



An Analysis  
of 2020  
Health First  
Colorado  
Births

# Maternal Health Equity Report

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**COLORADO**  
Department of Health Care  
Policy & Financing

## Executive Summary

Health First Colorado - Colorado's Medicaid program - covers over 40% of Colorado's births and utilizes its care networks and safety net coverage to provide prenatal, labor and delivery, and postpartum services for birthing parents across the state. Health First Colorado members represent some of the most vulnerable groups in Colorado, and the COVID-19 pandemic complicated their health care experiences. The public health emergency (PHE) was declared on Jan. 31, 2020, and the experience of those members giving birth in 2020 was quite different from previous cohorts.

Health First Colorado covered nearly 26,000 births in 2020, similar to previous years (roughly 27,000 in 2019). Many birthing members were frontline workers for whom working remotely was not an option, and lack of child care for their children created difficult choices. Other members lived in multi-generational households, weighing the need to generate income against protecting their aging parents from potential COVID-19 exposure. Further, many members had to shift their prenatal care to telehealth with problematic access in some areas, deliver their infants in hospitals without their families, and navigate postpartum recovery isolated from family, faith and social communities who have historically helped with child care and household chores.

The 2020 birth cohort also experienced new opportunities. The federal government allowed states to maintain coverage for all pregnant people in the postpartum period, so this was the first year Health First Colorado members received 12-month postpartum coverage—a now permanent policy. Also, while the rapid telehealth expansion created challenges, providers reported seeing record levels of appointments kept as members using telehealth did not need to overcome barriers such as time off work, child care, or transportation to be seen by their provider.

Concerningly, early national research shows that the rate of maternal mortality (defined as death during pregnancy and up to 365 days postpartum) increased by 33.3% in the first 9 months of the COVID-19 pandemic (25.1 per 100,000 births) when compared to the overall maternal mortality rate in 2018, 2019 and January through March of 2020 (18.8 per 100,000 births).<sup>1</sup> For Colorado data on maternal mortality, the Department of Health Care Policy & Financing (HCPF) partners with the Colorado Department of Public Health & Environment's (CDPHE) Maternal Mortality Review Committee. The Committee is currently assessing the impact of COVID-19 on Coloradans and Health First Colorado members. Given national trends, it is anticipated that an increase in the rate of deaths related to COVID-19 infection will be seen, as well as delays in care and social isolation due to the PHE—a burden likely disproportionately experienced by Health First Colorado members.

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<sup>1</sup> Journal of the American Medical Association research letter (2022).  
<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793640>

Maternal behavioral health is a key focus of this year's report. A report from CDPHE's Maternal Mortality Review Committee released prior to COVID-19 found that behavioral health conditions, including mental illness and substance use, are the number one cause of maternal mortality in Colorado. Data in this report reveal that some behavioral health related trends that were on the rise prior to the pandemic continued. One example is the trend in substance-exposed newborns (SEN) and babies diagnosed with Neonatal Abstinence Syndrome (NAS) that was already increasing pre-pandemic. In 2020, 3.8% of babies covered by Health First Colorado were SEN and/or diagnosed with NAS. This was a 30.6% increase from 2019 (2.9%). HCPF continues to participate in the Maternal Opioid Misuse (MOM) Model from the Centers for Medicare and Medicaid Services (CMS) to better integrate care for pregnant and parenting people with opioid use disorder. Through the MOM Model and delivery system reforms, HCPF aims to improve capacity for and access to integrated behavioral health services for pregnant and newly parenting members.

HCPF's first Maternity Report, released in 2021 and focused on calendar year (CY) 2019 data, laid the groundwork to establish areas of opportunity to improve maternal care outcomes for both the birthing parent and newborn. This year's report refreshes the data for CY 2020 and, in response to feedback from last year's stakeholder event, includes several new data points. Across the three main stages of a pregnancy - prenatal, labor and delivery, and the postpartum period - this report highlights:

## Key Points of this Report

### Prenatal

- Prenatal care rates remained stable between 2019 and 2020. Most birthing parents (76.0%) received prenatal care in the first trimester. Native Hawaiian Other Pacific Islander (57.7%), Black/African American (70.2%), and American Indian Alaska Native (70.6%) parents had the lowest rates.
- Prenatal Women, Infant, and Children (WIC) nutritional support enrollment was 52.3%. This represents a slight decline from 2019.

### Labor and Delivery

- Similar to the 2019 report, this report finds strong associations between chronic and gestational health conditions and poor birth outcomes.
- The rate of neonatal abstinence syndrome and substance exposed newborns increased from 2019, reflecting a nationwide trend.

### Postpartum

- Postpartum care was expanded for all parents who gave birth in 2020 due to the maintenance of effort for Medicaid eligibility during the COVID-19 public health emergency (PHE).
- The proportion of members receiving a postpartum behavioral health service remained stable between 2019 and 2020, a positive indicator that care largely remained accessible despite the pandemic disruptions.

The current data on this unique year reflects only a portion of the story. The impacts of COVID-19 on this population are varied, and it will take more time and data to determine the depth and breadth of that impact.

## HCPF Action Since the 2019 Report

HCPF's first Maternity Report, released in 2021 and covering the perinatal period for 2019 births, provides analysis of perinatal data that would inform next steps to improve existing programs and build new policies. Since the release of that report, HCPF and agency partners have responded by focusing on efforts to achieve three goals:

- 1) Improve rates of timely prenatal care appointments
- 2) Improve rates of postpartum visit completion
- 3) Improve rates of depression screening

HCPF has undertaken work in four main areas, with an explicit focus on health equity. A number of these changes are currently underway while others are in the planning stages and will be completed over the coming years. A fifth category - New Ideas for Accountable Care Collaborative (ACC): Phase III - is included below to highlight improvements being considered for the next phase of Health First Colorado's delivery system through its Regional Accountable Entities (RAEs).

### HCPF Roadmap to Improve Maternal Health Care and Equity

<b>1. Centering Member Experience</b>	Include maternity care as a pillar in the HCPF Equity Plan. (2022)
	Amplify member voice through the Maternity Advisory Committee. (2023)
	Create a Spanish-speaking Maternity Advisory Committee. (2024)
<b>2. Program Expansions</b>	Expand postpartum coverage to 365 days. (2022)
	Expand family planning services for non-citizens. (2022)
	Expand family planning and related service for expanded income. (2022)
	Enhance lactation support services. (2023)
	Cover donor breast milk to infants. (2025)
	Cover non-citizens prenatal and postpartum care. (2025)
	Implement non-citizen child benefit. (2025)
<b>3. Technical Changes</b>	Modernize maternity billing. (2023)
	Investigate solutions to billing for SBIRT screenings. (2023)
	Enhance depression screenings for parents and caregivers. (2023)
<b>4. System Reforms</b>	Explore coverage of Direct Entry Midwives. (2023)
	Promote hospital best practices through payment changes. (2023)
	Cover doula services. (2024)
	Implement maternity bundled payment. (2024)
<b>5. New Ideas for ACC Phase III (Launch: 2025)</b>	Explore member incentives to improve prenatal engagement.
	Increase member self-identification as pregnant.
	Improve integrated behavioral health services piloted in MOM grant.
	Improve performance on maternity outcomes across RAEs.
	Improve behavioral health screening incentives.

All the initiatives in the above roadmap have been deeply informed by member feedback. This year's report provides a window into the lived experience of members that cannot be captured by health care claims data alone. The members of the Maternity Advisory Committee (MAC) - a group of Health First Colorado members established in 2021 - were invited to participate in semi-structured interviews with HCPF, and several have generously shared their stories for the purposes of this report. The experiences reported by MAC members in monthly meetings informed the content in the report and readers will see excerpts of these interviews throughout.

We owe a great debt to all of the MAC members for the time they give HCPF each month—sharing stories of triumph and trauma. Their experiences, feedback and expertise will continue to shape policy, effect change, and improve the lives of pregnant people across the state. We are grateful for their passion, their compassion, and their service to this cause. We dedicate this report to them.

To the strong and gracious members of the Maternity Advisory  
Committee:

Your contributions are invaluable. “Never doubt that a small group of thoughtful, committed citizens can change the world.”

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## Introduction

Health First Colorado covers about 40% of all births in Colorado each year. In 2020, 25,926 births - 42.2% of Colorado's births - were covered by Health First Colorado. This includes babies born in 62 of Colorado's 64 counties. Parents who gave birth in 2020 come from a multitude of racial and ethnic backgrounds, areas of the states, and cultures. To identify any disparities in care or outcomes, demographic information including race/ethnicity and language collected from the medical assistance application is paired with data from health care claims submitted to Health First Colorado by maternity care providers. Claims data is then matched with birth certificate data to connect birthing parent and newborn outcomes. This data linking allows for a robust analysis of the health of Health First Colorado birthing parents and their babies. The data in this report are aggregated and do not include any identifiable patient information.

This report - a follow up to HCPF's inaugural [2019 Maternity Report](#)<sup>2</sup> - examines the health of birthing parents and their babies for births covered by Health First Colorado that took place during calendar year 2020. The first year of the COVID-19 pandemic was difficult for all Coloradans. For those who were pregnant or gave birth during 2020, the uncertainties, changes and heightened health risks brought by the COVID-19 pandemic introduced an additional level of complexity in their perinatal experience. Virtual appointments, trips to the doctor without a partner allowed in the room, and increased anxiety were among the many challenges faced by pregnant Health First Colorado members during this time.

In addition to the changes in the lives of individuals during the outbreak of the COVID-19 pandemic, there were many changes in federal and state health policy. Congress enacted the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 with a provision for state maintenance of effort (MOE) under the Centers for Medicare and Medicaid Services (CMS). Under this requirement, states are required to maintain coverage for individuals enrolled in Medicaid from March 18, 2020, until one month after the end of the federal public health emergency, which is ongoing at the time of this report's writing. The MOE means that for the first time, members in this category maintained coverage and access to services beyond the 60-day postpartum period.

Best practices recommend that birthing parents receive supportive postpartum services for one year after giving birth. Before the MOE provision was enacted, Medicaid coverage for pregnancy only lasted 60 days postpartum for those members who were only eligible for Medicaid due to pregnancy and had income levels higher than 133% of the Federal Poverty Level (FPL).

Disparities persist in outcomes for members of different races and ethnicities, those who speak languages other than English, and those who live in rural areas of the

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<sup>2</sup> 2019 HCPF Maternity Report (2021). <https://hcpf.colorado.gov/sites/hcpf/files/Maternity%20Report%20-%20Sept2021.pdf>



state. Given these disparities, this report applies a health equity lens to its analysis of the entire perinatal period: before, during, and after pregnancy. HCPF has reflected this urgency in its prioritization of maternal health equity as a focus area in its FY 2022-23 [Health Equity Plan](#).<sup>3</sup> This report is one of several efforts HCPF has undertaken to address equity in the perinatal period. Programmatic and legislative efforts are described in the Existing Special Programs and HCPF Action sections.

This report is structured into the three main stages of a pregnancy: prenatal, labor and delivery, and the postpartum period. Each section contains data relevant to that stage. Where applicable, these sections also include analyses of changes in service utilization between 2019 and 2020 that resulted from the pandemic. New for this year's report, each section also contains stories from members of HCPF's Maternity Advisory Committee (MAC). HCPF conducted interviews with members of the MAC on their experience giving birth as Health First Colorado members. Excerpts from these conversations are included in relevant sections to add a member perspective to enhance the quantitative data story. The report ends with a summary of HCPF programs targeted to this population and a response to calls to action made in last year's report.

## Background and Methods

### Matching Records

To look more closely at outcomes for the birthing parent and baby, HCPF has worked with the Colorado Department of Public Health & Environment (CDPHE) to link the birthing parent's Health First Colorado ID number to their baby's birth certificate. This allows for information like the parent's health conditions to be linked to the baby's birth outcomes. This report has a matching rate of 21,882 (84.4%) of 25,926 total Health First Colorado-covered births. Record matching is completed based on the parent or infant's Health First Colorado ID, parent or infant's Social Security number, and baby's date of birth or first three letters of first and last name. Reasons for unmatched records vary but may be related to missing or transposed digits in the identifying numbers or misspelled names. There also may be mismatches due to the timing of the match and when HCPF receives a claim. Less frequently, if a baby is placed for adoption or the

**N**ote on Terminology: When possible, this report uses gender inclusive language to speak about all members and increase visibility for the LGBTQIA+ community. While some constructs around federal reporting or self-reporting include gender or sex binary language, this report uses language that explicitly includes families who have a pregnant parent who does not identify as a woman, female, or mother. HCPF acknowledges that this is an iterative process and encourages feedback to increase language inclusivity of traditionally marginalized groups.

<sup>3</sup> HCPF Health Equity Plan (2022).

