Medi-Cal Explained FACT SHEET

# Medi-Cal Explained: Maternity Care

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## Introduction

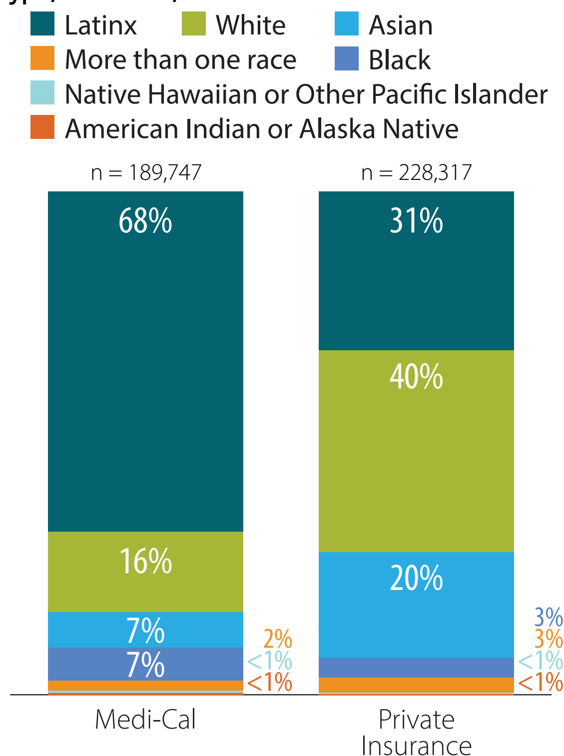
Almost 500,000 babies are born every year in California — and the state's Medicaid program, Medi-Cal, plays an outsized role in covering those births. When people become pregnant, the thresholds for Medi-Cal eligibility change, so that people at higher incomes or without verification of immigration status may qualify for coverage. As a result, although Medi-Cal covers one in three Californians, it pays for nearly one in two of the state's births. Still, from a cost perspective, maternity care is a relatively small piece of all that Medi-Cal covers. An estimate using median spending per live birth — about $7,000 — multiplied by the number of live births covered by Medi-Cal suggests that pregnant people[1] make up 1.4% of Medi-Cal enrollees and account for 1.8% of spending.[2] Note that this is an undercount, as it does not include spending on prenatal and postpartum care.

By comparison, median spending per year per enrollee for childless adults is $4,700 and for people with disabilities about $19,600.[3]

## Whose Maternity Care Does Medi-Cal Cover?

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

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




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

Source: Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018," accessed April 30, 2020.

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

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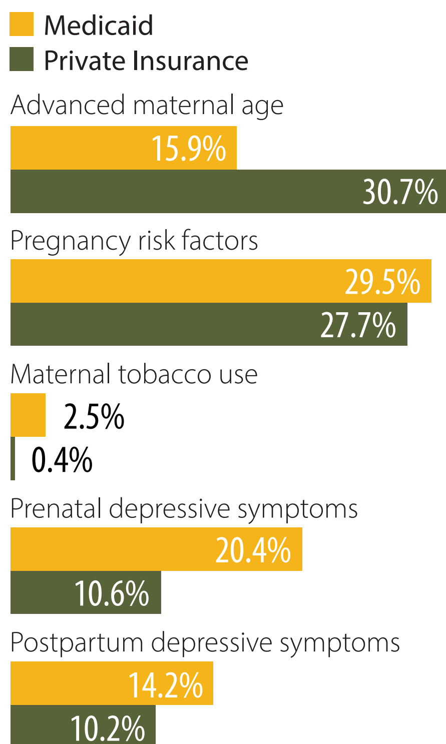
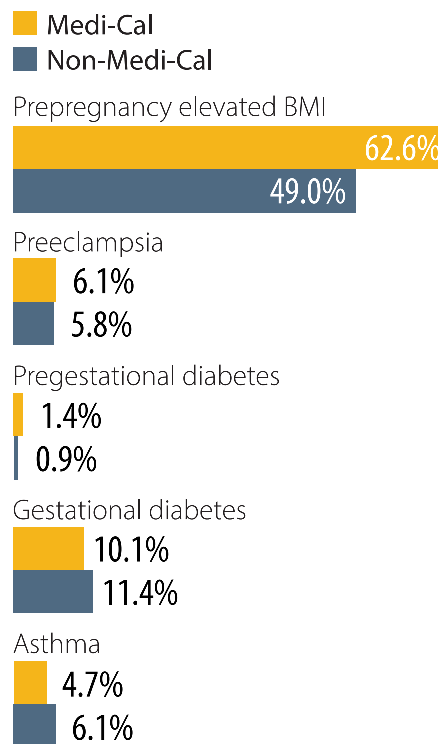
**Figure 2.1 Maternal Characteristics by Payer Type, California, 2016–2018**




