Pregnancy in Health Reform: Access, Benefits, and Continuity of Care

Maternal and Child Health Access

Prepared by Special Service for Groups (SSG)
Research and Evaluation Team

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Pregnancy in Health Reform: Access, Benefits, and Continuity of Care
March 2013-June 2016

Final Evaluation Report
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Introduction

Maternal and Child Health Access (MCHA) is a non-profit organization, based in Los Angeles, that works to improve the health of low-income women and families through advocacy, education, training and direct services. MCHA's core service programs include:

- application and enrollment assistance for Medi-Cal, the Medi-Cal Access Program (MCAP), Covered California and county health programs, and CalFresh,
- home visitation and case management for pregnant and parenting women, and
- training other agencies about all health programs for low-income people.

Their well-established and respected training programs cover the range of health programs and services available in LA County and statewide, and reach many health and social service providers each year. Lastly, MCHA also plays a critical role as a leading health access advocate for low-income women and children in LA County and across the state. It should be noted that while the crux of MCHA's work is with and for low-income women and children, the organization consciously targets policy issues that impact much broader populations. Consequently, the effects of MCHA's advocacy are generally systemic and far-reaching.

In 2013, MCHA received funding from First 5 Los Angeles to advocate for sustained or improved levels of access, benefits, and continuity of care for pregnant women during the implementation of the Patient Protection and Affordable Care Act (ACA). MCHA's extensive experience positioned them to provide critical input and guidance as California made changes to the main health coverage programs serving pregnant women and children, including Medi-Cal, MCAP (formerly known as Access for Infants and Mothers, AIM), and Covered California.

Policy change is complex. The political and policy landscape shifts frequently and multiple sectors of society impact policy decisions. While advocacy efforts seek to improve policy or systems, this process takes time and generally requires multiple interim changes in approach or direction. Consequently, traditional evaluation approaches may not provide useful measures of advocacy accomplishments. Experts have suggested that evaluation might focus instead on process outcomes, as well as the characteristics of the advocacy organizations themselves.[1] Therefore, the aims of this evaluation were to document the accomplishments enabled by the First 5 grant as well as to understand how and why MCHA can influence policy design and implementation.

This report presents a timeline of significant MCHA achievements and adaptations supported by this grant from 2013 to 2016. It documents findings from a series of key informant interviews to

[1] Teles, S. and Schmitt, M. The Elusive Craft of Evaluating Advocacy. *Stanford Social Innovation Review*. Summer 2011.

describe the qualities and approaches that shed light on MCHA's effectiveness in advocating for low- income women and families. Finally, it offers brief recommendations to further the work before summarizing the evaluation methodology and acknowledging those who contributed to this report.

Key Findings

Expertise

MCHA's expertise in the healthcare system, the law, and the communities and populations they serve emerged during interviews as key factors that enhance their advocacy work.

Healthcare and Legal Systems

State and county administration of Medi-Cal, MCAP, and Covered California is complex. The ability to advocate within these systems requires deep understanding as well as vigilance in tracking and responding to policy and systems changes. Several stakeholders identified legal expert Lucy Quacinella as a major asset to MCHA's work, and felt that her ability to track regulations and work through issues within the appropriate departments was invaluable. One stakeholder and advocate explained that MCHA hones their advocacy "at a level of detail that I just don't have the bandwidth to do."

While MCHA focuses on the health of low-income women and families, staff truly understand the larger health coverage programs. Several stakeholders shared that their agencies brought MCHA in for consultation and to conduct trainings on a range of issues related to health care access and the ACA:

> "We have relied on them to conduct the majority of all the training that is required for our other sub-contractors that are doing outreach and enrollment, including all the enrollment staff. We rely on them as subject matter experts. We rely on them for their training to outside entities, including all their staffing, and we also rely on them to do a lot of trouble-shooting, which is something that has become more and more important and more convoluted as the ACA rolled out."

It's standard for the State to ask MCHA staff, among others, to test the enrollment systems before they open to the public because of MCHA's familiarity with both the policies that govern these systems as well as the population they serve.

Communities and Populations

This familiarity with the population—specifically, low-income women and children—emerged as another major theme in key informant interviews. Although MCHA's work impacts a wide range of groups, having a very specifically defined population with whom they work allows the organization to hone in on the issues and advocate for concrete changes. Working on large-scale policy issues with broad populations presents significant challenges, and several stakeholders attributed MCHA's effectiveness to their understanding of this particular population. In addition, stakeholders highlighted that MCHA holds a unique piece of health advocacy work:

> "They really are the only organization that works on these issues in a focused and concentrated way, specific to the population. I think there are lots of broader healthcare policy organizations in the state. California has a very strong health policy field, and we fund most of those organizations but none of them take this particular interest and focus on pregnant women and what the specific policy issues are."

Many stakeholders emphasized that MCHA's model, which strategically combines direct service with advocacy work, is unusual. One stakeholder explained that there are "just a very few that do both statewide policy advocacy and have a deep reach into the community. There just aren't that many of them. Usually they focus on one or the other and [MCHA has] both." The direct service work gives MCHA critical insight into the issues that low-income women and children experience accessing health care. Moreover, stakeholders highlighted that MCHA grounds its work in cultural competence: "They're very culturally competent. They understand the community, and the work with the community. They can speak the language, and they can understand them and all of that. Empathy. Everything."

Relationships

Collaboration and collective work are important pieces of successful advocacy initiatives; the second set of themes that emerged from key informant interviews dealt with MCHA's leadership, presence and participation in workgroups and coalitions, and building and leveraging smart relationships.

Leading Partners

Given MCHA's expertise, many stakeholders discussed the ways in which their organizations look to MCHA for leadership and guidance. In some cases, this is formalized through contracts– for example, LA County Department of Public Health relies on MCHA to provide training to all subcontractors who do outreach and enrollment for the county. These and other trainings MCHA conducts serve as a means for MCHA to get to know the majority of the organizations in the county who work on health care for low-income women. These relationships do not end with trainings; MCHA staff provide ongoing technical assistance and troubleshooting to many community-based organizations, public agencies, and service providers.

