Medi-Cal Explained: Maternity Care

Author: Melora Simon

Introduction

Almost 500,000 babies are born every year in California — and the state’s Medicaid program, Medi-Cal, plays an outsized role in covering those births. When people become pregnant, the thresholds for Medi-Cal eligibility change, so that people at higher incomes or without verification of immigration status may qualify for coverage. As a result, although Medi-Cal covers one in three Californians, it pays for nearly one in two of the state’s births. Still, from a cost perspective, maternity care is a relatively small piece of all that Medi-Cal covers. An estimate using median spending per live birth — about $7,000 — multiplied by the number of live births covered by Medi-Cal suggests that pregnant people make up 1.4% of Medi-Cal enrollees and account for 1.8% of spending. Note that this is an undercount, as it does not include spending on prenatal and postpartum care.

By comparison, median spending per year per enrollee for childless adults is $4,700 and for people with disabilities about $19,600.

Whose Maternity Care Does Medi-Cal Cover?

Compared to pregnant people covered by private insurers, those covered by Medi-Cal are younger and more diverse in race and ethnicity. More than 84% of births covered by Medi-Cal are to people of color, compared to 60% of births covered by commercial insurance, as illustrated in Figure 1. Pregnant people with Medi-Cal coverage are also more likely to have or develop comorbidities that

Figure 1. Births by Mother’s Race/Ethnicity and Payer Type, California, 2018

Note: Latinx origin is determined first and includes any race group. Unknown and other races are not shown. Source uses Hispanic or Latino and Black or African American.


The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

For more information, visit www.chcf.org.
(2) persons with incomes that are 139% to 213% of the federal poverty level (FPL), which in 2020 is an income of $17,609 to $27,179 for a household of one person.

In addition to being FFS, this special Medi-Cal coverage differs from standard Medi-Cal coverage in two ways. First, the coverage ends 60 days after giving birth, at which point people revert back to their prepregnancy eligibility status. This may mean they are no longer eligible for Medi-Cal coverage, though their baby will continue to be covered automatically through the first year of life. Second, for persons without verification of satisfactory immigration status, the coverage is limited to pregnancy-related services and referred to as

complicate pregnancy, such as elevated body mass index (BMI), diabetes, preeclampsia, and depression, as illustrated in Figures 2.1 and 2.2.

### How Are Maternity Services Covered in Medi-Cal?

Like many other states, California has largely embraced managed care, with more than 80% of people covered by Medi-Cal now enrolled in a managed care plan. However, 40% of births paid for by Medi-Cal are still covered by the fee-for-service (FFS) system. The majority of FFS births are to two groups of people newly eligible for Medi-Cal on the basis of their pregnancy: (1) persons without verification of satisfactory immigration status and

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced maternal age</td>
<td></td>
</tr>
<tr>
<td>15.9%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Pregnancy risk factors</td>
<td></td>
</tr>
<tr>
<td>29.5%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Maternal tobacco use</td>
<td></td>
</tr>
<tr>
<td>2.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Prenatal depressive symptoms</td>
<td></td>
</tr>
<tr>
<td>10.6%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Postpartum depressive symptoms</td>
<td></td>
</tr>
<tr>
<td>14.2%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medi-Cal</th>
<th>Non-Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepregnancy elevated BMI</td>
<td></td>
</tr>
<tr>
<td>62.6%</td>
<td>49.0%</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td></td>
</tr>
<tr>
<td>6.1%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td></td>
</tr>
<tr>
<td>1.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>4.7%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Note: Pregnancy risk factors include prepregnancy and gestational diabetes and hypertension, eclampsia, previous preterm birth, infertility treatment and/or fertility-enhancing drugs or assistive reproductive technology, and previous cesarean delivery.


(2) persons with incomes that are 139% to 213% of the federal poverty level (FPL), which in 2020 is an income of $17,609 to $27,179 for a household of one person.
Specialty care and interventions (e.g., a glucometer for gestational diabetes, fetal well-being testing, prescription drugs, perinatal substance use disorder services) are covered when medically necessary. Some interventions, such as a blood pressure monitor for home use, generally require prior authorization by the California Department of Health Care Services (DHCS) or the plan.

Psychological care: Up to a total of 20 individual and/or group counseling sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth.