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

Sources: Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018," accessed February 11, 2020. Depressive symptoms data provided upon request for 2016-17, Maternal and Infant Health Assessment, California Department of Public Health, received June 19, 2019.

**Figure 2.2 Maternal Characteristics by Payer Type, California, 2016–2018**




Source: The California Maternal Quality Care Collaborative based on 2018 Patient Discharge Data from the Office of Statewide Health Planning and Development linked to Birth Certificate Data from the California Department of Public Health - Vital Records.

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

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

Like many other states, California has largely embraced managed care, with more than 80% of people covered by Medi-Cal now enrolled in a managed care plan.[4] However, 40% of births paid for by Medi-Cal are still covered by the fee-for-service (FFS) system. The majority of FFS births are to two groups of people newly eligible for Medi-Cal on the basis of their pregnancy: (1) persons without verification of satisfactory immigration status and (2) persons with incomes that are 139% to 213% of the federal poverty level (FPL), which in 2020 is an income of $17,609 to $27,179 for a household of one person.[5]

In addition to being FFS, this special Medi-Cal coverage differs from standard Medi-Cal coverage in two ways. First, the coverage ends 60 days after giving birth, at which point people revert back to their prepregnancy eligibility status. This may mean they are no longer eligible for Medi-Cal coverage, though their baby will continue to be covered automatically through the first year of life. Second, for persons without verification of satisfactory immigration status, the coverage is limited to pregnancy-related services[6] and referred to as

**Table 1. Medi-Cal Eligibility and Pregnancy**

| Immigration Status | Income Levels | Coverage Type | Medi-Cal Delivery System | Post-Pregnancy Eligibility |
|---|---|---|---|---|
| Citizen or legal permanent resident | <139% of FPL | Full-scope Medi-Cal | Managed care | Remain eligible for full-scope Medi-Cal managed care |
| Citizen or legal permanent resident | 139%–213% of FPL* | Full-scope Medi-Cal | Fee-for-service | Return to Covered California; no longer Medi-Cal eligible |
| Person without verification of satisfactory immigration status | 0%–213% of FPL* | Restricted scope — pregnancy-related Medi-Cal | Fee-for-service | No coverage except in case of emergency |

* For pregnant people with income levels that are 214%–322% of FPL, Medi-Cal can be accessed via buy-in to the Medi-Cal Access Program, which is administered by managed care plans. In 2020 for a household of one person, 139% of FPL is $17,609; 213% of FPL is $27,179; and 322% of FPL is $41,087.

