Texas CHIP Coalition
Meeting Minutes

March 11, 2016

Present: Will Francis, NASW
Clayton Travis, TPS
Anne Dunkelberg, CPPP
Melissa McChesney, CPPP
Julia Von Alexander, CPPP
Sharyn Malatok, March of Dimes
Adriana Kohler, Texans Care for Children
Brian Dees, HHSC
Michelle Erwin, HHSC
Amanda Woodall, HHSC
Leah Gonzalez, Healthy Futures
Helen Kent Davis, TMA

On the Phone: Sherry Vetter, Texas Children's Health Plan
Kathy Eckstein, CHAT
Laura Guerra Cardus, CDF
John Berta, THA
Jennifer Banda, THA
Greg Hansch, NAMI
Elizabeth Tucker, Every Child
Juanita Gutierrez, CommUnity Care
Angelica Davila, CommUnity Care
Sonia Lara, TACHC
Claudia Calderon, Texas Children's Health Plan
Sister J.T Dwyer
Jane Swanson, Attorney *Frew* lawsuit
Alanna Boulton, Central Health
Peggy Gulledge, Maximus
Kit Abney, Seton/insure a kid

Chair: Anne Dunkelberg, Center for Public Policy Priorities
Minutes Scribe: Julia Von Alexander, Center for Public Policy Priorities
Next meeting: April 15, 2016

I. Update from Medicaid/CHIP Division on STAR Kids (Brian Dees, HHSC)

- Why is HHSC not eliminating the waiting list for Medically Dependent Children's Program (MDCP) for SSI Kids? Question at last meeting.
- Senate Bill 7- creation of STAR Kids, includes MDCP in STAR Kids. Must consult with STAR Kids advisory committee and Children's Policy Council.
- Medically Dependent Children's program (MDCP waiver) Operated by DADS serves 5500-6000 children and young adults (i.e., through age 21)

- Main part is providing respite services (relief for parent/primary caretaker by home nurse or other professional). MDCP also provides minor home modification, transition assistance (from coming out of a facility), care coordination, etc.
- Transition assistance- not as utilized. Why? There are not many children who are long time nursing residents who are coming back into the community.
- Like most waivers is mix of families of children on SSI who already meet financial qualifications and of families of children just above SSI limits on waiver because they have medical necessity for institutional care, termed "medical assistance only" (MAO) in Texas Medicaid lingo. Similar to other Long term services and supports waiver programs, use income of 3 times that of SSI (about 200% FPL) to qualify MAO families. In MDCP, 40% of families are SSI, 60% are MAO.
- Per HHSC the barrier is appropriations. Appropriated certain amount, so have a specific number of waiver slots for MDCP. No increased appropriation through STAR Kids, so no additional slots. A clear legislative directive would make provisions of waiver services to all MDCP SSI children possible.
- STAR Plus- likely had an appropriations directive, or enough money to expand.
- HHSC-It was more expensive for all SSI adults in Medicaid to gain access to waiver services, because there was a much larger benefit upgrade moving from fee for service to STAR Plus because adult Texas Medicaid benefits are more limited than for children In contrast children outside the waiver already have access to private duty nursing, attendant care, and therapies cause federal Medicaid law requires access to all medically necessary care for children in Medicaid.. MDCP's additional family support (respite, transition, modifications, etc.) are largely non-medical and less costly.
- Anne D.: Don't believe most of the members are aware of this issue, which may be why it was not clarified in SB7.
  Any members respond to testimony for STAR Kids MDCP SSI? Seemed to register, need to follow up.
- How much would it cost? HHSC-not a lot. Ran the numbers 2 years ago, estimate of $40,000-$50,000 (in addition to what is already provided to those kids). Cost limit is 50% of what would have been paid at nursing facility.
- Clayton: TPS will formally request an estimate of the cost to move these kids to those waiver services from HHSC.
- Elizabeth Tucker-MDCP provides critical services. Home modifications are very important. Employment assistance and supportive employment is also a critical service offered through MDCP. If cost not that great, why aren't we doing that? When the Children's Policy Council completes its notes on this, Elizabeth will send to the CHIP coalition.
- LAR comment period for HHSC? Believe this has not happened yet; HHSC to follow up
- DADS LAR comment period ends 3/14 at 5pm and DARS LAR comment period ends 3/31 at 5pm. (Focus on the IDD system redesign)

II. Prenatal Care for Women (Amanda Woodall, HHSC & Sharyn Malatok, March of Dimes)

Roles of Medicaid and CHIP Division and of Maximus

- Impetus for discussion: 30 days maximum to get a pregnant woman to her first visit detailed in Texas Administrative Code. Coalition interested in how the several players coordinate to reach this goal.
- Maximus receives eligibility file- 24 hours to send enrollment packet with a flier about how to pick a plan and primary care provider.
- 15 business days from when packet is received by client to make that selection (made clear in letter, which also explains default option).
- Within that time period, Maximus has different benchmarks (will make phone calls, home visits)

- Maximus also attempts to see if a person has already seen a provider during their pregnancy so MCO can contact that provider.
- MCD has regular meetings with Maximus to help to identify systemic issues.
- Don't have to wait until receive packet in mail, can contact Maximus earlier. When is this communicated? In eligibility letter? Unsure if on eligibility letter, but enrollment packet is likely their first piece of mail.

Current March of Dimes Efforts

- **See slides.**
- Data on when women wanted care not just about when they got care. Shows the need to educate women on getting into their provider sooner.
- CDC data reports- number of births by when mother entered into prenatal care. 2013- Infant deaths by when women began prenatal care in TX. Can we compare TX to other states? Yes.
    - High correlation between getting no prenatal care and infant mortality
    - Can also break out by ethnicity/race
    - Data discussed at the meeting is attached & data source: http://wonder.cdc.gov/lbd.html
- Reimbursement rates- looking at Medicaid Managed Care changes based on quality of care; e.g., un-bundled payment for post-partum visit (e.g. extra payment to give provider incentive to get new mothers back for those visits)
- Anne D.: it would be even easier for MCOs and providers to make the push if they were already covering those women before they even need prenatal care. (Close the coverage gap)
- Transition to Texas Women's Health Plan- should be seamless from Medicaid now.
- Transportation issues- only available for mom and the baby (what about other children?)
- Go Before You Show campaign in conjunction with 2-1-1. Bus signs to advertise. Using maps in Houston to target where should message.
- Melissa M. Question: Does the messaging is it made it clear that there are services available for you if you make less than __XX_? Important since per PRAMS reports, many women reported they couldn't start the prenatal care process because they didn't have the money to pay for it.
- March of Dimes doesn't own the messaging campaign, but have the license for the state of TX. So must go through company for messaging changes. Could start using messaging around a 4 step process around being on Medicaid and getting on WIC. Partners that want to change/add messaging (e.g. points on access to Medicaid in Texas) would need to go through Sharyn, but the company will probably approve additions.
- Need extra encouragement for non-US citizen moms who are eligible.
- Idea is to push to 2-1-1 so can connect with services, need to work with 2-1-1 on a local level as their levels of accurate training are uneven across state. . Partners in the communities to spread the message to their clients. Need help getting more partners around the state. Have a partner agreement form, posters and referral cards.
- Provider side- resource guide to pilot in San Antonio with a few clinics (Healthy Start and the city to id clinics). A FQHC in Houston- went from 30% of clients getting care in the 1st trimester to 70% by focusing on processes and systems. Helps to have support for women for Medicaid application.
- Important to get women on Medicaid as quickly as possible. What can application assisters do to prevent denials? HHSC is following up with data on the most common reasons for denial of maternity coverage applications.
- Texans Care and other members would be interested in making messaging TX specific and working on adding to the messaging.
- Want to work on partner outreach- can get talking points/slides for potential partners from Sharyn.

