

**Access to Comprehensive Perinatal Services Among Pregnant Women
Enrolled in Both Medi-Cal and *Covered California* Health Plans:
Aligning and Integrating Care**

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Executive Summary

Medi-Cal-enrolled women who are pregnant are entitled to coverage for enriched pregnancy-related care as a result of Medi-Cal's Comprehensive Perinatal Services Program (CPSP), a national landmark in the care and management of low income pregnant women with elevated health risks as a result of their economic status. This entitlement applies to all Medi-Cal enrolled low income pregnant women, including women who also are enrolled in subsidized health plans purchased through Covered California. The task that jointly faces Medi-Cal and Covered California is how best to align these two sources of pregnancy care financing in order to achieve a central goal of SB 857 – ensuring that dually enrolled pregnant women continue to have full access to CPSP-level treatment.

With roots in California's acclaimed Obstetrical Access demonstration program, the CPSP program does not simply provide additional coverage. CPSP effectively alters the standard of care available to pregnant women facing elevated health and social risks by establishing a provider network certified and overseen by the California Department of Public Health and qualified to provide CPSP-level care. This care is furnished in a fully integrated manner, through treatment teams comprised of clinicians, social workers, health educators, nutrition counselors, and other health professionals. By contrast, California's essential health benefit regulations, which define the scope of coverage to which Covered California enrollees are entitled, do not specify either a range of maternity benefits comparable to those available through CPSP, or access to a provider network possessing the comprehensive treatment capabilities of CPSP providers. A review of health plans sold through Covered California reveals that these plans offer the standard level of maternity care expected from traditional commercial insurance. The care they offer, as described in their benefit summary materials, contains none of the special social, nutritional, enabling, or behavioral services available through CPSP, nor is there mention of special treatment standards that fully integrate a broader range of services into highly integrated care programs.

The absence of this higher standard of care is not surprising, since Covered California is designed to reflect the commercial insurance market. This fact also explains the legislative intent behind SB 857 – to ensure that women enrolled in both Covered California plans and Medi-Cal and receiving pregnancy-related care continue to have full access to the services and benefits of the CPSP program.

Two options exist for aligning and integrating the CPSP program and Medi-Cal coverage with Covered California for dually eligible women. The first is to specify CPSP providers as "essential community providers" and direct health plans to extend network membership to all CPSP providers in their service areas. This approach might be combined with special payment incentives to plans that provide additional risk adjustments related to the treatment of pregnant women at higher health risk. Plans would pay CPSP providers for the standard maternity care they furnish and that are part of women's Covered California coverage, and Medi-Cal would pay an enhancement to CPSP providers for the additional care they furnish. The California Department of Public Health would continue to maintain certification and oversight responsibilities for CPSP providers. The benefit of this model is that it would fully integrate CPSP providers into plan networks, thereby easing referral arrangements, especially for the treatment of underlying and diagnosed medical conditions. The limitation is the regulatory direction over plan network composition.

A second option would be to treat CPSP providers as covered out-of-network care. Medi-Cal would pay providers as it currently does and seek repayment from Covered California plans up to the level of payment for standard maternity care. The strength of this model is the absence of greater regulation of plan networks, while the limitation is the lesser level of integration of CPSP into broader health plan coverage and care through Covered California.

Introduction

For decades, California, a leader in improving access to affordable health insurance coverage for individuals and families, has guaranteed Medi-Cal coverage for low income pregnant women in order to address their elevated health and social risks.¹ This entitlement applies to all Medi-Cal-eligible pregnant women, including women who already are enrolled in subsidized health plans sold through Covered California. Enhanced Medi-Cal-financed care ensures that low income women with elevated health and social risks receive the highly enriched level of treatment shown through extensive research to be effective in achieving healthy birth outcomes.

Through its special Comprehensive Perinatal Services Program (CPSP), Medi-Cal provides benefits that extend beyond standard obstetrical practice. CPSP funds and delivers services and treatments that “are in addition to, not a replacement for, the services that are part of the American College of Obstetricians and Gynecologists (ACOG) visit standards.”² This enhanced standard of care is made available to women and their families through a network of certified providers overseen by the Maternal, Child, and Adolescent Health Division of the California Department of Public Health. California’s approach of using Medi-Cal to guarantee low income women an enhanced level of health care during pregnancy is expressly permitted under federal Affordable Care Act (ACA) implementing regulations, which allow dual enrollment in Medicaid and subsidized Exchange plans in the case of pregnancy-related care.³

This dual level of coverage also raises an important challenge: how best to align and integrate treatment when two distinct types of health insurance are involved, each of which operates under its own coverage standards, and each of which may be delivered through separate provider networks. Given the importance of optimizing the quality of health care during pregnancy, the task facing Medi-Cal and Covered California is to develop and implement a joint strategy for ensuring that the Legislature’s goal of enhanced care for dually eligible women is achieved.