"restricted scope." Coverage details are described in Table 1. The FFS system also covers those who are found to be presumptively eligible by participating providers and are granted immediate, no-cost temporary coverage that continues for 60 days while they apply for permanent Medi-Cal or other health coverage.[7]

## What Maternity Services Does Medi-Cal Cover?

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

Examples of services covered:

- Obstetric care in an office, clinic, hospital outpatient setting, or alternative birthing center:
  - Prenatal: Up to 13 visits across all primary obstetrical providers per pregnancy in a nine-month period
  - Delivery: Vaginal and c-section delivery
  - Postpartum care: One visit in a six-month period unless the individual has a medical or mental health postpartum complication or is at risk for a postpartum complication
- Diagnostic testing: Pregnancy determination, obstetric panel, depression screening, and genetic testing as part of the California Prenatal Screening Program; ultrasounds provided outside of those for routine prenatal care (e.g., nuchal translucency, advanced maternal age).
- Specialty care and interventions (e.g., a glucometer for gestational diabetes, fetal well-being testing, prescription drugs, perinatal substance use disorder services) are covered when medically necessary. Some interventions, such as a blood pressure monitor for home use, generally require prior authorization by the California Department of Health Care Services (DHCS) or the plan.
- Psychological care: Up to a total of 20 individual and/or group counseling sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth.

In addition, the following education and support services are offered by qualified providers through the Comprehensive Perinatal Services Program (CPSP):[8]

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

## Where Are Medi-Cal Maternity Services Delivered?

### Prenatal and Postpartum Care Services

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

Qualified Health Centers (FQHCs) and look-alikes,[9] assuming all pregnant patients who received prenatal care at FQHCs and look-alikes in 2018 were covered by Medi-Cal.[10] Kaiser Permanente provided prenatal care for approximately 5% of deliveries paid for by Medi-Cal, assuming all those that gave birth at Kaiser hospitals also received prenatal care through the Kaiser system.[11] About 60% of people covered by Medi-Cal who gave birth had prenatal care provided by private practices and medical groups, including non-FQHC public and district hospitals, community clinics, and the University of California system. Fewer than 1.5% of people whose delivery was covered by Medi-Cal reported no prenatal care at all.[12] Information about postpartum care is even more limited. The lack of information on where pregnant people with Medi-Cal receive prenatal and postpartum care presents challenges in understanding quality and access and in facilitating quality improvement.

### Deliveries

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

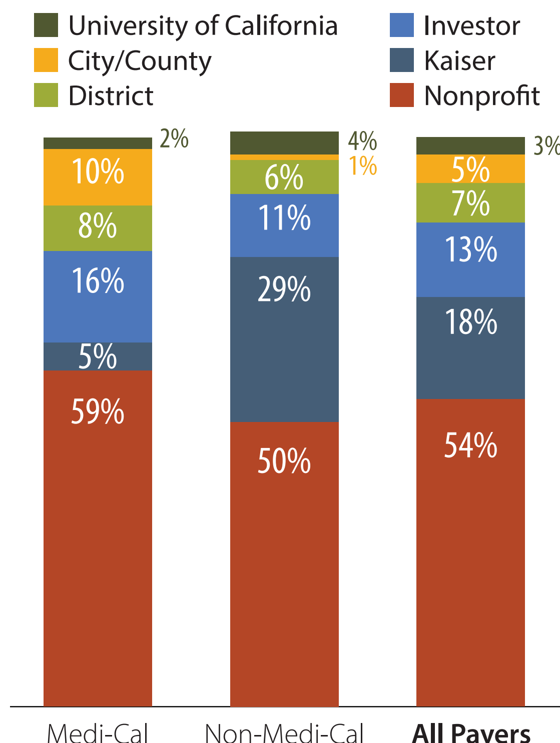
Freestanding birth centers provide care for low-risk patients and typically use a midwifery model of care. Deliveries in these centers have nearly quadrupled since 2007, but still comprise only 0.14% of Medi-Cal births.[15] Demand for birth center services outstrips supply. Although managed care plans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

## Who Provides Medi-Cal Maternity Services?

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

In California, midwives can practice under two different professions, certified nurse-midwives (CNMs) or licensed midwives.[18] In 2019, there were 753 CNMs and 386 licensed midwives in California.[19] Despite reimbursement parity mandated by the Affordable Care Act, access to midwives remains a challenge.[20] This is due to many factors, including scope-of-practice laws that require physician supervision for CNMs.[21]