- **Sharyn's contact information:** SMalatok@marchofdimes.org

III. Update on Medicaid for Former Foster Care Youth (Adriana Kohler, Texans Care)

- Last month discussed issues and work HHSC has done to fix those issues. Former Foster Care Youth can enroll in Medicaid 18-26.
- Updates on improvements:
    - 2-1-1 has improved staff training. Former foster care youth can ask to be escalated to the special former foster care youth Medicaid staff. Mary Christine (Texas-RioGrande Legal Aid) to work with clients to make sure that is going well.
    - Renewal form- allow for self-attestation now (verbally through 2-1-1 or written) to verify TX state residency. Still need to provide TX mailing address, but can be of friend or relative. Mary Christine has provided a template form and sent this info to state advocates.
- Anne D. New guidance may come soon on the question of out of state youth (potentially this spring) from the federal government. May clarify whether states can exclude Former foster care youth from other states.

IV. Hospital Presumptive Eligibility (John Berta, THA & Kathy Eckstein, CHAT)

- When initially proposed, coalition recommended that HHSC make the thresholds friendly for hospitals so can use presumptive eligibility more at hospitals. But, HHSC adopted fairly rigid standards.
- Criteria are too stringent for most to meet the qualifications, so many hospitals declined to participate.
- Hospitals say the standards undermine the purpose of presumptive eligibility, which is to yield immediate, short-term determinations. So restrictive that is surprising we have as many hospitals as we do that are participating. Hospitals can get 3 months retroactive Medicaid anyway, so what do they gain? Wanted to give the kids the ability to leave the hospital with Medicaid eligibility established so can fill prescriptions etc.
- Over the next few months the Coalition can figure out where things stand and see if this makes it on to the legislative agenda. Coalition could also request at administrative level and/or LBB. Need John/Kathy expertise in the future.
- Data was helpful, but would like a bit more. What was the most common occurrence of what hospitals in the performance review were doing wrong? Also, how many applications did each hospital submit? Can't really analyze b/c so few data points. Melissa M. to follow up with Kathy/John to refine data request.
- Brian Sperry of CHAT is retiring, Stacy Wilson (formerly THA) is his replacement. Anne D. expresses big thanks to Bryan and CHAT for two decades of support for Texas CHIP Coalition.

V. Medicaid Managed Care Stakeholder Meeting updates

- Clayton: HHSC series of 3 Medicaid Managed Care stakeholder meetings: Some issues we are familiar with, also concerns on IDD issues, care coordination, network adequacy/provider availability, provider recommendations
- Appreciated having these meetings. Not the clearest of next steps, but will post and update all information online. 1/3 responses in progress, 1/3 looking into, 1/3 can't do. Hopeful to see more on in progress pieces.
- Next steps? Reinstating advisory committees
- HHSC unsure of next public steps, but have the list at the staff level and working on it.
- Make sure get/read AARP written testimony- to HHSC.
- Biggest worry= network adequacy. Would like a public meeting to talk about what the standards might be. Better geographic standards? Break down by specialty? (including personal attendants)

- A number of CHIP Coalition members participate in an *ad hoc* Medicaid managed care consumer protection working group
- HHSC can ensure that there will be additional stakeholder meetings before SB 760 rules are formally posted to the register.
- Contract process- need opportunity for discussion on contracts. Early input should involve HHSC, health plans, providers and consumer advocates (not just the first 2). Fee for service- added to the website every time medical policy changed, opportunity for feedback. But currently doesn't exist for contract language (similar thing). Need to make sure that Medicaid Managed Care does not reduce stakeholder input or transparency.
- Would like a website similar to medical policy benefit changes for Medicaid Managed Care contract language changes, with ability to comment there. 10 days/2 weeks for comments- not asking for extended process.
- Per HHSC-contracting is a little different than medical benefits process. Uniform Medicaid Managed care contract is public so anything on that.
- Does really matter- affects consumers a lot. Currently don't fix until next contract period.
- HHSC to take back to see how might insert this into the process.

VI. Interim Hearing Updates and Discussion

- Health plans proposed that we eliminate single statewide formulary. So lots of testimony around this. Also, on managed care & MDCP.
- Inadequate professional fees for doctors in managed care. Haven't had regular inflation updates since 1993. Different methodology for each provider type and some have built-in increases for inflation. Anne to work on a way to visualize this with help from Clayton, Helen.
- Good for legislators/Appropriations to understand different situation for different types of providers.
- Concern that everyone doesn't have access to the same Rx benefit. State-wideness is a federal Medicaid law requirement. Currently, must cover everything under the Medicaid formulary, but may require a step process or prior authorization.
- Most plans use the same Pharmacy Benefit Managers (8 PBMs across the state). Prescribers can access the preferred drug list (PDL), but currently each plan can add variation through additional clinical edits. Can make clinical edits less stringent then the state. Problem occurs when enrollees and providers don't know and can't easily find out exactly what restrictions may be on a medication, even when it is preferred.
- Time and distance standards- provider level details and different geographic standards (rural/suburban/urban). Haven't upgraded our standards since roll out of managed care.
- Measure access to care by provider type. SB760 penalize plans if don't have accurate provider directories. Need metrics on critical specialties (e.g. personal attendants and others for long term services and supports, pediatric) more challenging to define for long term services, not a sure mileage standard. Welcome ideas on how to do that. Will take proactive research to determine this, not great standards anywhere & much variation.
- North TX UnitedWay- had to help support non-profit behavioral health services & providers to make up for low Medicaid reimbursement. Issue if no United Way people don't get same access to services.
- Managed care provider directories are online (in searchable form) and phone number to call. Can't limit access to provider/formulary info just to people who are enrolled-must be available to those looking for coverage too.
- NASW: Rates & ideas on how to increase. Common credentialing repository- 1 application to get on all managed care plans. Concerns for Medicaid revalidation-members having issues. Due 6/17/16.

- TMA- Credentialing issues & timeframe. Administrative burdens, vendor drug. Based on survey so far, expect plunge in physician participation now that ended parity payments and not renewed. Specialists/pediatric out or limited practices. National level- say average increase is 3%/year for physician practice. Hard to continue if Medicaid payments are stagnant. Hard time recruiting providers in the Valley (many Medicaid recipients). Dually eligible- cut hard for patients.

