**Answers to questions from the Senate Health and Human Services Hearing on Maternal Health Providers, SB21-194**

1. **Are there really disparities in maternal mortality rates by race in Colorado?**
    a. ***Yes.*** When taken together, the MMRC's reports from 2008-2013 and 2014-2016, make the racial inequities clear and reflect national data; that maternal mortality is worse for Black and Indigenous women than white women. The numbers of both the Black/African American and Indigenous populations are smaller than the white population in Colorado, making statistical analyses difficult to interpret. From national data we know that these inequities hold even when income and education are held constant -- no amount of income or education can protect people of color against the impacts of racism in the perinatal period. Further, qualitative data from BIPOC communities in Colorado (community voices report + AIM students documentary) support findings of inequities in maternity care delivery, experiences, and outcomes.

2. **Why are we extending Medicaid or CHIP coverage in the postpartum period? What is the evidence to support this policy?**
    a. We know from the CDPHE Maternal Mortality report, that in Colorado, the highest number of maternal mortalities occur after 6 weeks postpartum and before 12 months postpartum and that people who use Medicaid for their health insurance are twice as likely to die as people who do not use Medicaid. Medicaid here is an indicator of income level and is not the cause of maternal mortality.The most common causes include suicide, drug overdose, and cardiac conditions. A little over 76% of these deaths are preventable.
    b. Disproportionate deaths among people who use Medicaid are not due to the Medicaid coverage itself but because of the health inequities and structural barriers to wellbeing faced by people with low incomes.
    c. Behavioral health issues are driving causes of maternal mortality in Colorado, and perinatal mood and anxiety disorders are the most common complication of pregnancy, but those conditions can appear at any point in the year after childbirth, and often take time to treat effectively.
    d. In Colorado, 9% of people experience a period without insurance in the postpartum period -- likely because of the loss of their Medicaid or CHIP coverage.
    e. Moreover, coverage gains for new mothers could also produce both short- and long-term benefits for the health and well-being of their infants and other children.
    f. Extending postpartum Medicaid coverage to 12 months saves lives and promotes health.

3. **Why are we going up to 260 percent of the federal poverty level in providing this coverage? Can we go up to a lower income level or cover people for a shorter amount of time?**
    a. To get the match available through the federal American Rescue Plan states can use a waiver or "state plan" option. The American Rescue Plan requires that states align eligibility with the highest income level available for pregnant people in Medicaid or CHIP in the state. In Colorado this means going up to 260% FPL to align with coverage in our CHIP program. The state plan option does not allow for states to choose lower income levels, benefit restrictions, or shorter extension time periods.

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4. **Are other states moving forward with extending their Medicaid and CHIP coverage postpartum?**
    a. NASHP gives a great summary of what is happening in other states.
    b. States that have passed legislation to expand Medicaid coverage beyond 60 days include: California, Delaware, Georgia, Virginia, and Washington.
    c. Some states, including Georgia, Illinois, Indiana, Missouri, New Jersey, Tennessee, have submitted waivers to CMS.
    d. Others currently have legislation currently under consideration, including Alabama, Arkansas, Florida, Hawaii, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Nevada, New York North Carolina, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, West Virginia, and Wisconsin.
    e. Illinois is the first state to have gotten approved (via waiver) for the full 12 months postpartum Medicaid coverage, up to 208%FPL.

5. **Does this extension cover all health needs, including behavioral health?**
    a. Yes, under this state plan option, the state must provide full health benefits to this population, which is a critical policy.
    b. Perinatal mood and anxiety disorders are the most common complication of pregnancy, so behavioral health services are a critical component of postpartum care. Pregnancy also increases the risk of oral health complications, making dental care a critical postpartum service as well. Physical therapy, which can help people recover from injuries sustained during pregnancy and childbirth, is also critical.
    c. Studies of Medicaid expansions for postpartum people find that people who experience severe maternal morbidity (such as hemorrhage, acute myocardial infarction, or sepsis) during delivery use more health services in the postpartum period when provided with ongoing Medicaid coverage and receipt of these services among this population is particularly critical.

6. **What if someone gets a well-paying job or wins the lottery and yet stays on their Medicaid or CHIP coverage?**
    a. The odds of winning either Powerball or Mega Millions are roughly 1 in 292.2 million and 1 in 302.5 million respectfully. As this program will cover fewer than one million people in Colorado, the odds of having someone in the program win the lottery are miniscule.
    b. In fact, the risk of job loss in the postpartum period due to health or child care needs is much higher than the likelihood of experiencing a dramatic increase in earnings. Census Bureau research shows that the share of women who are working falls by 18 percentage points in the quarter they give birth to their first child. For mothers who continue to work, earnings fall by an average of $1,861 in the first quarter after birth relative to earnings pre-pregnancy or in early pregnancy (three quarters before the birth).

7. **Will this disincentivize people from choosing ACA – provided health care?**
    a. People are falling through the cracks now. 9% of people experience a period without insurance in the postpartum period in Colorado – likely because of the loss of their Medicaid or CHIP coverage.
    b. Some of these people may be eligible for subsidized coverage through the exchange, but unable to afford premiums that can average 4 percent of their income, even after subsidies. Cost-sharing can also be quite high in the exchange which makes it difficult to access needed health care – especially services like behavioral health care, physical therapy and dental care. Deductibles in subsidized plans can still be $4500 for people in this income bracket.

c. Further, many of these individuals may fall into what is know as the "family glitch." The "family glitch" is a rule under the Affordable Care Act that bases eligibility for a family's premium subsidies on whether available employer-sponsored insurance is affordable for the employee only, even if it's not actually affordable for the whole family. This makes family members ineligible for financial assistance in the exchange.

8. **Why do we need Section 2 (improved integration between community birth providers and facility-based providers)? Isn't this covered by EMTALA?**
    a. EMTALA is a narrow provision that doesn't cover the majority of transfers from community birth providers to hospital-based providers – because the majority of instances in which a community birth provider needs a hospital-based provider to take over a client's case are not emergencies or do not happen during active labor.
    b. In Colorado, most transfers from community birth to hospital birth take place before or after labor, very few occur during active labor, and very few are emergencies as defined by EMTALA, "such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy"
    c. Further, under existing Colorado law only community based providers must document their plans for interprofessional collaboration but hospital-based providers do not. Balancing this responsibility will improve midwifery integration, which is known to improve birth outcomes.

9. **Do Sections 1 and 7 of SB-194 require payment parity? It doesn't seem reasonable to reimburse health care providers with different skill levels the same dollar amount.**
    a. No. SB-194 as currently written requires that private health insurance and Medicaid services related to labor and delivery promote "high-quality, cost-effective care and prevents risk in subsequent pregnancies AND not discriminate based on the type of provider or facility."
    b. This is not intended to require payment parity across maternity care providers, but rather to broaden the equation around how reimbursement is determined with an eye toward prevention, cost and quality
    c. There are ongoing conversations with the stakeholders of this provision to find a way to amend SB-194 so that the language better reflects the intent.

10. **Are the provisions for perinatal care data collection in SB-194 duplicative of existing parts of the law?**
    a. No.