¹California Department of Public Health, Comprehensive Perinatal Services Program (Contract 01-15164)(2014). See National Academy for State Health Policy, *Supporting High Performance in Early Entry into Prenatal Care* (Available at) <http://www.nashp.org/supporting-high-performance-early-entry-prenatal-care-fact-sheets> (Accessed online September 5, 2014)

² State of California, Pregnancy: Comprehensive Perinatal Services Program (CPSP) (billing code instructions)

³ See, 78 Fed. Reg. 53648 (final IRS rules defining what constitutes “minimum essential coverage” (MEC) for purposes of determining eligibility for federal premium tax subsidies). Pregnancy-related Medicaid coverage is not considered MEC and thus is not a bar to premium subsidies.

Achieving integration and alignment requires several steps. First, the precise nature of the treatment guaranteed by each form of coverage must be identified. Under federal rules, Medi-Cal is the secondary payer,⁴ and its coverage, if broader than that offered through Covered California, would operate as a treatment enhancement.

Second, a determination must be made as to whether the primary insurer's provider network is positioned to deliver the enhanced level of care made available through supplemental coverage. If not, then a strategy for augmenting or supplementing the primary provider network must be developed. This step is essential, since today's insurance products tie coverage to care, making the provider network virtually as important as the coverage itself.

This analysis examines these issues in greater detail. It begins with a discussion of Medi-Cal coverage for women entitled to Medi-Cal during pregnancy, who also are enrolled in subsidized Covered California health plans. It then describes the Comprehensive Perinatal Services Program (CPSP), which forms the core of Medi-Cal's enhanced pregnancy treatment standard and compares the CPSP standard of coverage and care to the pregnancy care standard applicable to Covered California health plans. The analysis concludes by presenting options for care alignment and integration.

Coverage for Pregnant Women Entitled to Medi-Cal

Medi-Cal offers numerous eligibility pathways through which pregnant women may gain coverage. Regardless of eligibility pathway however, Medi-Cal enrolled pregnant women are entitled to a broadly defined benefit package, which includes treatment under Medi-Cal's CPSP program. The breadth of the Medi-Cal entitlement during pregnancy is evident in SB 857, signed into law in June 2014. Section 54 (a)(3) provides that pregnant Medi-Cal eligible women who are also enrolled in subsidized Covered California plan are entitled to "a benefit package equal to full scope, comprehensive benefits that are provided to Medi-Cal beneficiaries who are pregnant." This Medi-Cal benefit thus effectively supplements the treatment (and potentially, the network capable of furnishing enhanced treatment) available through Covered California plans during the pregnancy/postpartum period. For this supplemental treatment and care, SB 857 directs the Department of Health Care Services to assume primary responsibility for treatment and services that "are covered under the Medi-Cal program and . . . that are not available through the beneficiary's qualified health plan."⁵ SB 857 further directs Medi-Cal to pay all premium or cost-sharing obligations (i.e., copayments, deductibles, and coinsurance) incurred by women who are both enrolled in Medi-Cal and members of a subsidized Covered California plan.⁶

In sum, SB 857 is designed, in part, to preserve broad coverage for low income pregnant women who enroll in Medi-Cal and who also are covered through subsidized Covered California plans. Because

⁴ Federal Medicaid law makes Medi-Cal a secondary payer to other forms of health insurance. 42 U.S.C. §1396a(a)(25) (2013)

⁵ SB 857, §54(b)(2)

⁶ SB 857, §54(a)(3)

the enhanced Medi-Cal benefit is expressed as both coverage and care itself, SB 857 preserves women’s right to both aspects of Medi-Cal’s pregnancy-related care benefit.

Medi-Cal’s Comprehensive Perinatal Services Program (CPSP)

Added to Medi-Cal in 1987 in order to reduce mortality and morbidity among pregnant women and their infants and in response to California’s acclaimed OB Access Demonstration Project,⁷ the CPSP represents not merely coverage, but an approach to health care itself.⁸ The CPSP builds on the ACOG maternity care standard. But according to the California Department of Public Health, CPSP has been designed to surpass the ACOG standard in numerous respects, using specially certified providers to furnish enhanced care. To be sure, the ACOG standard of care lies at the heart of CPSP; that is, CPSP providers are expected to furnish maternity care meeting ACOG practice guidelines. But CPSP providers delivering prenatal and postpartum care go beyond the ACOG standard through the use of detailed risk assessment tools coupled with enhanced health interventions in the areas of nutrition, health behavior, and psychosocial health.

The broad range of health interventions that make up the CPSP treatment bundle is shown in **Figure 1**. Access to CPSP is tied to the receipt of care through a specially-certified CPSP provider. CPSP provider certification, ongoing training, and performance criteria are extensive, as presented in the CPSP Provider Handbook.

