CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

DHCS BIRTHING WEBINAR

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Speakers:

- Alice Lam
- Tyler Sadwith
- Palav Barbaria
- Anita Chacon Terry
- Bambi Cisneros
- Jen Elder
- Michelle Baass

TRANSCRIPT:

TIME—SPEAKER—VISUAL

Transcription

Introduction

00:00:33—Alice Lam—Slide 1

Hello and welcome. My name is Alice. I will be in the background answering any technical questions. We encourage you to write written questions anytime using the Q&A box, which is located on the zoom panel on the bottom of your screen. Finally, during today's screen live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I would like to introduce Tyler Sadwyth, the California state Medicaid director at DHCS.

00:01:02 – Tyler Sadwith

Good afternoon everybody. We are here to provide an overview in the birthing care pathway which the Department of healthcare services began developing in 2023, and we published a report on the birthing care pathway last month. Really looking forward to sharing information about sort of our journey, developing this resource and some of the information included in it, as you'll hear today from our team the berthing care pathway is a comprehensive policy and care model roadmap that covers the journey of all pregnant post-partum Medi-Cal members all the way from conception through 12 months postpartum. Our goals in launching the birthing care pathway are to reduce maternal mortality for all Medi-Cal members, and specifically, address the significant racial and ethnic disparities in maternal health outcomes that we unfortunately see among black, American Indian, Alaskan native, and Pacific Islander individuals. Taking a step back with the rest of the nation, California is facing a maternal health crisis. While California's pregnancy-related mortality ratio is lower than the national ratio, it has been rising in recent years. The majority of these deaths are preventable. California's severe maternal morbidity rate has also been rising and unfortunately that is higher than the national rate. We know one in every eight births in this country takes place in California. We know 40% of those births are covered by Medi-Cal. This department is uniquely positioned to drive significant improvements in maternal health and birth equity, policies and outcomes. To develop the birth and care pathway over the course of the past year and a half the department conducted a landscape assessment of California's existing maternal health policies and initiatives, reviewed national best practices and evidence-based programs, interviewed more than two dozen state leaders, maternity care providers, community-based organization leaders, Medi-Cal managed care plan representatives, and birth equity advocates. We launched three workgroups focused on clinical care, social drivers of health and the postpartum period, and for the first time, recruited a cohort of pregnant and post-partum Medi-Cal members to share their lived experience, their feedback, and their recommendations through focus groups, interviews, and journaling over the course of several months, which is foundational to ground and inform our policy work. In addition to investments made by the department in this area, we have been fortunate to have support from the California healthcare foundation and the David and Lucille Packard foundation as well. So on behalf of the department, I just want to say thank you to all of the feedback we have received from all of you, from expert stakeholders, from Medi-Cal members, thanks to you, we were able to publish the Birth and Care pathway report last month. The report includes a series of policy, solutions and strategic opportunities for further exploration that are designed to address the physical, behavioral and health-related social needs of pregnant and postpartum of Medi-Cal members. These include highlights of work that we are

undertaking it now to improve access to providers, strengthen clinical care, and care coordination across the continuum, provide whole person care and modernize how Medi-Cal pays for maternity care. During the discussion today you will hear an overview of literally the dozens of policies the department is implementing as part of the Birth and Care pathway and our progress to date in these efforts. We also plan to share strategic opportunities for further exploration. These strategic opportunities are really important to continue considering. They're subject to additional assessment and planning and contingent on a few external factors such as legislative authority or additional state budget authority. We recognize many of you joining us today have been offering recommendations to advance equitable maternal health over the past several years, and to this I want to say thank you, we are so appreciative of you for sharing your time, expertise and experience with us. All of your insights were tremendously helpful in designing the Birth and Care pathway. We look forward to continuing to engage with you. With that it is my pleasure to give over to Doctor Paula Babaria, who serves as the chief quality and medical Officer as well as the deputy director of policy population health management here at the Department of Health care management services. Thank you for being here with us today.

00:06:11—Palav Babaria—Slide 2

Thank you so much Tyler for kicking us off, laying the groundwork for the next 90 minutes we are going to spend together. Before we dig into our agenda for today, I will say I think we all recognize, let's not beat around the bush, that these are some challenging times that we are all experiencing and living in. And what I am really excited about the next 90 minutes is the policy roadmap that we are going to walk through as well as all the initiatives that are being done. They truly represent the collaborative, resilient spirit of all Californians and most importantly everyone on this call and others that are serving Medi-Cal members every day and really striving to improve quality and equity in our program. Hopefully, what it shows is there's a lot we can do we all come together and are rowing in the same direction and really being able to rise above our own silos in this process and connect and partner not just in the Medi-Cal program but across multiple state departments has really led us to the moment that we are at today. So thank you all for joining. As many of you know, for all of our quality and health equity work, we really want to ground the "why" of the work in the lived experiences of our Medi-Cal members. So we're really excited to kick off today's webinar with two member stories. The first one comes to us from Pamela who is a Medi-Cal member with Partnership Help Plan from Solano County. When she was pregnant 2024, she benefited from a number of different services through her health plan and local community. These

services included growing together program which is open to all pregnant and postpartum partnership members as well as families with children up to age five. The program seeks to connect with pregnant and postpartum members and really support them in getting appropriate and timely prenatal care, empowering postpartum members to attend their well care and well-child visits and really building strong patient and provider relationships throughout the pregnancy and postpartum period. I will turn over to the video so we can hear directly from Pamela about her experience.

00:08:15—Video—Slide 3

Hello, my name is Pamela and I would like to briefly talk about my personal experience with my pregnancy journey with Partnership Health Plan of California. So there are dualist services which can be online or in person. Also, getting breast-feeding moms and many more other supportive services through the growing together program which essentially is personalized according to your personal needs. In my personal experience as a pregnant mom, my anxiety and mental health was taken care of through gradually consistent phone calls just to make sure that baby and I are okay. Partnership Health Plan is truly more than just a health plan. As they will go the extra mile to walk through the journey with you. Not just journey of pregnancy, but postpartum too. So I would highly recommend anybody, especially new moms, to make use of every resource that they offer.

00:09:33—Palav Barbaria—Slide 3

Next, we're going to turn to Anita Chacon Terry, who is a manager of care, management and transitional care services at Health Net, which is one of our Medi-Cal managed care plans operating in multiple counties throughout the state to share another story from a Medi-Cal member that she is working with. Anita I will turn it over to you.

00:09:54 – Anita Chacon Terry—Slide 4

Thank you very much. I would love to share a story of our member, a 32-year-old female that our transitional care services team connected with upon her hospitalization. This number had a still birth at 38 weeks. She had been receiving prenatal care from her Medi-Cal doctors, including OB/GYN care. Once she had gone to the hospital, our transitional care services team reached out to offer our services and support. Our care manager did an initial assessment, and offered behavioral healthcare resources due to the member's struggle with grief. She also offered Doula services to her. The member had voiced that she was unsure if she was ready to start therapy and declined the Doula services. The member voiced that she was planning on she had family support and she was planning to discuss her emotions with her provider at her follow-up appointment.