Presence

MCHA also cultivates relationships and provides leadership through participation in a number of workgroups and coalitions. Multiple stakeholders remarked on the omnipresence of MCHA staff at all meetings or events focused on maternal and child health. Of the Executive Director, one stakeholder said "She is at all the meetings that are convened by the county. When [county leaders] want to hear about what is important, she's always there. She has unbelievable credibility. I think all the supervisors probably know her by name." Participation in these meetings allows MCHA to offer input into maternal and child health issues, but also to sustain relationships and mobilize partners. Importantly, it also helps MCHA keep its finger on the pulse

of the field by providing opportunities for continuous learning. Another stakeholder said of the MCHA staff:

> "When they're not training, they're out at meetings all the time, or advocating all the time. One is at every other meeting I go to sometimes–Celia or Liz or Donald–at all these meetings, where they're learning more stuff. Or you turn around and they're leading a break-out session to inform other people. I think it's...having their staff out there, they're constantly learning, and since they're out there in the community, they are recognized more as being the experts on this information."

Stakeholders noted the multiple ways that MCHA provides leadership to the workgroups in which they participate. One way is through coordinating comments on items like proposed legislation, notices to pregnant women, and provider manuals about Medi-Cal pregnancy coverage. Another is through developing agendas for meetings with the California Department of Health Care Services and Covered California. Perhaps most significantly, and as discussed above, stakeholders see MCHA as experts on the health care system and the issues pregnant women face accessing care.

Smart Relationships

The relationships cultivated through workgroups, trainings, and technical assistance serve an important function by creating an additional channel through which MCHA can identify systemic issues around healthcare access. This wider net of community contacts effectively supplements the issues they identify through their own direct services.

Finally, one important way that MCHA leverages its relationships to influence administrative bodies is through communications and messaging. MCHA has direct connections with key groups of stakeholders–policymakers and administrators, health care consumers/low-income women and children, and other clinical and social service providers. Given these connections, the organization serves as a critical conduit of information exchange between these groups. MCHA is able to translate policy into guidelines for providers as well as practical information for consumers, while ensuring that policymakers understand the issues faced by women seeking care and clinicians providing it.

Effectiveness

During interviews, stakeholders identified several factors that make MCHA particularly effective in influencing policy design and implementation; these include the organizational culture, impact, and credibility.

Organizational Culture

MCHA has built a culture of learning and teamwork. Staff is committed to serve women and children and it shows through their hard work, dedication and mission driven approach. They have demonstrated loyalty to MCHA despite everyday challenges of working in a non-profit health access organization. Staff describes work as an environment that is supportive through open communication, access to trainings and professional development as well as opportunities to grow within the organization. Their desire to work with families is evident to both community and partners. One of the partners interviewed for this report described MCHA staff as "remarkable". MCHA is constantly regarded as a culturally competent, compassionate, and accessible organization to advocates, partners, and community.

MCHA is a lead expert in the field of health access for pregnant women and children. Stakeholders describe MCHA as an organization that has maintained an exceptional leadership team for over a decade and continue to provide high quality service throughout the years. Their stability has helped them gain the respect of other leading organizations as well as the community they serve. Through their Community Enrollment Counselors, they are able to directly advocate for clients and at the same time they gain insight of the internal issues the health providers are facing every day. MCHA understands how complicated it can be for women in LA County to get care so they work through an ecological framework making sure that providers have the right information and women get the coverage they need.

Their grassroots connection and years of experience working with LA County has made MCHA a leader in community knowledge. Their level of engagement in direct service, individual and public level advocacy, as well as policy efforts make them a visible organization. They are well connected with other agencies and most view MCHA as a valuable resource. For example, they have served as readers in draft letters going out to women enrolled in Covered California because they can provide a real-world perspective and make adjustments so information is streamlined. One funder shared with us, "It's still confusing for pregnant women, but it's a whole lot better than it would have been otherwise had they [MCHA] not been involved."

Organizational Impact

Many partners described MCHA as the leading advocate in their groups. They have demonstrated their leadership through their consistent presence in issues related to pregnant women such as lobbying efforts, advocacy in California, and concerns related to the ACA. Partners rely on MCHA's leadership to stay updated on current issues related to health access and they also rely on them to outreach clients. The work that MCHA has helped move forward is significant, as shown in the timeline: "I think there's still a lot of work to be done just to make sure that women have access to providers. I think there are a lot of access issues that are

ongoing." Crucial milestones for health care access have been possible because MCHA is able to collaborate for the greater good of women and their families. They have invested many years in building legislation and regulations related to coverage for pregnant women and children. Additionally, they make sure new updates from legislation or policy don't disrupt benefits and eligibility access. A funder described, "They clearly know the mission, they know what they're about and they have a pretty good sense of what it takes to get it done." MCHA has a clear goal, and will continue to push the envelope to ensure women and children receive the health care they need.

Organizational Credibility

The healthcare system is constantly evolving and everyone from clients to providers needs support to navigate services. MCHA is at every meeting to ensure information is being explained properly to the right audience. They serve as a leader in educating partners and providers to understand the public health landscape for pregnant women. They are the go-to people when providers need help. They said, "They're our linkage to be able to do that behind the scenes, which is very complicated work." MCHA has the utmost credibility in the field and most partners and providers know MCHA staff very well. Given their very unique role of advocates and direct service providers, MCHA has the ground fieldwork experience where they can help families fill out applications and troubleshoot issues. Providers know the depth of knowledge that MCHA brings and they learned very quickly that it's important to build an alliance with MCHA. As a funder explained, "They knew how everything worked, so we relied on them to be able to give this information to other enrollers across the county and it's been a great partnership ever since." MCHA not only has consistency with community in Los Angeles but they have also maintained consistency and follow through with partners and providers.

MCHA has the ability to look at all the barriers from the individual to the systemic level. They have been doing this for a long time and they have a reputation for influencing change. One very important and recent change was the technical issues women were facing with the lack of MCAP availability: "Among the list of important policy accomplishments that several of us played a role in and MCHA certainly played a leadership role in was getting the state to finally incorporate MCAP into the computer system last fall." MCHA has also gained credibility statewide by keeping track of all legislation and administrative policies around pregnancy and being able to communicate to policy makers what is happening on the ground. They work diligently to make systemic changes by keeping their eye on the client and Sacramento: "That's an extremely strong asset of MCH Access, and it's not common. It's rare for one organization to be able to do the whole spectrum of work." As many funders and partners have mentioned MCHA has gained respect because they are not afraid to go above and beyond for the client. Their deep reach into community and clients lives makes them an outstanding advocate for statewide policy change. MCHA's model demonstrates effectiveness through seeing the problem first hand and then interpreting information to fix the problems in Sacramento.

