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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION**

ERICA JIMENEZ, individually and on
behalf of a class of similarly situated
individuals,

Plaintiff,

v.

DR. ERICA PAN, in her official capacity
as Director of the California Department
of Public Health, et al.,

Defendants.

No. 2:26-cv-03500-SPG-SP

**PLAINTIFF'S NOTICE OF
MOTION AND MOTION FOR
CLASS CERTIFICATION**

Date: November 18, 2026
Time: 1:30 pm
Place: Courtroom 5C, 5th Floor
Judge: Hon. Sherilyn Peace Garnett
Trial Date: Not Set
Action Filed: April 2, 2026

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that at 1:30 p.m. on November 18, 2026, or as soon thereafter as possible, in Courtroom 5C of the above-referenced court located at the First Street U.S. Courthouse, 350 W. 1st Street, Los Angeles, CA 90012-4565, Plaintiff Erica Jimenez will, and hereby does, move for class certification under Fed. R. Civ. P. 23(b)(2).

MOTION

Pursuant to Federal Rule of Civil Procedure 23, Plaintiff Erica Jiemenz moves for class certification. The proposed class will be represented by Plaintiff Erica Jimenez. The proposed class will consist of all persons who met, meet, or will meet the race-neutral eligibility requirements for participation in the California Black Infant Health Program, but who were, are, or will be ineligible for participation because they are not or do not identify as black.

In support of the relief sought herein, Plaintiff refers this Court to the Memorandum in Support of Class Certification, filed in conjunction with this motion. As more fully discussed in that Memorandum, class certification is warranted because all the requirements for class certification under Rule 23 are met. This Court should grant Plaintiff's Motion for Class Certification.

LOCAL RULE 7-3 COMPLIANCE STATEMENT

Plaintiff has satisfied all obligations under Local Rule 7-3. On August 27, 2026, the parties met and conferred via videoconference regarding Plaintiff's Motion for Class Certification. Declaration of Andrew Quinio in Supp. of Mot. for Class Certification (Quinio Class Cert. Decl.) ¶ 10. Defendants would not stipulate to certifying the proposed class because they contend that Defendants class motion is premature and that the proposed class does not satisfy Rule 23. The parties did not resolve the issues concerning Plaintiff's class motion. *Id.*

DATED: September 18, 2026.

Respectfully submitted,

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By s/ Andrew R. Quinio
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**PLAINTIFF'S MEMORANDUM
OF POINTS AND
AUTHORITIES IN SUPPORT
OF MOTION FOR
CLASS CERTIFICATION**

Date: November 18, 2026
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1 Plaintiff Erica Jimenez moves for class certification under Rule 23(b)(2) of
2 the Federal Rules of Civil Procedure. The proposed class consists of all persons who
3 met, meet, or will meet the race-neutral eligibility requirements for participation in
4 the California Black Infant Health Program, but who were, are, or will be ineligible
5 for participation because they are not or do not identify as black. The proposed class
6 will be represented by Plaintiff Eric Jimenez.

7 INTRODUCTION

8 Thousands of mothers across California receive vital prenatal and postnatal
9 assistance from the state. Maternal care programs are available through local county
10 providers that can give many first-time mothers important support during a delicate
11 time. But because many of these mothers are the wrong race, one form of assistance
12 is unobtainable. The Black Infant Health Program is inaccessible to mothers who are
13 not black and whose infants are not black. The program has no income requirements
14 and provides helpful benefits such as medical referrals, family planning guidance,
15 and group counseling sessions to first-time mothers. Without the racial barrier to this
16 program, numerous mothers would be able to benefit from this program.

17 Plaintiff Erica Jimenez is one of the mothers who is shut out of the Black
18 Infant Health Program. Like many first-time mothers in California, she qualifies for
19 the program but for her race and the race of her child. Because neither she nor her
20 newborn are black, she could not apply to the program on equal footing and local
21 providers directed her elsewhere.

22 Mrs. Jimenez and the many mothers like her are entitled to equal treatment
23 from California regardless of their race. They share a common barrier to a crucial
24 state maternal health program based on a suspect characteristic. The state and local
25 providers cannot implement and operate the Black Infant Health Program in this
26 unlawful manner.

27 The Court should certify the plaintiff class under FRCP 23(b)(2).
28

STATEMENT OF FACTS

I. State and Local Black Infant Health Program

Black Infant Health (BIH) is a program of the California Department of Public Health (CDPH) in collaboration with state and local health departments. It offers services exclusively to pregnant and postpartum mothers of any income who racially identify as black. *Black Infant Health Program*, Cal. Dep't of Pub. Health, <https://tinyurl.com/mrxuscrl> (California BIH Program Page)¹; *see also* Quinio Decl. ISO Opp'n to Mot. to Dismiss (Quinio MTD Decl.), Ex. A, ECF No. 45-2.

BIH was created in 1989 through the Budget Act of that year (S.B. 165). *Black Infant Health Program*, L.A. Cnty. Dep't of Pub. Health, <https://tinyurl.com/4pwfhhbth> (LA County BIH Program Page); *see also* Quinio MTD Decl. Ex. B, ECF No. 45-3. The Act declared the intent of the Legislature “that additional activities be undertaken by the department to reduce the abnormally high mortality rate among black infants.” Budget Act of 1989, ch. 93, 1989 Cal. Stat. 623 (attached as Ex. A to Decl. of Andrew Quinio in Supp. Of Mot. for Class Certification (Quinio Class Cert. Decl.)) It appropriated funds “for new and innovative projects to reduce the rate of black infant mortality in California,” and to “expand the Adolescent Family Life Program, with priority given to projects targeting black infant mortality.” *Id.* at 622.

In support of the current statewide BIH, the state legislature found and declared a continuing gap between mortality rates for black infants and those of other population groups. Thus, the BIH model is designed to reduce black infant mortality. Cal. Health & Safety Code § 123259.

¹ The Court may take judicial notice of information on government websites not subject to reasonable dispute. *See Daniels-Hall v. Nat'l Educ. Ass'n*, 629 F.3d 992, 998–99 (9th Cir. 2010); Fed. R. Evid. 201. Plaintiff requests that this Court do so for this document and all other public documents from government websites cited herein.

1 The goal of BIH is to “advance CDPH’s long-term goal of achieving healthy
2 pregnancy and birthing outcomes for Black infants, women, and birthing people.”
3 California BIH Program Page. It serves black women who are sixteen years or older,
4 pregnant, or up to six months postpartum at the time of enrollment, regardless of
5 income. *Id.*

6 BIH provides participants with group sessions and one-on-one support
7 services. The group sessions cover topics that include healthy pregnancy, labor and
8 delivery; prenatal, postnatal, and newborn care; stress management; and healthy
9 relationships. Participants also receive referrals for medical, dental, and social
10 services, family planning guidance, and assistance with goal setting. *Id.*

11 CDPH funds BIH through Federal Title V Maternal and Child Health Block
12 Grants, Federal Title XIX (Medicaid) funds, and state general funds. *Title V*
13 *Maternal & Child Health Block Grant Program*, Cal. Dep’t of Pub. Health,
14 <https://tinyurl.com/58zbe2wr>. CDPH provides this funding to local health
15 jurisdictions, including city and county public health departments, to implement and
16 support BIH. *Id.*

17 CDPH establishes minimum standards that govern funding allocations to
18 jurisdictions, including the services to be provided and eligibility for those services.
19 Cal. Health & Safety Code § 123255. Fourteen cities and counties provide BIH
20 services, including Los Angeles County and the City of Pasadena. California BIH
21 Program Page.

22 The Los Angeles County Department of Public Health provides BIH services
23 that include ten prenatal and ten postpartum group sessions that explore pregnancy
24 and parenting. LA County BIH Program Page. These sessions discuss topics like
25 stress management, newborn care, and healthy relationships. *Id.* The County also
26 provides complementary case management that provides participants with guidance
27 on applying for health insurance and family planning. *Id.*

1 Similarly, the Pasadena Public Health Department’s BIH program “provides
2 culturally appropriate services” that include “empowerment-focused group support
3 services and case management to improve the health and social conditions for
4 African-American women and their families.” *Black Infant Health Program*,
5 Pasadena Pub. Health Dep’t, <https://tinyurl.com/3sf7kmr8> (Pasadena BIH Program
6 Page); *see also* Quinio MTD Decl. Ex. D, ECF No. 45-5. These ten prenatal and ten
7 post-partum sessions cover topics that include healthy labor and delivery, postnatal
8 care, and pride in cultural heritage. *Id.* Participants in Pasadena’s BIH program also
9 receive complementary life planning, including assistance with health insurance
10 applications and family planning. *Id.*

11 **II. Racial Eligibility for BIH**

12 The racial eligibility for BIH is consistent among Los Angeles County, the
13 City of Pasadena, and several of the counties that offer BIH program services and
14 conforms with the state’s racial criteria.

15 To be eligible for Los Angeles County’s BIH program, a participant must be
16 a pregnant African American woman who is eighteen years of age and older and
17 living in the designated service areas of the Antelope Valley, The City of Pasadena,
18 and South Los Angeles. LA County BIH Program Page and Quinio MTD Decl. Exs.
19 B, C, ECF Nos. 45-3–45-4.

20 Eligibility for Pasadena’s BIH is likewise limited to individuals who identify
21 as black or African American, are at least sixteen years old, and are pregnant or up
22 to six months postpartum. Quinio MTD Decl. Exs. B–F; ECF Nos. 45-3–45-7; and
23 *Pasadena’s Black Infant Health Program Expands, Combatting Racial Disparities*,
24 Pasadena Now (July 16, 2024), <https://tinyurl.com/55h44saa>. Applicants must
25 complete and submit an interest and eligibility form that asks whether they are
26 pregnant, a first-time mother, and whether they or their baby identify as
27 Black/African American. Pasadena BIH Program Page and Quinio MTD Decl.
28 Ex. E, ECF No. 45-6.

1 Meanwhile, the statewide public-facing portal for the BIH Program, which the
2 CDPH and Los Angeles County BIH websites link to, advertises that it “focuses
3 exclusively on empowering Black/African American women.” Quinio MTD Decl.
4 Exs. A, B, G, ECF Nos. 45-2, 45-3, 45-8. And its eligibility and enrollment page
5 states it is “open to all Black women[.]” Jimenez Decl. ISO Opp’n to Mot. to Dismiss
6 (Jimenez Decl.), Ex. A, ECF No. 45-11.

7 Outside of Los Angeles County, local health agencies make clear that the BIH
8 Program conditions eligibility on race. For example, Alameda County advertises that
9 its BIH Programs are “open to all Black women[.]” Quinio MTD Decl. Ex. H, ECF
10 No. 45-9 at 62. Contra Costa County explicitly lists that “[i]dentify[ing] as Black”
11 is a condition of eligibility. *Id.* at 67. Kern County answers the question, “Who can
12 join?” explicitly with, “Black women[.]” *Id.* at 77. Riverside County confirms “[t]o
13 [e]nroll in this free service you must be an African American woman[.]” *Id.* at 87
14 (emphasis added). San Diego County only lists two eligibility criteria: pregnant
15 “African-American women” and “16 years of age or older.” *Id.* at 100. San Francisco
16 County “focuses exclusively on empowering Black and African American women
17 by connecting them” with services. *Id.* at 101 (emphasis added). And Long Beach
18 County states that being a “Black woman/birthing person” is one of the requirements
19 for the BIH Program being “for” prospective participants. *Id.* at 80.

20 None of the information on the websites for these local health jurisdictions,
21 including Los Angeles County, Pasadena, and California itself, states that BIH
22 accepts nonblack mothers, nonblack infants, or that any exceptions exist to the stated
23 eligibility conditions. *See* Quinio MTD Decl. Exs. A, B, D, G, H, ECF Nos. 45-2–
24 45-3, 45-5, 45-8–45-9.

25 **III. Erica Jimenez Is Ineligible for BIH Based on Her Race**

26 Mrs. Jimenez is a resident of Pasadena, California. She does not identify as
27 black or African American. Except for her race, she meets the criteria to participate
28 in BIH. Jimenez Decl. ISO Opp’n to Mot. to Dismiss (Jimenez Decl.) ¶¶ 1–2, 4,

1 ECF No. 45-10. Accordingly, Mrs. Jimenez submitted the enrollment form on the
2 BIH Program webpage. Jimenez MTD Decl. ¶ 3; Declaration of McKenzie Scott
3 (Scott Decl.) ¶ 4, ECF No. 26-3.

4 On February 24, 2026, Mrs. Jimenez received a voicemail from McKenzie
5 Scott, who identified herself as a coordinator for the BIH Program and asked to
6 connect later that week. Jimenez Decl. ¶ 5; Scott Decl. ¶¶ 4–5. The two spoke by
7 telephone on February 27, 2026. Jimenez Decl. ¶ 5; Scott Decl. ¶ 6. During the call,
8 Ms. Scott explained that the BIH Program “supports/empowers” pregnant and
9 postpartum mothers that self-identify as African American or black. Scott Decl. ¶ 6.
10 Mrs. Jimenez explained she did not identify as black or African American and
11 confirmed whether this would make her ineligible. Jimenez Decl. ¶ 5. Ms. Scott
12 responded, “No, you would not be eligible.” *Id.*

13 Prospective participants who are deemed to not qualify for BIH are directed
14 to other programs and resources. Nguyen Decl. ¶ 27, ECF No. 40-2. Accordingly,
15 Ms. Scott provided Mrs. Jimenez with information about other available resources.
16 Jimenez Decl. ¶ 5; Scott Decl. ¶¶ 6–8. Ms. Scott did not provide Mrs. Jimenez with
17 any further enrollment steps, explain any other way for Mrs. Jimenez to qualify for
18 the BIH Program, or tell Mrs. Jimenez about any additional steps required to enroll
19 or apply. Jimenez Decl. ¶ 5; Scott Decl. ¶ 9. Mrs. Jimenez thus did not ask to be
20 enrolled in the program or further pursue enrollment at that time because it was her
21 understanding that she was not eligible for the program based on her race, which the
22 call with Ms. Scott confirmed to her. Jimenez Decl. ¶ 5.

23 Mrs. Jimenez filed this action on April 2, 2026, individually and on behalf of
24 a putative class, alleging that the BIH Program’s racial eligibility criterion violates
25 the Equal Protection Clause and Title VI of the Civil Rights Act of 1964. Compl.
26 ¶¶ 42–66. The Complaint seeks declaratory and injunctive relief, and nominal
27 damages for the completed violation Mrs. Jimenez suffered on February 27, 2026.
28 *Id.* at 10–11.

1 On July 8, 2026, more than four months after the February 27 call and only
2 after the commencement of this suit, counsel for the City of Pasadena sent a letter to
3 Mrs. Jimenez’s counsel. Cusick Decl. ¶¶ 4–8, Ex. A, ECF No. 43. The letter invited
4 Mrs. Jimenez to “complete the next steps in the enrollment process,” described as
5 scheduling an assessment with a mental health professional and discussing the
6 logistics of participation in the program, and proposed four specific dates for that
7 assessment. *Id.* The letter did not state that the program’s eligibility criteria had
8 changed, that applicants would no longer be asked whether they or their infant
9 identify as black or African American, or that Mrs. Jimenez would be considered for
10 the program on the same terms as an applicant who so identifies. *See id.* And it did
11 not state that Mrs. Jimenez would avoid the extra hurdles of the exception procedures
12 to admission to BIH. *Id.*

13 Mrs. Jimenez did not respond to the letter because Pasadena did not disclaim
14 the racial eligibility criterion that had already been applied to her, and it did not state
15 that she would be considered for the program on the same basis as an applicant who
16 identifies as black or African American. Jimenez Decl. ¶ 7. Rather than curing the
17 unequal footing Mrs. Jimenez had already experienced, the letter’s silence on the
18 racial criterion confirmed that it remained in place. Scheduling the proposed
19 appointment did not, in Mrs. Jimenez’s understanding, address the issue raised in
20 this lawsuit, nor was Pasadena making it made in good faith. *Id.*

21 **IV. Other State Maternal and Infant Health Programs**

22 California offers a variety of assistance programs besides the BIH program
23 that do not use race as a criteria for eligibility.

24 The California Home Visiting Program (CHVP) serves pregnant and newly
25 parenting families who have one or more specific risk factors, including domestic
26 violence, inadequate income, unstable housing, education less than twelve years,
27 substance use disorder, and depression and/or mental health related challenges.
28 *California Home Visiting Program*, Cal. Dep’t of Pub. Health,

1 <https://tinyurl.com/yts5w24b>; see also Quinio Class Cert Decl. Ex. B. California
2 offers CHVP in fifty-seven local health jurisdictions. *CHVP by the Numbers*, Cal.
3 Dep't of Pub. Health, <https://tinyurl.com/y94k4p4w>; see also Quinio Class Cert
4 Decl. Ex. C. From 2024 to 2025, it served 6,105 adults. *Id.* Approximately ninety-
5 four percent of those whom CHVP served were races and ethnicities other than
6 black. See *id.*

7 The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal benefit
8 that provides culturally competent services to pregnant individuals from conception
9 through sixty days postpartum. *Comprehensive Perinatal Services Program*, Cal.
10 Dep't of Pub. Health, <https://tinyurl.com/3ewhv7w7>. An April 2022 analysis for the
11 California State Legislature reported that there were an estimated 69,861 users of
12 CPSP services in Department of Managed Health Care-regulated Medi-Cal
13 Managed Care Plans. Cal. Health Benefits Rev. Program, *Analysis of California*
14 *Assembly Bill 1930: Medi-Cal: Comprehensive Perinatal Services* 40 (Apr. 16,
15 2022), <https://tinyurl.com/mpmp8cfu> and Ex. D to Quinio Class Cert Decl.

16 A 2023 study of CPSP and birth outcomes identified that from 2012 to 2016,
17 there were 89,009 participants enrolled in Medi-Cal with CPSP. Snehal S. Lopes et
18 al., *California's Comprehensive Perinatal Services Program and Birth Outcomes*,
19 11 *Frontiers in Public Health* 1321313, 1 (2023) (attached as Ex. E to Quinio Class
20 Cert Decl.). Approximately 94.8 percent of those participants, totaling 84,423
21 individuals, identified as races and ethnicities other than black. See *id.* at 4, tbl. 1.

