BIRTHING CARE PATHWAY REPORT

FEBRUARY 2025

Medi-Cal

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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I. INTRODUCTION

I. INTRODUCTION

Every five days in California a person loses their life to pregnancy-related complications. While California's pregnancy-related mortality ratio—pregnancy-related deaths per 100,000 births—is lower than the national ratio, it has been rising in recent years, and the majority of these pregnancy-related deaths are preventable. California's severe maternal morbidity (SMM) rate—events of unexpected and potentially life-threatening complications per 10,000 delivery hospitalizations—has also been rising and is higher than the national rate.[1] This pregnancy-related mortality and morbidity crisis is disproportionately impacting Black, American Indian/Alaska Native, and Pacific Islander pregnant and postpartum individuals.

With nearly one in eight of U.S. births occurring in California and 40 percent of those births covered by Medi-Cal (California's Medicaid program), the California Department of Health Care Services (DHCS) is implementing strategies to reduce the California pregnancy-related mortality ratio and SMM rate and ensure a more equitable birthing experience for all pregnant and postpartum Medi-Cal members.

DHCS began developing a comprehensive policy and care model roadmap called the **Birthing Care Pathway** in spring 2023 to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum. The Birthing Care Pathway is designed to be a strategic roadmap for state entities, managed care plans (MCPs), counties, providers, social service entities, philanthropy, and other key partners serving pregnant and postpartum Medi-Cal members throughout the state. The roadmap includes a series of policy solutions that address the physical, behavioral, and health-related social needs of pregnant and postpartum members by improving access to providers; strengthening clinical care and care coordination across the care continuum; providing whole-person care; and modernizing how Medi-Cal pays for maternity care. The policy solutions and strategic opportunities for further exploration outlined in this report were developed based off feedback from a diverse array of partners, including pregnant and postpartum Medi-Cal members whose lived experience is central to the design of the Birthing Care Pathway. Many of these strategic opportunities are subject to additional assessment and planning and are also contingent on new funding.

The goals of the Birthing Care Pathway, which is generously supported by the California Health Care Foundation (CHCF) and the David & Lucile Packard Foundation, are to reduce maternal morbidity and mortality and address the significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander

[1] Both the California Department of Public Health (CDPH) and the Centers for Disease Control and Prevention (CDC) report pregnancy-related mortality ratios. Both CDPH and the Health Resources and Services Administration (HRSA) report severe maternal morbidity rates. DHCS uses these terms to support comparability between state and national maternal health outcomes.

individuals. These goals align with DHCS' Bold Goals 50x2025 initiative. Launched in 2022 with the release of the Comprehensive Quality Strategy, this initiative comprises a set of five goals to improve clinical and health equity outcomes by 50 percent by 2025. Two of the five goals are specific to maternal health—reducing maternity care disparities by 50 percent for Black and American Indian/Alaska Native individuals and improving maternal and adolescent depression screening rates by 50 percent.

To develop the Birthing Care Pathway, DHCS conducted a landscape assessment of California's existing maternal health policies and initiatives, national best practices, and evidence-based programs; recruited pregnant and postpartum Medi-Cal members to share their lived experience and recommendations; interviewed more than two dozen state leaders, maternity care providers, community-based organization (CBO) leaders, Medi-Cal MCP representatives, and birth equity advocates; and launched three workgroups focusing on clinical care, social drivers of health, and the postpartum period. DHCS invited additional input on the Birthing Care Pathway throughout 2023 and 2024 in meetings with clinical and nonclinical maternity care providers and association representatives, social services providers, MCPs, Tribal health providers, local public health and behavioral health representatives, and consumer advocates across the state. Manatt Health supported DHCS in the development of the Birthing Care Pathway.

This report explains the findings from the Medi-Cal member and Birthing Care Pathway partner engagement (see Section II) conducted to date and outlines the policies DHCS has implemented/is implementing for the Birthing Care Pathway as well as strategic opportunities for further exploration by DHCS and state partners to improve outcomes for pregnant and postpartum Californians covered by Medi-Cal (see Section III). The report was drafted under the direction of DHCS. While DHCS endeavored to engage with a broad set of partners, the findings and policy solutions included in this report should only be interpreted to represent the views of DHCS and not an endorsement nor agreement by any listed interviewees, Workgroup members, or other partners.

A. State of Maternal Health in California

While California's pregnancy-related mortality ratio is lower than the national ratio, it has increased by 61.2 percent over the last six years. California's SMM rate (109.1) has also increased in recent years, and as of 2021, it exceeds the national average (100.3).

California faces severe racial and ethnic disparities in maternal and infant health outcomes due to structural racism, implicit

Box A: Medi-Cal Births & Coverage
» 11 percent of all births in the United States occur in California.
» 40 percent of all California births per year are covered by Medi-Cal.
» 72 percent of pregnant and postpartum Medi-Cal members are enrolled in an MCP.

bias, chronic stress, trauma exposure, and associated structural barriers impacting access to resources, neighborhood conditions, and maternity care experiences.[2] These disparities exist despite national, state, and local initiatives aimed at reducing racial and ethnic inequities. For example, Black pregnant and postpartum individuals in California experience higher rates of pregnancy-related mortality and SMM relative to all other racial/ethnic groups for whom data is available, even when controlling for other factors such as age, income, educational attainment, and health insurance status. Black pregnant and postpartum individuals also face higher rates of selected maternal complications at delivery (e.g., hypertension, eclampsia, venous thromboembolism); and prenatal and postpartum depression than all other racial/ethnic groups for whom data is available. DHCS' commitment to reversing these inequities forms the core premise of the Birthing Care Pathway.

Box B: Key Terms
» **Pregnancy-Related Mortality Ratio:** Deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or its management per 100,000 live births.
» **Severe Maternal Morbidity Rate:** Events of unexpected and potentially life-threatening complications from labor and delivery, such as hemorrhage, infection, and cardiac events, that result in significant short- or long-term health consequences per 10,000 delivery hospitalizations.
» **Selected Maternal Complications:** Delivery hospitalizations with a maternal complication diagnosis code per 10,000 delivery hospitalizations.

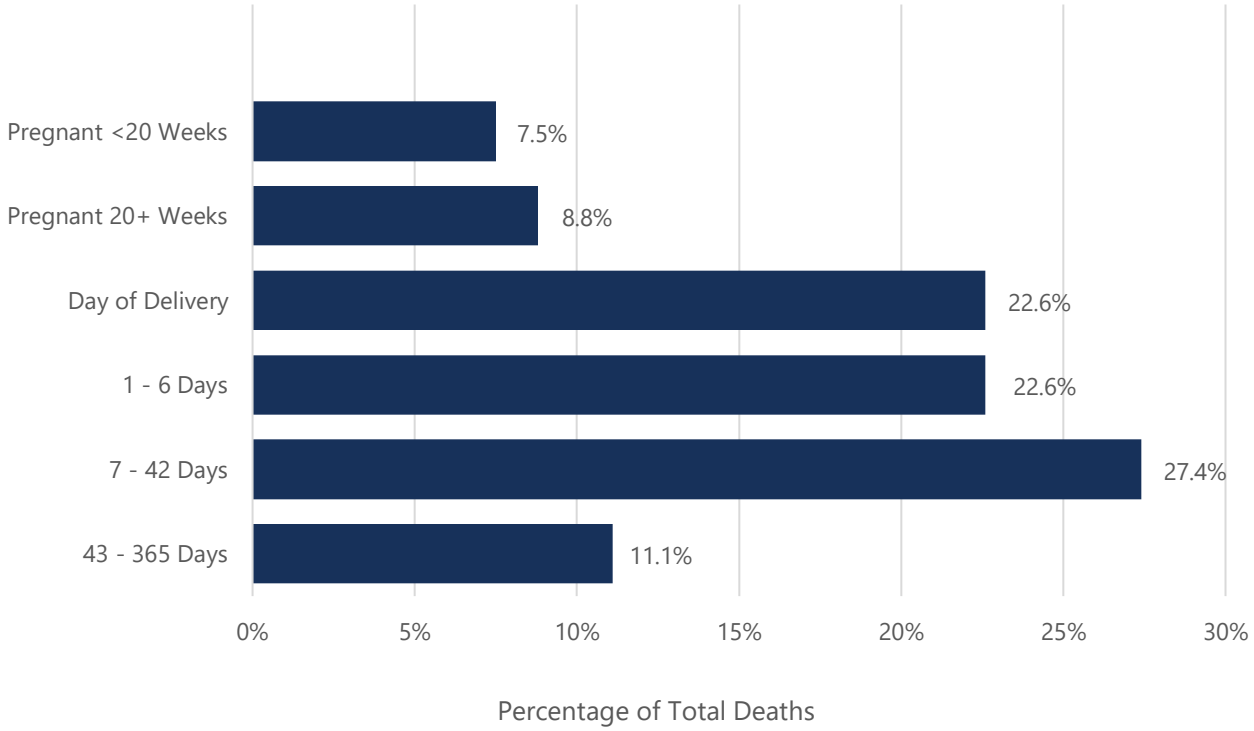
Pregnancy-Related Mortality

California's pregnancy-related mortality ratio, which is defined as deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or its management per 100,000 live births, was 21.6 in 2021, a sharp increase from 2015, when the ratio was 13.4. While COVID-19 was the primary cause of this increase in deaths, California's pregnancy-related mortality ratio was trending upward even before the pandemic. Deaths due to suicide, homicide, drug overdose, or injury are not included in California's pregnancy-related mortality ratio, though a 2019 report found that suicide accounts for about four percent of California deaths occurring during pregnancy or within 12

[2] California Department of Public Health and the University of California, San Francisco Center for Health Equity, 2023, Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants; California Department of Public Health, 2019, California American Indian / Alaska Native Maternal and Infant Health Status Report.

months postpartum. More than one in five perinatal deaths (23 percent) occur during labor and delivery in California, while more than half (61 percent) of perinatal deaths occur in the 12 months postpartum (see Figure A). The majority of postpartum deaths occur within the first six weeks after delivery.

Figure A: Pregnancy-Related Deaths by Timing of Death, California, 2019 - 2021

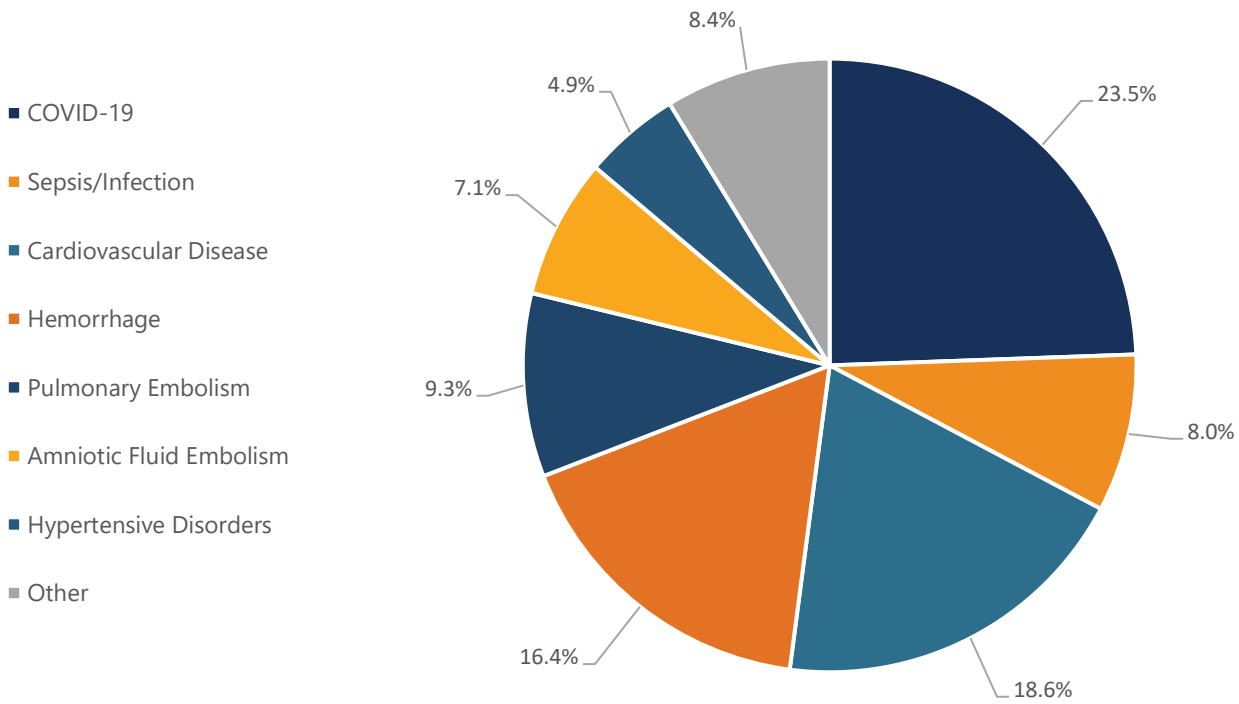


Data Source: California Department of Public Health Pregnancy-Related Mortality Dashboard | [Pregnancy-Related Deaths by Timing to Death, California, 2019-2021] https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

Sepsis/infection (including COVID-19), cardiovascular disease (CVD), and hemorrhage were the top three causes of perinatal death in California from 2019–2021 (see Figure B).[3]

[3] For 2019–2021: Anesthesia Complications, Cerebrovascular Accident, and Undetermined causes of death are not included due to small counts. The percentages in the pie chart do not sum to 100 percent.

Figure B: Pregnancy-Related Deaths by Cause of Death, California, 2019–2021

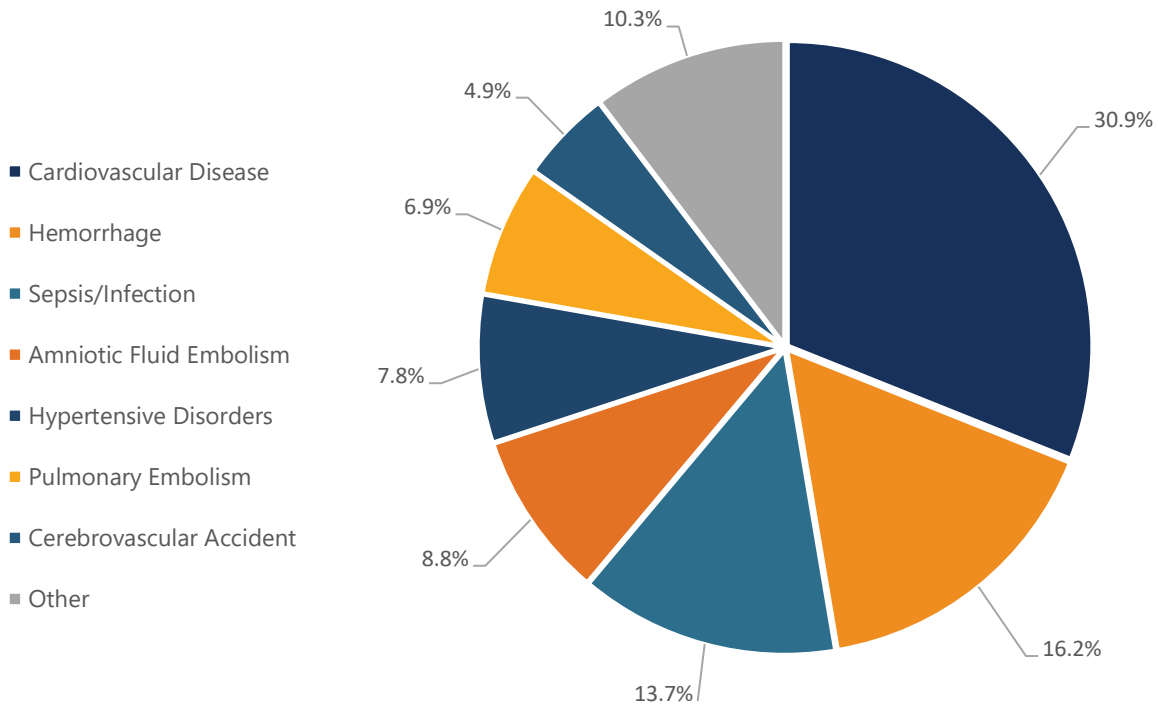


Data Source: California Department of Public Health Pregnancy-Related Mortality Dashboard | [Pregnancy-Related Deaths by Cause of Death, California, 2019-2021]
https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

Prior to the onset of the pandemic, CVD, hemorrhage, and sepsis/infection (not including COVID-19) were the top three causes of perinatal death in California from 2016–2018 (see Figure C).[4]

[4] For 2016–2018: Anesthesia Complications and Undetermined causes of death are not included due to small counts. The percentages in the pie chart do not sum to 100 percent.

Figure C: Pregnancy-Related Deaths by Cause of Death, California, 2016–2018



Data Source: California Department of Public Health Pregnancy-Related Mortality Dashboard | [Pregnancy-Related Deaths by Cause of Death, California, 2016-2018] https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

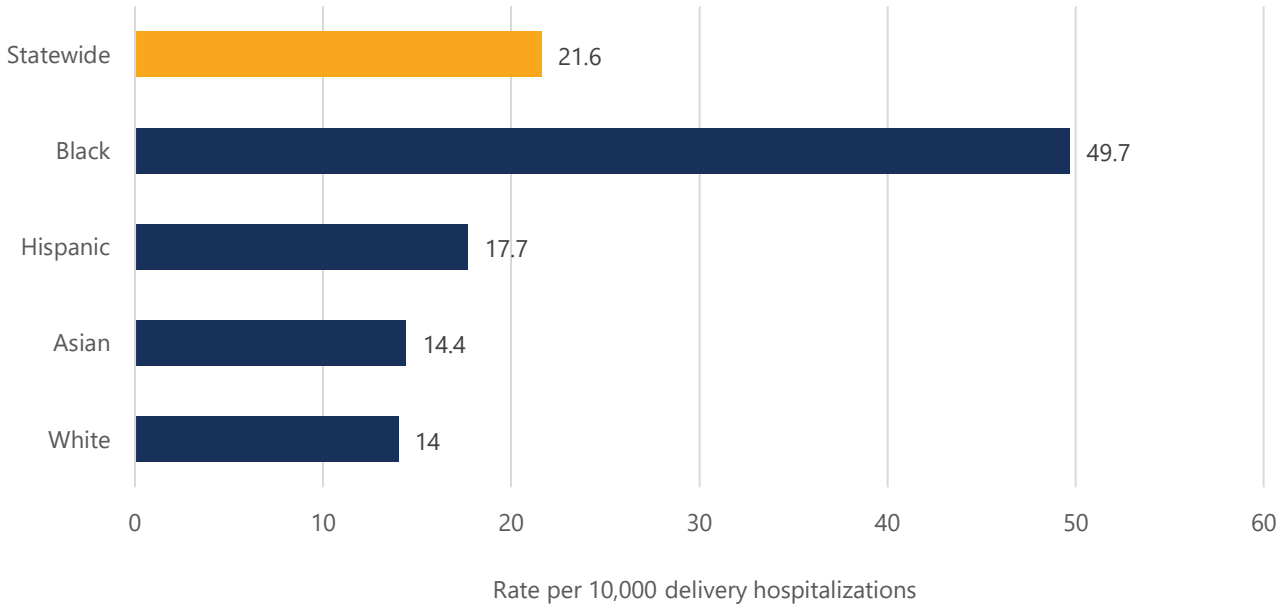
Medi-Cal-enrolled individuals are two to three times more likely to die during pregnancy or while postpartum compared to their peers with commercial insurance. The California regions with the highest pregnancy-related mortality ratios include Southern Central Valley and Northeastern/Northern Central Valley.[5]

[5] CDPH measures pregnancy-related mortality by the region of maternal residence at time of delivery. The Southern Central Valley region comprises Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, Tulare, and Tuolumne counties. The Northeastern/Northern Central Valley region comprises Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Yolo, and Yuba counties.

Birth Equity: Pregnancy-Related Mortality

Black pregnant people in California are 3.6 times more likely to die during pregnancy or while postpartum compared to their White peers (see Figure D). White pregnant and postpartum individuals have the lowest overall pregnancy-related mortality ratio of all races/ethnicities in California for whom data is available.

Figure D: Pregnancy-Related Mortality Ratio by Race/Ethnicity, California, 2019 - 2021



Data Source: California Department of Public Health Pregnancy-Related Mortality Dashboard | [Pregnancy-Related Mortality Ratio by Race/Ethnicity, California, 2019-2021] https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

While California does not report the pregnancy-related mortality ratios for American Indian/Alaska Native and Pacific Islander individuals due to low sample size in compliance with the state's data de-identification guidelines, the Centers for Disease Control and Prevention (CDC) notes that nationally, American Indian/Alaska Native individuals are twice as likely to die due to pregnancy-related causes compared to their White peers due to low resources, bias and discrimination, lack of culturally competent prenatal care, and generational trauma due to colonization and cultural erasure. In addition, a 2023 study found that nationally, Asian, Native Hawaiian, and Pacific Islander individuals, particularly those who

identified as Filipino, are more likely to die due to pregnancy-related causes compared to White and Hispanic individuals.

American Indian/Alaska Native individuals are underrepresented in national vital statistic data beyond pregnancy-related mortality due to racial/ethnic misclassification, or discrepancies in the racial/ethnic classification of an individual within a data source and that individual's self-identity or classification in a more valid source such as a Tribal enrollment list. American Indian/Alaska Native advocacy organizations have identified best practices for data collection for this population, including aggregating data over three or five years rather than a single year, to build a larger sample; using weighted sampling; linking data sets to correct for racial misclassification during data collection; and partnering with Tribal nations to identify ways to improve data collection and publication. The University of California Los Angeles (UCLA) Center for Health Policy Research (CHPR) is working to improve population data collection and health outcomes for American Indian/Alaska Native individuals through native-grounded research and evaluation and analysis of the California Health Interview Survey, which provides the largest population sample of American Indian/Alaska Native individuals in any United States health survey.

Severe Maternal Morbidity

The SMM rate, which is defined as events of unexpected and potentially life-threatening complications from labor and delivery (e.g., hemorrhage, infection, cardiac events) that result in significant short- or long-term health consequences per 10,000 hospital-based deliveries, in California was 109.1 in 2022, a 51.7 percent increase from 2015, when the rate was 71.9.[6] The most common indicators of SMM in 2022 were disseminated intravascular coagulation (a serious condition that causes abnormal blood clotting), renal failure, and sepsis (see Figure E).

