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Provider-Based Enrollment and the ACA: Pregnancy-Related Care, Family Planning Services, Children's Health Services, and More

California currently maximizes the opportunity to make medical care available to eligible low-income individuals and draw down federal matching funds to cover treatment through several "provider-based" enrollment programs under Medi-Cal or Healthy Families. These include the:

- Presumptive Eligibility (PE) Program for Pregnant Women;
- Family Planning, Access, Care and Treatment (Family PACT) Program;
- Breast and Cervical Cancer Treatment Program (BCCTP); and
- Child Health and Disability Prevention (CHDP) Gateway Program.

The Patient Protection and Affordable Care Act (ACA) did not change the federal PE rules underpinning these programs. Moreover, for states with PE programs for pregnant women or children, the ACA extends the temporary, PE option under Medicaid and the Children's Health Insurance Program (CHIP) to adults who qualify for either Section 1931(b) Medicaid or the new Medicaid expansion category.[1] The ACA has also created a new PE program for patients of any age receiving services at a hospital.[2]

PE provides important opportunities for California to continue the aspects of these provider-based enrollment programs that are working well, make improvements where needed, and apply successful approaches to new groups where appropriate.

Medi-Cal PE for Pregnant Women and Creating an Electronic Prenatal Gateway

California has long had a simple, effective process for pregnant women to enroll temporarily into Medi-Cal from a provider's office through the PE for Pregnant Women Program. Several aspects, however, have undercut the program's potential to better serve women and providers:

- No electronic record is created of the woman's temporary PE enrollment. This impedes access to services from providers that do not issue PE themselves, such as specialists, labs and pharmacies. Pharmacy services in particular are difficult for women with PE to access because this sector relies heavily on e-billing.

- A separate follow up application is required for the woman's coverage to continue more than 62 days at most. This results in inefficient eligibility "churning" and can also disrupt continuity and delay or even end access to pregnancy-related care.

- Some women need to complete the follow up application process in order for their prenatal providers to be reimbursed retroactively for services received during PE but that are excluded from this PE program's scope of coverage.

Recent developments in Medi-Cal policy, however, demonstrate that these shortcomings can be effectively addressed, in the immediate short run as well as in the longer term when the CalHEERS[3] system is implemented for enrollments into Medi-Cal, the Access for Infants and Mothers (AIM) program, Healthy Families and the Exchange. Approaches to consider for both the short and the long term set forth for discussion at the end of this memo.

Background and Recent Developments on PE for Pregnant Women

Medi-Cal's PE for Pregnant Women Program provides a very simple way for a pregnant women to immediately enroll into temporary Medi-Cal from a prenatal provider's office when gross income is at or below 200% of poverty.

Coverage extends only to ambulatory prenatal services; labor, delivery, and post-partum services are excluded. Any ambulatory service the Department of Health Care Services (DHCS) considers not to be pregnancy-related is also excluded. Even some ambulatory prenatal services that are included in Medi-Cal's 200% Program for Pregnant Women are excluded from PE.[4] In 2008, certain lab services were added to PE, as was coverage for emergency care provided in an ambulatory outpatient hospital clinic; these additions are especially important for women who miscarry. The remaining differences in scope of coverage between PE and Medi-Cal continue to be a concern. The best way to address them would be for DHCS to clarify that all ambulatory prenatal care covered by Medi-Cal is covered by PE. Either way, there is a pressing need to facilitate and expedite the process for individual women with PE to enroll in retroactive or on-going coverage or both when necessary to meet their needs.

To be reimbursed under PE, prenatal providers must generally be certified as both Medi-Cal providers and PE providers. The certification requirements help to ensure oversight and control of the PE program by DHCS.

Participating PE providers screen the woman using a short, paper form (MC 263 PREMED 1) that collects information about family income and size. The woman must also certify that she is a California resident. Providers are required to give the woman a PE Patient Fact Sheet (MC 264), to inform her of how the program works and what she must do to have coverage continue beyond the temporary PE period.

If the provider finds that the woman's information does not show eligibility, PE is denied and the provider gives the woman a denial form. No hearing to challenge the denial of PE is permitted, as the PE screen is not treated as a denial of eligibility for the Medi-Cal program itself.

Most women, however, do meet the screening requirements; and providers are authorized by DHCS to grant such women PE at the time of their visits. The provider issues the woman a paper PE enrollment card, pre-stamped by DHCS with a unique number that matches the unique

number of her PE screening form. The provider writes in the "good thru" date, indicating that the PE will last only until the end of the month following the month it was granted.

The PE screening forms and cards are all prepared in bulk by DHCS and issued directly to-- and only to-- participating PE providers. Providers are required to account to DHCS for each of the PE cards they issue.

