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Continuing Medicaid/CHIP Postpartum Coverage

— June 2020 —





Why Continue Medicaid/CHIP Postpartum Coverage for 12 Months?

The United States is Experiencing a Maternal Health Crisis

- The United States is the only developed country where the maternal mortality rate has been steadily rising.[1,2] The U.S. maternal mortality rate has increased from 10.3 per 100,000 live births in 1991[3] to 17.4 in 2018.[4]
- Black women and American Indian/Alaska Native women are 3.3 and 2.5 times more likely, respectively, to die from pregnancy-related causes than non-Hispanic white women.[5]
- Most pregnancy-related deaths are preventable, and many factors can stem from lack of/churn in coverage (e.g., limited access to clinical care, delayed diagnoses, lack of continuity of care).[6]
- For every woman who dies from pregnancy-related causes, significantly more suffer from severe maternal morbidity. In 2014, more than 50,000 women in the U.S. experienced unexpected outcomes of labor and delivery that resulted in significant short- or long-term consequences to their health.[7]

Medicaid is Key to Improving Maternal Health and Addressing Disparities in Outcomes

- Nearly half of all U.S. births are financed by Medicaid. In some states, that number is much higher; for example, 71% of all births in New Mexico in 2018 were Medicaid-financed.[8]
- Compared to women with private insurance, women with Medicaid coverage are more likely to have had a prior preterm birth, low birthweight baby, and experience certain chronic conditions (e.g., diabetes) – putting them at higher risk of maternal morbidity and mortality.[9]
- Compared to women with private insurance at delivery, those covered by Medicaid are more likely to be Black. Medicaid is key to addressing disparities among Black women.[10]

Twelve Months of Postpartum Coverage is Rooted in Clinical Evidence (the Status Quo is Arbitrary)

- Pregnancy-related deaths occur well beyond the arbitrary 60-day postpartum period. Since 1986, when Congress established the 60-day postpartum period for Medicaid coverage for pregnant women,[11] much more is known about pregnancy-related deaths and delivering postpartum care.
- Approximately 30% of pregnancy-related deaths—*not* counting those that were caused by suicide or overdose—occur 43 to 365 days postpartum.[12]
- State analyses of pregnancy-associated deaths, which include behavioral health-related causes, often find that 50% or more of deaths occur beyond the 60-day period.[13]

Severe Maternal Morbidity Costs Billions of Dollars Every Year, Including Costs that Could Be Avoided if Treated Earlier

- The #1 complication of pregnancy and childbirth—perinatal mood and anxiety disorders (PMADs)—affect at least 1 in 7 women, yet only half of perinatal women with depressive symptoms receive any treatment. Examining PMADs alone, the national economic costs of not treating these disorders amounted to $14.2 billion in 2017.[14]
- In 2011, Medi-Cal paid more than $210 million to treat maternal hemorrhage[15] and hypertensive disorders.[16]
- New Jersey found that 53% of women who lose Medicaid/CHIP coverage postpartum return to the Medicaid program within two years;[17] in other words, Medicaid (and other public insurance programs) bear the cost of untreated complications that result in long-term health complications for the woman and (when applicable) for her future children.

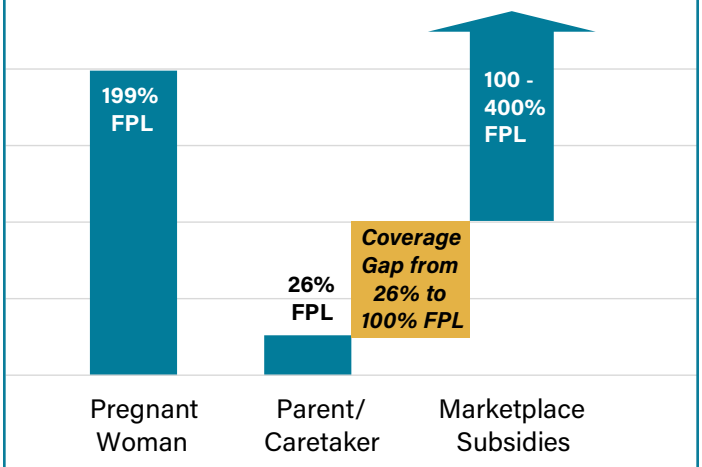
How Does Continuing Postpartum Coverage Address These Issues?