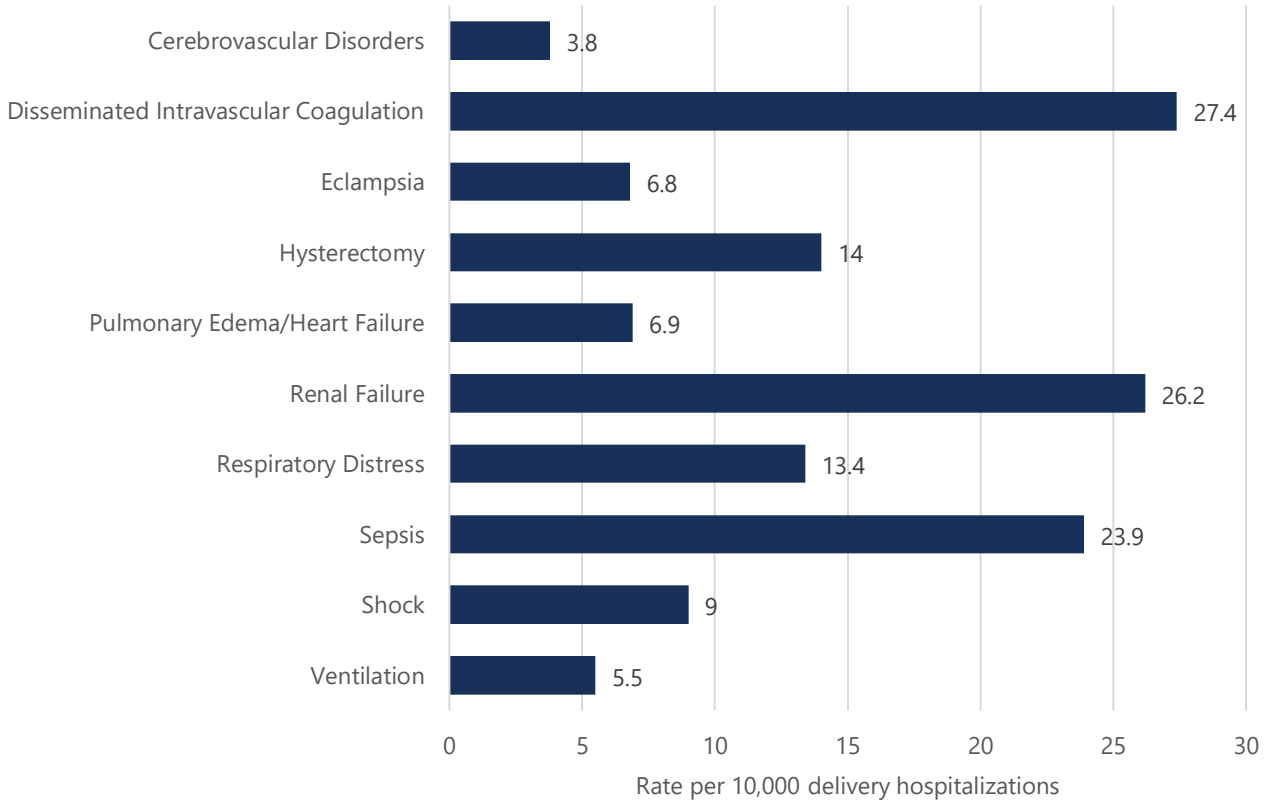
Birth Equity: Severe Maternal Morbidity

SMM rates in California are higher among pregnant individuals enrolled in Medi-Cal and other public insurance compared to those on commercial/private insurance. The California regions with the highest SMM rates in 2022 included North Coast-East Bay, Northeastern, Mid-Coastal, and LA-Santa Barbara-Ventura.[7] While SMM rates are rising for all races and ethnicities, Black pregnant individuals in California are about twice as likely to develop SMM

[6] CDPH defines and measures SMM events per 10,000 "delivery hospitalizations."
[7] CDPH measures SMM by the region where the patient's hospital is located. The North Coast-East Bay hospital region comprises Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, and Sonoma counties. The Northeastern hospital region comprises Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Yolo, and Yuba counties. The Mid-Coastal hospital region comprises Monterey, San Benito, San Luis Obispo, San Mateo, Santa Clara, and Santa Cruz counties. The LA-Santa Barbara-Ventura hospital region comprises Los Angeles, Santa Barbara, and Ventura counties.

compared to their White peers (181.3 SMM rate per 10,000 births compared with 90.9 SMM rate), followed by Pacific Islander individuals with a SMM rate of 167.2. California does not report the SMM rate for American Indian/Alaska Native individuals in California due to low sample size in compliance with the state's data de-identification guidelines. White pregnant and postpartum individuals have the lowest SMM rate of all races/ethnicities in California for whom data is available.

Figure E: Common Indicators of SMM, California, 2022



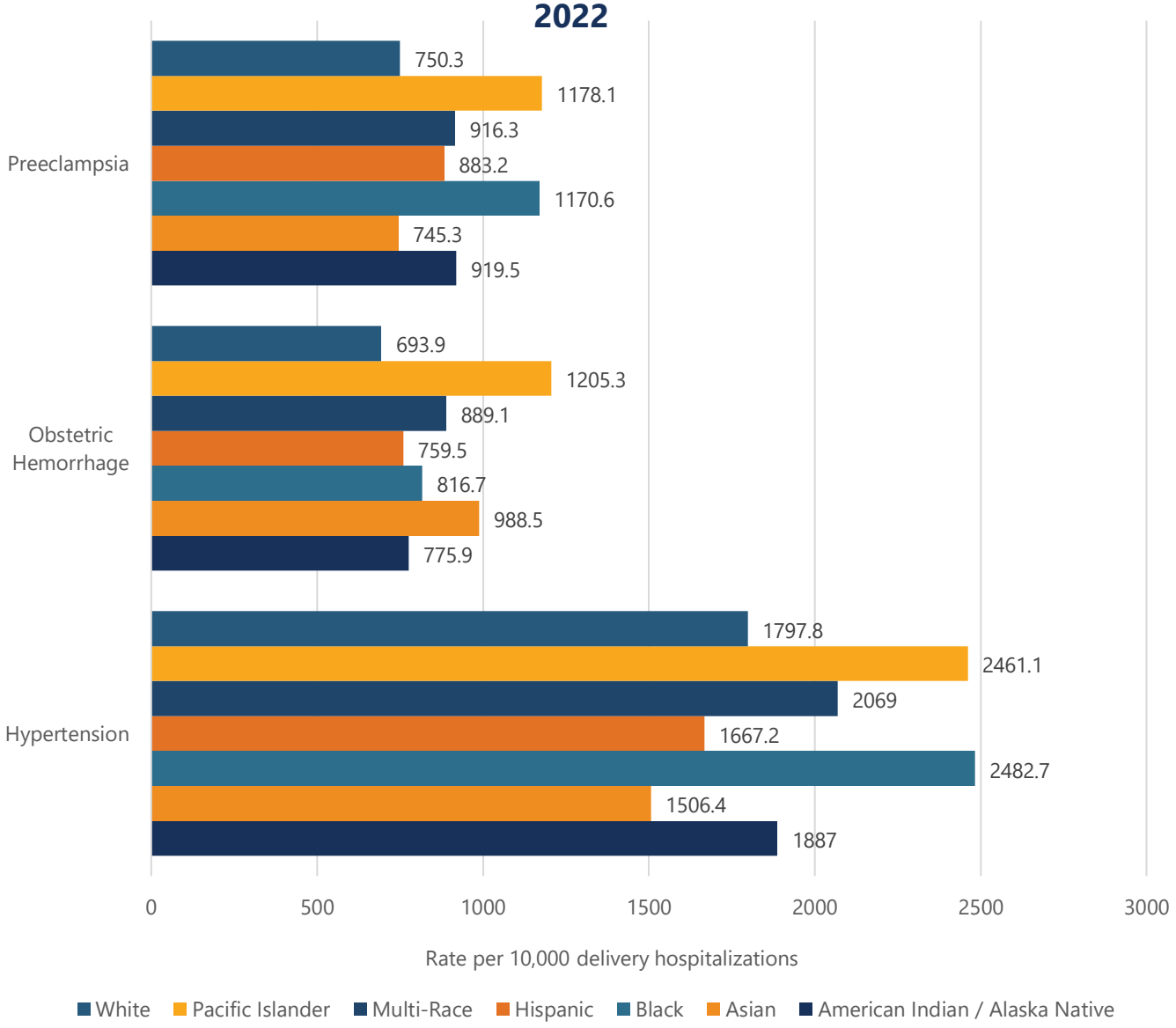
Data Source: California Department of Public Health Severe Maternal Morbidity Dashboard | [Common Indicators of Severe Maternal Morbidity, California, 2022]
https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

Maternal Complications and Health Disparities at Delivery

Maternal complications at delivery are distinct from SMM events in that they are defined simply by the presence of a maternal complication diagnosis code at the time of delivery hospitalization. Hypertension is the most common maternal complication at the time of delivery in California (1,725 occurrences per 10,000 deliveries), followed by preeclampsia (839

occurrences per 10,000 deliveries), and obstetric hemorrhage (778.3 occurrences per 10,000 deliveries). There are significant racial and ethnic disparities in the rates of these complications in California as shown in Figure F. Black pregnant individuals face the highest rates of hypertension at delivery (43.9 percent higher than the rate of the total population), followed by Pacific Islanders (42.7 percent higher) and multiracial individuals (19.9 percent higher). Preeclampsia rates are highest among Pacific Islanders (40.4 percent higher than the total population), followed by Black individuals (39.5 percent higher) and American Indian/Alaska Native individuals (9.6 percent higher). Pacific Islanders also face the highest rates of obstetric hemorrhage (54.9 percent higher than the total population), followed by Asian individuals (27.0 percent higher) and multiracial individuals (14.2 percent higher). Black and Hispanic individuals are at higher risk of eclampsia; Black individuals are at higher risk of venous thromboembolism; and Black, Asian, Pacific Islander, and multiracial individuals are at higher risk of sepsis at delivery than the total population. California does not report stratified data on eclampsia, venous thromboembolism, or sepsis among American Indian/Alaska Native individuals due to low sample size in compliance with the state's data de-identification guidelines.

Figure F: Maternal Complications at Delivery, California, 2022



Data Source: California Department of Public Health Selected Maternal Complications Dashboard | [Preeclampsia at Delivery by Race/Ethnicity, Obstetric Hemorrhage at Delivery by Race/Ethnicity, Hypertension at Delivery by Race/Ethnicity, California, 2022]
https://cdph.ca.gov | Date Downloaded: Jan 2025
Prepared by the California Department of Health Care Services

Maternal Behavioral Health and Disparities

Maternal behavioral health is distinct from SMM in that maternal behavioral health includes rates of prenatal and postpartum depression and substance use disorders (SUDs). In California, about 15 percent of pregnant individuals had prenatal depression between 2019–

2021 with 14 percent of postpartum individuals reporting postpartum depression in the same time period. Black individuals had the highest rate of prenatal depression at 23.5 percent compared to other races/ethnicities for whom data is available, including Hispanic (15.6 percent), Asian/Pacific Islander (15.3 percent), and White (11.5 percent) individuals. Similarly, Black individuals had the highest rate of postpartum depression at 18.4 percent, followed by Asian/Pacific Islander individuals at 15.2 percent, and both Hispanic and White individuals at 12.7 percent. California does not report data for American Indian/Alaska Native individuals due to low sample size in compliance with the state's data de-identification guidelines. Statewide, 1.5 percent of pregnant Californians had a SUD at delivery in 2022. This rate is highest among American Indian/Alaska Native (7 percent) and Black (5 percent) individuals compared to other races/ethnicities for whom data is available.

A November 2023 report from the Policy Center for Maternal Mental Health identified the top ten counties in the United States with the lowest maternal mental health resources by calculating the number of perinatal mental health certified providers and reproductive psychiatrists/prescribers by zip code and birth rates. Four California counties (Los Angeles, San Diego, San Bernardino, and Riverside) are included in the top ten counties nationwide with low maternal mental health resources. Los Angeles County is the top county nationwide for the highest gap of maternal mental health providers.

B. DHCS Maternal Health-Related Initiatives

DHCS has a long history of supporting pregnant and postpartum Medi-Cal members. In 1979, DHCS established a pilot program to support pregnant Medi-Cal members that eventually expanded statewide in 1987 as the Comprehensive Perinatal Services Program (CPSP), a Medi-Cal benefit.[8] DHCS and the California Department of Public Health (CDPH) jointly oversee CPSP which provides a set of services from conception through 60 days postpartum, including obstetric services; psychosocial assessment(s) and referrals to counseling, if needed; nutrition assessment(s) and referrals to counseling on food supplement programs, vitamins, and breastfeeding, if needed; health, childbirth, and parenting education; and care coordination.

In recent years, DHCS has taken steps to strengthen coverage and care for pregnant and postpartum Medi-Cal members by setting ambitious goals to improve outcomes, implementing Medi-Cal eligibility and benefit changes, and increasing maternity care provider reimbursement rates. These policy enhancements are outlined below in Box C.

[8] CPSP State Statute: California Welfare & Institutions Code § 14134.5; CPSP State Regulation: Title 22 § 55179–51179.9, 51249, 51348–51348.2, 51504.

Box C: Recent Medi-Cal Policy Enhancements for Perinatal Care

1) Improved Medi-Cal Coverage and Enrollment

- DHCS **extended Medi-Cal coverage from 60 days postpartum to 12 months postpartum** as of April 1, 2022 and **eliminated premiums and co-pays for all Medi-Cal members** in July 2022.
- Medi-Cal eligibility streamlining with the **Newborn Gateway** requires Medi-Cal providers beginning in July 2024 that participate in Medi-Cal presumptive eligibility programs to report newly eligible newborns born in their facilities within 72 hours after birth or 24 hours after discharge, whichever is sooner.
- The **Justice-Involved Reentry Initiative**, launched in January 2023, allows eligible Californians who are incarcerated (including those who are pregnant and postpartum) to enroll in Medi-Cal and receive a targeted set of services in the 90 days before their release and be connected post-release to Enhanced Care Management (ECM)—a statewide benefit available through MCPs for select members with complex needs.
- DHCS extended Medi-Cal full-scope eligibility to all eligible young adults (ages 19–25) in January 2020 and adults (ages 26–49) in January 2024, **regardless of immigration status.**

2) Improved Payment for Medi-Cal Providers

- DHCS **increased** maternity care provider reimbursement rates to ensure adequate reimbursement and promote provider participation in Medi-Cal:
  - January 1, 2024: Rate increased to 87.5 percent of Medicare rate for obstetric services providers (e.g., obstetrician-gynecologists (OB/GYNs), doulas, midwives).
  - January 1, 2025: Enhanced supplemental payments for Labor-and-Delivery (L&D) and hospital-based birthing center services.
- **CalHealthCares**, which launched in April 2019, provides loan repayment on educational debt for California physicians—including OB/GYNs and family physicians—who provide care to Medi-Cal members.

3) Improved Medi-Cal Services

- Medi-Cal coverage of **community health worker** (CHW) services, available through MCPs and Fee-For-Service (FFS), went live in July 2022. CHW services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.

- In January 2023, DHCS added **doula services**, available through MCPs and FFS, as a Medi-Cal benefit. Doula services include emotional and physical support provided to individuals and families during pregnancy, labor, birth, and the postpartum period, as well as support for and after miscarriage and abortion.
- **Dyadic services** were added as a Medi-Cal benefit through MCPs and FFS in January 2023. Dyadic services combine behavioral health treatment with pediatric care to simultaneously support children and their caregivers. Services covered include navigation and follow-up for referrals, psychoeducation, family training and counseling, and specified mental and behavioral health screenings for caregivers.
- The **ECM Birth Equity Population of Focus**, which launched in January 2024, provides systematic coordination of health and health-related services to pregnant and postpartum members who are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality, including Black, American Indian/Alaska Native, and Pacific Islander members.
- **Community Supports**, which launched in January 2022, includes 15 preapproved "in lieu of services" (e.g., housing supports, medically tailored meals, sobering centers) which are provided by MCPs to eligible Medi-Cal members, including pregnant and postpartum members, to help avoid higher levels of care. The Centers for Medicare and Medicaid Services (CMS) approved Transitional Rent, the newest Community Support, in December 2024.

4) Improved Approach to Health Equity and Quality

- The **Health Equity Roadmap**, including a statewide member feedback listening tour from September 2023 through March 2024 and an ongoing codesign process, will lay out specific, actionable items to help California root out systemic racism and identify opportunities to eliminate health disparities, including in maternity care.
- In 2022, DHCS released the **Comprehensive Quality Strategy**, a report that outlines DHCS' process for developing and maintaining a broader quality strategy to assess the quality of care that all Medi-Cal members receive, regardless of delivery system; defines measurable goals; and tracks improvement while adhering to federal regulatory managed care requirements.
    - The Comprehensive Quality Strategy identifies three focus areas for quality improvement: maternity outcomes and birth equity, children's preventive care, and behavioral health integration.
    - DHCS launched the **Bold Goals 50x2025 initiative** when it released the Comprehensive Quality Strategy which includes two goals that are specific to maternal health—reducing maternity care disparities by 50 percent for Black

and American Indian/Alaska Native individuals and improving maternal and adolescent depression screening rates by 50 percent.

» DHCS **evaluates quality scores** annually for all MCPs and imposes financial sanctions on MCPs that do not meet required performance targets. The quality reviews include an evaluation of MCP performance on Managed Care Accountability Sets (MCAS) measures, including two that focus on maternal health (timeliness of prenatal care and postpartum care). MCPs' quality scores are published publicly.

To help advance DHCS' maternal health policy priorities and invest in the future of equitable birthing care, in September 2024, DHCS submitted its application for the Transforming Maternal Health (TMaH) Model to CMS. TMaH is a ten-year Medicaid and Children's Health Insurance Program (CHIP) delivery and payment model designed to test whether effective implementation of evidence-informed interventions, sustained by a value-based payment (VBP) model, can improve maternal outcomes and reduce Medicaid and CHIP program expenditures. In January 2025, CMS announced that California is one of 15 states selected to implement the TMaH Model and awarded DHCS $17 million in federal funding to implement it. The Model's goals and requirements align with DHCS' vision, and TMaH funding will complement and bolster DHCS' work on the Birthing Care Pathway to strengthen the delivery system, improve maternal health outcomes, and reduce disparities. DHCS will work with MCPs, hospitals, providers, CBOs, and other partners to implement the required interventions under the three TMaH Model pillars (Access, Infrastructure, and Workforce; Quality Improvement and Safety; and Whole-Person Care Delivery) and advance a VBP model that will incentivize better quality and care experience for pregnant and postpartum Medi-Cal members. DHCS will implement TMaH in a sub-state region that includes **Fresno, Kern, Kings, Madera,** and **Tulare** counties (see Figure G); these counties were selected based on several factors, such as the rate of maternal mortality and

Figure G: CA TMaH Model Test Region Counties

morbidity; racial/ethnic and geographic diversity; and Tribal nation and federally qualified health center (FQHC)/public hospital representation. DHCS' TMaH Model test region is located in California's Central Valley, a largely agricultural region with several non-contiguous dense urban areas that is considered medically underserved. Populations of focus within the test region include Black, American Indian/Alaska Native, and Pacific Islander pregnant and postpartum individuals, aligning with both the Birthing Care Pathway and the Bold Goals 50x2025 initiative. To measure the TMaH Model's impact, CMS will evaluate rates of low-risk Cesarean section (C-Section); SMM; incidence of low birthweight infants; changes in experience of care for those who are pregnant, giving birth, or postpartum; and changes in Medicaid and CHIP program maternity and infant expenditures in each state's selected test region.

II. BIRTHING CARE PATHWAY COMMUNITY ENGAGEMENT

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Community engagement with both Medi-Cal members and partners was critical to the design of the Birthing Care Pathway.

Member Engagement. A foundational priority for DHCS is to ensure the Birthing Care Pathway design is shaped by Medi-Cal members with lived experience. In Fall 2023, DHCS partnered with Everyday Impact Consulting (EIC)—a California-based organization focused on community engagement—to support Medi-Cal member engagement for the Birthing Care Pathway. The Birthing Care Pathway member engagement activities included interviews with members, member journaling, and the Member Voice Workgroup. Through direct engagement with Medi-Cal members, DHCS learned about members' pregnant and postpartum experiences while enrolled in Medi-Cal, including what challenges they experienced and what recommendations they had for the Birthing Care Pathway. In January 2025, DHCS reconvened members who participated in the member engagement activities for a meeting to discuss how their lived experience and feedback shaped the policies in this report.

Partner Engagement. Beginning in Summer 2023, DHCS sought perspectives and recommendations from a diverse set of partners, including clinical and nonclinical maternity care providers, social services providers, state leaders, MCPs, and birth equity advocates. DHCS listened to what challenges and barriers exist today in the Medi-Cal birthing experience for Medi-Cal members and providers. DHCS also received feedback on successful practices and initiatives that could be expanded to more geographic areas and/or more Medi-Cal members. To gather these perspectives, DHCS conducted interviews with a subset of partners and launched new workgroups. Findings from the key informant interviews and workgroups are helping to inform the policies DHCS has implemented/is implementing and strategic opportunities for further exploration for the Birthing Care Pathway.

A. Member Engagement Activities and Findings

1. Member Engagement and Recruitment

In late 2023, DHCS created a Medi-Cal member engagement application and shared it with more than 70 CBOs to help recruit pregnant and postpartum Medi-Cal members who were interested in sharing their lived birthing experiences while enrolled in Medi-Cal. More than 400 Medi-Cal members applied to participate in the member engagement activities. DHCS engaged 30 members who were either currently pregnant or up to 24 months postpartum.

Medi-Cal members were selected to represent a diversity of experiences, especially the lived experiences of groups that experience health disparities. The members selected for member

engagement activities ranged from ages 18 to 45 and identified as Black/African American, American Indian, White, Filipino, Hispanic, Pacific Islander, Native Hawaiian, Alaska Native, and Asian. During the member engagement activities, 13 members were currently pregnant while 17 were postpartum. The members represented 16 counties from all regions in California. Sixteen members shared that they had experienced a pregnancy that did not result in a live birth while enrolled in Medi-Cal. One member was from a Tribal nation and Indigenous community. Three members identified as being LGBTQ+. Five members had experienced houselessness, and one member had experienced intimate partner violence (IPV). Four members had experienced serious mental health concerns, and four members were living with a SUD. One member shared that they were formerly incarcerated, and two members shared that they identified as being undocumented.

2. Member Engagement Activities

Member Engagement Interviews. Six members participated in a 60-minute interview conducted by EIC from March–April 2024. Members were compensated with a $100 Visa gift card at the completion of the interview.[9]

Member Engagement Journaling. Six members shared their written or voice-recorded real-time reflections on their pregnancy and/or postpartum experiences with EIC from March–May 2024. Journaling followed members as they navigated pregnancy and the postpartum period, their experiences with Medi-Cal health care providers, and their involvement with perinatal and postpartum programs. Members completed five biweekly journal entries and were compensated with a $200 Visa gift card for each month they participated in journaling.

Member Voice Workgroup. The Member Voice Workgroup included 18 Medi-Cal members who met virtually three times for two-hour meetings from March–April 2024 to share their perinatal experiences and participate in a group discussion. Members were compensated with a $100 Visa gift card for each Workgroup meeting they attended.

3. Key Findings

Key findings from the Birthing Care Pathway member engagement activities include:

1) **Feeling respected and heard by health care providers is critical to a member's perinatal experience in Medi-Cal.** Members often feel that their birth plans and breastfeeding choices are not respected. While some members had positive experiences and felt comfortable building trusted relationships with their OB/GYNs, other members felt like their OB/GYNs were not taking the time to listen to their concerns or personal preferences, including attempting a vaginal birth after C-section or wanting to labor

[9] The David & Lucile Packard Foundation paid for these gift cards as well as the gift cards for members who participated in journaling and the Member Voice Workgroup.

without an epidural. Some members felt dismissed and judged by their health care providers when they told them that they had decided not to breastfeed. A member shared that she was repeatedly told she should breastfeed even after letting her care team know she did not want to due to previous trauma associated with breastfeeding. Other members said their health care providers assumed they would use formula and did not discuss breastfeeding with them.