VII. Discussion on CHIP Coalition (Clayton Travis**)**

- Will update on specific name recommendations at next meeting
- 1 legislative briefing in fall- Medicaid 101 & 1 spring briefing- more narrow with priorities
- Hoping to get towards a more consolidated agenda.
- THA- doing legislative briefings. Make sure that we're not conflicting or duplicating. John Berta to follow up with Clayton/Laura/Sister J.T. on these briefings.

Member updates

- GAO report on supplemental payments only available to entities w/ access to IGT- CMS. Publishing rule between now and 6/21.
- US House Energy & Commerce hearing on Monday- bill that would end newer enhanced match for CHIP. Also, provider taxes. Email from the committee (supporting those proposals). Will send info out. Assume president would veto. Most governors will oppose. Targets prevention care fund too-.

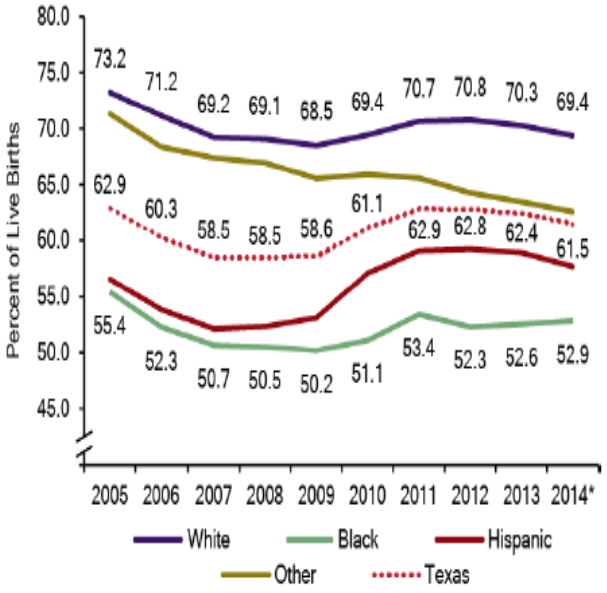
Will Francis will chair on April 15, which is a 90-minute meeting followed by Outreach and Eligibility Working Group meeting.

Early Entry into Prenatal Care

Sharyn Malatok, MPA
Regional Director,
MCH Program Impact

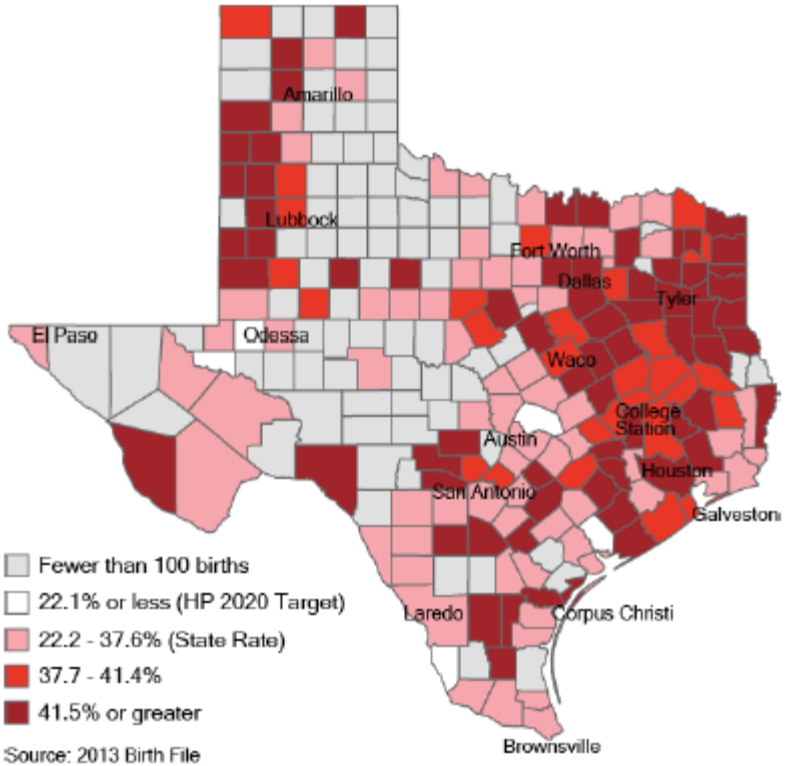
EEPNC Data

Figure 21
Percent of Live Births Where Mother Received Prenatal Care in the First Trimester Using Obstetric Estimate of Gestation, 2005-2014



*2014 Texas data are preliminary
Source: 2005-2014 Birth Files
Prepared by: Office of Program Decision Support
Sept 2015

Figure 22
Percent of Live Births Not Receiving Prenatal Care in the First Trimester (Obstetric Estimate), 2013

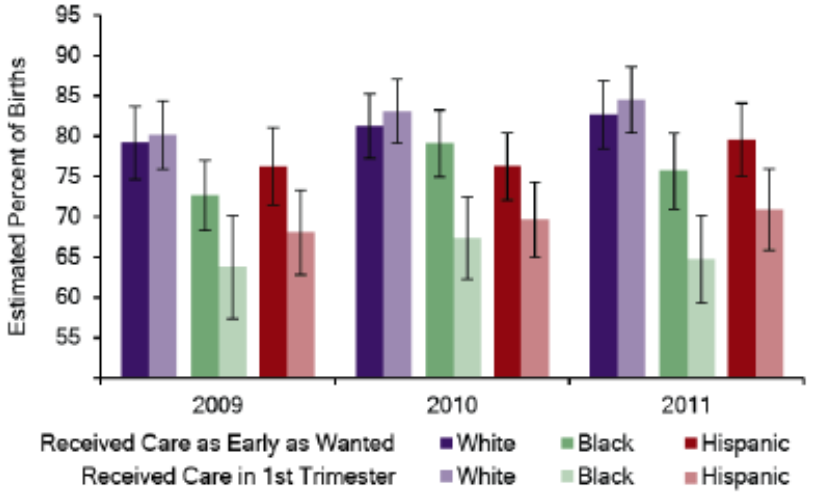


Source: 2013 Birth File
Prepared by the Office of Program Decision Support
Sept 2015