Continuing Medicaid/CHIP Coverage Postpartum Would Ensure—*and Simplify*—Postpartum Coverage

- Between 2015 and 2017, 17% of women experienced uninsurance between delivery and three to six months postpartum.[18] Nearly 1 in 4 women in non-expansion states and more than 1 in 10 women in expansion states experienced uninsurance between delivery and postpartum.[19]
- Continuing postpartum coverage provides an automatic coverage pathway during this vulnerable time, providing coverage for women without other options, mitigating barriers to other coverage pathways, and preventing disruptions in care.

Women in Expansion and Non-Expansion States Face Coverage and Continuity of Care Gaps[20, 21, 22]

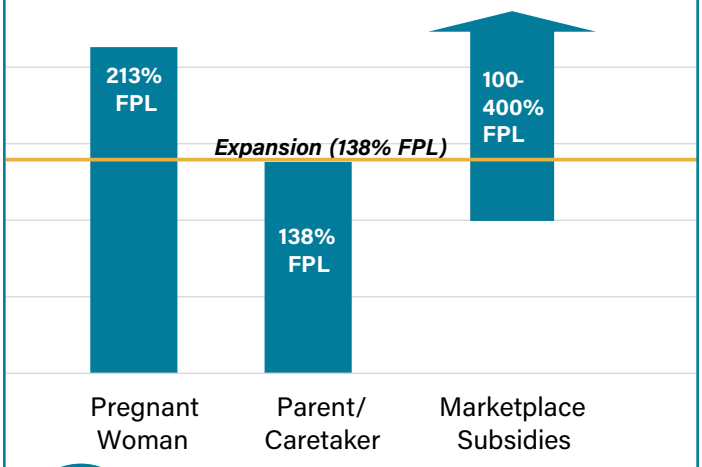
Non-Expansion State Example (Mississippi)



CARLA, Age 26
Lives in Jackson, Mississippi
Family of 3 Income: $8,688 (40% FPL)
Medicaid-enrolled, just gave birth

- *Coverage Gap:* When Medicaid coverage ends in 60 days, Carla will not be eligible for Medicaid or Marketplace tax credits.
- *Affordability:* Without Marketplace tax credits, Carla could purchase a Silver plan on the Marketplace for $373 per month —or 52% of her household income.

Expansion State Example (Illinois)



MIA, Age 26
Lives in Chicago, Illinois
Family of 3 Income: $32,580 (150% FPL)
Medicaid-enrolled, just gave birth

- *Burdensome Transitions:* Mia will lose Medicaid coverage in 60 days; she can enroll in Marketplace coverage—but must apply for a Special Enrollment Period while recovering from childbirth and caring for a newborn.
- *Cost-Sharing:* To purchase a Silver plan on the Marketplace, Mia must newly pay a monthly premium of $110, along with other out-of-pocket costs.
- *Disruptions in Care:* If Mia successfully enrolls in the Marketplace, her provider network will likely vary from her current providers.

Continuing Medicaid Coverage Postpartum is Foundational to Value-Based Payment Models

- Churn between sources of coverage and/or uninsurance hinder value-based payment models because no payer maintains responsibility for the mother-baby dyad's care during pregnancy and postpartum.
    - Indeed, in the Center for Medicare and Medicaid Innovation's (CMMI) Notice of Funding Opportunity for the Maternal Opioid Misuse (MOM) Model—one of the recent CMMI value-based payment models targeted at mothers and children—priority was given to applicants that proposed "sustainable postpartum coverage plans that address[ed] the period beyond 60 days after birth."[23]

Continuing Coverage for 12 Months Postpartum: Key Policy Components

Provide 12 Months of Continuous Medicaid/CHIP Coverage, *Regardless of Eligibility Pathway*

- All pregnant women enrolled in Medicaid/CHIP—regardless of their eligibility pathway—should be guaranteed 12 months of continuous postpartum coverage, as is done for their infants today.

Provide 12 Months of Medicaid/CHIP Coverage to Postpartum Women Nationwide

- As is the case with 60 days postpartum coverage today, the updated, 12-month postpartum period should apply to pregnant and postpartum women, regardless of which state they live in.
- To avoid fiscal challenges for states, the match rate for the postpartum extension (from the 61st day through 12 months postpartum) should be generous and not time-limited (e.g., 100% FMAP for the first 5 years and 90% thereafter).