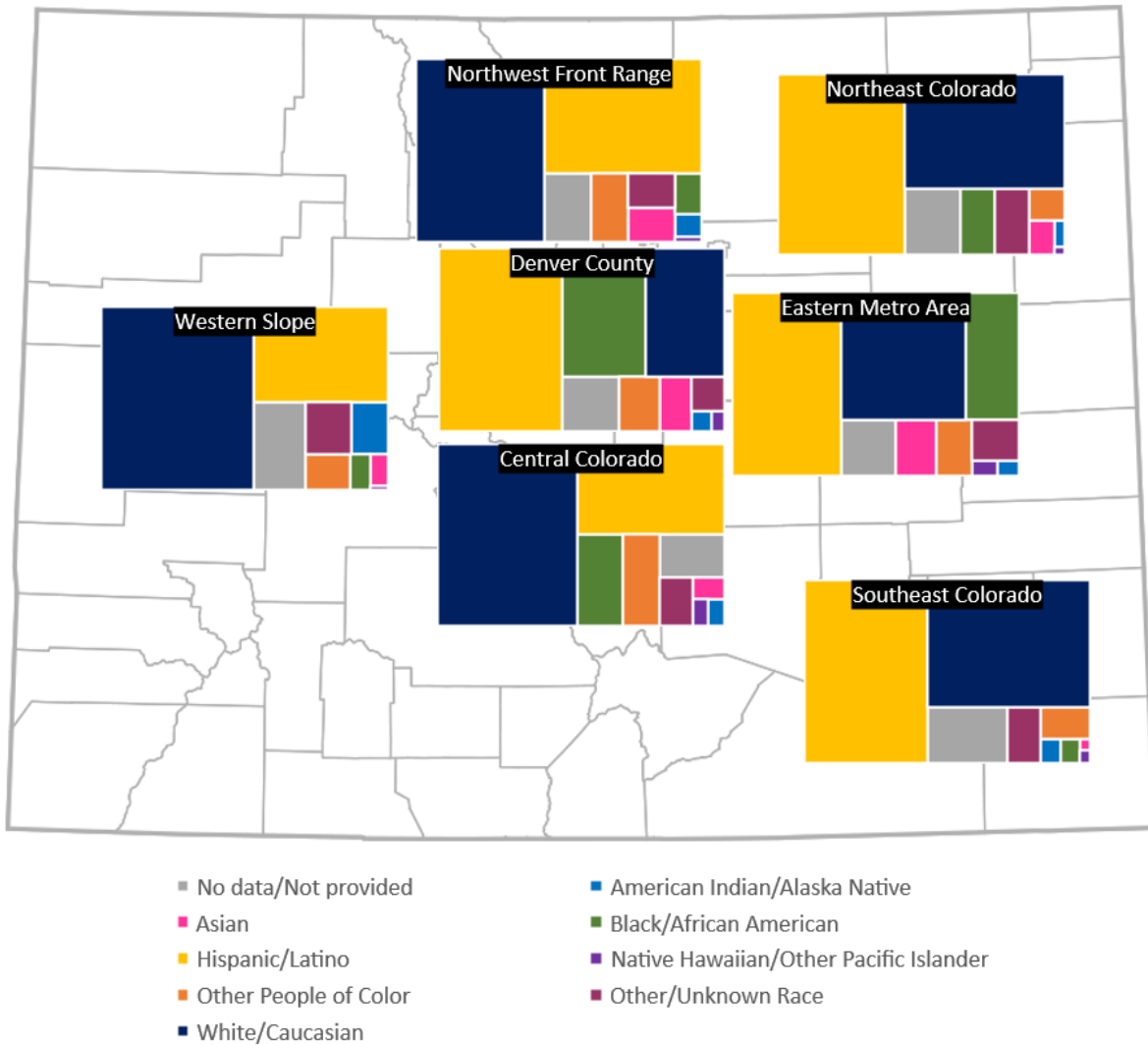
<https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Health%20Equity%20Plan.pdf>

parent is unable to maintain custody, records would also not be a match. Unmatched records provide incomplete information because a link cannot be made between the birthing parent's and baby's health information. The analysis in this report uses only matched records. Thus, numbers in this report may not match numbers HCPF reported elsewhere.

## State Demographics

The map below shows the race/ethnicity makeup of birthing parents in each of Health First Colorado's seven Regional Accountable Entity (RAE) regions. Members have the option to select race/ethnicity when filling out the medical assistance application. The categories below align with race/ethnicity categories on the application. On Map 1 below, the leftmost portion of each regional image represents the largest group; some regions have a majority of members who self-identify as white and some have a larger population of members who self-identify as Hispanic/Latino. Statewide, 42.5% of birthing parents self-identify as Hispanic/Latino and 32.7% identify as White/Caucasian. The next highest rates of birthing parents identify as Black/African American (7.7%), Other People of Color (3.5%), Other/Unknown Race (3.3%) and Asian (2.3%). American Indian/Alaska Native (AIAN) and Native Hawaiian/Other Pacific Islander (NHOPI) birthing parents make up 0.9% and 0.5% of all Health First Colorado births, respectively. Other People of Color is a HCPF-created category that combines those who chose multiple race/ethnicity options on the application. Other/Unknown race is an available response option listed on the application.

Map 1. Race/Ethnicity of Members Who Gave Birth by Region, CY 2020

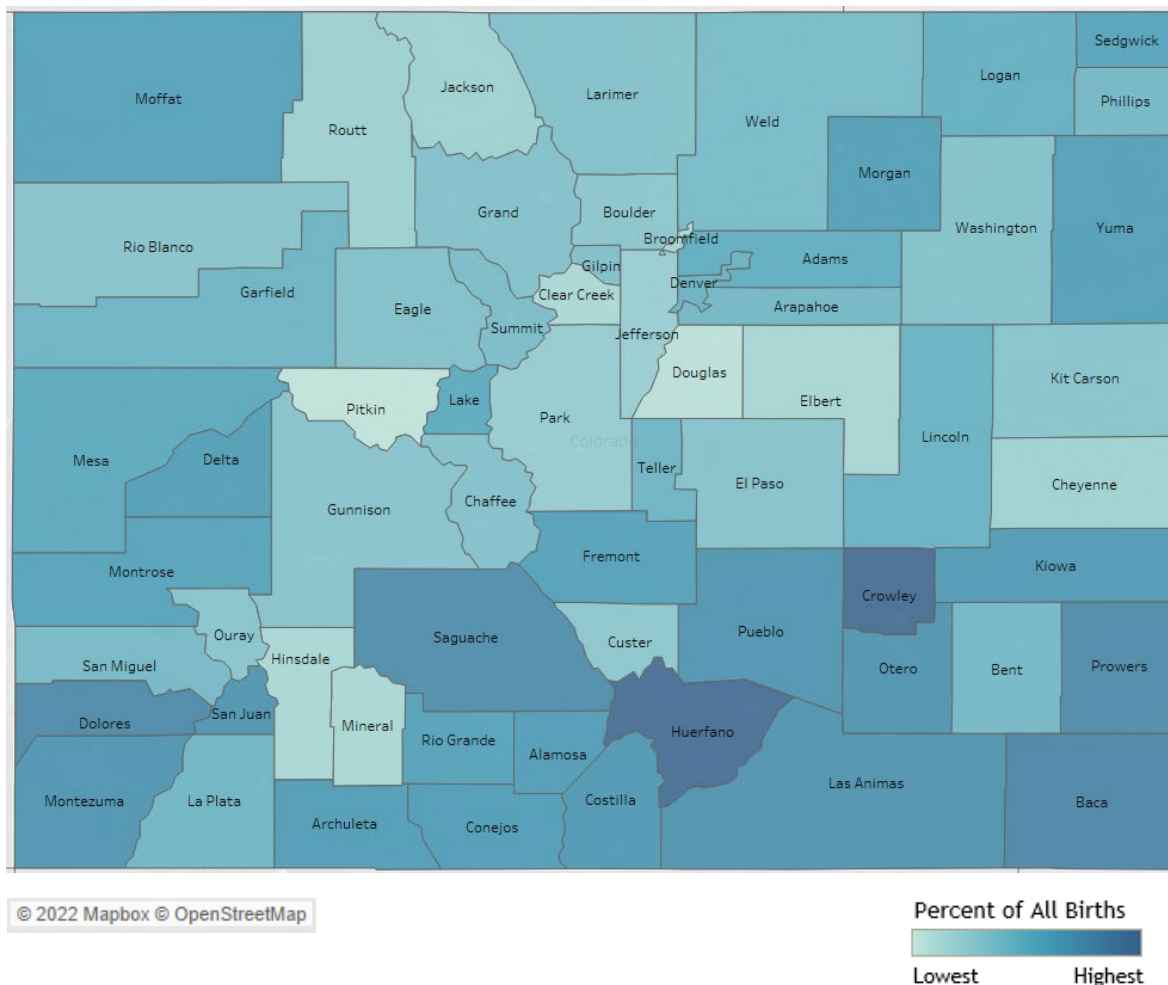


The regions in the above map of Colorado correspond with the RAE regions. RAEs are regional organizations charged with coordinating the care of Health First Colorado members in their area and connecting members to primary and behavioral health care services. The Western Slope region is covered by RAE 1, Northeast Colorado is covered by RAE 2, Southeast by RAE 4, Denver County by RAE 5, and the Northwest Front Range, Eastern Metro Area, and Central Colorado (El Paso, Park, and Teller counties) are covered by RAEs 6, 3, and 7, respectively. As shown above, the highest proportion of members in Northeast Colorado, the Eastern Metro Area, and Southeast Colorado self-identify as Hispanic/Latino, followed by members who self-identify as white. Denver County’s largest proportion of members identify as Hispanic/Latino, followed by Black/African American, then white. In the Northwest Front Range, Central Colorado, and Western Slope regions, the highest proportion of members self-identify as white and second-highest identify as Hispanic/Latino. The largest proportions of members who self-identify as Black/African American are in Denver County and the

Eastern Metro Area. Appendix I provides details on the race/ethnicity compositions in each RAE.

In Colorado’s three most populous counties in 2020, Health First Colorado covered more than one-third of all births (36.0% in El Paso County, 46.3% in Denver County, and 43.8% in Arapahoe County). In less populous counties the percentage of Health First Colorado covered births ranges from 11.2% in Pitkin County on the western slope, to 92% in Crowley County in the southeast region of the state. Huerfano County has the second highest rate of Health First Colorado covered births (90.9%). See Map 2 below for the percentage of births covered by county; a full list of county rates is located in Appendix II. Darker colors indicate counties with a higher proportion of Health First Colorado births and lighter colors indicate that fewer of the births in that county are covered by Health First Colorado.

Map 2. Percentage of Health First Colorado Births by County, CY 2020



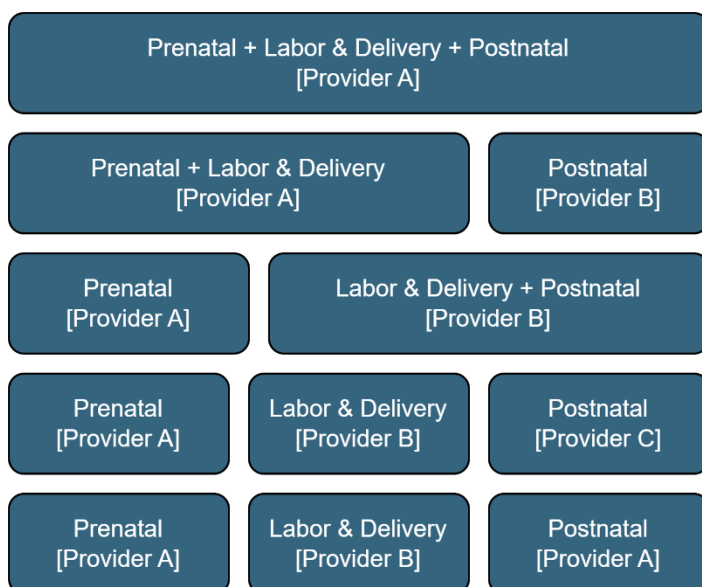
## Data Limitations

While HCPF’s method of matching claims with birth certificate data provides greater clarity on utilization and outcomes, limitations remain.

First, it is difficult to identify pregnant members; some birthing parents become eligible for Health First Colorado due to pregnancy, but some are existing members who then become pregnant. Those in the latter category are unable to be identified in HCPF data unless the member updates their eligibility type to “pregnant.” Each month, HCPF provides the RAEs with a list of members who have a new eligibility type of “pregnant” or received any obstetric services. Those who have not had obstetric services billed or who have not updated their status would not be represented in the RAE list, so the RAE is not able to outreach these members and coordinate their prenatal care. HCPF is leveraging the expansion of postpartum coverage to 365 days to encourage members to report their pregnancy to HCPF. Previously, this did not confer a benefit to members other than marking them for outreach from the RAEs, but with the new policy, the only way HCPF can guarantee 365 days of postpartum coverage for members is to have their pregnancy captured in the system. HCPF launched this messaging in May 2022 and will watch for an increase in reported pregnancies among existing members in the future. Note that in the future, HCPF will be exploring incentives that encourage member engagement and action, such as engaging in prenatal programs during their first trimester.

Second, the timing of a birthing parent’s first prenatal visit is difficult to determine due to HCPF’s use of global billing – a payment method HCPF uses to pay providers a lump sum for services after the baby is born. As Figure 1 below shows, there may be the same provider for prenatal, labor and delivery, and postnatal care or billing providers may differ by stage of pregnancy with a possible scenario of three different billing providers, one for each stage.

Figure 1. Global Billing Methodology



The global billing methodology is discussed at greater length on p. 14 of the first [Health First Colorado Maternity Report published in September 2021](#).<sup>4</sup> This methodology creates some challenges when billing claims data are used for analysis of maternal outcomes because all of the information is received at once; individual appointments are not represented. While reducing administrative burden for providers, this way of collecting data through global billing claims obscures HCPF’s ability to track the initiation or intensity of prenatal care, or other supportive services that may be provided. To compensate for this lack of specificity in claims data for the purpose of this report, HCPF collects prenatal visit information from the baby’s birth certificate, which is populated based on self-report of the birthing parent. If the member gives birth supported by the same provider where they received prenatal care, some birth certificate information may be populated from the electronic health record, but birthing parents may give birth supported by a different provider. Efforts to improve this reporting are discussed in the HCPF Action section below.

Third, behavioral health (BH) screenings have unique limitations. While HCPF recognizes screening as a significant area for intervention, the data on screening in this report will be undercounted. Depression screenings are reimbursable, and HCPF tracks positive (depression symptoms present) versus negative outcomes. However, providers report that separating out a depression screen from a more general office visit reimbursement code is administratively burdensome. HCPF is deploying an increasing number of alternative payment models (APMs) to incentivize this extra billing step, but 2020 data are minimally impacted by those because this work started in 2022. Additionally complicating depression data, depression screens are also billable under the child’s ID for the birthing parent (since 2016) for the purpose of increasing access; this can result in uncertainty when counting screenings for the parent. HCPF has initiated new tracking codes based on who is being screened under which Health First Colorado ID, which is discussed more below in Next Steps. HCPF will also underreport substance use screens due to minimum time requirements (discussed more on p. 25).

A final limitation is that provider types for perinatal services can be obscured by claims data. The provider who offers the service may only be visible as “physician.” This does not specify obstetrician, family practice doctor or maternal fetal medicine doctor. Similarly for the group of providers, claims data show that over 17,000 births were billed to “clinics,” but the variety of clinical experiences for members is challenging for HCPF to interpret.