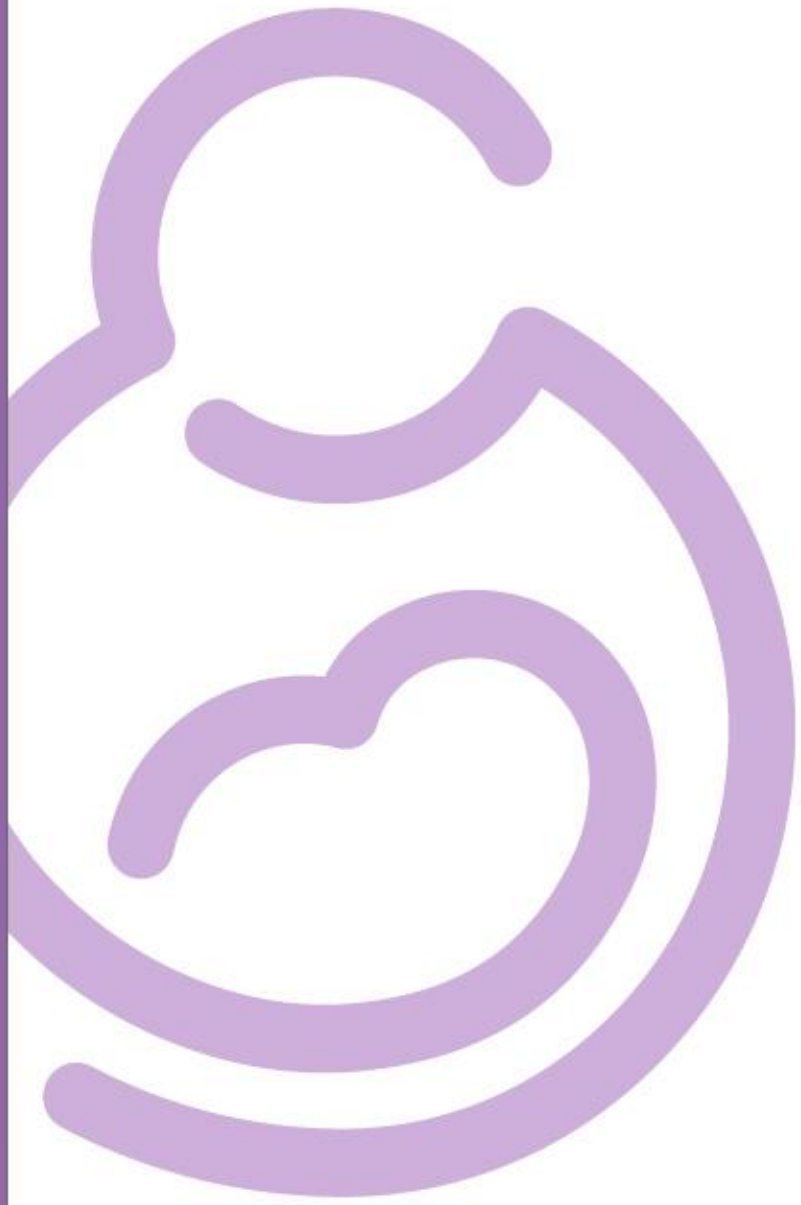
EEPNC Data

One of the challenges with increasing prenatal care access is the need to differentiate women who are not receiving care because they do not seek it from those that do not have access to it. While access is a barrier, PRAMS data indicate that the mother's desire to seek care in the first trimester may also be a factor in the low on-time access rates. There is a gap for Hispanics and Black women between the percent who received care on-time and the percent that received care as early as they wanted (see Figure 24). In the 2011 Texas PRAMS data, 65.2 percent of Black mothers received care in the first trimester; however, 75.5 percent said they received care as early as they wanted. This significant discrepancy suggests that many women were not seeking or wanting care in the first trimester.

Figure 24
Comparing Percent of Women Receiving Prenatal Care in First Trimester and Early as Wanted by Race/Ethnicity, PRAMS 2009-2011



Note: Prenatal care timing is self-reported in PRAMS and is not comparable to data from the birth file
Source: 2009-2011 Texas PRAMS
Prepared by: Office of Program Decision Support
Sept 2015



Removing the Barriers to Prenatal Care

Root Causes

Lack of education

Physician reimbursement rates from Medicaid

Lack of funding for “uncovered” individuals

Lack of transportation for patients

Age

Prenatal History

Lack of Education

Many women do not know or understand the importance of prenatal care.

- Many Community Outreach Programs focus on education once the patient is pregnant instead of prior to becoming pregnant.
- Teen sexual education programs focus on abstinence and the content does not include why prenatal care and pregnancy planning is important.

How Can We Improve the Lack of Education?

- Educate Community Outreach Programs
- Educate local High Schools to include the importance of prenatal care and pregnancy planning in their sexual education programs.
- Community Campaigns with broad outreach
- Some Health Plans offer quarterly education to members regarding women's health and prenatal care.

Physician Reimbursement Rates

- Medicaid and MCO's typically pay less than Commercial Health Insurance Plans for the same CPT and E&M codes.
- The average cost to run an OB practice per hour is $275-$450 per hour. That is approximately 6-8 Medicaid OB patients per hour. A nearly impossible scenario.
- Many times, Medicaid members transfer plans and present a card with invalid coverage, then causing billing and claims issues.

How Do We Improve Reimbursement Rates?

- Many Medicaid MCO's are making contractual changes based on quality of care provided and this can greatly increase provider pay if quality of care meets guidelines. There are also incentive plans available from some MCO's to increase case management participation and initiative participation.
- Educating Front and Back office staff regarding "financially safe" patient check-in protocol.
- Having front and back office staff attend provider orientation and trainings either in person or by webinar when offered.

Lack of funding for “Uncovered” Individuals

- Community outreach classes held quarterly demonstrating the importance of prenatal care and how to obtain coverage either through Medicaid or Indigent programs.
- Discussing eligibility options with existing community outreach programs to help assist the uncovered women in enrolling in a program for which they are eligible.

Lack of Transportation

- Medicaid has a transportation system in place that is greatly under-utilized. MTP must be contacted 2 weeks prior to the date of service for a ride to be arranged or reimbursement to be approved.
- Some MCO's have member relations departments which assist with these arrangements.

Age and Prenatal History

Women under the age of 19 are twice as likely to be late to prenatal care.

- Shame and embarrassment
- Lack of emotional and financial support

Women with a history of elective abortion are less likely to seek early prenatal care.

- Fear of judgment
- Fear of loss of pregnancy

How Do We Overcome the Age and Prenatal History Barriers?

- Again, stress the importance of prenatal care to the young women in local HS so that they seek prenatal care as soon as they know they are pregnant.
- When physician's advertise their services, include that they do see women with a history of miscarriage or elective abortion.
- As healthcare workers, many times we grow "numb and apathetic" to other's situations. There are sensitivity trainings offered by both the state and private entities to remind us why we got into this profession. But something as simple as a sign in the office break room can change a staff's demeanor.
- Remember that word of mouth is the best advertisement and can also be the worst. If you see a patient who is young or has a history that they are less than proud of, do less "preaching and scolding" and more "care" planning.

How Do We as a Community Remove the Barriers?

- Educate community members on the importance of early prenatal care
- Educate women on coverage options, eligibility for different programs and how to obtain that coverage.
- Educate physician office staffs, both back and front end as well as clinical staff on how to seek proper reimbursement and increase the reimbursement. Also, how to be sensitive to all patients' emotional needs.

Educate! Educate! Educate!

Go Before You Show

2·1·1 TEXAS
Connecting People and Services

Go Before You Show Community Campaign

Go Before You Show Campaign

"Go Before You Show" (GBYS) is a public education effort aimed at increasing knowledge about the importance of early prenatal care.

Deliver a community wide message regarding the early and consistent prenatal care.

