Key Findings

Analysis of California Assembly Bill 1930
Medi-Cal: Comprehensive Perinatal Services

Summary to the 2021–2022 California State Legislature, April 16, 2022

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

SUMMARY

The version of California Assembly Bill 1930 analyzed by CHBRP would mandate that coverage for specified comprehensive perinatal services, delivered through the Comprehensive Perinatal Services Program (CPSP), for Medi-Cal beneficiaries be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill also seeks to allow unlicensed perinatal health workers (PHWs) to be reimbursed for services rendered in a nonmedical setting and change their supervision requirements.

If enacted, the law would apply to the health insurance of enrollees in Department of Managed Health Care (DMHC)-regulated Medi-Cal managed care plans, County Organized Health Systems (COHS), and the Fee-for-Service (FFS) program.

Benefit Coverage: At baseline, CHBRP estimates 57% of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans subject to AB 1930 have coverage for comprehensive perinatal services delivered through CPSP for 12 months following the end of a pregnancy. Postmandate, 100% of eligible Medi-Cal beneficiaries would have coverage of comprehensive perinatal services through CPSP for 12 months postpartum.

At baseline, CHBRP estimates 0% of eligible Medi-Cal beneficiaries have coverage of preventive CPSP services rendered by unlicensed perinatal health workers (PHWs) in the home or other community setting away from a medical site. Postmandate, 100% of eligible Medi-Cal beneficiaries would have coverage of preventive services rendered by unlicensed PHWs in the home or other community setting. AB 1930 does not exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness: CHBRP did not identify any studies that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time. There are no CPSP-specific studies comparing these time periods because CPSP does not provide services past 60 days postpartum. Given the general lack of evidence on CPSP, CHBRP mostly included studies conducted in other states that covered comprehensive perinatal services similar to those that would be covered in California if AB 1930 were enacted. These studies provided inconclusive evidence of the impact of programs in which services were delivered solely by unlicensed PHWs on breastfeeding and maternal depression and insufficient evidence of the impact of programs delivered by a combination of unlicensed PHWs and licensed health professionals

Cost and Health Impacts[1]: In 2023, CHBRP estimates AB 1930 would result in an additional 349 Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans utilizing CPSP services, with an increase of approximately 0.27% (to 82.7 per 1,000 beneficiaries) for services rendered at a medical site and an increase from 0 to 0.4 per 1,000 beneficiaries for those CPSP services rendered at a location away from a medical site. This would result in an increase of $75,000 in annual expenditures. CHBRP estimates no measurable short-term or long-term public health impact at the population level, due to existing barriers to PHW supply and lack of evidence showing the effectiveness of comprehensive perinatal services when provided more than 60 days postpartum.

CONTEXT

Perinatal care is health care for pregnant people from prenatal through postpartum. It allows practitioners an opportunity to detect, monitor, and address health conditions and behaviors that can impact pregnancy, maternal health, and newborn/infant health outcomes.[2]

Receiving timely access to prenatal care is an important factor for maternal and infant health outcomes. Although California exceeded the Healthy People 2030 national goal of at least 80.5% of pregnant people receiving early and adequate prenatal care in 2019, disparities in utilization of prenatal care in the first trimester by race/ethnicity and insurance type persist across the state. There are several barriers to postpartum utilization

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

[2] Refer to CHBRP's full report for full citations and references.

of perinatal care including, among others, access to providers, coordination of care, challenges with scheduling, and lack of incentives to prioritize postpartum visits.

California's Comprehensive Perinatal Services Program (CPSP) program is a benefit for all Medi-Cal beneficiaries who become pregnant, including those covered by Medi-Cal Managed Care Plans. CPSP services supplement the obstetric care patients typically receive in an effort to improve pregnancy and postpartum outcomes. CPSP participants are provided enhanced, wraparound perinatal services, including those related to nutrition, psychosocial needs, and health education. Services are available from the date of conception through 60 days following the end of the pregnancy.

Participation by providers is limited to those preapproved by the California Department of Public Health (CDPH) as CPSP providers. CPSP providers may contract with or employ certain health professionals to act as CPSP practitioners to deliver comprehensive perinatal services.