## Cross-Agency Collaboration

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<sup>4</sup> 2019 HCPF Maternity Report (2021). <https://hcpf.colorado.gov/sites/hcpf/files/Maternity%20Report%20-%20Sept2021.pdf>

The maternity initiatives at HCPF would not be successful without the partnership of various colleagues throughout the state. Through these collaborations, several state entities are able to effectively combine efforts to provide a comprehensive and streamlined approach to this work. For example, HCPF staff are part of the Colorado Department of Public Health & Environment (CDPHE) Maternity Mortality Review Committee (MMRC), and Special Connections (substance use disorder treatment for pregnant and parenting people) is co-administered between the Behavioral Health Administration (BHA) and HCPF.

Additionally, collaboration between HCPF and the new Department of Early Childhood (CDEC) is strong, as both agencies jointly administer the Nurse Home Visitor program through a braided funding source. HCPF will continue to work closely with CDEC as both agencies embark upon large-scale efforts to expand home visitation programs through Health First Colorado and continue to sit on the Home Visitation Task Force for the state, ensuring HCPF's perspective and involvement in these projects.

Coordination between internal and external partners is essential to the work of Health First Colorado and the quality of care that members receive. The aforementioned are just a few examples of collaboration across departments.

## Maternity Advisory Committee

One of the notable additions to this second Maternity Report is the inclusion of interview data from the Maternity Advisory Committee (MAC). This report centers the member voice - prioritizing both member experiences and how they want those experiences represented - to give context to the quantitative data. The MAC defined their involvement in this report, from developing interview questions to reviewing the data and their interview excerpts. Highlights from interviews are included throughout this report.

Convened in 2021, the MAC is a group of up to 16 individuals with lived experience of being pregnant with Health First Colorado coverage in the last five years. HCPF publicized the forming of the committee to members in Spring 2021 and received over 100 applications. As required in the Colorado Code of Regulations, the MAC must be comprised primarily of people who identify as Black, Indigenous and People of Color and solicits input on existing and emerging policies from current or former Health First Colorado members who are most impacted by this work. The group is facilitated by HCPF staff and more recently began including a mental health professional to help create a trauma-informed, safe space for MAC members to share their stories.

HCPF interviewed MAC members to better understand how the data in this report align with the experiences of birthing Health First Colorado members throughout the state (see Appendix III for interview questions). Their quotes are included throughout the report to add context to the analysis. While data on a claim can tell us about a service provided, to whom it was provided, in what setting and at what cost, it cannot tell us how the member experienced a clinical encounter.

For example, members report experiences of stigma associated with their Medicaid status. Holly, a MAC member living in Adams County shared: “Being on Medicaid doesn’t make me less of a person than someone who has Anthem or Blue Cross Blue Shield... I want people to know that just because you are on Medicaid, doesn’t mean you are lesser than. You are human; you are allowed to ask for certain things even if you are on government assistance. It is your health and your child’s health.” MAC member Victoria from El Paso County adds, “We weren’t all dealt the same cards, and things like Medicaid help to level-up and even the playing field.”

Another member, Melissa from Garfield County, reported having to find new providers “because of how they treat you once you say you have Medicaid,” and Tyeesha from Arapahoe County reported feeling like her choices in alternative treatment plans were dismissed. She shared, “not feeling like you had a choice is how they make you feel. They always blame it on your insurance, and it’s like why is there always this conversation about my insurance?”

For MAC member Shay, teasing out the Medicaid status stigma and issues of racism can be challenging, so it’s cumulative, “Being a Health First Colorado member, and



Black woman, I have experienced having issues with getting proper health care.” She shares that “access to health care is one thing which you guys address,” but when it comes to the member experience, “treatment is a whole other thing—how fair is the treatment we are experiencing?” Tyeesha’s experience was similar; she explained, “I know this is bigger than a Medicaid thing, but for Black women...There are not many providers that look like us.”

*Aimee from Jefferson County captured the tension between the stigma and power of receiving Medicaid:*

“I am making the most money I have ever made in my life and I still cannot make it. That’s the reality of the times we are in. I have really come to learn and grow by using Medicaid and just realizing you can do the best you can do and that doesn’t mean it is a shameful thing to need Medicaid. Like not everyone is in the same place. If I didn’t have this help I needed, I probably wouldn’t be able to work, and then what would society say about me?”

**Throughout this report, quotes in these boxes represent the stories of the Maternity Advisory Committee (MAC) members.**

As a result of the powerful conversations in MAC meetings, HCPF will continue to center the experiences of these members, and next year’s maternity report will include a more thorough qualitative analysis from MAC members’ experiences. In the meantime, quotes punctuate the data presented in this year’s report and a few insets will explore themes from the members more thoroughly. HCPF is tremendously grateful to the MAC for their willingness to share their personal experiences and has dedicated this report to the MAC.



## Prenatal Care

The prenatal period is an important time for the birthing parent to work with their support system to meet their needs. This includes clinical supports, such as the management of any chronic health conditions, mental health, and community supports such as nutrition assistance. This section will cover the following topics:

- Timing of prenatal care
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Tobacco smoking
- Gestational and chronic conditions
- Prenatal depression screening
- Substance use

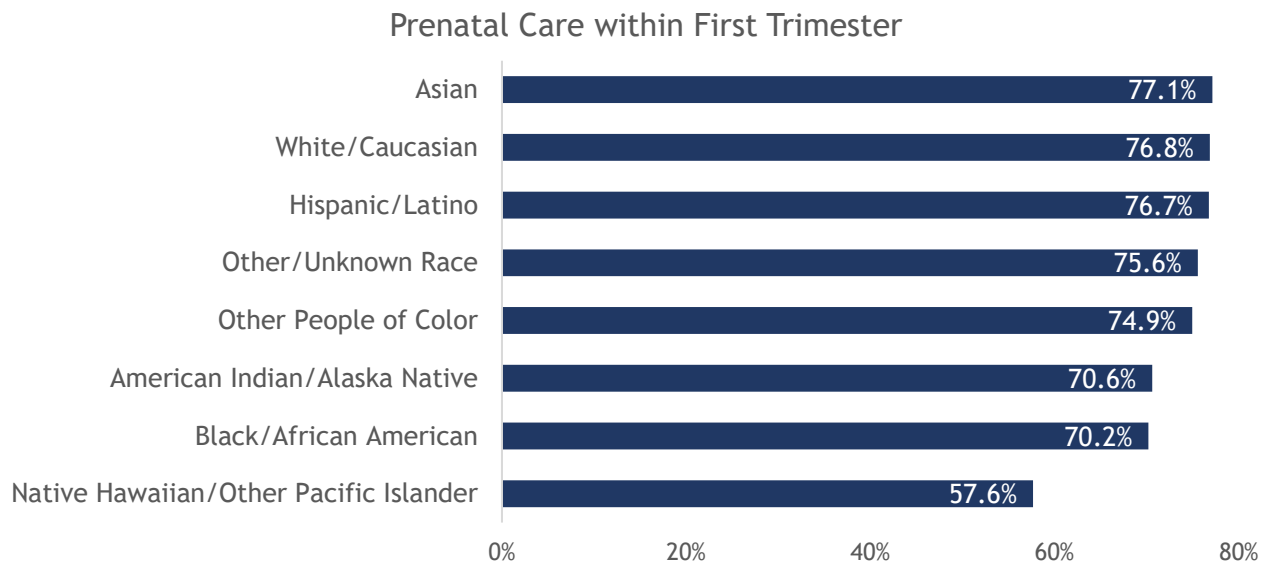
### Timing of Prenatal Care

The first medical prenatal visit within the first trimester (first 12 weeks) of pregnancy allows for early monitoring of any chronic conditions and the identification of health or social needs that may complicate the pregnancy or delivery. First trimester appointments are crucial as they correlate with better outcomes for birthing parents and babies. This is why improving the rate of timely prenatal care appointments is one of HCPF's top three priorities. For births that took place in 2020, 76.0% of all birthing parents received prenatal care within the first trimester of pregnancy. Compared to 2019, this is a slight decrease from the 77.1% of birthing parents who received prenatal care within the first trimester. As previously noted, global billing is utilized for Health First Colorado maternity care. Though the service date may be listed, multiple claims are submitted and paid together so data may not accurately reflect the first date of prenatal care. This limitation should be noted when interpreting these results. HCPF is working to improve reporting, which is discussed in more detail in the HCPF Action section below.

Among all race/ethnicity groups, individuals self-identifying as Native Hawaiian/Other Pacific Islander (NHOPI) had the lowest rate of first trimester prenatal care, followed by birthing parents identifying as American Indian/Alaska Native and Black/African American, as shown in Figure 2 below. The highest rate of first trimester prenatal care was among birthing parents who identify as Asian, followed by White. Birthing

parents ages 17 and under had the lowest rate of prenatal care in the first trimester (65.5%), followed by birthing parents aged 18 - 24 years (76.0%). There was also a gap in care between those whose preferred spoken language is Spanish (the second most spoken language in Colorado) and those whose spoken language is English. Of those whose spoken language is Spanish, 71.5% had a prenatal visit in the first trimester, compared to 76.8% for English speakers.

Figure 2. Percentage of Members Receiving Prenatal Care in First Trimester by Race/Ethnicity, CY 2020



## WIC

An ongoing consideration during the prenatal period is the birthing parent’s nutrition. Adequate nutrition during the prenatal period is critical for the health of both the birthing parent and the newborn.<sup>5</sup> Of birthing parents who delivered in 2020, 52.3% were enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) through CDPHE. The 2020 rate of enrollment was slightly lower than

“WIC is really good. They are wonderful people. They test your iron; they listen to you and hear if you’re telling them you aren’t feeling well. They advocate for you too. When I was having issues with my pediatrician, they immediately sent me a list of different pediatricians and were like ‘you probably need to go somewhere else because it doesn’t sound like this is working.’ So they are good, great people.”

- Tyeesha from Arapahoe County

WIC enrollment of pregnant members in 2019 (55.5%). This could have been impacted by COVID-19, both because WIC offices transitioned to largely virtual appointments, and because birthing parents may have been more hesitant to leave their homes and risk contracting the virus while pregnant. Across all race/ethnicity groups, enrollment

<sup>5</sup> United States Department of Agriculture nutrition resources (2020). <https://www.myplate.gov/life-stages/pregnancy-and-breastfeeding>

was lowest among NHOPI and White birthing parents (44.7% and 49.1% respectively) and highest among Hispanic/Latino birthing parents (58.4%). In addition to providing access to healthy food, WIC also offers nutrition counseling, breastfeeding supplies, and support for new parents. All Health First Colorado pregnant or postpartum birthing parents are eligible for WIC; there is a clear opportunity for more members to become involved with this supportive program.

## Tobacco Smoking

Of all birthing parents included in the current report, 10.9% reported that they smoked tobacco during their pregnancy. Medicaid members generally have higher smoking rates than the overall population,<sup>6</sup> though this should not be interpreted as a causal relationship. Smoking rates are higher among individuals with lower socioeconomic status than the general population with poverty as a confounding factor. Smoking during pregnancy is associated with a lower birth weight baby, preterm birth, birth defects, and sudden infant death syndrome.<sup>7</sup> Tobacco smoking rates among all Health First Colorado members (28.4%) and pregnant members (10.9%) decreased from 2019 when rates were 33.7% and 11.6%, respectively. Future years of data collection will allow for better interpretation of whether these smoking rate decreases point to a larger trend or a short-term occurrence.

Figure 3. Percentage of Births with Birthing Parent Reporting Smoking Tobacco by Race/Ethnicity, CY 2020

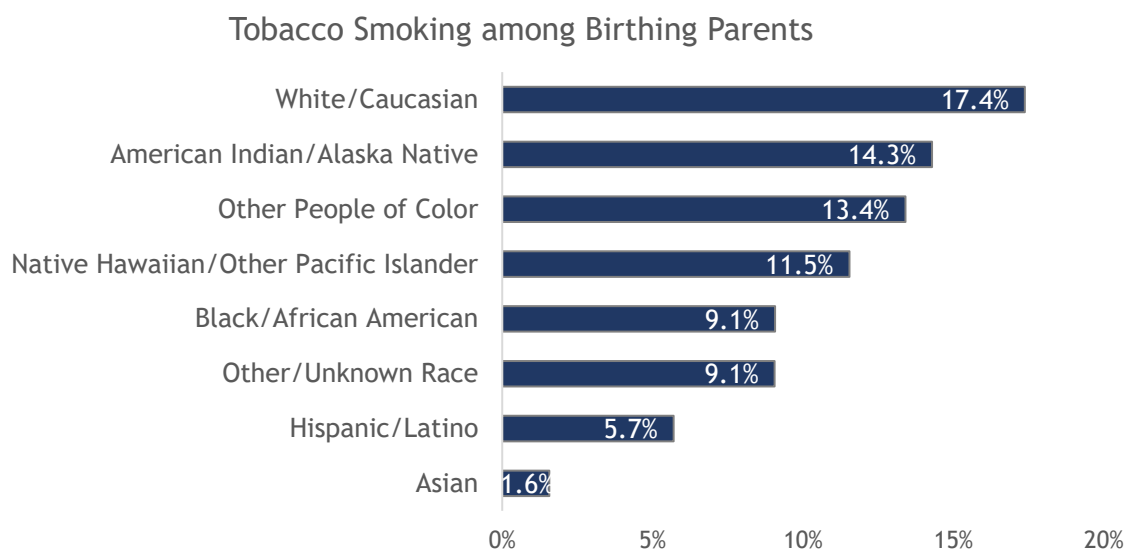


Figure 3 above compares rates of smoking across race/ethnicity groups, showing the smoking rate of White birthing parents to be more than three times the rate for Hispanic/Latino birthing parents. Asian birthing parents had the lowest rate.

<sup>6</sup> Center for Disease Control and Prevention (CDC) media release (2015).

<https://www.cdc.gov/media/releases/2015/p1112-smoking-rates.html>

<sup>7</sup> CDC resource site (2022). <https://www.cdc.gov/tobacco/campaign/tips/diseases/pregnancy.html>

Regionally, smoking rates were highest among pregnant members in Southeast Colorado (18.2%) and on the Western Slope (17.5%).

## Gestational and Chronic Health Issues

Prenatal care appointments are an important time to check-in on gestational and chronic health issues. Several chronic health conditions and health-impacting behaviors correlate with a higher risk for negative birth outcomes including, but not limited to, hypertension and diabetes. Type I or II diabetes and gestational diabetes can lead to birth defects, preterm birth, or even stillbirth.<sup>8</sup> Chronic and gestational conditions can be managed with the support of the member's health care team to decrease the risk of negative effects.