Our Message

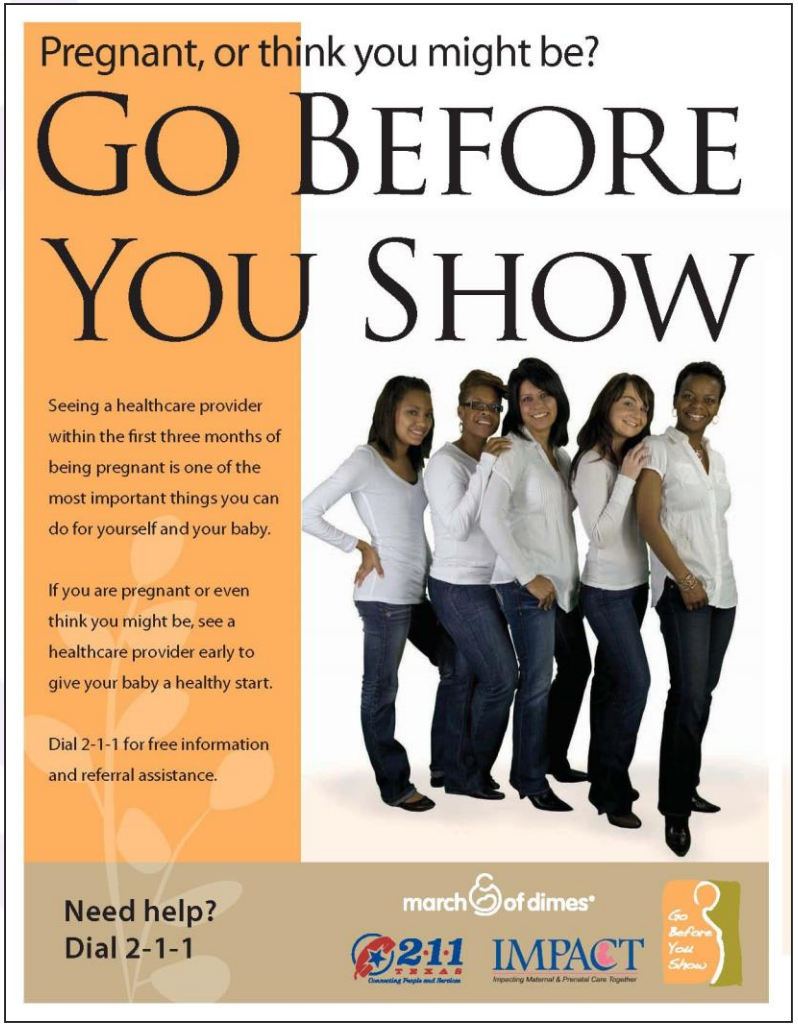
If you're pregnant or think you might be, then "Go Before You Show". Go see a healthcare provider for your first prenatal care appointment.

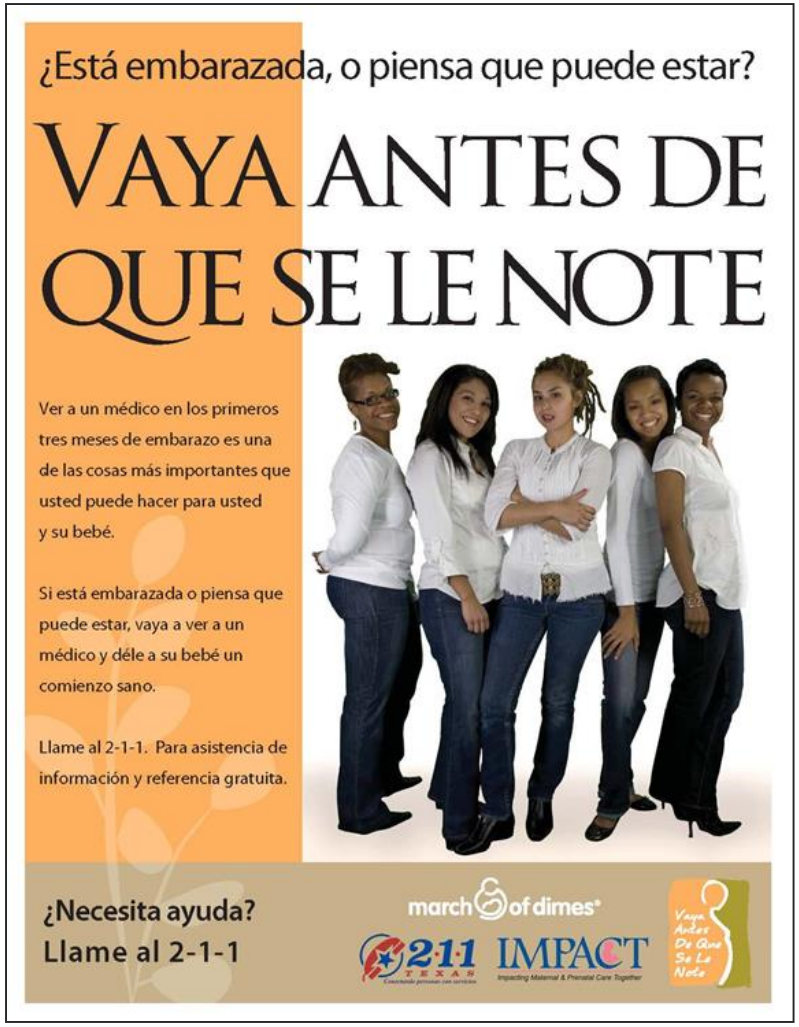
- Prenatal care is the care you get while you're pregnant.
- Early and regular prenatal care can increase your chances of a safe pregnancy and healthy baby.
- Dial 2-1-1 for free information and referral assistance.

Campaign Strategies

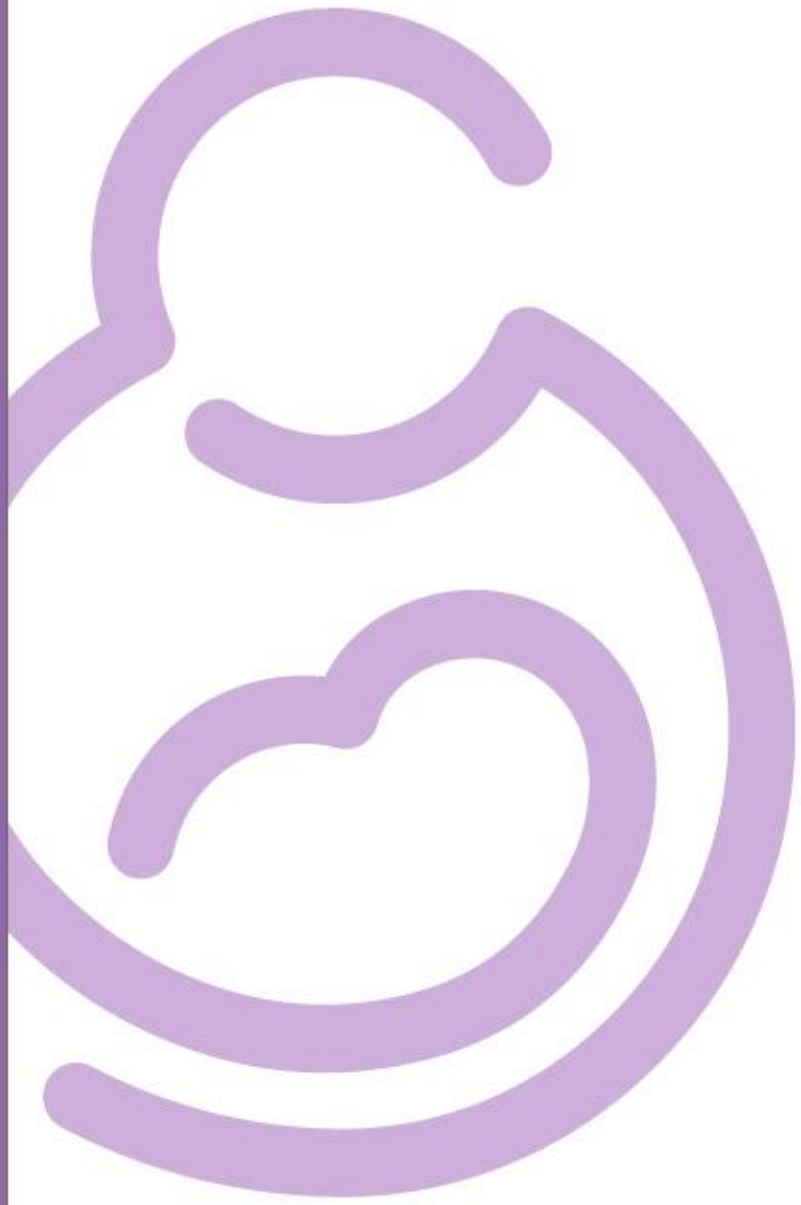
- Campaign Launch & Community Partners
- Public Service Announcements
- Posters
- Flyers
- Referral cards
- Provider education