Figure 1. CPSP Enhanced Treatment	
Office visits	
Initial comprehensive pregnancy-related office visit performed within 16 weeks of LMP	
Tenth antepartum office visit	
Initial comprehensive services	
Initial comprehensive nutrition, psychosocial and health education assessments and development of care plan; first 30 minutes each assessment (total of 90 minutes), (includes ongoing coordination of care); the three assessments must be completed within four weeks of the “initial visit” (either the first pregnancy related visit or any one of the three initial assessments)	
Nutrition Services	
Initial nutrition assessment and development of care plan; first 30 minutes-each subsequent 15 minutes (maximum of 1½ hours)	
Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (maximum of 2 hours)-group, per patient, each 15minutes (maximum of 3 hours)	
Postpartum nutrition assessment, treatment and/or intervention; including development of care plan, individual, each 15 minutes (maximum of 1 hour)	
Prenatal vitamins, 30-day supply	
Comprehensive psychosocial services	
Initial psychosocial assessment	
Psychosocial and development of care plan; first 30 minutes, each subsequent 15 minutes (maximum of 1½ hours)	

⁷ California Department of Public Health, *Comprehensive Perinatal Services Program Provider Handbook* (Contract No. 01-15164) (2014)

⁸ *Comprehensive Perinatal Services Program Provider Handbook* (1-4).

Follow-up antepartum psycho-social assessment, treatment, and/or intervention; individual, each 15 minutes (maximum of three hours)
Follow-up antepartum psycho-social assessment, treatment and/or intervention, group, per patient, each 15 minutes, (maximum of four hours)
Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (maximum of 1½ hours)
Comprehensive health education services
Client orientation (health education) each 15 minutes (maximum of two hours)
Initial health education assessment and development of care plan, first 30 minutes
Initial health education assessment and development of care plan, each subsequent 15 minutes (maximum of two hours)
Follow-up antepartum health education assessment, treatment, and/or intervention, individual, each 15 minutes (maximum of two hours)
Follow-up antepartum health education assessment, treatment, and/or intervention, group, per patient, each 15 minutes (maximum of two hours)
Perinatal education, individual, each 15 minutes (maximum of four hours)
Perinatal education, group per patient, each 15 minutes. (Maximum 16 units per day –72 units per pregnancy)
Postpartum health education assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (maximum of one hour)

Source: CPSP Provider Handbook Appendix. Page 20-21.

Underscoring the fact that the CPSP is designed to modify the scope and level of treatment itself, the program explicitly links its enhanced treatment and payment rules to receipt of care through clinical providers recognized as a distinct class of Medi-Cal provider.⁹ According to the California Department of Public Health’s Maternal, Child and Adolescent Health Division, CPSP providers meet certification standards covering numerous areas: the ability to conduct comprehensive risk assessment; the ability to identify the presence of one or more health risks; and the ability to deliver or arrange for enhanced nutrition, clinical, psychosocial, and behavioral treatments once risks have been identified.¹⁰ Selection of CPSP-level care is voluntary with pregnant women; that is, CPSP is an enhanced approach to treatment that is to be made available to all Medi-Cal enrolled pregnant women.

As of 2013, the California Department of Public Health reported participation by 1,500 certified CPSP providers.¹¹ While considerable, this number is well below the total number of obstetrical providers in the state, underscoring that CPSP-level treatment surpasses the general ACOG-level standard of care and amounts to a special approach to clinical care that has been designed to improve outcomes for pregnant women at higher risk due to economic status who elect to receive enhanced care during pregnancy.

In approaching the question of alignment and integration between Medi-Cal and Covered California for dually-enrolled women, it is essential to understand that the fundamental goal of the CPSP program, along with its special provider network, is to alter the nature of care itself for women at risk for poor health outcomes during pregnancy. This goal is achieved not only by establishing a bundle of

⁹ See, e.g., 22 CCR §51051 (specifying comprehensive perinatal providers as a distinct type of provider); CPSP Provider Manual (Appendix 6-7)

¹⁰ Comprehensive Perinatal Services Program Provider Handbook (1-4).

¹¹ Id. P. 1-3

covered treatments and procedures to which women are entitled, but to ensure that health care delivery itself happens through prenatal care providers that meet CPSP's extensive provider qualification standards that begin with initial certification and include ongoing oversight.

