House Committee on Appropriations  
Subcommittee on Labor, Health and Human Services, Education and Related Agencies  

Testimony for the Record in Support of Appropriations for the Title V Maternal and Child Health Services Block Grant  

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Chairman Cole and Distinguished Subcommittee Members:

I am grateful for this opportunity to submit written testimony on behalf of the Association of Maternal & Child Health Programs (AMCHP), our members, and the millions of women and children that are served by the Title V Maternal and Child Health (MCH) Services Block Grant. I am asking the Subcommittee to support an increase of $2 million in funding for the Title V MCH Services Block Grant for a total of $639 million for federal fiscal year 2016.

These funds are needed to extend evidence-based services and strategies that further the program’s statutory purpose to improve the health of all mothers and children by 1) ensuring access to quality maternal and child health services, 2) reducing infant mortality and preventable diseases and conditions, and 3) providing and promoting family centered, community-based, coordinated for children with special health care needs and facilitating the development of community-based systems of services for such children and their families.

I know you and your colleagues understand that this level of funding does not allow us to address all the health needs of our nation’s women, children, fathers and families. Despite recent progress, close to 24,000 babies tragically die each year. Many others are born too soon and cost our society upwards of $26 billion per year. Gaps in both private and public insurance create barriers for families needing services. Many pregnant women still smoke. The obesity epidemic continues to plague our country and the list goes on and on. In the face of these challenges, public health programs have already borne more than their fair share of deficit reduction with years of cuts and a budget cap that could cut funding even further. In total, more than 52,000 state and local public health jobs have been lost since 2008 due to the elimination of positions, hiring freezes, layoffs and furloughs. This represents a loss of 17 percent of the state and
territorial public health workforce and a 22 percent loss of the local public health workforce, with serious consequences for our capacity to address leading MCH challenges.

However, we recognize that during these tough budgetary times any substantial increase in funding would come at the detriment of other public health programs. Therefore, we strongly urge you to support a small $2 million increase in funding for the federal investment in the Title V MCH Services Block. Title V has proven to be a cost effective, accountable, and flexible funding source used to address the most critical, pressing and unique MCH needs of each state. States and jurisdictions use the Title V MCH Block Grant to design and implement a wide range of maternal and child health programs that respond to locally defined needs.

One of the most exciting developments with the Title V MCH Block Grant is a transformation that is happening right now under the leadership of Dr. Michael Lu, associate administrator of the Health Resources and Services Administration Maternal and Child Health Bureau. This transformation is focused on three main goals – to reduce burden, maintain flexibility and improve accountability. At its center is an effort to improve our performance measurement framework with a sharpened focus on national outcome measures, national performance measures and evidence-based strategy measures.

This transformation will ensure that investments made by the programs support evidence-based or informed strategies. Title V focuses on accountability and delivering results, and we are confident this transformation will build and strengthen that important focus so you can be assured that we are getting the best value for the taxpayer dollar while making real and measurable differences in the lives of our mothers and children. For more information on this effort, please contact me and my staff will help arrange further briefing and information on what this means for your state.

A key component of the Title V MCH Block Grant is the Special Projects of Regional and National Significance (SPRANS). SPRANS funding complements and helps ensure the success of state Title V, Medicaid and the Children's Health Insurance Program (CHIP) by driving innovation, training young professionals and building capacity to create integrated systems of care for mothers and children. Examples of innovative projects funded through SPRANS include guidelines for child health supervision from infancy through adolescence (i.e. Bright Futures); nutrition care during pregnancy and lactation; recommended standards for prenatal care; successful strategies for the prevention of childhood injuries; and health safety standards for out of home child care facilities.

One of the primary focus areas for states Title V programs is supporting systems of services for children and youth with special health care needs (CYSHCN). These systems serve a diverse group of children ranging from children with chronic conditions such as asthma or diabetes, to children with autism, to those with more medically complex health issues such as spina bifida or other congenital disorders, to children with behavioral or emotional conditions. Overall,
CYSHCN are defined as children birth to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and require health and related services of a type or amount beyond that required by children generally. In a recent national survey, children with a chronic condition birth to age 18 represented approximately 15 percent of the entire child population in the United States.

Creating a comprehensive, quality system of care for children and youth with special health care needs (CYSHCN) has been one of the most challenging areas for state health leaders and other stakeholders such as state Title V CYSHCN programs, health plans, private insurers, state Medicaid and CHIP agencies, pediatricians and family physicians, and families. By one critical measure, only 43 percent of all CYSHCN report receiving services via a recommended medical home. Medical homes are considered the gold standard because they promote care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

Recently AMCHP – with the generous support of the Lucile Packard Foundation for Children’s Health and a broad group of stakeholders – forged a project that we believe accelerates progress in this challenging area. For more than three decades, numerous national reports, initiatives, and research have described or called for frameworks, standards and various measures to advance a comprehensive system of care for CYSHCN and their families. These and other efforts have helped to establish important work in states, communities, health plans, provider practices, and other areas to build comprehensive systems of care for CYSHCN. However, until recently they have not resulted in an agreed on national set of standards that could be used and applied within health care and public health systems and other child-serving systems to improve health care quality and health outcomes for this population of children. It became clear to AMCHP and others that achieving consensus on the necessary capacity and performance of systems serving CYSHCN is essential to comprehensive, quality systems of care for this population of children.