> ***"I had two c-sections previously, but I had waited and did all the research for me to have vaginal this time. Now they're pushing for me to get induced, which caused my first C-section. So now I told her, I'm not going to have it, don't want it. Then the doctor was really pushing on me getting induced. I told her, you can set the appointment date, but I'm not going to go. I'm going to let my body ripen naturally when I come in."***

Many members underscored the trusting relationships they built with their midwives and how their needs and preferences were listened to. Similarly, doulas helped members craft and advocate for birth plans that outlined their personal preferences and decisions. Members who had a midwife and/or doula during labor and delivery appreciated the holistic approach to childbirth, indicating they felt empowered and supported during the labor process.

Group prenatal care models can help build community among pregnant individuals and empower them throughout their pregnancies, while home visiting programs can provide more individualized attention than some members found they can get with their perinatal provider during their pregnancy. Several members who participated in the Black Infant Health (BIH) program and the BElovedBIRTH Black Centering program shared that they felt supported and prepared for pregnancy, childbirth, and parenthood because of the sense of community support they received through these programs. A member enrolled in a home visiting program described the strong rapport built with her home visiting nurse throughout her pregnancy. The home visiting nurse reached out to her early in her pregnancy and visited her every two weeks. The member appreciated having someone to ask questions to and receive support from during her pregnancy.

2) **Some members experienced discrimination in health care encounters during pregnancy, birth, and the postpartum period, but felt connected to their health care providers and better supported when they received racially concordant care.** Some members described feeling dismissed by their health care providers or judged for their concerns or preferences. One member, who identifies as Latinx and Pacific Islander, shared that after giving birth, her nurse, who was White, was negative and condescending toward

her and would brush off her concerns. Once she was transferred to a room with a nurse who was another woman of color, she reported feeling more at ease and comfortable. During another member's recent pregnancy, the member did not feel her baby moving and shared this concern with her OB/GYN. Her OB/GYN instructed her to go the emergency room, and she ended up delivering the baby. This member was grateful that her provider listened to her concerns and attributed this to her doctor being a Black woman like her.

> ***"I really felt like she [the racially concordant provider] was just like she was there for me, and she was acting like it was one of her family members having this baby like we were already family. And then she made me like a nice little card with the baby's name on it, and everything I thought was sweet. She just really made me feel connected. She made it a point to feel like connected."***

3) **Key moments for trust building with members are often missed, particularly around trauma-informed approaches to IPV screening, smooth hospital discharge after birth, timely access to high-quality breast pumps, and mindful discussions on behavioral health screening results and referrals to services.** A member that self-disclosed having experienced IPV explained that when her midwife conducted an IPV screening, her abuser was in the room with her and therefore she was too scared to answer honestly. The member recommended that providers receive formal training on how to identify signs that someone is a victim of IPV and create trauma-informed care plans. Another member's newborn was diagnosed with jaundice prior to leaving the hospital, and the hospital staff informed her that she would be responsible for scheduling the follow-up appointments with a pediatrician. The member was unable to reach the pediatrician's office and ultimately left the hospital without a follow-up appointment scheduled for her newborn. Some members experienced delays getting a breast pump from their MCP while others had limited options and were not able to get a hospital-grade pump. One member shared that her provider's office was reluctant to give her a referral for an electric breast pump, impeding her access to the device. When her provider's office finally gave her the referral, she did not receive it for several weeks. The member believes this delay was detrimental to her ability to provide breast milk, and she ultimately ended up switching to formula.

> ***My provider's office was also very reluctant to give me a referral . . . to send me an electric breast pump. Medi-Cal took their time as well, and it took a few weeks postpartum for me to receive it. Luckily WIC lent me an old pump, and I finally got one from Riverside Life Services. I feel like this delay really hurt my breast milk supply and ultimately led to me giving up and switching to 100 percent formula. This was very hard on my mental health as breastfeeding can be very daunting, and everyone expects it to just come naturally. I wish I had had more support and had someone to tell me it was okay to stop trying sooner."***

4) **Medi-Cal members often felt like the onus was on them to independently navigate and coordinate many aspects of their perinatal care—ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.** Members described how the providers across their care teams did not communicate with one another, leaving that responsibility to fall on the member. It was often up to the members to share medical records with their different providers. Some members reported they were not aware of how long they would have Medi-Cal coverage postpartum or what they needed to do to get their baby enrolled. One member shared that her child did not have coverage until he was eight months old because she could not get in touch with a case worker to resolve this issue. Members also find it overwhelming to navigate their postpartum care due to lack of care coordination. A member shared that she was contacted by both a Women, Infants, and Children Program (WIC) lactation consultant and a lactation consultant assigned by her health plan and was unclear on who she should seek care from.

> ***It was mainly me working with each one of them. There wasn't any case conferencing, and that's been a huge obstacle is me having to go out of my way to get my medical records, and they can only accept them in certain forms. I have them digitally, but no one would take them, so I had to print them out. It's been a whole process, and there definitely hasn't been a lot of case conferencing between providers.***

5) **Finding mental health providers that accept Medi-Cal, are taking new patients, and have perinatal experience is difficult; Medi-Cal members want more frequent and intensive mental health supports.** Members faced long appointment wait times for mental health providers. One member called four different mental health providers seeking an appointment but could not reach anyone and never got a return call so she did

not end up receiving any mental health treatment. Some members tried using their MCPs' provider directories to identify behavioral health providers in network with their plans but found the directories outdated and confusing. Some members did not receive any mental health screening while others completed a screening but their health care provider did not review the results with them. One member shared that her OB/GYN did not ask her about her mental health at her six-week postpartum visit and seemed only focused on ensuring that she select contraception to support recommended birth spacing.

> ***I would have liked to receive more mental health care after the baby, but this was never addressed at my visits. Although I understand it is a different medical area, it was never even given as an option. No mental health questionnaire, nothing. I think it would be helpful to screen expecting mothers and definitely postpartum mothers.***

6) **Medi-Cal members often do not understand what Medi-Cal benefits and public benefits/social services are available to them in pregnancy or during the postpartum period (e.g., doula services, nutrition education, ECM, WIC/CalFresh, and transportation services).** Many members were not aware that Medi-Cal has a doula benefit or gave birth before it was launched in January 2023 and thought they had to pay for these services out of pocket, which was unaffordable. Members shared that they would have liked to work with a doula if they had known they could. Other members were not aware of Medi-Cal's ECM benefit, what it includes, and how they can find out if they are eligible. One member who was a CHW and had experience helping Medi-Cal members navigate their coverage and care still had challenges understanding their own MCP's coverage policies when they were pregnant. Many members underscored how important WIC and CalFresh were during their pregnancies to give them access to healthy food and nutrition education. However, a member who said she was undocumented shared that she has not sought out CalFresh, despite knowing nutrition support would be helpful to her and her family, because she is concerned that utilizing this aid will disqualify her from obtaining U.S. citizenship. Other members shared challenges with finding reliable transportation to get to and from prenatal appointments, resulting in missed or cancelled appointments.

> ***I didn't know it [a doula] was an option so, I feel like that's an important thing to at least know about because from what people said, it seems like something that every mom can benefit from, and it just seems more personal.***

B. Partner Engagement Activities and Findings

1. Key Informant Interviews

Throughout Summer and Fall 2023, DHCS interviewed more than 25 state leaders, perinatal care providers, advocates, and representatives from CBOs, associations, and health plans. Interviewees represented associations such as the American College of Obstetricians and Gynecologists (ACOG), the California Nurse-Midwives Association (CNMA), and the California Association of Licensed Midwives (CALM). Providers who were interviewed included OB/GYNs, family medicine physicians, certified nurse midwives (CNMs), licensed midwives (LMs), freestanding birth center (FBC) providers (also known as alternative birthing center (ABC) providers in California), pediatricians, addiction medicine physicians, reproductive psychiatrists, lactation consultants, doulas, and CHWs. DHCS also interviewed county leaders of BIH; WIC program services; and Maternal, Child, Adolescent Health (MCAH) programs as well as CBO leaders and advocates focused on LGBTQ+ health; IPV services; and birth justice and supports for Black, American Indian/Alaska Native, and Pacific Islander individuals. See Appendix A for the full list of interviewees.

Interviewees shared challenges associated with the Medi-Cal birthing experience, including but not limited to:

- **Rural Maternity Access:** Rapidly diminishing access to maternity hospitals, especially in rural communities.

- **Care Coordination:** Need for improved collaboration and integration among OB/GYNs, midwives, CHWs, doulas, lactation consultants, and behavioral health providers to support pregnant and postpartum members and provide coordinated care.

- **Perinatal Behavioral Health Care:** Barriers to accessing behavioral health care across non-integrated Medi-Cal delivery systems, including limited behavioral health providers that have perinatal training and long appointment wait times.

- **Housing Support During Pregnancy:** Limited housing programs for Medi-Cal-enrolled pregnant individuals; many programs are only available to single individuals or families.

» **Risk-Appropriate Care:** Pregnant individuals not consistently being connected to providers and facilities that meet their risk level.

Interviewees, however, underscored the importance of CHWs with perinatal training, home visiting programs, group perinatal care with racially concordant providers, and telehealth and remote patient monitoring for pregnant Medi-Cal members living in rural areas or facing childcare or transportation barriers.

2. Workgroups

In Summer 2023, DHCS launched three Workgroups—the **Clinical Care Workgroup, Social Drivers of Health Workgroup,** and **Postpartum Sub-Workgroup—**to inform the design of the Birthing Care Pathway. All three Workgroups met throughout 2023 and 2024 to discuss key challenges with the Medi-Cal prenatal, birthing, and postpartum experience and provide feedback on proposed policy solutions. Workgroup members who indicated financial barriers to participation were compensated with a $100 Visa gift card for each meeting they attended.

DHCS selected about two dozen people to serve in each of the Clinical Care and Social Drivers of Health Workgroups. The Clinical Care Workgroup is charged with identifying what needs to happen to ensure appropriate clinical care for Medi-Cal members, whether in a hospital, birth center, provider office, or in the community from conception through 12 months postpartum. This Workgroup is comprised of OB/GYNs; family medicine physicians; pediatricians; midwives; doulas; Tribal health providers; lactation consultants; FBC, behavioral health, and FQHC providers; MCP representatives; and local public health program representatives.

The Social Drivers of Health Workgroup is charged with identifying programs and providers that currently address and/or need to address health related social needs in the prenatal and postpartum period. This Workgroup's participants include CHWs; doulas; violence prevention organization representatives; local public health and social service program representatives, including Tribal social service partners; home visiting providers; and providers with Black birthing expertise. See Appendix B for the full lists of Clinical Care and Social Drivers of Health Workgroup members.

The Clinical Care and Social Drivers of Health Workgroups met three times each in 2023 and twice in 2024. During these meetings, participants shared many of the same challenges and barriers associated with the Medi-Cal birthing experience that key informant interviews identified. Key findings from the Clinical Care and Social Drivers of Health Workgroups include:

- **Racial and Ethnic Disparities:** Racism in health care and a lack of culturally and linguistically concordant care results in biased care across races and ethnicities and can exacerbate health disparities amongst Black, American Indian/Alaska Native, and Pacific Islander pregnant and postpartum individuals.

- **CPSP Modernization:** CPSP is provided inconsistently across delivery systems and counties, and many Medi-Cal members report being unaware of the services available. CPSP should be modernized to ensure uniform, high-quality access to comprehensive perinatal services for all pregnant and postpartum Medi-Cal members. The separate CPSP provider enrollment process with CDPH is burdensome for providers, and some Workgroup members recommend extending CPSP from 60 days to 12 months postpartum to align with Medi-Cal coverage through 12 months postpartum.

- **Screenings and Assessments:** Many of the screenings and assessments conducted during pregnancy and the postpartum period should be updated and streamlined, leveraging evidence-based tools where available, to better assess a Medi-Cal member's risk level, connect members to services, and prevent screening fatigue.

- **Access to Midwives:** Both CNMs and LMs face barriers to Medi-Cal provider enrollment and reimbursement that are inconsistent with state licensing and scope of practice requirements, limiting Medi-Cal members' access to midwives.

- **Access to Lactation Services:** Medi-Cal members also face barriers accessing lactation support. Lactation services may only be reimbursed through Medi-Cal if provided by a physician, registered nurse, or dietician; lactation consultants, such as International Board-Certified Lactation Consultants (IBCLCs) and Certified Lactation Counselors (CLCs), cannot be reimbursed by Medi-Cal.

- **Group Perinatal Care:** The group care model provides a team-based, whole-person care approach to birthing care, inclusive of both licensed and non-licensed providers such as doulas and CHWs. Group care models prioritize building community, empowering pregnant individuals, and connecting members to social supports.

DHCS created the Postpartum Sub-Workgroup to design a clinical practice-level approach for what clinical providers can do during the postpartum period to achieve positive birthing health outcomes. The Postpartum Sub-Workgroup, which met throughout Fall 2023 and early 2024, included cross-representation from both the Clinical Care and Social Drivers of Health Workgroups, as well as additional pediatricians, family medicine physicians, and FQHC providers. See Appendix B for the full list of Postpartum Sub-Workgroup members. Key findings from the Postpartum Sub-Workgroup include:

» **Care Coordination:** Maternal health care in Medi-Cal would benefit from a coordinated, team-based approach to care with the goal of creating a seamless experience as patients transition between providers, facilities, and sites of care. Roles and responsibilities of health care providers—including a lead maternity care manager—should be clearly identified to facilitate coordination across the different settings and throughout the patient's pregnancy and postpartum experience.

» **Data Sharing:** Data sharing across different providers and health systems should be enhanced and coordinated to improve continuity and quality of care for pregnant and postpartum Medi-Cal members. Best practices include creating shared communication systems, standardizing data-sharing protocols, and participating in health information exchanges and qualified health information organizations to ensure timely and effective care delivery.

» **Home Visiting and Telehealth:** Whole-person, patient-centered, and individualized maternal health care services, including those addressing health-related social needs, should allow flexibility in the site of care, providing access to home visiting services and telehealth based on a patient's medical history, care preferences, and geography. There is a need to expand access to home visiting and telehealth for pregnant and postpartum Medi-Cal members across the state.

» **Member Education:** Medi-Cal members would benefit from additional educational resources on how to navigate pregnancy and the postpartum period within the Medi-Cal system.

- **Provider Workforce Training and Diversification:** The Medi-Cal maternal health provider workforce should receive training on available social services to support pregnant and postpartum members and would benefit from increased diversity and cultural congruency.

- **Perinatal Behavioral Health:** Medi-Cal can address behavioral health concerns during pregnancy and the postpartum period by improving screening for perinatal mood and anxiety disorders, coordinating care and timely referrals, and investing in the training and development of a provider workforce with expertise in maternal behavioral health.

In addition to the interviews and workgroups discussed above, DHCS gathered feedback on the Birthing Care Pathway from a number of forums throughout 2023 and 2024, including:

- **State Agencies:** California Health and Human Services Agency (CalHHS); California Department of Public Health (CDPH); Office of the California Surgeon General (OSG); California Employment Development Department (EDD); California Department of Social Services (CDSS); and the California Department of Health Care Access and Information (HCAI)
- **Tribes and Indian Health Program (IHP) Representatives**
- **Provider Associations:** American College of Obstetricians and Gynecologists (ACOG) District IX; California Academy of Family Physicians (CAFP); American Academy of Pediatrics – California (AAP-CA); California Primary Care Association (CPCA); California Hospital Association (CHA); California Association of Public Hospitals and Health Systems (CAPH); California Medical Association (CMA); District Hospital Leadership Forum (DHLF); California Association of Licensed Midwives (CALM); Midwifery Access California (MACa); and the California Nurse-Midwives Association (CNMA)
- **Medi-Cal MCP Representatives:** California Association of Health Plans (CAHP); Local Health Plans of California (LHPC); and MCP Chief Medical Officers (CMOs) and staff
- **Local Partners:** County Health Executives Association of California (CHEAC) MCAH Committee; Local MCAH Directors; Local Health Officers (LHOs); the California WIC Association (CWA); and the County Behavioral Health Directors Association of California (CBHDA)
- **Other Key Partners:** California Maternal Quality Care Collaborative (CMQCC); Blue Shield of California Foundation; California Work and Family Coalition; Legal Aid At Work (LAAW); and the DHCS Doula Implementation Stakeholder Workgroup

III. BIRTHING CARE PATHWAY POLICY ROADMAP

III. BIRTHING CARE PATHWAY POLICY ROADMAP

The landscape assessment and member and partner engagement led to the crystallization of problem statements and drove DHCS' identification of an array of policies within its purview as the State Medicaid agency, and in collaboration with other State agencies and key partners, to support pregnant and postpartum Medi-Cal members through the Birthing Care Pathway. These policies are described below in the following two categories:

- **Policies DHCS Has Implemented/Is Implementing:** Forty-two policies in eight focus areas that DHCS has already implemented or is implementing for the Birthing Care Pathway. Medi-Cal members and Birthing Care Pathway partners provided a number of recommendations for how DHCS can implement these policies most effectively.
- **Strategic Opportunities for Further Exploration:** Opportunities in six focus areas that may be explored in the future. Many of these reflect issues and ideas surfaced through engagement with Medi-Cal members and partners and can inform future discussion of the "next generation" of Birthing Care Pathway policies. These opportunities require additional assessment and planning to determine if implementation is feasible, and would be contingent on external factors, such as legislative authority or additional state budget resources.

A. Policies DHCS Has Implemented/Is Implementing

The policies DHCS has implemented/is implementing for the Birthing Care Pathway are in the following eight focus areas:

1. Provider Access and MCP Oversight and Monitoring
2. Behavioral Health and Trauma-Informed Care
3. Risk Stratification and Assessment
4. Medi-Cal Maternity Care Payment Redesign
5. Care Management and Social Drivers of Health
6. Perinatal Care for Justice-Involved Individuals
7. Data and Quality
8. State Agency Partnerships

Each focus area contains a central problem statement that the policy solutions are responding to, and each policy solution that DHCS has implemented or is implementing provides additional context and a specific implementation approach.

Supporting and strengthening the implementation and sustainability of many of these policy solutions in the Medi-Cal program is their alignment with DHCS' Medi-Cal Transformation program areas currently being operationalized, such as Population Health Management (PHM), ECM, Community Supports, and the Justice-Involved Reentry Initiative. Some of these

policies will be implemented in Medi-Cal FFS and by Medi-Cal MCPs, and others will be implemented solely by MCPs given that approximately 72 percent of pregnant and postpartum Medi-Cal members are enrolled in MCPs.

Implementing the Birthing Care Pathway policy solutions described in this section will not require additional state budget resources. Additionally, it will require DHCS to place new emphasis on ensuring that each policy's implementation aligns with this report's recommendations. Implementing these policies will require updating Medi-Cal Managed Care All-Plan Letters (APLs) and the Medi-Cal Provider Manuals as well as reinforcing existing policy requirements and enhancing communication between DHCS and Medi-Cal members, providers, and MCPs. DHCS will continue to engage with partners and provide opportunities for feedback in implementing many of these policies.

1. Provider Access and MCP Oversight and Monitoring

Problem Statements.

Medi-Cal members who participated in the Birthing Care Pathway member engagement activities described experiencing discrimination in their health care encounters during their pregnancies, labor and delivery, and postpartum care. Medi-Cal members shared that they felt better supported and most connected to their health care providers when they received culturally and racially concordant care. However, there is limited racial and ethnic diversity of OB/GYNs, LMs, and CNMs in Medi-Cal today. Additionally, Medi-Cal members in California's rural areas face barriers to accessing maternal care due to maternity units in rural acute care hospitals closing from a lack of licensed maternity care clinicians and sustainability concerns.

Midwives—LMs and CNMs—are critical maternal health providers in California with Medi-Cal members and Birthing Care Pathway partners underscoring the trusting relationships midwives build with their patients. Members shared that midwives listened to their needs and preferences, and midwives' holistic approach to childbirth made them feel empowered and supported during labor and delivery. Birthing Care Pathway partners explained that certain Medi-Cal provider enrollment requirements created potential barriers for participating in Medi-Cal, particularly for LMs since they often practice independently and operate in homes and FBCs and can be unfamiliar with Medicaid enrollment and reimbursement requirements. While CNMs have also experienced some challenges, those challenges have typically been to a lesser extent than LMs since CNMs are more familiar with Medi-Cal requirements and typically practice in hospital settings. Additionally, some network contracting requirements with MCPs for LMs and CNMs go beyond Medi-Cal provider enrollment requirements and at times may not be fully aligned with the scopes of practice outlined by the Medical Board of California for LMs and the California Board of Registered Nursing for CNMs.

Some Medi-Cal members participating in the Birthing Care Pathway member engagement activities shared positive feedback on doulas who helped them craft and advocate for their

birth plans while others said they were not aware that doula services were a Medi-Cal benefit and available without having to pay out-of-pocket. Access to lactation support—both inpatient after delivery and outpatient—was noted by both Medi-Cal members and Birthing Care Pathway partners as inconsistent, with Medi-Cal members expressing a need for improved and timely access to a range of high-quality breast pumps that meet their needs. Medi-Cal members and their providers are often unaware of the full array of available maternity care services, leading to decreased access and utilization of covered benefits. For example, Birthing Care Pathway partners stressed that some MCPs and Medi-Cal-enrolled providers are unclear on what Medi-Cal covers and will reimburse for midwifery, lactation, and doula services. Additionally, partners have reported that group perinatal care models (e.g., CenteringPregnancy) are not available statewide and are not widely adopted by MCPs.

Medi-Cal members also expressed a need for smoother hospital discharges after birth to ease their transition into the postpartum period. While MCPs are required to provide transitional care services (TCS) to members who are transferring from one setting or level of care to another, including discharges from hospital to home, DHCS' TCS policy does not yet include specific requirements for MCPs to meet the unique needs of pregnant and postpartum members.

Birthing Care Pathway Policy Solutions.

Leverage CalHealthCares education loan repayment program to build pipeline and increase diversity of OB/GYN and family medicine workforce.

Context: CalHealthCares, which launched in April 2019 with $340 million in tobacco tax revenues, administers loan repayment on educational debt for California physicians and dentists who provide care to Medi-Cal members. Eligible physicians can apply for up to $300,000 in loan repayment in exchange for a five-year service obligation to serve a designated percentage of Medi-Cal members. In the fiscal year 2022–2023 CalHealthCares cohort, 14 out of 186 adult loan repayments went to OB/GYNs.

Implementation Approach: DHCS is in the early stages of planning for the next CalHealthCares cohort. DHCS will bolster communication and education about CalHealthCares, including how to apply, to OB/GYNs and family medicine physicians who provide obstetric care. DHCS intends to prioritize awarding loan repayments to OB/GYNs and family medicine physicians who provide obstetric care practicing in rural and shortage areas and those who are from populations underrepresented in medicine. DHCS will leverage the recommendations in

the California Black Birth Justice Agenda and consult the California Department of Health Care Access and Information (HCAI) on best practices for launching workforce development and diversification initiatives.

Remove administrative barriers to Medi-Cal provider enrollment and reimbursement requirements for all midwives, with a particular emphasis on LMs, by ensuring alignment with state licensing and scope of practice requirements.