Poster and Flyer





Referral Card

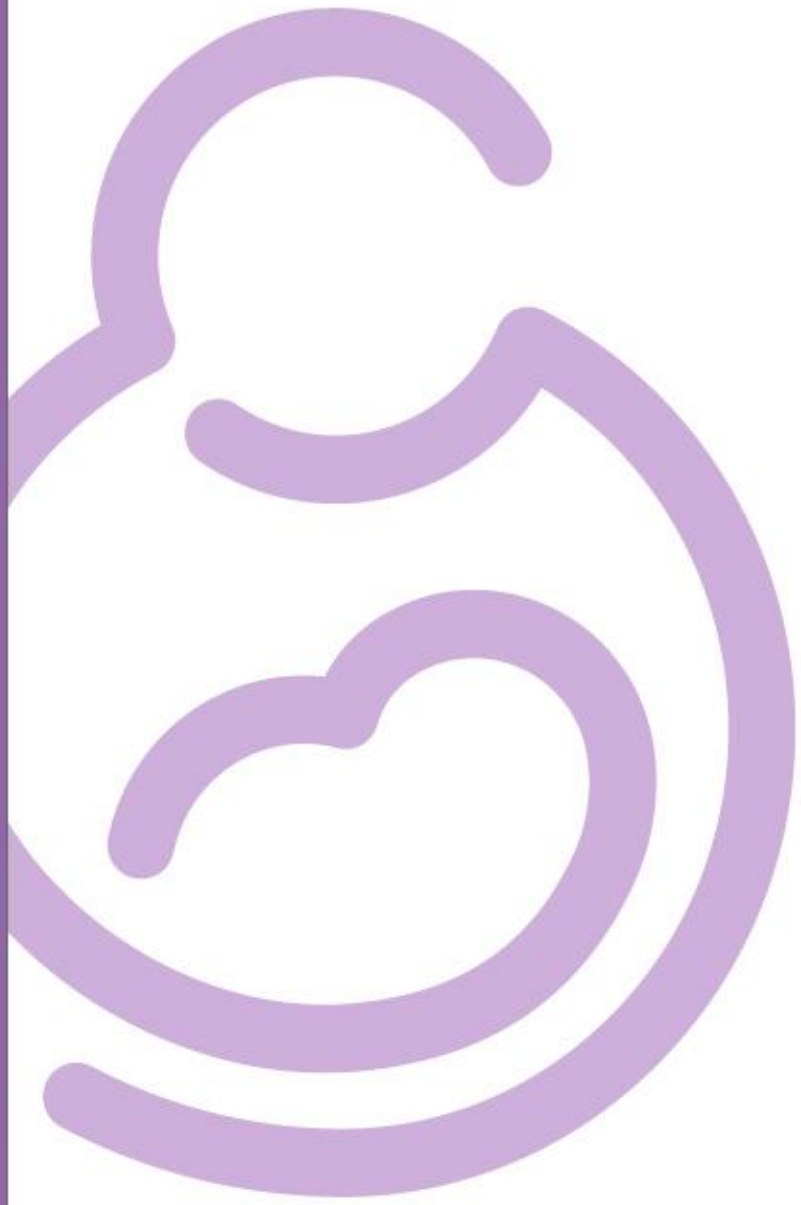


Call to Action

Become a Community Partner!

- Become a “Go Before You Show” (GBYS) campaign community partner.
- Complete the partner agreement form.
- Plan how you will reach out to individuals and agencies and spread the word about the importance of early prenatal care.
- Identify ways that your clinic/organization can remove barriers to care.


CLEAN, AFFORDABLE, TEXAS-MADE CNG
CCRTA.ORG
CORPUS CHRISTI REGIONAL TRANSPORTATION AUTHORITY
901
NOT IN SERVICE
march of dimes
Pregnant or think you might be?
Go Before You Show.
211 TEXAS
See a healthcare provider early or call 2-1-1 for assistance.
In Partnership With



Early Entry into Prenatal Care Resource Guide

A March of Dimes® Toolkit for Hospitals

Early Entry Into Prenatal Care Toolkit:

Overcoming Barriers and Improving Access to Care

DRAFT

march of dimes
A FIGHTING CHANCE FOR EVERY BABY

Sections of Resource Guide

Introduction: This section provides a brief background on the importance of prenatal care and discusses the benefits of EEPNC. We also take a closer look at access to care in Texas and at the barriers Texan women report. Finally, we provide a brief background about? Legacy Southwest Clinic.