Ensure States Maintain or Improve Medicaid/CHIP Eligibility Policies for Pregnant Women

- As has been done in the past,[24] a "maintenance of effort" provision should be added to prevent rollbacks in Medicaid/CHIP eligibility for pregnant women relative to standards in place as of the time of enactment.

Ensure All Medicaid/CHIP-enrolled Pregnant and Postpartum Women Receive Minimum Essential Coverage

- States currently have the option to limit coverage to pregnancy-related services for women eligible for Medicaid via poverty-level-related pregnancy pathways. In 2016, CMS determined that, as a result, three state Medicaid programs do not provide minimum essential coverage (MEC) to pregnant women.[25]
- To ensure comprehensive coverage for Medicaid/CHIP-enrolled pregnant women, states should be required to provide women with MEC during pregnancy and postpartum.

This analysis was conducted with support from Johnson & Johnson and developed in partnership with Manatt Health.

The following organizations contributed thought leadership to the development of this product:

- *Center on Budget and Policy Priorities*
- *Guttmacher Institute*
- *National Association of Nurse Practitioners in Women's Health*
- *Preeclampsia Foundation*
- *Washington University in St. Louis*

[1]The Lancet, "Global, Regional, and National or Territory Number of Maternal Deaths, Maternal Mortality Ratio, and Annualised Rates of Change in Percent, 1990-2015," October 2016, available at: https://www.thelancet.com/action/showFullTableHTML?isHtml=true&tableId=tbl1&pii=S0140-6736%2816%2931470-2.

[2]Commonwealth Fund, "What is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?" December 2018, available at: https://www.commonwealthfund.org/sites/default/files/2018-12/Gunja_status_womens_health_sb.pdf.

[3]"Pregnancy-related Mortality in the United States, 1991-1997," Obstet Gynecol. 2003 Feb; 101(2):289-96. Available at: https://www.ncbi.nlm.nih.gov/pubmed/12576252.

[4]Centers for Disease Control and Prevention, "Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018," available at: https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_02-508.pdf.

[5]Centers for Disease Control and Prevention, "Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017," May 10, 2019, available at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w.

[6]Centers for Disease Control and Prevention, "Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017," May 10, 2019, available at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w.

[7]Centers for Disease Control and Prevention, "Severe Maternal Morbidity in the United States," 1993-2014, available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

[8]Kaiser Family Foundation State Health Facts, "Births Financed by Medicaid," available at: https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/.

[9]Medicaid and CHIP Payment and Access Commission, "Access in Brief: Pregnant Women and Medicaid," November 2018, available at: https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf.

[10]Medicaid and CHIP Payment and Access Commission, "Access in Brief: Pregnant Women and Medicaid," November 2018, available at: https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf.

[11]This coverage period applies to women enrolled in Medicaid via poverty-level-related pregnancy pathways, meaning women who are mandatorily covered under SSA 1902(a)(10)(A)(i)(IV) (at or below 138% FPL and pregnant), and women who are optionally covered under SSA 1902(a)(10)(A)(ii)(IX) (above 138% FPL and pregnant).

[12]In 2018, a total of 658 women were identified as having died of maternal causes in the United States, and an additional 277 deaths were reported as having occurred more than 42 days but less than 1 year after delivery in 2018. These numbers are based on an updated method of coding (the "2018 method") maternal deaths based on the implementation of a revised U.S. Standard Certificate of Death. See Centers for Disease Control and Prevention, "Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018," available at: https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_02-508.pdf.