When granting PE, the provider is also expected to give the woman a follow-up Medi-Cal application form that is unique to women who start receiving Medi-Cal through PE, i.e., the MC 263 PREMED-2 (Revised 09/2011).[5] No other Medi-Cal application form is required of the woman, although other application forms are permitted and are used more often by women with PE. If the PREMED-2 (or any other Medi-Cal application form) is completed and submitted, the woman's PE legally continues until the county makes a final eligibility determination. However, only the issuing PE provider may extend the "good thru" date on the woman's PE card, and extensions are only in increments of 60 days.[6] This is an administrative burden for the provider. In addition, requiring a pregnant women to seek repeat extensions of her PE to avoid losing health insurance may contribute to stress, a known risk factor in pregnancy, as well as interfere with access to care when the woman needs medical services from a provider other than the one who issued her PE.

Even women who do not wish or need the on-going Medi-Cal may very much need retroactive coverage to pay for services that the PE scope of benefits does not include; a follow-up Medi-Cal application is necessary for retroactive benefits as well.

If no Medi-Cal application is submitted by the end of the month after the month in which a woman's PE was granted, her PE ends. Many women find it difficult to complete the Medi-Cal application on their own and so their PE ends automatically.

Until very recently, the special Medi-Cal application form for women with PE (MC 263 PREMED 2) was apparently below the radar of many PE providers. In addition, women who did receive the form had to deliver it to the county. In 2012, DHCS took an action that has both increased the form's profile and enhanced its utility: DHCS now permits providers to fax the completed form to a number dedicated for this purpose in each county.[7] All 58 fax numbers are now listed in the materials that each PE provider receives.[8]

DHCS' new approach is consistent with the findings of the SB 24 Prenatal Gateway stakeholders.[9] Prenatal providers, the counties, consumer advocates and DHCS staff concurred in 2008 that supplementing the PE form with a few additional questions would be manageable in busy medical practices and county Medi-Cal offices and a good investment in terms of preventing pregnant patients from losing coverage. However, the following concerns with the new fax-in application process remain to be addressed:

- The PE Patient Fact Sheets (MC 264) have apparently not been updated yet to reflect the new provider fax-in option. Women should be given this information so that they can work with their providers to ensure on-going access and continuity of care.

- The Provider Fact Sheet for PE (MC 286) should instruct providers that once a patient's completed MC 263 PREMED-2 is faxed to the county, the provider is to note on the woman's PE card that her "good thru" date lasts "until the final Medi-Cal eligibility determination by the county is complete."

- The new flowchart for providers[10] should also be updated to reflect the new fax-in application process.

- The MC 263 PREMED-2 form itself should be updated with a question to flag whether the woman needs retroactive Medi-Cal to cover services that her PE did not. Other recommendations of the SB 24 stakeholder group concerning the questions to be asked might also make this form more useful.

- A long-promised All County Letter on the latest developments in PE for pregnant women has yet to be shared in draft for public comment. Informing county staff and the public is essential to the success of this promising new approach.

- DHCS should also clarify that all ambulatory prenatal care covered by Medi-Cal is covered by PE.

Looking Forward

- **Low-tech can be good tech until better options are implemented:** With the necessary refinements noted above, the new fax-in process can be an effective way to ensure that pregnant women with PE do not lose coverage or miss out on the retroactive Medi-Cal benefits they may need until other solutions using appropriate technologies are in place.

- **Prenatal Gateway:** The recent policy improvement permitting providers to fax in the simple Medi-Cal application form also establishes the foundation for an *electronic* Prenatal Gateway. Providers would submit the information requested on the paper PE form on-line instead; women would be given a print out confirming that their PE continues until final eligibility has been determined by the county; labs, specialists and any other providers not involved with the issuance of the woman's PE would be able to confirm, on-line, that she has PE; and pharmacists and other providers who depend heavily on electronic billing would be able to do so for women with PE. Such measures would improve women's access to pregnancy-related care, including medications and other pharmacy benefits. The mother's enrollment in Medi-Cal also sets up "deemed eligibility" for her newborn's Medi-Cal eligibility as of the date of birth and continuously for the first year, another important goal.

    - Serious consideration should be given to building a Prenatal Gateway using the data elements of the MC 263 PREMED-2 form and/or the elements approved by DHCS through the SB 24 stakeholder process. The CalHEERS solicitation kept such a possibility open. Enrollment into the Access for Infants and Mothers (AIM) program should be included as well.