In addition, the following education and support services are offered by qualified providers through the Comprehensive Perinatal Services Program (CPSP):

- Health education services
- Nutritional services, including vitamin/mineral supplementation, and breastfeeding education and support
- Psychosocial services

What Maternity Services Does Medi-Cal Cover?

All pregnant enrollees are eligible for medically necessary covered services, regardless of whether their care is administered by FFS or a managed care plan.

Examples of services covered:

- Obstetric care in an office, clinic, hospital outpatient setting, or alternative birthing center:
  - Prenatal: Up to 13 visits across all primary obstetrical providers per pregnancy in a nine-month period
  - Delivery: Vaginal and c-section delivery
  - Postpartum care: One visit in a six-month period unless the individual has a medical or mental health postpartum complication or is at risk for a postpartum complication
- Diagnostic testing: Pregnancy determination, obstetric panel, depression screening, and genetic testing as part of the California Prenatal Screening Program; ultrasounds provided outside of those for routine prenatal care (e.g., nuchal translucency, advanced maternal age).
- Specialty care and interventions (e.g., a glucometer for gestational diabetes, fetal well-being testing, prescription drugs, perinatal substance use disorder services) are covered when medically necessary. Some interventions, such as a blood pressure monitor for home use, generally require prior authorization by the California Department of Health Care Services (DHCS) or the plan.

Where Are Medi-Cal Maternity Services Delivered?

Prenatal and Postpartum Care Services

Limited information is publicly available on the provision of prenatal and postpartum care for pregnant Californians with low incomes. In 2018, prenatal care for approximately one-third of Medi-Cal deliveries was provided by Federally
Who Provides Medi-Cal Maternity Services?

Within Medi-Cal, physicians provide the majority of prenatal and postpartum services, as well as deliveries. However, births attended by midwives, who deliver babies both in and out of hospitals, have grown across payer types by 52% since 2007. In 2018, midwives attended 6.8% of Medi-Cal births and 16% of privately insured births in California.\(^{17}\)

In California, midwives can practice under two different professions, certified nurse-midwives (CNMs) or licensed midwives.\(^ {18}\) In 2019, there were 753 CNMs and 386 licensed midwives in California.\(^ {19}\)

Despite reimbursement parity mandated by the Affordable Care Act, access to midwives remains a challenge.\(^ {20}\) This is due to many factors, including scope-of-practice laws that require physician supervision for CNMs.\(^ {21}\)

Deliveries

As with non-Medi-Cal births, almost all (99.6%) births to people covered by Medi-Cal take place in hospitals.\(^ {13}\) But these births are not distributed equally across hospitals as illustrated in Figure 3. Nearly 75% of births covered by Medi-Cal happen at one-fourth of California’s hospitals that offer labor and delivery — about 150,000 births annually at 80 California hospitals.\(^ {14}\)

Freestanding birth centers provide care for low-risk patients and typically use a midwifery model of care. Deliveries in these centers have nearly quadrupled since 2007, but still comprise only 0.14% of Medi-Cal births.\(^ {15}\) Demand for birth center services outstrips supply. Although managed care plans and Medi-Cal FFS are required to contract with freestanding birth centers, many freestanding birth centers do not accept Medi-Cal patients, citing the lower reimbursement rates they receive compared to commercially insured patients. In addition, it is not clear that there is active oversight of this requirement or a penalty for plans that fail to offer a freestanding birth center in their network.\(^ {16}\)

Figure 3. Births, Medi-Cal vs. Non-Medi-Cal, by Hospital Type, California, 2017

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Medi-Cal</th>
<th>Non-Medi-Cal</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of California</td>
<td>10%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>8%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Investor</td>
<td>5%</td>
<td>29%</td>
<td>13%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>59%</td>
<td>50%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Notes: In-hospital births at 237 hospitals that offer maternity services. Nonprofit hospitals include church-related hospitals. Investor hospitals are for-profit. Kaiser Permanente hospitals are nonprofit. Non-Medi-Cal includes uninsured patients. Segments may not total 100% due to rounding.

