



October 16, 2020

The Honorable Senfronia Thompson, Chair  
House Committee on Public Health  
*Submitted via email to [publichealth@house.texas.gov](mailto:publichealth@house.texas.gov)*

***RE: Interim Charge 1 – Women’s, Maternal and Infant Health***

Dear Chair Thompson and Committee Members:

On behalf of the Texas Medical Association, Texas Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists District IX (Texas Chapter), Texas Academy of Family Physicians, Texas Pediatric Society, and American College of Physicians, Texas Chapter, thank you for the opportunity to provide input on the House Committee on Public Health’s Request for Information (RFI) regarding *Interim Charge 1: Women’s, Maternal and Infant Health*.

During the 2019 legislative session, a chorus of physicians, providers, hospitals, consumer advocacy groups, and faith-based organizations called up on lawmakers to improve maternal and child health, particularly efforts to reduce the state’s disturbingly high number of maternal deaths. Then, as now, our organizations supported enactment of legislation to provide low-income women with 12-months comprehensive health care coverage before, during, and after pregnancy.

**Healthy pregnancies do not begin at conception, but well before.** Once a pregnant patient walks into a physician’s practice, prenatal care cannot undo the physical toll of any underlying health issues, including the impact of any inconsistently managed chronic conditions. For example, poorly regulated diabetes can result in congenital birth defects at the time of conception, well before a woman even knows she is pregnant. Obesity during pregnancy puts a woman at higher risk of developing serious complications, such as hypertension or gestational diabetes, and contributes to higher rates of miscarriages and birth defects.<sup>1</sup> Thus, access to timely, comprehensive preconception care ensures that women with underlying health conditions will be healthier before getting pregnant. **Likewise, following childbirth, postpartum women need ongoing treatment for any underlying chronic health conditions or to treat complications that might arise in the year following, such as postpartum depression.**

During pregnancy, many low-income Texas women qualify for Medicaid, but that coverage ends 60 days postpartum, except for the small number of women poor enough to qualify for Medicaid as a parent. However, according to the state’s own expert panel,<sup>2</sup> women’s lack of access to regular preventive, primary, and specialty care before and after pregnancy contributes to Texas’ high rates of maternal deaths, most of which occur 60 days or more postpartum – the same time many low-income women lose their pregnancy-related Medicaid services – and most of which are preventable. Moreover, **for every one maternal death, 50 to 100 women suffer a severe illness or complication, often with lasting consequences.**

Through the Healthy Texas Women (HTW) program and Family Planning Program (FPP), women can obtain preventive health care before and after pregnancy, including well-woman exams and contraceptives. For women eligible for HTW, limited primary care also is available, covering treatment

for diabetes, asthma, and hypertension *when provided in a primary care setting*. If specialty care is needed, such as a referral to a cardiologist or endocrinologist, it is not covered. However, legislation enacted during the 86<sup>th</sup> legislative session will help.

Senate Bill 750 directed the Texas Health and Human Services Commission (HHSC) to implement *limited*, enhanced postpartum benefits for new mothers eligible for HTW (no changes were made to the FPP benefits). On Sept. 1, HHSC launched the program, called HTW Plus. In addition to the benefits available under traditional HTW, it will cover treatment for three of the most common postpartum conditions experienced by women in the year following delivery:

- postpartum depression and other mental health disorders, including counseling and psychotherapy;
- Cardiovascular and coronary conditions; and
- Substance use disorders.

After 12 months, HTW Plus's heightened coverage will end regardless of whether a woman requires ongoing specialty or behavioral health services, though she can reapply for traditional HTW.

(Importantly, during the pandemic, states must maintain Medicaid coverage for anyone enrolled on or after March 18, 2020, including women who otherwise would have lost Medicaid 60 days postpartum. In March, Congress enacted the federal Families First Coronavirus Response Act, which provided states a 6.2% increase in their federal Medicaid matching dollars in exchange for maintenance of coverage.<sup>3</sup> As a result, in the coming months it will be difficult to ascertain HTW Plus's impact.)