However, when our care manager did her next outreach to the member to complete our postpartum assessment, the member disclosed she sometimes had thoughts of harming herself. The care manager then decided to transfer the call, with the members permission, to our crisis line to have the member further assess for immediate behavioral health needs and support. The member is now linked to behavioral health services she was provided resources for support groups, and this included online support from our online support chat as well as family bereavement support. The member has completed her goals in our postpartum transitional care program and has been referred to our behavioral healthcare management program to provide more long-term care management support and ensure the member is linked to behavioral health resources and providers. Thank you for allowing me to share our member story.

00:11:55—Palav Barbaria—Slide 4

Anita thank you so much for joining us today and sharing that story. For those of you who may be less familiar, transitional care services is one of our newer policy requirements that went live as a part of our Cal-AIM population health management program in January 2024 and requires specifically for high risk members for being discharged from a hospital, or another setting for them to have a dedicated care manager and we made an explicit policy decision to include all pregnant and postpartum individuals being discharged in the policy exactly to help support members like the one that Anita talked about. Thank you both. Hopefully that gives a little bit of context and real lived experience to the why of why we are here and doing this work. We can go to the next slide.

00:12:44—Palav Barbaria—Slide 5

We can go one more.

00:12:47—Palav Barbaria—Slide 6

So we are going to spend the first portion of our webinar today really talking about what is DHCS's vision for the maternity care in Medi-Cal. What is the process we took to actually develop the birthing care pathway? As many of you know, as we were doing policy development, the process we take and who we engage with and how we listen to them is a key part of our strategy to address health disparities, and achieve health equity in our estate. Even though, it may not be right away getting into the nitty-gritty policy details, we actually think this is foundational to all of the work we are doing. So those of you who haven't read it yet, you can link to our website and the full birthing care pathway report, all 130 something glorious pages of it, are available online and have a lot more detail. But we hope after this multiyear collaborative journey that is

going to require partnerships across state departments with local counties and governments with all of the providers, social service sector providers and members across the state, that we can really make sure the Medi-Cal members have access to all the maternity care providers and services they are entitled to under the Medi-Cal program, regardless of where they live. We know that access is not even across all parts of our state today. We also want to make sure that members can really get risk appropriate care and are empowered to choose what type of provider and birthing location that aligns with their needs and their preferences, and we also want all members to feel respected and heard throughout their pregnancy and postpartum journeys. We also want members to be educated and knowledgeable about the services that are available to them and that they can get support navigating these services, especially in that really crucial postpartum period where they are juggling their own care needs with the needs of their newborn child. We also heard loud and clear and want to support access expansion for all behavioral health services and social supports for members, their newborns, and their larger family in which they reside. We also heard a lot of opportunity to really improve care by streamlining data collection and supporting data exchange so there is enhanced care and visibility locally. You can go to the next slide.

00:15:06—Palav Barbaria—Slide 7

As mentioned, on the website, there is an actual document which is the comprehensive policy and care model roadmap. As you read through it and as you'll hear in today's webinar, many of these pieces are ones where DHCS is taking the lead. But, as we heard from all of our stakeholders and members, to truly achieve the vision we laid out for maternity care and postpartum care in Medi-Cal, it's going to require much partnership collaboration and support far beyond DHCS. It includes policy solutions that are all person in alignment with our Cal-AIM objectives that we're not just talking about clinical maternity care, we're also talking about behavioral and health-related social needs and our goal is explicitly to reduce maternal morbidity and mortality and close the significant racial and ethnic disparities that persist to this day in our state. We can go to the next slide.

00:16:00—Palav Barbaria—Slide 8

So, the report, as mentioned, has a lot of details. We will be doing a high level overview today but it walks through the entire process and does a deep dive into all the feedback we heard from members and stakeholders and then also provide more detailed policies that we are both implementing as well as proposing for future exploration. I would be remiss at this point if I did not pause to think of our funders. The entirety of this work

and especially the significant member engagement work that we did including member stipends were generously supported by healthcare foundation and the David and Lucille Packard foundation and we are really grateful for their support that enabled us to be here today. You can go to the next slide.

00:16:45—Palav Barbaria—Slide 9

I am going into these a little bit more detail but we really took a multipronged approach. I think as Tyler opened up, we have been hearing about challenges and also opportunities for improvement in our maternity policy from a variety of sources for a while now, and we knew, as we started to peel back the layers of the onion, that maternity care is one of the oldest parts of the Medi-Cal program, which is great because it means the services and benefits have been around for a long time, but it also means that there's a lot of layers and things have been added over the years. There is a lot of parts of our policies that have not been updated in a while. So, to really make sure we were taking a comprehensive, transformative approach, we did a landscape assessment to review all of California's existing policies as well as look at evidence-based practices and national best practices. We engaged Medi-Cal members directly, because at the end of the day, it does not matter what we have in our policy if that is not translating into the lived experience and services that are touching our members on the ground every single day. We also interviewed state leaders, providers, community-based associations, health plans, and advocates to get a broad base of perspectives on where things are going well, where there is opportunity for improvement, and we had a series of longitudinal work groups. One focused on clinical care, one on social drivers of health, and a postpartum work group, which I'll talk about more to really delve into the policy details and help suggest solutions and really guide the development of the report. We can go to the next slide.

00:18:17—Palav Barbaria—Slide 10

So, I do think one of the most novel pieces of this work, compared to other policy initiatives that DHCS has undertaken is how we engage Medi-Cal members, as many of you know, as a part of our comprehensive quality strategy as well as DHCS's strategic plan. We are very intentionally trying to engage members and have them inform our policy decisions, because at the end of the day, our program exists in service of our Medi-Cal members. For this project, we engaged 30 members who are currently pregnant or up to 24 months postpartum and invited them to share their lived experience with us. We purposely selected individuals so that we could get a broad representation across the state. We know the experiences of members in regards to maternity care looks very different if you are living in Los Angeles compared to

Humboldt County. We also tried to select for people who are at different phases of their pregnancy journey. Different age ranges, different races, ethnicities, and different other lived experiences to really have a diverse group. We then did deep dive interviews with six of the members that did longitudinal journaling throughout their pregnancy. Because we know that your experiences in the prenatal period, for example, may look different in first compared to third trimester or compared to the postpartum period. And then we also had a Member Voice work group with 18 members that had three work group meetings as well as a debrief meeting. They got a preview of this report before it went public to really learn from the group as a whole and digest a lot of the findings. I will also note that we asked for funding from our generous funders to engage 30 members. We had the invitations to join this Member Work group sent out through many of the stakeholders and providers and CBOS and other groups that we were working with, and we got 400 applications, which we were blown away by. We thought it would be hard to find 30 members and definitely did not expect that 400 Medi-Cal members would really want to participate in this project. And I think it's really a testament to how much people want to make our program better and provide feedback. We can go to the next slide.