    - Busy prenatal providers may not be in a position to help their patients complete and submit the CalHEERS application form that will be used more generally for

enrollment into public health coverage programs, including the Exchange. Moreover, referrals to navigators may not always be available, and an individual woman may not have Internet access or otherwise be able to complete the CalHEERS application on her own at home.

- While California has achieved much in terms of enrolling women in Medi-Cal during pregnancy, improvement is still needed on *early* enrollment into prenatal care, which lowers the risk of adverse birth outcomes. Nearly one in five California women still do not enter care early, i.e., in the first trimester.[11]

- Also of concern are the racial disparities in maternal and newborn mortality rates. African-American women in California are roughly four times as likely to die from pregnancy-related causes than all other racial/ethnic groups.[12] And African American babies still die at more than twice the rate of white babies in the state.[13] While improving early and continuous coverage and access to prenatal care alone will not reverse these trends, progress will be harder without doing so.

- Thus, PE for Pregnant Women through provider-based enrollments will continue to be essential for pregnancy-related care and to continue efforts to promote early entry into prenatal care even after CalHEERS comes on-line.

- **Family PACT and the Breast and Cervical Cancer Treatment Program:** The highly cost-effective Family PACT program with its provider-based enrollment process will continue to be necessary for women with income at or below 200% of poverty needing confidential access to reproductive health services as well as for the many other low-income individuals, especially young women and men, who may risk penalties instead of enrolling in Medi-Cal or purchasing health insurance through the Exchange (*see,* attached information sheet). Similar considerations apply to provider-based enrollments through the Breast and Cervical Cancer Treatment Program (BCCTP) for uninsured women and men at or below 200% of poverty who lack other affordable options for coverage. Where affordable coverage options do exist or emerge, these programs also provide opportunities for "in-reach", like PE for Pregnant Women does, to connect eligible individuals to coverage.

- **Potential for improving the CHDP Gateway:** The approaches discussed in this memo for promoting early and on-going enrollment for pregnant women who need and choose it could also apply to improving the CHDP Gateway for families who wish to have their children evaluated for on-going coverage. This is because the eligibility criteria for children and pregnant women are nearly identical, and the data elements needed for a short application to prevent PE from ending are similar for both groups. In addition, both groups share the characteristic of being "assembled" audiences for cost-effective "in-reach" for health care enrollments. And both are among the most in need of timely, continuous access to care.

    - The CHDP Gateway is also important because it automatically enrolls into Medi-Cal uninsured infants under the age of one year whose mothers had Medi-Cal for the delivery when the infant has a CHDP visit any time during the first year. Such

uninsured infants are "deemed eligible" (DE) by law to Medi-Cal *without an application*.[14] The infant's Medi-Cal number is issued the same day of the CHDP visit, is retroactive to the date of birth, and remains active at least until the end of the month in which the first birthday occurs, regardless of whether other family members drop off for failure to submit annual renewal forms or other reasons.[15] Approximately 71,000 infants are enrolled through the CHDP Gateway each year.[16] With improved renewal procedures under the ACA, DE infants are likely to retain coverage beyond the first year with minimal additional administrative burden to families or the county.

- Even more DE infants each year would be enrolled through the CHDP Gateway if the ability of the Medi-Cal Eligibility Data System to match mothers who had Medi-Cal to their infants were improved. ACA IT funds could be used for such improvements.

- The infants of AIM mothers could also be added for enrollment, as these infants are deemed eligible to Healthy Families. While the numbers are small, with AIM's current caseload at about 7,000 women[17] and highest past caseloads at about 25,000, any AIM-linked infant who comes through the CHDP Gateway uninsured should be identified and enrolled in Healthy Families without an application.

- **Newborn Hospital Gateway:** Approximately 230,000 newborns are deemed eligible to Medi-Cal each year.[18] All hospitals should have the option of using an on-line system, like the DE infants path in the CHDP Gateway, to enroll DE newborns into Medi-Cal *without an application* before the family leaves the hospital *(see,* AB 1296, § 1, adding Welfare and Institutions Code § 15925(b)(3)(C)). AIM-linked infants should also be enrolled into Healthy Families through the Newborn Hospital Gateway. The Newborn Hospital Gateway should be available to hospitals regardless of whether a hospital opts to complete the full CalHEERS application on-site for patients.

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- **Identifying DE infants through CalHEERS:** In addition to the Newborn Hospital Gateway, the new ACA application used by CalHEERS, in both its paper and digital versions, should solicit the information needed to identify DE infants: i.e., whether the mothers of child applicants under age one year had either Medi-Cal or AIM for the delivery. If the answer is yes, then the family should be asked to provide, at its option, the mother's Medi-Cal, AIM or Social Security Number. Infants identified as DE must be granted eligibility without the family being required to provide any additional information as to the infant and without regard to whether other family members complete the application process. As has been successfully done in the CHDP Gateway, a special pathway for DE infants should be included in the electronic version of CalHEERS.