22 The City of Pasadena offers CPSP and connects mothers with local program
23 providers. *Maternal/Perinatal Health*, City of Pasadena Pub. Health Dep't,
24 <https://tinyurl.com/32z6vtn2>. Participants must be Medi-Cal eligible women;
25 residents of Pasadena, Altadena, or surrounding cities; and pregnant or no more than
26 sixty days postpartum. *Id.*

27 In Los Angeles County, programs for expecting or new mothers, infants and
28 families that are not restricted to the black population serve approximately 45,000

1 individuals per year. *See* Declaration of Dr. Melissa Franklin (Franklin Decl.) ¶ 49,
2 ECF No. 24-1. These programs include the Home Visiting Program, Project Healing
3 Opportunities for Parenting and Empowerment (HOPE), MAMA’s Neighborhood,
4 Community Health Outreach Initiatives (CHOI), and SHIELDS, each of which are
5 available to all eligible mothers in Los Angeles County regardless of race and
6 provide the same types of services and support provided under BIH. *Id.* at ¶¶ 50–64.

7 **PROCEDURAL BACKGROUND**

8 On May 8, 2026, approximately one month following the filing of Plaintiff’s
9 Class Action Complaint, Plaintiff sent production requests to each of the
10 Defendants for material relevant to class certification. *See* Quinio Class Cert Decl.
11 ¶ 8. On June 8, 2026, Defendants declined to respond to Plaintiff’s discovery
12 requests on the grounds that Defendants neither consented to electronic service of
13 the requests nor deemed the requests served given the absence of a Rule 26(f)
14 conference, pursuant to Rule 26(d)(2)(B). *Id.* Defendant further rejected Plaintiff’s
15 proposal for the parties to commence early discovery. *Id.*

16 On August 17, 2026, Plaintiff proposed that the parties complete a Rule
17 26(f) conference. *Id.* ¶ 9. Defendants rejected Plaintiff’s proposal.

18 **ARGUMENT**

19 A Plaintiff seeking to certify a class must satisfy each of the requirements of
20 Fed. R. Civ. P. 23(a) and at least one of the three criteria for class certification under
21 Rule 23(b). *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 614–15 (1997). The
22 proposed class meets these requirements. The Court should therefore certify the
23 class.

24 **I. The Proposed Class Satisfies the Requirements of Rule 23(a)**

25 A Plaintiff seeking class certification must meet the four Rule 23(a)
26 requirements: numerosity, commonality, typicality, and adequacy.
27
28

1 **A. Numerosity**

2 Rule 23(a)(1) requires that “the class [be] so numerous that joinder of all
3 members is impracticable.” In determining class size, “[t]he numerosity requirement
4 is not tied to any fixed numerical threshold,” but “[i]n general, courts find the
5 numerosity requirement satisfied when a class includes at least 40 members.” *Rannis*
6 *v. Recchia*, 380 F. App’x 646, 651 (9th Cir. 2010) (citing cases)

7 The impracticability of joinder is not determined according to a strict
8 numerical test but upon the circumstances surrounding the case. *Harris v. Palm*
9 *Springs Alpine Ests., Inc.*, 329 F.2d 909, 913–14 (9th Cir. 1964). “In determining
10 whether numerosity is satisfied, the Court may consider reasonable inferences drawn
11 from the facts before it.” *In re Yahoo Mail Litig.*, 308 F.R.D. 577, 589–90 (N.D. Cal.
12 2015). When a class is not so numerous that joinder is presumptively impracticable,
13 “other factors such as the geographical diversity of class members, the ability of
14 individual claimants to institute separate suits, and whether injunctive or declaratory
15 relief is sought, should be considered in determining impracticability of joinder.”
16 *Jordan v. Los Angeles Cnty.*, 669 F.2d 1311, 1319 (9th Cir. 1982), *vacated on other*
17 *grounds*, 459 U.S. 810 (1982).

18 The proposed class satisfies the numerosity requirement for four reasons:
19 First, the number of persons in the class likely exceeds the number that courts have
20 found sufficient for certification. In Los Angeles County alone, there are 45,000
21 individuals who participate in programs for expectant or new mothers, infants, and
22 families that are not restricted to the black individuals. Franklin Decl. ¶ 49. It is
23 likely that at least more than forty individuals from this large population are first-
24 time mothers who meet the criteria for BIH, but do not identify as black or African
25 American. Indeed, the number of individuals participating in programs for new
26 mothers, infants, and families closely matches the average number of non-African
27 American or nonblack first live births in Los Angeles County over a 6-year period.
28 *See* Quinio Class Cert Decl. ¶ 7; Ex. F. From 2016 to 2021, there was an average of

1 44,137 first pregnancies resulting in live births. *See id.* An average of 41,152 first
2 pregnancies resulting in live births were not African American or black. *See id.*
3 Given this data, this year and subsequent years may expect a similar estimate of first
4 pregnancies resulting in live births to nonblack mothers, which would provide a class
5 of first-time mothers who are eligible for BIH but for their race. Moreover, the
6 number of individuals in the class increases beyond estimates in Los Angeles County
7 given that the BIH program spans the state and multiple counties offer its services.
8 Since Plaintiff seeks injunctive and declaratory relief, the numerosity requirement is
9 relaxed and permits the reasonable inference arising from these estimates. *See*
10 *Sueoka v. United States*, 101 F. App'x 649, 653 (9th Cir. 2004); *see also A. B. v.*
11 *Haw. State Dep't of Educ.*, 30 F.4th 828, 839 (9th Cir. 2022).

12 Second, joinder is impracticable because it includes mothers from numerous
13 counties across the state and individuals who are future applicants to the BIH
14 program. In addition to Los Angeles County and the City of Pasadena, eleven other
15 counties offer the BIH program under the same racial eligibility. The geographic
16 diversity of potential class members makes it impractical to join them in an
17 individual action. *Bentley v. United of Omaha Life Ins. Co.*, No. 2:15-cv-7870-DMG
18 (AJWx), 2018 WL 3357458, at *7 (C.D. Cal. May 1, 2018).

19 Meanwhile, “a class containing deterred and future applicants and employees
20 supports a finding that joinder is impracticable since by their nature such actions
21 involve class members who are difficult to identify.” *Adams v. Pinole Point Steel*
22 *Co.*, No. 3:92-cv-1962 MHP, 1994 WL 515347, at *6 (N.D. Cal. May 18, 1994).
23 Here, current and future first-time mothers who are eligible to apply for BIH but for
24 their race will similarly have an equal protection claim against Defendants. But their
25 eligibility is inherently time-limited: since BIH’s race-neutral eligibility criteria
26 limits participation up to six months postpartum, class members’ claims are
27 transitory and membership in the class will continuously change over time. As new
28 mothers become eligible for BIH, others necessarily age out of eligibility, causing

1 the class’s membership to continuously turn over. As such, joinder of all members
2 is impracticable. *A. B.*, 30 F.4th at 838. Because an estimated 41,152 nonblack first-
3 time mothers would need to be formally joined each year, this “tips the balance even
4 more strongly in favor of concluding that the ‘class is so numerous that joinder of
5 all members is impracticable.’” *Id.* at 839.

6 Third, many potential plaintiffs lack the resources to bring separate lawsuits.
7 Potential class members may be drawn from the CPSP, which serves Medi-Cal
8 recipients and had 69,861 individuals enrolled in 2022. *Comprehensive Perinatal*
9 *Service Program*, *supra*. It is unlikely these members would have the financial
10 means to challenge BIH individually, making class certification proper. *Sherman v.*
11 *Griepentrog*, 775 F. Supp. 1383, 1389 (D. Nev. 1991) (finding joinder impracticable
12 where many potential class members were Medicaid recipients “disbursed over a
13 wide geographical region who could not without great hardship bring multiple
14 lawsuits.”).

15 Fourth, adjudicating individual lawsuits against Defendants would strain
16 judicial resources. Separate lawsuits would result in duplicative discovery, including
17 numerous depositions of the same government officials and repetitive document
18 production. *Vasquez v. Coast Valley Roofing, Inc.*, 670 F. Supp. 2d 1114, 1121 (E.D.
19 Cal. 2009) (finding joinder impracticable where the filing of individual suits by 150
20 separate plaintiffs would burden judicial resources.). Additionally, repeated
21 adjudication of the same controversies will create the risk of inconsistent judgments.
22 *Weston Instruments, Inc. v. Systron-Donner Corp.*, No. C-74-1099, 1978 WL 21345,
23 at *2 (N.D. Cal. Aug. 16, 1978).

24 **B. Commonality**

25 Rule 23(a)(2) requires that “there [be] questions of law or fact common to the
26 class.” Rule 23(a)(2) requires only a “single common question” of law or fact as to
27 the entire class. *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 359 (2011)
28 (simplified); *see also Abdullah v. U.S. Sec. Assocs., Inc.*, 731 F.3d 952, 957 (9th Cir.

1 2013) (simplified). Commonality is satisfied when it can be demonstrated that class
2 members have suffered similar injuries. *Wal-Mart*, 564 U.S. at 349–50
3 (commonality requires common factual or legal questions that “generate common
4 answers apt to drive the resolution of the litigation”) (simplified).

5 Commonality is further satisfied where, as here, “the lawsuit challenges a
6 system-wide practice or policy that affects all of the putative class members.”
7 *Armstrong v. Davis*, 275 F.3d 849, 868 (9th Cir. 2001). The common question of
8 law concerns the legality under the Equal Protection Clause and Title VI of
9 Defendants’ race-based eligibility for the BIH program that prevents proposed class
10 members from seeking assistance on equal footing. The legal questions are tied to a
11 simple, single common fact: proposed class members must seek admission to BIH
12 on unequal ground because they are not the right race. The declaratory and injunctive
13 relief Plaintiffs seek will “generate common answers apt to drive the resolution of
14 the litigation.” *Wal-Mart*, 564 U.S. at 350 (simplified).

15 The commonality requirement is satisfied here because the legal questions
16 arising from Defendants’ procedures and practices do not vary from one class
17 member to another. The Defendants’ application of common policy to all class
18 members suffices to meet the commonality requirement. *Parsons v. Ryan*, 754 F.3d
19 657, 678 (9th Cir. 2014)

20 Further, class actions alleging statutory constitutional violations have been
21 held to satisfy the commonality requirement. *See, e.g., Torres v. Mercer Canyons*
22 *Inc.*, 835 F.3d 1125 (9th Cir. 2016) (alleging statutory violations); *Gonzalez v. U.S.*
23 *Immigration and Customs Enforcement*, 975 F.3d 788 (9th Cir. 2020) (alleging
24 constitutional violations); *Wilcox v. Swapp*, 330 F.R.D. 584 (E.D. Wash. 2019)
25 (statutory privacy violation); *Olson v. Brown*, 284 F.R.D. 398 (N.D. Ill. 2012) (First
26 Amendment free-speech rights). Given the need to resolve the claimed violations of
27 equal protection and Title VI, the proposed class meets the commonality
28 requirement.

1 **C. Typicality**

2 Rule 23(a)(3) requires that “the claims or defenses of the representative parties
3 [be] typical of the claims or defenses of the class.” Typicality exists where all class
4 members are at risk of being subjected to the same harmful practices, regardless of
5 any class member’s individual circumstances. *Parsons*, 754 F.3d at 685–86.
6 Differing fact situations of class members do not defeat typicality under Rule
7 23(a)(3) if the claims of the class representative and class members are based on “a
8 unitary course of conduct,” or on “the same legal or remedial theory.” 7A Wright &
9 Miller, *Federal Practice & Procedure* § 1764 (4th ed.) (discussing *Just Film, Inc. v.*
10 *Buono*, 847 F.3d 1108 (9th Cir. 2017) (unitary course of conduct); *Wolin v. Jaguar*
11 *Land Rover N. Am.*, 617 F.3d 1168 (9th Cir. 2010) (same); *Gonzalez*, 975 F.3d 788
12 (same legal or remedial theory)).

13 Here, the claims of the named Plaintiff, Mrs. Jimenez, are typical of the claims
14 of the members of the proposed class because she has the same interests in this case
15 as all other members of the class she would represent. Each of them suffers injuries
16 from the Defendants’ application of race-based eligibility criteria that prevents them
17 from applying to the BIH program on equal footing. Mrs. Jimenez’s claims thus
18 share the same legal theory as the claims of the class: that Defendant’s racial criteria
19 for accessing the BIH program violates the Equal Protection Clause and Title VI.
20 Accordingly, if Mrs. Jimenez succeeds in her claims, then that ruling will likewise
21 benefit every other class member.

22 The named Plaintiff suffered from the same scheme that has harmed,
23 continues to harm, and will harm other members of the proposed class. Her legal
24 arguments and claims for relief are the same as her classmates’. As a result, Plaintiff
25 satisfies the typicality requirement of Rule 23(a)(3).

26 **D. Adequacy**

27 Rule 23(a)(4) states that “the representative parties [should] fairly and
28 adequately protect the interests of the class.” The “adequacy-of-representation

1 requirement tends to merge with the commonality and typicality criteria.” *Amchem*,
2 521 U.S. at 626 n.20 (simplified). This factor looks to “competency and conflicts of
3 class counsel,” *id.*, and “serves to uncover conflicts of interest between named
4 parties and the class they seek to represent.” *Id.* at 625. The inquiry is whether “the
5 named Plaintiffs and their counsel have any conflicts of interest with other class
6 members.” *In re Volkswagen “Clean Diesel” Mktg., Sales Pracs., and Prods. Liab.*
7 *Litig.*, 895 F.3d 597, 607 (9th Cir. 2018) (quoting *Hanlon v. Chrysler Corp.*, 150
8 F.3d 1011, 1020 (9th Cir. 1998)); *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970,
9 985 (9th Cir. 2011) (giving the second adequacy-of-representation factor as “will the
10 named plaintiffs and their counsel prosecute the action vigorously on behalf of the
11 class” (quoting *Hanlon*, 150 F.3d at 1020)).

12 The named Plaintiff is an adequate representative because she shares her
13 classmates’ interests entirely in enjoining Defendants’ race-based eligibility criteria
14 for participating in the BIH program. The Plaintiff and the proposed class are also
15 represented by experienced counsel. *See* Fed. R. Civ. P. 23(g) (giving criteria for
16 class counsel); Quinio Decl. ¶¶ 11–18. Counsel can commit substantial resources to
17 represent the class. *Id.* ¶¶ 11–14.

18 Consequently, the adequacy-of-representation requirement of Rule 23(a) is
19 met. The Court should appoint undersigned counsel as class counsel under Rule
20 23(g).

21 **II. The Proposed Class Satisfies the Requirements of Rule 23(b)(2)**

22 In addition to the threshold requirements of Rule 23(a), Plaintiffs must also
23 demonstrate that the proposed class fits within one of the Rule 23(b) categories.
24 *Ellis*, 657 F.3d at 979–80. For the reasons discussed below, the class satisfies Rule
25 23(b)(2).

26 A class action is appropriate under Rule 23(b)(2) if “the party opposing the
27 class has acted or refused to act on grounds that apply generally to the class, so that
28

1 final injunctive relief or corresponding declaratory relief is appropriate respecting
2 the class as a whole.”

3 By its terms, Rule 23(b)(2) imposes two independent but related requirements:

4 First, Plaintiffs must show that Defendants’ actions or inactions are based on
5 grounds “generally applicable” to all class members; second, “final injunctive or
6 corresponding declaratory relief must be requested for the class.” 7AA Wright &
7 Miller, *Federal Practice & Procedure* § 1775 (3d ed.).

8 The primary role of Rule 23(b)(2) “has always been the certification of civil
9 rights class actions.” *Parsons*, 754 F.3d at 686 (*citing Amchem*, 521 U.S. at 614);
10 *see also Walters v. Reno*, 145 F.3d 1032, 1047 (9th Cir.1998) (Rule “23(b)(2) was
11 adopted in order to permit the prosecution of civil rights actions.”).

12 The declaratory and injunctive relief here satisfies Rule 23(b)(2) on two
13 grounds:

14 First, Defendants, through their racial eligibility criteria that gatekeeps access
15 to the BIH program, have acted on grounds generally applicable to all the class
16 members. Thus, a declaration that the program’s race-based criteria violates the
17 Equal protection Clause and Title VI benefits every member of the proposed class.
18 And “a single injunction or declaratory judgment would provide relief to each
19 member of the class.” *Wal-Mart*, 564 U.S. at 360–61.

20 Second, Plaintiff’s request for relief satisfies Rule 23(b)(2) because the
21 remedy she seeks would provide relief to all past, current, and future mothers who
22 were, are, and will be eligible for the BIH program but for their race. For instance,
23 the Court’s declaration that Defendants cannot deny any mother from applying to or
24 participating in the BIH program based on race will affect every mother who is
25 eligible based on race-neutral criteria. An injunction would protect each class
26 member. Defendants’ state-wide racial criteria that numerous localities implement
27 is particularly well-suited to a Rule 23(b)(2) class action.
28

1 Because the proposed class meets the Rule 23(a) and Rule 23(b)(2)
2 requirements, it fulfills all the prerequisites for class certification.

3 **III. Plaintiff Reserves the Right to Early Class-Related Discovery**

4 While the current evidence supporting Plaintiff's motion is sufficient to
5 certify the proposed class, Defendants possess a majority of the information relevant
6 for certification, including the number of ineligible current and former applicants to
7 the BIH program and participants of other maternal health programs. If discovery is
8 necessary before the Court can rule on this Motion, and given that relevant
9 information concerning class certification is largely in Defendants' possession, the
10 Court could, if necessary, permit limited discovery to determine with more
11 specificity the facts it identifies as relevant to class certification. *Oppenheimer Fund*
12 *v. Sanders*, 437 U.S. 340, 351 n.13 (1978) (noting the availability of discovery "to
13 illuminate issues upon which a district court must pass in deciding whether a suit
14 should proceed as a class action under Rule 23"). Plaintiffs reserve the right to
15 supplement this Motion after conducting discovery related to class certification as
16 needed or ordered.

17 **IV. The Court Should Appoint Undersigned Counsel as Class Counsel**

18 Per Rule 23(g), and for the preceding reasons and the facts averred to in
19 counsel's declaration attached to this motion, the Court should appoint undersigned
20 counsel as class counsel. *See* Quinio Class Cert. Decl. ¶¶ 11–18.

21 **CONCLUSION**

22 For the foregoing reasons, Plaintiff respectfully requests this Court to certify
23 the class described in this Motion.

24
25 DATED: September 18, 2026.
26
27
28

Respectfully submitted,

ANDREW R. QUINIO
SAMANTHA R. ROMERO-DREW
Pacific Legal Foundation

By s/ Andrew R. Quinio
ANDREW R. QUINIO

Attorneys for Plaintiffs

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for Plaintiff Erica Jimenez, certifies that
this brief contains 5,271 words, which complies with the word limit of L.R. 11-6.1.

DATED: September 18, 2026.

By s/ Andrew R. Quinio
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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION**

ERICA JIMENEZ, individually and on
behalf of a class of similarly situated
individuals,

Plaintiff,

v.