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



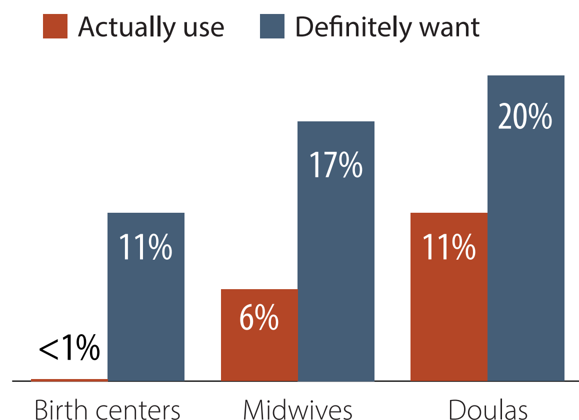

Notes: In-hospital births at 237 hospitals that offer maternity services. Nonprofit hospitals include church-related hospitals. Investor hospitals are for-profit. Kaiser Permanente hospitals are nonprofit. *Non-Medi-Cal* includes uninsured patients. Segments may not total 100% due to rounding.

Source: Custom data request, California Maternal Quality Care Collaborative, received June 14, 2019.

Community Perinatal Health Workers are also important members of the care team, though they cannot bill directly. They include doulas,[22] childbirth educators, and lactation consultants. Women covered by Medi-Cal are slightly more likely to report using a doula than those with commercial insurance.[23]

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

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




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

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

For details on how Medi-Cal pays for maternity services, please see companion paper *Medi-Cal Explained: Paying for Maternity Services* available for download on CHCF's website.

## How Does Medi-Cal Pay for Maternity Services?

### Fee-for-Service

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

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

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

### Professional Reimbursement Under FFS

Routine, uncomplicated obstetric care is reimbursed in three ways:

1. **Globally, for providers who render total obstetric care, which includes prenatal care, delivery, and postpartum care.** Payment is triggered by the baby's delivery and is all-inclusive for the obstetrician (e.g., routine urinalysis and ultrasounds are included and cannot be billed separately). This approach simplifies billing and can enable a team-based collaborative practice between physician and nonphysician providers. Global billing is more often used by private practice providers and is not typically used by FQHCs.
2. **Per visit, for providers who do not render total obstetric care or who provide fewer than 13 prenatal visits.** Providers receive a higher payment for the initial prenatal visit and a lower payment rate for follow-up visits (up to 13) and one postpartum visit. Per-visit billing

can result in a higher reimbursement per episode than global billing.

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

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

### Facility Reimbursement Under FFS

Hospitals are paid through a facility-specific case rate that is adjusted based on the reason for admission, severity of illness, and risk of mortality. This payment system, All Patient Refined Diagnosis Related Groups (APR-DRGs),[27] builds on a similar system used in Medicare that was introduced in 1983, but was developed with Medicaid populations in mind.[28] In California, DHCS implemented APR-DRGs in 2013.

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

### How DHCS Pays Managed Care Plans

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

For counties with a single managed care plan, maternity spending is factored into monthly capitation rates paid by DHCS. For counties with more than one plan, maternity services are treated differently because births are high-cost events and may not be evenly distributed between plans in a given year. As a result, plans receive a supplemental payment for every live birth, designed to cover the physician and facility spending for the birth episode.[29]

### How Managed Care Plans Pay Providers

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

In addition, some plans rely heavily on value-based payment mechanisms, such as global or professional services capitation to delegated medical groups.[31] These risk-bearing groups use a combination of capitation and fee-for-service to pay their contracted providers and, like managed care plans, vary in their rates and approaches, which are proprietary and confidential. Some stakeholders raised concerns about access to CPSP services in managed care and the delegated environment, and there is very little publicly available data about use of the program.

