California Policy Needs During COVID and Beyond: Reproductive and Sexual Health

Amy Chen

Introduction

COVID-19 has changed the landscape for reproductive and sexual health care services, delivery, and access. As has been the case across the board, the COVID-19 pandemic has laid bare racial and socioeconomic inequities, and in many cases exacerbated them. At the same time, the challenges raised by the pandemic have also suggested opportunities for improving reproductive and sexual health care in the areas of pregnancy care, abortion access, family planning, and telehealth.

Expand Flexibilities for Pregnancy and Postpartum Care

From the start of the pandemic, experiencing pregnancy has put people at higher risk of COVID-19. As such, hospitals and clinics were quick to put in place policies aimed at protecting and reducing risk to pregnant people and newborns.

Acknowledging the importance of continuity of care, the state waived monthly premiums and suspended discontinuances for the Medi-Cal Access Program (MCAP) during the Public Health Emergency (PHE) declared by the President and Health & Human Services Secretary. The financial hardships brought about by the pandemic have intensified as time has passed. Individuals and families who have lost jobs have also likely lost access to affordable health insurance coverage and now need other options or may remain uninsured. In recognition of these ongoing financial hardships, the state should consider extending the time for premium waivers and suspension of discontinuances for MCAP even after the PHE ends.

AB 577, extending Medi-Cal eligibility to one year postpartum for a pregnant person on Medi-Cal who is diagnosed with a mental health condition, was enacted into law effective August 1, 2020. Its availability has also sparked growing awareness of the broader need for one year postpartum Medi-Cal eligibility. Growing evidence suggests that many conditions that result in maternal mortality and morbidity do not necessarily take place within the first two or three months after the end of a pregnancy, but in fact can occur up to a year after the end of a pregnancy. Medi-Cal has long provided such extended coverage to infants born to someone who was active on Medi-Cal at the time of birth. While extending Medi-Cal coverage for a full twelve months when a person has a maternal mental health condition is clearly an important change, all Medi-Cal enrollees could benefit from the same extension of Medi-Cal eligibility at the conclusion of their pregnancies. DHCS should enact a policy that extends Medi-Cal eligibility to one year postpartum for all pregnant and postpartum Medi-Cal enrollees, whether or not the person has a maternal mental health condition.

To reduce overall risk and exposure, many hospitals were initially limiting pregnant people to only one support person to accompany them during labor and delivery. This meant that often a birth support person such as a doula was not permitted, as many pregnant people opted for a partner to accompany them during labor and delivery. This relegated doulas to supporting laboring pregnant people virtually, through video calls or even phone calls. For a tradition of support that is so inherently physical in nature, this created many challenges for birth doulas and the clients that they served. Much has already been written about the role doulas can play in addressing health disparities and reducing maternal mortality by mitigating the impact of racism and implicit bias for their pregnant and postpartum clients. These hospital limitations made it more difficult for doulas to provide that support. In October 2020, the California Department of Public Health issued guidance clarifying that doulas are in fact permitted to accompany a patient during labor and delivery, in addition to another support person.

As the pandemic continues, the need to limit unnecessary visitors in the hospital setting will likewise continue. However, it is critical that hospitals and clinics recognize the valuable role that doulas play in supporting pregnant and postpartum people, whether in labor or seeking prenatal or postpartum care. Doulas should continue to be permitted to accompany a pregnant or postpartum person, especially during labor and delivery, in addition to a support person such as a partner or family member. Naturally, any person accompanying the pregnant person, whether a partner or a doula, would have to otherwise follow the procedures required by the hospital (e.g. wearing PPE, being asymptomatic, etc.). Additionally, to accommodate situations where a loved one, doula, or other support person is not able to be physically present with the pregnant or postpartum person, hospitals must also permit the use of videoconferencing, videotaping, and/or video streaming during prenatal and postpartum appointments, and during labor and delivery.

The pandemic has also inspired increased interest in home births, midwifery services, and doula care. Pregnant people and their families, wary of seeking care in hospital and clinic settings where they may be exposed to COVID-19, are opting for ways for them to seek prenatal care and support closer to home. Perhaps in part due to recognition of this growing interest, and after decades of organizing and advocacy, the physician supervision requirement was finally eliminated for certified nurse-midwives practicing in California. On September 21, Governor Newsom signed SB 1237, the Justice and Equity in Maternity Care Act, which removed the physician supervision requirement for certified nurse-midwives who are supporting clients with low-risk pregnancy during childbirth, prenatal care, labor and delivery, and postpartum care, including family planning and newborn care. Interest in home births, midwifery services, and doulas will certainly continue beyond the COVID-19 pandemic. In addition to the expansions now available through the Justice and Equity in Maternity Care Act, the state should also explore other ways to decrease access barriers for midwifery services, birth center services, and home birth. Changes that should be considered include waiving licensing requirements, scope of practice limitations, and legal and regulatory restrictions. Additionally, restrictions on out-of-network care should be relaxed to accommodate pregnant and postpartum people who may be temporarily sheltering-in-place with friends or family away from home.