DR. ERICA PAN, in her official
capacity as Director of the California
Department of Public Health, et al.,
Defendants.

No. 2:26-cv-03500-SPG-SP

**DECLARATION OF ANDREW R.
QUINIO IN SUPPORT OF
MOTION FOR
CLASS CERTIFICATION**

Date: November 18, 2026
Time: 1:30 pm
Place: Courtroom 5C, 5th Floor
Judge: Hon. Sherilyn Peace Garnett
Trial Date: Not Set
Action Filed: April 2, 2026

1 I, Andrew R. Quinio, pursuant to 28 U.S.C. § 1746, declare as follows:

2 1. I am an attorney with Pacific Legal Foundation (PLF) and represent
3 Plaintiff in the matter of *Erica Jimenez v. Dr. Erica Pan, et al.* I am over eighteen
4 years of age. As to the following facts, I know them to be true of my own knowledge
5 and based on information and belief. If called as a witness, I would and could
6 competently testify thereto.

7 **Black Infant Health and Other Maternal**
8 **and Infant Health Program Background and Data**

9 2. Attached hereto as Exhibit A is a true and correct copy of select
10 California Statutes of 1989, including the Budget Act of that year, ch. 93, 1989 Cal.
11 Stat. 622-23. This is publicly available on the website for the Office of the Chief
12 Clerk for the California State Assembly at: <https://tinyurl.com/2z87uzpv>.

13 3. Attached hereto as Exhibit B is a true and correct printout of the website
14 for the California Home Visiting Program (CHVP). This is publicly available on the
15 California Department of Public Health at: <https://tinyurl.com/yts5w24b>.

16 4. Attached hereto as Exhibit C is a true and correct printout of the
17 website, “CHVP By the Numbers.” This is publicly available on the California
18 Department of Public Health at: <https://tinyurl.com/y94k4p4w>.

19 5. Attached hereto as Exhibit D is a true and correct copy of the report to
20 the 2021–2022 California State Legislature analyzing Comprehensive Perinatal
21 Services. It is publicly available at: <https://tinyurl.com/mpmp8cfu>.

22 6. Attached hereto as Exhibit E is a true and correct copy of the study,
23 entitled, “California’s Comprehensive Perinatal Services Program and birth
24 outcomes.” It is available at: <https://tinyurl.com/4psn8c6b>.

25 7. Attached hereto as Exhibit F is a true and correct copy of excerpts of
26 reports from 2016 through 2021 from the Los Angeles County Department of Public
27 Health regarding live births in Los Angeles County.

- a. The report from which the 2016 data on parity is excerpted is available at: <https://tinyurl.com/23yd95bv>.
- b. The report from which the 2017 data on parity is excerpted is available at: <https://tinyurl.com/msev766c>.
- c. The report from which the 2018 data on parity is excerpted is available at: <https://tinyurl.com/52p2kmmv>.
- d. The report from which the 2019 data on parity is excerpted is available at: <https://tinyurl.com/ystc8av7>.
- e. The report from which the 2020 data on parity is excerpted is available at: <https://tinyurl.com/y4rs7p5s>.
- f. The report from which the 2021 data on parity is excerpted is available at: <https://tinyurl.com/bdfua7hx>.

Class Discovery and Meet and Confer Efforts

8. On May 8, 2026, Plaintiff sent document requests to each of the Defendants for material relevant to class certification in the above matter. On June 8, 2026, Defendants declined to respond to Plaintiff's document requests because Defendants neither consented to electronic service of the requests nor deemed the requests served given the absence of a Rule 26(f) conference, pursuant to Rule 26(d)(2)(B). Defendant further rejected Plaintiff's proposal for the parties to commence early discovery.

9. On August 17, 2026, Plaintiff proposed that the parties complete a Rule 26(f) conference. Defendants rejected Plaintiff's proposal.

10. On August 27, 2026, the parties met and conferred regarding Plaintiff's Motion for Class Certification, pursuant to L.R. 7-3. Defendants would not stipulate to certifying the proposed class because they contend that Defendants class motion is premature in light of the dispute over Plaintiff's standing and that the proposed class does not satisfy Rule 23. The parties did not resolve the issues concerning Plaintiff's class motion.

F.R.C.P 23(g)

11. I am an attorney licensed to practice in California (Bar No. 288101) and am admitted to practice in the U.S. District Court for the Central District of California.

12. I am also admitted to practice in the following federal courts:

- a. U.S. District Court for the District of Northern California.
- b. U.S. District Court for the District of Southern California.
- c. U.S. District Court for the District of Western Michigan.
- d. U.S. Court of Appeals for the Fourth Circuit.
- e. U.S. Court of Appeals for the Sixth Circuit.
- f. U.S. Court of Appeals for the Ninth Circuit.
- g. Supreme Court of the United States.

13. PLF attorneys have experience litigating complex constitutional cases in federal court for over half a century. Of the 21 cases PLF has litigated in the Supreme Courts, it has won 18. *See PLF at the Supreme Court*, <https://tinyurl.com/wavt8rpt>.

14. I have litigated and served as lead counsel on cases involving racial classifications, race-based treatment, and equal protection of the laws, which are at issue in this case. *See, e.g., Nistler v. Petersen*, No. 0:24-cv-00186 (D. Minn. 2024); *Lynn v. Goff*, No. 1:24-cv-00211 (D. Or. 2024); and *Hubbell v. Acosta*, No. 3:25-cv-001105 (S.D. Cal. 2025).

15. I have litigated cases where I represented plaintiffs suing on behalf of themselves and a putative class of similarly situated individuals. *Cusano v. Cook Cnty.*, No. 1:22-cv-07196 (N. D. Ill. 2022); *Dalton v. Hao*, No. 1:23-cv-11216 (D. Mass. 2023); *Miall v. City of Asheville*, No 1:23-cv-00259 (W.D.N.C. 2023).

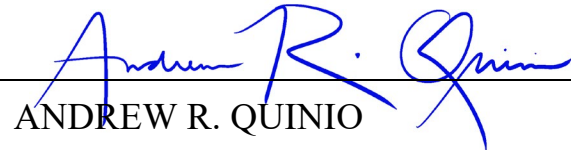
16. I will be assisted by PLF attorneys who have litigated cases involving racial classifications, race-based treatment, and equal protection of the laws. *See, e.g., American Alliance for Equal Rights v. Pritzker*, No. 3:24-cv-03299 (C.D. Ill.

2024); *Foundation Against Intolerance & Racism, Inc. v. Pickens*, No. 1:24-cv-00115 (N.D.W. Va. 2025).

17. I have researched and studied the policies and practices surrounding California's Black Infant Health Program and its implementation in several local health jurisdictions. I have also researched California's other maternal and child health programs. I have done substantial legal research over approximately the last twelve months pertaining to these programs and the above-captioned case.

18. PLF will continue to commit substantial resources to represent the class.

Dated this 18th day of September, 2026, at Laguna Hills, California


ANDREW R. QUINIO

**INDEX OF EXHIBITS TO THE DECLARATION OF ANDREW QUINIO
IN SUPPORT OF MOTION FOR CLASS CERTIFICATION**

Exhibit #	Description	Page #
A	Statutes of California, 1989, Chapter 93	007–010
B	California Home Visiting Program Website	011–016
C	California Home Visiting Program, “CHVP By the Numbers”	017–019
D	California Health Benefits Review Program, Analysis of California Assembly Bill 1930: Medi-Cal Comprehensive Perinatal Services, dated April 16, 2022	020–095
E	“California’s Comprehensive Perinatal Services Program and Birth Outcomes,” Frontiers in Public Health, dated December 21, 2023	096–104
F	Distribution of Live Births by Parity and by Mother’s Race/Ethnicity, Los Angeles County, 2016–2021	105–110

EXHIBIT A

STATUTES OF CALIFORNIA

1988–89

REGULAR SESSION

1989 CHAPTERS

Ch. 93]

STATUTES OF 1989

621

Item	Amount
portionate reductions to each category.	
(e) Of the funds appropriated in this item, \$50,000 shall be available for a management assistance grant to the Hupa Health Association to conduct a health care needs assessment.	
(f) Of the amount appropriated in this item, \$500,000 shall be made available as a one-time grant to Alameda County to compensate for major health care service disruptions due to the closure of Maxicare clinics.	
(g) Of the funds appropriated in this item, \$200,000 is appropriated to provide startup funding for a nonprofit organization to develop a Medi-Cal primary care case management plan to be operated in the City of Fresno.	
4260-111-137—For local assistance, Department of Health Services, payable from the Vital Records Improvement Project Fund.....	600,000
4260-111-890—For local assistance, Department of Health Services, payable from the Federal Trust Fund.....	25,872,000
Schedule:	
(a) 20-Family Health Services	25,287,000
(b) 40-Rural and Community Health.	585,000
Provisions:	
1. Subdivisions (a) and (c) of Provision 3 of Item 4260-111-001 are also applicable to this item.	
4260-113-890—For local assistance, Department of Health Services payable from the Federal Trust Fund.....	10,806,000
Provisions:	
1. Of the amount appropriated in this item, the department shall use the following amount for the following purposes:	
a. \$1,000,000 for various Sudden Infant Death Syndrome projects including development of a SIDS autopsy protocol, support services and training for county health officials, public health nurses and law enforcement, family intervention services, parent advisory groups and data assessment.	
b. \$1,000,000 for the provision of information, education, and referral services about sexually transmitted diseases to individuals seeking services through programs administered by the	

622

STATUTES OF 1989

[Ch. 93

Item

Amount

- Maternal and Child Health Branch.
- c. \$1,440,000 for new and innovative projects to reduce the rate of black infant mortality in California. Of this amount, \$140,000 may be used to establish one position and support a Black Infant Mortality Committee, and \$650,000 shall be used for outreach in Los Angeles housing projects.
 - e. \$1,800,000 to expand the Adolescent Family Life Program, with priority given to projects targeting black infant mortality. Of this amount, \$150,000 may be used to establish three positions to administer the program.
 - f. \$200,000 for the expansion of the Childhood Injury Prevention and Control Program. From this amount, the department may establish one support position.
 - g. \$1,500,000 to expand the High-Risk Infant Followup program.
 - h. \$740,000 for the Diabetes in Pregnancy Program, of which \$360,000 shall be used to establish three new regions, with priority given to those targeting black infant mortality, \$105,000 to replace SPRANS funds for program evaluation; \$100,000 to fund growth in the existing eight regional programs; \$35,000 for program education materials; \$10,000 for California Diabetes and Pregnancy Program state liaison activities; \$80,000 for affiliate development materials and training; and \$50,000 for affiliate administrative support.
 - i. \$141,000 to establish three positions to support the Comprehensive Perinatal Services Program.
 - j. \$135,000 for transfer to, and augmentation of, Item 4260-001-890 to fund a study to determine outcome measures suitable to evaluate pediatric critical care systems and improving medical care for children.
 - m. \$2,760,000 for implementation of nine perinatal substance abuse pilot projects in Los Angeles, San Francisco, Kern, Sacramento, Orange, San Diego, Alameda, and Santa Clara counties.
 - n. \$90,000 shall be transferred to, and is in augmentation of, Item 4260-001-890 to develop a brochure on the risks and benefits of a Caesarean delivery versus a vaginal delivery. This brochure shall be available for distribution to all pregnant women.

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STATUTES OF 1989

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Item

Amount

- o. It is the intent of the Legislature that additional activities be undertaken by the department to reduce the abnormally high mortality rate among black infants.

There shall be established in the department a Black Infant Mortality Leadership Committee. The following members shall be appointed by and serve at the pleasure of the Governor: the Director of Health Services (or designee); the Director of Maternal and Child Health; the Director of Alcohol and Drug Abuse (or designee); the Director of Social Services (or designee); a California County Supervisor (or designee); two local public health officers (or their designees); and a health care professional. The following members shall be appointed by and serve at the pleasure of the Speaker of the Assembly: a member of the State Assembly (or designee); two members of the Black Community Coalition; a consumer or member of a consumer advisory group; a member of the religious community, a health care professional; a pediatrician; and an obstetrician/gynecologist. The following members shall be appointed by and serve at the pleasure of the Senate Rules Committee: a member of the State Senate (or designee); two members of the Black Community Coalition; a consumer or member of a consumer advisory group, a member of the religious community; a health care professional; a pediatrician; and an obstetrician/gynecologist. The Superintendent of Public Instruction (or designee) shall also be a member of the committee.

The Black Infant Mortality Leadership Committee shall meet as frequently as necessary but no less than six times a year in order to conduct its business. It shall provide advice to and shall be consulted by the department on the establishment of policies, procedures, and programs designed to eliminate the disparity between the black and non-black populations in infant mortality. On or before January 1, 1991, the committee shall develop and present to the Legislature and Governor information which evaluates current programs; assesses current and ongoing needs; contains legislative, programmatic, and

EXHIBIT B

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California Home Visiting Program

California Home Visiting Program (CHVP)

The birth of a baby is an exciting time. It can also be overwhelming, especially for those without a positive parenting model or support network to guide them. The California Home Visiting Program (CHVP) is designed for overburdened families who are at risk for Adverse Childhood Experiences (ACEs), including child maltreatment, domestic violence, substance use disorder and mental health related challenges. Home visiting gives parents the tools and know-how to independently raise their children. It's a preventive intervention focused on promoting positive parenting and child development. Decades of research on home visiting shows that home visits by a trained professional during pregnancy and in the first few years of life improves the lives of children and families. Giving children a solid start in their first few years of life increases the opportunity for a brighter, more prosperous future.



HomeStory



Maternal Mental Health

Program Profile

▼ About Us

Our Goal: To promote maternal health and well-being, improve infant and child health and development, strengthen family functioning and cultivate strong communities.

We Serve: Pregnant and newly parenting families who have one or more of the following risk factors: Domestic violence, inadequate income, unstable housing, education less than 12 years, substance use disorder, and depression and/or mental health related challenges.

Service Delivery: Services are voluntary and provided by a Public Health Nurse or paraprofessional to pregnant and newly parenting families in the family's home or alternate agreed-upon location. Services are typically offered for two-to-three years. The frequency of visits is based on the needs of the family.

Outcomes: Research has shown that evidence-based home visiting programs produce positive outcomes that save taxpayer dollars by reducing societal costs associated with intimate partner violence, child maltreatment, youth crime, substance use disorder and need for government assistance.

Funding: CHVP administers the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program  grant, as well as the State General Funds allocated to local health jurisdictions to deliver evidence-based home visiting services and implement innovative home visiting projects.

► Program Services

Home visiting services are typically offered in the family's home where teachable moments naturally arise. Working one-on-one with a home visiting professional, families can ask questions, discuss concerns and gain valuable information. Home visitors build relationships as they provide services tailored to each family's needs, such as:

- Teaching parenting skills and modeling parenting techniques.
- Providing information and guidance on a range of topics, such as safe sleep position, injury prevention and nutrition.
- Providing referrals to address substance use disorder, family violence and maternal depression.
- Screening children for developmental delays and facilitating intervention.
- Promoting early learning in the home that emphasizes positive parenting and building a language-rich environment.



Contact Local CHVP Directors ►

► CHVP Funds Five Evidence-Based Home Visiting Models

CHVP local health jurisdictions serve clients using the Family Connects, Healthy Families America, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership or Parents as Teachers home visiting models based on the specific needs of the communities served. All five models are strengths-based and focus on a participant's individual interests and goals. For example, these models give parents the tools and know how to independently raise their children; increase parent knowledge of early childhood development and improve parenting practices; provide early detection of developmental delays and health issues; prevent child abuse and neglect; and increase children's school readiness and success. Below are additional characteristics of each model:

Family Connects

- Supports health for all families with newborns at a moment of life-changing transition. Trained Family Connects nurses offer home visits to assess the needs of newborns and postpartum parents, provide health information and refer to community and medical services when needed.
- Utilizes insights from home visits to align systems of care for families in support of health equity.

[Learn More](#) 

Healthy Families America

- Serves low-income families who must be enrolled within the first three months after an infant's birth.
- A trained paraprofessional provides home visits to parents and their children through three years postpartum.

[Learn More](#) 

Home Instruction for Parents of Preschool Youngsters (HIPPY)

- Offers parents support, training and material to engage in effective, developmental and fun activities with their children in the comfort of their own homes.
- Program is a developmentally appropriate, early literacy curriculum designed to promote children's cognitive, social, emotional and physical development. Parents engage with the curriculum by roleplaying the parent-child activities with a home visitor who is from the same community.

[Learn More](#) 

Nurse-Family Partnership

- Serves low-income, first-time moms who must be enrolled by the 28th week of pregnancy
- A Public Health Nurse provides one-on-one home visits to parents and their babies through two years postpartum.

[Learn More](#) 

Parents as Teachers

- Serves families with children (between pregnancy and Kindergarten entry) experiencing one or more stressors in their lives.
- A Parent Educator conducts personal visits with parents and their children, as well as monthly group

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California Home Visiting Program

events.

[Learn More](#) 

› CHVP by the Numbers

The California Home Visiting Program (CHVP) uses federal Maternal, Infant & Early Childhood Home Visiting (MIECHV) funds and State General Funds (SGF) to support implementation of four evidence-based home visiting (EBHV) program models, Healthy Families America (HFA), Parents as Teachers (PAT), Nurse-Family Partnership (NFP), and Home Instruction for Parents of Preschool Youngsters (HIPPI), in 57 Local Health Jurisdictions (LHJs) across California.

[See latest CHVP by the numbers](#) ›

› Where We Are

The California Home Visiting Program (CHVP) oversees local evidence-based and innovative home visiting programs in 59 California local health jurisdictions. Five evidence-based home visiting models are supported: Family Connects, Healthy Families America, Home Instruction for Parents of Preschool Youngsters (HIPPI), Nurse-Family Partnership and Parents as Teachers. CHVP also supports innovative home visiting projects, including evidence-based and evidence-informed home visiting programs, with a focus on addressing local needs, fostering ongoing learning and sharing best practices. CHVP is supported by funding from the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and the California State General Fund.

[Where We Are](#) ›

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California Home Visiting Program

External Resources

- Family Connects [↗](#)
- Healthy Families America [↗](#)
- Home Instruction for Parents of Preschool Youngsters (HIPPY) [↗](#)
- Home Visiting Evidence of Effectiveness [↗](#)
- MIECHV Performance Measures - Benchmarks (PDF) [↗](#)
- Nurse-Family Partnership [↗](#)
- Parents as Teachers [↗](#)

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California Home Visiting Program

Program Resources

- Policy Alerts
- Program Policy and Procedures
- State General Fund Innovation 3.0
- Where We Are

Data and Reports

- MCAH Data Dashboards
- CHVP by the Numbers
- MIECHV: California Fact Sheet (PDF) [↗](#)

Toolkits

- HomeStory
- Education Resources
- Communication Toolkits
- YouTube Videos

Page Last Updated : July 1, 2026

EXHIBIT C

California Home Visiting Program

CHVP By the Numbers

The California Home Visiting Program (CHVP) uses federal Maternal, Infant & Early Childhood Home Visiting (MIECHV) funds and State General Funds (SGF) to support four evidence-based home visiting (EBHV) program models:

- Healthy Families America (HFA)
- Nurse-Family Partnership (NFP)
- Parents as Teachers (PAT)
- Home Instruction for Parents of Preschool Youngsters (HIPPY)

These programs are offered in 57 local health jurisdictions (LHJs) across California.