00:20:31—Palav Barbaria—Slide 11

I am going to walk through these member findings a little bit in detail, because I do think these are the heart and soul of our birthing care pathway report at the end of the day. If we don't address these six findings, our project and our roadmap will not have been a success. So, the first three themes that you see listed on this slide, these were the top themes from our member voice work groups, and our member voice findings that they really said, "this is what we want out of our Medi-Cal experience." First and foremost, the members felt, you know, said that feeling respected and heard by health care providers is critical to their experience. Some members had great examples for this, but many others had specific examples where they felt like their choices and preferences, whether it came to the birth or breastfeeding, were dismissed and belittled and not taken seriously and it really changed their entire experience. We also heard from some members, unfortunately, that they had multiple experiences with discrimination in their healthcare encounters during all three perinatal phases. Some members felt that they had better care or felt more heard when they received racially concordant care, and then we heard pretty consistently loud and clear that often key moments for trust building with members were often missed. Specific examples of this were behavioral health screenings that were done, and then the results were never communicated to the members so they had no idea if they screened positive or negative, or needed a follow-up. There were times where a trauma-informed approach

to care was not taken, and a member who was experiencing intimate partner violence was screened for IPV in front of her abuser who was in the room with her and could not answer the question honestly. Many individuals had bumps and issues when they were transitioning from the labor, delivery and hospital setting to home and, often, key follow-up appointments or access to DME and breast pumps was not completed. One example we heard from a member is her infant had to stay in the NICU for a few extra days for jaundice and she was told her baby needed care within 24–48 hours after discharge, but she wasn't connected to a pediatrician and wasn't given any instructions about that care was not given any instructions on how to access the care and was really worried about the safety and health care of her newborn. You can go to the next slide.

00:22:47—Palav Barbaria—Slide 12

The three themes that you'll see that I'm going to walk through also came up in our member voice workgroup and were also really consistent from the feedback he heard from the other workers as will cover in a few minutes. So, it was often though that the onus to navigate all of the aspects of perinatal care was often put on the member, so both in the prenatal and postpartum when the member was often caring for an infant trying to get medical care for themselves, for their newborn infant. Also trying to get key social services, whether that was Cal Fresh or WIC or lactation support or behavioral health—everything was fragmented. At some point our members gave up that it was too much trying to go to 15 different appointments and they forewent critical services because it was too hard to coordinate and access them. We also heard loud and clear and consistently that finding behavioral health providers both for mental health as well as substance use disorder was very difficult. Often, members face long wait times to even get an appointment with a behavioral health provider and then, when they did finally have an appointment, sometimes those behavioral health providers told them they did not feel comfortable caring for pregnant or postpartum individuals and they had to start the process all over. From all of our workgroups and member findings, many members had no idea all of the benefits that Medi-Cal covered. One of the workgroups, a member talked about how positive her experience was everyone else in the group had no idea that Medi-Cal even covered dulas. Similarly, for key benefits like Enhanced Care Management, WIC, Cal Fresh, or transportation services, there was a lot of gaps in knowledge of what they were entitled to. We can go to the next slide.

00:24:34—Palav Barbaria—Slide 13

The other piece here is that we do key informant interviews as mentioned. We really wanted to interview all the different people who touched maternity populations across the state, so we had lots of interviews with provider associations—not going to read all

of them out here—as well as individual providers who represent the different provider types here. We also connected with county leaders especially for public health who provide a lot of local wraparound services for pregnant and postpartum populations, as well as CBOs participating in Cal-AIM and otherwise who really focus on providing specific services for specific subpopulations. We can go to the next slide.

00:25:22—Palav Barbaria—Slide 14

And then these are the three work groups that I mentioned. So in addition to the Member stakeholder engagement, all of the landscape scan and the interviews, we had three groups that met longitudinally the clinical care and social drivers of health groups met over the course of two years multiple times, and the postpartum sub workgroup met for about 12 to 18 months. The purpose of the clinical healthcare is really to focus on the clinical needs of our members. What is the actual medical behavioral health care that our member needs, both through the prenatal and the postpartum period all the way through 12 months postpartum.. We recognize this is team-based care, so really included hysicians, midwives, lactation consultants, doulas, tribal health providers, freestanding birth centers, behavioral health and FQHC providers, as well as plans and public health. The social drivers of Health Work Group was really laser focused on. What are all of those other health related social needs that we need to coordinate and connect, to provide that whole person care to the members. This group included community health workers, Doulas violence prevention, organization representatives, social service and public, health groups, housing providers, home visiting providers and providers with black birthing experience. I will also acknowledge this distinction between clinical and social care is somewhat artificial. So we had a lot of overlap between these two groups and did synthesize their findings. But we really wanted to create a safe space where people could do a deep dive into their areas of expertise. The postpartum subgroup also had members from both of these groups in addition to others and really was focused on the one year postpartum period. As many of you know, Medi-Cal expanded Medi-Cal individuals who qualify on basis of pregnancy from 60 days to 12 months similar to many other states under the last administration. Yet the clinical pathway for the services someone needs for the 12 month period. What are their challenges and where can we help them was unknown. The postpartum sub workgroup was really focused on building out that clinical pathway. You can go to the next slide.

00:27:34—Palav Barbaria—Slide 15

So, this is a summary of the birthing care partner engagement findings. It is probably not news to many of you on this call who work in the space daily. Access to maternity hospitals, especially in rural communities, is rapidly diminishing and there are many

areas where we do not have enough maternity providers or any maternity providers to care for their local populations. We also heard heard specifically that some of the challenges for midwives and lactation consultants and barriers they can face and Medi-Cal provider enrollment as well as reimbursement. If they can't get enrolled in our program and they can't get paid for providing services. This, in turn, really limits Medi-Cal member access to these services. We also heard about long appointment wait times and not having enough behavior health providers who are comfortable treating postpartum individuals, which limits access for this population, sometimes with really catastrophic consequences. We heard from these groups that there is a lot of deep silos both in terms of sharing, communication, care coordination, and collaboration and that really breaking down the silos between different types of providers as needed to deliver coordinated care. Specific examples we heard is someone could be engaging with WIC and have an entire WIC care plan and sometimes they show up to labor and delivery and no one knows what is in the care plan, does not have visibility into all the great work that is been done or what risk factors an individual has. Or vice versa—there could have been a tremendous amount that happens during hospitalization with huge impact to the member and the newborn and, sometimes in the postpartum setting, they show up to an appointment no one knows about that hospital labor and delivery course. We also heard about the promise and opportunity of using group care models like centering pregnancy, to really provide whole person, care and build community, especially hearing from some of our members that social isolation and not having a strong support network, was a major issue. We can go to the next slide.

00:29:44—Palav Barbaria—Slide 16

We also heard consistently that while folks really value the comprehensive perinatal services program (CPSP), I think we all know CPSP was founded in the 19 eighties and has not necessarily been updated much since then. And so there's a lot of opportunity to modernize CPSP to really align with how clinical services and social services are provided today that could really help uptake and use. We also heard that pregnant members are not always being consistently connected with providers and facilities that meet their risk level. Obviously, if the member is high risk, whether because of medical conditions or behavioral health conditions, really needing a facility that can accommodate the level of risk and that does not always happen. We also are clearly in a housing crisis in our state. Our pregnant and postpartum members are no more immune to that than other populations. Consistently, lack of housing and homelessness were cited as major barriers and issues that need to be solved to support pregnant and postpartum members. Also thinking about—we heard this from our workgroups—how

can we educate Medi-Cal members on all of the resources they are entitled to and take on the navigation burden, which, right now, that onus is entirely on the member. We can go to the next slide.