Discussion/Conclusion

In this report we have gained some insight into the critical role that MCHA has played in the improvement of health care access to pregnant women and their families. There are many

challenges facing pregnant women today particularly with the ACA and ongoing lack of clarity in health care access. Through numerous efforts MCHA has continued to advocate for improvements by providing critical input necessary to improve the health care system. Their expertise continue to make them the most suitable organization to ensuring women and children get the care they need. Having an organization like MCHA is crucial, not only for women and children but for policy change accountability. Moreover, they continue to work hard particularly for low-income pregnant women who struggle with health care access regularly. As the healthcare landscape continues to change there will continue to be a need for advocacy, education, and trainings. We have highlighted possible improvements to encourage a positive direction in the near future.

Recommendations/Considerations

Stakeholders represent a variety of organizations, including public agencies, funders, and other advocacy organizations. These different perspectives helped inform a multifaceted view of Maternal Child Health Access, and offered some insights into ways to leverage or scale up their advocacy work.

- *Develop Communications*
  Stakeholders saw MCHA as providing a critical and unique avenue for communication between policy makers, consumers, service providers, and other advocates, and acknowledged that the material MCHA communicates is fundamentally complicated. One stakeholder said "I feel like there has to be a way to figure out how to tell the story of their work that's not always about the weeds of the policy issues. Really for their benefit, because I think they are great and I want people around the state to know that and know why they're important and what they're contributing to the field, and for other funders, all of the things that telling your story better can help you do." Other stakeholders also expressed a wish for MCHA to do more self-promotion, and saw that as important to MCHA's sustainability.

- *Expand Reach*
  Many stakeholders found significant value in the trainings MCHA offers, as well as in the monthly meetings they hold in their offices in Los Angeles. One stakeholder inquired about their ability to broadcast these meetings to reach a broader audience. She said "I'm kind of jealous sometimes about not being in LA because I would love to go to their...to see their monthly presentations."

- *Obtain Core Support*
  Stakeholders understood the critical role of grant funding for programs; however, several felt that MCHA's track record and credibility made them deserving of unrestricted funding and core support. One stakeholder said "You just have to look at who they are and what they've done and understand that they're going to spend every last ounce of Lynn Kersey's breath advocating for women and children in LA County and at the state level and just give her a chunk of money to do it." Stakeholders expressed a wish to make funding less detail specific in order to give grantees more "room to breathe."

Methodology

The Research and Evaluation Team at SSG was contracted by MCHA to conduct an evaluation with a mixed-methods approach that included the review of secondary data from existing First 5LA reports and stakeholders input (or primary data) from interviews. The process was iterative (non-linear) as both the secondary and primary data were used to help inform each other. This section describes the type of secondary data and stakeholders input collected and methodology for collecting and interpreting it for this report.

Secondary Data

The SSG evaluation team gathered all First 5 LA quarterly reports from 2013-2016 for analysis. This information was reviewed and a timeline of MCHAs efforts was generated. These reports along with MCHA online summary updates were reviewed and provided some content for conversations with stakeholders.

Stakeholder Input

Maternal Child Health Access (MCHA) helped the SSG evaluation team identify groups of partners, funders, policy makers, and MCHA staff to solicit their input. To maintain a diverse group of contributors the SSG team selected 3-4 stakeholders per group to conduct primary data collection through in-person or phone interviews. A total of 13 interviews were completed in February 2016. All interviews were conducted with two members of the SSG evaluation team, one to facilitate the conversation and the other to take notes. With the permission of participants, all interviews were audio-recorded. Separate but similar guides were developed to support facilitation of discussion in interviews. The interviews were tailored to the specific experiences of the respective stakeholders and included probing questions in order to gather more specific information about MCHA. The purpose of these interviews was to identify MCHA's knowledgeability, network-relationships, uniqueness, and provide some recommendations.

Acknowledgements

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- Richard Figueroa, Director of Health and Human Services, The California Endowment
- Justin Garrett, Regional Director of Advocacy and Public Affairs, March of Dimes
- Kathy Kneer, President and CEO, Planned Parenthood Affiliates of California
- Elizabeth Landsberg, Director of Policy Advocacy, Western Center on Law and Poverty

- Monica Ochoa, Oral Health Advocacy Coordinator, MCHA
- Padmini Parthasarathy, Program Director, California Wellness Foundation
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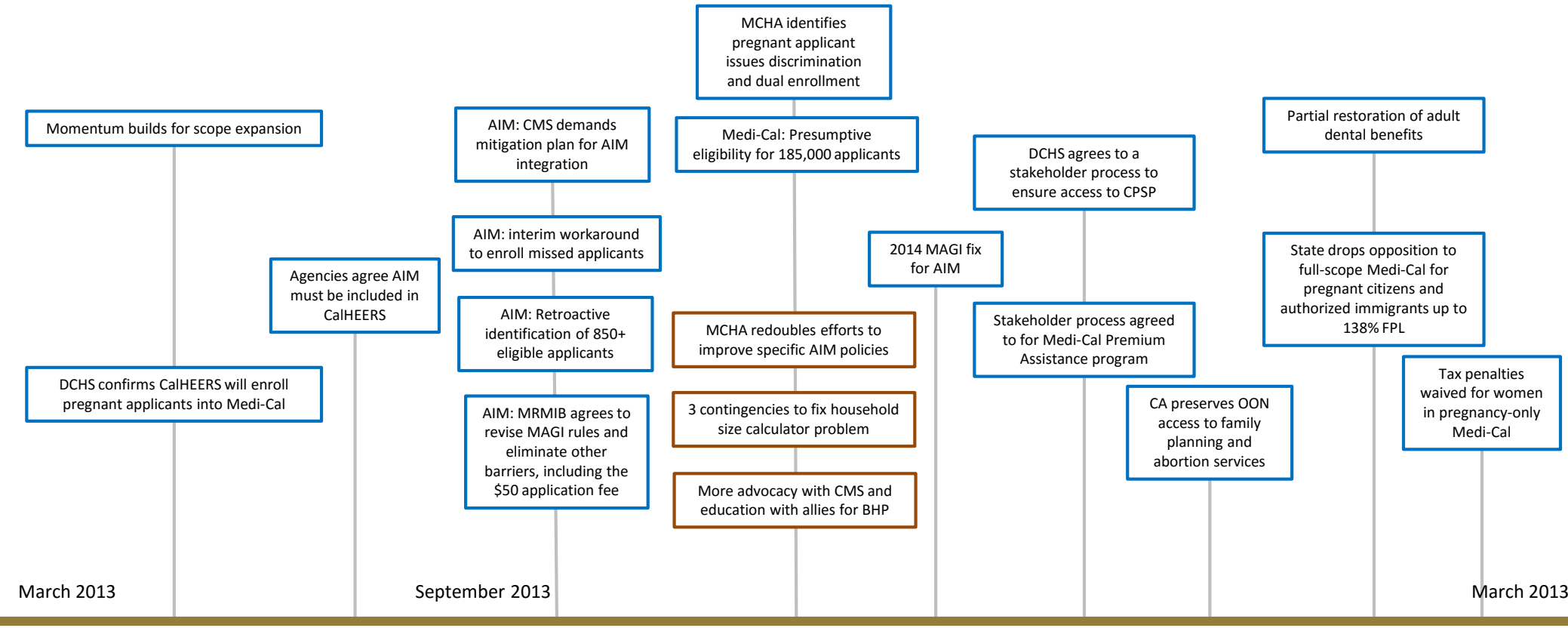
Pregnancy In Health Reform: Access, Benefits, and Continuity of Care
Project Timeline March 2013-March 2014