[13]For example, Georgia, Illinois, Maryland, New Jersey, New Mexico, Tennessee, Texas, Utah, and West Virginia all identified that more than 50% of pregnancy-associated deaths—and as high as 65% of deaths, in the case of Utah—occurred more than 43 days postpartum. See Georgia Department of Public Health, "Maternal Mortality Report," 2014, available at: https://reviewtoaction.org/sites/default/files/portal_resources/Maternal%20Mortality%20BookletGeorgia.FINAL_.hq_.pdf; Illinois Department of Public Health, "Illinois Maternal Morbidity and Mortality Report," October 2018, available at: http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf; Maryland Department of Health and Mental Hygiene Prevention and Health Promotion Administration, "Maryland Maternal Mortality Review 2015 Annual Report," 2015, available at: https://reviewtoaction.org/sites/default/files/portal_resources/2015MMR_FINAL%281%29.pdf; New Jersey Health, "Trends in Maternal Mortality: 2009-2013," available at: https://nj.gov/health/fhs/maternalchild/documents/nj_maternal_mortality_trends_2009_2013.pdf; New Mexico Department of Health, "Maternal Mortality in New Mexico 2010-2015," available at: https://reviewtoaction.org/sites/default/files/portal_resources/MMRC%20Poster%20-%20WHC%202019-FINAL.pdf; Tennessee Department of Health, "Tennessee Maternal Mortality: Review of 2017 Maternal Deaths," available at: https://reviewtoaction.org/sites/default/files/portal_resources/MMR%20Annual%20Report%202017.pdf; Texas Health and Human Services Maternal Mortality and Morbidity Task Force, "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report," September 2018, available at: https://www.dshs.texas.gov/mch/pdf/MMMTFJointReport2018.pdf; Utah Department of Health, "Maternal Mortality in Utah 2015-2016," available at: https://reviewtoaction.org/sites/default/files/portal_resources/PMR%20Update%200718_0.pdf; West Virginia Department of Health & Human Resources, "West Virginia Infant and Maternal Mortality Review Annual Report," Maternal CY 2013, available at: https://reviewtoaction.org/sites/default/files/portal_resources/2015%20legislative%20report.pdf.

[14]Mathematica Policy Research, "Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States," April 2019, available at: https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states

[15]UCLA Center for Health Policy Research, "Costs of Maternal Hemorrhage in California," October 2013, available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/maternalhemorrhagereport-oct2013.pdf.

[16]UCLA Center for Health Policy Research, " Costs of Gestational Hypertensive Disorders in California: Hypertension, Preeclampsia, and Eclampsia," October 2013, available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/gestationaldisordersreport-oct2013.pdf.

[17]State of New Jersey Department of Human Services Division of Medical Assistance and Health Services, public notice of intent to submit Section 1115 Demonstration, available at: https://www.state.nj.us/humanservices/providers/grants/public/publicnoticefiles/Public%20Notice%20Amendment%20Request%20-%20NJ%201115%2012-23-19%20Final.pdf.

[18]In this study, postpartum coverage is defined as the timing of the CDC Pregnancy Risk Assessment Monitoring System (PRAMS) postpartum interview, which occurs 3-6 months after childbirth for most women.

[19]Health Affairs, "High Rates of Perinatal Insurance Churn Persist after the ACA," September 2019, available at: https://www.healthaffairs.org/do/10.1377/hblog20190913.387157/full/.

[20]Kaiser Family Foundation, State Health Facts, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level," as of January 1, 2019, available at: https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/.

[21]Kaiser Family Foundation, "Health Insurance Marketplace Calculator," Oct 31, 2019, accessed at: https://www.kff.org/interactive/subsidy-calculator/.

[22]Medicaid-enrolled postpartum women who are losing coverage 60 days postpartum and whose household incomes are above 100% FPL may qualify for a Marketplace Special Enrollment Period in two ways: (1) due to past or future loss of minimum essential coverage; or (2) due to gaining a dependent due to birth. See Centers for Medicare & Medicaid Services Center for Consumer Information & Insurance Oversight, "Special Enrollment Periods: An Overview for Marketplace Agents and Brokers," February 15, 2018, available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB-SEP-Slides-Feb152018.pdf. (Note: a small number of State-based Marketplaces also have a Special Enrollment Period specifically for pregnant women).

[23]Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services, "Maternal Opioid Misuse Model (MOM) Notice of Funding Opportunity (NOFO) and Application Review," available at: https://innovation.cms.gov/Files/slides/mom-model-nofo-appreview-slides.pdf.

[24]For example, the Omnibus Reconciliation Act of 1989 (P.L. 101-239) required the 19 states with eligibility levels for pregnant women above 138% FPL as of 12/19/89 to maintain that higher eligibility level. More recently, in 2018, Congress passed the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act) and the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act. Together, these bills appropriated federal funds for CHIP through federal fiscal year (FFY) 2027 and included a requirement that states maintain certain coverage levels for children enrolled in Medicaid and CHIP.

[25]Medicaid and CHIP Payment and Access Commission, "Issue Brief: Update on Pregnancy-Related Medicaid and Minimum Essential Coverage," June 2016, available at: https://www.macpac.gov/wp-content/uploads/2016/06/Update-on-Pregnancy-Related-Medicaid-1.pdf.