00:31:12—Palav Barbaria—Slide 17

As I mentioned, multiple times so far, this is really a group effort. These are all the organizations that we have been connecting with and working with. I am sure we did not get all their logos on here but, if you look at the report, there is much more detailed information about who participated in all the workgroups that I mentioned and who has been a part of the review process for the birthcare pathway. We can go to the next slide.

00:31:39—Palav Barbaria—Slide 18

I know there was a lot of information about the process and how we got here. I know everyone's excited to move on to the policy pieces, but I'm going to pause there and asked our team who is moderating. What questions have folks sentimentally want to tackle before we move on? If you have not sent in a question, please use the chatroom Q&A feature to do so.

00:42:34—Alice Lam—Slide 18

We had a few questions come in about the member recruitment process for Medi-Cal member engagement. How did DHCS recruit pregnant and postpartum Medi-Cal members to participate in the birthing care pathway member engagement activities and what were the demographics of those members who were selected and participated?

00:32:26—Palav Barbaria—Slide 18

Great question. As mentioned, we had these clinical and social drivers of help workgroups and their rosters are available online. We know the individuals and organizations serving on the workgroups work with pregnant and postpartum members Medi-Cal members every day. We had a recruitment flyer with instructions on how to apply if you are interested and what the time commitment and stipend would look like. It was really our partners who distributed that call or request for participation to their networks, clients, and patients they would work with. Again, I think we're just blown away by the responses that so many people wanted to devote their time to supporting this cause. Then, we did—in hindsight, we should have asked for more funding to be able to accommodate more than 30 members. That is a lesson learned for next time. There is a lot of interest had we had more funding, which is the constraint here, we could've accommodated more than just 30 of those applicants. Given we were limited to the 30, we did try to make sure that we are having a good mix of diversity in the group,

based on geography, lived experience, sexual orientation, social drivers of health, behavioral health, justice involvement, as well as race and ethnicity. Ultimately, the group that was chosen was as diverse as we could make it across all of those demographic lines.

00:33:54—Alice Lam—Slide 18

I think in the interest of getting to the policy roadmap portion, we're going to move on, but will have other opportunities for questions. So, keep them coming in through the Q&A.

00:34:07—Palav Barbari—Slide 19

Great, let's keep going. So, now, we're going to get to the meat of what I know everyone is here for. What are we actually doing with all of those lessons learned and feedback and thoughts? We can go to the next Slide.

00:34:19—Palav Barbari—Slide 20

The report is split up into two portions. One, what are policies that DHCS is committed to implementing or is in the process of implementing? For the most part, these are policies we did not need additional resources for. We did not need additional authority or state statue for, and that were in our control to start moving on right away. You will see today we started this listening tour for the birthing care pathway project over two years ago. Some of these policies, we did not want to sit on it and wait for the report to come out if it made sense and it was recommended by our stakeholders—we started moving on implementation, so that's why some of these are already completed. There are 42 policies—10 are done, 27 are in progress, and five we yet to start. We'll be getting to them as soon as possible. We'll get into, in the next section, what are some of the strategic opportunities for further exploration, and those are policies we heard loud and clear from listening to all of you and the members and other state partners. They are a good idea, but they will be a heavier lift and/or require some sort of investment or authority or resources that we don't have today. You can go to the next slide.

00:35:39—Palav Barbari—Slide 21

So the 42 policies are split up in these eight focus areas—not going read them all out loud because we will go through them in detail. This is how the report is organized as well. We can go to the next slide.

00:35:52—Palav Barbari—Slide 22

So, the first bucket is really provider access and managed care plan oversight and monitoring. As of 2024, we estimate 99% of all Medi-Cal members are now enrolled in managed care plan. Because of how pregnant individuals are enrolled in our program, that percentage is slightly lower for pregnant individuals, but it is still true that most of our pregnant individuals and postpartum individuals are enrolled in a Medi-Cal managed care plan. Making sure we are providing access and doing the appropriate oversight and monitoring is a key need to improving maternity care. Some of the problem statements we are trying to solve— in current state, we heard loud and clear, especially from our members, we have limited diversity in the workforce for who provides maternity care and our members really want options in terms of who their providers are, both with types of providers as well as cultural humility and linguistic concordance of those providers. We heard about delays in getting basic things like breast pumps and having a lot of issues with transition after hospital-based birth to home. The specific policies we are working on are one, DHCS has an existing loan or payment program called CalHealthCares. We're working on leveraging the program specifically to improve the pipeline and access to a diverse OB/GYN and family medicine workforce, especially in those parts of our state where we know there is no maternity provider or few limited maternity providers. We are also working on streamlining requirements for approval and how members get high-quality breast pumps. This is another part of our policy that, I think, has not been updated in some time. There have been a lot of advancement breast pump technology and quality. We are also working on additional guidance and policy revisions for managed care plans when it comes to transferring to different care settings and levels of pregnant and postpartum members. They can go to the next slide.

00:38:05—Palav Barbari—Slide 23

The other piece, again, from all the listening that we did, is that we really need better member facing communications to tell them what we can access and how and to make the process easy. We are currently in the process of developing member facing materials and communication tools. One was launched as birthing care pathway report launch and is available on our website. If you work with Medi-Cal members, please go access that—we have translated it into threshold languages and start using it, if you aren't already. Please go access that we have translated into threshold languages. Start using it if you are not already. One of the things we were able to complete is a standing recommendation for doula services. In current state, to get a doula, there does need to be a standing order. We were able to do that at the DHCS level such that members don't have to find someone to order or recommend a doula. We are working on a doula

directory done by Medi-Cal members, providers, and MCPs to make sure, to the extent possible, all the doulas who are interested and willing in serving Medi-Cal members can participate in our program. We also have been working with her doula implementations stakeholder workgroup, which is still ongoing, to work through all of the challenges and issues around the benefit to make sure we can support our doulas and make sure all members who want a doula have access to one. We did hear consistently in our member workgroups that they really valued the doula experiences they had and it was an incredible part of their birthing experience. You can go to the next slide.

00:39:39—Palav Barbari—Slide 24

These are the member of fact sheets I alluded to. There are two—one around sort of the medical care team for the pregnancy as well as other services that are wraparound services. They have been translated. Please use them liberally, share them with anyone you think could benefit. You can go to the next slide.