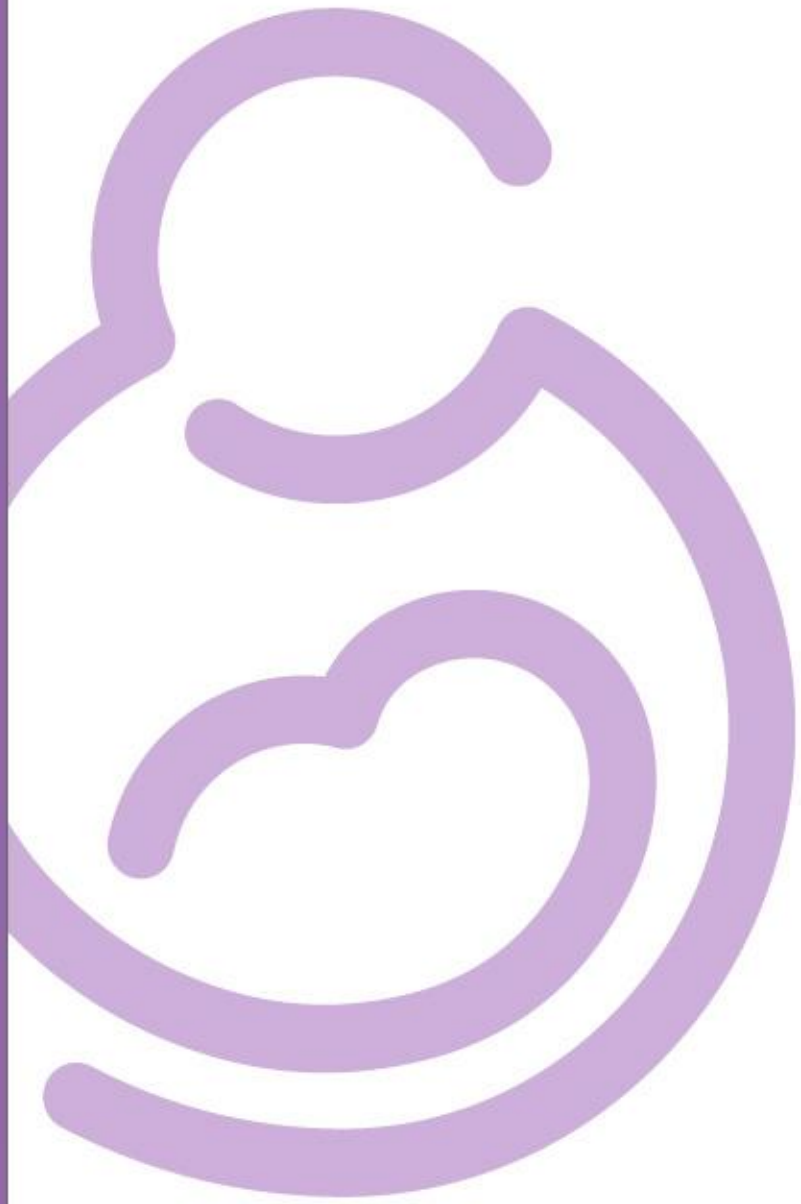
Tools for Getting Started: This section discusses the importance of gathering baseline data and provides the framework in ascertaining whether the clinic has "high" or "low" rates of early entry into prenatal care. This section will describe steps of an organizational self-assessment to determine an agency's readiness to pursue an EEPNC quality improvement initiative.

Tools to Strengthen Infrastructure for Quality Improvement: This section illustrates how to gather organizational and community buy-in. This section has information and tools to help you engage staff, providers and the community with new health initiatives.

Tools for Increasing Access Prenatal Care: This section highlights the importance of increasing community awareness regarding new and expanded services, of increasing staff awareness of policy and system changes, and of addressing community needs. This section provides specific strategies on how to market and tailor services to fit community needs.

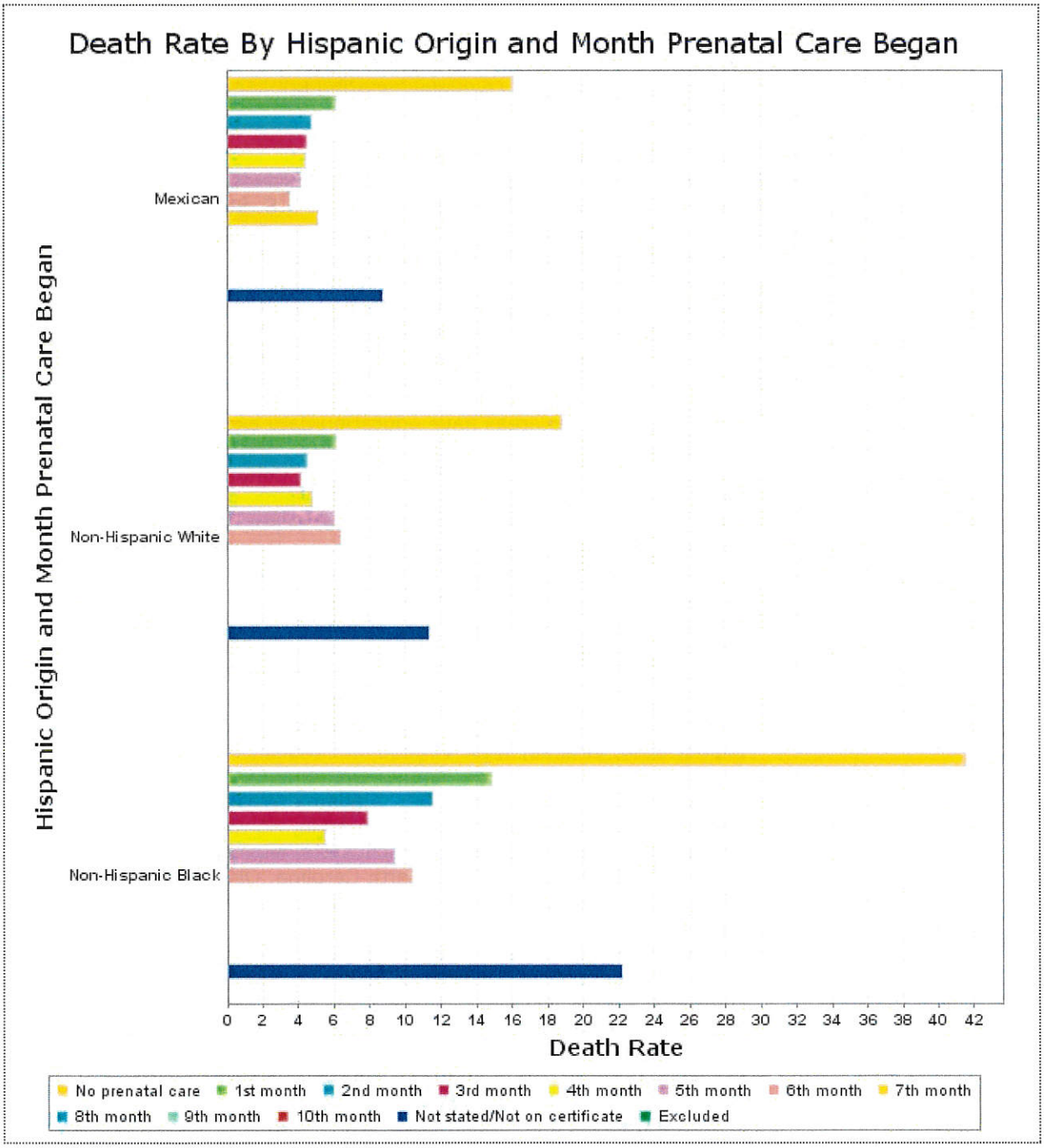
Measuring Progress: This section outlines methods to evaluate and monitor office-based and patient outcomes.

Appendices: Includes a list of definitions, tools, reference, and additional resources.



Thank You!