High blood pressure, or hypertension, may cause a lack of oxygen for the baby, and slower growth which could lead to premature birth and/or low birth weight.<sup>9</sup> Hypertension may be a chronic condition that the birthing parent was diagnosed with prior to pregnancy, or it may develop during the pregnancy (gestational hypertension). If untreated, gestational hypertension could develop into preeclampsia or eclampsia and cause significant risks for the birthing parent and baby. In 2020, 7.8% of birthing parents had preexisting hypertension, with Black/African American birthing parents having the highest rate (12.6%). This coincides with national data that show “cardiac and coronary conditions” to be the number one cause of pregnancy-related deaths among Black/African American birthing parents. For all groups, “cardiac and coronary conditions” is the number three cause of pregnancy-related deaths.<sup>10</sup> Chronic hypertension rates across race/ethnicity groups in Health First Colorado are shown in Figure 4 below. Given the importance of prenatal care appointments in addressing these conditions early in the pregnancy, HCPF is exploring member incentives as one strategy to increase prenatal engagement.

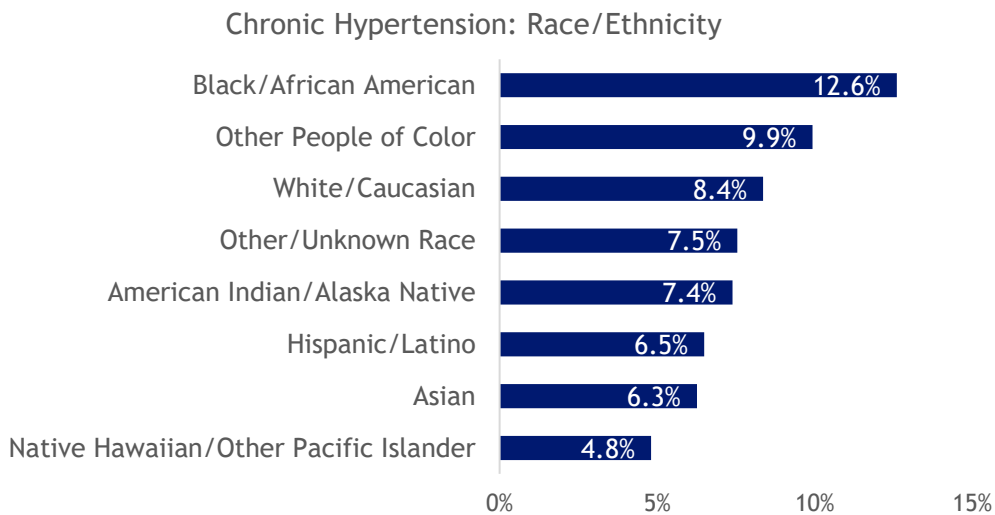
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<sup>8</sup> CDC resource site (2018). <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/diabetes-during-pregnancy.htm>

<sup>9</sup> CDC resource site (2021). <https://www.cdc.gov/bloodpressure/pregnancy.htm>

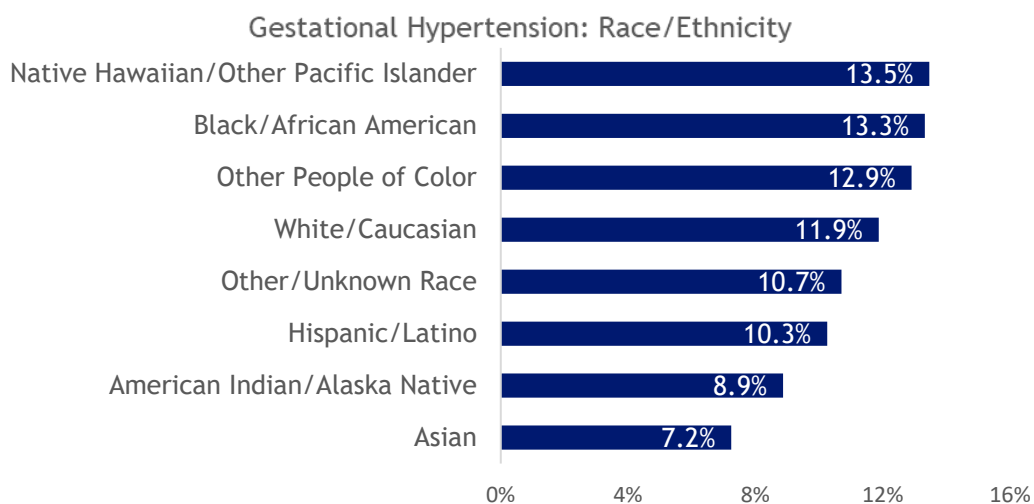
<sup>10</sup> CDC resource site (2022). <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html>

Figure 4. Percentage of Births by Members with Chronic Hypertension by Race/Ethnicity, CY 2020



Gestational hypertension was a factor in 11.2% of 2020 births, with the highest rates among NHOPI (13.5%) and Black/African American (13.3%) birthing parents. Rates of gestational hypertension across race/ethnicity groups is shown in Figure 5 below. In addition to the health risks associated with gestational hypertension, there is also a larger financial cost associated with these births. The full cost of perinatal care including prenatal, delivery, and postpartum care, or “maternal episode” was 38.4% higher for a birthing parent with gestational hypertension than that of a parent without gestational hypertension. Focusing on preventive care and management of preexisting chronic conditions is likely to lower costs and improve outcomes for birthing parents and their babies.

Figure 5. Percentage of Births Among Members with Gestational Hypertension by Race/Ethnicity, CY 2020



Similar to hypertension, Type I and II diabetes as well as gestational diabetes mellitus (GDM) can all complicate pregnancy and delivery. Preexisting diabetes diagnoses were

seen in 6.1% of births in 2020, with Black/African American (8.5%) and AIAN (8.4%) birthing parents having the highest rates of preexisting diabetes. GDM was seen in 9.5% of births and was highest among birthing parents aged 40+ years (24.8%), more than double the rate for birthing parents aged 25-34 years (10.5%). Among race/ethnicity groups, Asian birthing parents had the highest rate (14.9%) followed by AIAN birthing parents (14.8%). The rate for white birthing parents (7.5%) was half as high as that of Asian birthing parents. Among birthing parents with GDM, 15.0% of babies were born preterm, compared to 9.9% among birthing parents without GDM.

Similar to gestational hypertension, a cost difference is apparent between maternal episodes with and without GDM as well. The average maternal episode for a birthing parent with GDM in 2020 was 46.0% higher than for a birthing parent without GDM. Diabetes education and prevention, which is a focus of all RAEs, could lead to cost savings as well as better outcomes for the birthing parent and infant.

## **Prenatal Service Utilization and COVID-19 Impact**

The COVID-19 pandemic impacted every part of our state's health care system. Pregnant people faced changes to their visit schedule, engaged in telemedicine, and in some cases had to attend visits without a partner. This section summarizes the changes in prenatal service utilization between 2019 and 2020, which are assumed to be at least partially attributable to the pandemic. Overall, these changes are not as stark as may have been expected during the PHE.

### ***Medical Services***

Health First Colorado services used during the prenatal period vary based on the birthing parent's needs and any chronic health conditions they may be managing. In 2019, 92.9% of birthing parents received one or more prenatal service covered by Health First Colorado. In 2020, 92.3% received one or more prenatal service. This stable percentage indicates that overall, pregnant members were able to receive some type of prenatal care during the pandemic. Due to the global billing system described in this report, submitted claims do not provide sufficient information to HCPF for analysis around whether claims during the prenatal period were medical visits, prescriptions, or services related to the pregnancy, or unrelated general medical claims.

Despite this limitation, it's clear that during the prenatal period the highest utilized category of services is professional services, which includes physician visits for prenatal care, averaging 8.5 visits per person in 2019 and 7.9 visits per person in 2020. The slightly lower rate in 2020 may be due to the transition from in-person to virtual care or members' hesitancy to seek in-person care due to COVID-19. The second highest utilized category of services is pharmacy, averaging 5.5 services per person in 2019 and 4.9 services per person in 2020, followed by imaging, which includes ultrasound scans (4.5 services per person in 2019 and 4.3 services per person in 2020).

### **Behavioral Health Services**

Behavioral health (BH) during the perinatal period is a persistent concern, as BH issues have been identified by CDPHE to be the leading cause of maternal mortality in Colorado.<sup>11</sup> This corresponds with national data, also showing “mental health conditions” as the overall leading cause of mortality at 22.7% of pregnancy-related deaths.<sup>12</sup> Early identification and treatment are key in preventing perinatal depression from causing more severe symptoms for the birthing parent. In 2020, a prenatal depression screen was billed for 8.2% of births. Due to data capture issues and inconsistent billing for these screens, HCPF acknowledges that this is an undercount. In 2020, analysis of claims data shows that out of all births 4,405 birthing parents (17.0%) received one or more prenatal BH service; one in three (32.9%) members who had a BH visit only had one visit. Comparatively, in 2019, 4,431 birthing parents (16.5%) had at least one prenatal BH visit, with one in three (36.5%) having received only one visit.

*Melissa from Garfield County reflects on her experience of having Medicaid and receiving prenatal care in her rural community:*

“When I lived in the city I was given more opportunities and I had more options for support and things that are [more] available than what I have had here in the rural areas... I had two [children] in each; two very rural and two in the city. The options for care are minimal here; you only have so many [providers] that actually accept [Medicaid]. And you don't get the perks that you get in the city. In the city there are a lot more available to be offered.”

*In spite of the challenges of seeking care in her rural area, Melissa is grateful to have Medicaid:*

“I don't know what I would have done if I didn't have a couple of my children on Medicaid. I have seen the bills. When you actually see the bills and see what it could have cost, it's a blessing.” “I wouldn't be able to afford [my daughter's] medications if we didn't live here and Colorado Medicaid didn't make it so simple.”

<sup>11</sup> Colorado Department of Public Health & Environment (CDPHE) legislative report (2020).

<https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87eI3KMHN6oBy5t2y/view>

<sup>12</sup> CDC report (2022). <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html>



The overall number of BH visits provided in 2019 and 2020 did not differ significantly, which suggests stable access to care in spite of the turbulence of the pandemic.

Screening and treatment of any existing substance-use disorders is a key component to behavioral health during pregnancy. Claims data for 2020 show that 49 birthing parents were screened during the prenatal period under Screening, Brief Intervention and Referral to Treatment (SBIRT) procedure codes. Responses from providers indicate that this is an underreporting due to billing constraints: the billing code for the shortest SBIRT screening must reach 15 minutes to be billed by providers. Because the screening typically takes 5-10 minutes,<sup>13</sup> most providers do not bill for the service. HCPF will explore solutions to gather more accurate information on SBIRT screening. For birthing parents in need of substance use treatment, HCPF collaborates with the Behavioral Health Administration (formerly the Office of Behavioral Health) and their [Special Connections program](#).<sup>14</sup> More information about this program can be found on the program website.

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<sup>13</sup> Substance Abuse and Mental Health Services Administration (SAMHSA) SBIRT white paper (2011). [https://www.samhsa.gov/sites/default/files/sbirtwhitepaper\\_0.pdf](https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf)

<sup>14</sup> HCPF Special Connections Program website (2022). <https://hcpf.colorado.gov/special-connections>



## Labor and Delivery

Childbirth can be a complex and intense experience. Complete prenatal care prepares the birthing parent and baby for the best possible outcome. This section will include the following topics related to labor and delivery:

- Provider type
- Delivery type
- Chronic conditions impacting birth
- Preterm birth
- Preeclampsia
- Low birth weight
- Exposure to substances and neonatal abstinence

### *COVID-19 and Pregnancy*

“I had him right at the start of the pandemic so it was just like a nightmare... It was just a lot.” - Aimee from Jefferson County

“My first pregnancy was very, very, strange because it was dead in the middle of COVID. So there was a lot of things that I didn’t know better because I was a first time mom. But there was a period of four, almost five months where I didn’t see any practitioner. It was like over the phone, you know? I feel like that was really hard.” - Greta from San Miguel County

## Provider Type

Health First members give birth assisted by a variety of professionals. Physicians specializing in obstetrics, family practice, or maternal fetal medicine assisted in 71.9% of births, while a certified nurse midwife assisted in 16.9%. The remaining 11% represent births where provider type was not available or births were assisted by other professionals. Members most often receive their outpatient prenatal and postpartum care at a clinic (81.3%) and very infrequently at a birthing center (0.53%).

Provider availability varies across the state. In rural and frontier areas of the state, members travel longer distances for appointments and have fewer choices in providers.

*Greta from San Miguel County shares her experience of traveling for perinatal care in a rural area and her gratitude for insurance coverage:*

“I’m glad that my voice is part of the moms/women in the Western Slope that can be heard. It is different out here, whereas if you’re in the Denver Metro area you have probably, I don’t know, like 30 choices as far as like doctors and you’re driving minutes, or maybe 45 at the most, for an appointment, and here we are choosing between an hour and a half drive to Montrose or two and a half to Junction. So that does make things different. Like this new baby is due in the middle of February, so that has to factor in, in case there is a blizzard or something like that. So it is kind of stressful!”

“I’m just grateful that I have [Medicaid] and I don’t have to decide between going to a prenatal appointment and putting gas in the car. I mean things are tight for sure, but I don’t have to worry about care. I am getting the care that I need. And [my son] is on it too, so he gets the care that he needs.”

National trends during and after the time of the COVID-19 pandemic’s highest impact show a growing interest in community births (those not in hospitals). Many states are exploring how to support members who choose a birth external from a hospital, often in a Freestanding Birth Center (FSBC). These facilities offer a low-intervention approach to low-risk pregnant people who may choose this facility based on geographic limitations and provider or delivery preference. In Colorado, from 2019 to 2020, the number of people choosing to birth outside the hospital increased by 18.5%.<sup>15</sup> This analysis was not limited to Health First Colorado and includes all coverage types. HCPF is looking into eliminating coverage restrictions to allow FSBCs as an eligible facility type with full access to relevant billing codes.

Of note, these birth centers are often staffed by “Direct Entry Midwives,” (DEMs) also called “Certified Professional Midwives” (CPMs). Health First Colorado does not currently cover this provider type, but other states have begun expanding coverage to CPMs, who often specialize in FSBC births. HCPF is currently examining this provider type to determine if and how we might cover it.