CHVP home visiting services support pregnant people and new parents by improving maternal health, child development, and family wellbeing. Services are voluntary and provided in the family's home or another agreed upon place by a public health nurse or trained paraprofessional. Families typically receive services for two to five years. Visit frequency follows each program's requirements but can be adjusted to meet a family's needs. To learn more, visit the California Home Visiting Program website.

This dashboard provides an annual summary of how many families participate in CHVP, their characteristics and the services they receive. Data can be viewed for CHVP overall and by funding source.

Note: This dashboard only shows data from EBHV programs that receive CHVP funding. It does not include services paid for by other sources or the CHVP Innovation Projects.

[About the Data](#)

[Download Data \(EXCEL\)](#)

[Dashboard Instructions](#)

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CHVP By the Numbers

Fiscal Year
2024-2025

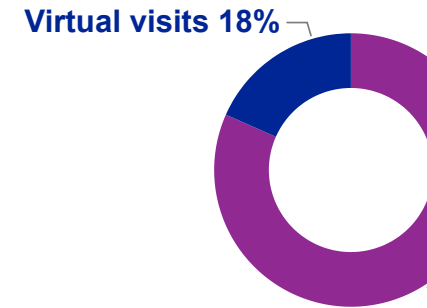
Funding Source
All

How Much Did We Do

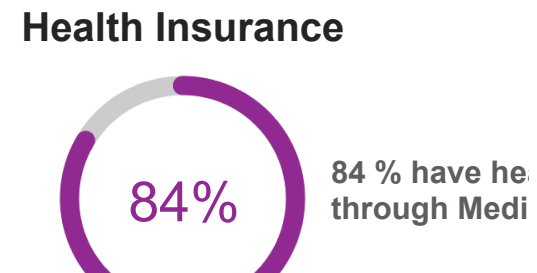
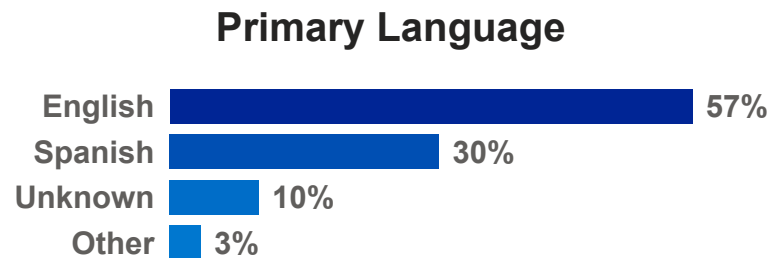
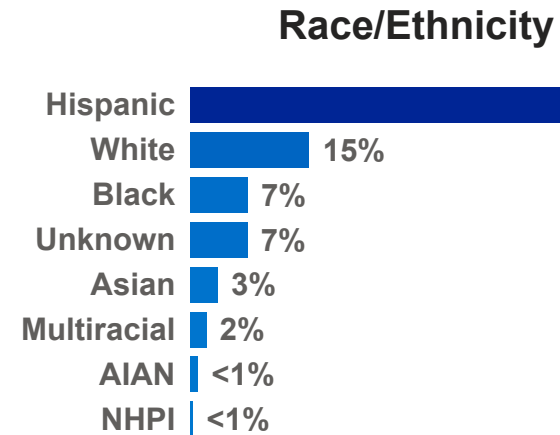
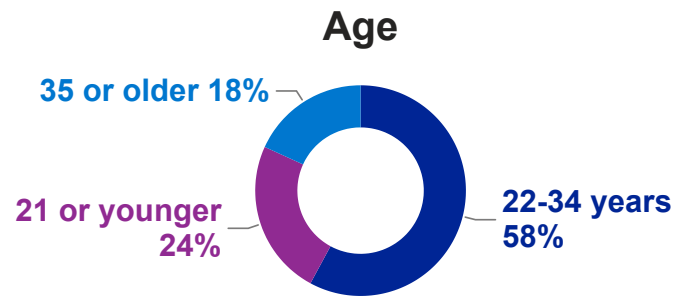

6,105
Families served


5,298
Children served


57,024
Total home visits completed



Who We Serve*



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CHVP By the Numbers



* Adult participants, N=6,105

For race/ethnicity, 'Unknown' includes those that declined to respond and missing responses. AIAN = American Indian or Alaska Native, NHPI = Native Hawaiian or Other Pacific Islander

For primary language, 'Unknown' includes missing data.

Data Source: Data extracted from CHVP model-specific data systems for State Fiscal Year **2024-2025** (July 1 - June 30).

[Microsoft Power BI](#)

Page Last Updated : July 14, 2026

EXHIBIT D

California Health Benefits Review Program

Analysis of California Assembly Bill 1930 Medi-Cal: Comprehensive Perinatal Services

A Report to the 2021–2022 California State Legislature

April 16, 2022



Key Findings

Analysis of California Assembly Bill 1930 Medi-Cal: Comprehensive Perinatal Services

Summary to the 2021–2022 California State Legislature, April 16, 2022



SUMMARY

The version of California Assembly Bill 1930 analyzed by CHBRP would mandate that coverage for specified comprehensive perinatal services, delivered through the Comprehensive Perinatal Services Program (CPSP), for Medi-Cal beneficiaries be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill also seeks to allow unlicensed perinatal health workers (PHWs) to be reimbursed for services rendered in a nonmedical setting and change their supervision requirements.

If enacted, the law would apply to the health insurance of enrollees in Department of Managed Health Care (DMHC)-regulated Medi-Cal managed care plans, County Organized Health Systems (COHS), and the Fee-for-Service (FFS) program.

Benefit Coverage: At baseline, CHBRP estimates 57% of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans subject to AB 1930 have coverage for comprehensive perinatal services delivered through CPSP for 12 months following the end of a pregnancy. Postmandate, 100% of eligible Medi-Cal beneficiaries would have coverage of comprehensive perinatal services through CPSP for 12 months postpartum.

At baseline, CHBRP estimates 0% of eligible Medi-Cal beneficiaries have coverage of preventive CPSP services rendered by unlicensed perinatal health workers (PHWs) in the home or other community setting away from a medical site. Postmandate, 100% of eligible Medi-Cal beneficiaries would have coverage of preventive services rendered by unlicensed PHWs in the home or other community setting. AB 1930 does not exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness: CHBRP did not identify any studies that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time. There are no CPSP-specific studies comparing these time periods because CPSP does not provide services past 60 days postpartum. Given the general lack of evidence on CPSP, CHBRP mostly included studies conducted in other states that covered comprehensive perinatal services

similar to those that would be covered in California if AB 1930 were enacted. These studies provided inconclusive evidence of the impact of programs in which services were delivered solely by unlicensed PHWs on breastfeeding and maternal depression and insufficient evidence of the impact of programs delivered by a combination of unlicensed PHWs and licensed health professionals

Cost and Health Impacts¹: In 2023, CHBRP estimates AB 1930 would result in an additional 349 Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans utilizing CPSP services, with an increase of approximately 0.27% (to 82.7 per 1,000 beneficiaries) for services rendered at a medical site and an increase from 0 to 0.4 per 1,000 beneficiaries for those CPSP services rendered at a location away from a medical site. This would result in an increase of \$75,000 in annual expenditures. CHBRP estimates no measurable short-term or long-term public health impact at the population level, due to existing barriers to PHW supply and lack of evidence showing the effectiveness of comprehensive perinatal services when provided more than 60 days postpartum.

CONTEXT

Perinatal care is health care for pregnant people from prenatal through postpartum. It allows practitioners an opportunity to detect, monitor, and address health conditions and behaviors that can impact pregnancy, maternal health, and newborn/infant health outcomes.²

Receiving timely access to prenatal care is an important factor for maternal and infant health outcomes. Although California exceeded the Healthy People 2030 national goal of at least 80.5% of pregnant people receiving early and adequate prenatal care in 2019, disparities in utilization of prenatal care in the first trimester by race/ethnicity and insurance type persist across the state. There are several barriers to postpartum utilization

¹ Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

² Refer to CHBRP's full report for full citations and references.



of perinatal care including, among others, access to providers, coordination of care, challenges with scheduling, and lack of incentives to prioritize postpartum visits.

California's Comprehensive Perinatal Services Program (CPSP) program is a benefit for all Medi-Cal beneficiaries who become pregnant, including those covered by Medi-Cal Managed Care Plans. CPSP services supplement the obstetric care patients typically receive in an effort to improve pregnancy and postpartum outcomes. CPSP participants are provided enhanced, wraparound perinatal services, including those related to nutrition, psychosocial needs, and health education. Services are available from the date of conception through 60 days following the end of the pregnancy.

Participation by providers is limited to those preapproved by the California Department of Public Health (CDPH) as CPSP providers. CPSP providers may contract with or employ certain health professionals to act as CPSP practitioners to deliver comprehensive perinatal services.

All CPSP services must be provided by or under the personal supervision of a physician. The state typically requires CPSP services to be delivered in a direct, face-to-face manner with the client in order to be reimbursed. Only CPSP providers who enrolled as Medi-Cal providers and in CPSP may bill for services rendered and receive reimbursements; CPSP practitioners that are employed or contract with CPSP providers to render CPSP services are not eligible for reimbursement. Hospital-based outpatient departments/clinics and non-hospital-based clinics that are CPSP providers may bill for CPSP services that are delivered off-site or outside of the clinic (e.g., a physician's office, a school auditorium, or a clinic-run mobile van). For at-home settings, CPSP providers may only be reimbursed for preventive services.

BILL SUMMARY

AB 1930 would make three changes to coverage for CPSP services. The bill would: 1) extend coverage for CPSP services from 60 days to 12 months postpartum; 2) request federal approval to cover certain services by unlicensed perinatal health workers (PHWs); and 3) change the supervision requirements of unlicensed PHWs delivering CPSP services.

AB 1930 does not change the reimbursement rates for CPSP services.

Extension of coverage

AB 1930 requires coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries to be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill specifies the comprehensive perinatal services during the extended coverage period would include additional comprehensive perinatal assessments and individualized care plans. It would also include provision of additional visits, and units of service.

The bill also requires the Department of Health Care Services (DHCS) to collaborate with the California Department of Public Health (CDPH) and a broad stakeholder group to determine the specific number of additional comprehensive perinatal services to be covered. AB 1930 specifies that additional services must be at least proportional in amount, duration, and scope to those available to participants in California's CPSP on July 27, 2021.

Unlicensed perinatal health workers: reimbursement and supervision

AB 1930 also requires the state to request federal approvals to cover preventive services rendered by an unlicensed perinatal health worker outside of a medical setting, and allow these workers to be supervised by either of the following:

- A Medi-Cal provider that is a clinic, hospital, a community-based organization, or a licensed practitioner; or
- A community-based organization (CBO) that is not a Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates at baseline, there are 69,861 users of CPSP services in Department of Managed Health Care (DMHC)-regulated Medi-Cal Managed Care Plans, and that 0% of which have coverage of preventive CPSP services rendered by unlicensed PHWs in the home or other community setting away from a medical site. CHBRP also estimates that annual utilization of CPSP services rendered at a medical site is 82.5 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care at baseline.

Utilization and Cost

Postmandate, CHBRP estimates that an additional 349 Medi-Cal beneficiaries in DMHC-regulated managed care would use CPSP services.

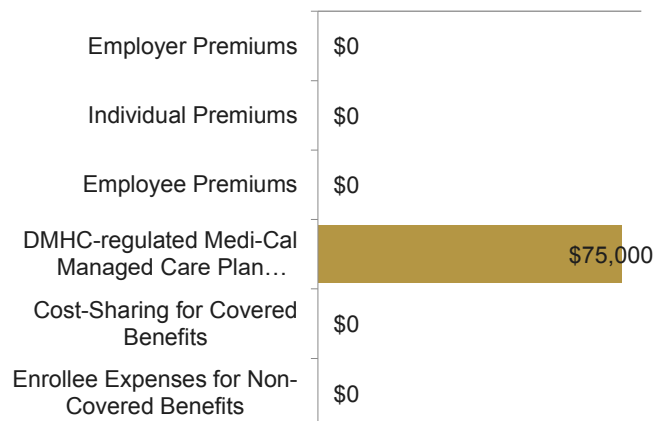
CHBRP estimates that annual utilization of CPSP services rendered at a medical site will increase by approximately 0.27% to 82.7 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care postmandate. Annual utilization of CPSP services rendered at a beneficiary's home or other community setting away from a medical site will increase from 0 per 1,000 covered Medi-Cal beneficiaries in DMHC-regulated managed care at baseline to 0.4 per 1,000 postmandate.

Expenditures

AB 1930 would raise total net annual expenditures by \$75,000 (0.0001%) due to an increase in expenditures by Medi-Cal Managed Care Plans. CPSP services do not have cost sharing for enrollees, meaning the entire increase would be a Medi-Cal expenditure and would not be borne out by enrollees.

No expected offsets are projected due to an increase in CPSP visits. There are no measurable cost offsets due to CPSP services provided by unlicensed PHWs or in a setting away from a medical site.

Figure B. Expenditure Impacts of AB 1930



Source: California Health Benefits Review Program, 2022.

Medi-Cal County Organized Health Systems and Fee-for-Service

In addition to the expected increase of \$75,000 in Medi-Cal Managed Care Plan expenditures CHBRP is estimating for the approximately 8 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans, it

seems reasonable to assume that a population proportional increase of approximately \$16,000 would occur for the approximately 1.7 million beneficiaries enrolled in County Organized Health Systems (COHS) managed care. It seems likely that a similar impact would occur for beneficiaries with health insurance through Medi-Cal's Fee-for-Service (FFS) program (though the exact amount is unknown).

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1930.

Medical Effectiveness

CHBRP identified several studies regarding the strength of evidence of the impact of comprehensive perinatal services on birth and maternal outcomes. AB 1930 would have little impact on birth outcomes, but reporting birth outcomes remains important for two reasons. Although AB 1930 does not change that Medi-Cal beneficiaries receive coverage for CPSP services during the prenatal period, it would allow unlicensed PHWs to provide preventive services outside the medical setting if supervised by a Medi-Cal provider or a community-based organization (CBO) that is not a Medi-Cal provider under certain conditions (see *Policy Context* section) during the prenatal and postpartum period. Additionally, CHBRP reports on birth outcomes because part of the original intent of the CPSP program was to improve birth outcomes.

Overall, there is a lack of evidence on the efficacy of CPSP specifically. CHBRP identified two older studies of CPSP and included them in this analysis. Given the lack of evidence on CPSP, CHBRP mostly included studies that covered comprehensive perinatal services similar to those that would be provided in California's CPSP if AB 1930 were enacted.

CHBRP did not identify any studies that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time. CHBRP identified some studies that compared the provision of comprehensive perinatal services in medical versus nonmedical settings, and these studies were primarily focused on home visiting programs. However, these home-visiting studies did not control for additional perinatal services that may have been received outside of the studied intervention. CHBRP did not identify any studies that compared the provision of comprehensive perinatal services in medical



to nonmedical settings where the nonmedical setting was a location other than a home.

Regarding birth outcomes, CHBRP found there is:

- Insufficient evidence³ that enrollment in CPSP or the pilot project reduces risk of low birth weight (LBW).
- Insufficient evidence that comprehensive perinatal services reduce risk of newborn intensive care unit admission.
- Limited evidence⁴ that comprehensive perinatal services delivered solely by unlicensed PHWs reduce risk of LBW; insufficient evidence that they reduce risk of very low birth weight or extremely low birth weight; and inconclusive evidence⁵ that they reduce risk of preterm birth.
- A preponderance of evidence⁶ that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals reduce risk of LBW; insufficient evidence that they reduce risk of being small for gestational age or infant mortality; and limited evidence that they reduce risk of preterm birth.

Regarding maternal outcomes, CHBRP found there is:

- Inconclusive evidence that comprehensive perinatal services increase breastfeeding initiation; limited evidence that they do not increase breastfeeding duration; and insufficient evidence that they increase breastfeeding exclusivity and self-efficacy.
- Inconclusive evidence that comprehensive perinatal services delivered solely by unlicensed PHWs decrease the occurrence of postpartum depression or depressive symptoms after childbirth; insufficient evidence that they improve psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

³ *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

⁴ *Limited evidence* indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

⁵ *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

⁶ *Preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

- Insufficient evidence that comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs decrease the occurrence of postpartum depression or depressive symptoms after childbirth, or improve psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

Public Health

CHBRP concludes that passage of AB 1930 would have no measurable short-term or long-term public health impact at the population-level, due to existing barriers to PHW supply and lack of evidence showing the effectiveness of comprehensive perinatal services when provided more than 60 days postpartum. It is important to note that the absence of evidence is not “evidence of no effect.” It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

At the individual level, evidence of effectiveness indicates that some Medi-Cal beneficiaries who would use CPSP services postmandate, particularly home visiting interventions when delivered by a combination of unlicensed PHWs plus licensed professionals, may see improved birth outcomes, including reduced risk of low birth weight and preterm birth, and increased breastfeeding duration. However, CHBRP is unable to estimate a specific number.

For these reasons, CHBRP also concludes that AB 1930 would have no measurable impact on disparities or social determinants of health for birth and maternal health outcomes.

Long-Term Impacts

Given the insufficient and inconclusive evidence on CPSP or CPSP-like services on maternal health outcomes, CHBRP is unable to determine the potential long-term utilization of CPSP services and long-term cost impacts.

Essential Health Benefits and the Affordable Care Act

AB 1930 would not result in new benefit coverage that exceeds the definition of essential health benefits (EHBs) in California. Benefit coverage of Medi-Cal beneficiaries is not subject to the same set of EHBs as the benefit coverage of enrollees in nongrandfathered small-group and individual market plans and policies.

Key Findings: Analysis of California Assembly Bill 1930



A Report to the California State Legislature

Analysis of California Assembly Bill 1930 Medi-Cal: Comprehensive Perinatal Services

April 16, 2022

California Health Benefits Review Program
MC 3116; Berkeley, CA 94720-3116
www.chbrp.org

Suggested Citation: California Health Benefits Review Program (CHBRP). (2022). Analysis of California Assembly Bill 1930 Medi-Cal: Comprehensive Perinatal Services. Berkeley, CA.