Context: LM and CNM services are Medi-Cal covered benefits, and as such, LMs and CNMs may enroll as Medi-Cal providers. However, there have been some barriers to Medi-Cal provider enrollment and reimbursement for midwives, particularly for LMs, which were not wholly consistent with state licensing and scope of practice requirements.[10] Additionally, unlike CNMs, LMs may not be as familiar with Medi-Cal program requirements, including those relating to enrollment and reimbursement. LMs have requested additional technical assistance from DHCS.

Implementation Approach: In March 2024, as part of an update to the Non-Physician Medical Practitioners Medi-Cal Provider Manual, DHCS modified how CNMs can bill Medi-Cal to promote better alignment with their scope of practice as dictated by California state licensing requirements rather than focus on specific codes. Additionally, DHCS created a new list of reimbursable codes for LMs to promote clarity and better align with their scope of practice. DHCS continues to work with LMs to refine this list of reimbursement codes. In May 2024, DHCS developed a DHCS-specific webpage related to Midwifery Services in Medi-Cal. In September 2024, DHCS developed instructions for LMs to support enrollment in the Provider Application and Validation for Enrollment portal, and published a provider bulletin clarifying that the established place of business for LMs and CNMs can be an "administrative location" such as their home address. In October 2024, DHCS hosted a Medi-Cal billing training for LMs. DHCS continues to provide technical assistance on billing for LM and CNM services covered under Medi-Cal and is working closely with CDPH to support LMs' enrollment in Medi-Cal as direct/billing providers and applications to be CPSP providers.

[10] SB 1237: CNM Scope of Practice; AB 1308: LM Scope of Practice; California Board of Nursing Nurse-Midwife Certification Application; Medical Board of California LM Licensing Requirements.

Clarify MCP network adequacy requirements for CNMs, LMs, and FBCs as Mandatory Provider Types and strengthen thresholds that must be met.

Context: Federal and California law requires MCPs to contract with "Mandatory Provider Types" (e.g., CNMs, LMs, FBCs) in their service areas.[11] MCPs must contract or demonstrate efforts to contract with a CNM, LM, and FBC in every service area in which they operate. If an MCP does not meet this requirement, DHCS will impose a corrective action plan that establishes temporary access standards including out-of-network authorizations and provisions of transportation services. The current threshold for MCPs is set at a minimum of one of each Mandatory Provider Type in their service area.

Implementation Approach: DHCS will clarify in APLs that MCPs must contract with sufficient numbers of CNMs, LMs, and FBCs based on the level of need in each of their service areas, revisit those levels of need annually, and adjust contracting as necessary.

Reiterate Medi-Cal requirements that the MCPs whom DHCS are contracted with are responsible for ensuring all covered services are accessible and the provider network is adequate. Enhance oversight of network agreements and/or delegated arrangements for maternity/perinatal care services to ensure covered benefits (midwifery, doula, and lactation services) are clearly outlined.

Context: Partners explained that downstream subcontracting arrangements to Independent Physician Associations (IPAs) or other delegated arrangements can create barriers to perinatal services (e.g., more stringent provider enrollment requirements). Some MCPs require LMs and CNMs to join IPAs and be supervised by a physician to enroll with that MCP, though this is not required based on

[11] FQHCs, rural health centers (RHCs), and Indian health facilities are also considered Mandatory Provider Types under federal and California law.

their scopes of practice. In addition, the IPA contracting agreement may fully delegate all maternity care services for a specific population to the IPA but fail to list out specific Medi-Cal covered services that must be provided to pregnant and postpartum members including doula services, lactation and nutrition services, FBC services, and LM and CNM services.

Implementation Approach: DHCS will update its APLs reminding MCPs to review (1) network agreements and (2) Divisions of Financial Responsibility (DOFRs) to include midwifery, doula, and lactation services as appropriate. If the MCP maintains direct full financial responsibility and contracts with midwives and doulas, then this should be apparent in DOFRs with maternity care/perinatal care providers. DHCS will issue clarifying guidance to MCPs that if the MCP assigns a population to another MCP or a downstream subcontractor, such as an IPA, then the MCP that DHCS is contracted with continues to be ultimately responsible for ensuring that all Medi-Cal covered services are accessible and the provider network to deliver those services is adequate. DHCS will review network agreements and delegated arrangements as part of DHCS' existing audit processes to ensure access to these perinatal services is not being limited.

Establish a Doula Implementation Stakeholder Workgroup comprised of doulas, Black birthing justice experts, Tribal representatives, local health departments, advocates, and provider associations to inform DHCS' doula benefit design and reimbursement approach.

Context: DHCS added doula services as a covered Medi-Cal benefit in January 2023, making California one of 25 states actively reimbursing for doula services through Medicaid as of January 2025. Doula services are available in Medi-Cal FFS and through MCPs and include emotional and physical support provided to individuals and families during pregnancy, labor, birth, and the postpartum period as well as support for and after miscarriage and abortion. Senate Bill (SB) 65 (Chapter 449, Statutes of 2021) required DHCS to seek input from doulas and other maternal health partners to ensure that the doula services benefit is publicized and made accessible to eligible Medi-Cal members and that Medi-Cal doulas receive timely reimbursement for their services.

Implementation Approach: DHCS launched the Doula Implementation Stakeholder Workgroup in March 2023 as an independent policy advisory group with 30 members. The Workgroup is comprised of doulas, health care providers, consumer and community advocates, health plan representatives, county representatives, hospital and health plan association representatives, and other partners who have experience with doula services; its meetings are open to the public. As required by SB-65, the Workgroup is developing a report with DHCS (expected by July 1, 2025) that will include the number of Medi-Cal members utilizing doula services; compare birth outcomes among individuals who do and do not receive doula support; identify barriers impeding Medi-Cal members' access to doulas; and present Workgroup recommendations to address barriers to doula services. When available, these Workgroup recommendations will also be evaluated by DHCS for the Birthing Care Pathway. In December 2023, CMS approved DHCS' proposal to increase Medi-Cal doula reimbursement rates to up to $3,100, making California's rate one of the highest in the country.

Issue a standing recommendation for doula services for all pregnant and postpartum Medi-Cal members to increase access to doula services and launch a Doula Directory for use by Medi-Cal members, providers, and MCPs to identify doulas in their community/network.

Context: Doula services require a written recommendation from a physician or other licensed practitioner of the healing arts for Medi-Cal coverage. To support access to doula services, the Doula Implementation Stakeholder Workgroup recommended that DHCS create a Doula Directory.

Implementation Approach: The DHCS Medical Director issued a statewide standing recommendation in November 2023 for doula services for Medi-Cal members who are pregnant or were pregnant within the past year, eliminating the need for Medi-Cal members to obtain a written referral for doula services. The standing recommendation authorizes one initial visit; up to eight additional visits that may be provided prenatal or postpartum; support during labor and delivery (including stillbirth, abortion, or miscarriage); and up to two extended three-hour postpartum visits. Additionally, DHCS' Doula Directory, launched in August 2023, lists Medi-Cal-enrolled

doulas by county who opted to be included in the directory along with their specialties, language, race/ethnicity, and other information. As of December 2024, DHCS has enrolled 529 individual doula providers; this number is inclusive of any individual doulas who may be part of a doula group that enrolled in Medi-Cal. To further promote the Doula Directory, DHCS will release a member notice highlighting this resource in early 2025.

Streamline requirements and improve access to a range of high-quality breast pumps.

Context: Lactation management aids, classified as durable medical equipment (DME), are Medi-Cal covered benefits. MCPs must provide medically necessary lactation DME, such as breast pumps and breast pump kits, to breastfeeding members. Personal grade (single-user) electric breast pumps are covered when medically necessary for rental or purchase though they require a treatment authorization request (TAR) if the cumulative cost within the calendar month exceeds $100. Hospital grade (multiuser) electric breast pumps are covered when medically necessary for daily rental only; a TAR is required if the rental amount exceeds $164 in a 15-month period. TARs must include a detailed description of the medical necessity of the requested equipment and an explanation of why an electric pump must be used instead of a less expensive manual device; a prescription from the treating practitioner must be accompanied with a TAR. If an MCP requires prior authorization for lactation management DME, criteria must be developed based on sound clinical principles and the medical needs of both the breastfeeding member and infant. Partners—including postpartum Medi-Cal members—have requested that DHCS remove prior authorization/TAR requirements that can cause delays in obtaining breast pumps.

Implementation Approach: DHCS plans to modify the DME Medi-Cal Provider Manual to reduce barriers and increase access to various types of breast pumps available to breastfeeding members by removing the TAR requirements. DHCS will also clarify in an APL that equivalent types of breast pumps are covered by Medi-Cal. This policy update would apply to both the FFS delivery system and MCPs. Additionally, since most Medi-Cal covered benefits are the same in both Medi-Cal FFS and managed care delivery systems, DHCS expects that if Medi-Cal removes TAR

requirements in FFS, Medi-Cal MCPs would similarly relax prior authorization requirements which would help ensure parity and also ensure that Medi-Cal providers in both FFS and managed care are able to provide Medi-Cal members with clinically appropriate choices when selecting breast pumps.

Survey MCPs on promising practices to promote covered perinatal benefits among members as well as providers (e.g., among hospital partners on use of doulas and lactation support) to drive appropriate utilization. The survey will also include questions related to practices to reduce administrative burden for providers (e.g., contracting support through hub models, streamlining authorization processes).

Context: Partners have underscored that some MCPs and Medi-Cal-enrolled providers are not aware that Medi-Cal covers and reimburses for home births, CNM and LM services, and lactation and doula services.

Implementation Approach: DHCS will develop and share with MCP chief medical officers (CMOs) a survey with questions on service utilization, service promotion, prior authorization requirements, and best practices for promoting home births, CNM and LM services, and lactation and doula services. DHCS will analyze survey results and may share them with MCPs to foster discussion of lessons learned.

Consolidate and update Medi-Cal perinatal policies through a single APL and update provider manuals to clearly define perinatal benefits and provider enrollment requirements for midwives, birth centers, and doulas, and encourage MCPs to incentivize network providers to offer group perinatal care models to pregnant and postpartum members.

Context: DHCS' Medi-Cal perinatal benefits and related policies are currently documented across multiple APLs, provider manuals and bulletins, webpages, and other documents which have been issued across multiple decades. As a result of this fragmentation, partners have reported confusion over what Medi-Cal benefits are available to pregnant and postpartum members, including group perinatal care models, as well as the Medi-Cal provider enrollment requirements for maternity care providers, particularly CNMs, LMs, FBCs, and doulas. Group perinatal care models such as CenteringPregnancy empower participants to engage in their own care and build community and have shown improved maternal and infant outcomes. Although DHCS reimburses MCPs for group perinatal care services through existing billing codes, partners have noted that adoption is low.

Implementation Approach: DHCS will solicit input from partners—including the full spectrum of maternity care providers—before issuing the consolidated APL and updated provider manuals. DHCS will retire any APLs that the new one supersedes and update relevant webpages with the new guidance. In its consolidated guidance, DHCS can educate MCPs on group perinatal care models and note opportunities to leverage existing incentive and directed payment programs to encourage their adoption at care delivery sites across the state. DHCS will conduct additional partner engagement on the final policy updates with MCPs, providers, and other interested partners.

Create and enhance member-facing communications materials and outreach strategies on perinatal Medi-Cal benefits and provider types to bolster awareness during and after pregnancy.

Context: Some Medi-Cal members who participated in the Birthing Care Pathway member engagement activities explained that they did not understand what Medi-Cal benefits and public benefits/social services were available to them during pregnancy or while postpartum and would have benefitted from more educational materials. Member-facing communication through print and digital media can help pregnant and postpartum Medi-Cal members and eligible Californians to understand the benefits and services that are available to them. Leveraging widely used and readily accessible social media platforms can further extend reach and enhance message impact with pregnant and postpartum Medi-Cal members.

Implementation Approach: In September 2024, DHCS launched a new website with information on maternal and perinatal health care services. In January 2025, DHCS released member-facing fact sheets that explain the different maternity care provider types and perinatal benefits available through Medi-Cal as well as certain public benefits such as WIC/CalFresh and Paid Family Leave (PFL). DHCS will also launch new member-facing webpages in early 2025 that explain Medi-Cal benefits, eligibility requirements, application procedures, and coverage renewals. These webpages will contain information for pregnant and postpartum members on prenatal, delivery, and postpartum care; midwife and doula services; breastfeeding; and infant coverage and care. DHCS will also include information on perinatal Medi-Cal benefits and providers in an updated MyMedi-Cal—a guide for members on how to use their Medi-Cal benefits—in April 2025. Building on DHCS' work conducted with EIC as well as other partnerships, DHCS will recruit Medi-Cal members and perinatal care providers (e.g., doulas) who participated in the Birthing Care Pathway member engagement activities to be featured in social media videos to be distributed across Medi-Cal channels. These stories will be shared alongside links to the new member-facing webpages that discuss pregnancy and postpartum care options for members. DHCS will also leverage social media to share posts promoting maternal health awareness, particularly newer benefits such as doula and dyadic services. Each of the member-facing materials will be translated into DHCS' threshold languages. DHCS will consider partnering with CDPH, the California Department of Social Services (CDSS), and CBOs to amplify these messages to Medi-Cal members.

Create guidance and/or technical assistance for MCPs on supporting pregnant and postpartum members transferring to different care settings and levels of care.

Context: As part of DHCS' Medi-Cal Transformation PHM Program, MCPs are required to provide TCS to Medi-Cal members who are transferring from one setting or level of care to another, including discharges from a hospital to home. Pregnant and postpartum members are considered high-risk under TCS and therefore are required to have a single point of contact for the duration of their transition. The care manager's responsibilities include, but are not limited to, assessing the member's risk; ensuring appropriate clinical information is shared with the member and follow-up providers; ensuring the completion of all recommended follow-up care; and ensuring members are assessed for ECM, Complex Care Management, and Community Supports eligibility and referred within 30 days post discharge. Partners have recommended that TCS requirements for pregnant and postpartum members include referrals for home visiting programs, lactation services, PFL, and WIC before the pregnant or postpartum member is discharged.

Implementation Approach: DHCS will develop guidance and/or technical assistance for MCPs to support the implementation of TCS for pregnant and postpartum members undergoing transitions of care. DHCS will conduct partner engagement to understand challenges and potential solutions to improve TCS for pregnant and postpartum members.

2. Behavioral Health and Trauma-Informed Care

Problem Statements.

Pregnant and postpartum Medi-Cal members face challenges accessing timely behavioral health care with limited mental health providers—particularly psychiatrists—who accept Medi-Cal, are taking new patients, and have perinatal experience. This is troubling because in California, one in five pregnant and postpartum people experience maternal mental health issues (e.g., perinatal mood and anxiety disorders); however, 75 percent do not receive treatment. This crisis is further exacerbated for Medi-Cal members, 50 percent of whom report maternal depression. Black and American Indian/Alaska Native postpartum Californians report higher rates of anxiety and depression compared to other races/ethnicities. Left untreated, maternal mental health conditions can lead to negative outcomes for the Medi-Cal member and child, as well as significant financial costs (e.g., more use of emergency care

services, higher rates of work absenteeism) estimated at about $35,000 for each pregnant or postpartum member/child dyad.

SUDs—including alcohol and tobacco use—are also prevalent and common co-occurring conditions with maternal mental health concerns. SUD was identified as a precipitating factor in the deaths of 29 percent of California pregnant or postpartum individuals who died by suicide between 1999 and 2016. Medi-Cal-enrolled providers have reported confusion around how long a pregnant or postpartum individual can receive residential SUD treatment in Medi-Cal which results in barriers to life-saving care.

Trauma—which may include adverse childhood experiences (ACEs), IPV, community violence, racism, and discrimination—can impact an individual's physical and mental health outcomes, relationships with health care providers, engagement with the health care system, and adherence to treatment. Medi-Cal members who participated in the Birthing Care Pathway member engagement activities shared that their experiences with discrimination in their health care encounters throughout the perinatal period have negatively impacted their overall Medi-Cal experiences.

Birthing Care Pathway Policy Solutions.

Raise awareness of Children and Youth Behavioral Health Initiative (CYBHI) ongoing investments to provide behavioral health services and supports to pregnant and postpartum individuals and their children.

Context: The CYBHI is part of Governor Newsom's Master Plan for Kids' Mental Health, a historic investment by the State of California that takes a "whole child" approach to addressing the factors that contribute to the mental health and well-being of California's children, youth, and families.

Implementation Approach: In January 2024, DHCS launched, via a partnership with Brightline, the BrightLife Kids program. BrightLife Kids is for parents or caregivers and kids 0–12 years old. It offers free coaching services with qualified behavioral health wellness coaches in English and Spanish, telephone-based coaching in all Medi-Cal threshold languages, age-tailored educational content, online tools and assessments, care navigation services, peer communities, and crisis and safety resources for users who are experiencing mental health crises or need immediate assistance.

Review MCP, Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC), and Specialty Mental Health Services (SMHS) contracts to identify opportunities for strengthening existing contract language, including monitoring and oversight requirements, to ensure pregnant and postpartum members have access to qualified behavioral health providers and their perinatal care is integrated with behavioral health care.

Context: Behavioral health care for pregnant and postpartum Medi-Cal members is provided across Medi-Cal delivery systems, including MCPs, DMC-ODS, DMC, and SMHS.

Implementation Approach: DHCS will analyze how MCP, DMC-ODS, DMC, and SMHS contracts, plan guidance, and provider training can be modified and improved to support Medi-Cal members who are pregnant and postpartum and address behavioral health concerns. Using existing data on rates of screening for prenatal and postpartum depression and follow up, DHCS will identify programs to incentivize and promote screening and treatment of non-specialty mental health, specialty mental health, and SUDs across delivery systems.

Reinforce communication of existing Medi-Cal coverage policy of no maximum stay (e.g., 60 days) for members—including pregnant and postpartum members—receiving residential SUD treatment.

Context: The California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration permits pregnant and postpartum Medi-Cal members to receive residential SUD treatment with no maximum stay limitation. The CalAIM Transformation 1115 demonstration Standard Terms and Conditions (STCs) stipulate that California should aim for a statewide average length of stay of 30 days or less in residential treatment settings, but this does not apply to individual stays. DHCS learned through key informant interviews that there is confusion around the length of time a pregnant or postpartum Medi-Cal member can stay in a residential SUD treatment facility with some providers erroneously believing there is a 60-day limit.

Implementation Approach: DHCS issued Behavioral Health Information Notice (BHIN) No. 24-001 in December 2023 which reflects that Medi-Cal members can stay in residential SUD treatment programs for as long as clinically appropriate as determined by a Licensed Practitioner of the Healing Arts (LPHA). DHCS issued clarifying guidance via a CalAIM Behavioral Health Initiative FAQ in May 2024 and reinforced this guidance in a meeting with county behavioral health plans in June 2024.

Update and disseminate SUD Perinatal Practice Guidelines for providers that deliver SUD treatment to pregnant and parenting women.

Context: In accordance with DMC, DMC-ODS, CalAIM, and the Substance Use Prevention, Treatment and Recovery Services Block Grant Perinatal Set-Aside from the Substance Abuse and Mental Health Services Administration, the SUD Perinatal Practice Guidelines address requirements for perinatal care delivery and best practices for serving pregnant and parenting women. Providers must adhere to all requirements outlined in the SUD Perinatal Practice Guidelines and are encouraged to use the best practices as a reference tool in developing comprehensive, individualized, gender-specific, and family-centered SUD services.[12]

Implementation Approach: DHCS updated the SUD Perinatal Practice Guidelines in August 2024. DHCS provides training and technical assistance (e.g., phone calls, literature, webinars) to counties, providers, and members of the public regarding services for pregnant and parenting individuals with SUDs, assisting with program development and increasing public awareness of the potential impact of SUDs.

[12] California Health and Safety Code (HSC) Division 10.5, Part 1, Chapter 2, Alcohol and Drug Affected Mothers and Infants Act; Code of Federal Regulations (CFR), Title 45, Public Welfare, Part 96, Subpart L; California HSC Division 10.5, Part 1, Chapter 2, Alcohol and Drug Affected Mothers and Infants Act.

Re-frame services in a trauma-informed context, acknowledging how care needs to be delivered to pregnant and postpartum members who are experiencing or have experienced ACEs, IPV, community violence, and racism.

Context: Consistent with ACOG's Committee on Health Care for Underserved Women recommendations and the Office of the California Surgeon General's (OSG's) first-in-the nation ACEs Aware initiative, DHCS has an opportunity to better integrate a trauma-informed care approach for the care of pregnant and postpartum Medi-Cal members and their Medi-Cal covered services. The U.S. Preventive Services Task Force (USPSTF) also recommends providing counseling interventions to prevent perinatal depression to individuals at increased risk for perinatal depression, including those with low socioeconomic status, lack of social or financial support, or recent IPV, among other factors.

Implementation Approach: DHCS will continue to promote the existing ACEs Aware training among maternity care providers. The ACEs Aware training outlines how providers should share scores and findings from ACEs screenings with families, caregivers, and appropriate providers, and refer pregnant and postpartum members and their children to more in-depth Child and Family Strength Needs assessments and/or assessments to facilitate connection to needed services. DHCS will update its Medi-Cal Provider Manuals and PHM and ECM Policy Guides and issue guidance to MCPs reiterating its commitment to trauma-informed care.

3. Risk Stratification and Assessment

Problem Statements.

There is a lack of standardization with regard to how Medi-Cal MCPs use risk stratification algorithms, employ risk tiers, and connect members to services. Many current risk stratification methodologies are not specific to pregnant and postpartum members and rely on utilization or cost data only which may result in racial, condition, or age bias.

Partners also shared that IPV screening as a maternal risk factor was inconsistent with limited follow-up care or support. This is troubling because a 2024 report suggests that nearly half of all women in California will experience IPV in their lifetime, and additional studies have found that the risk of IPV increases during the perinatal period. One study found that 54 percent of pregnancy-associated suicides and 45 percent of pregnancy-associated homicides involved IPV. American Indian/Alaska Native pregnant and postpartum individuals in California report

IPV rates that are nearly twice as high as those reported by other races/ethnicities. Additionally, IPV survivors are more likely to experience behavioral health conditions such as depression, anxiety, post-traumatic stress disorder, and SUD compared to those who have not experienced IPV, and about half of all women experiencing homelessness reported IPV as the immediate cause of their homelessness.

Birthing Care Pathway Policy Solutions.

Develop a risk stratification, segmentation, and tiering (RSST) process in Medi-Cal Connect to identify pregnant and postpartum members who are high risk, including risks across medical, behavioral, and social domains, and that aims to reduce the bias documented in current methodologies. The RSST will identify members who may benefit from connections to additional social support and clinical care.

Context: As a part of its Medi-Cal Transformation PHM Program and in partnership with a group of national experts in DHCS' RSST Workgroup, DHCS is currently designing an algorithm that will perform risk stratification. The RSST algorithm will be deployed within Medi-Cal Connect, a statewide data solution to drive population health management, close gaps in services, and improve member lives. By aggregating data from trusted partners, Medi-Cal Connect provides a complete picture of a member's benefits and health and population-level insights that inform policy and programs. Medi-Cal Connect also empowers Medi-Cal health plans, providers, and trusted partners with secure access to data and easy-to-use tools to improve health outcomes and equity throughout California. The RSST algorithm will identify each pregnant or postpartum Medi-Cal member as having high, medium rising, or low risk of an adverse event for the purposes of receiving additional assessments and linkage to appropriate Medi-Cal services.