## Delivery Type

Nearly three in four Health First Colorado births in 2020 were vaginal births (74.0%) and the Caesarean section (C-section) rate among Health First Colorado members (26.0%) was lower than the national average of 31.8%. A strong linear relationship

<sup>15</sup> Gregory ECW, Osterman MJK, Valenzuela CP journal article (2021). <https://dx.doi.org/10.15620/cdc:110853>

exists between birthing parent's age and C-section rate when individuals with prior C-sections are removed from analysis to correct for the influence of prior C-sections. Across birthing parents grouped by age, the highest C-section rate, was among those aged 40 and older (37.2%). In comparison, birthing parents aged 17 and younger had a C-section rate of 13.2%. The average cost of a birth differs based on type of delivery; an average vaginal delivery costs half as much as a C-section birth.

Across race/ethnicity groups (see Figure 6 below), Black/African American and AIAN birthing parents had the highest rates of C-section births, 31.4% and 31.0%, respectively. Hispanic birthing parents had the lowest C-section rate at 24.3%. Reducing the number of elective C-section births is a high priority because surgery presents serious health risks, and HCPF has included C-section rates reporting in its Hospital Quality Incentive Program (HQIP)<sup>16</sup> to achieve this goal. The C-section measure is based on the Joint Commission<sup>17</sup> calculation and only awards credit to hospitals that perform better than the Healthy People 2030 benchmark of 23.6%. Additionally, this measure uses the evidence based strategy of sharing individual provider rates within hospital systems to encourage outlier providers driving higher rates to reduce them to parity with their peers.

*MAC Members commonly report the experience of not feeling properly educated or having their preferences respected when giving consent to having interventions or tests performed, such as C-sections:*

“Don’t ask me in the middle of my labor if I want a C-section. I kind of feel like that’s how they got me. Because I feel like I got got... I didn’t enjoy the experience at all with my daughter, having my daughter.”

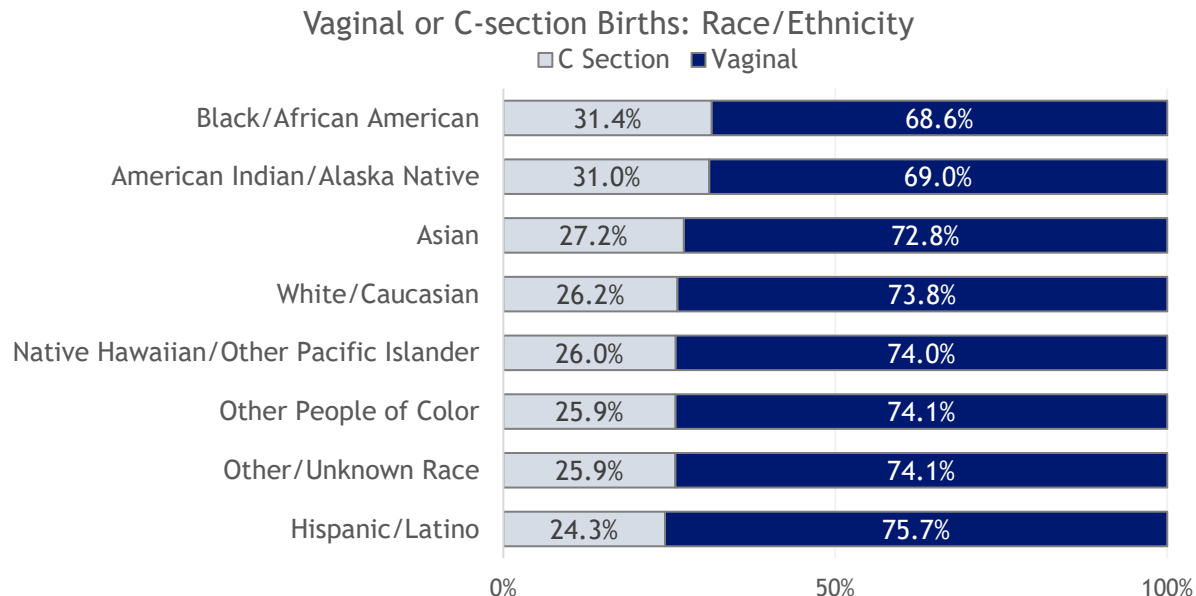
- Tyeesha from Arapahoe County

<sup>16</sup> Colorado Healthcare Affordability and Sustainability Enterprise program report (2022).

<https://hcpf.colorado.gov/sites/hcpf/files/2022%20CO%20HQIP%20Measure%20Detail%20Revisions%202.4.22.pdf>

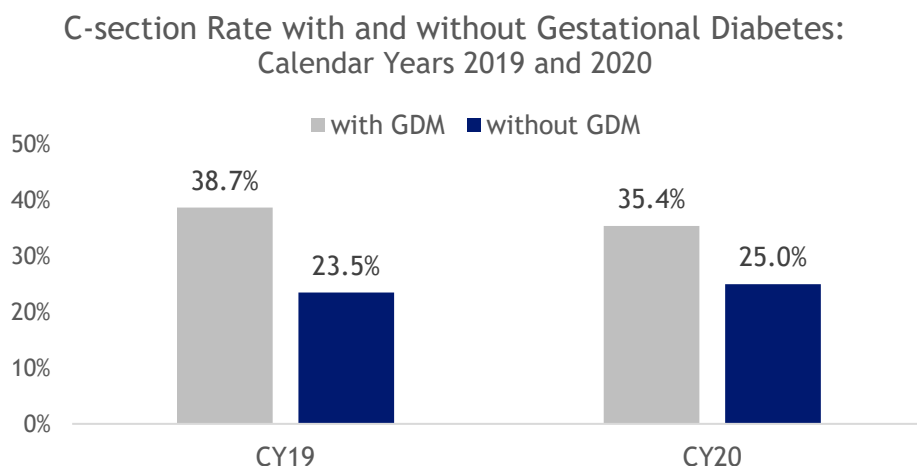
<sup>17</sup> <https://www.jointcommission.org/standards/>

Figure 6. Percentage of Vaginal or C-Section, All Births by Race/Ethnicity, CY 2020



Birthing parents with gestational diabetes have a higher C-section rate at 35.4%, compared to 25.0% for birthing parents without gestational diabetes, as shown below. The rates of C-sections among birthing parents with chronic hypertension (39.4%) or chronic diabetes (41.4%) are also higher than those of birthing parents without these chronic conditions.

Figure 7. Percentage of C-Section Births for Birthing Parents with and Without Gestational Diabetes, CY 2019 and CY 2020

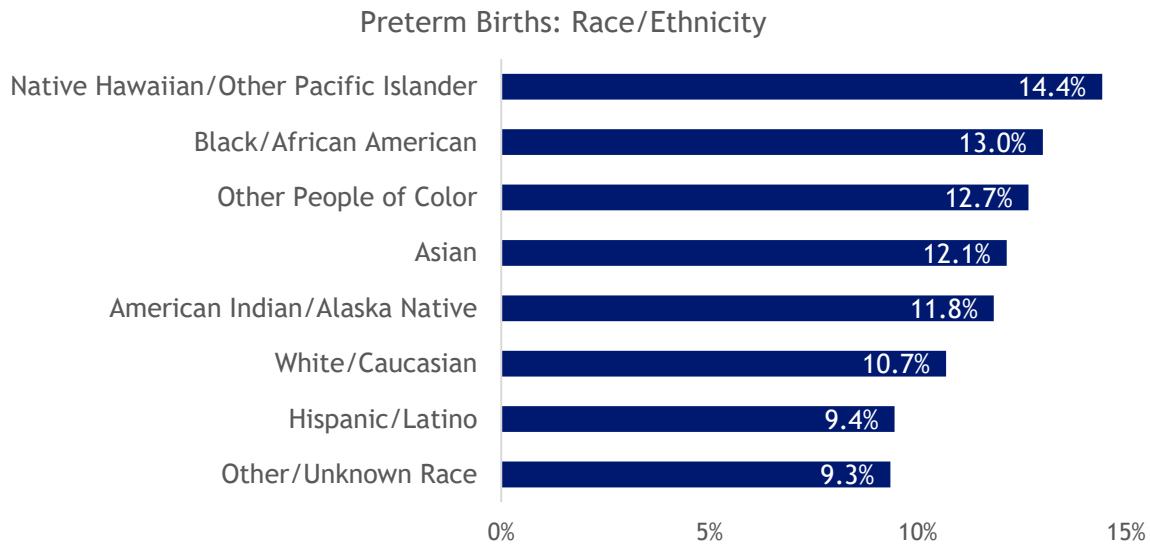


### Preterm Births

Preterm births represented 10.4% of Health First Colorado births in 2020. This rate remained consistent from 2019 (10.4%). Colorado’s overall preterm birth rate in 2020

for all payers was 9.1%.<sup>18</sup> Nationally, the preterm birth rate was 10.1% in 2020 and appears to be declining slowly in recent years.<sup>19</sup> Health First Colorado birthing parents over 40 had a higher-than-average rate of preterm births at 15.6%, while for parents aged 25 - 34 the preterm rate (10.3%) was closer to average. Across race/ethnicity groups, NHOPI birthing parents had the highest rate of preterm births, followed by Black/African American birthing parents; see Figure 8 below.

Figure 8. Percentage of Preterm Births (gestational age less than 37 weeks) among Members by Race/Ethnicity, CY 2020



Preterm birth occurs more frequently among birthing parents with pre-existing hypertension. In 2020, 22.7% of births involving chronic hypertension resulted in preterm birth, compared to 9.4% of preterm births among birthing parents without hypertension. Gestational hypertension has a similar effect, with 15.6% of preterm births among birthing parents with gestational hypertension and 9.8% for parents without. Preeclampsia, a pregnancy complication associated with high blood pressure, was seen in 3.2% of births in 2020, consistent with the national rate of approximately 4.0% of births.<sup>20</sup>

As shown in Figure 9 below, preterm birth is also more common among birthing parents with chronic or gestational diabetes. In 2020, among birthing parents with diabetes, 18.2% of births were delivered preterm birth. This was compared to 9.9% of preterm births among birthing parents without diabetes resulting in preterm birth. Cost of preterm birth varies based on gestational age. For earlier preterm babies (28-

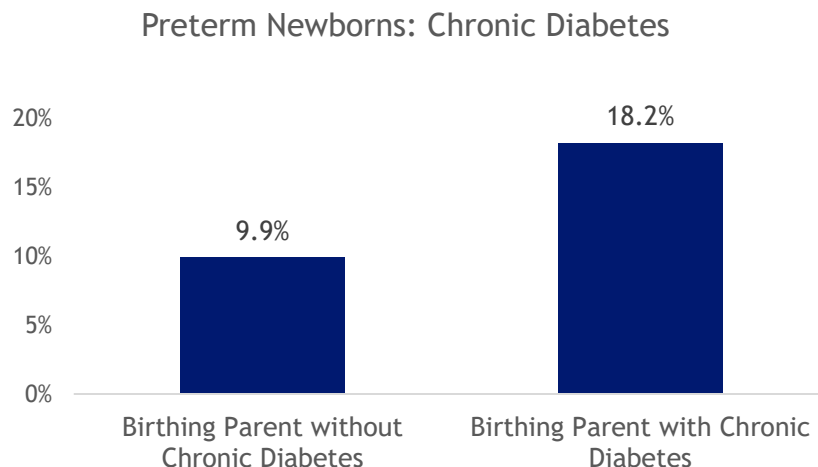
<sup>18</sup> March of Dimes report (2021). <https://www.marchofdimes.org/peristats/reports/colorado/prematurity-profile>

<sup>19</sup> CDC resource site (2020). <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm#:~:text=Preterm%20birth%20is%20when%20a,2019%20to%2010.1%25%20in%202020>.

<sup>20</sup> CDC resource site (2021). <https://www.cdc.gov/bloodpressure/pregnancy.htm#:~:text=Preeclampsia/Eclampsia, Preeclampsia, -happens%20when%20a>

32 weeks gestation), the cost incurred is much higher, while later preterm babies (33-36 weeks gestation) have a lower, but still higher than average cost.

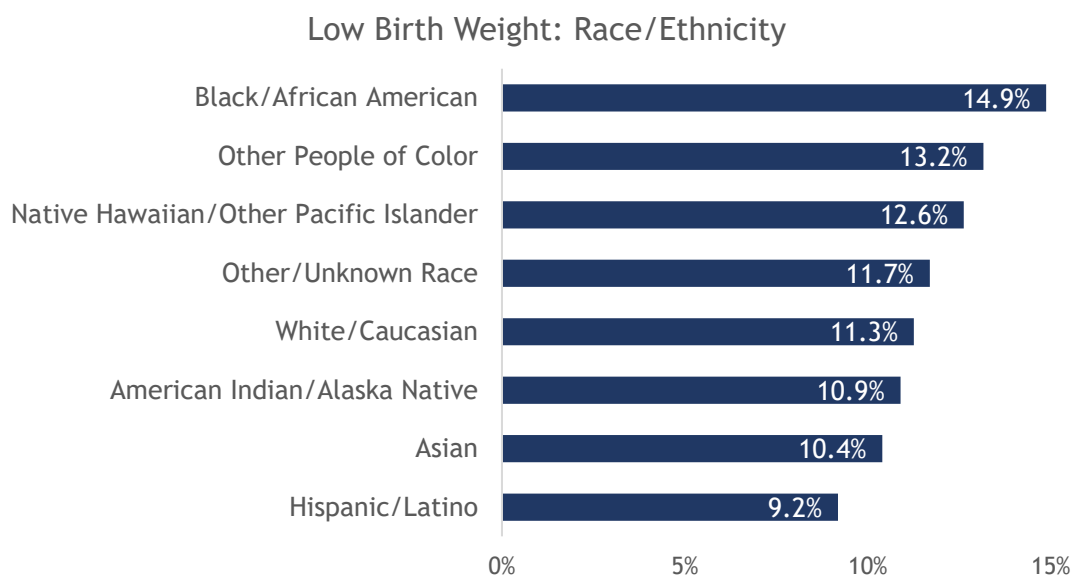
Figure 9. Percentage of Preterm Births (gestational age less than 37 weeks) among Members with and Without Chronic Diabetes, CY 2020



### Low Birth Weight

The overall rate of low birth weight babies among all Health First Colorado births was 10.6%, consistent with the 2019 rate (10.5%). As shown in Figure 10 below, the highest rate of low birth weight babies among race/ethnicity groups was among Black/African American births (14.9%) and the lowest was among Hispanic/Latino births (9.2%).

