Maternal and Child Health Access

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August 29, 2011

Senator Hernandez, O.D.
State Capitol, Room 4805
Sacramento, CA 94248-0001

Delivered by fax: (916) 445-0485

RE: SB 703 (Hernandez): SUPPORT IF AMENDED

Dear Senator Hernandez:

As you know from our previous correspondence, meetings with staff and testimony in committee, MCH Access seeks to ensure that the SB 703 Basic Health Program (BHP), which would cover adults with income 139%-200% of poverty, will:

- not impose cost-sharing in excess of Medi-Cal's limits for pregnant women;
- avoid barriers to timely access to pregnancy-related benefits covered by Medi-Cal that commercial health insurance often does not cover, such as psychosocial services, nutrition counseling, health education, lactation consultation, breast pumps, and dental;
- provide for careful coordination with Medi-Cal on eligibility, enrollment, transitions between other health insurance programs, and scope of benefits, so that coverage is seamless for pregnant women as well as all other eligible individuals; and
- address the unique need for continuity in pregnancy-related and interconception care.

Placing the BHP within the Department of Health Care Services (DHCS), as we understand may occur, would certainly help to address some of our concerns. But more must be done.

In recently proposed Medicaid regulations, the Centers for Medicare and Medicaid Services (CMS) confirmed that Medicaid's federal poverty level program for pregnant and post-partum women is a "mandatory" eligibility category.[1] If California wishes to continue to receive any Medicaid funding at all, Medi-Cal must continue to cover otherwise eligible pregnant women with income to at least 185% of poverty. This obligation does not end with the end of the "maintenance of effort" requirement for adults on January 1, 2014.

In addition, women who are eligible for "limited scope" Medicaid programs, such as Medi-Cal's 200% Program for only pregnancy-related care, are *not* excluded from the BHP.[2] Regrettably, the opposite view was held by the private consultants who prepared the BHP's actuarial review, and no analysis has been done on the impacts on eligibility, enrollment, cost-sharing, access and

continuity of pregnancy-related and interconception care for women meeting both Medi-Cal's and the BHP's eligibility requirements.

MCHA's concerns are not hypothetical.

- **Maternal mortality:** California's maternal mortality rate was a disturbing 49% higher in 2006-2008 than in 1999-2001.[3] African-American women in California are four times more likely to die from pregnancy-related causes according to DHCS' most recent data.[4]

- **Infant mortality and morbidity and Medi-Cal managed care:** Low birthweights are a major contributor to infant mortality. Surviving infants born at low or very low birthweights are at increased risk for life-long and disabling health conditions. Low birthweights occur more frequently for women in Medi-Cal whose services are delivered through managed care (6.3%) instead of fee-for-service (5.2%) (cf. private insurance: 4.7%), according to the most recent DHCS data.[5] Preterm deliveries are a major cause of low birthweights. Preterm rates were similar among Medi-Cal fee-for-service beneficiaries (10.2%) and births paid by private insurance (10.0%), but more prevalent among Medi-Cal managed care beneficiaries (12.4%).[6]

All of these troubling trends underscore the urgent need for careful planning and coordination between the SB 703 BHP (sponsored by "Local Initiative" Medi-Cal managed care plans) and Medi-Cal's 200% program (which is all fee-for-service).[7]

To address our concerns, MCHA recently shared proposed amendments with the sponsor, your staff and the Administration. We look forward to continuing to work with all involved to ensure that women's health care needs are thoroughly considered and fully addressed as the SB 703 process moves forward.

Sincerely,

Lynn Kersey, MA, MPH
Executive Director

cc: The Honorable John A. Pérez, Speaker of the Assembly
Assembly Committee on Appropriations

[1] Preamble, Table 1, p. 26, and pp. 27-28 and § 435.116(a) - (c) of CMS proposed rulemaking, *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010.*

[2] S*ee* ACA § 1331(e)(1): For the BHP, an " 'eligible individual' means. . a resident of the State who is not eligible to enroll in the State's Medicaid program. . .for benefits that at a minimum consist of the essential health benefits described in section 1302(b)" of the ACA. The strict interpretation DHCS gives to pregnancy-related care under Medi-Cal's 200% program would not meet the ACA's description of "minimum essential health benefits".

Although proposed federal regulations for BHPs have not been issued yet, CMS has already stated that eligibility for at least one type of "restricted scope" Medicaid, i.e., emergency services, does not exclude an otherwise eligible person from the Exchange. *See*, Preamble, p. 61, proposed rulemaking, *[PPACA]; Exchange Functions in the Individual Market: Eligibility Determiniitons; Exchange Standards for Employers.*

[3] California Maternal Quality Care Collaborative: http://www.cmqcc.org/maternal_mortality.

[4] *The California Pregnancy-Associated Mortality Review: Report from 2002-2003 Maternal Death Reviews*, California Department of Public Health (April 2011).

[5] *Medi-Cal Births 2006*, California Department of Health Care Services, Research and Analytic Studies Section (October 2010), p. 17 (update based on 2007 data is expected from DHCS soon.)

[6] *Id.* at p. 18.

[7] CMS has also confirmed that the federal definition of pregnancy-related care for women in federal poverty level programs includes full-scope Medicaid. Preamble, pages 28-29 and § 435.116(d) of proposed rulemaking, *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010*.

Should DHCS provide all medically necessary services under Medi-Cal's 200% Program, women would no longer qualify for the BHP during pregnancy, as they would acquire "minimum essential health benefits" through Medi-Cal (see endnote 2). MCHA's concerns would accordingly narrow to seamless transitions between Medi-Cal and the BHP and continuity for both pregnancy and interconception care as a woman's eligibility shifts between the two programs.