00:39:57—Palav Barbari—Slide 25

The other two policies which are still in progress—one, we are working to survey members to figure out what is working. You heard two amazing success stories from our plans that kicked off this webinar other solutions that members found to support in scaling best practices across the state, as well as reduce administrative burden for providers. We also recognize—this is a little wonky—as mentioned, our maternity policy, because that is been around for multiple decades layered on top of each other in exists in probably a dozen or more places. We are working to both modernize, update, and consolidate all of that into one place. Sometimes people don't even know what the policies are, because some date back 30 years, some date back 10 years. They've gotten varied. Were working on a one-stop shop for all maternity care policies for managed care plans that will make it much easier to know what our members are entitled to, what are the requirements, and how will you get the services to all of the members. We can go to the next slide.

00:41:08—Palav Barbari—Slide 26

The other piece—you will see the problem statements that we were trying to solve around midwifery care as well as subcontracting arrangements. We heard loud and clear from our members that, where possible—obviously, medical risk may require a higher level of care, but they want a choice for providers. Members were unaware they could access midwifery services or lactation services, or that there were big barriers into getting the services. One of the things were working on with midwife partners and midwifery associations, is streamlining Medi-Cal provider enrollment and

reimbursement requirements, taking away unnecessary barriers that were sort of going above and beyond the state licensing requirements were, and making it difficult for midwives to participate. A lot of that has been improved. We are also working to clarify network adequacy requirements for managed care plans to raise the bar of how many certified nurse midwives, licensed midwives, and freestanding birth centers an MCP has to contract with. We are also looking at network requirements and delegated arrangements look like. We know in some cases maternity care was delegated to another plan, an IPA or some group. If the group did not provide lactation consultants that our members are having a hard time getting services not included in the delegation. You can go to the next slide.

00:42:39—Palav Barbari—Slide 27

The next bucket is behavioral health, and trauma informed care. So, we know there is a lot of needs both amongst children and youth when it comes to behavioral health services, but also opportunities through dyadic services and other CYBHI investments to treat the whole family and postpartum individuals, along with children in the pediatric setting. We've been working on raising awareness through our CYBHI initiative. In current state, we are going through all of our Medi-Cal managed care plan contracts. Our managed care plans provide non-specialty mental health services, as well as county behavioral contracts, which provide substance use disorder and specialty mental health services. To look at, are we specific enough that the providers in both of these contracts must be qualified to take care of pregnant and postpartum individuals and strengthening contract requirements were needed, so we can make sure everyone has access to a provider who is qualified to take care of them and that we don't have the scenarios where a member is waiting weeks or months for an appointment, only to find out the provider will treat the individual because they are pregnant or postpartum. You can go to the next slide.

00:44:00—Palav Barbari—Slide 28

The other pieces we heard about, especially when it comes to substance use disorder, there was some provider confusion how long a postpartum around how long a postpartum member could stay in a residential treatment setting for substance use disorder. We have already reinforced that existing policy that there is no maximum stay for members receiving residential SUD treatment, as well as updated and shared the substance use disorder perinatal practice guidelines to all of our SUD treatment providers. The other big bucket, as you heard me share from those member experiences, it is critical for all of our members, but especially those who are pregnant and postpartum, that they receive care in a trauma-informed manner. We know for

individuals experiencing intimate partner violence that risk is significantly elevated during pregnancy postpartum period. Really making sure that all of our providers are trained in this and that we are actively appropriate screening for adverse childhood experiences, intimate partner violence, community violence and racism, and connecting people to resources is critical. We are working on those policy updates right now. You can go to the next slide

00:45:17—Palav Barbari—Slide 29

The next bucket is risk stratification and assessment, I think many of you are tracking that, as part of our population health management program, we require all of our managed care plans to do risk stratification to say, based off of data that we have available, is a member a high risk, medium risk, or low risk. Our plans do this in a variety of ways today and it's not always the same way across the state. As part of our health program, we are developing standardized, state-wide risk stratification segmentation and tiering process which will aim to make sure there is a single common standard across the state. In one plan, low risk, the same person in another plan might be high risk. Instead, everyone will have the same risk level, independent of what plan or county they are assigned to, and they will be developing a specific process for individuals who are pregnant and postpartum based on unique risk factors. We also know intimate partner violence screening is done inconsistently right now. That can be a major predictor for at risk outcomes and additional services needed. We will be working to make sure that that is incorporated in all Medi-Cal assessments.

00:46:34—Palav Barbari—Slide 30

We know that often the barrier to improving care is often based off of how and what we are paying providers, and that payment reform and payment redesign needs to be a key part of the Birthing Care Pathway. We heard loud and clear from partners the historic reimbursement rates for maternity partners was really lagging other parts of our system. Many providers could not afford to expand services or participate in the Medi-Cal program. We also heard challenges, especially from FQHCs and rural health clinics for dyadic services—the way we set up a benefit which is intended to provide group services to the child and caregiver, often postpartum caregiver that they could not make that work, given FQHC reimbursement rates. Two things we've already done through the rate increase met in the Medi-Cal program in 2024, we increased the base reimbursement rates for all maternity providers. Then, we also increased supplemental payments through some of our directed payment programs for labor and delivery and hospital-based breathing centers to level that playing field. We also have the directed payment called the quality incentive pool that helps reimburse certain hospitals for

achievements and quality. We also expanded the maternity measures available in that program to reward high quality maternity care. In partnership with federal quality health centers and rural health centers, we strengthened implementation for dyadic services by creating a separate payment methodology to support practice settings to scale up the dyadic services Benefit. That one is almost done, but still in progress. We can go to the next slide.

00:48:29—Palav Barbari—Slide 31

The other two things in progress. One, we are looking at how we can redesign how Medi-Cal pays for maternity care in general to create a new birthing care payment model. That one is still in progress. You will hear me talk about later as related to our team project have been selected into. We will be developing billing and reimbursement guidance for Medi-Cal providers and managed care plans, specifically for license midwife homebirth and freestanding birth center services, as we heard loud and clear there is a lot of confusion in that space that needs to be cleared up. We can go to the next slide.

00:49:09—Palav Barbari—Slide 32

The next bucket is care management and social drivers of health. As I mentioned earlier, housing and security and homelessness, especially for pregnant and postpartum members, emerged as a major theme. Really exciting that the transitional rent benefit was approved under the DH connect 1115 waiver that DHCS got approval for in the last administration. Individuals who are pregnant and up to 12 months postpartum and experiencing or at risk of experiencing homelessness will qualify for transitional rent, so we see that as a huge opportunity to dedicate real important resources to solve this problem. We are also going to encourage—we haven't started this part yet—managed care plans to work with facilities to offer rooming-in with short-term post hospitalization stays for medical respite to members experiencing homelessness and who meet clinical criteria. You can go to the next slide.

00:50:13—Palav Barbari—Slide 33

The other areas are we heard a lot of opportunity is around—we've had ECM and community supports for a while, but sometimes even my ECM are lacking expertise needed to serve pregnant and postpartum individuals. We know housing trio for general population is a little bit different than what housing services are need for someone who is pregnant or has a newborn. We know there's a lot not a lot of awareness among members about ECM and community support benefits. We are working on—and this is just started and few pieces we will be starting in the upcoming months—thinking how

we can outreach to key social service organizations like WIC, home-visiting programs CBO's and others who have perinatal and postpartum expertise to join the ECM and community support program so we can have special providers who can support this population. We will be working managed care plans to build stronger community partners with community-base organizations addressing intimate partner violence. This is another key need for members who are experiencing IPV. Also thinking about how MCPs partner with housing providers to meet the needs of perinatal populations all the way through 12 months postpartum. You can go to the next slide.