The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. AB 1930 Impacts on Benefit Coverage, Utilization, and Cost, 2023

	Baseline (2023)	Postmandate Year 1 (2023)	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	22,810,000	22,810,000	0	0.00%
Total enrollees with health insurance subject to AB 1930	8,034,000	8,034,000	0	0.00%
Total % of enrollees with coverage of Comprehensive Perinatal Services Program (CPSP) services for 1 year postpregnancy	57%	100%	43%	76.54%
Total % of enrollees with coverage of preventive services rendered by unlicensed perinatal health worker away from a medical site	0%	100%	100%	N/A
Utilization and cost				
Number of enrollees utilizing CPSP services	69,861	70,210	349	0.50%
Utilization of CPSP services per 1,000 covered enrollees				
At a medical site	82.5	82.7	0.2	0.27%
In a beneficiary's home or other community setting away from a medical site	N/A	0.4	0.4	N/A
Average cost per unit of CPSP services				
At a medical site	\$15.83	\$15.81	\$(0.02)	-0.12%
In other community setting away from a medical site	N/A	\$15.81	\$0.00	0.00%
Expenditures				
<u>Premium (expenditures) by payer</u>				
Private employers for group insurance	\$52,967,575,000	\$52,967,575,000	\$0	0.00%
CalPERS HMO employer expenditures (b) (c)	\$5,895,476,000	\$5,895,476,000	\$0	0.00%
Medi-Cal Managed Care Plan (DMHC-regulated only) expenditures (d)	\$25,989,411,000	\$25,989,486,000	\$75,000	0.00%
<u>Enrollee premiums (expenditures)</u>				
Enrollees for individually purchased insurance	\$24,029,788,000	\$24,029,788,000	\$0	0.00%
Individually purchased – outside exchange	\$6,324,312,000	\$6,324,312,000	\$0	0.00%
Individually purchased – Covered California	\$17,705,476,000	\$17,705,476,000	\$0	0.00%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	\$24,504,936,000	\$24,504,936,000	\$0	0.00%
<u>Enrollee out-of-pocket expenses</u>				
Cost-sharing for covered benefits	\$15,807,011,000	\$15,807,011,000	\$0	0.00%

(deductibles, copayments, etc.)

Total expenditures	\$149,194,197,000	\$149,194,272,000	\$75,000	0.0001%
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Source: California Health Benefits Review Program, 2022.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal.

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) In addition to the possible increase in premiums CHBRP is estimating for the 8,034,000 Medi-Cal beneficiaries enrolled in DMHC-regulated plans subject to AB 1930, CHBRP assumes that a proportional increase of \$16,000 would occur for the approximately 1.7 million beneficiaries enrolled in COHS managed care. It seems likely that there would also be an additional increase for the Medi-Cal beneficiaries with health insurance through the FFS program (though the exact amount is unknown).

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health System; CPSP = Comprehensive Perinatal Services Program; DMHC = Department of Managed Health Care; FFS = Fee-for-Service.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)⁷ conduct an evidence-based assessment of the medical, financial, and public health impacts of AB 1930, Comprehensive Perinatal Services, as amended on March 16, 2022.

Bill-Specific Analysis of AB 1930, Comprehensive Perinatal Services

Bill Language

AB 1930 would make three changes to coverage for services provided under the California Comprehensive Perinatal Services Program (CPSP). The bill would: 1) extend coverage for CPSP services from 60 days to 12 months postpartum; 2) request federal approval to cover certain services by unlicensed perinatal health workers; and 3) change the supervision requirements of unlicensed perinatal health workers delivering CPSP services.

Extension of coverage

AB 1930 requires coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries to be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill specifies the comprehensive perinatal services during the extended coverage period would include additional comprehensive perinatal assessments and individualized care plans. It would also include provision of additional visits, and units of service.

The bill also requires the Department of Health Care Services (DHCS) to collaborate with the California Department of Public Health (CDPH) and a broad stakeholder group to determine the specific number of additional comprehensive perinatal services to be covered. AB 1930 specifies that additional services must be at least proportional in amount, duration, and scope to those available to participants in California's Comprehensive Perinatal Services Program (CPSP) on July 27, 2021.

Unlicensed perinatal health workers: reimbursement and supervision

AB 1930 also requires the state to request federal approvals to cover preventive services rendered by an unlicensed perinatal health worker outside of a medical setting, and allow these workers to be supervised by either of the following:

- A Medi-Cal provider that is a clinic, hospital, a community-based organization, or a licensed practitioner
- A community-based organization (CBO) that is not a Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.

The full text of AB 1930 can be found in Appendix A.

Relevant Populations

If enacted, the law would apply to the health insurance of enrollees in Department of Managed Health Care (DMHC)-regulated Medi-Cal managed care plans, County Organized Health Systems (COHS), and the Fee-for-Service (FFS) program.

⁷ CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

Definitions

- CHBRP acknowledges that persons who do not identify as “women” may also experience pregnancy and therefore refers to “pregnant people” and “postpartum people” in this analysis. When referring to the literature, CHBRP uses terminology from the source material cited, which frequently uses the term “women” to describe the study populations.
- CHBRP uses the following terms throughout this analysis:
 - **Comprehensive perinatal services:** refers to nonobstetrical care (e.g., psychosocial, nutritional, health education, etc.) delivered during the perinatal period and are not specific to CPSP.
 - **CPSP services:** refers to specific perinatal assessments and care provided exclusively under the CPSP program. These services may only be provided by CPSP providers and CPSP practitioners. See the *Background* section for more information.
 - **Perinatal care:** refers to care provided from the time of conception through the first year of birth.⁸
 - **Perinatal health worker (PHW):** refers to a broad category of health care workers that deliver comprehensive perinatal services and/or CPSP services. This workforce includes social workers, health paraprofessionals, marriage and family therapists, registered dietitians, health educators, childbirth educators, community health workers, promotoras/es, and doulas (e.g., birth, postpartum, antepartum, and full-spectrum). PHWs are referenced frequently in the literature analyzed by CHBRP. This analysis uses the terminology from the source material cited, which examines several of the professions listed in the provision of comprehensive perinatal services.
 - **Prenatal:** refers to the period between conception and the end of a pregnancy.
 - **Postpartum:** refers to the period between the end of a pregnancy through the following 12 months.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

Federal Policy Landscape

The American Rescue Plan Act of 2021

Prior to the passage of the American Rescue Plan Act (ARPA) of 2021, federal law required that all states extend Medicaid eligibility to pregnant women with incomes up to 138% of the federal poverty level (\$38,295 for a family of four in 2022⁹). Pregnancy-related coverage for the woman was required to last through at least 60 days postpartum. The enactment of ARPA authorizes states to extend coverage for Medicaid beneficiaries from 60 days to 12 months postpartum through a state plan amendment or section 1115 waiver. The option became effective on April 1, 2022, and is available until March 31, 2027. All states that choose to extend coverage through this option must provide full Medicaid benefits during the

⁸ HSC Section 123485(d).

⁹ U.S. Health and Human Services Poverty Guidelines for 2022 (<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>).

entire length of the pregnancy and the extended postpartum period. States that do not elect this option may provide a more narrow set of pregnancy-related benefits (KFF, 2021).

Essential health benefits

The Affordable Care Act requires nongrandfathered small-group and individual market health insurance – including, but not limited to, Qualified Health Plans sold in Covered California – to cover 10 specified categories of essential health benefits (EHBs).^{10, 11}

AB 1930 would not result in new benefit coverage that exceeds the definition of EHBs in California. Benefit coverage of Medi-Cal beneficiaries is not subject to the same set of EHBs as the benefit coverage of enrollees in nongrandfathered small-group and individual market plans and policies.

California Policy Landscape

California law and regulations

Existing law states that pregnant people and targeted low-income children, who are eligible for Medi-Cal benefits and are participating in a Medi-Cal program, are eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for 12 months following the last day of the person's pregnancy.¹²

Medi-Cal eligibility for pregnant people

Pregnant or postpartum people can be eligible for and access Medi-Cal through several routes, including traditional Medi-Cal eligibility, eligibility through Medi-Cal expansion, and pregnancy-specific eligibility and coverage.^{13,14}

- **Pregnant people with incomes between 0% up to 138% of the federal poverty level (FPL)** are eligible for full-scope benefit coverage through Medi-Cal Managed Care Plans or Fee-for-Service (FFS).
- **Pregnant people with incomes above 138% up to 213% of the FPL:**
 - Are eligible for pregnancy-related Medi-Cal coverage. Pregnancy-related services are services required to assure the health of the pregnant woman and the fetus. These include, but are not limited to, prenatal care, services for other conditions that might complicate the pregnancy, labor, delivery, postpartum care, and family planning services. Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally for a period of 1 year following the last day of pregnancy.
 - Pregnant people whose incomes are above 138% up to 213% of the FPL can also choose to enroll in a Qualified Health Plan (QHP) through Covered California and receive advanced premium tax credit (APTC) to reduce their monthly premiums. Pregnant people who are enrolled in a QHP prior to becoming pregnant and are eligible for Medicaid may enroll in Medi-Cal or stay enrolled in their QHP and continue to receive APTC and cost-

¹⁰ Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website:

www.chbrp.org/other_publications/index.php.

¹¹ Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

¹² WIC Section 14005.185.

¹³ Department of Health Care Services (DHCS). Full-scope Medi-Cal Coverage and Affordability and Benefit Program for Low-Income Pregnant Women and Newly Qualified Immigrants. 2019. Available at:

www.dhcs.ca.gov/services/medi-cal/Pages/Affordability-and-Benefit-Program.aspx.

¹⁴ Covered California. Health Coverage Options for Pregnant Women. Available at: www.coveredca.com/individuals-and-families/getting-covered/pregnant-women/.

share reductions. Pregnant people in this income range may not, however, be enrolled in Medi-Cal and a QHP at the same time.

- **Pregnant people who have income over 213% up to 322% of the FPL may be eligible for the Medi-Cal Access Program (MCAP).** Pregnant people who are not eligible for full-scope or pregnancy-related Medi-Cal may qualify for the MCAP, regardless of citizenship and immigration status. MCAP offers low-cost comprehensive coverage, with no copayments, deductibles, or coinsurance. However, there is a fee equal to 1.5% of the yearly family income. The fee can be paid in monthly installments over 12 months. Pregnant people may qualify for both Covered California and the MCAP, but cannot enroll in both programs and must choose one program.
- **Undocumented pregnant people** through age 26 years who meet the income eligibility thresholds may be eligible for full-scope Medi-Cal coverage or may be eligible for partial-scope pregnancy-related Medi-Cal or MCAP if their income exceeds 138% FPL. Undocumented people over age 26 years may be eligible for partial-scope pregnancy-related Medi-Cal coverage or MCAP.

Provisional Postpartum Care Extension and ARPA

In 2020, California implemented the Provisional Postpartum Care Extension (PPCE) program. Prior to PPCE, a pregnant person who was eligible for and received Medi-Cal or MCAP during their last month of pregnancy was eligible for those services for only 60 days following their pregnancy. Under PPCE, if a pregnant person was diagnosed with a maternal mental health condition (e.g., postpartum depression) during their pregnancy, postpartum period, or within 90 days from the end of the postpartum period, the person remains eligible for Medi-Cal or MCAP for up to 1 year following the last day of the pregnancy.

California elected to participate in the federal option to extend Medi-Cal coverage through ARPA. The federal allowance under ARPA requires coverage for the full breadth of medically necessary services under pregnancy and postpartum period, regardless of immigration status or how the pregnancy ends. The ARPA extension replaced the PPCE in California beginning on April 1, 2022.

Comprehensive Perinatal Services Program

California's CPSP program is a benefit for all Medi-Cal beneficiaries who become pregnant, including those covered by Medi-Cal Managed Care Plans. The program is administered by CDPH, with reimbursements for services provided to enrollees overseen by DHCS. CPSP services supplement the obstetric care patients typically receive in an effort to improve pregnancy and postpartum outcomes. CPSP participants are provided enhanced, wraparound perinatal services, including those related to nutrition, psychosocial needs, and health education. Services are available from the date of conception through 60 days following the end of the pregnancy.

Participation by providers is limited to those preapproved by CDPH as CPSP providers. CPSP providers may contract with or employ certain health professionals, authorized by CDPH to act as CPSP practitioners, to deliver comprehensive perinatal services.¹⁵ See the *Background* section for more information.

All CPSP services must be delivered by or under the personal supervision of a physician.¹⁶ Under CPSP, personal supervision is defined as the evaluation of services delivered by others through direct communication, either in-person or electronic means, in accordance with protocols. Each CPSP provider's protocols must define how personal supervision by a physician will occur and will be documented.¹⁷

¹⁵ Welfare and Institutions Code, Section 14134.5.

¹⁶ CCR Title 22, Section 51179.

¹⁷ CCR Title 22, Section 51179.5.

The state typically requires CPSP services to be delivered in a direct, face-to-face manner with the client in order to be reimbursed. Since March 24, 2020, in light of the Coronavirus disease 2019 (COVID-19) public health emergency, DHCS has allowed CPSP services to be provided via telehealth if the service meets certain requirements.¹⁸ Reimbursement rates vary depending on the service provided and coverage type (i.e., managed care vs. FFS).¹⁹ Only CPSP providers who enrolled as Medi-Cal providers and in CPSP may bill for services rendered and receive reimbursements; CPSP practitioners that are employed or contract with CPSP providers to render CPSP services are not eligible for reimbursement. Hospital-based outpatient departments/clinics and non-hospital-based clinics that are CPSP providers may bill for CPSP services that are delivered off-site or outside of the clinic (e.g., a physician's office, a school auditorium, or a clinic-run mobile van). For at-home settings, CPSP providers may only be reimbursed for preventive services, which must be delivered by a licensed practitioner (DHCS, 2020).²⁰

Similar requirements in other states

There are 15 states, Alaska, Idaho, Indiana, Louisiana, Maine, Michigan, Minnesota, New Mexico, North Dakota, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin, that reimburse community health worker services through their Medicaid programs. Community health workers in the District of Columbia, Indiana, Michigan, Pennsylvania, and South Dakota are currently authorized to provide perinatal care (NASHP, 2021). Community health workers are one type of PHW that is eligible to deliver CPSP services. AB 1930 would change the supervisory requirements.

Several states are actively seeking to expand Medicaid postpartum coverage through the allowance under the American Rescue Plan Act of 2021 (see *Federal Policy Landscape*). The Centers for Medicare & Medicaid Services approved the section 1115 waivers for Georgia, Illinois, Missouri, New Jersey, and Virginia. Twelve states, in addition to California, have enacted legislation to seek federal approval for the expansion through a state plan amendment or 1115 waiver. An additional five states have legislation pending to seek federal approval or are planning to submit a state plan amendment or 1115 waiver (KFF, 2022).

Legislation pending in Illinois would require the Department of Healthcare and Family Services to amend managed care contracts to require managed care organizations to pay for preventive prenatal and perinatal health care services rendered by a nonaffiliated provider at the same rate that the department would pay for such services.²¹

¹⁸ DHCS policy on Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19). Available at: www.dhcs.ca.gov/Documents/COVID-19/Telehealth_Other_Virtual_Telephonic_Communications_V3.0.pdf.

¹⁹ CCR Title 22, Section 51504.

²⁰ The U.S. Health Care Financing Administration defines "preventive services" as "services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to (1) prevent disease, disability, and other health conditions or their progression, (2) prolong life, and promote physical and mental health and efficiency." HCFA regulation 42 CFR 440.130 (c).

²¹ Illinois House Bill 5013.

BACKGROUND ON PERINATAL CARE IN CALIFORNIA

This section provides context for consideration of AB 1930 and includes information about perinatal care, the Comprehensive Perinatal Services Program (CPSP), and a description of disparities and social determinants of health related to perinatal care and birth and maternal health outcomes for pregnant people and infants.

Childbirth and Perinatal Care in California

Medi-Cal plays a significant role in coverage for pregnant people in California. In 2020, 39.9% of the 420,259 live births in California were covered by Medi-Cal (March of Dimes, 2022).

Racial/ethnic minorities are disproportionately represented in Medi-Cal. Latino people make up 50% of the Medi-Cal Managed Care population, followed by White people (18%), Asian people (10%), Black people (7%), and Other/Unknown (15%) (CHCF, 2021). As shown in **Error! Reference source not found.**, racial/ethnic minorities comprised more than 84% of births covered by Medi-Cal in 2018 (Simon, 2020b).

Table 2. Births by Mother's Race/Ethnicity and Payer Type, California 2018

	Medi-Cal	Private Insurance
Total	189,747	228,317
Latino	68%	31%
White	16%	40%
Asian	7%	20%
Black	7%	3%
More than one race	2%	3%
American Indian/Alaska Native	<1%	<1%
Native Hawaiian/Pacific Islander	<1%	<1%

Source: California Health Benefits Review Program, 2022 (adapted from Simon, 2020b).

Perinatal care is health care for pregnant people from prenatal through postpartum. Perinatal care allows practitioners an opportunity to detect, monitor, and address health conditions and behaviors that can impact pregnancy, maternal health, and newborn/infant health outcomes.

CHBRP found literature identifying disparities (differences between groups that are modifiable) in perinatal care and outcomes by race/ethnicity and insurance type (Medi-Cal vs. private insurance). See the *Disparities and Social Determinants of Health* section below for more information.

Barriers to Perinatal Care

Receiving timely access to prenatal care is an important factor for maternal and infant health outcomes. Although California exceeded the Healthy People 2030 national goal of at least 80.5% of pregnant people receiving early and adequate prenatal care in 2019, disparities in utilization of prenatal care in the first

trimester by race/ethnicity and insurance type persist across the state (see *Disparities and Social Determinants of Health* section below) (Thomas and Valentine, 2021).

There is a dearth of literature on barriers to access and utilization of prenatal care. A study from 2003 investigating access to prenatal care in California found lack of insurance coverage to be a significant barrier to prenatal care among low-income women (Braveman et al., 2003). Other noninsurance barriers for pregnant people included lack of childcare, transportation problems, inconvenient clinic hours, low educational attainment, lack of family planning, and lack of a usual source of prepregnancy care (Braveman et al., 2000, 2003).

Barriers to postpartum utilization include lack of provider continuity over the course of prenatal care, discontinuity with delivery and postpartum care providers, insufficient patient information on coverage and duration of postpartum services/programs, inadequate referrals, inadequate community-based services to meet population needs, lack of transportation and child care, out-of-date patient contact information for patient visit scheduling and reminders, lack of effective processes for ensuring postpartum visits are scheduled, and lack of incentives for payers, providers, and women to prioritize postpartum visits (de Bocanegra et al., 2017; DiBari et al., 2014; Henderson et al., 2016; Rodin et al., 2019; Wilcox et al., 2016).