Implementation Approach: This RSST algorithm is expected to be available in Summer 2025. The DHCS PHM RSST approach is designed to predict which members may benefit from additional Medi-Cal or other public services (e.g., care management program enrollment, WIC enrollment, doula services, etc.) based off physical, behavioral, or social risk factors. This algorithm is not designed to be a clinical decision-making support tool and will not define 'high risk pregnancy' from a medical perspective to guide clinical interventions. MCPs will be required to use the RSST algorithm to conduct outreach to all high-risk members and connect them to needed services. Starting in the second half of 2025, providers who use Medi-Cal Connect will be able to see the risk tier of any member. DHCS will consider creating guidance for MCPs

and providers on how to use this tool most appropriately for pregnant and postpartum members.

Incorporate IPV screening as part of Medi-Cal assessments performed by providers and clinical care managers.

Context: The USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer those who screen positive to ongoing support services. MCPs are required to cover all preventive services identified as USPSTF Grade A or B; USPSTF classifies IPV screening as Grade B. Clinicians may use a number of screening tools, such as the Humiliation, Afraid, Rape, Kick (HARK) tool, that have been proven to accurately detect IPV. In 2015, the University of California San Francisco launched the Aspire to Realize Improved Safety and Equity (ARISE) program which includes a validated IPV screening tool and universal IPV education. ARISE increased the number of Californians with positive IPV disclosures from 157 in 2016 to 1,652 in 2019.

Implementation Approach: In 2022, DHCS incorporated a review of provider IPV screening into its Facility Site Review and Medical Record Review requirements. DHCS will issue guidance to MCPs on how to incorporate IPV screening in required assessments conducted by providers and care managers under the PHM Program (including for members entering ECM) and under CPSP.

4. Medi-Cal Maternity Care Payment Redesign

Problem Statements.

Partners explained that Medi-Cal's reimbursement rates for licensed and non-licensed maternity care providers are not high enough to incentivize some providers to enroll as Medi-Cal providers. In addition, the existing Medi-Cal maternity payment model is hospital-oriented, making it challenging for FBCs and midwives providing home births to be recognized and reimbursed for their birthing approaches. For example, birthing hospitals charge a facility fee for services provided to a pregnant or postpartum member by a team of care providers (e.g., nurses, medical assistants) such as fetal monitoring, medication administration, newborn care, and health education. FBCs and midwives providing home

births provide these services as part of their other obstetric care but do not charge a facility fee. This makes it difficult for midwives practicing in non-hospital settings to be reimbursed for their complement of services as there are still supply and other costs associated with home and FBC births. Partners also underscored confusion among providers and MCPs about how to bill and be appropriately reimbursed for home births and FBC services which has led to some midwives choosing not to offer home births and FBCs opting to not participate in Medi-Cal.

Partners report that the existing Medi-Cal maternity payment model does not incentivize providers to appropriately transfer a patient to a higher level of care based on the patient's needs. In FFS, global obstetrical billing codes and payment rates are used to reimburse one bundled reimbursement rate for all perinatal services, including antepartum care, labor and delivery, and postpartum care. If a perinatal provider providing care in Medi-Cal FFS supports a pregnant member through the first part of prenatal care but then must transfer the member to a higher level of care due to a condition that developed during pregnancy, then the perinatal provider will not receive the total FFS global payment. Instead, the perinatal provider will need to bill Medi-Cal on a per service basis for each individual service provided before transferring the pregnant member.

Lastly, partners report that the existing FQHC and Rural Health Clinic (RHC) reimbursement methodology does not incentivize clinics to provide dyadic services because they do not get reimbursed for the dyadic services separately from and in addition to the prospective payment system (PPS) reimbursement rate for dyadic services provided during or on the same day as an eligible FQHC/RHC visit.

Birthing Care Pathway Policy Solutions.

Increase rates for maternity care providers and enhance supplemental payments for L&D and hospital-based birthing center services.

Context: Partners—including midwives and doulas—report that Medi-Cal rates are perceived to be low, presenting a barrier to provider enrollment.

Implementation Approach: Effective January 1, 2024, DHCS increased reimbursement rates for maternal health services, including those provided by OB/GYNs, doulas, and midwives (CNMs and LMs), to no less than 87.5 percent of the Medicare rate across Medi-Cal FFS and MCPs. DHCS leveraged hospital-specific

state-directed payment arrangements to enhance reimbursement for and improve the availability of L&D and hospital-based birthing center services effective January 1, 2025.

Expand maternity measures in the Quality Incentive Pool (QIP) for Designated Public Hospitals (DPHs) and District and Municipal Public Hospitals (DMPHs).

Context: The QIP for DPHs and DMPHs allows Medi-Cal-enrolled hospital providers to earn performance-based incentive payments based on their performance against designated performance metrics in primary care, specialty care, inpatient care, and resource utilization. The QIP includes priority and elective measures. DPHs and DMPHs are required to report all priority measures for which they meet specific criteria, outlined in the program policies. If a DPH or DMPH does not provide the relevant clinical service or otherwise cannot report a priority measure, they may substitute a measure from the elective measures list.

Implementation Approach: DHCS added maternal health-focused QIP performance measures for 2024, which include priority (cesarean birth, timeliness of prenatal care, postpartum care) and elective (exclusive breast milk feeding, prenatal depression screening and follow-up, postpartum depression screening and follow-up, prenatal immunization status) measures.

Redesign how Medi-Cal pays for maternity care services to create a new birthing care payment model that rewards value-based care, incentivizes best practices for pregnant and postpartum members, and supports the goals of the Birthing Care Pathway.

Context: Key principles for maternity care services payment redesign include rewarding equitable service utilization and quality outcomes, supporting member choice of the full range of birthing care options, and incentivizing provider best practices (e.g., using integrated clinical teams with doulas and CHWs; providing group perinatal care; screening for behavioral health; care coordination). DHCS

will need to consider how the birthing care payment model will apply to the range of birthing provider types, including OB/GYNs, CNMs, LMs, Tribal providers, Indian Health Service (IHS) providers, FQHCs, doulas, ECM Birth Equity providers, and CHWs, and how to optimize financial incentives for providers to appropriately transfer a patient to a higher level of care based on the patient's needs.

Implementation Approach: DHCS will conduct payment redesign through the TMaH Model in the five test counties (Fresno, Kern, Kings, Madera, and Tulare) and then evaluate scaling statewide after the TMaH performance period concludes. Certain incremental payment changes may be implemented on a parallel track.

Develop billing/reimbursement guidance for Medi-Cal providers as well as MCPs and their subcontractors on LM services, including home births, and FBC services.

Context: Partners explained there is confusion among providers, MCPs, and MCPs' subcontractors around how to bill for home births and services provided at a FBC. This has resulted in many LMs not offering home births and birth centers choosing to not participate in Medi-Cal. Partners asked for DHCS to develop clear billing guidance for providers and MCPs to mitigate this access barrier and cited Washington State's guidance as an example DHCS can look to.

Implementation Approach: In October 2024, DHCS hosted a webinar for LMs on Medi-Cal provider enrollment, member eligibility verification, billing and claims submission guidelines (including common denials, root causes, and follow-up forms), and the different billing options for LMs. DHCS will provide additional billing and payment guidance on LM services, including home births and FBC services, via updates to Medi-Cal Provider Manuals and provider bulletins, and the consolidated perinatal policy APL.

Strengthen implementation of dyadic services by establishing an alternative payment methodology (APM) allowing FQHCs, RHCs, and Tribal Health Programs (THPs) to be reimbursed for dyadic services at the Medi-Cal FFS reimbursement rate in addition to the FQHC/RHCs' PPS reimbursement rate and THPs' All-Inclusive Rate (AIR)[13] for an eligible visit.

Context: FQHCs, RHCs, and THPs, which include both IHS-Memorandum of Agreement (MOA) 638 Clinics and Tribal FQHCs, provide covered health care services, including dyadic services, to Medi-Cal members. Per federal Medicaid law and regulations, FQHCs and RHCs receive an all-inclusive rate (i.e., PPS rate) for all qualifying services provided during each visit. FQHCs/RHCs are reimbursed at the PPS rate from DHCS for each billable visit that a Medi-Cal member in FFS has at the FQHC/RHC.[14] When covered services are provided to MCP members, FQHCs/RHCs bill the MCP directly for the specific services that were provided based on negotiated rates. However, because the MCP payment to the FQHC/RHC is typically less than the PPS rate, the FQHC/RHC bills DHCS the "MCP wrap around" payment to bring the reimbursement up to the PPS rate. Under federal law, IHS-MOA 638 Clinics must be paid the AIR, which is established by the federal Office of Management and Budget and published annually in the Federal Register by the IHS; IHS-MOA 638 Clinics are paid the AIR rate for both FFS and MCP members[15]. Tribal FQHCs are paid at an APM, which is set by the AIR, for both FFS and MCP members.[16]

Implementation Approach: In January 2025, CMS approved DHCS' State Plan Amendment to authorize an APM allowing FQHCs, RHCs, and THPs to be reimbursed at the Medi-Cal FFS reimbursement rate in addition to the FQHC/RHCs' PPS reimbursement rate or the THPs' AIR/APM for dyadic services provided during or on the same day as an eligible FQHC/RHC or THP visit. DHCS anticipates this change will better incentivize FQHCs, RHCs, and THPs to provide dyadic services to Medi-

[13] THPs include both IHS-Memorandum of Agreement (MOA) 638 Clinics and Tribal FQHCs. IHS-MOA 638 Clinics receive the All-Inclusive Rate (AIR). Tribal FQHCs are reimbursed through an APM that is set at the AIR.
[14] Statutory Provision: 1902(bb); 1902(a)(15); 1915(b); Regulation: Title 42, CFR 447.371(c); 405.2462(c); 405.2467.
[15] IHS-MOA 638 Clinics allow up to three visits per day if one is a medical visit, one is a mental health visit, and one is an ambulatory visit which can include dental.
[16] Tribal FQHCs allow up to three visits per day in any combination of medical, mental health, and dental and ambulatory visits.

Cal members and appropriately code those services so DHCS can more accurately track utilization.

5. Care Management and Social Drivers of Health

Problem Statements.

Partners expressed a need for more technical assistance, support, and educational materials for perinatal providers to support the implementation of the ECM Birth Equity Population of Focus, which went live in January 2024. Partners also requested additional education about which Community Supports services can best support pregnant and postpartum Medi-Cal members. Several Medi-Cal members who participated in the Birthing Care Pathway member engagement activities shared that they were unaware of ECM and Community Supports, what they include, and how they can find out if they are eligible or which Community Supports are offered by their MCP. Partners stressed the need for ECM and Community Supports providers serving pregnant and postpartum members to have perinatal expertise. Partners also identified a need to prevent and address the adverse maternal and infant health outcomes that result from homelessness and housing insecurity.

Birthing Care Pathway Policy Solutions.

Leverage Providing Access and Transforming Health (PATH) to support ECM Birth Equity providers by providing technical assistance and prioritize ECM Birth Equity providers for Capacity and Infrastructure, Transition, Expansion, and Development (CITED) Initiative awards.

Context: PATH is a five-year, $1.85 billion Medi-Cal initiative to support capacity building for CBOs, public hospitals, counties, Tribes, and other providers participating in ECM and Community Supports, among other Medi-Cal Transformation initiatives. PATH includes an online technical assistance (TA) marketplace with off-the-shelf resources from vendors; regional collaborative planning and implementation initiatives among MCPs, providers, and other partners; and direct funding through the CITED Initiative to support the delivery of ECM and Community Supports services. CITED funds are available to CBOs, county agencies, hospitals, clinics, community-based providers, Tribes, and other providers currently contracted or planning to contract with MCPs for capacity building to deliver ECM and Community Supports.

Implementation Approach: DHCS encouraged maternal health providers who deliver ECM-like services and are best practice models to apply to become vendors in the PATH TA Marketplace to support other providers and CBOs who are interested in becoming ECM Birth Equity providers. As of September 2024, 24 of the 117 PATH TA Marketplace vendors were identified as providers who serve the ECM Birth Equity Population of Focus. DHCS conducted targeted outreach to ECM Birth Equity providers via emails, guidance, webinars, and office hours encouraging them to apply for CITED Round 3. DHCS announced the CITED Round 3 awardees in August 2024. Eighty-three of the 206 awardees are or plan to become ECM Birth Equity providers.

Conduct outreach to WIC, home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise to become ECM providers.

Context: ECM is designed to be delivered by community-based providers who contract with MCPs. Many WIC providers, home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise have an existing footprint in the communities and counties they serve and may already be working with pregnant and postpartum individuals who are eligible for ECM. However, they may be unaware of how they would benefit from enrolling as ECM providers.

Implementation Approach: DHCS will update the ECM Policy Guide to require MCPs to conduct outreach to these entities to encourage them to enroll as ECM providers with dedicated perinatal expertise. DHCS will consider coordinating with local MCAH programs on this outreach.

Expand ECM referral pathways, particularly from social services and behavioral health providers, for pregnant and postpartum members.

Context: MCPs are responsible for identifying members for ECM, and members may be identified in multiple ways, including community referrals, self- and family referrals, and by MCPs using available member data. Early data from MCPs shows that member engagement in ECM is more successful when initiated through community-generated referrals compared to data mining. DHCS strongly encourages referrals to ECM from the community, especially when they originate from entities that already have trusted relationships with members. Settings for preexisting trusted relationships include clinical settings such as primary care and specialty care clinics, hospitals, and county-based behavioral health; nonclinical settings such as housing agencies and schools; and other entities providing care and case management such as Regional Centers and California Children's Services. Referrals can come from enrolled ECM providers or unaffiliated community partners.

Implementation Approach: In August 2024, DHCS released new ECM Referral Standards to standardize and streamline ECM referrals made to MCPs from providers, CBOs, and other entities and make the referral process easier; these standards went live in January 2025. DHCS will conduct targeted outreach to social services (e.g., WIC, housing) and behavioral health providers who serve pregnant and postpartum Medi-Cal members to familiarize them with the ECM benefit and the process for making a referral. DHCS released Closed-Loop Referral Implementation Guidance in December 2024 that will bolster MCP support and tracking of ECM referrals.

Encourage utilization of Transitional Rent under the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 waiver demonstration as a Community Supports service for eligible Medi-Cal members – i.e., those who (1) meet one or more of the qualifying clinical risk factors[17] (e.g., pregnancy and up to 12 months postpartum), are (2) experiencing or at risk of homelessness, and (3) fall within one or more of the transitioning populations[18] (e.g., transitioning out of a hospital after giving birth).

Context: Effective July 1, 2025, DHCS will provide coverage of rent/temporary housing as an optional Medi-Cal service available through MCPs—to be known as "Transitional Rent"—for up to six months. Transitional Rent will be the first Community Support that becomes mandatory for MCPs to cover through a phased implementation approach. DHCS' vision is that Transitional Rent will help prevent and address the adverse health outcomes that result from homelessness.

[17] To meet the clinical risk factor requirement, a member must have one or more of the five qualifying clinical risk factors: (1) meets the access criteria for Medi-Cal SMHS; (2) meets the access criteria for DMC or DMC-ODS; (3) one or more serious chronic physical health conditions; (4) one or more physical, intellectual, or developmental disabilities; and (5) individuals who are pregnant up through 12 months postpartum.

[18] To be eligible for Transitional Rent, individuals must fall within one or more of the transitioning populations: (1) transitioning out of an institutional or congregate residential setting (including hospitals after giving birth); (2) transitioning out of a carceral setting; (3) transitioning out of interim housing; (4) transitioning out of recuperative care or short-term post-hospitalization housing; (5) transitioning out of foster care; (6) unsheltered homeless as described in 24 CFR part 91.5; and (7) eligible for Full-Service Partnership (FSP).

Implementation Approach: In August 2024, DHCS released a Transitional Rent Concept Paper for public comment and solicited input from a broad range of partners, including Birthing Care Pathway Workgroup members currently working to address health-related social needs in the prenatal and postpartum periods. CMS approved DHCS' request to cover Transitional Rent under the BH-CONNECT demonstration in December 2024. In July 2025, Transitional Rent will go live as an optional service for MCPs; MCPs can choose to go live for the BH Population of Focus[19] and/or other Transitional Rent-eligible populations (e.g., individuals transitioning out of an institutional or congregate residential setting, including hospitals after giving birth), with DHCS approval. In January 2026, Transitional Rent will become mandatory for MCPs to provide the service to the BH Population of Focus; MCPs may also choose to go live with additional populations within the Transitional Rent-eligible populations. MCPs electing to launch earlier than this mandatory launch phase will be required to continue covering Transitional Rent for all Transitional Rent-eligible populations they previously elected to cover for the duration of the demonstration (through 2029). As Transitional Rent goes live, DHCS will continue coordinating with maternal health partners to refine its design of Transitional Rent to meet the specific needs of pregnant and postpartum Medi-Cal members.

Encourage MCPs to partner with housing providers that meet the needs of perinatal populations from pregnancy through 12 months postpartum to serve as ECM and Community Supports providers.

Context: Today, most Community Supports housing providers are only open to either single adults or families, not pregnant Medi-Cal members. Similarly, most ECM providers supporting individuals experiencing homelessness do not specialize in the pregnant and postpartum population.

[19] Individuals who qualify for the BH Population of Focus must meet the access criteria for SMHS, DMC, or DMC-ODS, be experiencing or at risk of homelessness and be within a specified transitioning population *OR* unsheltered *OR* FSP-eligible.

Implementation Approach: DHCS will encourage MCPs to contract with housing providers that meet the needs of individuals from pregnancy through 12 months postpartum and promote best practice models through the PATH TA Marketplace. DHCS will encourage MCPs to support ECM providers for the Individuals Experiencing Homelessness Population of Focus and Community Supports providers in addressing the needs of pregnant and postpartum members. DHCS will encourage MCPs and ECM and Community Supports providers to conduct outreach within family homeless shelters and coordinate with homeless outreach teams and other entities (e.g., local housing and homelessness programs serving families, Head Start, schools, WIC centers) where families are known to be experiencing or at risk of homelessness to connect more Medi-Cal members with ECM and Community Supports. Now that DHCS has received federal approval to cover Transitional Rent as a Community Supports service for which some pregnant and postpartum members will be eligible, DHCS will continue to encourage MCPs to establish housing provider partnerships.

Encourage MCPs to build partnerships with IPV CBOs to serve as ECM and Community Supports providers.

Context: IPV CBOs across California have valuable expertise in how to create trauma-informed care plans for individuals experiencing IPV, such as documenting the care plan in a private section of the medical record, discussing contraceptive options that are less vulnerable to tampering, and identifying places to refer patients when they disclose IPV. This knowledge makes them well suited to contract with MCPs as ECM and Community Supports providers for Medi-Cal members experiencing IPV.

Implementation Approach: DHCS will encourage MCPs to contract with IPV CBOs that meet the needs of members from pregnancy through 12 months postpartum and promote best practice models through the PATH TA Marketplace.

Encourage MCPs to consider working with facilities that offer rooming in with short-term post-hospitalization stays and have the requisite capabilities to contract as Community Supports providers to provide Recuperative Care (medical respite) or Short-Term Post-Hospitalization Housing to postpartum members experiencing homelessness and who meet clinical criteria.

Context: The Recuperative Care Community Support, also referred to as medical respite care, is short-term residential care for members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. By having an extended stay in a recovery care setting, members can continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services such as transportation, food, and housing. This Community Support is primarily used for members who are experiencing homelessness. The Short-Term Post-Hospitalization Housing Community Support is designed for members who do not have a residence and who have high medical or behavioral health needs to receive short-term housing for up to six months to continue their recovery. To receive this service, members must also have been discharged from an inpatient clinical setting, residential SUD or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care facility.

Implementation Approach: DHCS and MCPs will encourage facilities that offer rooming in—where the postpartum individual and newborn are kept together—and coordinate discharge planning to safe interim or permanent housing options to enroll as Community Supports providers. DHCS will connect these facilities to PATH for technical support and highlight these facilities in a housing services Community Supports "spotlight" and an MCP Technical Assistance webinar.

6. Perinatal Care for Justice-Involved Individuals

Problem Statements.

Nationally, between 1980 and 2022, the number of incarcerated women increased by more than 528 percent, rising from a total of 26,326 in 1980 to 180,684 in 2022. Today, there are an estimated 58,000 admissions of pregnant individuals into prisons and jails every year across the country; 8,000 of those admissions are pregnant individuals with opioid use disorder

(OUD). Up to 4 percent of women entering a correctional facility are pregnant.[20] National rates of OUD in pregnant individuals have dramatically increased in recent years, including an 81 percent increase in pregnancy-associated overdose mortality from 2017 to 2020.[21] Numerous county jails across California have implemented medication-assisted treatment (MAT) for OUD and alcohol use disorder (AUD), with roughly 35 out of 58 counties participating in the "Expanding MAT in Criminal Justice Settings" initiative; within those 35 counties, jails have taken varied approaches in the types of MAT they provide. While some jails provide medications for opioid use disorder (MOUD) during pregnancy, there are few policies in place to ensure MOUD are continued after delivery, meaning many individuals are abruptly discontinued from these medications postpartum.

In January 2023, through the Medi-Cal Transformation **Justice-Involved Reentry Initiative**, California became the first state in the country to gain federal approval to offer a targeted set of Medicaid services to Medi-Cal/CHIP-eligible youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. By providing reentry services to Medi-Cal/CHIP-enrolled individuals who are incarcerated, California aims to build a bridge to community-based care for justice-involved enrollees, offering them services to stabilize their physical and behavioral health conditions and establishing, prior to release, a reentry plan for their community-based care.

Birthing Care Pathway Policy Solutions.

Ensure pregnant and postpartum individuals are enrolled in Medi-Cal pre-release.

Context: Enrollment of eligible pregnant and postpartum individuals in Medi-Cal prior to release from incarceration is key to ensuring that the pregnant and postpartum population has access to 90-day pre-release services as a part of the Medi-Cal Transformation Justice-Involved Reentry Initiative and streamlines immediate Medi-Cal coverage after release.

[20] Pregnancy Prevalence and Outcomes in U.S. Jails, 2020, Obstet Gynecol.
[21] US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020, 2022, JAMA.

Implementation Approach: Pre-release enrollment processes were required statewide as of January 1, 2023, as described in in All-County Welfare Directors Letter 24-04 and in Section 4 of the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative.[22]

Ensure eligible pregnant and postpartum individuals receive 90-day pre-release services.

Context: Provision of pre-release services including—pre- and post-release case management, MAT, clinical consultation, medications, and a supply of medications upon release—increases the likelihood of stabilization of health conditions prior to release as well as promotes connection to community-based providers. Individuals who are pregnant, up to 12 months postpartum, former foster care youth up to the age of 26, and/or under age 21 are automatically eligible for pre-release services under the Justice-Involved Reentry Initiative. Adults who meet certain eligibility criteria (e.g., individuals with mental illness, SUD, or chronic conditions) are also eligible for pre-release services.