Without question, HTW Plus represents progress in the state's efforts to improve maternal health. The conditions covered are indeed ones most likely to contribute to maternal death or complications and ones our organizations support incorporating into HTW's enhanced benefit package. **But designing a program that offers treatment only for certain diagnoses means women with multiple complex conditions will not get all the care they need.** It also puts physicians and providers in an ethical and financial quandary, since many HTW Plus patients will need care beyond the HTW Plus benefit package. **That is why our organizations' position remains unchanged from 2019: comprehensive coverage matters most.**

Under the Affordable Care Act, states have the option to extend Medicaid to uninsured, working-age adults and parents earning less than 138% of the federal poverty level (in 2020, \$29,973 for a family of 3; \$17,608 for an individual). Moreover, each state can design coverage in a way best suited to their populations.<sup>4</sup> **Thirty-nine states, including all of Texas' neighbors** – Arkansas, Louisiana, Oklahoma, and New Mexico – **have exercised this option.** In fact, in July Oklahoma voters approved a ballot initiative to extend Medicaid coverage, ensuring that their state's tax dollars will come back to help their residents

According to the United States Census Bureau, prior to the arrival of Sars-Cov-2 18.4% of Texans – 5.2 million – lacked health care coverage. Among Texas women of reproductive age, 25% fell into that category. Yet, over the past nine months, these numbers have certainly grown. Data show that women with young children have been harder hit by pandemic-related job losses<sup>5</sup> and thus are more likely to become uninsured due to the loss of associated employer-sponsored health care coverage.

**Studies show that women who live in Medicaid-expansion states fare better.** They are:

- More likely to obtain preventive health care, including cancer screenings;
- More likely to have ongoing health care coverage, both before and after pregnancy<sup>6</sup>;
- More likely to get postpartum treatment when they suffer severe complications<sup>7</sup>; and
- Less likely to die postpartum.<sup>8</sup>

**Moreover, a large and growing body of research shows that by ensuring low-income families have access to affordable, comprehensive health care coverage states strengthen families themselves,**

**making them healthier, more economically stable, and productive** – healthy parents can go to work and their children to school.

**When parents have health care coverage, their children also are more likely to be covered too.**

Insured children are healthier children, able to obtain not only preventive care, such as well-child checks and vaccinations, but also other medically necessary services, ranging from developmental screening exams to treatment for asthma or acute injuries. Studies show that children enrolled in Medicaid not only have healthier childhoods, but also go on to become healthier, better educated, higher earning adults.<sup>9</sup> Alarmingly, in 2019 the number of children without health insurance increased. **Today, 1 million Texas children are uninsured**, up from 752,000 in 2016.<sup>10</sup> **Of the 20 counties with the highest number of uninsured children, seven are in Texas, with Harris and Dallas counties leading the pack.**<sup>11</sup>

It is for these reasons that we continue to strongly advocate for *enactment of comprehensive health care coverage initiatives for women, children, and families including:*

- Extending Medicaid coverage to low-income uninsured working-age adults.
- Providing 12 months comprehensive coverage for women who lose Medicaid 60 days postpartum.
- Ensuring children enrolled in Medicaid receive 12 months continuous coverage, the same benefit children enrolled in the Children’s Health Insurance Plan (CHIP) receive.
- Increasing outreach and enrollment initiatives to help families obtain health care for their children who are eligible but not enrolled in Medicaid or CHIP.

As important as coverage is to improving women’s health, it is most certainly not the only barrier to improving timely access to care, particularly for women in need of early intervention and treatment related to postpartum depression and other perinatal mood disorders.