Comprehensive Perinatal Services Program

As discussed in the *Policy Context* section, AB 1930 would impact services administered through the CPSP, a benefit of the Medi-Cal program that provides comprehensive perinatal services for eligible low-income pregnant people from the date of conception through 60 days following the end of the pregnancy. A 2014 report on CPSP estimated that approximately half of Medi-Cal–eligible pregnant people were receiving services through CPSP (Kinsler, 2014). CHBRP was unable to find statewide enrollment data for CPSP, as enrollment is tracked at the county-level.

In 1979, the California Department of Health Services, under the sponsorship of the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), started a 3-year pilot program called the Obstetrical Access Project (OB Access Project) focused on improving pregnancy outcomes through enhanced prenatal care. The pilot results showed that supplementing obstetric care with nutrition, health education, psychosocial services, and prenatal vitamins and minerals could reduce the incidence of low birth weight in infants by more than one-third, and saved approximately \$2 in short-term neonatal intensive care unit costs for every \$1 spent (Lennie et al., 1987). Following the OB Access Project in 1982, the California State Legislature enacted a law (AB 2821, Bates) requiring all publicly subsidized prenatal care to include nutrition, health education, and psychosocial services in addition to obstetric care. Then, in 1984, legislation (AB 3021, Margolin) implemented a Medi-Cal reimbursement mechanism for these enhanced perinatal care services. The CPSP was officially created in 1987 to continue efforts in reducing morbidity and mortality among low-income pregnant people and their infants (MCAH, 2018).

Comprehensive perinatal services, as defined in the CPSP Provider Handbook, include “obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the supervision of a physician during pregnancy and 60 days following delivery.” Nutrition, health education, and psychosocial services are considered enhanced services, which supplement the obstetric care a client receives. See Table 3 for a description of CPSP enhanced services (MCAH, 2018).

Table 3. Enhanced Services Provided Under the California Comprehensive Perinatal Services Program

Service	Description
Client orientation	The purpose of the client orientation is to orient the client to comprehensive perinatal services. It includes but is not limited to the following: where to obtain services, where, when, and how comprehensive services are provided, including initial assessments, reassessments, interventions, and referrals, what to expect at prenatal and postpartum visits, information about routine tests and procedures, clinic hours (scheduling missed appointments, etc.), identifying danger signs and symptoms during pregnancy and what to do in case of an emergency, an opportunity to ask questions and express concerns.
Initial assessments	A qualified CPSP practitioner in a face-to-face interview with the client will complete four initial assessments – obstetric, nutrition, health education and psychosocial – to determine the client's strengths, risks, and needs.
Individualized care plan (ICP)	An ICP is developed by a CPSP practitioner, in consultation with the client, based on her unique risk conditions, problems, and strengths identified during the CPSP initial assessments and re-assessments. It is a summary of the perinatal services planned for the client during pregnancy and during the postpartum period. It maximizes the coordination of care and documentation of services provided by all CPSP practitioners: obstetrics, nutrition, health education, and psychosocial.
Interventions	Interventions must be identified for the risk conditions and problems included on the ICP. These interventions may include teaching, counseling, providing referrals, problem solving, or any other action the client or staff takes to resolve a risk or problem.
Trimester reassessments	Reassess client needs in each trimester to identify changes or new developments since the last assessment.
Postpartum assessment	Assess the mother and infant, addressing various issues that may arise, such as breastfeeding difficulties, postpartum depression, bonding challenges, birth control, and birth spacing.
Vitamin/mineral supplement	A 300-day supply of vitamin/mineral supplements may be dispensed to the client or prescribed as medically necessary.
Referrals to mandated services	The CPSP provider shall refer patients, as appropriate, to services not specifically made part of comprehensive perinatal services. These include, but are not limited to the following: Women, Infants and Children's (WIC) Supplemental Nutrition Program, genetic screening, dental care, family planning, and Child Health and Disability Prevention Program (CHDP).

Source: California Health Benefits Review Program, 2022.

CPSP Providers and Practitioners²²

CPSP services are delivered through providers approved to participate in CPSP by the California Department of Public Health (CDPH). A certified CPSP provider must be enrolled as an active Medi-Cal provider, in good standing with an approved National Provider Identifier (NPI) number, and be in one of the categories listed below:

- Physician in general practice, family medicine, obstetrics/gynecology, or pediatrics

²² CHBRP uses the terminology "provider" and "practitioner" as found in the CPSP Provider Handbook and California Code of Regulations, Title 22.

- Group medical practice, if at least one member is one of the physician types identified above
- Preferred provider organization
- Clinic (hospital, community, or county)
- Certified nurse midwife (CNM)
- Alternative birth center²³

To become a certified CPSP provider, the Medi-Cal enrolled provider must submit a completed application to their local health jurisdiction's perinatal services coordinator (PSC). The PSC reviews the application and submits it to the CDPH Maternal, Child and Adolescent Health (MCAH) Division for final approval. The application approval process may take up to 60 days from the date that CDPH/MCAH receives a completed application (MCAH, 2022).

PSCs in local health jurisdictions provide administrative support to CPSP providers and are available in all 58 California counties, in addition to the City of Berkeley, Long Beach, and Pasadena, which have their own health departments separate from their counties' health departments. In 2019, CDPH reported that CPSP had approximately 1,600 approved providers throughout the state (MCAH, 2020).

CPSP providers may employ or contract with any or all of the following practitioners for the purpose of providing CPSP services and working directly face-to-face with clients:

- Physicians (general practitioner, family physician, obstetrician/gynecologist, pediatrician)
- CNMs
- Nurse practitioners
- Physician associates
- Registered nurses
- Licensed vocational nurses
- Social workers
- Psychologists
- Marriage and family therapists
- Registered dietitians/registered dietitian nutritionists
- Health educators
- Certified childbirth educators (Lamaze, Bradley, International Childbirth Education Association)
- Licensed midwives
- Comprehensive perinatal health workers (CPHWs) (e.g., community health workers (CHWs), doulas, and lactation consultants) These health workers are not licensed and can provide preventive services if supervised by a physician and if provided in a medical setting. Qualifications are a minimum of:
 - 18 years old or older
 - High school diploma or GED
 - One year full-time paid perinatal experience

²³ "Alternative or free-standing birth center services" as defined in Title 42 United States Code, Section 1396d (l)(B), is an alternative to traditional, hospital-based maternity care.

Disparities²⁴ and Social Determinants of Health²⁵ Related to Perinatal Care and Birth and Maternal Health Outcomes

Per statute, CHBRP includes discussion of disparities and social determinants of health (SDoH) as it relates to perinatal care and birth and maternal health outcomes.

As shown in Table 4, CHBRP found literature identifying disparities (differences between groups that are modifiable) in perinatal care and outcomes by race/ethnicity and insurance type (Medi-Cal vs. private insurance). Further literature identifies that SDoH contribute to disparities in perinatal care and birth and maternal health outcomes (Howell, 2018; Wang, et al., 2020).

Disparities in Perinatal Care in California

Perinatal care is thought to promote healthy pregnancies through screening and management of a woman's risk factors and health conditions, and to promote healthy behaviors during and after pregnancy. The American College of Obstetricians and Gynecologists recommends shifting postpartum care from a single encounter to an ongoing process, with an initial assessment by a maternal care provider occurring within the first 3 weeks postpartum and assessing physical, social, and psychological well-being. (ACOG, 2018).

Pregnant people covered by Medi-Cal were less likely to receive prenatal care in the first trimester in 2018, compared to pregnant people with private insurance. Among pregnant people with Medi-Cal coverage in 2018, starting prenatal care in the first trimester also varied by race/ethnicity, including Native Hawaiian/Pacific Islander people at 63%, American Indian/Alaska Native people at 65%, Black people at 73%, White people at 78%, Latino people at 79%, and Asian people at 80%. Fewer Medi-Cal beneficiaries attended at least one postpartum visit, compared to pregnant people covered by private insurance, in 2018. Fewer Latino pregnant people accessed postpartum office visits compared with pregnant people of other races/ethnicities (Simon, 2020b).

Disparities in Birth and Maternal Health Outcomes in California

Key maternal and infant health outcomes in California demonstrate disparities. Black Californians experience the highest rates of maternal and infant mortality, preterm and low-birth-weight births, low-risk, first-birth cesarean deliveries (C-sections), and prenatal and postpartum depressive symptoms (Thomas and Valentine, 2021). Black pregnant people covered by Medi-Cal have the highest rates of C-sections, preterm and low-birth-weight births, and newborn intensive care unit (NICU) admissions, compared to all other racial/ethnic groups with Medi-Cal coverage, according to data from 2018 (Simon, 2020b).

Maternal and infant mortality

CDPH conducts surveillance of maternal mortality through vital statistics, as reported through the California Pregnancy Mortality Surveillance System (CA-PMSS). Released in September 2021, their California Pregnancy-Related Deaths 2008-2016 report concluded that 1,934 women died while pregnant or within one year of the end of a pregnancy during this time period.

²⁴ Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population. (Wyatt et al., 2016).

²⁵ CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from: (CDC, 2014; Healthy People 2020, 2019).

Eighteen percent (18%) of the pregnancy-related deaths in California occurred while pregnant, and of the remaining 82% that occurred after pregnancy ended, nearly half (44%) of the deaths were within six days of childbirth (or end of pregnancy), 24% occurred 7-42 days after pregnancy ended and 14% were 43-365 days after pregnancy. Timing to death varied greatly depending on the cause of death. The top five leading causes of pregnancy-related deaths were cardiovascular disease (28%), sepsis or infection (17%), hemorrhage (15%), hypertensive disorders (13%) and thrombotic pulmonary embolism (7%).

The state's pregnancy-related mortality ratio (number of pregnancy-related deaths per 100,000 live births, up to 1 year after the end of pregnancy) fluctuated between 9.5 and 14.9 from 2008 to 2016. From 2014 to 2016, the pregnancy-related mortality ratio for Black people was 56.2 deaths per 100,000 live births, four to six times greater than the mortality ratios for people of other racial/ethnic groups, including White people (9.4), Latino people (11.0), and Asian/Pacific Islander people (13.3) (MCAH, 2021).

The infant mortality rate in California is 4.2 per 1,000 live births. Racial/ethnic differences can also be found among infant mortality rates. In 2018, Black infants in California experienced the highest rate of infant mortality among all races/ethnicities at 8.5 deaths per 100,000 live births, more than double the state's goal to reach a target of 4 or lower by 2022 (Let's Get Healthy, 2016). Asian and White infants experienced the lowest rates at 3.4 and 3.0 deaths per 100,000 live births. The rate for Latino infants was 4.4 deaths per 100,000 live births (Thomas and Valentine, 2021).

Preterm and low weight births

Preterm and low birth weight infants have higher rates of mortality. There are serious health problems associated with preterm and low weight births as well, including trouble eating, gaining weight, and fighting infections. An increased risk of serious developmental disabilities may lead to long-term health problems (Ward and Beachy, 2003).

In 2019, the rate of preterm births among all pregnant people in California was 10.4%. Black pregnant people experienced a rate (14.4%) approximately 54% higher than preterm births for Asian (9.3%) and White (8.8%) pregnant people. Native Hawaiian/Pacific Islander pregnant people experienced a rate of 12.5%, followed by American Indian/Alaska Native people at 11.7% and Latino people at 10.9%. One in nine Black infants in California in 2019 had a low birth weight, the highest rate (11.9%) among all races/ethnicities and double the rate for White infants (5.7%), followed by Asian (8%), American Indian and Alaska Native (7.7%), Latino (6.8%), and Native and Pacific Islander (6.3%) (Thomas and Valentine, 2021).

Black pregnant people with Medi-Cal coverage experienced the highest rates of preterm and low weight births (both 13%) compared to all other racial/ethnic groups with Medi-Cal coverage in 2018 (Simon, 2020b).

Cesarean deliveries

Avoiding unnecessary C-sections is a quality metric for hospitals. The state's goal is to reduce the rate of first-birth, single, head-down full-term C-sections to 23.6% by 2030 (Let's Get Healthy, 2016).

In 2019, nearly one in four births among low-risk, first-births across the state were C-sections, nearing the state's goal. However, disparities in C-section rates were found by race/ethnicity and insurance status as well. Black pregnant people experienced the highest rate at 27.0% (Thomas and Valentine, 2021). Pregnant people covered by Medi-Cal are slightly more likely to deliver via C-section compared to pregnant people covered by private insurance. Among all pregnant people with Medi-Cal coverage in 2018, Black pregnant people had the highest rate (36%), followed by American Indian/Alaska Native and multiracial people (32%), Native Hawaiian/Pacific Islander, Latina, and White people (31%), and Asian people (30%) (Simon, 2020b).

Prenatal and postpartum depression

Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, can impact maternal and infant health. In addition to risks to the pregnant person, risks for infants associated with prenatal depression include preterm birth, low birth weight, and behavioral problems. Risks for infants associated with postpartum depression include impaired bonding and attachment, reduced breastfeeding success, and problems with infant cognitive and social development. Risks to the postpartum person range from lethargy to increased maternal disengagement and hostile, coercive behaviors, and less commonly, suicide ideation (Freeman, 2019).

From 2018 to 2019, Black pregnant people in California were two times more likely to experience symptoms of prenatal depression compared to White pregnant people (24.3% vs. 10.8%). Latino pregnant people followed at 16.7%, then Asian, Native Hawaiian/Pacific Islander people at 15.2%.

Black people also showed the highest percentage for symptoms of postpartum depression at 18.4%, compared to Asian, Native Hawaiian/Pacific Islander people (14.3%), Latino people (12.9%), and White people (11.1%) (Thomas and Valentine, 2021).

Pregnant people covered by Medi-Cal from 2016 to 2018 showed higher rates of prenatal depressive symptoms, compared to pregnant people with private insurance (20.4% vs. 10.6%). Postpartum depressive symptoms were also higher in pregnant people covered by Medi-Cal compared to pregnant people covered by private insurance over that same time period (14.2% to 10.2%) (Simon, 2020b).

Breastfeeding

The health benefits of breastfeeding are well recognized and apply to both postpartum people and children. The American Academy of Pediatrics recommends exclusive breastfeeding for about the first 6 months with continued breastfeeding along with introducing appropriate complementary foods for 1 year or longer (Dieterich, 2013; Eidelman et al., 2012).

According to 2016-2018 Maternal Infant and Adolescent Health Survey data, 47.8% of all California postpartum people reported exclusive breastfeeding 1 month after delivery. However, rates of exclusive breastfeeding 3 months after delivery dropped to 33.5%. People with Medi-Cal coverage experienced a larger decrease in breastfeeding rates, dropping from 44.3% at 1 month after delivery to 27.1% at 3 months after delivery, compared to the privately insured population (51% to 40.6%). Latino people in California had the lowest rate of exclusive breastfeeding, 3 months after delivery at 26.4% compared to White people (48.8%), Black people (32.8%), and Asian people (28.2%) (CDPH, 2022).

Table 4. Disparities Among Key Maternal and Infant Health Outcomes in California

	Pregnancy-Related Mortality Ratio (a) (2014-2016)	Infant Mortality (b) (2018)	Preterm Birth (b) (2019)	Low Birth Weight Infants (b) (2019)	Cesarean Deliveries (b) (2019)	Prenatal Depression (b) (2018-2019)	Postpartum Depression (b) (2018-2019)	Exclusive Breastfeeding 3 Months Postpartum (c) (2016-2018)
	(per 100,000 live births)	(per 1,000 live births)	%	%	%	%	%	%
California average	13	4.2	10.4	7.1	22.8	15.1	12.9	33.5
American Indian/Alaska Native	—	7.8	11.7	7.7	—	—	—	—
Asian	13.3*	3.4	9.3	8	—	—	—	28.2*
Black	56.2	8.5	14.4	11.9	27	24.3	18.4	32.8
Latino	11	4.3	10.9	6.8	21.9	16.7	12.9	26.4
White	9.4	3	8.8	5.7	22.5	10.8	11.1	48.8

Source: California Health Benefits Review Program, 2022.

Note: *Data includes Asian and Pacific Islander populations.

(a) MCAH, 2021.

(b) Thomas and Valentine, 2021.

(c) CDPH, 2022.

Social Determinants of Health

Social determinants of health (SDoH) include factors outside of the traditional medical care system that influence health status and health outcomes (e.g., income, education, geography, etc.). CHBRP found evidence for the influence of race and ethnicity, insurance, and education on maternal morbidity and mortality. A 2020 systematic review found a large number of studies that examined individual-level indicators of socioeconomic position in relation to maternal outcomes in the United States, of those, the majority suggested that Black race and Hispanic ethnicity, lack of insurance, and lower education are significantly associated with higher risk of maternal mortality and morbidity. (Wang et al., 2020). Further, CHBRP found literature suggesting that although these patient-level factors, such as race, insurance, and education may contribute to maternal mortality and morbidity, they do not fully explain the observed racial/ethnic differences in perinatal care and birth and maternal health outcomes (Howell, 2018). There is a growing body of evidence that associates health system quality and the impact of racism and chronic stress during pregnancy with poor health outcomes, including birth and maternal health outcomes (Howell et al., 2016; Leonard et al., 2019).

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, AB 1930 would mandate that coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill also seeks to allow unlicensed perinatal health workers (PHWs) to be reimbursed for services rendered in a nonmedical setting and change their supervision requirements. The *Medical Effectiveness* section uses the term "perinatal health worker" to describe a broad category of health care workers that deliver comprehensive perinatal services, as outlined in the "Definitions" subsection of the *Policy Context* section.

Additional information on comprehensive perinatal services is included in the *Background* section. The medical effectiveness review summarizes findings from evidence²⁶ on the effectiveness of comprehensive perinatal services for pregnant and postpartum persons.

Research Approach and Methods

As described in the *Background* section, comprehensive perinatal services in California are delivered through the Comprehensive Perinatal Services Program (CPSP), a Medi-Cal benefit for all Medi-Cal beneficiaries who become pregnant, including those covered by Medi-Cal Managed Care Plans. CPSP participants are provided multicomponent, wraparound services, including prenatal and postpartum health and parenting education, nutrition and psychosocial assessments, individual case coordination, and referral support, which supplement obstetric care they receive in an effort to improve pregnancy and postpartum outcomes. This medical effectiveness review assesses the impact of comprehensive perinatal services on birth and maternal outcomes compared with standard perinatal care alone.

Studies of comprehensive perinatal services were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: PubMed Health, the Agency for Healthcare Research and Quality (AHRQ), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network.