During this period of health reform, MCHA worked to ensure that affordable, comprehensive, and high-quality care was provided to pregnant women through Medi-Cal, Covered CA, and the Medi-Cal Access Program (MCAP, formerly AIM). This timeline highlights two types of events:

Wins are instances in which MCHA successfully influenced policy or administrative systems, and reflect the organization's effectiveness

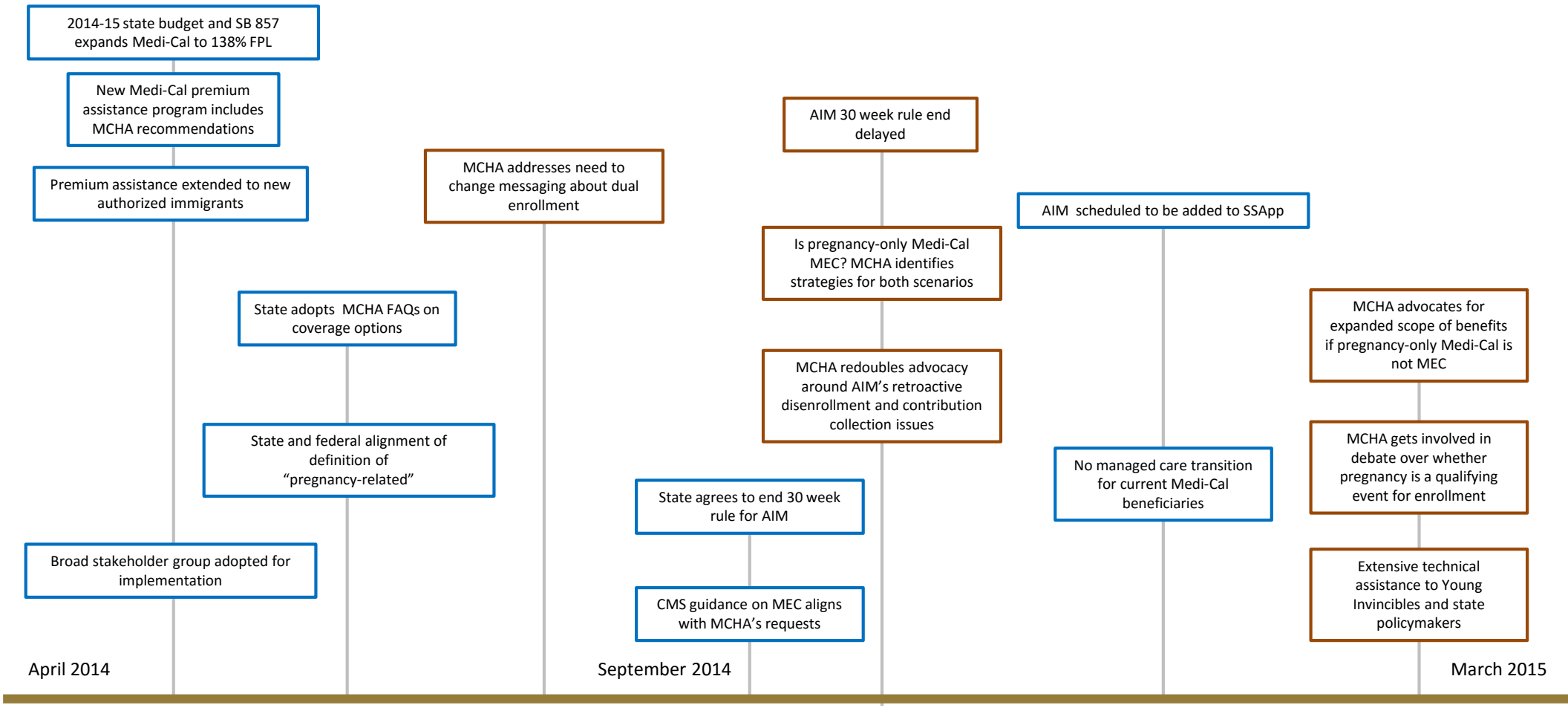
Pivots are instances in which MCHA adapted strategies in response to changes in the health care access landscape.



CONTEXT

- California is one of few states not providing full-scope Medicaid to pregnant women in certain income brackets.
- There is wide variety and lack of clarity around perinatal benefits in exchange health plans.
- AIM is not included in online enrollment system in choice of programs for pregnant women.
- More changes are needed to make online enrollment system compliant with ACA guidelines.
- The Centers for Medicare and Medicaid Services (CMS) issue proposed regulations for the Basic Health Program; these regulations fail to take into account state-specific factors and do not allow for reconciliation with updated data.
- CMS issues guidance that pregnancy-only Medicaid does not qualify as "minimum essential coverage."