All CPSP services must be provided by or under the personal supervision of a physician. The state typically requires CPSP services to be delivered in a direct, face-to-face manner with the client in order to be reimbursed. Only CPSP providers who enrolled as Medi-Cal providers and in CPSP may bill for services rendered and receive reimbursements; CPSP practitioners that are employed or contract with CPSP providers to render CPSP services are not eligible for reimbursement. Hospital-based outpatient departments/clinics and non–hospital-based clinics that are CPSP providers may bill for CPSP services that are delivered off-site or outside of the clinic (e.g., a physician's office, a school auditorium, or a clinic-run mobile van). For at-home settings, CPSP providers may only be reimbursed for preventive services.

BILL SUMMARY

AB 1930 would make three changes to coverage for CPSP services. The bill would: 1) extend coverage for CPSP services from 60 days to 12 months postpartum; 2) request federal approval to cover certain services by unlicensed perinatal health workers (PHWs); and 3) change the supervision requirements of unlicensed PHWs delivering CPSP services.

AB 1930 does not change the reimbursement rates for CPSP services.

Extension of coverage

AB 1930 requires coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries to be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill specifies the comprehensive perinatal services during the extended coverage period would include additional comprehensive perinatal assessments and individualized care plans. It would also include provision of additional visits, and units of service.

The bill also requires the Department of Health Care Services (DHCS) to collaborate with the California Department of Public Health (CDPH) and a broad stakeholder group to determine the specific number of additional comprehensive perinatal services to be covered. AB 1930 specifies that additional services must be at least proportional in amount, duration, and scope to those available to participants in California's CPSP on July 27, 2021.

Unlicensed perinatal health workers: reimbursement and supervision

AB 1930 also requires the state to request federal approvals to cover preventive services rendered by an unlicensed perinatal health worker outside of a medical setting, and allow these workers to be supervised by either of the following:

- A Medi-Cal provider that is a clinic, hospital, a community-based organization, or a licensed practitioner; or
- A community-based organization (CBO) that is not a Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates at baseline, there are 69,861 users of CPSP services in Department of Managed Health Care (DMHC)-regulated Medi-Cal Managed Care Plans, and that 0% of which have coverage of preventive CPSP services rendered by unlicensed PHWs in the home or other community setting away from a medical site. CHBRP also estimates that annual utilization of CPSP services rendered at a medical site is 82.5 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care at baseline.

Utilization and Cost

Postmandate, CHBRP estimates that an additional 349 Medi-Cal beneficiaries in DMHC-regulated managed care would use CPSP services.

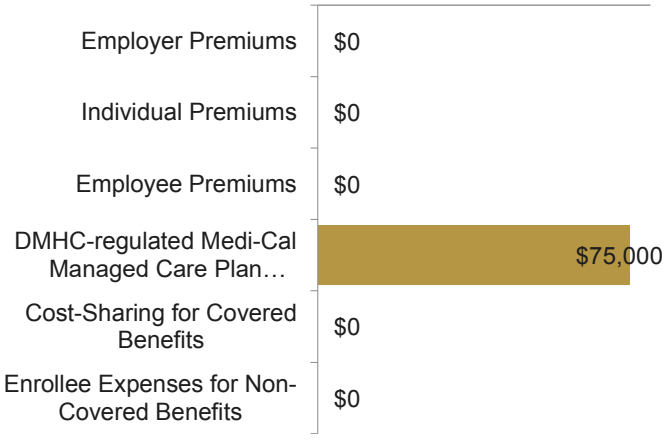
CHBRP estimates that annual utilization of CPSP services rendered at a medical site will increase by approximately 0.27% to 82.7 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care postmandate. Annual utilization of CPSP services rendered at a beneficiary's home or other community setting away from a medical site will increase from 0 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care at baseline to 0.4 per 1,000 postmandate.

Expenditures

AB 1930 would raise total net annual expenditures by $75,000 (0.0001%) due to an increase in expenditures by Medi-Cal Managed Care Plans. CPSP services do not have cost sharing for enrollees, meaning the entire increase would be a Medi-Cal expenditure and would not be borne out by enrollees.

No expected offsets are projected due to an increase in CPSP visits. There are no measurable cost offsets due to CPSP services provided by unlicensed PHWs or in a setting away from a medical site.

Figure B. Expenditure Impacts of AB 1930



Source: California Health Benefits Review Program, 2022.

Medi-Cal County Organized Health Systems and Fee-for-Service

In addition to the expected increase of $75,000 in Medi-Cal Managed Care Plan expenditures CHBRP is estimating for the approximately 8 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans, it seems reasonable to assume that a population proportional increase of approximately $16,000 would occur for the approximately 1.7 million beneficiaries enrolled in County Organized Health Systems (COHS) managed care. It seems likely that a similar impact would occur for beneficiaries with health insurance through Medi-Cal's Fee-for-Service (FFS) program (though the exact amount is unknown).