## What Experience and Outcomes Does Medi-Cal Produce?

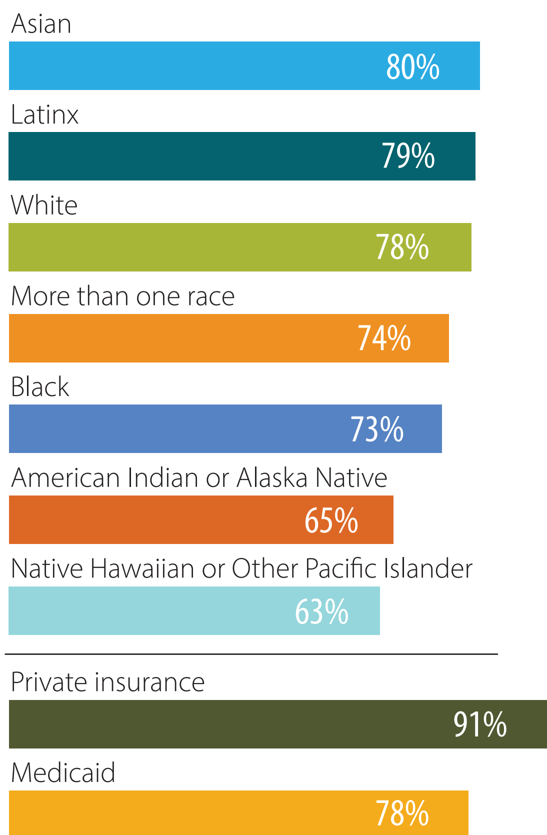
Overall, compared to people covered by private insurance, those covered by Medi-Cal are much less likely to access early prenatal care or robust postpartum care, as illustrated in Figures 5 and 6 on page 7.

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

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

Like many in the general health care system, Medi-Cal members face challenges of timely access to care, bias and racism in the health care delivery system, and food and housing insecurity.

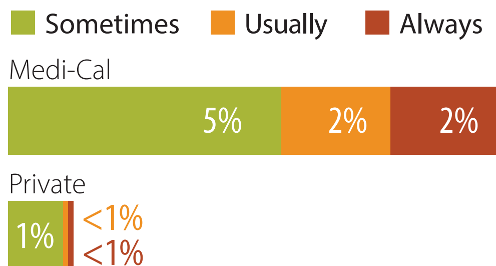
**Figure 5. Prenatal Care in the First Trimester by Payer Type and Race/Ethnicity Within Medi-Cal, California, 2018**




Note: Sources uses *Hispanic or Latino* and *Black or African American*.

Source: Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018," accessed February 11, 2020, and April 30, 2020.

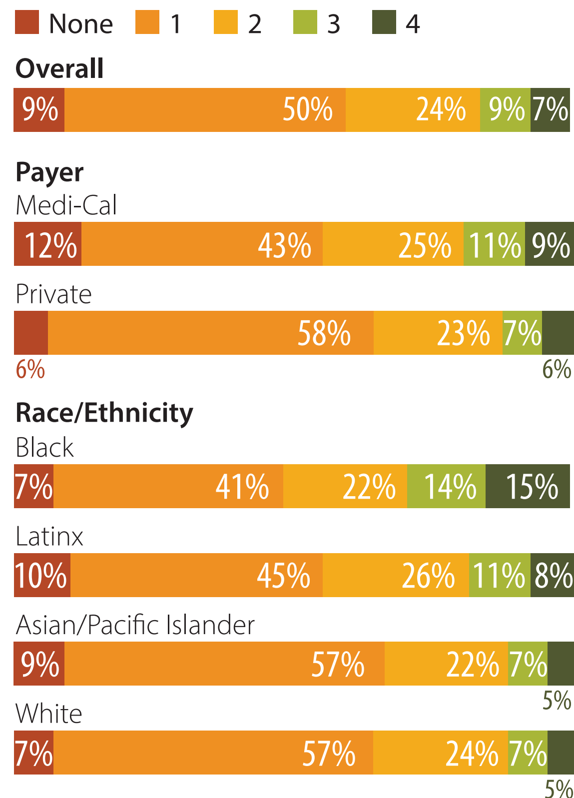
**Figure 7. Unfair Treatment Due to Type of Insurance by Payer, California, 2016**




Notes: Not all eligible respondents answered each item. "Never" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. $p < .01$ for differences by payer.

