fiscally advantageous for Texas.

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