Figure 10. Percentage of Low Birth Weight Babies (less than 5.5 lbs.), CY 2020



Smoking during pregnancy can lead to delivery of a low birth weight baby, as described in the prenatal section above. In 2020, the rate of low birth babies among

smoking birthing parents was 17.5%. This low birth weight rate among smoking birthing parents was a slight increase from 2019 (16.2%), though the overall rate of smoking birthing parents decreased, as mentioned in the Prenatal section above. The rate of low birth weight babies among nonsmokers remained unchanged at 9.8%.

## Substance Exposure and Neonatal Abstinence

Substance use during pregnancy and in the postpartum period can also have serious impacts on the health of birthing people and their infants. Nationwide and in Colorado, mental health and substance use disorders are leading causes of maternal morbidity and mortality.<sup>21</sup> In 2020, 3.8% of babies covered by Health First Colorado were substance exposed newborns (SEN) and/or diagnosed with Neonatal Abstinence Syndrome (NAS). This was a 30.6% increase from 2019 (2.9%). Even prior to the public health emergency, the national NAS rate had been increasing; between 2010 and 2017 the rate of NAS diagnosis increased 82% nationwide.<sup>22</sup>

In an effort to address substance use among pregnant members, HCPF is a participant in the Maternal Opioid Misuse (MOM) Model. The MOM Model is a five-year, \$4.6 million cooperative agreement from the federal Centers for Medicare and Medicaid Services (CMS) to better integrate care for pregnant and parenting people with opioid use disorder (OUD). HCPF selected three subgrantees - Denver Health (Denver), River Valley Family Health Centers (Montrose), and Southern Colorado Harm Reduction Association (Pueblo) - to implement culturally appropriate, trauma-informed, and locally specific programs. Through the MOM Model, and in partnership with stakeholders across the state, HCPF aims to build an innovative and sustainable model for providing equitable maternal care to pregnant and parenting people with OUD.

Hospitals are a key player in improving care for substance-exposed newborns. The Colorado Hospital Substance Exposed Newborns Quality Improvement Collaborative (CHoSEN QIC) is an effort led by 31 hospitals (up from 20 hospitals in 2019) in Colorado, Wyoming and Montana to standardize care and improve outcomes for newborns who were exposed to substances during the prenatal period. The collaborative has made progress over the last three years with a focus on teaching the Eat, Sleep, Console assessment tool, developing guidelines for breastfeeding eligibility, employing comfort measures before pharmacologic therapy and administering opiate therapy on an as-needed basis.

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<sup>21</sup> CDPHE legislative report (2020). <https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view>

<sup>22</sup> US Department of Health and Human Services press release (2021).

<https://www.hhs.gov/about/news/2021/01/12/nationwide-study-shows-continued-rise-in-opioid-affected-births.html>





## Postpartum Care

After delivering a baby, best practice involves regular postpartum follow-up appointments to monitor the health of the baby and birthing parent. This section will cover the postpartum period with the following topics:

- Postpartum behavioral health
- Postpartum service utilization
- Long-acting reversible contraception (LARC)

### Postpartum Behavioral Health

Behavioral health conditions, including mental health and substance use disorders, are Colorado's leading cause of maternal mortality within the first postpartum year. HCPF recognizes the risk that behavioral health issues pose for birthing parents, especially in the postpartum period; thus, it is clear that screening for postpartum depression is of the utmost importance.<sup>23</sup> A recent meta-analysis found that among pregnant low-income women in developed countries, the prevalence of depression is 33.8%.<sup>24</sup> In 2020, up to three postpartum depression screens were covered by Health First Colorado and could be billed to the birthing parent's or baby's Health

*Some MAC members were not aware that behavioral health care is also covered during the perinatal period:*

*"With my first one I wasn't ready for postpartum depression at all, I didn't think it would happen at all and then I went way off the Richter... I think after 6 weeks they quit asking how you are doing. And I think that would be beneficial to mom and baby because like I am going to assume that the better [mental health] spaces I am in, the better spaces I am able to raise my kids."*

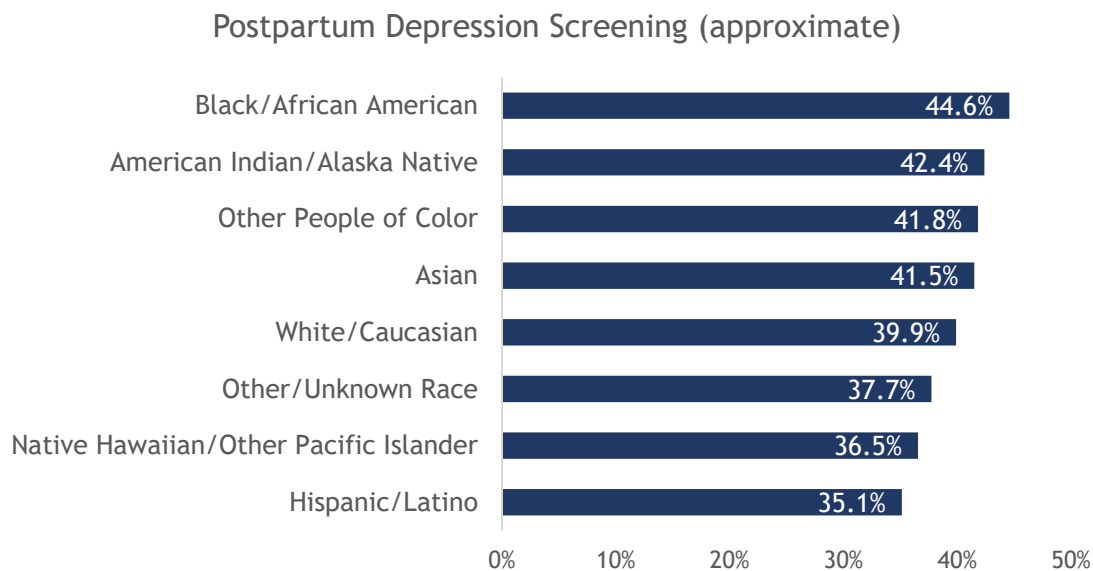
*- Victoria from El Paso County*

<sup>23</sup> CDPHE legislative report (2020). <https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view>

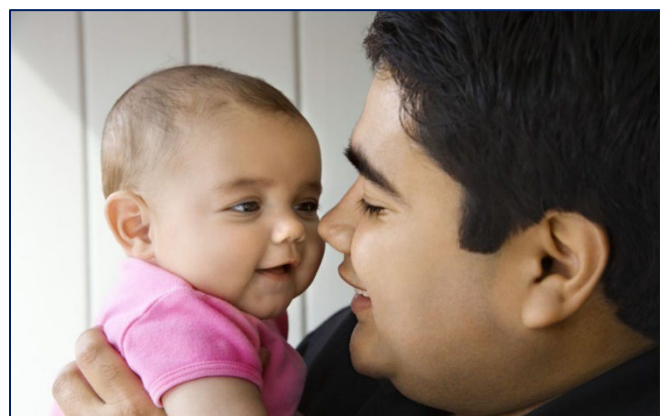
<sup>24</sup> Corcoran, J., Marinescu, I., Vogelsang, C., & Kim, J. C. journal article (2022). <https://doi.org/10.1007/s10389-021-01662-3>

First Colorado ID.<sup>25</sup> The overall depression screening rate of 38.1% suggests opportunity for improvement (the goal is for all birthing parents to receive at least one screen, more if depressive symptoms exist), likely in both billing practices and screening prevalence. Figure 11 below shows the rate of depression screens received by birthing parents across race/ethnicity groups. Black/African American and AIAN birthing parents received depression screening more than other race/ethnicity groups. The screening rate for all groups was lower than 50%.

Figure 11. Percentage of Births Where Birthing Parent Was Screened for Depression at Any Time After Delivery, CY 2020



These results should be interpreted with caution as screening may be performed at a postpartum follow-up visit without a specific billing claim for the screen in addition to the billing claim for the visit. HCPF is exploring better solutions for collecting this screening information with the goal of increasing the overall rate of depression screening for members, so that members who could benefit from behavioral health treatment can receive the care they need.



Postpartum anxiety disorders can also have a significant impact on the birthing parent and their ability to care for their new baby. According to CDPHE’s Health eMoms survey, the rate of Health First Colorado birthing parents reporting

<sup>25</sup> This cap on covered depression screenings has since been removed so that providers can bill for universal screening; see the HCPF Action section below (p. 39) for more information.

having felt anxious for “several,” “more than half,” or “nearly every day” during the past 14 days in 2020 was 69.0%.<sup>26</sup> It is likely that COVID-19 and related stressors played a role in this high rate of anxiety symptoms. Anxiety levels may remain at this higher level or decrease over upcoming years. This trend should be monitored across care settings so that appropriate outreach and treatment is available.

## Postpartum Service Utilization

In 2020, due to the federal maintenance of effort requirement to keep Medicaid members enrolled regardless of eligibility, as described above, birthing parents who were only Medicaid-eligible due to pregnancy were covered for a full year after giving birth rather than just 60 days. HCPF did not see an increase in average service utilization per person from 2019 to 2020. In 2019, 98.3% of birthing parents received one or more postpartum service covered by Medicaid. In 2020, 98.9% received one or more postpartum service. As described in the prenatal section, global billing and using claims data primarily for analysis limits the specificity of information about the type of service a member received, so services provided during the postpartum period may not be pregnancy-related. However, the highest utilized service category during the postpartum period was professional services, which includes physician visits for postpartum follow-up, averaging 6.3 services per person in 2019 and the same rate in 2020. The second highest utilized category of postpartum services is pharmacy, averaging 5.8 services per person in 2019 and 5.4 services per person in 2020, followed by visits to a Federally Qualified Health Center, Rural Health Clinic, or Indian Health Services at 1.5 services per person in 2019 and 1.3 services per person in 2020. It must also be noted that this report covers data for parents who gave birth in 2020, which would include those who gave birth in the later months of 2020 but received most of their postpartum care in 2021.

*Two MAC members said that they felt forgotten after giving birth:*

“So, postpartum I feel like someone could have reached out... I guess sometimes they think we are just another number... sometimes they could reach out and say... ‘how are you doing?’ or, ‘Do you have any questions about the plans for the baby? What will the medical transport be for you and the child? Does the child have an appointment, or do you just have an appointment and need a Medicaid ride?’”

- Holly from Adams County

“It’s like as soon as my son left my body, it was all about the baby and then I was just left in the wind. I ended up having postpartum [depression] very bad and I did not feel like I could reach out to anyone, and I felt like I was forgotten.”

- Aimee from Jefferson County

<sup>26</sup> CDPHE Health eMoms Survey Data (2020). <https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/health-emoms/health-emoms-survey-data>

Because the postpartum period is a critical time for the health of birthing parents and babies, increasing the rate of members' postpartum visits is one of the top three goals HCPF identified. Improving data collection around these appointments is the first step toward increasing this rate.

Looking closer at behavioral health service utilization, in CY 2019, 4,004 individuals (14.9%) had one or more postpartum behavioral health visit. Comparatively, in CY 2020, a similar overall total of 4,033 individuals (15.6%) had one or more postpartum behavioral health visit. In 2020, claims data show that 87 birthing parents were screened for SBIRT after delivery. As discussed in the prenatal services section above, this is more than likely an underrepresentation of actual SUD screening taking place due to a billing coding issue. Overall, the stability in the number of members utilizing postpartum behavioral health visits between 2019 and 2020 indicates that behavioral health care remained accessible during the pandemic.

### Long-acting Reversible Contraception

In CDPHE's 2020 survey of Coloradans who had recently given birth, 83.0% of respondents reported that they were currently using birth control.<sup>27</sup> Long-acting reversible contraception (LARC) (e.g., intrauterine device, or implant like Nexplanon)

"I also love the fact that they cover the cost of birth control. Like let's be honest - I also feel like that is a part of being responsible when you're doing family planning, so I'm glad that they are able to cover the cost of birth control, to help me plan for my current kids' future and then whatever children I will have in the future, if I chose to do so. So I feel like that is just awesome that they do that."

- Holly from Adams County

is covered and available for birthing parents who choose to utilize contraception after giving birth. To facilitate expanded use of LARCs, HCPF improved reimbursement policy to pay for LARC devices outside of global and hospital payments to ensure financial viability of insertion. In 2020, one in five (22.4%) postpartum birthing parents took advantage of LARC for family planning. This does not include other methods of birth control such as pill, patch, vaginal ring, or condom use; the percentage of all postpartum members using some method of birth control is higher.

### Existing Special Programming

HCPF has a history of advancing maternal health goals through its programs. Last year's report highlighted special programming for the perinatal period that has historically improved outcomes. HCPF continues to invest in the following programs

<sup>27</sup> CDPHE Pregnancy Risk Assessment Monitoring System (PRAMS) dashboard (2020). [https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/2020TableauSummaryTables\\_NewLogo/2020PRAMSSummaryTables?%3Aembed=y&%3Aiid=5&%3AisGuestRedirectFromVizportal=y](https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/2020TableauSummaryTables_NewLogo/2020PRAMSSummaryTables?%3Aembed=y&%3Aiid=5&%3AisGuestRedirectFromVizportal=y)

while also exploring new and innovative ways to keep these programs accessible and member friendly:

- **Prenatal Plus** is a team-based model that provides a mental health professional, a dietitian, and a specialized care coordinator to members with increased risk factors throughout their pregnancy and postpartum period. The model is delivered in addition to obstetric care and can be offered through local public health agencies, obstetric care clinics or home visitation. The program is offered through several packages that range from least to most intensive, and at the highest intensity of services the program has been shown to improve critical outcomes, such as reducing rates of prematurity.
- **Nurse-Family Partnership** is offered during pregnancy, and until the child is two years old. Nurses visit first-time parents at home to educate them on parenting, share resources and perform health checks. The program is primarily funded through Colorado Department of Human Services dollars including the Maternal Infant and Early Childhood Home Visiting funds and Tobacco Master Settlement Agreement dollars. Health First Colorado currently covers a set of reimbursable services and continues to explore more opportunities to sustain program funding. The program has short- and long-term impacts on families including reducing low birth weight, increasing interbirth intervals and even increasing graduation rates for children whose parents were enrolled in the program.
- **Special Connections** is a residential and outpatient substance use disorder treatment program for pregnant members up to one year postpartum. The program, co-administered with the Behavioral Health Administration, credentials providers to offer specialized gender-responsive, trauma-informed services. This benefit will expand as the new statewide residential substance use disorder benefit is implemented, so sites will be able to increase the number of beds.