Guidelines published by the California Department of Public Health emphasize CPSP as a "model of care." According to the California Department of Public Health, this model of care builds on the clinical obstetrical guidelines established by ACOG while emphasizing interventions that extend beyond a standard prenatal care visit that might be anticipated for healthy women facing no elevated social or health risks. As such, the CPSP effectively sets an enhanced treatment standard that integrates ACOG-level clinical services into a comprehensive approach to pregnancy management that couples clinical care with a range of nutritional, educational, and behavioral health enhancements. As the state's materials make clear, CPSP is not merely a bundle of add-on benefits that can be furnished by any provider; instead, CPSP constitutes a *distinct approach to treatment* that is more intensive, requires more time, and therefore is secured through specially trained providers. To this end, Departmental guidelines emphasize not only clinical competency that conforms to ACOG standards but also enhanced capacities in the areas of nutrition care (both basic and specialized), health education (both basic and specialized), and both basic and specialized psychosocial treatment.¹²

In sum, CPSP represents an approach to treatment that extends beyond standard obstetrical clinical practice and elevates the standard of care in numerous respects, especially in the nutritional, behavioral, and psychosocial realms. Provider certification requirements are extensive, and site specific protocol requirements are substantial. In effect, the CPSP does not merely involve coverage; it creates an obstetrical standard of care for women who are pregnant, at high risk, and have sought Medi-Cal benefits to supplement their Covered California coverage during their pregnancy in order to receive this higher level of care.

CPSP thus is not simply a means to more coverage; it is a pathway to a higher standard of care. That the program is intended to be understood in this manner is further underscored by §54(b)(2) of SB 857. In extending Medi-Cal coverage to eligible women also receiving coverage through qualified health plans sold through Covered California, this provision specifically addresses the question of access to CPSP providers as a continued right: "[B]eneficiaries shall have the right to access Medi-Cal providers' services through the Medi-Cal program that are not contracting with the Exchange qualified health plan . . . including but not limited to . . . services provided by Comprehensive Perinatal Services Program (CPSP) Medi-Cal providers. . .". In other words, the law provides that if CPSP providers are not part of the plan network available to pregnant women enrolled in Covered California plans, they are to be guaranteed access to such providers on an out-of-network basis. Presumably where out-of-network care is obtained, Medi-Cal, under federal third party liability recovery standards, would recover from Covered California plans the payments that they would have made to network providers for standard covered

¹² See, generally, State of California, Resources for CPSP Providers, available at <http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx> (Accessed online September 3, 2014). See, also *CPSP Provider Handbook*

treatment, with a payment supplement to CPSP providers for the treatments and services unique to Medi-Cal.

Obstetrical Care Furnished by Health Plans Sold Through Covered California

The Essential Health Benefit Coverage Standard

Women enrolled in health plans sold through California’s Exchange are entitled to coverage at a level that meets the federal “essential health benefit” (EHB) standard.¹³ As defined in the ACA, the EHB standard is comprised of 10 basic benefit classes for which at least some coverage must be provided, as well as an actuarial value test.¹⁴ Maternity care is an explicit coverage class. However, neither the ACA nor implementing regulations defines the term “maternity” care. Instead, the HHS Secretary has delegated to states the discretion to define covered benefits in a manner consistent with the parameters of the EHB statute.¹⁵

California has elected to define “maternity care” within its EHB regulations. These regulations define “maternity care” as encompassing the following services: prenatal diagnosis of fetal genetic disorders; inpatient maternity care; prenatal care; urgent maternity services; maternity hospital stay; alpha-fetoprotein testing; inpatient hospital and ambulatory maternity services; breastfeeding support, supplies, and counseling; and PKU Services. Additionally, health plans governed by the EHB statute are expected to cover some level of mental health services (one of the required federal EHB benefit classes) and other services of potential relevance to pregnancy, even though not classified as such (e.g., prescription drugs).

What becomes evident in considering this rule is that CPSP enhanced pregnancy treatment required under Medi-Cal surpasses California’s EHB definition, the standard that applies to the EHB governed plan market, including Covered California plans. Both types of coverage recognize standard clinical interventions (i.e., prenatal clinical care, delivery services). But the CPSP standard of care goes well beyond the EHB coverage standard in areas of psychosocial, nutritional, and behavioral care. The EHB standard mentions breastfeeding (i.e., support, supplies and counseling), but does not speak to the numerous other social, behavioral and health risks that CPSP is designed to address. That California’s EHB rule is not the equivalent of CPSP is underscored by SB 857, which, recognizing these differences, guarantees pregnant Medi-Cal eligible women continued access to the CPSP program regardless of their underlying membership in a subsidized Covered California plan.

¹³ 42 U.S.C. §18031(b)

¹⁴ 42 U.S.C. §18031

¹⁵ 45 C.F.R. §126.101 et seq

Figure 2 provides a comparative overview of EHB-level maternity care and maternity care as expressed by the Medi-Cal program. Further evidence that the Medi-Cal standard of care extends beyond the level offered under the Knox-Keene Act (which governs the structure and operations of health plans sold in the state including those sold through Covered California) can be found in the provider billing codes for CPSP. The CPSP program includes unique billing codes that have no counterpart under the standard billing system used by health plans. In other words, certain types of treatments recognized and paid for under the Medi-Cal CPSP program are not recognized and paid for under EHB-governed plans (although at their option, health plans certainly could decide to do so).