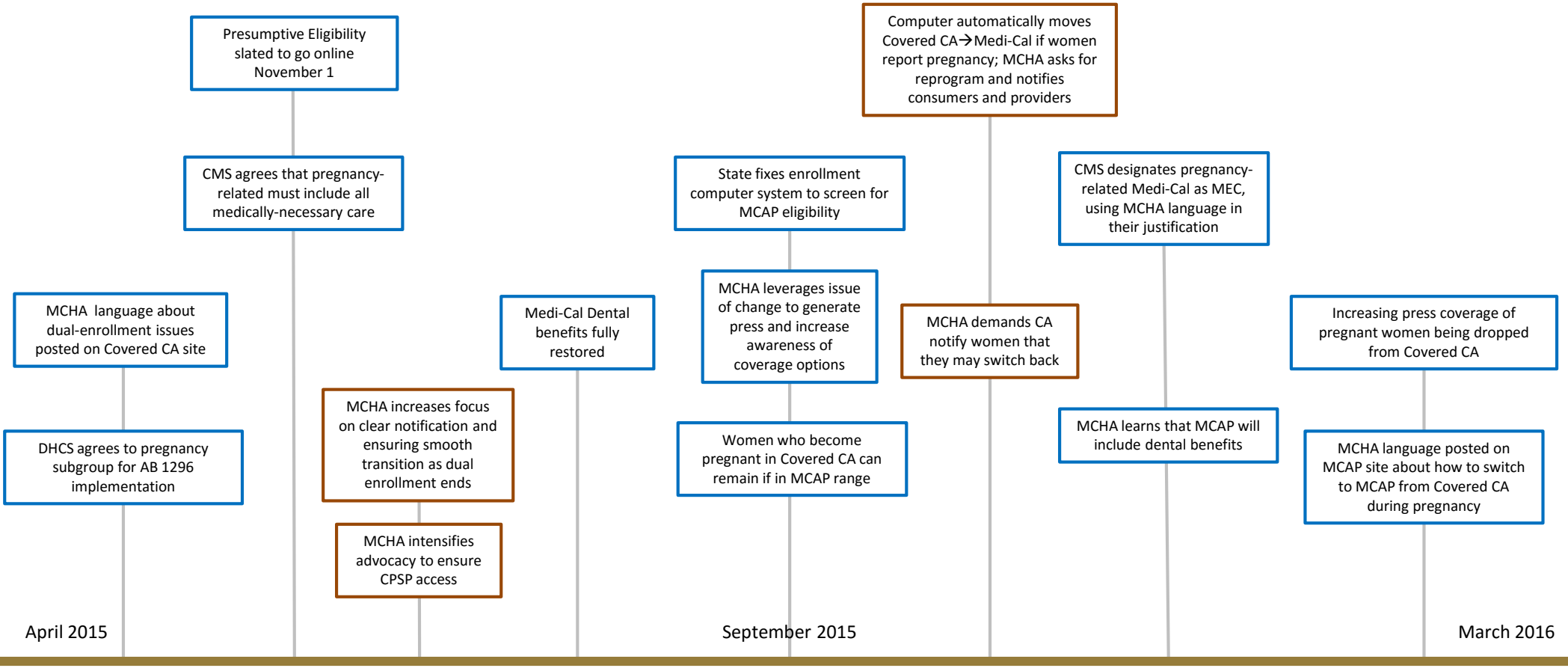
Pregnancy In Health Reform: Access, Benefits, and Continuity of Care
Project Timeline April 2014-March 2015



CONTEXT

- Implementation of SB 857 delayed until 2016
- Income limit for full-scope Medi-Cal expanded to 138% FPL.
- Women are enrolling in Medi-Cal and Covered California plans without know about dual enrollment issues.
- GWU report on dual enrollment and CPSP access.
- CMS has yet to issue guidance as to whether pregnancy-only Medi-Cal constitutes MEC or on the premium assistance wrap-around program.
- MCHA and six other advocacy orgs request that pregnant women not be moved to managed care when Medi-Cal expanded.
- 35,000 pregnant women inadvertantly dropped due to computer error.
- Ongoing uncertainty about CPSP access by dually-enrolled women.
- DHCS insists that CMS has communicated that pregnancy-related Medi-Cal will be considered MEC.

Pregnancy In Health Reform: Access, Benefits, and Continuity of Care
Project Timeline April 2015-March 2016



CONTEXT

- Full-scope Medi-Cal expansion to 138% FPL applied to applications through CalHEERs.
- State believes CMS will find pregnancy-related Medi-Cal to be MEC, though not postpartum coverage.
- Women who become pregnant while covered by a Covered CA plan can switch to Medi-Cal but risk losing continuity of care.
- Computer moves women in Covered Ca to Medi-Cal if woman reports pregnancy.
- Stakeholder meetings yield first sets of statistics that MCAP enrolling about 1000 women/month.
- DHCS provides proposed updates to pregnancy aid codes MCHA/advocates had submitted and to comments on Medi-Cal Provider Bulletin on Medi-Cal for pregnancy.
- MCHA continues to press for Prenatal Gateway in enrollment computer.
- MCHA "soft launches" toll-free line for pregnancy coverage.
- As of Feb. 12, dual enrollment into Cov CA and Medi-Cal for pregnancy not an option.
- MCHA learns in stakeholder meetings that women reporting pregnancy to CalHEERS moved to Medi-Cal if income drops, as are all Cov CA enrollees reporting a change in income. Computer won't be fixed until September, 2016.

Appendix A

Maternal and Child Health Access
Pregnancy in Health Reform: Access, Benefits, and Continuity of Care
March 15, 2013-March 14, 2016
Program Timeline

Pre-July 2013

Context

- California is one of few states opting not to provide full-scope Medi-Cal to all pregnant women in its federal poverty level program. Instead, it provides a "limited scope" of "pregnancy-only" benefits.
- California has a separate CHIP-funded comprehensive coverage program for pregnant women with income over the Medi-Cal limit of 213% of poverty, up to 322%, the Access of Infants and Mothers (AIM) program.
- Consumer advocates were repeatedly assured by state that eligible low-income women's affordable coverage through Medi-Cal and AIM would be available for enrollment in state's eligibility computer
- Wide variety in and lack of clarity around perinatal benefits in exchange health plans.

July-September 2013

Context

- Under the ACA, CHIP-funded programs like AIM must be included in both the on-line and paper versions of the ACA Single Streamlined Application (SSApp), as well as in the computer's ACA eligibility logic for pregnant women
- State declines to include AIM, advocates finally learn
- Many other policy reforms still needed in AIM to make it ACA and CHIP-compliant.
- How will women in pregnancy-only Medi-Cal get comprehensive coverage? Avoid tax penalties for not having comprehensive coverage?

Wins

Medi-Cal

- With MCHA's advocacy, DHCS confirms that CalHEERS will enroll pregnant applicants with income in the Medi-Cal range into Medi-Cal.
- Momentum builds among stakeholders and policymakers for expanding the scope of coverage for women in pregnancy-only Medi-Cal.