Implementation Approach: Correctional facilities in three California counties (i.e., Inyo, Santa Clara, and Yuba) were approved to go-live with pre-release services in October 2024. Additional counties will go live each quarter; and all state prisons, county jails, and youth correctional facilities in the state are required to go live by October 2026. Pre-release services include a range of services that can support pregnant and postpartum individuals including, but not limited to, family planning counseling; ultrasounds; contraceptives/birth control; postpartum screenings; sexually transmitted infection (STI) screenings; physical and behavioral health screenings and diagnostic services; MOUD; and a supply of medications to have in hand upon release. In October 2023, DHCS released the Policy and Operational Guide for Planning and Implementing the CalAIM Justice Involved Initiative and, in August 2024, launched a partner engagement Learning Collaborative series to provide specific technical assistance to state and county correctional facilities on a variety of topics including providing specialized treatment to pregnant and postpartum individuals to prevent and reduce

[22] This process was already in place in state prisons.

health risks during pregnancy. The Learning Collaborative series also provided technical assistance on policies to continue delivery of MOUD for postpartum individuals, determined by both the clinician and the patient in accordance with evidence-based practices. The Justice-involved Reentry Initiative requires pre-release care managers to comprehensively screen individuals (including pregnant and postpartum individuals) via the Health Risk Assessment to identify physical and behavioral health needs as well as social needs. Through a warm hand-off to a community-based ECM provider, the pre-release care manager must establish post-release medical care for pregnant and postpartum individuals (e.g., OB-GYN, mental or behavioral health care) and work with the individual and the post-release care manager to develop a comprehensive reentry transition plan. These connections to care in the community reduce the risk of rapid decompensation of existing physical and mental health conditions and ensure access to ongoing and essential care.

Encourage connection to ECM upon release.

Context: Providing post-release case management by an ECM Lead Care Manager once a pregnant or postpartum individual is released into the community is one of the most effective ways to ensure reentering individuals have access to early and preventative care services for themselves and their children upon release.

Implementation Approach: ECM for the Justice Involved Population of Focus went live statewide in January 2024. As correctional facilities go live with pre-release services as a part of the Justice-Involved Reentry Initiative between October 2024 and October 2026, individuals who receive pre-release services will be presumptively/retroactively authorized to receive ECM services in the community for 12 months and are expected to begin receiving ECM services on the day of their release or on the day of their MCP enrollment. DHCS has outlined expectations for warm handoffs to ECM, the transfer of relevant health records and the Health Risk Assessment to the post-release ECM provider (among other post-release health care providers), and integration of pre-release screenings and health records into an individual's ECM Care Management Plan in the Policy and Operational Guide for Planning and Implementing the CalAIM Justice Involved Initiative (see Section 8.4 and Section 13). DHCS expects

MCPs to have a sufficient network of ECM providers for the Justice Involved Population of Focus to meet capacity needs in their county of operation and will engage in ongoing monitoring to ensure delivery of services to eligible members.

7. Data and Quality

Problem Statements.

Like every other state in the nation, California does not have a statewide Medi-Cal technology platform for maternal health providers, programs, and MCPs to easily and safely share patient data and help members manage their medical, behavioral, and social needs. Eligibility and enrollment data sharing across public benefits and programs are inconsistent in California causing gaps in care and service delivery. For example, only 65 percent of eligible Californians are enrolled in WIC, indicating missed enrollment opportunities for pregnant Medi-Cal members among whom WIC participation is linked to better birth and infant outcomes.

Maternity care quality metrics that are used for MCP quality improvement and accountability processes are often limited to two Healthcare Effectiveness Data and Information Set (HEDIS) metrics—timeliness of prenatal care and postpartum care. Additional metrics are needed to fully understand the scope and quality of Medi-Cal maternity care. DHCS currently uses the MCAS to evaluate MCP quality performance on maternal health and other health domains annually. MCPs are required to meet minimum performance levels (MPLs) for a subset of MCAS measures (including timeliness of prenatal care and postpartum care) and complete quality improvement activities to improve their performance (see Box D for additional details on these measures). MCPs are subject to quality enforcement actions, such as monetary or administrative sanctions, if they do not meet quality measures' MPLs based on the methodology outlined in APL 23-012.

In addition, the timeliness of prenatal care and postpartum care measures are used as part of quality metrics factored into MCP member auto-assignment in the DHCS Auto Assignment Incentive Program (AAIP). MCPs who perform higher on this set of quality metrics will be awarded with a greater percentage of assigned mandatory enrollees (e.g., those who do not choose an MCP). Separately, under DHCS' Quality Withhold and Incentive (QWI) Program, as of 2024, California withholds 0.5 percent of base capitation from MCPs. MCPs can earn back the withhold based on achievement or improvement of ten different quality metrics, including the timeliness of prenatal care and postpartum care measures.

Box D: MCAS Measures Related to Maternal, Women's, and Children's Health (Measurement Year 2025 and Reporting Year 2026)

- **Maternal Health:**
  - Postpartum Care*[i]
  - Timeliness of Prenatal Care*[i]
  - Low-Risk Cesarean Delivery
  - Postpartum Depression Screening and Follow-Up
  - Prenatal Depression Screening and Follow-Up
  - Prenatal Immunization Status

- **Women's Health:**
  - Chlamydia Screening*
  - Breast Cancer Screening*
  - Cervical Cancer Screening*

- **Children's Health:**
  - Child and Adolescent Well-Care Visits*[i]
  - Childhood Immunization Status—Combination 10*[i]
  - Developmental Screening in the First Three Years of Life*
  - Immunizations for Adolescents—Combination 2*[i]
  - Lead Screening in Children*
  - Topical Fluoride for Children*
  - Six or More Well-Child Visits in the First 15 Months of Life*[i]
  - Two or More Well-Child Visits in the First 15–30 Months of Life*[i]

**Measure that is held to an MPL and subject to quality enforcement actions*
[i]Measure that is part of the AAIP and QWI Program

Birthing Care Pathway Policy Solutions.

Leverage Medi-Cal Connect to support whole person care and provide population insights by safely sharing integrated health care and social data and insights about members among providers, delivery systems, programs, and state agencies that support Medi-Cal members as well as sharing with the Medi-Cal members themselves.

Context: Since 2022, DHCS has been building Medi-Cal Connect to be a statewide service to integrate disparate information to support the PHM Program and DHCS' vision of linking Medi-Cal partners together in a single data sharing platform. DHCS envisions that Medi-Cal Connect will enable DHCS, health plans, state partners and agencies, health care delivery partners, local business partners, and Tribes and Tribal/Urban Indian Organizations to access a comprehensive overview of an individual's benefits and health, tools and assessments, and population-level insights to improve health outcomes and equity.

Implementation Approach: DHCS is rolling out Medi-Cal Connect in five phases to allow feedback, refinement, and implementation of its capabilities. DHCS launched Medi-Cal Connect in mid-2024 to a limited user group within DHCS and expanded access to all DHCS staff in December 2024. Medi-Cal Connect is on track to become available to health plans, state partners and agencies, local partners, and members at different stages throughout 2025 and 2026. Its goals are to promote informed policymaking, enhance population-level insights, enable personalized whole-person care, and improve the Medi-Cal member experience. For pregnant and postpartum members, this will also include the RSST (see above) as well as linking data and health history for patients with maternal health providers, MCPs, and counties for both health care data (e.g. physical and behavioral health), as well as relevant social data (e.g. housing status).

Leverage learnings from the efforts aimed at cross-enrolling Medi-Cal members into crucial safety net supports upon pregnancy through 12 months postpartum, including new linkages in administrative data between Medi-Cal, CalFresh, and WIC pilot programs currently under development in partnership with CDPH, CDSS, the California Center for Data Insights and Innovation (CDII), and Medi-Cal MCPs to inform strategies to facilitate cross-enrollment and the ongoing rollout of Medi-Cal Connect.

Context: DHCS, CDSS, and CDPH executed data sharing agreements in 2024 to permit partner agencies to share member-level eligibility and enrollment data across WIC, CalFresh, and Medi-Cal to maximize enrollment across these critical public programs. DHCS plans to launch a pilot program in 2025 in Fresno, Monterey, and San Bernardino counties that will aim to test outreach and enrollment strategies to maximize enrollment of eligible Medi-Cal children and families into WIC. Strategies center on targeted outreach process improvement and improved coordination between MCPs and county WIC agencies. CDII, CDSS, CDPH, and DHCS are collaborating on a pilot in 2025 to increase enrollment in public benefits with a specific focus on understanding the experiences of members.

Implementation Approach: In October 2023, DHCS published an APL establishing the minimum requirements for MCPs' Memoranda of Understanding (MOUs) with WIC agencies. In January 2024, DHCS released the WIC MOU template that sets forth minimum standards for data sharing to facilitate referrals and case coordination between MCPs and WIC agencies. As of January 2025, 28 WIC MOUs have been executed. DHCS is currently supporting MCPs in the pilot counties by developing rosters of Medi-Cal members likely eligible but not yet enrolled in WIC. DHCS will provide these rosters to MCPs in early 2025 to conduct outreach and to collaborate with local WIC agencies and community partners on enrollment strategies. Later in 2025, MCPs and providers should be able to use Medi-Cal Connect to view data that can facilitate cross-referrals between WIC and CalFresh as well as Medi-Cal data across delivery systems. DHCS plans to leverage feedback and insights from pilot participants to develop guidance on best practices for conducting outreach and facilitating enrollment as well as exploring what other cross-enrollment opportunities this model may also be useful for such as enrollment into California Work Opportunity and Responsibility to Kids (CalWORKs), which is California's Temporary Assistance for Needy Families (TANF) program.

Identify opportunities to leverage and integrate existing California maternity data centers (e.g., CMQCC, CDPH MCAH) with Medi-Cal data to more comprehensively measure and monitor birth outcomes.

Context: The California Maternal Quality Care Collaborative (CMQCC) collects and publishes data on four quality measures endorsed by the National Quality Forum—Cesarean Rate for Low-Risk First Birth Women; Infants Under 1500g Delivered at Appropriate Site; Exclusive Breastfeeding at Hospital Discharge; and Unexpected Newborn Complications. CDPH MCAH publishes similar data on delivery methods, maternal mental health, prenatal care, folic acid use during pregnancy, perinatal weight changes, and other perinatal health metrics.

Implementation Approach: DHCS is meeting regularly with CMQCC and CDPH MCAH to discuss how to integrate existing CMQCC and CDPH MCAH maternal and infant outcome data with DHCS' Medi-Cal data and potentially streamline and integrate existing reporting in this area. The State Maternal Health Innovation (MHI) grant that the U.S. Health Resources and Services Administration (HRSA) awarded to CMQCC in September 2023 requires the state to improve data access and transparency and can be leveraged in pursuit of this goal.

Create key performance indicators (KPIs) to track the efficacy of maternity care and monitor adherence to Birthing Care Pathway policies.

Context: In 2023, DHCS launched a monitoring approach for its PHM Program. The PHM monitoring approach includes about a dozen KPIs to help monitor MCPs' implementation and performance on PHM Program components. MCP reporting on these KPIs is currently on pause as DHCS finalizes refinements to KPI technical specifications. DHCS communicated to MCPs that additional monitoring measures for the pregnant and postpartum population would be added in the future.

Implementation Approach: DHCS will add the new KPIs to its PHM monitoring approach to better monitor the efficacy of the PHM Program for pregnant and postpartum members by adding them to the PHM Policy Guide. Possible measures may include:

- Perinatal service utilization by type of provider (e.g., OB/GYN, CNM, LM, doula, CHW);
- Perinatal service utilization by location of service (e.g., hospital, FBC, home birth); and
- PHM monitoring measures specific to the pregnant and postpartum population (e.g., TCS for pregnant and postpartum individuals).

8. State Agency Partnerships

There are multiple programs and systems serving pregnant and postpartum Medi-Cal members that are under different state agencies' purviews. In developing the Birthing Care Pathway, DHCS did not limit its scope to areas solely within its purview but looked for opportunities to partner with other state agencies.

Problem Statements.

More than 80 percent of pregnancy-related deaths are preventable, and there is an urgent need for a movement to reduce pregnancy-related mortality in California. Such a movement will require coordination across state agencies and with partners and community members. California state agencies have collectively identified multiple challenges and gaps in maternal health, including inadequate culturally appropriate care delivery; a lack of access and links to risk-appropriate care; no universal standards for risk assessment and inconsistent follow-up for medical, behavioral, and social drivers of health needs; limited maternal health data access and transparency; and siloed services, programs, and interventions. California has multiple home visiting programs for pregnant and postpartum members, but they are not coordinated across state agencies, causing a lack of member awareness and underutilization of these programs. While Paid Family Leave (PFL) and State Disability Insurance (SDI) have been shown to decrease parental stress levels and infant hospitalizations and increase parental involvement, breastfeeding rates, healthy infant growth and development, and household economic security, partners report that low-income individuals in California are less likely to take advantage of the state's PFL and SDI programs.

Birthing Care Pathway Policy Solutions.

Partner with CDPH, OSG, and CMQCC to develop the statewide Maternal Health Strategic Plan that prioritizes the care experience; risk-appropriate perinatal care; comprehensive risk assessment and appropriate follow-up; data transparency; and integrated care across systems, programs, and communities.

Context: In September 2023, CMQCC—in partnership with DHCS, CDPH, and OSG—received a five-year State MHI grant for $10 million from HRSA to develop a Maternal Health Strategic Plan to reduce maternal mortality and SMM in California. The Birthing Care Pathway serves as a foundational element for the Maternal Health Strategic Plan, which will be informed by community engagement with pregnant and postpartum individuals in California and a statewide Maternal Health Task Force (MHTF) Steering Committee of state leaders, providers, and maternal health advocates.

Implementation Approach: CMQCC, CDPH, OSG, and DHCS submitted a draft version of the Maternal Health Strategic Plan to HRSA in September 2024. The draft outlines strategies California could take to ensure pregnant and postpartum individuals are provided quality access to the care team and services they desire and need to ensure a healthy and positive birth outcome. It commits to ensuring that pregnant and postpartum individuals' medical and social needs are systematically and universally identified through universal risk assessment and comprehensively met in communities. The draft Maternal Health Strategic Plan also outlines strategies for ensuring that California systems serving this population are integrated and data interoperability standards are adopted. Finally, it emphasizes that racial/ethnic disparities will be addressed to reduce maternal mortality and SMM. Over the next year, DHCS will collaborate with CMQCC, its partner agencies, and the MHTF Steering Committee to stand up subcommittees with subject matter experts from across the state and engage pregnant and postpartum community members via statewide listening sessions to help refine the draft plan. The final Maternal Health Strategic Plan is expected to be published in September 2025.

Collaborate with CDPH, CDSS, and MCPs to promote home visiting for Medi-Cal members and ensure eligible members can access home visiting programs.

Context: The California Home Visiting Program (CHVP), managed by CDPH, is evidence-based and available in 58 counties for pregnant and newly parenting families with at least one of the following risk factors: low-income, domestic violence, less than 12 years of education, unstable housing, SUD, depression, and/or mental-health related issues. In 2022, 83 percent of adult CHVP participants and 89 percent of child CHVP participants were Medi-Cal-enrollees. The CalWORKs Home Visiting Program, managed by CDSS, is available in 41 counties for pregnant or parenting individuals who are enrolled in CalWORKS. The American Indian Maternal Support Services program, managed by DHCS, provides perinatal case management and home visiting services and is available in four counties for pregnant or postpartum members who are American Indian/Alaska Native. While each of the above home visiting programs is structured differently, all three programs provide pregnant and postpartum individuals with health education, parenting skills, referrals to address behavioral health and family violence, and screening for developmental delays. Partners explained that some counties' home visiting programs are not at capacity and recommended that MCPs and maternity care providers increase referrals to home visiting programs for pregnant and postpartum Medi-Cal members.

Implementation Approach: DHCS is collaborating with CDPH and CDSS to identify opportunities to further promote home visiting programs to pregnant and postpartum Medi-Cal members. DHCS will reiterate to ECM Birth Equity providers and CPSP providers to refer eligible members to home visiting programs. DHCS will consider requiring closed-loop referrals for referrals to home visiting programs in the future.

Partner with the Employment Development Department (EDD) and Legal Aid at Work (LAAW) to develop a resource guide for perinatal providers on how their pregnant and postpartum patients can access the state's PFL and SDI programs.

Context: California's PFL program, which launched in 2004 and is managed by the EDD, provides up to eight weeks of wage replacement benefits in a 12-

month period, and the SDI program provides at least four weeks of pregnancy-related leave. As of January 2025, lower-income workers in California receive 90 percent of their paychecks while other workers receive 70 percent.

Implementation Approach: In January 2025, LAAW and EDD developed a guide for health care and social services providers on the different types of leave, pay, and accommodations for pregnant and postpartum workers in California. This guide will be disseminated to MCPs to share with their providers and care managers. The guide will also be posted on a new CMQCC webpage on the leave rights of pregnant and postpartum individuals in California.

Leverage the Family First Prevention Services Act (FFPSA) to support SUD and mental health treatment services for pregnant and postpartum individuals at risk of child welfare involvement.

Context: The FFPSA enables states to access Title IV-E federal financial participation (FFP) for providing specified services to children at imminent risk of entering foster care, pregnant and parenting foster youth, and the parents or kin caregivers of these children. Services that may be funded include evidence-based mental health services, SUD services, and in-home parent skill-based services that have been rated and approved by the Title IV-E Prevention Services Clearinghouse. County child welfare agencies and/or probation departments are required to develop a Comprehensive Prevention Plan (CPP) that outlines the services that the Title IV-E agency will provide and identifies prevention strategies to be implemented. Prevention strategies must align with the goals of the FFPSA, including improving access to evidence-based, trauma-informed services in the categories of mental health and substance use prevention and treatment.

Implementation Approach: CDSS and DHCS are in the process of developing joint All-County Letters and BHINs to support implementation of the local CPPs by county child welfare agencies, juvenile probation departments, Tribes with an Intergovernmental Agreement with the State of California, and county behavioral health agencies. Specifically, CDSS and DHCS will provide guidance on evidence-based practices for providing behavioral health services to

pregnant and postpartum individuals at risk of child welfare involvement, such as Parent-Child Interaction Therapy, Parents as Teachers, and Nurse Family Partnership.

Continue to support the OSG Strong Start & Beyond movement through participation in the Perinatal Advisory Group (PAG).

Context: Launched in May 2024 by OSG, Strong Start & Beyond is a movement that leverages California's investments and partnerships to implement transformative solutions to improve Californians' reproductive and maternal health. Diverse partners across community, government, health care, private, public, and non-profit sectors will form the core of this collaborative partnership. The goals of Strong Start and Beyond are to (1) educate and empower individuals on their reproductive health and (2) reduce maternal mortality by building patient trust and empowering patients to become active participants in their health through creative use of social media and other forms of technology and artificial intelligence. Strong Start & Beyond is particularly focused on reducing hypertension amongst pregnant and postpartum individuals, which is the leading maternal complication at delivery in California.

Implementation Approach: DHCS will continue in its role on the PAG.

B. Strategic Opportunities for Further Exploration

In addition to the clear challenges and policy solutions outlined above that DHCS is leading in partnership with a wide range of state and other implementation partners, the extensive community engagement with Medi-Cal members and Birthing Care Pathway partners, including Medi-Cal members, illuminated a number of additional opportunities for DHCS to improve maternal outcomes and birth equity. This section is intended to capture the additional issues and ideas identified through community engagement. These opportunities can inform future discussion and help to lay the foundation for the "next generation" of policy solutions as DHCS continues to develop the Birthing Care Pathway.

These opportunities are subject to additional assessment and planning and are contingent on external factors. At this time, DHCS presents these potential policy options to set a direction

for the future and recognize the ways that California can continue the work to reduce maternal morbidity and pregnancy-related mortality and address the significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander Californians.

The opportunities for future discussion are in the following six focus areas:

1. Provider Access and MCP Oversight and Monitoring
2. Behavioral Health
3. Maternal Care Models and Access
4. Provider Resources
5. Data and Quality
6. State Agency Partnerships

1. Provider Access and MCP Oversight and Monitoring

Problem Statements.

Partners stressed that access issues persist despite MCPs meeting existing Medi-Cal network adequacy standards; some Medi-Cal members, especially those living in rural areas, must travel far distances to see a maternity care provider. Significant racial and ethnic disparities in maternal health outcomes persist among Black, American Indian/Alaska Native, and Pacific Islander Californians. These include disparities in health outcomes—such as a higher pregnancy-related mortality ratio for Black individuals and higher SMM rates for Black and Pacific Islander individuals compared to their white peers—and in experience with IPV during pregnancy, as American Indian/Alaska Native pregnant and postpartum Californians report IPV rates that are nearly twice as high compared to other races/ethnicities. Partners expressed that many perinatal providers lack the training to conduct IPV screening despite the risk of IPV during the perinatal period and IPV being associated with adverse health outcomes for pregnant and postpartum individuals and their infants.

Partners also emphasized that DHCS' lactation policy creates a barrier for Medi-Cal members to be able to access timely lactation support services because only physicians, registered nurses, and dieticians working under the supervision of a physician can provide lactation services in Medi-Cal today. A 2024 UCLA report found that there is an overall shortage of lactation consultants in California, particularly in rural areas, as well as a lack of racial/ethnic representation in the lactation consultant workforce.

Birthing Care Pathway Potential Opportunities.

i. **Strengthen oversight and monitoring of network adequacy standards for maternal providers, including adopting an appropriate threshold for accepting Alternative Access Standards (AAS) requests.** DHCS requires Medi-Cal MCPs to maintain a provider network that meets time or distance standards—a cap on how far or for how long members must travel to reach an in-network provider. This means that, for example, an OB/GYN within the MCP's network must be within a maximum number of miles or maximum amount of travel time from a member's place of residence. The time or distance standard for OB/GYNs, which varies based on county, ranges from up to 10 miles or 30 minutes to up to 60 miles or 90 minutes from the member's residence. If MCPs are unable to comply with time or distance standards, they must submit an AAS request for DHCS to review and approve.

ii. **Require MCPs to participate in a joint performance improvement project (PIP) in which all MCPs are required to participate, focused on reducing disparities for Black, American Indian/Alaska Native, and Pacific Islander pregnant and postpartum members**. Per federal requirements, states must require MCPs to execute PIPs that implement interventions, measure and evaluate performance, and increase or sustain improvement over time.[23] States may mandate one or more specific PIP priority areas. All Medi-Cal MCPs in California are required to participate in a minimum of two PIPs per year, one of which must address a plan-specific health disparity.

iii. **Require MCPs to incorporate IPV training into required network provider training and promote universal IPV education in health care settings.** Many providers lack the knowledge and training to effectively identify and follow up on IPV disclosures or might feel uncomfortable doing so. Required IPV training can help providers understand IPV prevalence, IPV impact on health, risk factors for IPV, and how to protect the privacy and confidentiality needs of IPV survivors. MCPs are already required to ensure that their network providers complete training every other year on the managed care program, including diversity, equity and inclusion; covered services, including required preventive health care services and care management services; information sharing; prior authorization and utilization management; member access and rights; and social drivers of health and disparity impacts on members' health.[24] The training must also include education on the health needs of specific populations including members with mental health and SUD needs and children with special health care needs. Universal IPV education is an evidence-based approach in which providers speak with all patients about elements of healthy versus unhealthy relationships and the health effects of violence and connect

[23] 42 CFR §438.330(d)

[24] DHCS 2024 MCP Boilerplate Contract, Exhibit A, Attachment III, 3.2.5 Network Provider Training

patients with resources such as crisis hotlines even if they do not disclose IPV. Disclosure rates among patients screened for IPV in health care settings are much lower than the known prevalence of IPV.

iv. **Update lactation policy to recognize IBCLCs and CLCs as a provider type that can bill Medi-Cal.** Lactation consultants, such as IBCLCs and CLCs, cannot be reimbursed today by Medi-Cal for providing lactation support. Lactation services may only be provided by a physician, registered nurse, or a dietician that is working under the supervision of a physician. IBCLCs are certified by the International Board of Lactation Consultant Examiners and required to complete either 95 hours of lactation-specific education or 14 health science courses; 300–1,000 hours of lactation-specific clinical practice through one of three pathways; and pass the IBCLC examination. CLCs are certified by the Academy of Lactation Policy and Practice and required to complete either 95 hours of breastfeeding counseling education or graduate from an approved lactation consultant program; and pass the CLC examination.