In July, our organizations submitted comments on the state’s Postpartum Depression Strategic Plan. An estimated 14% of postpartum women in Texas suffer from the disorder each year compared with an estimated one in eight nationally.<sup>1</sup> However, across states and populations, the rates vary considerably, ranging from 9.7% in Illinois to 23.5% in Mississippi.<sup>2</sup> While Texas’ rate is closer to the national average, there is clearly room for improvement by adopting a comprehensive, proactive, and deliberate postpartum depression (PPD) reduction plan.

In addition to coverage, we strongly recommended that HHSC pursue regulatory and/or legislative initiatives to meaningfully advance the state’s PPD screening and treatment improvement plan. We respectfully submit these same recommendations for the committee’s consideration:

- Collaborate with the Texas Child Mental Health Care Consortium to explore implementation of a Postpartum Depression Access Network akin to the Child Psychiatric Access Network ([CPAN](#)), which Texas launched this year. CPAN offers a network of mental health specialists to train and provide virtual consultations to primary care physicians to expand capacity to treat and manage child and adolescent behavioral health disorders. Massachusetts implemented such a program – Massachusetts CPAN for Moms Program ([MCPAP](#)) – focused on postpartum depression.
- Expand the types of settings and physician specialties for which postpartum depression screening exams are payable under Texas Medicaid to improve early identification of PPD, including:
  - Increasing from one to four the number of PPD screening exams provided during a newborn’s well-child visits, which would align Texas Medicaid policy with the American Academy of Pediatrics’ recommendations to conduct screening exams during the 1-, 2-, 4-, and 6-month well-baby checks.
  - Extend Medicaid/CHIP coverage for PPD screening exams for mothers with newborns admitted to the neonatal intensive care unit for an extended stay. Mothers of infants in the

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<sup>1</sup> [Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018](#), Centers for Disease Control and Prevention, *Weekly* / May 15, 2020 / 69(19);575–581.

<sup>2</sup> *Ibid.*


- NICU are more likely to experience maternal mental health challenges, and research shows the benefits of screenings in NICUs as a critical part of every family assessment; and
- Pay obstetrical care physicians and providers for conducting PPD screening in accordance with guidance from the American College of Obstetricians and Gynecologists, which recommends at least one screening exam be provided prenatally or within six weeks postpartum.
  - Maintain Medicaid audio-only telemedicine and telehealth services as well as new telemedicine and telehealth flexibilities extended to the HTW and FPP. Access to virtual care is critical to improving the availability of PPD screening and treatment for women who lack transportation or face other barriers accessing in-person or traditional telemedicine.
  - Collaborate with stakeholders to identify strategies to seamlessly transition women from pregnancy-related Medicaid to HTW Plus in order to maintain continuity of care (please refer to comments on Interim Charge 2, Healthy Texas Women’s waiver, for detailed comments on ensuring continuity of care for women)
  - Establish a mechanism for physicians and providers to quickly refer women with moderate to severe PPD to local mental health authorities (LMHAs). At a minimum, each LMHA should explain on its website how to make such a referral and establish a point of connection for physicians to call. Furthermore, it important for the state to collect data on whether LMHAs themselves have capacity to diagnose and treat women with PPD. Many physicians report their LMHA lacks the capacity or expertise to do so. Each LMHA should report on the number of women referred for PPD treatment compared with those the center could serve. Likewise, we request that HHSC establish a similar process to simplify referrals to substance use disorder treatment facilities. There is a strong link between PPD and substance use, thus women with co-occurring conditions need timely treatment for both.
  - Establish a reference tool on the HTW Plus website for physicians to quickly identify covered benefits. A common complaint among physicians about HTW is that it is difficult to determine what the HTW benefit package covers.
  - Increase awareness of the Postpartum Depression Tool Kit. Several physicians commented they were unaware of the tool kit but found it to be informative. We recommend that HHSC work with our organizations, as well as the Medicaid managed care organizations (MCOs), to promote the kit to physicians who participate in Medicaid and HTW.
  - Provide a centralized, regularly updated electronic portal where patients and physicians can quickly search to identify regional resources, building on requirements of [Resource Guide Provided to Parents of Newborn Children](#) (Section 161.501 of Health and Safety Code) as found on the DSHS website.
  - Collaborate with state physician societies, faith-based organizations, hospitals, and advocacy groups, among others, to develop a coordinated outreach and educational campaign to educate mothers and families about PPD and reduce stigma associated with treatment.
  - Incorporate into PPD educational materials and resources information about the interconnection between untreated PPD and substance use disorders and suicide. Additionally, as HHSC develops the PPD referral network as required by SB 750, it will be important that the state work with MCOs and physicians/providers to ensure a holistic network that can connect women with PPD to an array of services to address co-occurring behavioral health needs rather than focusing on a single disorder.
  - Add language within the Strategic Plan describing how health care disparities, including lack of health insurance and transportation, have an impact on PPD screening, referral, treatment, and management.