To pursue this vision, AMCHP recently led a National Consensus Framework for Improving Quality Systems of Care for Children and Youth with Special Health Care Needs project to develop a core set of structure and process standards for systems of care for CYSHCN, based on the research and national consensus among a diverse group of stakeholders with expertise in their field. The resulting standards – available on our website - are intended for use by a range of national, state and local stakeholder groups including state Title V CYSHCN programs, health plans, state Medicaid and CHIP agencies, pediatric provider organizations, children’s hospitals, insurers, health services researchers, families/consumers and others. These standards represent a major breakthrough that can help improve our system of care for all children – and this committee can help further accelerate progress by assessing the resources needed to make sure every state has the capacity to fully operationalize and implement them.

In our view, one of the biggest under-celebrated success stories of recent times are the contributions this committee makes in funding programs such as the Title V MCH Services
Block Grant that contribute to substantial progress in reducing infant mortality. In fact, a few months ago President Obama responded to a question about priorities in media coverage by saying in an interview, "There's just not going to be a lot of interest in a headline story that we have cut infant mortality by really significant amounts over the last 20 years…” He noted that plane crashes and terrorism are more likely covered, and that other complex stories are harder for the media to report.

He’s right, and yet those who take a closer look will find that in 2013, 23,440 babies in the United States died in their first year of life, which is equivalent to about 117 average sized passenger planes crashing every year. That’s close to one every three days. The president also is right that we made tremendous progress in reducing that toll in recent decades – as mentioned, perhaps one of the greatest public health success stories rarely covered in the press.

For a long time, infant mortality rates have been one of the sentinel measures to gauge how well any society is doing to ensure the health of women, children and families. And here is the headline news: since we began collecting statistics in 1915, the overall infant mortality rate declined from nearly 100 of every 1,000 babies born in 1915 to nearly just 6 per 1,000 in 2011. That is a stunning 94 percent improvement and represents millions of lives saved.

Ensuring that babies are born in optimal health is all the more important considering the recent scientific advances in our understanding about how a baby’s early years are critical to building a strong foundation for the rest of their life course. That is the good news – but there also are a few caveats and contradictions. First, there are persistent and unacceptable disparities among racial and ethnic groups that have existed since the data collection began. The black and Native American infant mortality rates are twice the rates of whites, and in some communities it is even three times higher.

The second caveat is that the political will to accelerate progress and eliminate disparities is inconsistent. Perhaps the biggest contradiction is that the United States spends more money on maternity care than any other nation on earth, yet still lags behind 26 other industrialized nations on the key outcome of infant mortality.

Part of the problem is that too often we spend more on high tech treatments – think elective C-sections and neonatal intensive care units – than on basic prevention programs to address risk factors that can lead to poor birth outcomes. For example, we know that breastfeeding, family planning, immunization, smoking cessation and safe sleep are effective in reducing infant mortality. However, funding levels for these key public health programs have never matched actual need, have slowly eroded over time, and are suffering further threats from budget caps and looming sequestration.

Additionally, in June 2012, then Secretary of Health and Human Services Kathleen Sebelius called for the first ever National Strategy to Reduce Infant Mortality. A federally appointed
Secretary’s Advisory Committee on Infant Mortality (SACIM) submitted detailed recommendations but, to date, no formal strategy has been adopted.

Congress of course has the power of the purse, but has not consistently delivered on its obligation to annually review programmatic funding levels for public health programs and match resources to national needs. Instead, it has allowed the slow erosion of critical programs like the Title V MCH Block Grant – which has a statutory purpose to reduce infant mortality – by imposing cuts of close to $100 million over the past decade.

Currently funded at $637 million, this preventive program represents less than one day’s worth of the nation’s spending on the Medicaid program, which at $1.2 billion a day reached a total of $450 billion in 2013. This demonstrates once again that our health system spends plenty on health care but invests precious little in prevention and public health efforts. In terms of total potential cost savings to our health system, far too little attention is consistently given to health economics and the measurable financial impact of public health and the prevention of disease, illness and early death.

To move forward, we suggest four things: 1) your committee could ask the current leadership of the U.S. Department of Health and Human Services to take another look at the existing recommendations and deliver on the promise to create a national strategy to reduce infant mortality; 2) your committee could take a close look at that strategy, ask for briefings, assess where improvement is possible, and provide the resources and leadership needed to bring proven efforts to scale; 3) members of this committee and your colleagues can visit and highlight the communities where public health efforts are succeeding to help create the political will to accelerate those successes; and 4) you can support the small $2 million increase in funding for the federal investment in the cost effective and accountable Title V MCH Block Grant.

Taken together, this should generate some interest in headline stories and more importantly, help ensure that every baby that enters this world is born healthy and loved.

About AMCHP: The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs. AMCHP’s members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs. Our members directly serve all women and children nationwide, and strive to improve the health of all women, infants, children and adolescents, including those with special health care needs, by administering critical public health education and screening services, and coordinating preventive, primary and specialty care. Our membership also includes academic, advocacy and community based family health professionals, as well as families themselves. For additional information, please reach me at 202-775-0436 or lfreeman@amchp.org.