DEPARTMENT OF HEALTH & HUMAN SERVICES

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

March 26, 2012

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

Dear Madam Secretary:

We strongly believe that the Patient Protection and Affordable Care Act (ACA) offers major opportunities to further reduce infant mortality in the United States. This letter affirms our views on the importance of the ACA in reducing infant mortality and outlines some important implementation opportunities.

Over the past fifty years, progress in reducing infant mortality has largely been the result of saving babies born too soon or too small. Preterm birth (prior to 37 weeks gestation) and low birthweight (less than 2,500 grams) are together the greatest cause of infant mortality. While all of the factors driving adverse birth outcomes are not understood, the Institute of Medicine has identified risks that can be addressed now, with current knowledge. To do so will require a continuum of care starting before pregnancy, continuing with high-quality prenatal and birth services, and addressing the needs of women and infants after the birth.

For many, prenatal care comes too late to reduce risks, complications, or deaths among women and infants. Evidence indicates that the health of a woman prior to conception can significantly affect the outcome of any future pregnancy. National recommendations call for use of preconception (and interconception) care to further reduce infant mortality. In 2008, prior to the reform, policy experts recommended: 1) coverage for adult women; 2) preventive services, including family planning and preconception care, without cost sharing; 3) patient protections; and 4) interconception care to women with a prior adverse pregnancy outcome in Medicaid.

With continued implementation of ACA, these recommendations can be fulfilled. The Patient's Bill of Rights protections are already in place. Women's clinical preventive services, as recommended by the Institute of Medicine, will be covered by most health plans without cost sharing beginning in August, 2012. ACA will make affordable coverage available in 2014 to the one in five women of childbearing age who is uninsured.

Moving forward, we believe that the following opportunities to fine tune implementation of the ACA are particularly important for reducing infant mortality and improving the health of women, infants, and families.

Coverage, Benefits, and Patient Protections

- **Inform women of their coverage options, rights, and opportunities to gain access to health coverage and care**. This would include promotion of the women's clinical preventive services package. The Office of Women's Health has created one grant opportunity. This work should be continued and expanded.

- **Inform families about the preventive services coverage for Bright Futures well-baby care, immunizations, and newborn screening**. Continued emphasis on well-baby visits, immunizations, and newborn screening can save lives as those factors that lead to death during the post-neonatal period are well-known and amenable to intervention.

- **Promote utilization of benefits among newly covered young adults to age 26**. Pregnancy and birth rates are highest for women in their twenties, particularly ages 20-24. Promoting the use of preventive and other health care is especially important for this age group. (Let's not wait until they are pregnant.)

- **Protect CHIP and Medicaid coverage for children**. The ACA's "maintenance of effort" provision requires that States maintain eligibility for children enrolled in the Medicaid program in families earning <133% of the federal poverty level or the CHIP program until 2019. These provisions, plus automatic newborn eligibility and continuous eligibility through the first year of life under Medicaid, are vital to low-income infants.

- **Monitor pre-existing condition exclusions for children**. Infants are protected by the ACA provision that prohibits health plans from denying insurance to children due to pre-existing conditions. Birth defects and other congenital conditions were formerly considered pre-existing conditions by some plans. DHHS should monitor compliance.

Innovation and Focus through Medicaid

- **Use the Center for Medicare and Medicaid Innovations to demonstrate the effectiveness of new care models**. The *Strong Start* grant opportunity to evaluate the effect of enhanced prenatal care is an important step. Future innovations grants – maybe another stage of *Strong Start* – could demonstrate approaches that span the continuum from family planning through pregnancy and birth to 24 months of interconception care for low-income, high-risk women and infants. Innovation Grant Challenge projects also should include efforts aimed at improved quality in newborn and regional perinatal care.

- **Support States' use of Medicaid health homes for women of childbearing age with chronic conditions**. For women of childbearing age, for example, such projects might aim to provide an effective, patient-centered medical home for women with two or more

chronic conditions (e.g., asthma, obesity, diabetes, substance use disorder, mental health conditions). Each of these conditions increases risk for an adverse birth outcome.

- **Support additional states that are ready to apply for and use interconception/ interpregnancy care waivers under Medicaid**. In 2011, Georgia implemented the first Medicaid waiver to focus on interconception care building on a successful Atlanta project. Louisiana is seeking Centers for Medicare and Medicaid Services approval for a similar project. Other states hope to develop interconception waivers as a lead in to expanded coverage under ACA in 2014.

Home Visiting

- **Enhance the role of home visiting programs in supporting interconception health.** Current home visiting models for mothers and young children have not shown consistent and significant improvements in maternal health outcomes. *Strong Start* will link to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program evaluation (particularly in relationship to birth outcomes); however, we call for more attention to prevention of adverse outcomes in subsequent pregnancies through interconception care for mothers served in the MIECHV program.

Primary Care Capacity and Workforce Development

- **Maintain the ACA multi-billion dollar commitment to expansion of community health centers**. (CHCs, also known as federally qualified health centers–FQHCs–under the Medicare and Medicaid programs). CHC/FQHCs are experts in delivering care in a patient-centered medical home, with teams of providers and address both the medical and social determinants of health. The comprehensive primary care delivered by CHC/FQHCs can help to reduce racial/ethnic and income disparities in infant mortality.

- **Maximize opportunities in the ACA to improve the primary care and public health workforce.** These include investments in training for primary care physicians, nurses, the public health workforce, and community health workers. Such investments will generate the workforce needed to care for women, infants, and families.

Prevention and Public Health

- **Protect the Prevention and Public Health Fund**. Twice, the Prevention and Public Health Investment Fund dollars have been used to fund other priorities. These funds are vitally needed to focus on the health and wellness of our families and communities.

- **Encourage states to use Community Transformation Grants (CTGs) to address the chronic disease risks and needs of women of childbearing age**. The CTGs program awarded $103 million to 61 states and communities. Without specific direction related maternal and child health, many grantees have not partnered or focused on women of reproductive age and/or children. More explicit guidance is needed.

- **Guide states and communities toward approaches for improving the health of women and infants through the National Prevention Strategy.** The Strategy calls for increased preconception, prenatal, and other reproductive health services. The tobacco control, healthy eating, limited use of drugs and alcohol, active living, and safe home and community environments called for in the Strategy also are critical to healthy babies.

- **Promote breastfeeding.** DHHS should collaborate with the Department of Labor to monitor and protect breastfeeding mothers' right to reasonable break time and appropriate space in the workplace to express breast milk as enacted through the ACA.

- **Engage the National Prevention Council.** The Council has a potential role, in partnership with the Secretary's Advisory Committee on Infant Mortality, to advance a cabinet-level, inter-agency focus on reducing infant mortality and closing the gap between African American and white babies.

As we approach the second anniversary of this landmark legislation, this letter affirms the importance of the ACA in reducing infant mortality. Health reform will improve health equity by giving millions of additional women, children, and families access to affordable health coverage with essential health benefits and patient protections across the lifespan.

Sincerely,

/s/

Kay A. Johnson, M.Ed., M.P.H.
Acting Chairperson
Secretary's Advisory Committee on Infant Mortality