Sources: *Listening to Mothers in California* (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

**Figure 6. Number of Maternal Postpartum Office Visits by Payer and Race/Ethnicity, California, 2016**



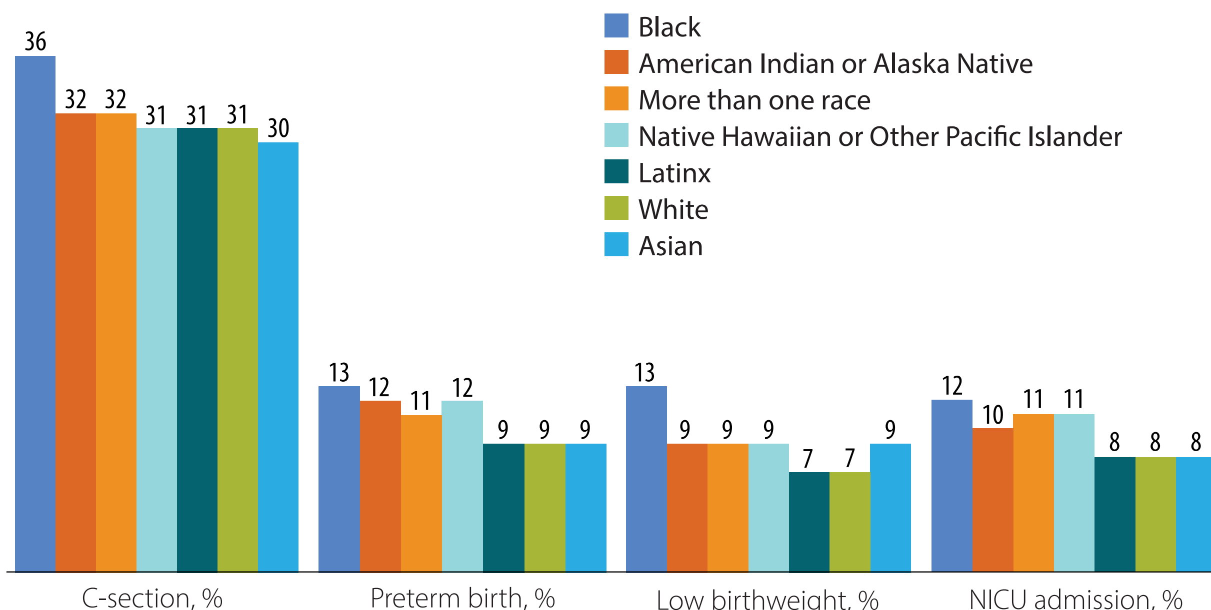

Notes: Based on a statewide survey of 2,539 women who gave birth in California hospitals in 2016. Medi-Cal respondents were identified based on a Medi-Cal record of a paid 2016 childbirth claim. Source uses *Latina*.

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

These factors result in heightened health risks, poorer outcomes, and poorer patient experiences for pregnant people, and notably for Black pregnant people, as seen in Figure 8 on page 8. These disparities cannot be fully explained by patient-level factors such as age, income, education level, insurance status, cesarean birth, or higher prevalence of comorbidities.[32] Instead, the evidence points to multiple factors at different levels, including health system quality[33] and the impact of racism and chronic stress during pregnancy,[34] including that coming from the health system[35] and the individual provider.[36]

In summary, California is a large state, home to one-eighth of the births that happen in the US annually. It is varied in both its geography and the racial and

**Figure 8. Perinatal Characteristics of Pregnant People with Medi-Cal Coverage, by Race/Ethnicity, California, 2018**




Notes: Source uses *Hispanic or Latino* and *Black or African American*.