The lack of a payment mechanism for enhanced treatment is crucial, since without a financing base that is coextensive with treatment itself, maintaining this higher level of treatment is simply not possible. CPSP providers tend to treat large numbers of low income women and families and thus lack the ability to engage in the type of cost-shifting onto other revenue sources that one might expect from health care providers that offer discounted care. Furthermore, Knox-Keene regulations explicitly clarify that although Knox-Keene-governed health plans must cover treatments for diagnoses recognized under the DSM IV as mental disorders, they do not have to treat mental conditions not holding a DSM IV classification status, such as “relational problems (e.g., couples counseling or family counseling).” By contrast, CPSP providers are explicitly directed to address relational problems, stress, and family discord among many other psychosocial problems as well as postpartum depression and intimate partner violence, regardless of whether severe enough to meet DSM criteria. Indeed, CPSP providers include social workers, psychologists and marriage, family, and child health therapists, treating providers that in all likelihood would not found in EHB provider networks, since this type of counseling is not covered.

Similarly, the Knox-Keene standards have no counterpart to the CPSP directive that participating providers help women secure resources to address food insecurity, financial hardship, housing, utilities, and legal problems along with new immigrant challenges and other psychosocial issues.¹⁶ Nor does Knox-Keene require providers to make referrals to the following programs, as CPSP expressly does: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Child Health and Disability Prevention program, family planning services, services for addressing genetic disease risks, and dental and oral health care.¹⁷ The link to oral health care through CPSP presents an especially important distinction given the relationship between poor oral health and poor pregnancy outcomes, a fact that has led California to extend oral health benefits to Medi-Cal enrolled women as a pregnancy-related service.¹⁸ CPSP covers home visits for preventive services,¹⁹ of particular importance for poor women with few or no transportation options, home visits are not required under Knox-Keene rules. Nutritional counseling for breastfeeding and other nutritional needs and dental²⁰ and other health education

¹⁶ California Department of Public Health, *Comprehensive Perinatal Services Program Provider Handbook* (Contract No. 01-15164)(2014) and Assessment Forms.

¹⁷ Title 22, California Code of Regulations (C.C.R.), § 51348.1(j).

¹⁸ See generally, U.S. Surgeon General, *The Surgeon General’s Report on Oral Health in America* (2000) (Available at) <http://www.nidcr.nih.gov/datastatistics/surgeongeneral/>

¹⁹ Medi-Cal Provider Manual, *Pregnancy: Comprehensive Perinatal Services Program*, preg com at 7.

²⁰ California Department of Public Health, *Steps to Take, , Oral Health During Pregnancy*, Health Education, pages 63-90.

requirements are robust under the CPSP, as demonstrated by the combined units of service that may be reimbursed²¹ as well as the directive that nutritional counseling and health education be incorporated into a woman's individualized care plan.²² Knox-Keene plans have no similar health education service requirement; while some health plans may in fact offer services, it is not a basic expectation of EHB-governed health plans. Indeed, there is evidence that some plans may expressly exclude educational services or nutritional counseling²³ or both.²⁴

Similarly, a standard obstetrical package calls for initial visits of about 20 minutes followed by 10-minute-visits at regular intervals (about 120 minutes in all).²⁵ By contrast, CPSP performance standards assume up to 30 hours of time spent with patients to deliver clinical care as well as the additional treatments and supports required under the program.²⁶ Furthermore, CPSP providers can receive prior approval to spend additional time with patients²⁷ (for example, an additional 6 hours of time on nutritional consultation).²⁸

Thus, what emerges from a comparison of CPSP and California's EHB standards is that the EHB standard is far more limited, giving health plans far greater discretion to define coverage and to set the performance standards for their network providers. Indeed, it is the very fact of health plan discretion to sponsor maternity programs that operate at a level of clinical performance that is lesser than that specified under the CPSP that explains both the purpose and the specific provisions of SB 857, including both coverage enhancements and the legislative directive to ensure continued access to CPSP providers.

²¹ Figure 1. – CPSP Enhanced Treatment.

²² Figure 1. – CPSP Enhanced Treatment.

²³ Blue Shield (2014).

²⁴ HealthNet (2014).

²⁵ Correspondence from Dr. Gail Newell, MD, Medical Director, of Maternal, Child and Adolescent Health, of Fresno County Department of Public Health; Director of Obstetrics, UCSF-Fresno Obstetrics and Gynecology Residency Program; and member of the Advisory Board of the American College of Obstetricians-Gynecologists, District IX.

²⁶ Figure 1. – CPSP Enhanced Treatment.

²⁷ 22 C.C.R. § 51348(a).

²⁸ California Department of Public Health, *Comprehensive Perinatal Services Program Provider Handbook* (Contract No. 01-15164) (2014).