Source: Custom data request, California Maternal Quality Care Collaborative, received June 14, 2019.
Community Perinatal Health Workers are also important members of the care team, though they cannot bill directly. They include doulas, childbirth educators, and lactation consultants. Women covered by Medi-Cal are slightly more likely to report using a doula than those with commercial insurance.23

Like birth centers, demand also exceeds supply for midwives and doulas, as depicted in Figure 4, and these gaps are more pronounced than among people with private coverage (not pictured) due to a greater interest among people with Medi-Cal coverage and more limited access.24

Figure 4. Gap Between Actual Use and Future Interest Among Medi-Cal Recipients: Birth Centers, Midwives, and Doulas, California, 2016

<table>
<thead>
<tr>
<th></th>
<th>Actually use</th>
<th>Definitely want</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1%</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>1%</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Based on a statewide survey of 2,539 women who gave birth in California hospitals in 2016. Medi-Cal respondents were identified based on a Medi-Cal record of a paid 2016 childbirth claim.

Source: Carol Sakala et al., Listening to Mothers in California: A Population-Based Survey of Women’s Childbearing Experiences, National Partnership for Women & Families, September 2018. California Department of Health Care Services, MIS/DSS Data Warehouse.

How Does Medi-Cal Pay for Maternity Services?

Fee-for-Service

Under the fee-for-service system, providers are paid directly by DHCS using the methodologies described below.

For nearly all maternity care services, Medi-Cal reimbursement rates are significantly lower than commercial reimbursement rates. These reimbursement disparities also exist in other types of care, both primary care and specialties such as oncology and orthopedics, but maternity providers see a much larger portion of Medi-Cal patients than do providers in most other specialties.25

Historically, Medi-Cal FFS rates are among the lowest in state Medicaid programs nationally.26 However, DHCS provides supplemental payments to certain providers. For maternity services, FQHCs and hospitals that serve Medi-Cal and uninsured patients are each eligible for specific types of supplemental payments, which can provide a substantial revenue stream.

Professional Reimbursement Under FFS

Routine, uncomplicated obstetric care is reimbursed in three ways:

1. **Globally, for providers who render total obstetric care, which includes prenatal care, delivery, and postpartum care.** Payment is triggered by the baby’s delivery and is all-inclusive for the obstetrician (e.g., routine urinalysis and ultrasounds are included and cannot be billed separately). This approach simplifies billing and can enable a team-based collaborative practice between physician and nonphysician providers. Global billing is more often used by private practice providers and is not typically used by FQHCs.

2. **Per visit, for providers who do not render total obstetric care or who provide fewer than 13 prenatal visits.** Providers receive a higher payment for the initial prenatal visit and a lower payment rate for follow-up visits (up to 13) and one postpartum visit. Per-visit billing

For details on how Medi-Cal pays for maternity services, please see companion paper Medi-Cal Explained: Paying for Maternity Services available for download on CHCF’s website.
can result in a higher reimbursement per episode than global billing.

3. Based on face-to-face time spent for Comprehensive Perinatal Services Program (CPSP) services, which are additional to obstetric care services described above, with bonuses for early initiation of care. To be eligible, providers must enroll as a CPSP provider. FQHCs are reimbursed at their Prospective Payment System (PPS) rate for CPSP services rather than according to the CPSP fee schedule.

Other care, including mental health services and specialty care, are provided on a fee-for-service basis.

Facility Reimbursement Under FFS

Hospitals are paid through a facility-specific case rate that is adjusted based on the reason for admission, severity of illness, and risk of mortality. This payment system, All Patient Refined Diagnosis Related Groups (APR-DRGs), builds on a similar system used in Medicare that was introduced in 1983, but was developed with Medicaid populations in mind. In California, DHCS implemented APR-DRGs in 2013.

Freestanding birth centers are paid a flat rate for deliveries that is about 35% of the average APR-DRG rate for low-risk vaginal births. If the patient needs to be transferred to a hospital, the birth center gets 25% to 75% of the rate, depending on when the transfer occurs.

How DHCS Pays Managed Care Plans

Plans typically receive a monthly capitation amount for every individual enrolled based on their aid code. Importantly, specialty mental health and substance use disorder services are delivered by an enrollee’s county, distributing accountability and adding complexity to care coordination for a higher-risk group of pregnancies.

For counties with a single managed care plan, maternity spending is factored into monthly capitation rates paid by DHCS. For counties with more than one plan, maternity services are treated differently because births are high-cost events and may not be evenly distributed between plans in a given year. As a result, plans receive a supplemental payment for every live birth, designed to cover the physician and facility spending for the birth episode.