Source: Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018," accessed February 11, 2020, and April 29, 2020.

ethnic diversity of its population. While the Medi-Cal health care system is highly complex, there are some things it does very well. The success of its work to reduce maternal mortality and the c-section rate have been held up as national models.

California has also made important strides in recent years to address maternal mental health and pilot a more integrated approach for infants and children born with special needs. While it is too soon to assess the impact of these new policies, they represent progress, and it is important to track their outcomes.

- **Maternal mental health:** In 2019, Medi-Cal introduced enhanced reimbursement for perinatal screening for depression. Postpartum depression screening is also allowed as part of a well-child visit to be billed under the infant's coverage throughout the first year of life. In addition, up to 20 individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic, and mental health–related risk factors are now covered. Finally, Senate Bill 104 (Chapter 67, Statutes of 2019) authorized the extension of "pregnancy pathway" Medi-Cal coverage by 10 additional months beyond the 60-day postpartum period for individuals who have been diagnosed with a maternal mental health condition. This new coverage was implemented August 1, 2020. However, unless further legislative action is taken, the program may be suspended on December 31, 2021.
- **Whole Child Model:** As of July 2019, five plans covering 21 counties operate under the Whole Child Model. This model integrates coordination and financing for all required newborn care and the care of children with special health care needs, historically carved out to the FFS system under California Children's Services. These plans now bear neonatal intensive care unit (NICU) risk, which creates more of an incentive to embrace value-based payment and/or innovative care models that improve outcomes and reduce costs in birth and infancy.