2. Behavioral Health

Problem Statements.

Partners—including Medi-Cal members—explained how pregnant and postpartum members face challenges accessing behavioral health providers that have perinatal training and available appointments. Partners also stressed the need for more trauma-informed care. In addition, Medi-Cal-enrolled newborns are approximately ten times more likely to have neonatal abstinence syndrome (NAS)—a drug withdrawal syndrome caused by maternal use of opiates—than those on commercial coverage, and partners underscored a need for parents to be allowed to stay with their infants while undergoing treatment.

Birthing Care Pathway Potential Opportunities.

i. **Develop statewide perinatal behavioral health consultation line for maternal providers and therapists without perinatal training to receive consultations from qualified mental health and SUD providers with perinatal expertise for pregnant and postpartum members living with behavioral health needs.** Perinatal behavioral health consultation lines provide real-time, perinatal psychiatric consultation, resources, and referrals for obstetric, pediatric, primary care, psychiatric, and SUD providers to effectively prevent, identify, and manage their pregnant and postpartum patients' mental health and substance use concerns. Los Angeles County received a federal HRSA grant in late 2023 to fund a perinatal consultation line where perinatal and primary care providers can call to receive consultations from reproductive health psychiatrists and physicians with expertise in perinatal substance use. The statewide perinatal behavioral health consultation line could be modeled after the Los Angeles County Department of Health Services' (DHS) consultation line, MAMA's Perinatal Resources to Optimize Mental Health Interventions

and Substance Use Treatment Excellence, which launched in May 2024 and is currently staffed by two psychiatric nurse practitioners (NPs). As of January 2025, the county has facilitated 30 training sessions for 504 providers on how to utilize the consultation line.

ii. **Support implementation of perinatal workforce training on trauma-informed, culturally relevant crisis care and integration of county behavioral health services into obstetric provider practices for pregnant members living with SUD or serious mental health needs.** Partners stressed the need for Medi-Cal maternity care provider trainings and member screenings to be trauma-informed. They also reported a need for integrated and collaborative care for pregnant and postpartum members with behavioral health concerns and suggested that psychiatrists be available onsite at obstetric care facilities.

iii. **Support CBOs serving pregnant and postpartum individuals living with behavioral health needs by providing counties with a list of proposed uses for Behavioral Health Services Act (BHSA) funds that address gaps identified for this population.** The BHSA is designed to increase access to community-based behavioral health services in California. Through the BHSA, DHCS prioritizes early intervention, especially for children and families, youth, and young adults, to provide early linkage to services and prevent mental health conditions and SUDs from becoming severe. DHCS also prioritizes serving individuals experiencing homelessness or at risk of homelessness, especially individuals and families experiencing long-term homelessness. In addition, through the BHSA, HCAI is implementing a behavioral health workforce initiative to increase the number of people providing high-quality, equitable, and affordable services to all Californians. This will be achieved by providing financial and training support to individuals seeking careers in behavioral health fields through scholarships, loan repayments, and paid clinical and apprenticeship opportunities as well as support for organizations and educational institutions that grow the workforce.

iv. **Support postpartum members to stay in the hospital with their newborns (e.g., rooming in) while the newborn is being treated for NAS/Neonatal Opioid Withdrawal Syndrome (NOWS) and not be discharged until their newborn is discharged.** Washington State leveraged State Plan authority in 2022 to permit a birth parent to room in with their newborn who is receiving NAS/NOWS treatment.[25] This authority covers the birth parent's room and board while their newborn receives treatment. Washington anticipated that this policy will be offset by a reduction in the length of stay required for infants with NAS/NOWS, citing studies with a reduction in hospital stays from 35–74 percent due to continuous parental presence.

[25] See State Plan Amendment (SPA) WA #21-0032.

3. Maternal Care Models and Access

Problem Statements.

A California State Auditor's February 2024 report found that DHCS and CDPH provide limited oversight of CPSP and lack sufficient data to track utilization of CPSP services. Partners report that the separate CPSP provider enrollment process with CDPH is burdensome for providers, and the existing CPSP payment structure for FQHCs/RHCs encourages clinics to have members come in for multiple separate appointments across several days instead of combining services into a single visit to reduce member burden. Partners also underscored a need for more racially concordant providers, including midwives, particularly for Black, American Indian/Alaska Native and Pacific Islander Medi-Cal members. With nearly seven percent of California counties designated as maternity care deserts requiring pregnant individuals to travel 3.9 times farther than individuals living in areas with full access to perinatal care for an average of 107 miles or about 132 minutes, there is a need for short-term housing solutions to make it easier for high-risk pregnant individuals to be closer to risk-appropriate care.

Birthing Care Pathway Potential Opportunities.

i. **Enhance the delivery of comprehensive perinatal services across the FFS delivery system and Medi-Cal MCPs.** CPSP is a Medi-Cal benefit that provides a set of services from conception through 60 days postpartum, including obstetric services; psychosocial assessment(s) and referrals to counseling, if needed; nutrition assessment(s) and referral to counseling on food supplement programs, vitamins, and breastfeeding, if needed; health, childbirth, and parenting education; and care coordination. While CPSP is currently a Medi-Cal FFS program, MCPs are required to provide quality prenatal and postpartum services to members that are comparable to ACOG and CPSP standards (known as "CPSP-like services") as outlined in the MCP contract. DHCS could explore aligning CPSP with the most recent clinical guidelines and best practices including ACOG and the USPSTF; updating the structure by which the benefit is offered and delivered to members; improving state oversight by prioritizing data-driven monitoring and including quality metrics and birth outcomes; modernizing the CPSP payment structure to be member centric; and eliminating local CPSP billing codes and replacing them with nationally recognized codes.

ii. **Develop perinatal specialization for CHWs.** DHCS added CHW services as a Medi-Cal benefit in July 2022. Medi-Cal CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served. CHWs can enroll as a Medi-Cal CHW through one of two pathways: (1) Certificate Pathway by completing a California-issued certificate program or the violence prevention certificate for services related to gang intervention; or (2) Work Experience Pathway by meeting a minimum number of hours over the last three years. Medi-Cal CHW services may be

provided in individual or group settings and may include health education and navigation services; certain screenings and assessments, connecting members to appropriate services; and individual support or advocacy. While Comprehensive Perinatal Health Workers (CPHWs) under the CPSP benefit have perinatal expertise, they can only provide services up to 60 days postpartum.

iii. **Develop loan repayment program to increase diversity and rural representation of midwives.** CalHealthCares, which is managed by DHCS, administers loan repayment on educational debt for California physicians and dentists who provide care to Medi-Cal members. Eligible physicians can apply for up to $300,000 in loan repayment in exchange for a five-year service obligation. CalHealthCares is currently not available to CNMs and LMs. While the California State Loan Repayment Program (SLRP), which is managed by HCAI and is targeted to providers practicing in federally designated Health Professional Shortage Areas (HPSAs), is available to CNMs, LMs are not eligible.

iv. **Provide short-term housing for high-risk pregnant members who live in remote counties that is near hospitals equipped to care for complex maternal and fetal medical conditions and obstetric complications.** DHCS' Community Supports currently include several housing-related services, such as Housing Transition Navigation Services that assist members in securing housing, Housing Deposits to help members with establishing housing, Housing Tenancy and Sustaining Services that help members maintain housing, and Short-Term Post-Hospitalization Housing that provides members with high medical or behavioral health needs with housing settings for recuperation and recovery. However, high-risk pregnant members who need to be close to hospitals equipped to care for complex conditions do not currently meet eligibility criteria for these housing-related services.

4. Provider Resources

Problem Statements.

Perinatal providers have highlighted a need for additional Medi-Cal provider education on the full spectrum of programs and services for which pregnant and postpartum members may be eligible.

Birthing Care Pathway Potential Opportunities.

i. **Require MCPs to augment provider training requirements to include focus on Medi-Cal perinatal benefits, perinatal mental health, and SUD.** While MCPs are already required to ensure their network providers complete training every other year on covered services and the health needs of specific populations, including members with mental health and SUD needs, partners have stressed that Medi-Cal perinatal providers still do not feel comfortable discussing behavioral health screening results with pregnant and

postpartum members and are not equipped to refer them to the appropriate services and supports.

5. Data and Quality

Problem Statements.

Maternity care quality metrics used for MCP quality improvement and accountability processes are often limited to two HEDIS metrics—timeliness of prenatal care and postpartum care—and partners stressed the need for additional quality measures beyond those currently tracked. DHCS collects quality data on many prenatal and postpartum metrics but does not currently require reporting on patient-reported measures around access and patient experience for perinatal care and services. Partners stressed the need to create opportunities for members to share ongoing feedback about their health care experience and hold health systems accountable for implementing related quality improvement measures.

Birthing Care Pathway Potential Opportunities.

i. **Develop technical workgroup to advise on perinatal health and birth outcome quality measures.** A technical working group could look to identify additional quality metrics not used in Medi-Cal today that could help California effectively monitor quality of care and outcomes for pregnant and postpartum members.

ii. **Identify quality metrics and require reporting on patient-reported outcome measures (PROMs) around access and patient experience for perinatal care and services.** A PROM is used to assess quality of care and the impact that treatment or interventions have on a patient's self-assessed health and health-related quality of life.[26] PROMs are increasingly being used to assess clinical effectiveness, safety, and patient experience, and to guide service improvement. Partners have recommended several PROMs that assess structural factors related to systemic discrimination, racism, and patient experience, such as the Patient-Reported Experience Measure of Obstetric Racism and the Childbirth Experience Survey.

6. State Agency Partnerships

DHCS did not limit its scope to areas solely within its purview but looked for opportunities to partner with other state agencies when identifying policies to explore for the Birthing Care Pathway.

Problem Statements.

Today, pregnant and postpartum Medi-Cal members and their providers may be unaware of which birth setting (e.g., hospital, FBC, home) would be best suited based on their level of risk

[26] Dickinson, F., McCauley, M., Smith, H. *et al.* Patient reported outcome measures for use in pregnancy and childbirth: a systematic review. *BMC Pregnancy Childbirth* 19, 155 (2019).

during pregnancy. Pregnant individuals are often unaware of the impact their current health has on pregnancy outcomes until they attend their first prenatal appointment.

California faces maternal health care workforce shortages across multiple provider types causing access barriers for members. Furthermore, low-income individuals in California are less likely to take advantage of the state's PFL and SDI programs.

Partners shared that stigma around SUD treatment during the perinatal period results in many pregnant and postpartum individuals forgoing necessary care for fear of prosecution or child protective services involvement. Finally, evidence-based home visiting programs can promote maternal health and well-being and strengthen family functioning. While there are multiple home visiting programs for pregnant and postpartum individuals in California, none are available statewide, and each has differing eligibility criteria.

Birthing Care Pathway Potential Opportunities.

i. **Partner with CDPH to require birthing hospitals to have a verified ACOG Levels of Maternal Care designation.** The Levels of Maternal Care, developed by ACOG and the Society for Maternal-Fetal Medicine in 2015, provide a standardized classification system for risk-appropriate perinatal care. The goal of the Levels of Maternal Care is to reduce maternal morbidity and mortality by ensuring risk-appropriate care specific to the pregnant member's needs. ACOG Levels of Maternal Care designations are verified by The Joint Commission and then made publicly available whereas the web-based CDC Levels of Care Assessment Tool is used by hospitals to self-assess their levels of maternal care, and that information is proprietary and not publicly available. As of January 2025, sixteen states require or encourage their hospitals to receive an ACOG Level of Maternal Care designation.[27] The Levels of Care designations (Level I–Level IV) help perinatal providers and patients understand what capacities (e.g., availability of providers, services, and equipment) hospitals and birth centers have and ensure risk-appropriate care can be provided. Research supports the benefit of this risk-appropriate care and suggests that odds of severe adverse outcomes for some risk conditions were lower for births occurring at higher-level facilities. DHCS and CDPH could explore collaborating on providing technical assistance to support hospitals reaching a Level of Care designation.

ii. **Partner with OSG to promote community education and pregnancy risk awareness.** OSG's California Maternal Health Blueprint, published in September 2024, outlined its

[27] States with mandatory levels of maternal care designation: Illinois (legislation and regulation), Indiana (legislation and regulation), Louisiana (regulation), Maryland (regulation), Massachusetts (regulation), Missouri (legislation and regulation), New York (regulation), Ohio (regulation), South Carolina (regulation), Texas (legislation and regulation). States with voluntary levels of maternal care designation: Arizona, Arkansas, Georgia (legislation and regulation), Iowa (regulation), Mississippi (regulation), Tennessee, Washington, Wisconsin.

vision to educate reproductive-age individuals about the possible health risks they may encounter during pregnancy and decrease pregnancy-related mortality in California. OSG identifies the implementation of evidence-based comprehensive risk assessment measures as a key mechanism to reduce maternal morbidity and pregnancy-related mortality. DHCS can collaborate with OSG to encourage providers to adopt evidence-based pregnancy risk assessments that support patient safety, promote favorable maternal health outcomes, and broaden community awareness.

iii. **Explore options to obtain data from EDD to improve outreach to pregnant and postpartum Medi-Cal members about the state's PFL and SDI programs.** Similar to its partnerships with CDPH and CDSS to share data to increase enrollment of Medi-Cal members into WIC and CalFresh, DHCS can collaborate with EDD to share data to help more Medi-Cal members get access to these programs.

iv. **Coordinate with HCAI to fund workforce development strategies for perinatal providers.** HCAI administers numerous workforce development initiatives with the goal of increasing the volume and diversity of healthcare providers in areas of unmet need across California. The California SLRP aims to increase the number of primary care physicians, dentists, dental hygienists, physician assistants, NPs, CNMs, pharmacists, and behavioral health providers practicing in federally designated California HPSAs. LMs are currently not eligible to apply for the California SLRP, though LMs and doulas are both eligible to apply for HCAI's Allied Health Scholarship Program (AHSP). The Song-Brown Healthcare Training Program aims to increase the number of students and residents receiving quality primary care education and training in areas of unmet need throughout California. Accredited family practice residency programs, physician assistant/family NP programs, registered nurse (RN) programs, and California-accredited/-approved CNM and LM programs are eligible to apply. Currently, there are only two CNM programs in California (one of which is in the process of converting from a Masters program to a Doctoral program) and no LM programs. The California Health Workforce Education and Training Council coordinates California's health workforce education and training to develop a workforce that meets the state's health care needs. The council is composed of 18 members representing various graduate medical education and training programs and health professions (e.g., primary care, behavioral health, and consumer representatives). HCAI and DHCS will also collaborate on the administration of a behavioral health workforce initiative proposed as part of DHCS' BH-CONNECT initiative which received CMS approval in December 2024.

v. **Examine opportunities to partner with state agencies to protect pregnant and postpartum individuals from prosecution for drug-related offenses that may be initiated after they seek SUD treatment.** Partners shared that pregnant and postpartum members are often concerned about seeking out SUD treatment for fear that they will be prosecuted. In California, there is no law that protects pregnant and postpartum

individuals from being investigated and/or prosecuted for drug related offenses after they seek treatment. Some states have created these types of laws. For example, Montana enacted a Safe Harbor law in 2019 for pregnant women seeking SUD treatment; the law exempts pregnant individuals seeking or receiving treatment for SUDs from certain criminal provisions and voids mandatory reporting obligations.

vi. **Partner with CDSS to educate health care partners on child welfare policy nuances that may inadvertently require or permit revoking custody from the parent due to use of medications for SUD treatment and consider modifications to the policies.** Existing laws and policies that support children and their families when children are victims of, or at risk of, abuse, neglect, exploitation, or parental absence may result in custody loss upon seeking SUD treatment.

vii. **Collaborate with CDSS on training for labor and delivery clinical care teams and child welfare case managers about perinatal SUDs to reduce stigma, misinformation, and barriers to treatment, along with training that uplifts research that demonstrates how promoting parenting resources and coaching can help support healthy attachment and infant brain development.** Partners shared that pregnant and postpartum members are often concerned about asking providers for help for a SUD for fear that Child Protective Services will be alerted.

viii. **Collaborate with CDPH, CDSS, and MCPs to provide at least one voluntary home visit to every newly pregnant Medi-Cal member and develop a standard to identify members who would benefit from more than one home visit in the prenatal and postpartum periods.** As stated above, there are several home visiting programs for pregnant and postpartum individuals in California, but local availability and eligibility vary. Some programs are underutilized in certain geographic areas, and none are available statewide. Furthermore, partners have explained that despite multiple home visiting programs being available across the state, many Medi-Cal members are unaware of these services. In 2019, Oregon established Family Connects Oregon, a universal nurse home visiting program that engages health plans to deliver universal home visiting services to all families with newborns in the state. DHCS can review Oregon's model to support a potential approach.

IV. LOOKING AHEAD

IV. LOOKING AHEAD

The Birthing Care Pathway is a multi-year initiative for DHCS to advance maternal health and birth equity in California. DHCS will continue working with maternity care and social services providers, state and local leaders, MCPs, birth equity advocates, and other partners to implement the identified Birthing Care Pathway policies outlined in this report using existing resources. DHCS aims to continue to engage a diverse set of partners to implement and further develop the Birthing Care Pathway.

As DHCS continues to implement the Birthing Care Pathway, it will also be implementing the federal ten-year TMaH Model. DHCS will work with MCPs, providers, CBOs, and other partners to implement TMaH model elements, which are aligned with and complementary to the Birthing Care Pathway, in Fresno, Kern, Kings, Madera, and Tulare counties. The Birthing Care Pathway will also be a foundational element of the California Maternal Health Strategic Plan, which DHCS will work with CMQCC; CDPH; OSG; the MHTF Steering Committee of state leaders, providers, and maternal health advocates; and community members to finalize and publish in September 2025.

With nearly one in eight of U.S. births occurring in California and 40 percent of those births covered by Medi-Cal, DHCS is committed to reducing pregnancy-related mortality and SMM in California and closing the significant racial and ethnic disparities in maternal health outcomes through the Birthing Care Pathway but also recognizes this will only be possible with the partnership, engagement and support of all of the individuals and organizations committed to the care of pregnant and postpartum Medi-Cal members.

V. ACKNOWLEDGEMENTS

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VI. APPENDIX

VI. APPENDIX

Appendix A. Interviewees

Birthing Care Pathway Interviewees		
No.	**Name**	**Title and Organizational Affiliation**
1	Jimina Afuola	• Advocacy Coordinator, Empowering Pacific Islander Communities (EPIC)
2	Lisa Bain	• Senior Director for U.S. Programs, Global Communities
3	Dannie Ceseña	• Director, California LGBTQ Health and Human Services Network
4	Shantay R. Davies-Balch	• President & Chief Executive Officer, BLACK (Belonging, Love, Affinity, Community, & Kinship) Wellness & Prosperity Center • Doula & Certified Lactation Educator
5	Liz Donnelly	• Health Policy Vice Chair, California Nurse-Midwives Association (CNMA) • Certified Nurse Midwife
6	Emily C. Dossett	• Founder and Director, Reproductive Mental Health Consultants • Associate Clinical Professor, Departments of Psychiatry and OB/GYN, Keck School of Medicine, University of Southern California (USC) • Reproductive Psychiatrist
7	Angela Egbuchulam	• Black Infant Health (BIH) Coordinator, San Joaquin County Public Health Services
8	Robbie Gonzalez-Dow	• Former Executive Director, California Breastfeeding Coalition

Birthing Care Pathway Interviewees		
No.	**Name**	**Title and Organizational Affiliation**
9	Barbara Hart	• Nurse Consultant, Office of Tribal Affairs, California Department of Health Care Services (DHCS)
10	Tipu Khan	• Chief of Addiction Medicine, Ventura County Medical Center • Fellowship Director, Ventura County Primary Care Addiction Medicine Fellowship • Core Faculty, Ventura County Family Medicine Residency Program • Director of Addiction Medicine for Southern California, HealthRight 360 • Adjunct Clinical Professor, Keck School of Medicine, USC • Family Medicine Physician & Addiction Medicine Specialist
11	Antoinette Martinez	• Family Medicine with Obstetrics, United Indian Health Services, Inc., Arcata, California • Co-Director/Associate Professor, University of California Davis (UCD) School of Medicine (SOM) Tribal Health PRograms in Medical Education (PRIME) (THP) • Co-Director, Huwighurruk Postbaccalaureate Program at Cal Poly Humboldt with UCD SOM THP • Family Medicine Physician & OB/GYN
12	Jasmine Pettis Marquez	• Executive Director, California Breastfeeding Coalition • International Board Certified Lactation Consultant
13	Marisela Montoya	• Executive Director, South LA Health Projects (Lundquist WIC) • International Board Certified Lactation Consultant

Birthing Care Pathway Interviewees		
No.	**Name**	**Title and Organizational Affiliation**
14	Robert Moore	• Chief Medical Officer, Partnership HealthPlan • Family Medicine Physician
15	Gail Newel	• Retired Public Health Officer, Santa Cruz County • OB/GYN
16	Malini Nijagal	• Professor, University of California, San Francisco (UCSF) Department of Obstetrics, Gynecologists, and Reproductive Services (Zuckerberg San Francisco General Hospital Division) • Director, SF Respect Initiative • OB/GYN
17	Sayida Peprah-Wilson	• Founder/Executive Director, Diversity Uplifts, Inc.
18	Diana Ramos	• California Surgeon General • OB/GYN
19	Holly Smith	• Health Policy Chair and Legislative Coordinator, CNMA • Co-Facilitator, Midwifery Access California (MACa) • Certified Nurse Midwife
20	Elizabeth Smith	• Director, Santa Rosa Midwifery Center • Former Treasurer, CNMA • Certified Nurse Midwife & International Board Certified Lactation Consultant
21	April Torres	• Deputy Chief Behavioral Health Officer, HealthRIGHT 360
22	Laura Turner	• Senior Public Health Nurse, Maternal, Child, and Adolescent Health Planning and Coordination, Sonoma County Department of Health Services