How Managed Care Plans Pay Providers

In interviews with seven Medi-Cal managed care organizations conducted in fall 2019, many said they use the FFS schedule in determining payment, while others said they may pay 10% to 30% more than FFS rates. Contracts vary by provider and are often proprietary and confidential.

In addition, some plans rely heavily on value-based payment mechanisms, such as global or professional services capitation to delegated medical groups. These risk-bearing groups use a combination of capitation and fee-for-service to pay their contracted providers and, like managed care plans, vary in their rates and approaches, which are proprietary and confidential. Some stakeholders raised concerns about access to CPSP services in managed care and the delegated environment, and there is very little publicly available data about use of the program.

What Experience and Outcomes Does Medi-Cal Produce?

Overall, compared to people covered by private insurance, those covered by Medi-Cal are much less likely to access early prenatal care or robust postpartum care, as illustrated in Figures 5 and 6 on page 7.

People covered by Medi-Cal were much more likely to report feeling that they were treated unfairly in the hospital because of the type of insurance they had, as shown in Figure 7 on page 7.

In terms of birth outcomes, mothers covered by Medi-Cal are slightly more likely to deliver via c-section and to deliver babies with more complex needs.

Like many in the general health care system, Medi-Cal members face challenges of timely access to care, bias and racism in the health care delivery system, and food and housing insecurity.
These factors result in heightened health risks, poorer outcomes, and poorer patient experiences for pregnant people, and notably for Black pregnant people, as seen in Figure 8 on page 8. These disparities cannot be fully explained by patient-level factors such as age, income, education level, insurance status, cesarean birth, or higher prevalence of comorbidities. Instead, the evidence points to multiple factors at different levels, including health system quality and the impact of racism and chronic stress during pregnancy, including that coming from the health system and the individual provider.

In summary, California is a large state, home to one-eighth of the births that happen in the US annually. It is varied in both its geography and the racial and
In 2019, Medi-Cal introduced enhanced reimbursement for prenatal screening for depression. Postpartum depression screening is also allowed as part of a well-child visit to be billed under the infant’s coverage throughout the first year of life. In addition, up to 20 individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic, and mental health–related risk factors are now covered. Finally, Senate Bill 104 (Chapter 67, Statutes of 2019) authorized the extension of “pregnancy pathway” Medi-Cal coverage by 10 additional months beyond the 60-day postpartum period for individuals who have been diagnosed with a maternal mental health condition. This new coverage was implemented August 1, 2020. However, unless further legislative action is taken, the program may be suspended on December 31, 2021.

### Whole Child Model
As of July 2019, five plans covering 21 counties operate under the Whole Child Model. This model integrates coordination and financing for all required newborn care and the care of children born with special needs. While it is too soon to assess the impact of these new policies, they represent progress, and it is important to track their outcomes.

**Maternal mental health**: In 2019, Medi-Cal introduced enhanced reimbursement for prenatal screening for depression. Postpartum depression screening is also allowed as part of a well-child visit to be billed under the infant’s coverage throughout the first year of life. In addition, up to 20 individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic, and mental health–related risk factors are now covered. Finally, Senate Bill 104 (Chapter 67, Statutes of 2019) authorized the extension of “pregnancy pathway” Medi-Cal coverage by 10 additional months beyond the 60-day postpartum period for individuals who have been diagnosed with a maternal mental health condition. This new coverage was implemented August 1, 2020. However, unless further legislative action is taken, the program may be suspended on December 31, 2021.

**Whole Child Model**: As of July 2019, five plans covering 21 counties operate under the Whole Child Model. This model integrates coordination and financing for all required newborn care and the care of children born with special needs. While it is too soon to assess the impact of these new policies, they represent progress, and it is important to track their outcomes.

- **Maternal mental health**: In 2019, Medi-Cal introduced enhanced reimbursement for prenatal screening for depression. Postpartum depression screening is also allowed as part of a well-child visit to be billed under the infant’s coverage throughout the first year of life. In addition, up to 20 individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic, and mental health–related risk factors are now covered. Finally, Senate Bill 104 (Chapter 67, Statutes of 2019) authorized the extension of “pregnancy pathway” Medi-Cal coverage by 10 additional months beyond the 60-day postpartum period for individuals who have been diagnosed with a maternal mental health condition. This new coverage was implemented August 1, 2020. However, unless further legislative action is taken, the program may be suspended on December 31, 2021.