AIM

- None of the three state agencies responsible for administering, CalHEERS, i.e., the new ACA eligibility and enrollment system, disputes that CHIP-funded programs like AIM must be included in CalHEERS.

October-December 2013

Context

- Covered CA open enrollment begins.
- CHCF report estimates that a Basic Health Program (BHP) in CA would incur lower cost to lowest income consumers than exchange health plans.
- CMS issues proposed regulations for BHP that do not take into account state-specific factors or more recent data, and are thus seriously flawed.
- Labor vigorously opposes BHP implementation in CA, preferring a larger pool for the exchange.
- Pregnant applicants 139-213% FPL are dually enrolling in MC and Covered CA, but not informed that Covered CA blocks use of Medi-Cal or that they have the legal right to drop Covered CA to avoid premiums and cost-sharing or gain access to Medi-Cal.
- Pregnant applicants face a patchwork of eligibility depending on income limit. From 60-138% FPL, pregnant women are not granted full-scope Medi-Cal as are other adults, but rather "pregnancy-related only."

Wins

AIM

- MCHA's advocacy leads to major policy improvements in AIM:
- Interim workaround to identify and offer enrollment to missed AIM applicants is adopted. MRMIB identifies 850+ AIM-eligible applicants who were missed when their applications were submitted to Covered CA between October and December 2013. MRMIB contacts these applicants to give them option to enroll in AIM. [MCHA learned in January 2016 that about 1,000 AIM-eligible applicants *a month* were likely missed from October 2013 through October 2015}
- MRMIB agrees it must revise AIM regulations to comply with ACA's modified adjusted gross income (MAGI) rules and verification procedures.
- CMS demands formal mitigation plan from DHCS on integrating AIM into ACA's computerized eligibility logic re: both the online and paper versions of the SSApp.
- To comply with ACA, MRMIB agrees to stop requiring medical documentation of pregnancy, $50 application fee, and answering questions about last menstrual period and smoking as conditions of eligibility
- MCHA identifies the pregnant applicant issues of discrimination vs. other adults and co-enrollment in Covered CA; begins work with CMS, informing advocacy networks, creating briefs and materials and using in training enrollers and others.

Medi-Cal

- MCHA, in collaboration with other partners, identifies flaws in online application system; at MCHA's insistence, DHCS agrees to grant presumptive eligibility to 185,000 individuals with pending Medi-Cal applications while glitches are resolved.

Pivot

- MCHA redoubles advocacy efforts with state and CMS to end AIM's policy and practice of excluding women after the 30th week of pregnancy, retroactively disenrolling women who "fail" to report the end of their pregnancies, and collecting total annual subscriber contributions for women whose income declines or who leave AIM to enroll in Medi-Cal or to move out of state. [Eventually dropped 9/1/2015].
- MCHA offers three contingencies to address household size calculator misalignment between Covered CA and Medi-Cal.
- More advocacy is needed with CMS, as well as educational work with potential allies, for BHP.

January-March 2014

Context

- The impact in California of CMS guidance on when pregnancy-only Medicaid does not qualify as "minimum essential coverage" is that otherwise eligible pregnant women can be enrolled in both Medi-Cal and Covered California at the same time, with Premium Assistance to cover premiums and cost-sharing. Governor's budget proposal for FY 2014-15 proposes doing that.

Wins

AIM

- MCHA's work ensures that MRMIB starts 2014 with a MAGI application for AIM, that paper verification requirements for income are dropped, that women are protected by the ACA's procedures for resolving discrepancies between current self-reported income vs.e-verified income based on tax and wage database sources that may be quarters or years out of date, and that a new paper application form and handbook that are ACA-compliant are developed pending AIM's integration into CalHEERS .

Medi-Cal and Covered CA

- State DHCS agrees to MCHA's demand to preserve out of network access to family planning and abortion services for women enrolled in Covered CA with premium assistance from Medi-Cal, since such women remain entitled to Medi-Cal's protections though enrolled in Covered CA.
- DHCS also agrees to a stakeholder process for ensuring that dually enrolled women do not lose access to Medi-Cal, which includes the Comprehensive Perinatal Services Program, a visionary set of benefits through which Medi-Cal providers can be reimbursed for connecting pregnant women to nonclinical psychosocial services designed to address social determinants of health, such as assistance with housing, transportation, food insecurity, immigration status issues, and intimate partner violence that does not meet DSM-IV diagnosis criteria for behavioral health services.
- State agrees to stakeholder process for implementation of the Premium Assistance program more generally, as many details would still remain even if the Governor's budget proposal and related legislation were to pass.
- CMS and IRS agree on exemption from tax penalties for 2014 for women in pregnancy-only Medi-Cal without dual enrollment in Covered CA.

- State drops opposition to Full-Scope Medi-Cal for pregnant citizens and lawfully present women with income up to 138% of poverty.
- Pregnancy-only Medi-Cal recipients are included in partial restoration of dental benefits for adults receiving full-scope Medi-Cal.

April-June 2014

Wins

- 2014-15 state budget and SB 857 health trailer bill extend income eligibility for full-scope Medi-Cal from 60% to 138% FPL for pregnant women.
- State adopts MCHA's comprehensive FAQs on coverage options for pregnant women and posts it on Covered CA website.
- SB 857 includes a new program of Medi-Cal premium assistance for women with income 139%-213% FPL to acquire MEC by enrolling in Covered CA plans at no cost and/or to preserve continuity of care. Nearly all of MCHA's core policy recommendations are adopted for this program.
- MCHA's recommendation to include a broad stakeholder group in the implementation process is adopted.
- SB 857 premium and cost-sharing protections extended to the "new" authorized immigrants Premium Assistance Program.
- State agrees to align the definition of "pregnancy-related" with broader definition required under federal regulations and to revise the provider manual accordingly. Many implementation details remain.

July-September 2014

Context

- Implementation of SB 857 is delayed until 2016.
- The income requirement for full-scope Medi-Cal is expanded to 138% FPL for pregnant women.
- Women are enrolling in Medi-Cal and Covered CA plans without knowing about the problems created by dual enrollment: expensive premiums and hospital charges under Covered CA and no access to CPSP in the common situation where provider networks do not overlap.

Pivots

- With the implementation of SB 857 delayed until January 2016, MCHA addresses need to change the messaging about dual enrollment, educate women about option to drop Covered CA to gain access to no cost Medi-Cal and CPSP, and continues to advocate for inclusion of Comprehensive Perinatal Services Program or equivalent benefits in Covered CA plans.