The search was limited to abstracts of studies published in English and from 1990 to present. Of the 747 articles found in the literature review, 62 were reviewed for potential inclusion in this report on AB 1930, and a total of 14²⁷ were included in the medical effectiveness review for this report. The other articles were eliminated because services described in the articles did not encompass multiple components of care as described by CPSP (i.e., only addressed one or two components of comprehensive perinatal services), did not span the duration of pregnancy and postpartum (e.g., services were only provided during pregnancy), were of poor quality, or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

²⁶ Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence on page 11 of the *Medical Effectiveness Analysis and Research Approach* document (posted at http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

²⁷ We identified one dose-response study that found each prenatal visit with a paraprofessional home visitor was associated with approximately 62 grams increase in birth weight and approximately 0.38 weeks (2.66 days) increase in gestational age at birth (Guo et al., 2016). We excluded this study because it did not directly answer our Key Questions.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.²⁸ Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. What is the impact of providing comprehensive perinatal services on birth and maternal outcomes?
2. What is the impact of providing comprehensive perinatal services for a period of 60 days versus 12 months post-delivery following the last day of the individual's pregnancy on birth and maternal outcomes?
3. What is the impact of providing comprehensive perinatal services recommended by a physician or other licensed practitioner and rendered by an unlicensed PHW²⁹ when delivered in a nonmedical setting on birth and maternal outcomes?

Methodological Considerations

CHBRP's literature review identified two studies that assessed the impact of CPSP on birth outcomes, but both studies were published in 1995 (Korenbroet et al., 1995; Perkocha et al., 1995). CHBRP also identified one study that assessed the impact of the Obstetrical Access Demonstration Project, the pilot project to CPSP, on birth outcomes (Lennie et al., 1987). However, this study was excluded from the *Medical Effectiveness* analysis because the pilot project only provided enhanced prenatal care (i.e., did not include postpartum care). Due to the lack of current literature on the CPSP program, CHBRP included studies of similar interventions conducted in other states in its review. To maximize generalizability of findings to AB 1930, CHBRP included studies that assessed programs that administer multiple, major components of CPSP, such as home visiting, health screenings and assessments, case management, and health education. (Table 3 in the *Background* section contains a list of all "enhanced services" provided by CPSP.) However, none of these programs encompassed all elements of the CPSP model.

In addition to physicians and other licensed practitioners, California's CPSP allows unlicensed PHWs to administer CPSP services under the supervision of a physician. If passed, AB 1930 would allow CPSP services to be delivered outside of a medical setting. The provision of services by unlicensed PHWs outside medical settings would distinguish it from other programs in California aimed at improving maternal and infant health. In light of this, CHBRP's literature review focused on studies of programs that provide home visits aimed at improving maternal and child health, such as Healthy Families America (HFA, 2022) and Healthy Start (NHSA, 2010). CHBRP's literature review identified many studies that assessed the impact of home visiting models where nurses, social workers, and/or other licensed health workers delivered care on maternal and infant health. However, CHBRP excluded these studies because AB 1930 stipulates coverage of preventive services rendered by unlicensed PHWs outside of a medical setting. Several of the studies included in CHBRP's review the home visits were delivered by nurses or social workers as well as unlicensed PHWs. Findings from these studies are discussed separately from findings from studies of interventions in which home visits were provided solely by unlicensed PHWs.

Ten of the 14 studies included in the *Medical Effectiveness* analysis have limited generalizability to CPSP. Nine studies only enrolled groups of low-income people at high risk for poor birth outcomes, and four studies only enrolled adolescents. Findings from these studies may not be generalizable to all pregnant and postpartum people enrolled in Medi-Cal who receive CPSP services. CHBRP included

²⁸ Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

these studies in its review because they provide evidence about the impact of programs like CPSP on subgroups of Medi-Cal beneficiaries who are high risk for poor birth and maternal health outcomes.

Outcomes Assessed

Studies of comprehensive perinatal services have examined a range of birth and maternal outcomes related to the prenatal and postpartum periods. Birth outcomes assessed include birth weight or low birth weight (LBW), preterm birth (PTB)/gestational age, infant mortality, and neonatal intensive care unit (NICU) admission. Maternal outcomes assessed include postpartum depression, psychosocial resources (self-esteem, social support, mastery, locus of control), breastfeeding initiation, breastfeeding duration, and breastfeeding self-efficacy and exclusivity.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the impact of comprehensive perinatal services on birth and maternal outcomes (Key Question #1), as addressed by AB 1930. Findings regarding effects on birth outcomes are summarized briefly because AB 1930 would not change Medi-Cal beneficiaries' coverage for CPSP services during the prenatal period. However, AB 1930 would allow unlicensed perinatal health workers (PHWs) to be reimbursed for services rendered in a nonmedical setting, which could affect birth outcomes. Findings regarding impact on maternal health outcomes are discussed in greater depth because AB 1930 would extend coverage for CPSP services from 60 days to 12 months post-delivery.

CHBRP did **not** identify any studies that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time (Key Question #2).

CHBRP identified some studies that compared the provision of comprehensive perinatal services in medical vs. nonmedical settings, and these studies were primarily focused on home visiting programs (Key Question #3). However, these home-visiting studies did not control for additional perinatal services that may have been received outside of the studied intervention. CHBRP did not identify any studies that compared the provision of comprehensive perinatal services in medical to nonmedical settings where the nonmedical setting was a location other than a home. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

More information is available in Appendix B.

Birth Outcomes

Nine studies assessed the impact of comprehensive perinatal services on birth outcomes, which included LBW, PTB, infant mortality, and NICU admission. Of these nine studies, one reported on the general occurrence of adverse birth outcomes (Perkocha et al., 1995), eight reported on LBW (Anthony et al., 2021; Arima et al., 2009; Cooper et al., 2013; Guo et al., 2016; Hans et al., 2018; Hillemeier et al., 2015; Korenbrot et al., 1995; Pan et al., 2020; Redding et al., 2015; Sabo et al., 2021), six reported on PTB/gestational age (Anthony et al., 2021; Arima et al., 2009; Cooper et al., 2013; Guo et al., 2016; Hans et al., 2018; Hillemeier et al., 2015; Pan et al., 2020; Sabo et al., 2021), one reported on infant mortality (Arima et al., 2009), and two reported on NICU admission (Hans et al., 2018; Pan et al., 2020). Table 5 describes the populations studied, the types of services provided, the settings in which interventions were provided, the types of personnel who delivered interventions, the duration of interventions, control/comparison groups, and outcomes assessed.

Two of the nine studies assessed the impact of CPSP on birth outcomes (Korenbrot et al., 1995; Perkocha et al., 1995). Although these studies are older (both conducted in 1995), CHBRP has included them in this analysis because they are the only studies that directly assessed the impact of CPSP.

Table 5. Summary of Studies Assessing Birth Outcomes

Study	Population Served	Services Offered to Mothers	Settings in Which Intervention Was Delivered	Who Delivered Intervention	Duration of Intervention	Control / Comparison Group	Outcomes Assessed
Studies of CPSP							
Korenbro et al. (1995)	Group 1: CPSP-eligible people in California (CPSP: n = 3,648) Group 2: Pilot Project—eligible people in California (Pilot: n = 5,336)	See <i>Background</i> section	Medical settings	See <i>Background</i> section	Pregnancy through 60 days postpartum	People receiving routine perinatal services provided by obstetric providers generally participating in Medicaid (n = 10,836)	LBW
Perkocha et al. (1995)	CPSP- and CTAPPP-eligible people in California aged 12-18 (CPSP: n = 143) (CTAPPP: n = 132)	CPSP: see <i>Background</i> section CTAPPP: specialized education curriculum; referrals to medical and social services programs; case management services; academic, health, nutrition, perinatal, and parenting education support	CPSP: Medical settings CTAPPP: School	CPSP: See <i>Background</i> section CTAPPP: Not described	CPSP: Pregnancy to 60 days postpartum CTAPPP: Not described	CPSP- and CTAPPP-eligible people in California who delivered singleton births and did not receive either of these services (CPSP: n = 70) (CTAPPP: n = 124)	Composite measure of adverse perinatal outcomes

Studies of interventions delivered solely by unlicensed PHWs

Anthony et al. (2021)	(Predominantly) Black pregnant people of all ages with low-income who gave singleton births in Cleveland, Ohio (n = 4,065)	Case management; Education on prenatal care, substance use, breastfeeding, family planning, and safe sleep; screening and assessment; referrals to community agencies	Home and other community-based settings	Community health workers	<33 weeks gestation up to 2 years postpartum	All people who gave singleton births between 2008 and 2012 in Cleveland, Ohio, who did not receive MomsFirst services (n = 22,749)	LBW; PTB
Hans et al. (2018)	High-poverty Black, Latino, and mixed-ethnic people aged 14-26 years in Illinois (two in a large city, two in smaller urban areas) (n = 156)	Doulas: pregnancy health education, childbirth preparation, and breastfeeding Home visitors (a): child development education and basic needs screening	Home	Doulas (primary provider during pregnancy and first weeks postpartum) Home visitors (primary provider by 6 weeks postpartum)	<34 weeks gestation up to 3 months postpartum	People meeting the same eligibility requirements for Healthy Families America or Parents as Teachers who receive case management (2 visits total – one prenatal and one postpartum) instead of doula-home-visiting services (n = 156)	LBW; PTB; NICU admission
Redding et al. (2015)	Pregnant people of all ages at risk of poor birth outcomes in Richland County, Ohio (n = 115)	Intensive home visiting and community-based care coordination	Home	Community health workers	Pregnancy to an unspecified length of time postpartum	People who gave singleton births between 2001-2004 in Richland County, Ohio, who did not receive Community Health Access Project services (n = 115)	LBW

Sabo et al. (2021)	Medically and socially high risk, racially and ethnically diverse, rural and urban pregnant people of all ages in Arizona (n = 7,212)	Providing perinatal and postpartum, nutrition, and breastfeeding education; providing referral and advocacy services; assisting with access and enrollment of perinatal care; screening for maternal behavioral health disorders	Home	Community health workers	Pregnancy to 2 years postpartum	People who were similar to Health Start Programme participants who did not receive services (n = 53,948)	LBW; VLBW; ELBW; PTB
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Studies of interventions delivered by a combination of unlicensed PHWs and licensed professionals

Arima et al. (2009)	Low-income pregnant people of all ages in Washington State (n = 19,668)	Maternity support services (pregnancy and parenting information, screening for possible pregnancy risk factors, brief counseling for identified risk factors, referral to community resources); infant case management; childbirth education; outreach; transportation; interpreter services ^(b)	Clinic or office; home setting; community setting	Nurses; dietitians; behavioral health specialists; community health workers (some locations)	As early as people discover they are pregnant to 1 year postpartum	People who indicated Medicaid as their primary payer for prenatal services and gave singleton births between 1999-2002 in Washington State who did not receive First Steps services (n = 56,728)	LBW; SGA; PTB; infant mortality
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Cooper et al. (2013)	Medicaid-eligible Black people of all ages in their first trimester of pregnancy who lived in one of three high-risk zip codes in St. Louis, Missouri (n = 84)	Intensive case management and home visitation, including risk assessment, depression screening, health education, and outreach ^(c)	Home	Nurses; community outreach mothers	First trimester of pregnancy up to 2 years postpartum ^(b)	People similar to those who received St. Louis Healthy Start Program services who did not receive program services (n = 168)	LBW; PTB
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Pan et al. (2020)	Pregnant people of all ages in Rochester, New York (which has a high poverty rate) (n = 353)	Linking participants with health and community support services; educating participants on perinatal- and parenting-related topics; providing support and advocacy for participants	Home	Community health workers; social workers	Pregnancy up to 1 year postpartum	People who were eligible for and referred to the Baby Love program but were not successfully enrolled because of inability to contact them (n = 102)	LBW; PTB; NICU admission
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Source: California Health Benefits Review Program, 2022.

Note: (a) In the study, home visitors were also called a Family Support Worker or Parent Educator and focused on the mother–infant relationship, child development, child safety, and educational-work planning, as well as screening to make sure that family basic needs were being met.

(b) Information obtained from <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/first-steps-maternity-and-infant-care>.

(c) Information obtained from https://www.nationalhealthystart.org/wp-content/uploads/2021/04/NHSA_WhitePaper.pdf.

Key: CPSP = Comprehensive Perinatal Services Program; CTAPPP = Comprehensive Teenage Pregnancy and Parenting Program. ELBW = extremely low birth weight. LBW = low birth weight; NICU = newborn intensive care unit; PTB = preterm birth; SGA = small for gestational age; VLBW = very low birth weight.

Composite measure of adverse perinatal outcomes

One observational study assessed the impact of participation in CPSP and a school-based program called the Comprehensive Teenage Pregnancy and Parenting Program (CTAPPP) (n = 469) on adverse perinatal outcomes, which were defined as the occurrence of one of the following: LBW (<2,500 grams), PTB (gestational age <37 weeks), or NICU admission (not related to congenital syphilis). Details about CPSP can be found in the *Background* section. Based on findings from this one study, there is insufficient evidence that comprehensive perinatal services are associated with reduced risk of perinatal outcomes among adolescents. More details about this study can be found in Table 5 (Perkocha et al., 1995).

Figure 1. Impact of Comprehensive Perinatal Services on Adverse Perinatal Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing

Low birth weight (LBW)

Nine studies reported on LBW, one of which also reported on very low birth weight (VLBW) and extremely low birth weight (ELBW). All studies defined LBW as <2,500 grams with the exception of three studies (Hans et al., 2018; Pan et al., 2020; Redding et al., 2015), which did not provide definitions of LBW. One study reported on small for gestational age (SGA), which was defined as <10th percentile birth weight for Washington State-born infants of the same gestational age and sex (Arima et al., 2009).

Study of CPSP

One study compared effects on birth outcomes for state-wide implementation of CPSP (program details can be found in the *Background* section) to outcomes of CPSP's pilot project (Obstetrical Access Demonstration Project) and services provided by non-CPSP and non-pilot project-participating Medicaid providers (n = 19,820). The major components of the pilot project, which operated in 13 California counties from the summer of 1979 to 1982 (Lennie et al., 1987), were similar to CPSP, but the two programs had several differences. More details about this study can be found in Table 5. Based on findings from this one study, there is insufficient evidence that enrollment in CPSP or the pilot project is associated with reduced risk of LBW (Korenbrod et al., 1995).

Figure 2. Impact of CPSP and Pilot Project on LBW

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing

Studies of interventions delivered solely by unlicensed perinatal health workers

Four studies conducted in other states examined whether comprehensive perinatal services provided via a home visiting intervention that utilized either community health workers (CHWs) or doulas directly affected birth outcomes (Anthony et al., 2021; Hans et al., 2018; Redding et al., 2015; Sabo et al., 2021). Anthony et al. (2021) conducted a retrospective study, utilizing a propensity score technique, to assess the impact of a CHW home visiting program (MomsFirst) on birth outcomes of people in Cleveland, Ohio (n = 26,814). Redding et al. (2015) conducted an evaluation of an intensive CHW-based home visiting program (Community Health Access Project) on birth outcomes of pregnant people in Richland County,

Ohio (n = 230). Sabo et al. (2021) conducted a quasiexperimental retrospective study utilized propensity score matching to assess the impact of a CHW-based home visiting program (Health Start Programme) on birth outcomes among pregnant people in Arizona (n = 61,160). Hans et al. (2018) conducted a randomized controlled trial (RCT) assessed the impact of doula home visiting programs (Healthy Families America, Parents as Teachers) on birth outcomes of pregnant people (n = 312). More details about these studies can be found in Table 5. Two studies (Anthony et al., 2021; Redding et al., 2015) found that home visiting provided by CHWs and doulas was associated with lower odds of delivering a LBW baby among all enrollees. Sabo et al., (2021) found a reduced risk of LBW among American Indian participants. One study found no statistically significant difference between intervention and comparison groups (Hans et al., 2018). Based on the findings of these four studies, there is limited evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of LBW.

Figure 3. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on LBW



Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

Three studies conducted in other states examined whether comprehensive perinatal services provided via an intervention that utilized a combination of CHWs and licensed health workers, such as nurses and social workers directly affected birth outcomes (Arima et al., 2009; Cooper et al., 2013; Pan et al., 2020). Pan et al. (2020) conducted an evaluation of a CHW- and social worker-based home visiting program (Baby Love) to assess the impact of the program on birth outcomes of pregnant people in Rochester, New York (n = 455). Cooper et al. (2013) utilized a retrospective, case-control design and a propensity score technique to assess the impact of an intensive case management program (St. Louis Health Start Program) on birth outcomes of pregnant people (n = 252). Arima et al. (2009) conducted a retrospective, population-based cohort study to assess the impact of a comprehensive perinatal services program (First Steps) on birth outcomes of low-income pregnant people in Washington State (n = 76,396). More details about these studies can be found in Table 5. All three of these studies concluded that the intervention was associated with lower odds of delivering a LBW baby. Based on findings from these three studies, there is a preponderance of evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of LBW.

Figure 4. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on LBW



Very Low Birth Weight (VLBW)

One study assessed the impact of a CHW-based home visiting program on VLBW, which was defined as <1,500 grams. More details about this study can be found in Table 5. This study found no statistically significant difference when comparing all participants to non-participants, but found that among Latinas, participation was associated with a lower VLBW rate, and that the difference was statistically significant.

Based on the findings from this one study, there is insufficient evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of VLBW (Sabo et al., 2021).

Figure 5. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on VLBW

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Extremely low birth weight (ELBW)

One study assessed the impact of a CHW-based home visiting program on ELBW, which was defined as <1,000 grams. More details about this study can be found in Table 5. This study found no statistically significant difference when comparing all participants to nonparticipants, but found that among Latinas, participation was associated with a lower ELBW rate and that the difference was statistically significant. Based on the findings from this one study, there is insufficient evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of ELBW. (Sabo et al., 2021).

Figure 6. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on ELBW

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Small for gestational age (SGA)

Arima et al. (2009) examined the First Steps program. More details about this study can be found in Table 5. The authors found that participating in the program did not have a statistically significant effect on risk of SGA. Based on the findings from this one study, there is insufficient evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of SGA.

Figure 7. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on SGA

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Preterm birth (PTB)

Six studies reported on preterm birth (prematurity). All studies defined PTB as <37 weeks gestation with the exception of two studies (Hans et al., 2018; Pan et al., 2020), which did not provide definitions of PTB.