Figure 2. Maternity Benefits: California’s Essential Health Benefits Rules versus Medi-Cal

Covered California EHBs	Medi-Cal
MATERNITY/NEWBORN CARE	
<ul style="list-style-type: none"> • Prenatal Diagnosis of Fetal Genetic Disorders • Inpatient Maternity Care • Prenatal Care • Urgent Maternity Services • Maternity Hospital Stay • Alpha-Fetoprotein Testing • Inpatient Hospital and Ambulatory Maternity Services • Breastfeeding Support, Supplies, Counseling • PKU Services 	<ul style="list-style-type: none"> • Prenatal care • Labor and delivery services • Postpartum care • Breastfeeding education • Nurse midwife services • Dental (extended benefits for pregnant women) • Vision (extended benefits for pregnant women) • Comprehensive Perinatal Services • Family planning • Women-specific treatment and recovery services for alcohol and other drugs that may complicate a pregnancy • Day care rehabilitative services for pregnant and postpartum women • Perinatal residential substance use disorder program • Services for any other medical conditions that may complicate pregnancy • Alternative Birthing Centers (with limitations)
EXCLUSIONS	
<ul style="list-style-type: none"> • Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not required to be covered except as otherwise specified • Treatments for conditions identified in the DSM IV as other than a “mental disorder” (e.g. relational problems) may be excluded 	No comparable language or exclusions

Sources: 28 CCR Sec 1300.67.005 and H&SC Sec 1367.005; Medi-Cal Benefits PDF from the Department of Health Care Services available at <http://www.dhcs.ca.gov/services/medi-cal/Documents/Benefits%20Chart.pdf>; California SPA; Supplement 2 to Attachment 3.1-A

In order to gain at least some insight into how health plans use their discretion, we reviewed the maternity care language contained in several Covered California silver-level plans, the metal level that qualifies for cost sharing reduction assistance. Our findings are set forth in **Figure 3**, which shows how selected health plans sold through Covered California define their maternity coverage. This figure makes clear that, at least with respect to their summary descriptions (the information provided to consumers; comprehensive provider performance and payment manuals are considered proprietary and are not publicly available), Covered California plans define maternity care in the standard fashion that one would expect from private insurers, which logically gear their coverage to average consumers rather than high-risk patients. This form of coverage, appropriate for a typical population with typical health risks, fundamentally differs from the enhanced treatment guaranteed through the CPSP program.

Figure 3. Maternity Benefits Language in Select Plans Offered in Covered California

Plan Name	How Maternity Care is Described	Examples of Covered Services
Blue Shield Silver EPO & PPO	“Pregnancy and Maternity Care Benefits”	<ul style="list-style-type: none"> • Prenatal care • Inpatient hospital maternity care including labor, delivery and post-delivery care
Molina Silver HMO	“Maternity Care”	<ul style="list-style-type: none"> • Comprehensive perinatal services (perinatal and postpartum care, health education, nutrition assessment, psychological services) • EPSDT Services
Anthem Silver HMO	“Maternity Care Services”	<ul style="list-style-type: none"> • Delivery and Labor • Prenatal and Postnatal Services
Chinese Community Individual Silver 70 HMO	“Maternity Care”	<ul style="list-style-type: none"> • Prenatal and Postnatal Care • Inpatient hospital maternity care, including normal delivery, delivery by cesarean section, miscarriage, and any complications of pregnancy or birth
Contra Costa Silver HMO	“Maternity Care” and “Newborn Care”	<ul style="list-style-type: none"> • Health Education • Social Support Needs • Prenatal and Postnatal Care
Health Net CommunityCare Silver HMO	“Care for Conditions of Pregnancy”	<ul style="list-style-type: none"> • Prenatal and Preconception Visits • Delivery Services
Kaiser Silver 70	No specific maternity category	<ul style="list-style-type: none"> • Prenatal Care • Obstetrical Care and Delivery
L.A. Care Covered Silver HMO	“Pregnancy and Maternity Care Benefits”	<ul style="list-style-type: none"> • Prenatal Care • Nutrition Counseling/Breastfeeding Support
Sharp Silver 70 HMO	“Maternity and Pregnancy Services”	<ul style="list-style-type: none"> • Infertility Services • Postnatal Care
Valley Silver HMO	“Maternity Services”	<ul style="list-style-type: none"> • Prenatal and newborn support classes • Post-delivery Care
WHA Silver	No specific maternity category	<ul style="list-style-type: none"> • Delivery and all Inpatient Services • Breastfeeding Support

Source: GW review of selected health plan policies

During the pendency of SB 857, the question of how the scope of EHB-level maternity coverage compares to that offered under Medi-Cal was addressed in a letter to Medi-Cal Director Toby Douglas from Shelley Rouillard, Director of California's Department of Managed Health Care. In the letter, dated May 20, 2014, a month prior to the enactment of SB 857, Director Rouillard stated that "the Department of Managed Care *believes* [emphasis added] that" with respect to CPSP benefits "the Knox-Keene Act [governing coverage and performance under managed care plans sold in the state] mandates coverage of these services as Essential Health Benefits (EHBs) offered by Covered California." The basis for this assertion was not offered. Director Rouillard went on to note that qualified health plans were free to decide how best to deliver covered services as long as they were delivered "consistent with good professional practice and in accordance with the Knox-Keene Act and all regulations thereunder." In other words, qualified health plans, according to the Department of Managed Care, are bound only by the Knox-Keene Act, not by Medi-Cal's higher performance requirements under its CPSP program.