- **The need for a new program of provider-based enrollments for adults:** Federal guidance has not been issued yet on the new state option to grant PE to adults in states that provide PE to pregnant women or children.[19]

  - Serious consideration should be given to exercising the new option to include adults. This is especially important in view of the fact that, while individuals are entitled to a "point in time" income eligibility determination for Medi-Cal, CalHEERS' income

verifications will rely on tax and wage databases containing information that will be months or even over a year old. An applicant's income may have dropped considerably since the most recent tax or wage database was updated. To prevent real-time eligibility *denials of eligible applicants* based on out-of-date databases, this issue will need to be addressed as part of the CalHEERS real-time eligibility verification process. Individuals screened eligible to the Exchange whose income as reported on the application does not check out against the databases in real-time will have up to 90 days to resolve discrepancies. Individuals screened eligible to Medi-Cal or Healthy Families deserve similar protection from premature eligibility denials.

- In the meantime, provider-based PE can bridge some of the gap. This approach serves the dual purpose of promoting timely access to medical care, compensating providers for services rendered, and helping the individual initiate the application process for on-going coverage when needed and desired. As with PE for Pregnant Women, the CHDP Gateway and Family PACT, operating the program through providers facilitates a high level of state oversight and monitoring.

- **Hospital enrollments for all children and adults:** As noted, the ACA provides for a new hospital PE category for patients of all ages. This option merits serious consideration. Federal guidance on implementation seems particularly important here, however, as some commentators have described the option as being available to hospitals regardless of whether the state Medicaid agency adopts it. Another interpretation, however, is that the hospital PE option is available to the state without regard to whether the state provides PE for children and pregnant women or the new ACA PE option for adults.[20]

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[1] ACA § 2001(a)(4)(B), adding subdivision (e) to 42 U.S.C. § 1396r-1.
[2] ACA § 2202(a)(3), adding paragraph (B) to 42 U.S.C. § 1396a(a)(47).
[3] California Health Eligibility, Enrollment and Retention System.
[4] *See, e.g.,* All County Welfare Directors Letter, No. 94-03, *Medi-Cal Services Not Covered Under Presumptive Eligibility (PE).*
[5] Because each form contains a unique identifier linked to the woman's PE number, this form is not available on-line at the DHCS forms page.
[6] *See, e.g.,* PDF p. 3 at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Provider%20Enrollment%20Information%20Package.pdf.
[7] http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_currentQP.aspx and http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Provider%20Enrollment%20Information%20Package.pdf.
[8] http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/County%20Fax%20Numbers.pdf.
[9] *Prenatal Gateway Analysis: Implementation Solutions for SB 24* (DHCS and Harbage Consulting, March 2008).
[10] PDF p. 5 at *id.*
[11] California Department of Public Health, Center for Health Statistics, Vital Statistics Section, CD-Rom Public Use Birth Files and Vital Statistics Query System.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. (2011). *Pediatric and Pregnancy Nutrition Surveillance System: PNSS health indicators.* http://www.cdc.gov/pednss/what_is/pnss_health_indicators.htm.

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

[13] http://www.cdph.ca.gov/data/statistics/Documents/MO-MCAH-StatewideInfantMortalityData.pdf.

[14] Deemed eligible infants can also be enrolled into Medi-Cal without an application by a phone call, letter, fax or submission of a Newborn Referral Form (MC 330). AIM-linked infants can be enrolled with the Healthy Families Infant Registration form; however, the Managed Risk Medical Insurance Board (MRMIB) does not permit enrollment of AIM-linked infants through the CHDP Gateway.

[15] The many ways that infants benefit from being identified as DE are described in recently updated local rules for Los Angeles County, which has now fully automated DE in its LEADER computer system for eligibility determinations and renewals. *See,* Administrative Directive Supp: 1 *Automation of Deemed Eligibility*. Los Angeles also facilitates Medi-Cal enrollments for extremely vulnerable DE infants whose mothers were covered through the Medi-Cal Inmate Eligibility Program. *Id.*

[16] 2008 data from DHCS.

[17] http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041912/Agenda_Item_13.a._AIM_Mar_2012_summary.pdf.

[18] *Medi-Cal Funded Births, Calendar Year 2006* (DHCS 2010)).

[19] ACA § 2001(a)(4)(B), adding subdivision (e) to 42 U.S.C. § 1396r-1.

[20] *See,* ACA § 2202(a)(3), adding paragraph (B) to 42 U.S.C. § 1396a(a)(47).