Lastly, in recognition of the impact COVID-19 has had on pregnant and postpartum people, a group of advocacy organizations, led by the Black Women for Wellness Action Project, put together a Birthing People's Bill of Rights: COVID-19 edition, which articulate a set of rights for pregnant and postpartum people. The guide includes questions that pregnant and postpartum people can ask their providers about their care, hospital intake procedures, and informed decision making, among other topics. The National Association to Advance Black Birth has also published a similar Black Birthing Bill of Rights, in recognition of the extreme disparities in maternal mortality and morbidity that exist especially for Black pregnant and postpartum people. Hospitals, clinics, and providers that serve pregnant and postpartum people should embrace the recommendations in these Bills of Rights, especially those related to respect, bodily autonomy, and informed consent. We can all do a better job in supporting pregnant, birthing, and postpartum people in our state, especially Black pregnant, birthing, and postpartum people, who are experiencing the brunt of racism, disparities, and inequities in health care access, services, and delivery.

Expanding Ongoing Access to Abortion Services

On July 13, 2020 a federal district court issued a nationwide preliminary injunction permitting providers to mail or deliver mifepristone (one of the two drugs used in the FDA-approved medication abortion regimen) to patients during the COVID-19 PHE and 30 days after its conclusion. The ruling found that an FDA requirement to pick up medication abortion in person, when there is no requirement for in-person administration, places an undue burden on patients' constitutional right to abortion and severely jeopardizes patients' health and financial stability during the PHE.

Two weeks after the ruling, California's Department of Health Services (DHCS) changed its policy to comply with the court order. Specifically, DHCS instructed Medi-Cal providers to prescribe mifepristone for abortions without an in-person visit or signature.

Because the provision of mifepristone is subject to FDA requirements, which prohibited mail order or delivery, individual states could not on their own have changed the rule without the court order. Even so, DHCS can and should do more to facilitate easier access to medication abortion. For example, research has demonstrated that DHCS can relax the requirements for in-person pregnancy testing, pelvic examination, ultrasound or labs when they are not medically necessary. This would enable providers to evaluate patients remotely via a telehealth visit (e.g. video or phone) to determine their clinical eligibility for this service based on their health and gestational age.

Continuing Family Planning Flexibilities

Family PACT, or FPACT, provides comprehensive family planning services to low income individuals in California. During the pandemic, the state waived some requirements to allow for greater access and ease of access to family planning services and supplies. For example, the state temporarily allows pharmacies to dispense Depo-SubQ Provera for self-administration in both Medi-Cal managed care and fee-for-service. Additionally, utilization limits on quantity, frequency, and duration of FPACT-covered medications can be waived when medical necessity is documented. DHCS should continue these policies to increase access to FPACT services, supplies, drugs, and devices even once the pandemic is over or the PHE ends.

Retain Expanded Telehealth and Application Options

In order to limit exposure to others who may have COVID-19, many health providers, including Family PACT providers, are currently being permitted to use telehealth, virtual or telephone communications as an alternative for seeing patients in-person. The state should continue to allow health providers to offer telehealth options for patients not just for the duration of the pandemic, but also going forward. Importantly, this should be an option but not a requirement.

Individuals interested in enrolling in FPACT are also being allowed to enroll and renew electronically or by phone, and to receive services on the same day. For individuals who do not have Internet access to apply online, Medi-Cal, Every Woman Counts, BCCTP, PE4PW, and MCAP are accepting applications over the phone, including with a "telephonic" signature. DHCS should continue this flexibility and allow for both electronic and phone applications for these programs even once the PHE is over.

DHCS is also permitting minors to apply for Minor Consent services by phone, waiving the longstanding requirement for minors to apply in-person at a county office. Additionally, DHCS is in the process of expanding coverage renewals for Minor Consent mental health and SUD services from monthly to six months at a time. All other Minor Consent services, including family planning, STI/STD, sexual assault, pregnancy, and abortion services, will still require renewal each month. Given the longstanding continuity issues in Minor Consent, DHCS should continue waiving the in-person application requirement as well as continue extended coverage renewals for this program for all services both during the PHE and once it has ended.

Conclusion

The COVID-19 pandemic and public health emergency has required individuals, communities, and institutions to make drastic changes, often on a dime. In the area of reproductive and sexual health care services, many changes have helped to increase access and flexibility during the PHE. However, while spurred on by the unique consumer needs during a pandemic, many of these changes would continue to have great benefit for health consumers even once the PHE has passed. It is our recommendation that some changes be made in the areas of pregnancy care, abortion access, family planning, and telehealth, both during the PHE and continuing after the pandemic has passed.

Complete List of Recommendations for Post-COVID Reproductive and Sexual Health Policy Needs in California

- DHCS should extend the time for premium waivers and suspension of discontinuances for the Medi-Cal Access Program
- DHCS should extent Medi-Cal eligibility to one year postpartum for all pregnant and postpartum Medi-Cal enrollees
- Clinics and hospitals should allow doulas to accompany a pregnant or postpartum person to clinics or hospitals, especially during labor and delivery, in addition to a support person such as a partner or family member
- Hospitals should permit the use of videoconferencing, videotaping, and/or video streaming during prenatal and postpartum appointments, and during labor and delivery
- DHCS should decrease access barriers for midwifery services, birth center services, and home birth
- Hospitals and clinics should recognize and honor pregnant, birthing, and postpartum peoples' need for respect, bodily autonomy, informed consent, especially Black pregnant, birthing, and postpartum people
- DHCS should facilitate greater access to medication abortion
- DHCS should keep in place policies that increase access to FPACT services, supplies, drugs, and devices even once the pandemic is over
- DHCS should continue to allow health providers to offer telehealth options for patients even once the pandemic is over
- DHCS should continue to allow for both electronic and phone applications even once the pandemic is over
- DHCS should continue waiving the in-person application requirement as well as extend and expand coverage renewals for the all Minor Consent services during and after the pandemic is over