SB 857, enacted a month later, effectively refutes the interpretation of law offered by the Department of Managed Care. By preserving access to CPSP-level care for women insured through Covered California, the law presumes that in its absence, the standard of care offered through Covered California plans would be significantly lower and seeks to maintain the high standard of care available through the CPSP benefits and its participating providers. In other words, the purpose of SB 857, enacted in the wake of Director Rouillard's letter, was to preserve for low income women the standard of care under Medi-Cal, precisely because it is far more extensive than the standard of care required of health plans governed by Knox-Keene.

Options for Aligning the Medi-Cal Level of Treatment with Standard Obstetrical Care Made Available Through Covered California Plans

In approaching possible solutions to the problem of alignment and integration between Covered California and Medi-Cal's pregnancy related coverage benefit, we begin by noting that our focus here is on two distinct types of women. The first type consists of women who are enrolled in Covered California plans and who elect to also receive the enhanced care to which they are entitled under Medi-Cal; that is, their Covered California membership is established and active when they acquire Medi-Cal coverage. The second type would be women who enter insurance through the Medi-Cal pregnancy-related pathway and also enroll in Covered California, either simultaneously (perhaps using a special enrollment period) or during open enrollment. These women effectively acquire Covered California plan membership during their pregnancies.

Regardless of the manner in which dual coverage is received, Covered California members receiving CPSP services either will already have acquired Covered California membership status or will likely soon do so. In either case, it is possible that women who elect to use the CPSP program for maternity care either may have already-diagnosed underlying health conditions (e.g., high blood pressure) for which they are under care, or else they may receive a diagnosis of an underlying and/or

complicating condition while maternity care patients. An example of this would be a pregnant woman who during her pregnancy is diagnosed with breast cancer.

In either scenario, it is evident that not only will the patient require enriched pregnancy care as a result of her low socioeconomic status, which elevates a constellation of health risks, but she will also need a maternity care provider that can freely communicate with other treating providers in order to best manage her underlying conditions as part of a program of comprehensive maternity care. For example, part of comprehensive prenatal care for a patient already under treatment for diabetes would be continual monitoring of the diabetes, additional nutritional and behavioral counseling about diabetes and pregnancy, additional fetal monitoring, and intensive care management to ensure adherence to prescribed treatment regimens.

In achieving alignment and integration that works well for dually enrolled patients, two considerations arise. The first is benefits and coverage alignment; the second is alignment of care and treatment systems. The benefits and coverage issue are the simpler of the two considerations, but there are sensible solutions to care and treatment alignment as well.

With respect to benefits, certain covered services lend themselves to a relatively straightforward solution. For example, Medi-Cal covers enhanced vision and dental care for pregnant women; Covered California plans are not required to offer a counterpart for adults, since neither is an EHB coverage requirement for pregnant women over the age of 18. Thus, where services unique to Medi-Cal are concerned, Medi-Cal would act as the primary insurer, and women would receive treatment from a Medi-Cal participating provider.

More nuanced solutions are required in the case of care, since the CPSP program is predicated on a special, certified provider network that has demonstrated the ability to practice in a manner that differs significantly from the routine maternity care that is, of course, appropriate for pregnant women who face no elevated health risks, but not for low income women who do face elevated risks and who need and want a more comprehensive care experience. In this regard, the challenge becomes how to ensure that women have access to what is best thought of as a more comprehensive standard of care. It is not simply a matter of a payment add-on, but an emphasis on health care provision that incorporates social and behavioral interventions into the clinical care experience itself. Put another way, CPSP is not merely an augmented benefit package – it is augmented approach to health care itself, one that relies on an identifiable group of providers that have oriented their practice approach to low income women who, as a group, face higher health risks.

On the matter of care, it is readily apparent that from an alignment and integration perspective there are two possible solutions. Both solutions fall well within the terms of SB 857 to create a pathway to CPSP-level treatment for all Medi-Cal eligible women.

1. Ensure out-of-network access to CPSP providers

The first approach would be to formally treat CPSP providers as “out of network” providers. That is, CPSP providers would be recognized by plans as out-of-network in a manner similar to that used by issuers when paying for out-of-network care in the case of PPO-type coverage arrangements. As formal out-of-network providers, CPSP providers would be made available to dually enrolled members; health plans would pay up to the level they normally would pay for maternity care. Medi-Cal would pay all cost-sharing owed as well as the care increment representing the treatments and services covered under Medi-Cal but not included in standard obstetrical care as offered under Covered California. The California Department of Public Health would continue to oversee CPSP certification and performance. As formal out-of-network providers, CPSP programs could be recognized for purposes of necessary referrals of patients back to their Covered California providers for treatment of underlying health conditions not addressed as part of maternity care and could be recognized as qualified to prescribe covered drugs and order necessary covered tests. In other words, CPSP providers could be given a formal out-of-network status that allows payment for standard maternity care covered under women’s plans and for referral and prescribing purposes.