Birthing Care Pathway Interviewees		
No.	**Name**	**Title and Organizational Affiliation**
23	Mike Weiss	• Vice President of Population Health, Children's Hospital of Orange County (CHOC) • Pediatrician
24	Madeleine Wisner	• Chief Executive Officer, Welcome Home Midwifery Services • Vice President, California Association of Licensed Midwives (CALM) • Licensed Midwife, Registered Midwife (New Zealand), & International Board Certified Lactation Consultant
25	Jyesha Wren	• Co-Founder & Program Director of BElovedBIRTH Black Centering within Alameda Health System, & Founding Director of Beloved Birth Collective • Certified Nurse Midwife
26	Andrea Zubiate	• Chief, Office of Tribal Affairs, DHCS

Appendix B. Workgroup Participants

Birthing Care Pathway Clinical Care Workgroup		
No.	**Name**	**Organization & Title**
1	Susan D. Crowe	• Clinical Professor, Obstetrics and Gynecology–Maternal Fetal Medicine, Stanford University • District IX Executive Committee, American College of Obstetricians and Gynecologists (ACOG) • OB/GYN
2	Shantay R. Davies-Balch	• President & Chief Executive Officer, BLACK (Belonging, Love, Affinity, Community, & Kinship) Wellness & Prosperity Center • Doula & Certified Lactation Educator
3	Emily C. Dossett	• Founder and Director, Reproductive Mental Health Consultants • Associate Clinical Professor, Departments of Psychiatry & Obstetrics & Gynecology, Keck School of Medicine, University of Southern California (USC) • Reproductive Psychiatrist
4	Kimberly Gregory	• Director, Division of Maternal Fetal Medicine, Cedars Sinai • Vice Chair, Women's Healthcare Quality & Performance Improvement, Department of Obstetrics and Gynecology, Cedars Sinai • Chair, California Pregnancy-Associated Review Committee, California Department of Public Health (CDPH) • OB/GYN
5	Virginia Hedrick	• Executive Director, California Consortium for Urban Indian Health (CCUIH) • Board of Directors Member, The California Wellness Foundation

Birthing Care Pathway Clinical Care Workgroup		
No.	**Name**	**Organization & Title**
6	Tipu Khan	• Chief of Addiction Medicine, Ventura County Medical Center • Fellowship Director, Ventura County Primary Care Addiction Medicine Fellowship • Core Faculty, Ventura Country Family Medicine Residency Program • Director of Addiction Medicine for Southern California, HealthRight 360 • Adjunct Clinical Professor, Keck School of Medicine, USC • Family Medicine Physician & Addiction Medicine Specialist
7	Monica Koenig	• Health Services Nursing Supervisor, Napa County Health and Human Services Agency (HHSA) • First 5 Co-Chair, First 5 Napa County • Registered Nurse
8	Antoinette Martinez	• Family Medicine with Obstetrics, United Indian Health Services, Inc., Arcata, California • Co-Director/Associate Professor, University of California Davis (UCD) School of Medicine (SOM) Tribal Health PRograms in Medical Education (PRIME) (THP) • Co-Director, Huwighurruk Postbaccalaureate Program at Cal Poly Humboldt with UCD SOM THP • Family Medicine Physician & OB/GYN
9	Pooja Mittal	• Chief Health Equity Officer, Health Net • Family Medicine Physician
10	Robert Moore	• Chief Medical Officer, Partnership HealthPlan • Family Medicine Physician

Birthing Care Pathway Clinical Care Workgroup		
No.	**Name**	**Organization & Title**
11	Malini Nijagal	• Professor, University of California, San Francisco (UCSF) Department of Obstetrics, Gynecology, & Reproductive Services (Zuckerberg San Francisco General Hospital Division) • Director, SF Respect Initiative • OB/GYN
12	Kelly O'Connor	• Executive Director, Maternal Mental Health NOW
13	Karen Ramstrom	• Chief, Maternal & Infant Health Branch, Maternal Child & Adolescent Health (MCAH) Division, CDPH • Preventive Medicine & Public Health Physician
14	Karen Roslie	• Former Executive Director, Best Start Birth Center
15	Erin Saleeby	• Chair, Department of Obstetrics & Gynecology, Harbor-University of California, Los Angeles (UCLA) Medical Center • Associate Clinical Professor, Department of Obstetrics & Gynecology—David Geffen School of Medicine at UCLA • Director, Women's Health Programs & Innovation, Los Angeles County Department of Health Services • Medical Director, Essential Access Health • OB/GYN
16	Dana Sherrod	• Co-Founder & Executive Director, California Coalition for Black Birth Justice
17	Holly Smith	• Health Policy Chair and Legislative Coordinator, California Nurse-Midwives Association (CNMA) • Co-Facilitator, Midwifery Access California (MACa) • Certified Nurse Midwife

Birthing Care Pathway Clinical Care Workgroup		
No.	**Name**	**Organization & Title**
18	Elizabeth Smith	• Director, Santa Rosa Midwifery Center • Former Treasurer, CNMA • Certified Nurse Midwife & International Board Certified Lactation Consultant
19	Mike Weiss	• Vice President of Population Health, Children's Hospital of Orange County (CHOC) • Pediatrician
20	Amanda Williams	• Clinical Innovation Advisor, California Maternal Quality Care Collaborative (CMQCC) • Interim Chief Medical Officer, March of Dimes • Adjunct Clinical Associate Professor, Department of Obstetrics and Gynecology, Stanford University School of Medicine • OB/GYN
21	Jyesha Wren	• Co-Founder & Program Director of BElovedBIRTH Black Centering within Alameda Health System & Founding Director of Beloved Birth Collective • Certified Nurse Midwife

Birthing Care Pathway Social Drivers of Health Workgroup		
No.	**Name**	**Organization & Title**
1	Ninoska (Nina) Ayala	• Women, Infants, & Children (WIC) Director, Native American Health Center
2	Priya Batra	• Deputy Director, Health Promotion Bureau, Los Angeles County Department of Public Health • Physician Policy Researcher, Adjunct, RAND Corporation • OB/GYN
3	Stephanie Bryant	• Program Chief, Maternal, Child, & Adolescent Health/Public Health Nursing for Riverside University Health System-Public Health • Registered Nurse
4	Susan D. Crowe	• Clinical Professor, Obstetrics and Gynecology–Maternal Fetal Medicine, Stanford University • District IX's Executive Committee, American College of Obstetricians and Gynecologists (ACOG) • OB/GYN
5	Arlene Cullum	• Director of Special Projects, Stanford University School of Medicine
6	Shanica Davis	• Program Coordinator, African American Infant Maternal Mortality (AAIMM) Doula Program (led by Los Angeles County Department of Public Health) • Doula
7	Angela Egbuchulam	• Black Infant Health (BIH) Coordinator, San Joaquin County Public Health Services
8	Alexander Fajardo	• Executive Director, El Sol Neighborhood Educational Center • Community Health Worker

Birthing Care Pathway Social Drivers of Health Workgroup		
No.	**Name**	**Organization & Title**
9	Crystal Gil	• Mental Health Therapist, Kern Medical
10	Raena Granberry	• Director, Maternal & Reproductive Health, California Black Women's Health Project
11	Robert Hickman	• Member, Sacramento Maternal Mental Health Collaborative • Community Engagement Lead, Be Mom Aware • Member, Sacramento County Maternal, Child, and Adolescent Health Advisory Board • Licensed Marriage and Family Therapist
12	Leslie A. Kowalewski	• Executive Director of Maternal, Child and Family Health for California Maternal Quality Care Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), and the Prematurity Research Center (PRC)
13	Maria Lemus	• Executive Director, Visión y Compromiso • Promotora
14	Brittany Lobo	• Community & Family Health Section Manager, Sonoma County Department of Health Services
15	Marisela Montoya	• Executive Director, South Los Angeles Health Projects (Lundquist WIC) • International Board Certified Lactation Consultant
16	Malini Nijagal	• Professor, University of California, San Francisco (UCSF) Department of Obstetrics, Gynecology, & Reproductive Services (Zuckerberg San Francisco General Hospital Division) • Director, SF Respect Initiative • OB/GYN
17	Stephanie Nishio	• Director of Programs, California Association of Food Banks

Birthing Care Pathway Social Drivers of Health Workgroup		
No.	**Name**	**Organization & Title**
18	David Pisani	• Director of Advocacy & Government Affairs, March of Dimes
19	Lissa Pressfield	• Chief, Child & Adolescent Health Branch, California Department of Public Health (CDPH)
20	Alejandra Ramos	• Children's Program Manager, Marjaree Mason Center
21	Griselda Zamora	• Director of Community Health, Community HealthWorks

Birthing Care Pathway Postpartum Sub-Workgroup[28]		
No.	**Name**	**Organization & Title**
1	Sean Atha	• Senior Vice President of CalAIM Initiatives and Community Health Integration, Vivant Health
2	Priya Batra^	• Deputy Director, Health Promotion Bureau, Los Angeles County Department of Public Health • Physician Policy Researcher, Adjunct, RAND Corporation • OB/GYN
3	Susan D. Crowe^	• Clinical Professor, Obstetrics and Gynecology–Maternal Fetal Medicine, Stanford University • District IX Executive Committee, American College of Obstetricians and Gynecologists (ACOG) • OB/GYN
4	Shantay R. Davies- Balch*	• President & Chief Executive Officer, BLACK (Belonging, Love, Affinity, Community, & Kinship) Wellness & Prosperity Center • Doula & Certified Lactation Educator
5	Liz Donnelly	• Health Policy Vice-Chair, California Nurse-Midwives Association (CNMA) • Certified Nurse Midwife
6	Emily C. Dossett*	• Founder and Director, Reproductive Mental Health Consultants • Associate Clinical Professor, Departments of Psychiatry & Obstetrics & Gynecology, Keck School of Medicine, University of Southern California (USC) • Reproductive Psychiatrist

[28] * represents individuals who are also members of the Clinical Care Workgroup. ^ represents individuals who are also members of the Social Drivers of Health Workgroup.

Birthing Care Pathway Postpartum Sub-Workgroup[28]		
No.	**Name**	**Organization & Title**
7	Angela Egbuchulam^	• Black Infant Health (BIH) Coordinator, San Joaquin County Public Health Services
8	Sayeed Khan	• Chief Medical Officer, Molina Healthcare of California • Internal Medicine Physician
9	Tipu Khan*	• Chief of Addiction Medicine, Ventura County Medical Center • Fellowship Director, Ventura County Primary Care Addiction Medicine Fellowship • Core Faculty, Ventura Country Family Medicine Residency Program • Director of Addiction Medicine for Southern California, HealthRight 360 • Adjunct Clinical Professor, Keck School of Medicine, USC • Family Medicine Physician & Addiction Medicine Specialist
10	Michelle Lubahn	• Community Education Manager/Project Lead, Developmental Understanding and Legal Collaboration for Everyone (DULCE) Population Health, Children's Hospital of Orange County (CHOC)
11	Antoinette Martinez*	• Family Medicine with Obstetrics, United Indian Health Services, Inc., Arcata, California • Co-Director/Associate Professor, University of California Davis (UCD) School of Medicine (SOM) Tribal Health PRograms in Medical Education (PRIME) (THP)

Birthing Care Pathway Postpartum Sub-Workgroup[28]		
No.	**Name**	**Organization & Title**
		• Co-Director, Huwighurruk Postbaccalaureate Program at Cal Poly Humboldt with UCD SOM THP • Family Medicine Physician & OB/GYN
12	Marisela Montoya^	• Executive Director, South Los Angeles Health Projects (Lundquist WIC) • International Board Certified Lactation Consultant
13	Robert Moore*	• Chief Medical Officer, Partnership HealthPlan • Family Medicine Physician
14	Malini Nijagal^	• Professor, University of California, San Francisco (UCSF) Department of Obstetrics, Gynecology, & Reproductive Services (Zuckerberg San Francisco General Hospital Division) • Director, SF Respect Initiative • OB/GYN
15	Kelly O'Connor*	• Executive Director, Maternal Mental Health NOW
16	Yeri Park	• Provider, Family Care Specialists Medical Group • Teaching Faculty, Adventist Health White Memorial • Family Medicine Physician
17	Karen Ramstrom*	• Chief, Maternal & Infant Health Branch, Maternal Child & Adolescent Health (MCAH) Division, California Department of Public Health (CDPH) • Preventive Medicine & Public Health Physician
18	Erin Saleeby *	• Chair, Department of Obstetrics & Gynecology, Harbor-University of California, Los Angeles (UCLA) Medical Center

Birthing Care Pathway Postpartum Sub-Workgroup[28]		
No.	**Name**	**Organization & Title**
		• Associate Clinical Professor, Department of Obstetrics & Gynecology–David Geffen School of Medicine at UCLA • Director, Women's Health Programs & Innovation, Los Angeles County Department of Health Services • Medical Director, Essential Access Health • OB/GYN
19	Holly Smith *	• Health Policy Chair and Legislative Coordinator, CNMA • Co-Facilitator, Midwifery Access California (MACa) • Certified Nurse Midwife
20	Mike Weiss*	• Vice President of Population Health, CHOC • Pediatrician
21	Madeleine Wisner	• Chief Executive Officer, Welcome Home Midwifery Services • Vice President, California Association of Licensed Midwives (CALM) • Licensed Midwife, Registered Midwife (New Zealand), & International Board Certified Lactation Consultant
22	Jyesha Wren*	• Co-Founder & Program Director of BElovedBIRTH Black Centering within Alameda Health System & Founding Director of Beloved Birth Collective • Certified Nurse Midwife

Appendix C. Policies DHCS Has Implemented/Is Implementing for the Birthing Care Pathway

Policy Solution	Status
A. Provider Access and MCP Monitoring and Oversight	
1. Leverage CalHealthCares education loan repayment program to build pipeline and increase diversity of OB/GYN and family medicine workforce.	In Progress
2. Remove administrative barriers to Medi-Cal provider enrollment and reimbursement requirements for all midwives, with a particular emphasis on LMs, by ensuring alignment with state licensing and scope of practice requirements.	Completed
3. Clarify MCP network adequacy requirements for CNMs, LMs, and FBCs as Mandatory Provider Types and strengthen thresholds that must be met.	In Progress
4. Reiterate Medi-Cal requirements that the MCPs whom DHCS are contracted with are responsible for ensuring all covered services are accessible and the provider network is adequate. Enhance oversight of network agreements and/or delegated arrangements for maternity/perinatal care services to ensure covered benefits (midwifery, doula, and lactation services) are clearly outlined.	In Progress
5. Establish a Doula Implementation Stakeholder Workgroup comprised of doulas, Black birthing justice experts, Tribal representatives, local health departments, advocates, and provider associations to inform DHCS' doula benefit design and reimbursement approach.	In Progress
6. Issue a standing recommendation for doula services for all pregnant and postpartum Medi-Cal members to increase access to doula services and launch a Doula Directory for use by Medi-Cal members, providers, and MCPs to identify doulas in their community/network.	Completed

Policy Solution	Status
7. Streamline requirements and improve access to a range of high-quality breast pumps.	In Progress
8. Survey MCPs on promising practices to promote covered perinatal benefits among members as well as providers (e.g., among hospital partners on use of doulas and lactation support) to drive appropriate utilization. The survey will also include questions related to practices to reduce administrative burden for providers (e.g., contracting support through hub models, streamlining authorization processes).	In Progress
9. Consolidate and update Medi-Cal perinatal policies through a single APL and update provider manuals to clearly define perinatal benefits and provider enrollment requirements for midwives, birth centers, and doulas, and encourage MCPs to incentivize network providers to offer group perinatal care models to pregnant and postpartum members.	Not Started
10. Create and enhance member-facing communications materials and outreach strategies on perinatal Medi-Cal benefits and provider types to bolster awareness during and after pregnancy.	In Progress
11. Create guidance and/or technical assistance for MCPs on supporting pregnant and postpartum members transferring to different care settings and levels of care.	In Progress
B. Behavioral Health and Trauma-Informed Care	
1. Raise awareness of Children and Youth Behavioral Health Initiative (CYBHI) ongoing investments to provide behavioral health services and supports to pregnant and postpartum individuals and their children.	Completed
2. Review MCP, Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC), and Specialty Mental Health Services (SMHS) contracts to identify opportunities for strengthening	Not Started

Policy Solution	Status
existing contract language, including monitoring and oversight requirements, to ensure pregnant and postpartum members have access to qualified behavioral health providers and their perinatal care is integrated with behavioral health care.	
3. Reinforce communication of existing Medi-Cal coverage policy of no maximum stay (e.g., 60 days) for members—including pregnant and postpartum members—receiving residential SUD treatment.	Completed
4. Update and disseminate SUD Perinatal Practice Guidelines for providers that deliver SUD treatment to pregnant and parenting women.	Completed
5. Re-frame services in a trauma-informed context, acknowledging how care needs to be delivered to pregnant and postpartum members who are experiencing or have experienced ACEs, IPV, community violence, and racism.	Not Started
C. Risk Stratification and Assessment	
1. Develop a risk stratification, segmentation, and tiering (RSST) process in Medi-Cal Connect to identify pregnant and postpartum members who are high risk, including risks across medical, behavioral, and social domains, and that aims to reduce the bias documented in current methodologies. The RSST will identify members who may benefit from connections to additional social support and clinical care.	In Progress
2. Incorporate IPV screening as part of Medi-Cal assessments performed by providers and clinical care managers.	Not Started
D. Medi-Cal Maternity Care Payment Redesign	
1. Increase rates for maternity care providers and enhance supplemental payments for L&D and hospital-based birthing center services.	Completed

Policy Solution	Status
2. Expand maternity measures in the Quality Incentive Pool (QIP) for Designated Public Hospitals (DPHs) and District and Municipal Public Hospitals (DMPHs).	Completed
3. Redesign how Medi-Cal pays for maternity care services to create a new birthing care payment model that rewards value-based care, incentivizes best practices for pregnant and postpartum members, and supports the goals of the Birthing Care Pathway.	In Progress
4. Develop billing/reimbursement guidance for Medi-Cal providers as well as MCPs and their subcontractors on LM services, including home births, and FBC services.	Not Started
5. Strengthen implementation of dyadic services by establishing an alternative payment methodology (APM) allowing FQHCs, RHCs, and Tribal Health Programs (THPs) to be reimbursed for dyadic services at the Medi-Cal FFS reimbursement rate in addition to the FQHC/RHCs' PPS reimbursement rate and THPs' All-Inclusive Rate (AIR)[29] for an eligible visit.	In Progress
E. Care Management and Social Drivers of Health	
1. Leverage Providing Access and Transforming Health (PATH) to support ECM Birth Equity providers by providing technical assistance and prioritize ECM Birth Equity providers for Capacity and Infrastructure, Transition, Expansion, and Development (CITED) Initiative awards.	Completed
2. Conduct outreach to WIC, home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise to become ECM providers.	In Progress

[29] THPs include both IHS-MOA 638 Clinics and Tribal FQHCs. IHS-MOA 638 Clinics receive the All-Inclusive Rate (AIR). Tribal FQHCs are reimbursed through an APM that is set at the AIR.

Policy Solution	Status
3. Expand ECM referral pathways, particularly from social services and behavioral health providers, for pregnant and postpartum members.	In Progress
4. Encourage utilization of Transitional Rent under the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 waiver demonstration as a Community Supports service for eligible Medi-Cal members – i.e., those who (1) meet one or more of the qualifying clinical risk factors[30] (e.g., pregnancy and up to 12 months postpartum), are (2) experiencing or at risk of homelessness, and (3) fall within one or more of the transitioning populations[31] (e.g., transitioning out of a hospital after giving birth.	In Progress
5. Encourage MCPs to partner with housing providers that meet the needs of perinatal populations from pregnancy through 12 months postpartum to serve as ECM and Community Supports providers.	Not Started
6. Encourage MCPs to build partnerships with IPV CBOs to serve as ECM and Community Supports providers.	Not Started
7. Encourage MCPs to consider working with facilities that offer rooming in with short-term post-hospitalization stays and have the requisite capabilities to contract as Community Supports providers to provide Recuperative Care (medical respite) or Short-Term Post-	Not Started

[30] To meet the clinical risk factor requirement, a member must have one or more of the five qualifying clinical risk factors: (1) meets the access criteria for Medi-Cal SMHS; (2) meets the access criteria for DMC or DMC-ODS; (3) one or more serious chronic physical health conditions; (4) one or more physical, intellectual, or developmental disabilities; and (5) individuals who are pregnant up through 12 months postpartum.

[31] To be eligible for Transitional Rent, individuals must fall within one or more of the transitioning populations: (1) transitioning out of an institutional or congregate residential setting (including hospitals after giving birth); (2) transitioning out of a carceral setting; (3) transitioning out of interim housing; (4) transitioning out of recuperative care or short-term post-hospitalization housing; (5) transitioning out of foster care; (6) unsheltered homeless as described in 24 CFR part 9.15; and (7) eligible for Full-Service Partnership (FSP).

Policy Solution	Status
Hospitalization Housing to postpartum members experiencing homelessness and who meet clinical criteria.	
F. Perinatal Care for Justice-Involved Individuals	
1. Ensure pregnant and postpartum individuals are enrolled in Medi-Cal pre-release.	Completed
2. Ensure eligible pregnant and postpartum individuals receive 90-day pre-release services.	In Progress
3. Encourage connection to ECM upon release.	In Progress
G. Data and Quality	
1. Leverage Medi-Cal Connect to support whole person care and provide population insights by safely sharing integrated health care and social data and insights about members among providers, delivery systems, programs, and state agencies that support Medi-Cal members as well as sharing with the Medi-Cal members themselves.	In Progress
2. Leverage learnings from the efforts aimed at cross-enrolling Medi-Cal members into crucial safety net supports upon pregnancy through 12 months postpartum, including new linkages in administrative data between Medi-Cal, CalFresh, and WIC pilot programs currently under development in partnership with CDPH, CDSS, the California Center for Data Insights and Innovation (CDII), and Medi-Cal MCPs to inform strategies to facilitate cross-enrollment and the ongoing rollout of Medi-Cal Connect.	In Progress
3. Identify opportunities to leverage and integrate existing California maternity data centers (e.g., CMQCC, CDPH MCAH) with Medi-Cal data to more comprehensively measure and monitor birth outcomes.	In Progress

Policy Solution	Status
4. Create key performance indicators (KPIs) to track the efficacy of maternity care and monitor adherence to Birthing Care Pathway policies.	Not Started
H. State Agency Partnerships	
1. Partner with CDPH, OSG, and CMQCC to develop the statewide Maternal Health Strategic Plan that prioritizes the care experience; risk-appropriate perinatal care; comprehensive risk assessment and appropriate follow-up; data transparency; and integrated care across systems, programs, and communities.	In Progress
2. Collaborate with CDPH, CDSS, and MCPs to promote home visiting for Medi-Cal members and ensure eligible members can access home visiting programs.	In Progress
3. Partner with the Employment Development Department (EDD) and Legal Aid at Work (LAAW) to develop a resource guide for perinatal providers on how their pregnant and postpartum patients can access the state's PFL and SDI programs.	Completed
4. Leverage the Family First Prevention Services Act (FFPSA) to support SUD and mental health treatment services for pregnant and postpartum individuals at risk of child welfare involvement.	In Progress
5. Continue to support the OSG Strong Start & Beyond movement through participation in the Perinatal Advisory Group (PAG).	In Progress