00:51:39—Palav Barbari—Slide 34

The other pieces that we heard about was that providers themselves need some technical assistance and support for scaling ECM for equity population of focus, as well as figuring out what community supports can support pregnant how can we support ECM pathways. So we are working on , how can we expand ECM referral pathways and really target those areas where pregnant postpartum are getting care and increased community referrals to the right types of to the right types of providers. Also leveraging path, which we have done the last few cycles, t specifically scale and support the ECM birth equity population of focus through cited awards. We can go to the next slide.

00:52:21—Palav Barbari—Slide 35

We are almost the end of this and will open it up for the existing policy initiatives, I promise. As everyone is tracking, our justice involved initiative is a huge part of Cal-AIM being able to provide in-reach services up to 90 days pre release and connecting individuals with a warm hand off to all the services they need post release. We know, similar to the housing conversation we were just having, the needs of a pregnant or postpartum individual who is in custody can often be unique and different. In the pre-release Medi-Cal services design, there is a whole section unique and specific to the needs of pregnant and postpartum individuals. All of the policy has been updated and available in the JI policy guide. We are making sure there that they are able to receive these pre release services—this part is in progress because the calendar of how each facility or county is going live for pre-release services is happening in a phased approach in the state. Were also working on making sure that the handoff to the ECM provider post release is really appropriate for the unique and specific needs of pregnant JI individuals. You can go to the next slide.

00:53:37—Palav Barbari—Slide 36

So, it's hard to talk about any quality in equity improvement without talking about data. We heard loud and clear that lots of people are trying to support pregnant and

postpartum individuals in our state. I'm grateful to live in a state where we have so many programs in so many organizations and individuals really striving to do the best by their clients and patients and members. Yet, in current state for most part we all do this work in deep silos and often have no idea that my organization next-door is also serving the same client or member that I have. If we can get to more transparency and data sharing, we could coordinate efforts better, really reduce the navigation fatigue we heard loud and clear from our members and make our resources go much further. We know we are not reaching every individual for need of services in the state. We're currently in the progress—Medi-Cal connect is our population health management analytics platform that DHCS is launching to the best of our ability integrate healthcare social data and have key partners, including plans and providers and agencies use that information for better, more coordinated care across all of our different programs. We have some very exciting pilots happening locally that are looking at how we can do better targeted outreach work for Medi-Cal members who may be eligible for key supports Cal fresh and WIC, and yet are not enrolled. You can go to the next slide.

00:55:13—Palav Barbari—Slide 37

The other pieces we are working on—we have a lot of deep data silos between DHCS which has a lot of the healthcare data and our public health partners who are obviously tracking maternal morbidity and mortality and maternal quality across the state. Exploring opportunities about how we can leverage each other's data to integrate have better insights and better meet the needs of providers and members. Also, working on what measures do we need to track quality and equity of care for the birthing care pathway. Many are tracking current state. We track C-sections, prenatal and postpartum visits—all that shows is that someone showed up for a visit. It does not tell you: Was it high quality care? Did we avert some of that preventable morbidity? Are we controlling cardiovascular disease in pregnant or postpartum individuals? So there's a lot of work to be done here. We can go to the next slide.

00:56:15—Palav Barbari—Slide 38

Even though DHCS is the face of this call. it really is a multistate department effort especially with all of our sister Health and Human Services departments. So many of our programs span and population span across departments. There is a lot we can do if we really partner together. One huge opportunity is home visiting. We know that not everyone was eligible for home visiting isn't necessarily being referred or benefiting from the service, so really thinking through how can we break down silos between Medi-Cal providers and plans, as well as home visiting agencies, locally that are mostly funded through public health and social services. Then, move forward to really having

that be more integrated referral process. We've also started conversations with our employment development department colleagues and legal aid at work. We similarly know that, even though we as a staff a of paid family leave benefit and state disability programs to cover when people are pregnant or postpartum need to go on disability, for the most part, Medi-Cal members uses programs far less frequently than other individuals in the state who are more privileged and have access to the process. We want to break down the silos so all of our pregnant postpartum members get the paid time off they need to bond with their child and recover. You can go to the next slide.

00:57:48—Palav Barbari—Slide 39

The other silos we're breaking down is there is a HRSA grant that is supporting a statewide maternal health strategic plan where the Department of Public Health, Office of the Surgeon General, DHCS, and the California Maternal Quality Care Collaborative are trying to align all of our maternity efforts so we can all grow in the same direction, be aware of what each other is doing, and build upon each other's work. We also are working on leveraging the Family First Prevention Services Act to support substance use disorder and mental health treatment services and continuing to support the Office Of Surgeon General Strong Star And Beyond initiative was very similar aims to our work. We can go to the next slide.

00:58:33—Palav Barbari—Slide 40

I talked a lot. We are now going to pause. Please ask any and all questions you have. I'm really excited to have representation for all of the different program teams at DHCS who are implementing these various policies. Even if your question is weedy, I can phone a friend to help.

Q&A

00:58:54—Jen Elder—Slide 40

Thanks Palav the first question I have for you is how our managed care plans held accountable for ensuring community awareness and access to covered perinatal services like training services?

00:59:09—Palav Barbaria—Slide 40

I will kick this off and then, Bambi, if you want to chime in as well. The short answer is there is a number of different ways. There are quality measures that we look at for maternity services and I think, as people are tracking, we started sanctioning our Medi-Cal managed care plans when they do not meet those quality targets, as well as issuing

corrective action plans and we have needed to do that for the last two years. In addition, the revised all plan letter, the policy guidance I mentioned pull all the maternity requirements into one place. I think we'll make it more clear and transparent. Sometimes it is so dispersed it is hard to know what is the policy or what do we need to do here, so we really want to make sure we are being good partners and making sure what we expect, in terms of all of the perinatal services, is very clear to our planned partners. We will be monitoring and enforcing those as well. For newer benefits like doula services, we do have an entire action plan we've been using on the state side to monitor utilization and access. Bambi, I'll turn it over to you if you want to add more on that front.

00:55:13—Bambi Cisneros—Slide 40

Yes, can press buttons. Thank you Palav the only thing I would add is we do work with plans and a lot of different ways and through a lot of different venues. The comment that Palav raised is ensuring the policy is clear to the managed care plans. We have wide latitude to work with them. That can be in ways such as providing technical service improved connective service or, as previously mentioned, we can also impose sanctions on managed care plans as well. We just want to make sure our policy is clear and well understood and plans are aware of what their obligations are in contract and APL requirements set forth by the department.

01:01:16—Palav Barbari—Slide 40

Thanks, Bambi.

01:01:17—Alice Lam—Slide 40

The next question here is what is being done or can be done to address challenges in finding and accessing perinatal services?