The strength of this option is that it is consistent with standard health plan operations in relation to payment for out-of-network care. Health plans are accustomed to paying out-of-network when necessary; the CPSP arrangement would, for all practical purposes, simply be a variation on this practice. This approach avoids direct regulation of health plan provider networks, has clear precedents in out-of-network practice, and leaves the question of certification and oversight under the direction of the California Department of Public Health, where the CPSP program historically has resided.

The limitation of this approach is that patients would lose the benefit and simplification of full network integration of their CPSP providers and might have additional trouble gaining access to information about the CPSP program, since it would be treated as out of network.

2. Include certified CPSP providers in all health plan networks as essential community providers

A second option would be full integration of certified CPSP providers into plan networks across plan service areas. This could be accomplished by establishing CPSP providers as a subclass of “essential community provider (ECP),” as envisioned under the ACA, which applies to health plans sold in the Exchange. The federal ECP statute obviously does not mention CPSP providers, since CPSP is unique to California. But the statute itself sets only minimum standards (340B providers that are available in a plan’s service area); California has the authority to set its own ECP standard.

Were CPSP providers to be designated as a matter of Covered California policy as in-network ECP providers in the service areas in which they are available, they would assume the responsibilities and rights of any plan network provider, including the ability to refer patients with underlying diagnosed

medical conditions to other network specialty providers, while maintaining closer ties to patients' regular primary care providers. They would be paid for Covered California pregnancy services to the same extent that all network obstetrical providers are paid. Medi-Cal could then supplement the standard payment made to CPSP network providers with additional funds covering both out-of-pocket cost-sharing covered by Medi-Cal as a pregnancy-related benefit, as well as the added costs associated with CPSP-level treatment to which patients are entitled. In addition, the state health agency could continue to maintain oversight of CPSP performance rather than delegating that function to the health plans. Covered California might also combine an in-network strategy with an incentive designed to encourage voluntary plan contracting with CPSP providers, by considering additional risk adjustment payments to Covered California plans that elect to include CPSP providers into their networks and operations.

The benefit of this approach is that CPSP providers become full network providers, able to make full utilization of health plans' provider networks for specialized clinical care that might be needed for diagnosed physical or mental health conditions. The limitation of such an approach might be its greater level of regulatory intervention into plan network composition, but one that is consistent with the already-established ECP concept as well as with general oversight activities associated with plan networks.

Conclusion

By extending Medi-Cal to low income women during the pregnancy/postpartum time period, even when they are enrolled in Covered California health plans, the California Legislature has sought to ensure that low income pregnant women retain full access to highly enriched prenatal care, without cost-sharing barriers in the form of deductibles, coinsurance, and copayments. This commitment to the health of mothers, infants, and families is not only commendable health policy; it is a basic aspect of Medi-Cal, which covers enhanced treatment during pregnancy regardless of how women receiving enhanced pregnancy-related treatment also are otherwise covered – through traditional fee-for-service Medi-Cal, enrollment in a managed care plan, or enrolled in qualified health plans sold through Covered California (whether paid for with federal premium subsidies or Medi-Cal premium assistance). However women may obtain their general coverage, Medi-Cal is structured to enhance the standard level of coverage and care during pregnancy for low income women, given the strong association between low income and elevated health risk. This enhancement is based in substantial evidence showing the impact of enhanced treatment on maternal, infant, and family health outcomes among low income pregnant women. The enhancement also means that the state must devise solutions to aligning and integrating this enhanced treatment into ongoing coverage arrangements.

Two approaches are possible: out-of-network coverage and payment of CPSP providers; or inclusion of CPSP providers in Covered California networks. By explicitly guaranteeing continued access to both Medi-Cal level coverage and access to CPSP providers for pregnant women enrolled in Covered

California, the Legislature has effectively placed both options on the table, even as it has made clear its underlying intent that one or both options be exercised so that the problem can be resolved.

The level of care available to low income California women enrolled in both Exchange plans and Medi-Cal represents perhaps the most visible nationwide example of a state's effort to ensure universal coverage while maintaining special treatment enhancements for key low income populations whose exposure to the health risks that arise from low income pose a matter of special public health concern. For this reason, we believe that not only should careful attention be given to developing a working alignment model between Medi-Cal and Covered California, but furthermore, that the two agencies should collect information regarding the frequency of dual enrollment and should develop performance measures and outcomes standards to measure whatever strategy addressing the problem ultimately is selected. There is every reason to believe that with careful planning and ongoing oversight, either approach can succeed in continuing Medi-Cal's highly effective approach to maternity care.