In addition to HCPF-run special programs, HCPF incentivizes the Regional Accountable Entities (RAEs) to improve health outcomes. As part of the Key Performance Indicator initiative, the RAEs are eligible for enhanced payments from HCPF by improving prenatal care rates. The RAEs are also required to expand maternity-specific models under the condition management program. HCPF has set expectations around five universal characteristics for maternity programming and has developed individualized clinical components. The five universal characteristics are: member identification and risk stratification; culturally competent specialized care team, collaborating with PCMP/care provider as appropriate; facilitate enrollment to ensure appropriate resources of community programs; evidence-based/informed or local promising initiatives; and measurement and reporting (adjusted as needed) to improve outcomes. These programs were implemented during FY 2020-21, and some highlights from the different regions include:

- 1) Rocky Mountain Health Plans, covering RAE Region 1, contracted with SimpliFed to provide virtual lactation support from nurse practitioners who are also International Board Certified Lactation Consultants, offering services at no cost to the member. RMHP has already seen SimpliFed utilization by pregnant and postpartum members.
- 2) Northeast Health Partners (Region 2) and Health Colorado Inc (Region 4) both deploy Elevance Health’s evidence-based maternity program, “Taking Care of Baby and Me.” While the platform has many components, a strength is its inclusion of culturally appropriate birth planning activities for care coordinators to help members to create individualized birth plans based on their culture, language, customs, and preferences. These birth plans include birth location, type of birth, type of birth attendant, preferred pain medication or supports, which family members are to be included, lighting, positioning, communication preferences, etc. This approach advocates for mothers’ choices and supports mothers in planning.
- 3) Colorado Access, covering RAE Regions 3 and 5 in the metro area, created a new reproductive health value-based payment model that aligns with the patient population of women’s health providers and created a “Black Birthing Design Challenge” that brought together community-based organizations and providers to direct flexible funds into projects promoted and designed by the community, for the community. These programs will include a doula program, a resource hub for refugees and mental health grants for Black, Indigenous and People of Color (BIPOC) groups.
- 4) Colorado Community Health Alliance (CCHA), covering Regions 6 & 7, partnered with Jefferson County Public Health and the Developmental Disabilities Resource Center (DDRC) to provide hospital systems with education on CCHA’s maternity program, NICU2HOME, and DDRC Early Intervention initiatives. CCHA took the lead on developing the presentation and has presented to Denver Health, Children’s Hospital Colorado, and Littleton Adventist Hospital. This will help increase referrals to these programs and ensure members receive all the necessary services and support.
- 5) Denver Health, which covers Denver residents, has behavioral health services co-located at their Women’s Health Clinic and within their clinics as well as a Quality Improvement Initiative focused on depression screening and follow up for members.

The diversity of these programs highlights the strength of HCPF’s regional model, which allows different areas of the state to focus on that region’s most pressing concerns.

Finally, hospitals remain a critical site of intervention. HCPF’s Hospital Quality Improvement Program was introduced above for the focus on Cesarean-section reduction, but it includes other measures to improve outcomes discussed in this report: increasing rates of exclusive breastfeeding, improving identification and

reporting on perinatal anxiety and depression, improving hospital responses to maternal emergencies with a focus on severe hypertension and improving processes for immediate postpartum insertion of long-acting reversible contraceptives. In addition to maternity specific measures, other measures may impact this community such as pay for performance associated with the implementation of the “Reduction of Racial and Ethnic Disparities Safety Bundle” and promoting adverse event reporting. For more information on this program, visit the [HQIP website](#).<sup>28</sup>

The Department’s Hospital Transformation Program (HTP) focuses hospital efforts in ways that will impact maternal health as well. The program implements social needs screening for all Health First Colorado patients in the hospital inpatient setting as one of its measures. The program also incentivizes hospitals to improve care coordination for Health First Colorado patients with behavioral health and substance use disorder diagnoses. Additionally, within the optional measures for HTP, 34 hospitals are implementing interventions to improve screening and referral for perinatal and postpartum depression and anxiety and notification of positive screens to the RAE. Finally, Senate Bill 22-200 created the Rural Provider Access and Affordability Stimulus Grant Program which will award \$9.6 million of American Relief Plan Act (ARPA) funding to qualified rural hospitals. The purpose of the grant payments is to improve health care affordability and access to care in rural Colorado. Grant payments will be allocated into two categories, affordability-related projects and access to care-related projects. Expanding access to maternity care is one of the intended uses of the funding. Grant applications will be submitted Spring 2023 with awards expected to begin in July 2023. More information is available [online](#).

## HCPF Action

In 2021, HCPF published its first ever Maternity Report to deeply analyze strengths and opportunities. Since then, this data, as well as feedback from the community on the report and subsequent event, have been utilized to make advancements in current and planned benefits to support preconception to postpartum health.

This community engagement work included creating the Maternity Advisory Council and infusing member experience into our work. HCPF also included content from various stakeholder meetings in the community to inform ongoing improvement efforts. These included stakeholder meetings on the postpartum expansion and family planning benefits, content shared in November 2021’s Maternity Report Event, a HCPF internal birth equity event with an invited guest speaker panel (doula, midwife, member and advocate), and participation in various workgroups including CDPHE’s Maternal Mortality Review Committee and CDHS’s Home Visiting Taskforce. Upcoming stakeholder work will include maternal equity outreach on the bundled payment and doula benefit, Cover All Coloradans specific meetings, and member focused spaces to

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<sup>28</sup> Hospital Quality Incentive Payment Program website (2022). <https://hcpf.colorado.gov/hospital-quality-incentive-payment-program>

solicit feedback with the support of trusted community partners through HCPF's Community-Based Organization Ambassador Program, an initiative that will compensate Health First Colorado members within Spanish- and Vietnamese-speaking communities to improve member communications and outreach.

Using feedback and input gathered in these engagements, HCPF's advancements fall into four major categories: **centering member experience; program expansions; technical changes to improve reporting; and system reforms**—all influenced by HCPF's mission to “improve health equity, access and outcomes.” A fifth category - the launch of Phase Three of the Accountable Care Collaborative - is included below to highlight initiatives being explored for the next iteration of Health First Colorado's delivery system. HCPF's Roadmap to Improve Maternal Health Care and Equity below lists all new and upcoming efforts to improve the outcomes and reduce the disparities discussed in this report, illustrating a multi-year commitment to reducing maternal morbidity and mortality, and some highlights are discussed below.

## Centering Member Experience

In addition to changes that were already in progress last year, HCPF has made a commitment to maternal health equity by making it a pillar of our [Health Equity Plan](#).<sup>29</sup> The plan details HCPF's goals to strengthen maternal health equity, including using an equity framework to evolve an Alternate Payment Model (APM), providing 365 days of postpartum coverage (SB21-194), expanding access to family planning services for undocumented Coloradans (SB21-009 and SB21-025), and leveraging existing programs to close the health disparities gap.

HCPF also heard feedback from the community that member voice and experiences have not been sufficiently centered in policy development. The MAC had only been in existence for three months for the 2019 report but has now become an effective coalition. In addition to providing input on specific programs and communications such as how to best message the process of declaring pregnancy, the MAC members also vocalized a desire to share their stories. That feedback informed the addition of their stories to this 2020 report, which is only the first step; HCPF is committing to more systematically collecting member stories for the next report. Through ethical storytelling and community-based participatory research methodologies, the next report will be a fully integrated, mixed methods report that equally weighs the quantitative and qualitative data representing members. The program has been so successful that HCPF will be building out a Spanish-speaking MAC in the next 18 months.

## Program Expansions

An important indicator of maternal wellness is intendedness of a pregnancy. Unintended pregnancies are associated with higher rates of perinatal depression,

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<sup>29</sup> HCPF Department Health Equity Plan (2022). <https://hcpf.colorado.gov/health-equity>



preterm birth, and low birth weight.<sup>30</sup> In 2020, 53.1% of pregnancies in Colorado were unintended or mistimed. To address this, the 2021 legislative session included a suite of bills that were designed to give an expanded group of individuals in Colorado the ability to better prevent or plan a pregnancy. Effective July 1, 2022, Health First Colorado now covers family planning services for eligible non-citizens (SB21-009) and expanded family planning and related services to now include individuals 0%-260% of the Federal Poverty Level (FPL) (up from 0%-133% FPL previously) (SB21-025). These benefits include coverage for a year of prescribed birth control methods, thus reducing the chance of a lapse in care. These initiatives have expanded access to essential health care services to thousands of Coloradans previously not eligible for any Medicaid coverage with the intent of addressing disparities in unintended pregnancies. Besides the family planning expansions to new populations, SB21-016 increased access to family planning related services by ensuring that services provided pursuant to family planning visits were provided free of co-pay and with the ability to choose a provider regardless of managed care enrollment.

The 2021 legislative session also took advantage of a recent federal provision that made it easier for states to extend coverage for pregnant people from 60 to 365 days postpartum. While many Health First Colorado members become pregnant while enrolled, approximately 4,000 members per year become eligible for Medicaid due to being pregnant because the income threshold for eligibility is higher than for non-pregnant individuals. Historically, those individuals would lose their eligibility at 60 days postpartum. Instead, the maintenance of effort protected those individuals from disenrollment during the COVID-19 PHE, but the implementation of SB21-194 on July 1, 2022, guarantees that all Health First Colorado members who give birth and report their pregnancy can now retain benefits for a full year after birth. A primary motivator for this policy is to reduce maternal morbidity in the latter postpartum period, discussed in the previous Health First Colorado Maternity Report:

“Recent analysis from CDPHE shows that while people who gave birth on Medicaid have a higher maternal mortality rate than other payers, there was no significant difference in the rate of death during the early postpartum period (up to six weeks). However, birthing people on Medicaid were significantly more likely to die during the late postpartum period than parents covered by other payers. The late postpartum period is defined as six weeks up to one year postpartum—after current Medicaid coverage may have ended for those Medicaid enrolled parents.”

The previous definition of postpartum as being restricted to about two months postpartum limited the ability of payers, providers, and communities to effectively provide resources to families during this vulnerable period. This policy change has

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<sup>30</sup> Fellenzer, J.L. and Cibula, D.A. journal article (2014). <https://pubmed.ncbi.nlm.nih.gov/36318133/>

implications for increasing access to health care and supports through this important first year of parenthood.

Other expansions underway are a result of Cover All Coloradans (SB22-1289), which will be implemented over the next several years. One aim of the bill was to expand access to comprehensive lactation support services, lactation supplies and equipment including access to hospital grade pumps and parts. This will include updating relevant durable medical equipment policy, adding lactation counselors as a reimbursable provider type, and collaborating with

WIC, community providers, and members to ensure the services reach those who need them. Efforts to meet these requirements are underway. On June 8, 2022, HCPF made an enhanced lactation benefit available that provides electric breast pumps and related supplies. HCPF continues to work toward providing both coverage of multi-user pumps and lactation support from independent lactation consultants (in addition to those supervised by medical providers) starting in early 2023.

The last major program expansion to highlight is another component of SB22-1289 that will expand health coverage to children and pregnant people (up to one year postpartum)—regardless of immigration status. These benefits will be available starting January 1, 2025, and community members will be invited to participate in stakeholder engagement to inform this benefit expansion through our website, [Cover All Coloradans](#).<sup>31</sup> More information and progress will be shared in subsequent years' reports while communities and systems prepare for this coverage expansion.

Finally, HCPF requested and is in the process of receiving budget approval to provide donor breast milk to eligible infants. While 95% of Coloradans who give birth breastfeed their children, low-income birthing persons face far greater challenges when trying to breastfeed.<sup>32</sup> To increase equity and promote evidence-based best practices on the benefits of human milk (especially in high-risk infants), the Department prioritized this resource for members. HCPF would work with milk banks to ensure interested and eligible members can access breast milk, as the out-of-pocket cost is often a barrier.

*The importance of postpartum care is often a discussion among MAC members:*

“Postpartum exacerbated anything I had wrong with me. And that is the time when you need the most support. You have a newborn, you are getting no sleep, sometimes no support in your personal life.”

- Aimee from Arapahoe County

<sup>31</sup> Cover all Coloradans website (2022). <https://hcpf.colorado.gov/coverallcoloradans>

<sup>32</sup>

[https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/2020TableauSummaryTables\\_NewLogo/2020PRAMSSummaryTables?%3Aembed=y&%3Aiid=5&%3AisGuestRedirectFromVizportal=y](https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/2020TableauSummaryTables_NewLogo/2020PRAMSSummaryTables?%3Aembed=y&%3Aiid=5&%3AisGuestRedirectFromVizportal=y)

## Technical Changes to Improve Reporting

A critical component to understanding the success of policies and programs is improving the quality of the data HCPF collects. As described in this report, challenges with global billing limit visibility into when prenatal care begins and how many prenatal and postpartum visits occur. HCPF has initiated changes to global billing (challenges discussed more on p. 14 above) to improve visibility on initiation and intensity of prenatal and postpartum care that are anticipated to be implemented by July 1, 2023. These enhanced data will enable HCPF to better identify gaps in maternal health access so that we may address those gaps.

This report also described challenges associated with tracking behavioral health screening rates. Effective July 1, 2023, a new way of billing depression screens will allow HCPF to more accurately report on depression screens that may be billed to a birthing parent or caregiver under a child's ID (SB21-137).<sup>33</sup> Also, effective starting the summer of 2022, billing limitations that capped the number of depression screens allowed per member per year were lifted so that now, providers can conduct universal screening at every appropriate encounter. Finally, HCPF continues to work on creative solutions to increase the viability of the SBIRT codes discussed above as requiring too many minutes for most providers to bill in order to enable expanded use of the SBIRT. These changes better enable providers to screen for maternal behavioral health issues more often, addressing a major factor of promoting maternal health.