October-December 2014

Context

- MCHA partners with George Washington University to investigate dual enrollment in Medi-Cal and Covered California and access to CPSP.

- CMS has not decided whether pregnancy-only Medi-Cal constitutes MEC.
- CMS issues significant new guidance on the MEC question and coverage for pregnant women.
- CMS has not issued guidance on the premium assistance wrap-around program.
- MCHA and six other advocacy organizations send urgent request letter asking that when expansion to 138% is implemented for pregnant adults, don't move existing pregnant women into managed care, which could disrupt continuity of care.
- In November, 35,000 pregnant women statewide are inadvertently dropped from coverage due to computer error. MCHA notifies advocacy networks.

Wins

AIM

- State agrees to end 30-week eligibility rule for AIM.

Medi-Cal

- New CMS guidance on MEC aligns with MCHA's requests to: 1) reaffirm that pregnancy-only Medicaid programs can be designated MEC only if they provide women with the equivalent of full-scope coverage during pregnancy; and 2) allow for preserving continuity of care for women in Medi-Cal's income range who become pregnant after enrolling in an exchange plan with APTCs.

Pivot

AIM

- State delays rescinding 30-week rule until April 2015; MCHA pushes for immediate implementation.
- MCHA redoubles advocacy efforts with CMS on AIM's retroactive disenrollment and subscriber contribution collection issues.

Medi-Cal

- MCHA identifies issues/solutions for either scenario when CMS issues guidance on whether pregnancy-only Medi-Cal is MEC.

January-March 2015

Context

- There is ongoing lack of clarity as to whether CPSP will be accessible by dually-enrolled women.
- DHCS insists CMS has communicated that pregnancy-only Medi-Cal will be considered MEC.

Wins

AIM

- AIM is scheduled to be added to Covered CA's Streamlined Single Application (SSApp) for the next enrollment period.

Medi-Cal

- Current Medi-Cal beneficiaries will not be transitioned into managed care when the expansion to full-scope is implemented.

Pivot

Medi-Cal

- Based on the November 2014 CMS guidance, MCHA believes the best way forward is to ensure that, if pregnancy-only Medi-Cal is considered to be MEC, the state in practice provides substantially the same benefits to pregnant women as are provided to all other adult Medi-Cal beneficiaries. This involved improving the provider manual and related policies and procedures to ensure access to all medically-necessary care.

Covered CA:

- MCHA gets involved in debate of whether pregnancy is a qualifying event in order to enroll in Covered CA with APTCs during special enrollment periods.
- MCHA provides extensive technical assistance to Young Invincibles and state policymakers.

April-June 2015

Wins

- DHCS agrees to MCHA's request for a pregnancy subgroup working on AB 1296 implementation. MCHA agrees to take the lead among advocates, disseminating information and gathering feedback.
- CMS agrees with MCHA's stance that "pregnancy-related" Medi-Cal for women ineligible for full-scope with incomes up to 213% must be the same as "all medically necessary care during pregnancy."
- MCHA's informing materials about dual-enrollment issues are posted on the Covered California website as a stop-gap measure until computers are reprogrammed.
- MCHA learns that the Presumptive Eligibility (PE) for Pregnant Women program will go online, with a target date of November 1; PE ensures access to care for pregnant women until final Medi-Cal eligibility determinations can be made.

Pivots

- As California prepares to end dual enrollment, MCHA shifts efforts to ensuring that the State provides timely information to women and that the transition process is smooth.
- MCHA intensifies advocacy for access to CPSP for women in Medi-Cal managed care programs and other non-Medi-Cal QHPs.
- MCHA redoubles efforts to create Newborn Hospital Gateway, so that newborns have on-going Medi-Cal before leaving the hospital when "deemed eligible" through the mother's Medi-Cal coverage for the delivery.

July-September 2015

Context

- Full-scope Medi-Cal expansion to 138% FPL is applied to applications through CalHEERs.

- State continues to believe CMS will find pregnancy-related Medi-Cal to be MEC, though not postpartum coverage.
- MCHA leads discussions with State to push for all medically necessary care, including during postpartum period.
- Women who become pregnant while covered by a Covered California plan can switch to Medi-Cal but risk losing continuity of care. Timely, accurate messaging about options is therefore key.

October-December 2015

Context

- MCHA learns women who get pregnant in Covered California and drop to Medi-Cal income level don't have same protections as those in MCAP income range to remain in Covered California during pregnancy; computer moves them to Medi-Cal if woman reports pregnancy.

Win

- State fixes ability for enrollment computer to screen for Medi-Cal Access Program, including real time enrollment when all e-verifications check out online, and informs women they have the right to opt into Covered CA instead of MCAP. Otherwise, as with Medi-Cal and Covered CA, pregnant women applicants in MCAP's eligibility levels are called or mailed to complete the verification process and ensure they want MCAP and not Covered California. [Dual enrollment not allowed for pregnant women eligible for MCAP, per CMS guidance, as, from the federal perspective, the CHIP funding covers a child "from conception", but Covered CA subsidy would cover the woman herself; under these circumstances, CMS guidance lets the woman choose one or the other program, but not bot].
- Women who become pregnant in Covered California stay there if also in MCAP income range, receive notice of their option to switch to lower cost MCAP if they prefer.
- MCHA is able to use issue of change to get press and get word out about overall coverage options:
    - KPCC: Covered California adds Medi-Cal option for some pregnant women http://www.scpr.org/news/2015/10/14/55045/covered-california-adds-medi-cal-option-for-some-p/
    - Center for Health Reporting: Pregnant and Insured? You have options http://centerforhealthreporting.org/article/pregnant-and-uninsured-you-have-options
    - California Healthline: Covered California Fixes Gap in Coverage for Pregnant Women http://californiahealthline.org/news/covered-california-fixes-gap-in-coverage-for-pregnant-women/
    - KQED News: Pregnant and Uninsured? Here are your options. http://ww2.kqed.org/stateofhealth/2015/10/13/pregnant-and-uninsured-here-are-your-options/?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+kqed%2FStateOfHealth+%28KQED%27s+State+of+Health%29
- MCHA learns definitively that MCAP will include dental benefits when fall 2017 contracts are renewed.

