DEPARTMENT OF HEALTH & HUMAN SERVICES

Secretary's Advisory Committee on Infant Mortality
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http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality//

November 22, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary:

In this time of budget cutting and deficit reduction, it is particularly important for the Secretary's Advisory Committee on Infant Mortality (SACIM) to provide you and your agency with strategies for reducing infant mortality and improving the health and well-being of all women, children and families in the United States. As you know, according to the World Health Organization and other sources the US now ranks 41st in the world in infant mortality (representing a drop in our standing from 33rd in 2000-2005). Because infant mortality rates reflect how well we take care of women and children with respect to medical care, housing, food, and income, this ranking is unwelcome news and suggests that the progress we have made in reducing infant mortality over the last twenty years is in jeopardy.

With these troubling data in mind, and after a review of the current proposed budget by Congress for Fiscal Year 2012, the SACIM has discussed the value of the core maternal and child health (MCH) programs that are currently in danger of being cut by the US Congress and the devastating impact these cuts would have on infant mortality, as well as its precursors, low birthweight, preterm birth, and maternal morbidity. Programs such as the Title V Maternal and Child Health Services (MCH) Block Grant, Medicaid (Title XIX), Title X/Family Planning, and Community Health Centers are facing major cutbacks and in some cases, elimination, in he various budget discussions and negotiations. Because all of these programs provide core maternal and child health services and play a major role in infant mortality reduction, we urge you to actively support full funding of the Medicaid, MCH Block Grant, the Title X Family Planning Program, and Community Health Centers. We urge you to support full funding of these programs for the following reasons:

> **Medicaid:** An estimated 40% of US infants are born to women covered by Medicaid. In some states, where families are more likely to be poor, more than half of births are financed by Medicaid. Although women and children comprise the majority of Medicaid recipients, the health care needs of pregnant women and children, in

particular, represent only 20% of the Medicaid dollars spent. Cuts in Medicaid translate into reduced access to care for pregnant women and infants. For example, enhanced prenatal care is in the optional benefits category (and recommended by the Institute of Medicine [IOM]); these categories are a target for cuts if Medicaid funds are reduced. Outreach to enroll women in early prenatal care, a hallmark of our success since the mid 1980s, is also threatened. As it stands, one in five low income women is without coverage prior to a first pregnancy, and further cuts into adult optional eligibility would worsen the situation.

The MCH Block Grant: The MCH Block Grant has been at the heart of infant mortality reduction efforts in the US for more than 75 years; by leveraging federal dollars with a state match, the MCH Block Grant provides the essential infrastructure at the national, state, and local level for the delivery of MCH services. In particular, state and local health departments depend on these resources to maintain operations and provide women and children with essential MCH services such as lead screening and immunizations. Since its inception, the Title V MCH Block Grant has served as the incubator for innovation in MCH services, seeding new approaches and programs and then working with public and private partners to ensure widespread and effective implementation. The creation of regional perinatal systems of neonatal intensive care units (NICUs) and our national strategy for newborn screening are prime examples. Importantly, because the MCH Block Grant is already severely underfunded, any cuts will have a major negative impact on the services and workforce training that can be provided at the state and local level. As you know, the new Home Visiting Funds provided by the Affordable Care Act (ACA) are separate from the MCH Block Grant; it is critical that one funding stream not be used to supplant the other.

Title X Family Planning: The Title X Family Planning program assures access to family planning education and services for millions of women, particularly low-income and young women. Sixty percent of the women using Title X clinics consider these clinics their usual source of care. Each year, Title X prevents 973,000 unintended pregnancies. Without Title X funding, it is expected that the number of unintended pregnancies would grow by a third. Importantly, unintended pregnancies are highly correlated with adverse pregnancy outcomes including low birthweight, preterm delivery, and infant mortality. Elimination of the Title X program is likely to lead to an increase in infant mortality.

Community Health Centers: Community Health Centers (CHCs, also known as Federally Qualified Health Centers – FQHCs – under Medicaid and Medicare) provide services to more than 20 million patients each year in medically underserved areas and at an average rate of $1.30 per patient per day. Women, nearly half of whom are of childbearing age (15-44 years), comprise 59 percent of CHC patients. Moreover, CHCs provide the care associated with more than 17% of the births to low-income families. CHCs provide comprehensive primary care, including family planning, prenatal care, and infant care in communities that are otherwise medically underserved. Data show that as CHCs serve more low-income individuals in a state, the state's

African-American/white and Hispanic/white health disparities decline in such key areas as infant mortality and prenatal care rates. More CHCs will be needed with implementation of the ACA and the provision of health insurance coverage to 32 million people, a majority of whom will be low-income individuals who live in medically underserved communities. As the expansion of CHCs is a key to the success of ACA implementation, the nation cannot afford to scale back efforts to expand primary care for underserved communities.

WIC: Although your Department does not oversee the Supplemental Nutrition Program for Women, Infants & Children (WIC) program, we believe that because the same population of women and families served by DHHS is also served by WIC and because of the collaborative relationship between HHS and USDA, your support of WIC funding is imperative. The WIC program provides 2.14 million pregnant and postpartum women, 2.17 million infants, and 4.86 million children through age 5 each year with nutrition counseling and food during the most vulnerable stages of child development, pregnancy and the first years of life. Data have demonstrated that WIC is associated with reduced rates of low birthweight, a major precursor of infant mortality.

The SACIM believes that these four DHHS programs together with WIC are essential to reducing infant mortality and play a critical role as the nation moves to implement health reform. We believe that cutting core programs for women and children at a time when our nation's poverty rate is the highest it has been in two decades makes no sense and will have a direct adverse impact on the health of women and infants. We cannot hope to maintain, let alone improve, our progress in reducing infant mortality and improving birth outcomes if these programs are not maintained or are significantly scaled back. If our nation is concerned about our long-term future, short-sighted cuts are not the answer. We urge you to vigorously defend these core MCH programs.

The SACIM stands ready to assist you with specific guidance and advice on how to advance the MCH agenda in a fiscally responsible manner. We look forward to your reply.

Thank you.

Sincerely yours

/S/

Michael C Lu, M.D., M.P.H.
Chairperson

Enclosure

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