01:01:30—Palav Barbaria—Slide 40

Thanks, Alison. I'm going to kick us off. And then Eric and Bambi, if you both want to respond both from the managed care and county behavioral health perspective. That would be great. This one is challenging. We can't invent our workforce where it does not exist. As mentioned you heard some of the strategies of we want to make sure our contract language and requirements for both Medi-Cal managed care plans to cover non-specialty mental to health and mild to moderate services, as well as county behavioral health partners who cover the substance use and specialty mental health services are clear, explicit, and we can enforce those and look at network advocacy for these types of providers. We also know we have workforce issues in this space. I do

think some of the opportunities are BH connect and the 1115 waiver that got approved, as well as through behavioral health transformation and BHSA help us look at where there are gaps and where we need to invest dollars and building of workforce or services. I will also put out a shout out in the next section of things we're exploring—there is an exciting HRSA grant LA County is implementing to implement a warm line. We know it is hard. It is a nationwide training program that not all psychiatrists are trained specifically in perinatal behavioral health conditions. They are piloting a consultation service for someone who is providing behavioral health services can reach out and get expert advice from someone who really does have the perinatal expertise as a way to support and scale services. Excited about that pilot opportunity. We'll be looking at ways is that a model we can scale across our state?

01:03:20—Jen Elder—Slide 40

Jen Elder

Thanks the last question will do for the section is, are there any plans in the future to include more pregnant and postpartum patients to inform policy and landscape analysis?

01:03:32—Palav Barbaria—Slide 40

The short answer is, yes, this has been such an invaluable experience and we do see Medi-Cal members as partners as we move through this you'll hear more is transforming health opportunity that DHCS was selected to participate in. We will be recruiting members, for sure, to help advise on the initiative. I see the clock is ticking down and we have to get through the rest of it. Let's keep going and we'll try to reserve as much time for Q&A at the end as possible.

01:04:02—Palav Barbaria—Slide 41

The next phase I will breeze through so we can really get to questions. There is sort of six focus areas where we heard amazing ideas and gaps and needs. But we don't have the resources, funding or authority to implement these right this second. We didn't want to squash them or hide them—we see this as a strategic roadmap for the future when the state has resources or desire to implement these, but we will not be taking them on right this time. We can go to the next slide.

01:04:37—Palav Barbaria—Slide 42

The first bucket is really on access, and I think the last question was getting to this. How do we monitor network adequacy standards for maternity providers and make sure that there is access, and can we work with our MCPs to focus on this? Looking at access for

culturally and linguistically appropriate care, specifically for Black, American Indian, Alaska native, and Pacific Islander populations, that really disproportionately bear the brunt of disparities in maternity care in our state. We can go to the next slide.

01:05:14—Palav Barbaria—Slide 43

We also heard loud and clear that there is probably more we can do to really strengthen intimate partner violence screening and then referral to appropriate services. More training and technical support would be helpful here, but would require resources. One of the barriers uncovered around lactation services is that, even though the lactation services themselves are covered, we currently do not recognize international board certified lactation consultants or IBCLCs or certified lactation consultants, known as CLC's, as a provider type that can go Medi-Cal. They are unable to independently provide services and bill, which means it becomes another barrier for Medi-Cal members to access services.

01:06:04—Palav Barbaria—Slide 44

Sorry, on that last slide, on the proposal would be, we can add them as an independent provider type, but that obviously comes with a lift and resource needs as well as potential cost impacts. On the behavioral health front, the first proposal I gave it away in our last section. Depending on what the lessons are learned from this initiative in LA County, it could be an opportunity with an additional investment to develop a statewide perinatal consultation line for maternal providers and therapists without perinatal training to really help get these services into the community, even if the individual serving does not have all the specific training. There is a lot of opportunities to improve training of the perinatal workforce on trauma informed, culturally relevant crisis care, as well as to support CBOs serving pregnant postpartum individuals. All the ways in which BHSA funds can help identify gaps in populations. These are all opportunities that we got recommendations this training and support, or these toolkits can be helpful. They do require resources to put together. You can go to the next slide.

01:07:22—Palav Barbaria—Slide 45

This last one is really around when a newborn is being treated for neonatal opioid withdrawal syndrome and needs to stay in the hospital. Are there opportunities to allow the postpartum member to stay with them and room in to really promote bonding? We can go to the next slide.

01:07:40—Palav Barbaria—Slide 46

The other big bucket is around maternal care models and access. We did talk about CPSP and some of the limited oversight here, as well as modernization needed of CPSP with different duplicate provider enrollment processes, as well as the current payment process which rewards volume but not necessarily quality. One of the future potential opportunities, could we modernize how CPSP services are provided to create standardization and strengthen across both fee-for-service and Medi-Cal managed care delivery systems and update it to align with current clinic guidelines. You can go to the next slide.

01:08:21—Palav Barbaria—Slide 47

The other piece here, as everyone knows, we did launch our CHW benefit. There was a lot of opportunity we heard to create a perinatal specialization, so that we could have a workforce of CHWs who really understand the needs of pregnant and postpartum individuals As mentioned, one of the things we are already doing is using our existing loan repayment program for physicians to provide maternity services—that program is limited to physicians, the way it was authorized and exists. There is clearly opportunity to also create a loan repayment program for midwives, which, there is a huge demand for, and limited access across the state. Also thinking about short-term housing for high risk pregnant members that live in remote areas, which is a major barrier for them accessing all the appropriate care prenatal care and postpartum services. You can go to the next slide.

01:09:14—Palav Barbaria—Slide 48

We heard about the support providers need and thinking about how can we train providers so they are aware of all the different services that Medi-Cal covers and figuring out how they can refer their patients for those services. You can go to the next slide.

01:09:31—Palav Barbaria—Slide 49

And then around data and quality, as mentioned earlier, there's a lot of opportunity to develop better quality measures and develop a patient reported outcome measure. This came out of some of our members' experiences around feeling not heard and not respected. In current state, outside of some of these qualitative interviews that we do, there is not a great way for DHCS, providers, or plans to get that information on a regular basis. You can go to the next slide.

01:10:00—Palav Barbaria—Slide 50

Within state agency partnerships, as some of you may be tracking, there is an acog levels of care designation. There are other states that require this so that they can monitor and make sure a member is high-risk delivers at the right level of care facility. This is not currently a requirement in California but there could be an opportunity to partner with CDPH. The Office of the Surgeon General is doing a lot of work around pregnancy risk and there may be opportunities to scale and support some of those tools. You can go to the next slide.

01:10:33—Palav Barbaria—Slide 51

The other areas we touched upon earlier but obviously there are a lot of data silos, so really thinking about how can we improve our reach across all the benefits members are eligible for, whether it is paid family leave, SDI, WIC, Cal Fresh, how can we work with our HK partners to better workforce strategy around perinatal providers inclusive of perinatal behavioral health providers. The other thing that came up is there are some states that cover home visiting through Medi-Cal program. In current state, our evidence base visiting models are covered through our Department of Public Health and and Department of Social Services, but are not necessarily a bundle benefit and Medi-Cal, so there are opportunities there as well. We can go to the next slide.