Thank you for the opportunity to comment. Should you have any questions, please contact Helen Kent Davis, associate vice president, governmental affairs, Texas Medical Association, at [helen.davis@texmed.org](mailto:helen.davis@texmed.org) or (512) 415-8048; Michelle Romero, director, TMA legislative affairs, at [michelle.romero@texmed.org](mailto:michelle.romero@texmed.org) or (512) 743-8665; or Sam Cooper, health policy analyst, at [sam.cooper@texmed.org](mailto:sam.cooper@texmed.org); mailing address: 401 West 15<sup>th</sup> St., Austin, Texas 78701.

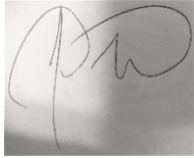
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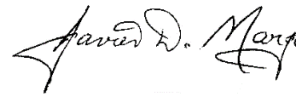
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<sup>1</sup> [Obesity and Pregnancy](#), American College of Obstetricians and Gynecologists

<sup>2</sup> Joint Biennial Report of the Maternal Mortality and Morbidity Task Force and the Department of State Health Services, September 2018, [https://www.dshs.texas.gov/mch/maternal\\_mortality\\_and\\_morbidity.shtm](https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm)

<sup>3</sup> Per the law, the protections must remain in effect through the end the quarter in which two emergency declarations have been issued: a national emergency, declared by the president, and a public health emergency, declared by the secretary of the Department of Health and Human Services. In March, the president announced a national emergency, which remains in effect. Soon thereafter, the DHHS Secretary Alex Azar announced the first 90-day PHE, which has been extended three times, including on Oct. 2, when Sec. Azar announced the extension of the PHE from Oct. 23 (the expiration date of the current PHE) to Jan. 20, 2021. The Secretary can subsequently renew it for another 90 days or withdraw it at any time.

<sup>4</sup> Oklahoma voters approved a ballot initiative to expand Medicaid in July 2020. The measure will be implemented in 2021.

<sup>5</sup> [Mothers Are 3 Times More Likely Than Fathers to Have Lost Jobs in Pandemic](#), Stateline, Sept. 28, 2020

<sup>6</sup> [High Rates of Perinatal Insurance Churn Persist After The ACA](#), Jamie Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, *Health Affairs*, Sept. 2019

<sup>7</sup> [Effects Of Medicaid Expansion On Postpartum Coverage And Outpatient Utilization](#), Sarah H. Gordon, Benjamin D. Sommers, Ira B. Wilson, and, Amal N. Trivedi, *Health Affairs*, Jan. 2020

<sup>8</sup> [Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality](#), Erica L. Eliason, MPH, *Women’s Health Issues*, Feb. 25, 2020

<sup>9</sup> [Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?](#), National Bureau of Economic Research, Working Paper 20835, Jan. 2015

<sup>10</sup> [Children’s Uninsured Rate Rises by Largest Annual Jump in More Than a Decade](#), Joan Alker and Alexandra Corcoran, Georgetown Center for Children and Families, Oct. 9, 2020

<sup>11</sup> Ibid, 17