## System Reforms

The above initiatives are critical pieces of a multi-level maternal health strategy. Yet, improving equity by confronting institutionalized racism requires additional tactics. HCPF is embarking on two major reforms that have the potential to reduce disparities and improve outcomes.

First, the Maternity Bundled Payment (MBP) Program was the first step in an Alternative Payment Model (APM) initiative that supports the transition from traditional fee-for-service (FFS) payments to value-based payments. This shift promotes payment to providers for outcomes rather than services, incentivizing value over volume. HCPF began this work in 2020 with a pilot involving three practices and advanced it through a budget request in state fiscal year 2021-22. In the budget process, the community raised concerns that the existing design of the Maternity Bundled Payment program could create unintended consequences. As a result, HCPF re-prioritized stakeholder engagement and committed to building a new APM for maternal care to thoughtfully and thoroughly center maternal health equity. Initial key informant interviews with trusted community partners began in Fall 2022. Support for the new maternity APM development is contained within the Colorado Providers of Distinction Invitation to Negotiate (ITN), which is expected to be awarded in spring

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<sup>33</sup> HCPF provider bulletin (2022). [https://hcpf.colorado.gov/sites/hcpf/files/Bulletin%200622\\_B2200479.pdf](https://hcpf.colorado.gov/sites/hcpf/files/Bulletin%200622_B2200479.pdf)

2023. The Providers of Distinction ITN is intended to improve access to care and address disparities. The new maternity APM design work will begin after the ITN is awarded and stakeholder engagement will be ongoing.

While much is left to develop in this process, member experience and opportunities to reduce health disparities will inform the model design. The experience of being othered due to Medicaid status is a common theme that arises during the MAC meetings, with one member Aimee stating: “I just cannot deal with feeling like I am being judged or not listened to or not cared for just because of Medicaid.” The new APM aims to improve how perinatal care is reimbursed to ensure members are getting the care they deserve regardless of their insurance carrier.

Second, the Governor’s budget, published on Nov. 1, 2022, includes a commitment from HCPF to pursue doula support for all Health First Colorado members who choose to receive doula care. A doula is a trained, non-medical professional who provides continuous physical, mental health, and educational support to a birthing parent before, during and after childbirth and advocates on their behalf to help them achieve the healthiest experience possible. Doula support is associated with a host of

*MAC member Shay spoke specifically about doulas:*

“There are a lot of poor statistics related to Black birthing outcomes. I believe access to culturally responsive midwives and doula support would foster and improve healthier outcomes of maternal and infant mortality of Black women and children.”

- Shay from Denver County

positive outcomes: lower rates of Caesarean birth, postpartum depression,<sup>34</sup> preterm birth, low birth weight,<sup>35</sup> and increased breastfeeding<sup>26,36</sup> as well as increased adherence to infant safety protocols.<sup>37</sup> In addition to these positive health outcomes, there is also evidence to suggest that women who have doula support are more likely to receive postpartum follow-up care.<sup>38</sup>

Colorado expects to join an emerging cadre of states across the nation providing doula services to Medicaid members. With anticipated approval of the Governor’s 23-24 Budget, HCPF intends to incorporate lessons learned from other states like Oregon, Washington and New Jersey. A

stakeholder process will determine components including but not limited to: the optimal model of care (e.g., how many prenatal versus postpartum visits to cover); reimbursement strategy (e.g., bundled or service by service); equitable credentialing to balance accessibility with an evidence-based standard of care; and how to increase

<sup>34</sup> Falconi et al. journal article (2022). <https://doi.org/10.1016/j.eclinm.2022.101531>

<sup>35</sup> Gruber et al. journal article (2013). <https://pretermbirthca.ucsf.edu/sites/g/files/tkssra2851/f/wysiwyg/Gruber%20-%202013%20-%20Impact%20of%20doulas%20on%20healthy%20birth%20outcomes.pdf>

<sup>36</sup> Futch Thurston et al. journal article (2019). <https://doi.org/10.1016/j.xjep.2019.100278>

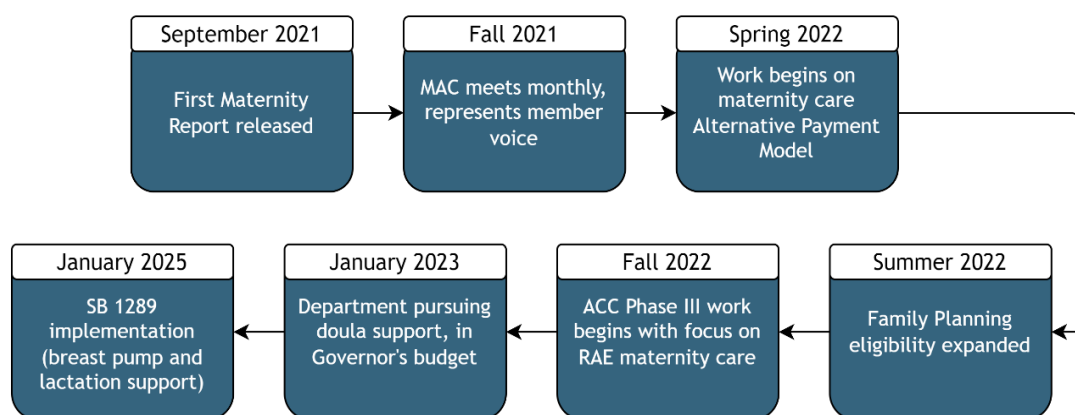
<sup>37</sup> Hans et al. journal article (2018). <https://doi.org/10.1007/s10995-018-2537-7>

<sup>38</sup> Health Connect One report (2014). <https://www.healthconnectone.org/wp-content/uploads/2020/03/The-Perinatal-Revolution-CBD-Study.pdf>

the doula workforce to include BIPOC members who are part of the communities they will be serving. Additional funds will be used to outreach members and build an online doula hub that supports this workforce. Therefore, the newly proposed policy reflects not only evidence-based practice but a response to several calls from the MAC to increase: a) postpartum support; b) participation from BIPOC populations in the health care workforce; and c) community-based support to birthing people to understand options and how to advocate for themselves.

HCPF looks forward to sharing updates on and impacts from the four focus areas of the road map in next year’s report. While some of this work is still emerging, HCPF is confident this multi-pronged strategy represents the most comprehensive effort to date to improve maternal health equity. Figure 12 displays a timeline for major efforts underway and those yet to come.

Figure 12. Timeline for Upcoming Efforts to Improve Maternity



## Conclusion and Next Steps

This 2020 Maternity Report shows that in a year of uncertainty, birthing parents continued to receive prenatal and postpartum care, though it may have looked different from previous years with additional precautions in place. While some members may have been hesitant to access in-person care or opted for virtual prenatal and postpartum care, utilization of care remained largely unchanged. The pandemic’s maintenance of effort requirement allowed for additional coverage for the segment of birthing parents who would have previously lost coverage after 60 days postpartum. The newly implemented policy that expands Health First Colorado coverage for members for a full year after giving birth means that all birthing parents enrolled in Health First Colorado will be able to receive critical postpartum services. This policy, along with the other program expansions in the four areas of work HCPF launched this year, is part of the ongoing strategy to center the voices of members and promote maternal health equity among Health First Colorado’s members.

The work on perinatal health equity and feedback from the community highlights HCPF’s need to advance these three goals:

- 1) Improving rates of timely prenatal care appointments
- 2) Improving rates of postpartum visit completion
- 3) Improving rates of depression screening

HCPF has organized its work to address these goals into the four areas listed below. A fifth category - the launch of Phase Three of the Accountable Care Collaborative - is included to highlight initiatives being explored for the next iteration of Health First Colorado’s delivery system.

### HCPF Roadmap to Improve Maternal Health Care and Equity

<b>1. Centering Member Experience</b>	Include maternity care as a pillar in the HCPF Equity Plan. (2022)
	Amplify member voice through the Maternity Advisory Committee. (2023)
	Create a Spanish-speaking Maternity Advisory Committee. (2024)
<b>2. Program Expansions</b>	Expand postpartum coverage to 365 days. (2022)
	Expand family planning services for non-citizens. (2022)
	Expand family planning and related service for expanded income. (2022)
	Enhance lactation support services. (2023)
	Cover donor breast milk to infants. (2025)
	Cover non-citizens prenatal and postpartum care. (2025)
	Implement non-citizen child benefit. (2025)
<b>3. Technical Changes</b>	Modernize maternity billing. (2023)
	Investigate solutions to billing for SBIRT screenings. (2023)
	Enhance depression screenings for parents and caregivers. (2023)
<b>4. System Reforms</b>	Explore coverage of Direct Entry Midwives. (2023)
	Promote hospital best practices through payment changes. (2023)
	Cover doula services. (2024)
	Implement maternity bundled payment. (2024)
<b>5. New Ideas for ACC Phase III (Launch: 2025)</b>	Explore member incentives to improve prenatal engagement.
	Increase member self-identification as pregnant.
	Improve integrated behavioral health services piloted in MOM grant.
	Improve performance on maternity outcomes across RAEs.
	Improve behavioral health screening incentives.

HCPF welcomes feedback or questions on this report. Please contact Susanna Snyder, Child and Family Health Division Director, at [susanna.snyder@state.co.us](mailto:susanna.snyder@state.co.us) or Tamara Keeney, Research and Analysis Manager, at [tamara.keeney@state.co.us](mailto:tamara.keeney@state.co.us). We also invite community participation and feedback in all existing and emerging initiatives to promote improvements in maternal health outcomes and equity. Please reach out to [hcpf\\_maternalchildhealth@state.co.us](mailto:hcpf_maternalchildhealth@state.co.us) on these inquiries.

## APPENDIX I

### Table of Proportion of Health First Colorado Members by Race/Ethnicity, Region

The table below shows the proportion of Health First Colorado members within each Regional Accountable Entity (RAE) under the Accountable Care Collaborative (ACC). Members self-selected from the below race and ethnicity categories when completing a medical assistance application. Across all RAEs, 5-7% of race/ethnicity data were missing or not provided on the application. Within the table below, “Not Available” denotes categories where the number of individuals was fewer than 30. Other People of Color is a HCPF-created category that includes those who chose multiple race/ethnicity options on the application. Other/Unknown race is an available response option listed on the application. Not provided indicates that the question was not answered on the application.

RAE	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	Other People of Color	Other/ Unknown Race	White/ Caucasian	Not provided
No RAE data	0.47%	1.50%	5.35%	62.19%	Not Available	1.76%	3.00%	18.55%	6.85%
ACC Region 1	3.63%	Not Available	Not Available	24.50%	Not Available	2.96%	4.58%	53.06%	8.69%
ACC Region 2	Not Available	1.75%	4.50%	44.13%	Not Available	2.14%	4.33%	35.36%	7.13%
ACC Region 3	0.62%	4.28%	13.11%	37.86%	0.76%	3.75%	3.62%	30.27%	5.74%
ACC Region 4	Not Available	Not Available	Not Available	43.25%	Not Available	3.08%	3.46%	39.64%	8.36%
ACC Region 5	Not Available	3.30%	20.45%	43.10%	Not Available	4.23%	2.20%	19.48%	5.93%
ACC Region 6	Not Available	3.13%	2.09%	34.44%	Not Available	4.86%	3.18%	44.57%	6.27%
ACC Region 7	Not Available	1.33%	8.05%	25.49%	Not Available	6.66%	2.97%	48.48%	5.40%

## APPENDIX II

The table below presents the proportion of Health First Colorado births in each county in 2020, out of all Colorado births.<sup>39</sup>

County	% of Health First Colorado Births	County	% of Health First Colorado Births
Adams	50.9%	Kit Carson	35.8%
Alamosa	61.6%	La Plata	45.0%
Arapahoe	43.8%	Lake	53.0%
Archuleta	61.2%	Larimer	37.4%
Baca	75.7%	Las Animas	67.8%
Bent	43.6%	Lincoln	47.8%
Boulder	33.2%	Logan	49.5%
Broomfield	21.2%	Mesa	53.6%
Chaffee	37.0%	Mineral	20.0%
Cheyenne	25.0%	Moffat	57.9%
Clear Creek	19.7%	Montezuma	66.7%
Conejos	61.4%	Montrose	57.3%
Costilla	64.3%	Morgan	60.0%
Crowley	92.0%	Otero	67.0%
Custer	32.6%	Ouray	34.3%
Delta	60.1%	Park	29.5%
Denver	46.3%	Phillips	43.3%
Dolores	73.3%	Pitkin	11.2%
Douglas	14.0%	Prowers	72.9%
Eagle	37.8%	Pueblo	66.1%
El Paso	36.0%	Rio Blanco	35.2%
Elbert	21.6%	Rio Grande	58.5%
Fremont	59.0%	Routt	25.6%
Garfield	45.9%	Saguache	70.9%
Gilpin	37.8%	San Juan	66.7%
Grand	37.0%	San Miguel	42.1%
Gunnison	35.2%	Sedgwick	57.1%
Hinsdale	20.0%	Summit	40.7%
Huerfano	90.9%	Teller	45.9%
Jackson	25.0%	Washington	37.2%
Jefferson	27.8%	Weld	42.0%
Kiowa	63.6%	Yuma	60.0%

Note: County data were not available for 693 births; those are excluded from the above table.

<sup>39</sup> CDPHE Live Birth Statistics (2021).

<https://cohealthviz.dphe.state.co.us/t/HealthInformaticsPublic/views/COHIDLiveBirthsDashboard/LiveBirthStatistics>



## APPENDIX III

### Maternity Advisory Committee Interviews

The Maternity Advisory Committee (MAC) developed the following interview questions to share their experiences for this report. HCPF staff conducted the interviews. The semi-structured interviews took place virtually and lasted approximately 30 minutes each.

1. What is your name? How many children do you have and what are their ages?
2. In your opinion how did being a Health First Colorado member impact your pregnancy and postpartum?
3. What was the hardest part? Were there any advantages?
4. What do you wish people knew about having a baby on Medicaid?
5. Do you understand your choices in benefits on Medicaid? How did you understand your options?
6. Is there anything else you want to share that we haven't covered today?

After the interviews were organized, analyzed and incorporated into the report, HCPF team members scheduled one-on-one time with interviewees to review quotes included in the context of the report. This process included a signed consent for the inclusion of their quote, with the opportunity to edit quotes or context. Additionally, all MAC members (including those not interviewed) reviewed the dedication and MAC section during the November 2022 meeting.