Linked Birth / Infant Death Records, 2007-2013 Charts



Notes:

Caveats:

Infant deaths are weighted so numbers may not exactly add to totals due to rounding. More information. (/wonder/help/lbd.html#WeightFactors-Totals)

Rates are suppressed when there are fewer than 20 deaths in the numerator, because the figure does not meet the NCHS standard of reliability or precision. Deaths, births and rates are suppressed when the value represents 0-9 sub-national events, in keeping with the data use restrictions. More information. (/wonder/help/lbd.html#Assurance of Confidentiality)

About excluded education and prenatal care data:
Education and prenatal care data are recoded to "Excluded" for those reporting areas that used the 1989 revision of the U.S. Standard Certificate of Birth, because their data for education and prenatal care are not comparable to the data from the reporting areas using the 2003 revision of the U.S. Standard Certificate of Birth. Note that prior data years (data for deaths ocurring in years 2003 - 2006) excluded education and prenatal care data from those reporting areas that had adopted the 2003 revision of the U.S. Standard Certificate of Birth. In California, only the prenatal care data are recoded to "Excluded" for deaths occurring in 2007.

- The following reporting areas have education data excluded:
  - For deaths that occurred in 2007: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (33 reporting areas).
  - For deaths that occurred in 2008: Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (30 reporting areas).
  - For deaths that occurred in 2009: Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, Oklahoma, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (24 reporting areas).
  - For deaths that occurred in 2010: Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, Oklahoma, Rhode Island, Virginia, West Virginia and Wisconsin (23 reporting areas).
  - For deaths that occurred in 2011: Alabama, Alaska, Arizona, Arkansas, Connecticut, Hawaii, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, New Jersey, North Carolina, Rhode Island, Virginia, West Virginia and Wisconsin (17 reporting areas).
  - For deaths that occurred in 2012: Alabama, Alaska, Arizona, Arkansas, Connecticut, Hawaii, Maine, Massachusetts, Minnesota, Mississippi, New Jersey, Rhode Island, Virginia, and West Virginia (14 reporting areas).
  - For deaths that occurred in 2013: Alabama, Alaska, Arizona, Arkansas, Connecticut, Hawaii, Maine, Mississippi, New Jersey, Rhode Island, Virginia, and West Virginia (12 reporting areas).
- The following reporting areas have prenatal care data excluded:

- For deaths that occurred in 2007: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (34 reporting areas).
- For deaths that occurred in 2008: Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (30 reporting areas).
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Note that there may be slight differences in the number of infant deaths when comparing the Linked Birth / Death Records to the other vital statistics. More information. (/wonder/help/lbd.html#Weight Factors)

Help: See Linked Birth / Infant Death Records, 2007-2013 Documentation (/wonder/help/lbd.html) for more information.

Query Date: Mar 11, 2016 11:19:33 AM

Suggested Citation:

United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current.html on Mar 11, 2016 11:19:33 AM

Query Criteria:

Title:

Age of Infant at Death:	All
Age of Mother:	All
Birthplace:	All

Birth Weight:	All
Delivery Method:	All
Education:	All
Gender:	All
Gestational Age Group1:	All
Hispanic Origin:	Mexican, Non-Hispanic White, Non-Hispanic Black
ICD-10 Codes:	All
Live Birth Order:	All
Marital Status:	All
Medical Attendant:	All
Month Prenatal Care Began:	All
Plurality or Multiple Birth:	All
Race:	All
States:	Texas (48)
Year of Death:	2013
Group By:	Hispanic Origin, Month Prenatal Care Began
Show Totals:	False
Show Zero Values:	False
Show Suppressed:	False
Calculate Rates Per:	1,000

All charts were created using the JFreeChart library.

Linked Birth / Infant Death Records, 2007-2013 Results

Hispanic Origin	Month Prenatal Care Began	Deaths	Births	Death Rate Per 1,000
Mexican	No prenatal care	95	5,908	16.08
	1st month	47	7,690	6.11
	2nd month	152	31,705	4.79
	3rd month	165	36,525	4.52
	4th month	89	20,158	4.42
	5th month	49	11,762	4.17
	6th month	25	7,198	3.47
	7th month	23	4,508	5.10
	8th month	11	3,394	Suppressed
	Not stated/Not on certificate	41	4,688	8.75
	Total	**704**	**135,638**	**5.19**
Non-Hispanic White	No prenatal care	64	3,401	18.82
	1st month	44	7,186	6.12
	2nd month	189	42,363	4.46
	3rd month	193	47,127	4.10
	4th month	79	16,522	4.78
	5th month	43	7,121	6.04
	6th month	27	4,253	6.35
	7th month	16	3,059	Suppressed
	8th month	19	2,246	Suppressed
	Not stated/Not on certificate	23	2,022	11.37
	Total	**704**	**136,608**	**5.15**
Non-Hispanic Black	No prenatal care	105	2,528	41.53
	1st month	31	2,096	14.79
	2nd month	112	9,755	11.48
	3rd month	98	12,458	7.87
	4th month	37	6,754	5.48
	5th month	38	4,055	9.37
	6th month	28	2,698	10.38
	7th month	11	1,888	Suppressed
	Not stated/Not on certificate	26	1,171	22.20
	Total	**502**	**45,825**	**10.95**
Total		**1,911**	**318,071**	**6.01**

Caveats: Infant deaths are weighted so numbers may not exactly add to totals due to rounding. More information. (/wonder/help/lbd.html#WeightFactors-Totals)

Rates are suppressed when there are fewer than 20 deaths in the numerator, because the figure does not meet the NCHS standard of reliability or precision. Deaths, births and rates are suppressed when the value represents 0-9 sub-national events, in keeping with the data use restrictions. More information. (/wonder/help/lbd.html#Assurance of Confidentiality)

About excluded education and prenatal care data:
Education and prenatal care data are recoded to "Excluded" for those reporting areas that used the 1989 revision of the U.S. Standard Certificate of Birth, because their data for education and prenatal care are not comparable to the data from the reporting areas using the 2003 revision of the U.S. Standard Certificate of Birth. Note that prior data years (data for deaths ocurring in years 2003 - 2006) excluded education and prenatal care data from those reporting areas that had adopted the 2003 revision of the U.S. Standard Certificate of Birth. In California, only the prenatal care data are recoded to "Excluded" for deaths occurring in 2007.

- The following reporting areas have education data excluded:
  - For deaths that occurred in 2007: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (33 reporting areas).
  - For deaths that occurred in 2008: Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Utah, Virginia, West Virginia and Wisconsin (30 reporting areas).
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Minnesota, Mississippi, New Jersey, Rhode Island, Virginia, and West Virginia (14 reporting areas).
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Help: See Linked Birth / Infant Death Records, 2007-2013 Documentation (/wonder/help/lbd.html) for more information.

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Query Criteria:

Title:	
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Age of Mother:	All
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Birth Weight:	All
Delivery Method:	All
Education:	All
Gender:	All
Gestational Age Group1:	All
Hispanic Origin:	Mexican, Non-Hispanic White, Non-Hispanic Black
ICD-10 Codes:	All
Live Birth Order:	All
Marital Status:	All
Medical Attendant:	All
Month Prenatal Care Began:	All
Plurality or Multiple Birth:	All
Race:	All
States:	Texas (48)
Year of Death:	2013
Group By:	Hispanic Origin, Month Prenatal Care Began
Show Totals:	False
Show Zero Values:	False
Show Suppressed:	False
Calculate Rates Per:	1,000