## Endnotes


1. We use the term "pregnant people" to recognize that not all people who become pregnant and give birth identify as a woman or a mother.
2. Author analysis of Fiscal Year 2017/18 Maternity Kick Payments from "Rate Range Development and Certification Reports by Plan Model Type," Department of Health Care Services, accessed June 15, 2020.
3. Len Finocchio, Matthew Newman, and Eunice Roh, *Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians,* California Health Care Foundation, February 2019.
4. Elizabeth Hinton et al., *10 Things to Know About Medicaid Managed Care*, Kaiser Family Foundation, December 16, 2019.
5. "Federal Poverty Level (FPL)," HealthCare.gov, accessed July 7, 2020.
6. Pregnancy-related services include prenatal care, labor, delivery, postpartum care, family planning services, and services for other diagnoses, illnesses, or medical conditions that might threaten the safe, full-term delivery of the fetus. Pregnancy-related coverage qualifies as Minimum Essential Coverage as required by the Affordable Care Act.
7. Finocchio, Newman, and Roh, *Medi-Cal Facts and Figures.*
8. Comprehensive Perinatal Services Program (CPSP) grew out of a perinatal demonstration project called the Obstetrical Access Project, which operated from 1979 to 1982 in 13 California counties. Comprehensive services were shown to reduce low-birth-weight rate by one-third and to save approximately $2 in short-term neonatal intensive care unit costs for every $1 spent. CPSP services became a Medi-Cal benefit in 1987.
9. An FQHC look-alike is a health center that meets all requirements and is part of the Health Center Program but does not receive federal award funding.
10. Author analysis of California FQHCs from "2018 Uniform Data System (UDS) Resources," Healthcare Resources and Services Administration, Bureau of Primary Health Care, accessed August 1, 2020.
11. Jen Joynt, *Maternity Care in California: A Bundle of Data,* California Health Care Foundation, November 2019.
12. Author analysis of Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018," accessed April 30, 2020.
13. Author analysis of Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018."
14. Author analysis of custom data request from the California Maternal Quality Care Collaborative, received December 17, 2019.
15. Author analysis of Centers for Disease Control and Prevention, CDC WONDER Online Databases, "Natality Public-Use Data, 2016-2018."
16. Blair Dudley, *Promoting Midwifery and High Value Care in Medi-Cal,* Pacific Business Group on Health, April 2020.
17. Author analysis of custom data request from the California Maternal Quality Care Collaborative, received December 17, 2019.
18. The professions share a philosophy of women-centered care that recognizes and supports childbirth as a normal physiologic process, but differ in education requirements, certifying organizations, regulatory bodies, licensing policies, and enabling statutes. More detail is available at *California's Midwives: How Scope of Practice Laws Impact Care*.
19. Connie Kwong et al., *California's Midwives: How Scope of Practice Laws Impact Care,* California Health Care Foundation, October 2019.
20. Carol Sakala et al., *Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences,* National Partnership for Women & Families, September 2018.
21. Kwong et al., *California's Midwives.*
22. Doulas are nonmedical professionals who provide emotional, physical, and informational support and guidance in different aspects of reproductive health. More detail is available from the National Health Law Program's fact sheet "What Is a Doula?" (PDF).
23. Sakala et al., *Listening to Mothers in California.*
24. Sakala et al., *Listening to Mothers in California.*
25. Steve Zuckerman, Aimee Williams, and Karen Stockley, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare,* California HealthCare Foundation, April 2009.
26. Zuckerman, Williams, and Stockley, *Medi-Cal Physician and Dentist Fees.*
27. Department of Health Care Services, "Diagnosis Related Group Hospital Inpatient Payment Methodology," last modified April 8, 2020.
28. Richard F. Averill et al., *All Patient Refined Diagnosis Related Groups (APR-DRGs), Version 20.0: Methodology Overview* (PDF), 3M Health Information Systems, 2003.
29. Michael Engelhard, Steve Soto, and Athena Chapman, *Medi-Cal Payment to Managed Care Plans — Current Process and Challenges,* California Health Care Foundation, February 2019.
30. Plans interviewed included CalOptima, Community Health Group of San Diego, Health Net, Inland Empire Health Plan, L.A. Care Health Plan, Partnership HealthPlan of California, and Santa Clara Family Health Plan.
31. Dudley, *Promoting Midwifery and High Value Care in Medi-Cal.*
32. Elizabeth Howell, "Reducing Disparities in Severe Maternal Morbidity and Mortality," *Clinical Obstetrics and Gynecology* 61, no. 2 (June 2018): 387–399, doi:10.1097/GRF.0000000000000349.

33. Elizabeth Howell et al., "Black-White Differences in Severe Maternal Morbidity and Site of Care," *American Journal of Obstetrics & Gynecology* 214, no. 1 (January 2016): 122.e1–7, doi:10.1016/j.ajog.2015.08.019.
34. Stephanie Leonard et al., "Racial and Ethnic Disparities in Severe Maternal Morbidity Prevalence and Trends," *Annals of Epidemiology* 33 (May 2019): 30–36. doi:10.1016/j.annepidem.2019.02.007.
35. Rachel Hardeman, Eduardo Medina, and Katy Kozhimannil, "Structural Racism and Supporting Black Lives — The Role of Health Professionals, *New England Journal of Medicine* 375, no. 22 (December 1, 2016): 2113–2115, doi:10.1056/NEJMp1609535.
36. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, ed. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson (Washington, DC: National Academies Press [US], 2003), doi:10.17226/12875.
37. Elliott K. Main, Cathie Markow, and Jeff Gould, "Addressing Maternal Mortality and Morbidity In California Through Public-Private Partnerships," *Health Affairs (Millwood)* 37, no. 9 (September 2018): 1484–1493, doi:10.1377/hlthaff.2018.0463.
38. Elliott K. Main et al., "Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates," *Obstetrics & Gynecology* 133, no. 4 (April 2019): 613–623, doi:10.1097/AOG.0000000000003109.
39. Department of Health Care Services, *All-Plan Letter 18-023: California Children's Services Whole Child Model Program* (PDF), December 23, 2018.


## Acknowledgments

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

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