Pivot

- MCHA seeks to have state reprogram computers and creates alert regarding changing to Medi-Cal during pregnancy; sends to Los Angeles Best Babies Network Perinatal Links, Legal Advocates list and Orange County MOMS program director: http://www.mchaccess.org/pdfs/misc/Alert%20CC%20to%20MC%2012-10-15.pdf
- MCHA demands state notify each affected woman that she may move back to Covered California if she chooses, integrate key information into the on-line application process that may alert a Covered California enrollee of what to do to avoid the switch from happening and that state service center staff be adequately trained on the issue.

January-March 2016

Context

- Stakeholder meetings yield first sets of statistics that MCAP enrolling about 1000 women/month.
- DHCS provides proposed updates to pregnancy aid codes MCHA and other advocates had submitted and to comments on Medi-Cal Provider Manual on pregnancy-related Medi-Cal.
- MCHA continues to press for Prenatal Gateway in enrollment computer, as state's contact with Xerox to complete this work by November 1, 2015 is being re-negotiated. MCHA also continues to advocate for Newborn Hospital Gateway.
- MCHA "soft launches" toll-free line for pregnancy coverage issues.
- As of the February 12 CMS letter regarding MEC, dual enrollment into Covered California and Medi-Cal for pregnancy is no longer an option.
- MCHA learns in stakeholder meetings that women reporting pregnancy to CalHEERS moved to Medi-Cal if income drops, as are all Covered California enrollees reporting a change in income. 1400 women affected October, 2015-Feb., 2016; Letters start to go out to cover this group.
- Women already in Covered California when get pregnant have legal right to be in either.
- Computer won't be fixed until September, 2016.
- MCHA sends out 4-point bulletin about MEC change, comprehensiveness of pregnancy coverage formerly known as "pregnancy only"; MCAP now being screened for in CalHEERS; and ability to stay in Covered California or switch to MCAP or Medi-Cal if pregnant after enrolling in Covered California.
    - http://www.mchaccess.org/pdfs/misc/Changes%20to%20Pregnancy%20Coverage%20-%20%203-8-16.pdf
    - http://www.mchaccess.org/pdfs/misc/California%20MEC%20(Pregnancy)%20Determination%202-12-16.pdf
    -

Wins

- CMS issues Feb. 12 letter determining pregnancy-related Medi-Cal as MEC, and uses important language in their justification that MCHA has helped set up.

- Given another story of dropped Covered California coverage, discussions with KFF reporter worked with MCHA before; she is interested in story.
- MCHA creates language posted on MCAP website about how to switch to MCAP from Covered California during pregnancy.

April 2016

Context

- More Activity around women being transferred from Covered California to Medi-Cal issue:
    - 4-18-16 California Healthline story "More Customers Dumped From Covered CA Without Notice"; Sacramento Bee, Daily News: "Glitches prompt Covered California to drop some pregnant women"; KQED, "Newly Pregnant? You May Not Want to Tell Covered California"
    - 4-20-16 Lynn does radio interview KFI; contacted by CBS and KCRW as well.
    - 4-23-16 Los Angeles Daily News "Why pregnant women are being bumped from Covered California coverage"
    - 4-28-16 Congressional letter to Medi-Cal Director Kent and Covered CA Director Peter Lee regarding transfers of pregnant women to Medi-Cal without notice.
    - On Bera's webpage and separate 4-29-16 article in California Healthline, "Lawmakers Demand Quick Action on Covered California Pregnancy Snafu" and in LA Times online, "Members of Congress want fix for Covered California glitch dropping coverage for pregnant women"
    - MCHA and advocates make recommendation to state for language for enrollment computer to identify Deemed Eligible infants and not submit new application online

Pivot

- MCHA ponders whether and how to respond to Bera and Congressional members

Win

- MCHA gets wording in 4-29 Bera article, "After reading the Congressional letter, Kersey called on state leaders to "allocate sufficient resources to speed up the many urgent computer fixes needed for low-income Californians applying for coverage."

May 2016

Context

- More activity around women being transferred from Covered California to Medi-Cal issue:
    - Covered CA Board gets letter from Bera and 14 members of Congress, writes May 3 response, list both in May 12 packets for Covered California Board meeting http://board.coveredca.com/meetings/2016/5-12/Comments%20to%20the%20Board%20-%20Master%20-%20May%2012,%202016%20(External).pdf

- DHCS/Board response mischaracterizes Restricted Medi-Cal coverage for pregnant women four times as "full scope"
- DHCS/Board letter gives impression more will be done to "fix" glitch prior to Sept; MCHA learns this means phone calls to women, not a computer fix any faster than Sept.
- Joint Legislative Audit Committee has an agenda item to hear request to audit Covered California's implementation of federal guidance regarding maternity care for women through Covered California and Medi-Cal. The meeting is scheduled for 9:30 am in Room 126 on Wednesday May 25th. MCHA strategizes on how to address, whether to attend, as it appears timed to affect Bera's re-election. Item gets postponed.
- State ends Pregnancy Workgroup; meant for implementation and feels job "done". Work will continue in at least two other existing workgroups: Consumer-Focused Stakeholder Workgroup and AB1296 workgroup.
- State affirms it will not change language in provider bulletins, materials to be more inclusive of CMS paragraph, nor "full-scope comprehensive coverage" noted by Medi-Cal director Kent in her response to Congressmember Bera.

<u>Pivot</u>

- Because of factual errors in response letter to Bera, and because no less than four times does the letter refer to "full scope" Medi-Cal as what women dropping from Covered CA will get, MCHA decides to send letter June 1 and utilize it as an opportunity to raise multiple issues about maternity care and reiterate our ongoing request to clarify the language for formerly "pregnancy only" coverage now determined MEC.

<u>Win</u>

- MCHA sees a major media response to the issue of changes in continuity of care and lack of notice for pregnant women.

May- June 2016

- MCHA drafts letter to Covered CA and DHCS with cc's to Ami Bera and other Congressional signatories:
  - Background to computer issues in CalHEERS for pregnant women
  - Clarifying that choice to remain in Covered California or move to MCH or MCAP during pregnancy for women a legal right, not granted by state
  - Asking for clarification for pregnant women formerly pregnancy-only, now determined MEC
  - Informing about, since Covered CA and Congress may not be aware, four other pregnancy-related issues they can assist with

SSG

SPECIAL SERVICE FOR GROUPS

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The SSG Research and Evaluation Team applies rigorous techniques in evaluation, community research, public health and planning with cultural sensitivity and deep community roots to help organizations, philanthropy and public agencies make greater impact.

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This report was published July 2016. For questions/comments on this report, please contact: research@ssg.org