**Whole Child Model**: As of July 2019, five plans covering 21 counties operate under the Whole Child Model. This model integrates coordination and financing for all required newborn care and the care of children born with special needs. While it is too soon to assess the impact of these new policies, they represent progress, and it is important to track their outcomes.

**Maternal mental health**: In 2019, Medi-Cal introduced enhanced reimbursement for prenatal screening for depression. Postpartum depression screening is also allowed as part of a well-child visit to be billed under the infant’s coverage throughout the first year of life. In addition, up to 20 individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic, and mental health–related risk factors are now covered. Finally, Senate Bill 104 (Chapter 67, Statutes of 2019) authorized the extension of “pregnancy pathway” Medi-Cal coverage by 10 additional months beyond the 60-day postpartum period for individuals who have been diagnosed with a maternal mental health condition. This new coverage was implemented August 1, 2020. However, unless further legislative action is taken, the program may be suspended on December 31, 2021.
Endnotes

1. We use the term "pregnant people" to recognize that not all people who become pregnant and give birth identify as a woman or a mother.


4. Elizabeth Hinton et al., 10 Things to Know About Medicaid Managed Care, Kaiser Family Foundation, December 16, 2019.


6. Pregnancy-related services include prenatal care, labor, delivery, postpartum care, family planning services, and services for other diagnoses, illnesses, or medical conditions that might threaten the safe, full-term delivery of the fetus. Pregnancy-related coverage qualifies as Minimum Essential Coverage as required by the Affordable Care Act.


8. Comprehensive Perinatal Services Program (CPSP) grew out of a perinatal demonstration project called the Obstetrical Access Project, which operated from 1979 to 1982 in 13 California counties. Comprehensive services were shown to reduce low-birth-weight rate by one-third and to save approximately $2 in short-term neonatal intensive care unit costs for every $1 spent. CPSP services became a Medi-Cal benefit in 1987.

9. An FQHC look-alike is a health center that meets all requirements and is part of the Health Center Program but does not receive federal award funding.

10. Author analysis of California FQHCs from “2018 Uniform Data System (UDS) Resources,” Healthcare Resources and Services Administration, Bureau of Primary Health Care, accessed August 1, 2020.


13. Author analysis of Centers for Disease Control and Prevention, CDC WONDER Online Databases, “Nativity Public-Use Data, 2016-2018.”

14. Author analysis of custom data request from the California Maternal Quality Care Collaborative, received December 17, 2019.

15. Author analysis of Centers for Disease Control and Prevention, CDC WONDER Online Databases, “Nativity Public-Use Data, 2016-2018.”


17. Author analysis of custom data request from the California Maternal Quality Care Collaborative, received December 17, 2019.

18. The professions share a philosophy of women-centered care that recognizes and supports childbirth as a normal physiologic process, but differ in education requirements, certifying organizations, regulatory bodies, licensing policies, and enabling statutes. More detail is available at California’s Midwives: How Scope of Practice Laws Impact Care.

19. Connie Kwong et al., California’s Midwives: How Scope of Practice Laws Impact Care, California Health Care Foundation, October 2019.


21. Kwong et al., California’s Midwives.

22. Doulas are nonmedical professionals who provide emotional, physical, and informational support and guidance in different aspects of reproductive health. More detail is available from the National Health Law Program’s fact sheet “What Is a Doula?” (PDF).

23. Sakala et al., Listening to Mothers in California.

24. Sakala et al., Listening to Mothers in California.


30. Plans interviewed included CalOptima, Community Health Group of San Diego, Health Net, Inland Empire Health Plan, L.A. Care Health Plan, Partnership HealthPlan of California, and Santa Clara Family Health Plan.

31. Dudley, Promoting Midwifery and High Value Care in Medi-Cal.

Acknowledgments

Melora Simon, MPH, is an independent consultant who provides strategic planning, project management, meeting facilitation, and organizational support to health care organizations. She has previously held positions with the Pacific Business Group on Health, Health Plan of San Mateo, Stanford Clinical Excellence Research Center, and McKinsey & Company.