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1930.

Medical Effectiveness

CHBRP identified several studies regarding the strength of evidence of the impact of comprehensive perinatal services on birth and maternal outcomes. AB 1930 would have little impact on birth outcomes, but reporting birth outcomes remains important for two reasons. Although AB 1930 does not change that Medi-Cal beneficiaries receive coverage for CPSP services during the prenatal period, it would allow unlicensed PHWs to provide preventive services outside the medical setting if supervised by a Medi-Cal provider or a community-based organization (CBO) that is not a Medi-Cal provider under certain conditions (see *Policy Context* section) during the prenatal and postpartum period. Additionally, CHBRP reports on birth outcomes because part of the original intent of the CPSP program was to improve birth outcomes.

Overall, there is a lack of evidence on the efficacy of CPSP specifically. CHBRP identified two older studies of CPSP and included them in this analysis. Given the lack of evidence on CPSP, CHBRP mostly included studies that covered comprehensive perinatal services similar to those that would be provided in California's CPSP if AB 1930 were enacted.

CHBRP did not identify any studies that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time. CHBRP identified some studies that compared the provision of comprehensive perinatal services in medical versus nonmedical settings, and these studies were primarily focused on home visiting programs. However, these home-visiting studies did not control for additional perinatal services that may have been received outside of the studied intervention. CHBRP did not identify any studies that compared the provision of comprehensive perinatal services in medical

to nonmedical settings where the nonmedical setting was a location other than a home.

Regarding birth outcomes, CHBRP found there is:

- Insufficient evidence[3] that enrollment in CPSP or the pilot project reduces risk of low birth weight (LBW).
- Insufficient evidence that comprehensive perinatal services reduce risk of newborn intensive care unit admission.
- Limited evidence[4] that comprehensive perinatal services delivered solely by unlicensed PHWs reduce risk of LBW; insufficient evidence that they reduce risk of very low birth weight or extremely low birth weight; and inconclusive evidence[5] that they reduce risk of preterm birth.
- A preponderance of evidence[6] that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals reduce risk of LBW; insufficient evidence that they reduce risk of being small for gestational age or infant mortality; and limited evidence that they reduce risk of preterm birth.

Regarding maternal outcomes, CHBRP found there is:

- Inconclusive evidence that comprehensive perinatal services increase breastfeeding initiation; limited evidence that they do not increase breastfeeding duration; and insufficient evidence that they increase breastfeeding exclusivity and self-efficacy.

- Inconclusive evidence that comprehensive perinatal services delivered solely by unlicensed PHWs decrease the occurrence of postpartum depression or depressive symptoms after childbirth; insufficient evidence that they improve psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

- Insufficient evidence that comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs decrease the occurrence of postpartum depression or depressive symptoms after childbirth, or improve psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

Public Health

CHBRP concludes that passage of AB 1930 would have no measurable short-term or long-term public health impact at the population-level, due to existing barriers to PHW supply and lack of evidence showing the effectiveness of comprehensive perinatal services when provided more than 60 days postpartum. It is important to note that the absence of evidence is not "evidence of no effect." It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

At the individual level, evidence of effectiveness indicates that some Medi-Cal beneficiaries who would use CPSP services postmandate, particularly home visiting interventions when delivered by a combination of unlicensed PHWs plus licensed professionals, may see improved birth outcomes, including reduced risk of low birth weight and preterm birth, and increased breastfeeding duration. However, CHBRP is unable to estimate a specific number.

For these reasons, CHBRP also concludes that AB 1930 would have no measurable impact on disparities or social determinants of health for birth and maternal health outcomes.

Long-Term Impacts

Given the insufficient and inconclusive evidence on CPSP or CPSP-like services on maternal health outcomes, CHBRP is unable to determine the potential long-term utilization of CPSP services and long-term cost impacts.

Essential Health Benefits and the Affordable Care Act

AB 1930 would not result in new benefit coverage that exceeds the definition of essential health benefits (EHBs) in California. Benefit coverage of Medi-Cal beneficiaries is not subject to the same set of EHBs as the benefit coverage of enrollees in nongrandfathered small-group and individual market plans and policies.

[3] *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.
[4] *Limited evidence* indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.
[5] *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.
[6] *Preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.