01:11:23—Palav Barbaria—Slide 52

Then, also there was a number of opportunities for key subpopulations, especially those suffering from substance use disorder, have child welfare involved cases, as well as sort of training for labor and delivery around members who come in with child welfare cases or perinatal SUDs. There is a lot of stigma and misconception around the space that can be resolved. You can go to the next slide.

01:11:54—Palav Barbaria—Slide 53

So, I know that was a whirlwind. We do want to get to TMaH and our closing remarks. As mentioned, those are ones that are proposed out there and not committed to and not sort of moving forward at this time. We will continue to engage with our partners. As you attend this webinar, digest the report, if you have feedback on what's on your wish list for future activities or which are more important or higher impact, we was welcome that feedback. You can email to us and we can drop into the chat. Jen I know we are short on time are there any critical questions we can tackle? Or should we move on to the next section?

01:12:31—Jen Elder—Slide 53

That was actually the question we were gonna ask, and you already addressed it. So I think we can keep going.

01:12:35—Palav Barbaria—Slide 54

Fantastic. So, hopefully what you walked away with is that report is not the end of our journey—report is a start of our journey. This is where all the work gets going. It is not going to happen without partnership from all of you. Thank you so much for joining us. Don't leave, we still have a few things to get there. You'll be hearing a lot more through departments through numerous venues as these various policy pieces roll out. We hope you'll take the time to engage and provide feedback so we can make this as high impact as possible. You can go to the next slide.

01:13:18—Palav Barbaria—Slide 55

Now, I am pleased to turn it over to Karen Mark, our medical director who will provide an update and transforming maternal health model.

01:13:28—Karen Mark—Slide 55

Thank you so much. If you could go to the next slide.

01:13:33—Karen Mark—Slide 56

So, we are really thrilled to let everyone know that, in January of this year, the CMS announced that California is one of 15 states selected to implement the transforming maternal health model. And we know that there is a lot of uncertainty about everything going on at the federal level these days. We have been meeting with our project officer every week. As far as I know it is moving forward as planned. TMaH is a tenure delivery on payment model designed to test whether evidence informed interventions sustained by value-based payment model can improve maternal outcomes and reduce expenditures. We will implement TMaH in five central valley counties, specifically, Fresno, Kern, Kings, Madera, and Tulare. We chose these counties because they have a number of challenges, they're relatively rural and under resourced in terms of providers. For many of these reasons, there are also poor maternal health outcomes in those counties. We are thrilled to support these counties in improving maternal health outcomes. We will receive 17 million in federal funding over the 10 years, as well as targeted technical assistance to achieve these goals of improving maternal health outcomes. Next slide.

01:15:00—Karen Mark—Slide 57

We will certainly not be in this work alone. We will be working with many partners to do this work. We have already begun engaging as many of these partners and will continue to do so over the course of the TMaH award. This includes provider partners. OB/GYN family doctors, midwives, maternal fetal medicine specialists, nurses, doula, lactation consultant, perinatal CHWs. We realize all these partners are critical to the work. There is a large focus in TMaH on making sure including and utilizing all the maternity care providers available, including licensed midwife, certified nurse midwives and birth centers, so we'll be providing a lot of support in those areas. We will also be working with various partner care delivery locations including hospitals, clinics, tribal clinics, FQHCs, Safety net practices, birth centers, and other sites of care. We have been engaging with and will continue to engage with a lot of partner organizations. All the managed care plans in the five counties have agreed to participate. Many thanks to them—we could not of done it without them. As well as our public health partners, from CPH and our local health departments. We know there's a lot of great resources for pregnant and postpartum women in the local public health departments. California Maternity Care Collaborative, universities, community-based organizations and other nonclinical partners. Next slide.

01:16:51—Karen Mark—Slide 58

This is, as I mentioned, a ten-year effort. It's divided into two periods. First there's a pre-implementation period, which is model years one through three. This began in January and goes through December 2027. During these first three years, we will be receiving technical assistance to develop the model and we'll be working to achieve a set number of pre-implementation milestones. Specifically, in model year three, we will be providing, through our managed care plans, infrastructure payments, directly to providers in those five counties, to prepare them for implementing value-based payment model. Model years four through ten will focus on implementing the model. In model year four, there will be quality incentive payments made available to providers and subsequent model years will fully transition to a value-based payment model. Next slide

01:17:56—Karen Mark—Slide 58

Thanks so much. Happy to take any questions I will defer to you Palav before we move on.

01:18:20—Palav Barbaria—Slide 58

Almost made it through an entire webinar without forgetting to unmute myself. Any burning questions they should tackle before he moved to closing?

01:18:30—Alice Lam—Slide 58

Think we have time for one question before he moved to close. We've been getting questions about how DHCS will hold itself accountable to implementing the policies that have been reviewed today. How will that progress be reported and shared?

01:29:15—Palav Barbaria—Slide 58

Great question. While Karen was presenting, I did skim through the questions. I recognize we don't have time to answer everyone's questions. We intend to provide regular updates. If you have not already, I encourage you to subscribe to DHCS's stakeholder blast that we do on a weekly basis and/or attend stakeholder advisory community meetings will be reporting regular updates. We have a birthing care pathway webpage. If you want to get the birthing care pathwayupdates, we'll be updating that very regularly so you can see what materials we've developed, what policy is going out, and that is our dedicated inbox where, as you are working on things, if you have questions or feedback, feel free to email us. As we said, will take a village to implement this to fidelity. Any other questions Alice?

01:19:44—Alice Lam—Slide 58

Think will move to closing to get folks out on time.

01:19:50—Palav Barbaria—Slide 59

Thank you all. As you heard at the start, Tyler Sadwith, our Medicaid director, kicked us off. I think it is a testament to how critical this initiative is as a key part of DHCS strategy. I am honored that director Michelle Baass director of is joining us to close us out. Michelle, I'll turn it over to you.

01:20:12—Michelle Baass—Slide 59

Thank you Palav sincere thank you for your time today. As Palav mentioned, Michelle Baass, director of healthcare services and it is great to see so many people are engaged in this work and care so deeply about the birthing and care experience and Medi-Cal. We want to thank you for your feedback and how we can continue to improve this work—we could not of gotten here without you and really your help and feedback, and the frank discussions we've had with so many of our Medi-Cal members and new parents in the past and years and months to come is so invaluable to us. I also want to thank the DHCS team and Palav for leading this work. It has been a cross departmental effort and I want to express gratitude to the team. We will continue to deepen the birthing care pathway over the next several years. Many additional opportunities for community members to provide input. We'll keep you posted on different ways to

engage. Palav mentioned the DHCS stakeholder news that comes out every week as well. We will continue to keep you updated on our progress, as we just mentioned. As he began implementation of the TMaH in the Central Valley. Again, your partnership, feedback, and insights will be critical to the success of all this work. Thank you again to everyone. Hope you have a great rest of your day. Take care, goodbye.