Studies of home visiting interventions delivered solely by unlicensed perinatal health workers

Three studies conducted in other states examined comprehensive perinatal services provided via a home visiting intervention that utilized either community health workers (CHWs) or doulas (Anthony et al. (2021; Sabo et al., 2021; Hans et al., 2018). One study (Anthony et al., 2021) found that participation in the program was associated with lower odds of delivering a premature baby, but another study (Hans et al., 2018) found that participation had no statistically significant effect on odds of premature birth. A third study found that participation reduced the rate of preterm birth among teenage mothers, but not among other participants (Sabo et al., 2021). Based on findings from these three studies, there is inconclusive evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of PTB.

Figure 8. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on PTB

*Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals*

Three studies examined comprehensive perinatal services provided via an intervention that utilized a combination of CHWs and licensed health workers, such as nurses and social workers (Arima et al., 2009; Cooper et al., 2013; Pan et al., 2020). Two of these three studies found that comprehensive perinatal services were associated with reduced odds of delivering a premature baby across all persons enrolled in the program (Cooper et al., 2013; Pan et al., 2020). One study found that participation was associated with a reduced risk of preterm birth among Latina participants but not among other participants (Arima et al., 2009). Based on findings from these three studies, there is limited evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of PTB.

Figure 9. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on PTB.

*Infant mortality*

One study reported on infant mortality and concluded that participation did not reduce odds of infant death within one year of birth (Arima et al., 2009). This study examined the First Steps program. More details about this study can be found in Table 5. Based on the findings from this one study, there is insufficient evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of infant mortality.

Figure 10. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on Infant Mortality

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

NICU admission

Two studies reported on NICU admission. Hans et al. (2018) examined the Healthy Families America and Parents as Teachers programs, where comprehensive perinatal services were delivered solely by doulas and home visitors, and found no statistically significant difference in odds of NICU admission between the intervention and comparison groups. Pan et al. (2020) examined the Baby Love program, where comprehensive perinatal services were delivered by CHWs and social workers and found that babies born to participants were less likely to be admitted to a NICU. More details about these studies can be found in Table 5. Based on the findings from these two studies, there is insufficient evidence that comprehensive perinatal services is associated with reduced risk of NICU admission.(Hans et al., 2018).

Figure 11. Impact of Comprehensive Perinatal Services on NICU Admission

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Maternal Outcomes

Six studies assessed the impact of comprehensive perinatal services on maternal outcomes, which included postpartum depression, psychosocial resources, breastfeeding initiation, breastfeeding duration, and breastfeeding self-efficacy and exclusivity. Of these six studies, all six reported on postpartum depression (Barlow et al. , 2006, 2015; Barnett et al., 2007; Hans et al., 2018; Lutenbacher et al., 2018; Roman et al., 2009), two reported on psychosocial resources (Barlow et al., 2006; Roman et al., 2009), two reported on breastfeeding initiation (Hans et al., 2018; Lutenbacher et al., 2018), two reported on breastfeeding duration (Hans et al., 2018; Lutenbacher et al., 2018), and one reported on breastfeeding self-efficacy and exclusivity (Lutenbacher et al., 2018). Table 6 describes the populations studied, the types of services provided, the settings in which interventions were provided, the types of personnel who delivered interventions, the duration of interventions, control/comparison groups, and outcomes assessed. The only pertinent studies CHBRP identified are RCTs.

Table 6. Summary of Studies Assessing Maternal Outcomes.

Study	Population Served	Services Offered to Mothers	Settings in Which Intervention Was Delivered	Who Delivered Intervention	Duration of Intervention	Control/Comparison Group	Maternal Outcomes Assessed
Studies of interventions delivered solely by unlicensed PHWs							
Barlow et al. (2006)	American Indian adolescents aged 12-19 years from Apache and Navajo communities in New Mexico and Arizona (n = 28)	25 home visits and 41 discrete lessons covering prenatal care, labor, delivery, breastfeeding, nutrition, parenting, home safety, immunizations, well-baby care, family planning, sexually transmitted disease prevention, and maternal goal setting for personal and family development	Home	Paraprofessionals	28 weeks gestation to 6 months postpartum	Adolescents meeting the same eligibility requirements received 23 home visits covering 20 breastfeeding lessons (n = 25)	Postpartum depression, psychosocial resources
Barlow et al. (2015)	American Indian adolescents aged 12-19 years from Apache and Navajo communities in New Mexico and Arizona (n = 159)	43 structured lessons following a culturally congruent format on positive parenting, maternal behavior, and maternal mental health problems	Home	Family health educators	32 weeks gestation to 36 months postpartum	Adolescents meeting the same eligibility requirements received transportation to recommended prenatal and well-baby clinic visits, pamphlets about child care and community resources, and referrals to local services delivered by family health liaisons (n = 163)	Postpartum depression

Barnet et al. (2007)	Low-income, Black adolescents aged 12-18 years from Baltimore, Maryland (n = 44)	Primary care coordination; assessment of depression; education on parenting, child development, safe sexual practices, prevention of repeat pregnancy	Home and other community-based settings	Community health workers	Third trimester of pregnancy to 24 months postpartum	Adolescents meeting the same eligibility requirements received usual care* (n = 40)	Postpartum depression
Hans et al. (2018)	High-poverty Black, Latino, and mixed-ethnic people aged 14-26 years in Illinois (two in a large city, two in smaller urban areas) (n = 156)	Doulas: pregnancy health education, childbirth preparation, and breastfeeding Home visitors: child development education and basic needs screening	Home	Doulas (primary provider during pregnancy and first weeks postpartum) Home visitors (primary provider by 6 weeks postpartum)	<34 weeks gestation to 3 months postpartum	People meeting the same eligibility requirements for Healthy Families America or Parents as Teachers who receive case management (two visits total – one prenatal and one postpartum) instead of doula-home-visiting services (n = 156)	Postpartum depression, breastfeeding initiation, breastfeeding duration, breastfeeding self-efficacy and exclusivity
Lutenbacher et al. (2018)	Low-income, Hispanic people aged 18 years and above from large metropolitan area in Tennessee (n = 91)	Listening to maternal concerns; education about objectives relevant to the woman's stage of pregnancy or the age of the child, such as healthy eating, developmental milestones, attachment, and breastfeeding; and care coordination between medical and social services	Home	Peer mentors (Women recruited from the community of the same race, culture, and language)	<26 weeks gestation to 6 months postpartum	People meeting the same eligibility requirements for the Maternal Infant Health Outreach Worker (MIHOW) program received printed educational materials instead of peer mentor home-visiting services (n = 87)	Postpartum depression, breastfeeding initiation, breastfeeding duration

Studies of interventions delivered by a combination of unlicensed PHWs plus licensed professionals

Roman et al. (2009)	Medicaid-eligible, low-income people above the age of 16 years from Kent County, MI (n = 266)	Nurses and CHWs: care coordination, case management, risk assessment, nutritional counseling, health education, home visiting, and health and mental health assessment; CHWs: relationship-based support delivered by community health workers	Home	Nurses and CHWs	24 weeks gestation to 12 months postpartum	People eligible for Medicaid received enhanced prenatal and postnatal services delivered by nurses, including care coordination, case management, risk assessment, nutritional counseling, health education, and home visiting (n = 264)	Postpartum depression, psychosocial resources
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Source: California Health Benefits Review Program, 2022.

* Barnett et al. (2007) did not define the services that control group participants under usual care.

Key: CHW = community health worker; PHW = perinatal health worker.

Postpartum depression

Postpartum depression is depression that occurs within the first year after giving birth. Feelings of postpartum depression are more intense and last longer than those of “baby blues,” a term used to describe the worry, sadness, and tiredness many people experience after having a baby (CDC, 2020).

CHBRP identified six RCTs that evaluated the impact of comprehensive perinatal services on postpartum depression among individuals who have given birth; all six studies were conducted among low-income people, and two were conducted in American Indian reservation communities (see Table 6 for more details on each study). Five RCTs compared home visiting interventions delivered by unlicensed PHWs with usual or standard care, and one RCT compared a home visiting intervention that was delivered by a combination of unlicensed PHWs and licensed professionals with an intervention delivered solely by licensed professionals.

Studies of interventions delivered solely by unlicensed perinatal health workers

Two of the five RCTs that compared home visiting interventions delivered by unlicensed PHWs with usual or standard care enrolled adults as well as adolescents. The first RCT (Hans et al., 2018) assessed the impact of doula home visiting programs (Healthy Families America, Parents as Teachers) on postpartum depression of people in four high-poverty communities in Illinois (n = 312). Pregnant people in the intervention group received home visits from doulas during the last half of pregnancy and for 6 weeks postpartum in addition to labor support in the hospital. Participants in the intervention were equally as likely as participants in the control group to report a high burden of depressive symptoms at the 3-week and 3-month follow-up assessments. A second RCT (Lutenbacher et al., 2018) assessed the impact of the Maternal Infant Health Outreach Worker Program, a peer mentor home visiting program, on postpartum depressive symptoms of underserved Latino people in living in a large city in Tennessee (n = 178). Participants were randomized to receive home visits from peer mentors from the third trimester of pregnancy to 6 months postpartum. The peer mentors, who were recruited from the community of the same race, culture, and language, provided health education, social support, and linkage to community resources. Compared to the control group, who only received printed educational materials, those who received home visits reported fewer depressive symptoms at the 2-week and 2-month assessment, but not at the 6-month assessment.

Three of the five RCTs that compared a home visiting intervention delivered by unlicensed PHWs with usual or standard care enrolled only adolescents (aged 12 to 19 years at conception). The generalizability of these studies to all pregnant and postpartum persons enrolled in Medi-Cal is limited. In Barlow et al. (2006), pregnant adolescents between the ages of 12 and 19 years from American Indian reservation communities in New Mexico and Arizona (n = 53) were randomized to receive home visits from paraprofessionals during the third trimester of pregnancy and for 6 months postpartum during which the paraprofessionals provided education about a wide range of perinatal care topics. Those in the control group also received home visits from paraprofessionals but the content of the visit was limited to breastfeeding. Adolescents in the intervention displayed a nonsignificant reduction in depression symptoms compared to adolescents in the control at both 2 months and 6 months postpartum. In Barlow et al. (2015), pregnant adolescents between the ages of 12 and 19 years from American Indian reservation communities in New Mexico and Arizona (n = 322) were randomized to receive home visits from family health educators during the third trimester of pregnancy and for 3 years postpartum. Relative to those in the control group, adolescents receiving the home visits had fewer depressive symptoms at the end of the 3-year intervention. The data were averaged across all time points, so it was not possible to disaggregate the impact of the intervention over time. In Barnett et al. (2007), pregnant Black adolescents between the ages of 12 and 18 years from Baltimore, Maryland (n = 84) received home visits from community health workers during the third trimester and for 2 years postpartum. The program displayed no impact on the mothers’ depressive symptoms at the 1-year and 2-year follow-up assessments.

Studies of interventions delivered by a combination of licensed professionals and unlicensed perinatal health workers

One RCT compared an intervention that combined paraprofessionals and nurses to an intervention delivered by nurses alone. In Roman et al. (2009), Medicaid-eligible, low-income pregnant people above the age of 16 years in Kent County, Michigan were randomized into two groups (n = 613). Among all studies that reported maternal outcomes, this study's population is most generalizable to the population whose coverage would be affected by AB 1930. Participants in the first intervention group received home visits from a nurse and CHW team during the last trimester pregnancy and for 1 year postpartum. Nurses were present at two initial prenatal visits, a post-delivery visit, and two additional visits during the postpartum year to provide crisis intervention, case management, and manage health problems. CHWs provided additional relationship-based support that targeted stressors and maternal mental health. Participants in the control group received home visits through a Medicaid enhanced prenatal and postpartum services program, which included care coordination, case management, risk assessment, nutritional counseling, and health education delivered by a professional nurse. Individuals in the control group did not have access to a CHW and services did not target stressors and maternal mental health. Compared to the group who did not receive relationship-based support from CHWs, those who did displayed significantly fewer depressive symptoms, and reductions in depressive symptoms were most pronounced for women with low psychosocial resources, high stress, or both high stress and low resources.

Summary of findings regarding the impact of comprehensive perinatal services delivered solely by unlicensed PHWs on postpartum depression: There is inconclusive evidence from five RCTs that comprehensive perinatal services delivered solely by unlicensed PHWs is effective in decreasing the occurrence of postpartum depression or depressive symptoms after childbirth. Of these five studies, two studies with home visiting interventions demonstrated a decrease in postpartum depression or depressive symptoms after childbirth. Three studies demonstrated no significant effect. Findings from three of the trials may be limited in their generalizability to CPSP because they enrolled adolescent participants.

Figure 12. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on Postpartum Depression



Summary of findings regarding the impact of comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs on postpartum depression: There is insufficient evidence from 1 RCT that comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed perinatal health workers is effective in decreasing the occurrence of postpartum depression or depressive symptoms after childbirth. In the study, people who received a home visiting intervention delivered by both licensed and unlicensed professionals displayed decreased depressive symptoms compared with people who received the intervention delivered solely by licensed professionals.

Figure 13. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on Postpartum Depression



Psychosocial resources

Psychosocial resources are the skills, beliefs, talents, and individual personality factors that influence how people manage stressful events. They include self-esteem, optimism, a sense of mastery, active coping skills, and social support (Taylor and Seeman, 1999). Pregnancy, childbirth, and new parenthood are large stressors, helping to explain why people may be especially vulnerable to depression at this life stage. Psychosocial resources may ameliorate postpartum depression.

Two RCTs evaluated the impact of comprehensive perinatal services on improvement of psychosocial resources (see Table 6 for more details). One RCT compared a home visiting intervention delivered by unlicensed PHWs with usual or standard care, and one RCT compared a home visiting intervention delivered by a combination of licensed professionals and unlicensed PHWs with an intervention delivered solely by licensed professionals.

Studies of interventions delivered solely by unlicensed perinatal health workers

In Barlow et al. (2006), pregnant adolescents in the intervention group received home visits from paraprofessionals during the third trimester of pregnancy and for 6 months postpartum. Results from the study found significant improvement of self-esteem, but no significant changes for social support or locus of control.

Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

In Roman et al. (2009), participants in the intervention group received home visits from a nurse and community health worker team during the last trimester of pregnancy and for 1 year postpartum with a focus on relationship-based support from community health workers. Individuals in the control group received home visits from a nurse and services did not focus on relationship-based support. Compared to the control group, those in the intervention group displayed some significant improvement of psychosocial resources, including less perceived stress, and greater mastery. However, no differences between the groups were found for self-esteem and social support.

Summary of findings regarding the impact of comprehensive perinatal services delivered solely by unlicensed PHWs on psychosocial resources: There is insufficient evidence from 1 RCT that comprehensive perinatal services is effective in improving psychosocial resources. One RCT found significant improvement of self-esteem but no significant changes for social support or locus of control.

Figure 14. Impact of Interventions Delivered Solely by Unlicensed Perinatal Health Workers on Psychosocial Resources

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Summary of findings regarding the impact of comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs on psychosocial resources: There is insufficient evidence from one RCT that comprehensive perinatal services is effective in improving psychosocial resources. One RCT found significant improvement in perceived stress and mastery but not significant changes for self-esteem and social support.

Figure 15. Impact of Interventions Delivered by a Combination of Unlicensed Perinatal Health Workers and Licensed Professionals on Psychosocial Resources

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE	
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing	

Breastfeeding initiation

Breastfeeding is associated with a range of positive infant and maternal outcomes. The American Academy of Pediatrics recommends that children be breastfed during the first year of life (American Academy of Pediatrics, 2012). Breastfeeding initiation is an important measure of potential future breastfeeding and typically occurs in hospital settings shortly after birth.

Two RCTs assessed differences in breastfeeding initiation between persons who received home visits and persons who received standard care (see Table 6 for more details). In Hans et al. (2018), pregnant and postpartum people who received home visits from doulas were significantly more likely to initiate breastfeeding. However, Lutenbacher et al. (2018) did not find a significant difference in breastfeeding initiation between people who received prenatal and postpartum home visiting versus women who received standard care.

Summary of findings regarding the impact of comprehensive perinatal services on breastfeeding initiation: There is inconclusive evidence from two RCTs that comprehensive perinatal services delivered by unlicensed PHWs affect breastfeeding initiation. One RCT found significant improvement in breastfeeding initiation and 1 RCT did not find a significant difference in breastfeeding initiation.

Figure 16. Impact of Comprehensive Perinatal Services on Breastfeeding Initiation

NOT EFFECTIVE				EFFECTIVE		
Clear and Convincing	Preponderance	Limited	INCONCLUSIVE	Limited	Preponderance	Clear and Convincing

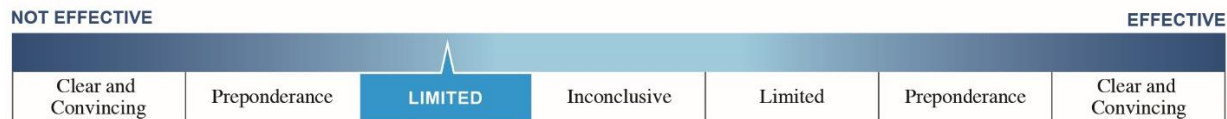
Breastfeeding duration

Not all individuals who initiate breastfeeding after birth will continue to breastfeed throughout the first year of the infant's life as recommended by the American Academy of Pediatrics. Although there are many reasons why some individuals cannot breastfeed, studies indicate that disparities in breastfeeding duration may be attributable to differences in health care access and education and social supports such as maternity leave, working conditions, and influence of family members (Jones et al., 2015; Lind et al., 2014).

CHBRP identified 2 RCTs which reported breastfeeding outcomes at three months postpartum or longer (see Table 6 for more details). In their study of home visiting by doulas, Hans et al. (2018) observed no differences in duration of breastfeeding among patients who started breastfeeding at the 3-month follow-up between individuals who received prenatal and postpartum home visits from a doula versus individuals who received standard care. In their study of home visiting by peer mentors, Lutenbacher et al. (2018) observed that people who received home visiting showed no difference in duration of breastfeeding at 6 months postpartum when compared with the control group.

Summary of findings regarding the impact of comprehensive perinatal services on breastfeeding duration: There is limited evidence from 2 RCTs that comprehensive perinatal services provided by unlicensed PHWs do not affect breastfeeding duration. Both RCTs observed no significant differences in the duration of breastfeeding between participants who received home visiting by paraprofessionals and participants who received standard care.

Figure 17. Impact of Comprehensive Perinatal Services on Breastfeeding Duration



Breastfeeding exclusivity and self-efficacy

Breastfeeding self-efficacy is defined as a mother's confidence in her ability to breastfeed her new infant and has been positively associated with breastfeeding duration and exclusivity in various cultures and age groups (Dennis, 1999). Maternal breastfeeding self-efficacy has been identified as an important psychometric factor for improving breastfeeding outcomes.

CHBRP identified 1 RCT that reported outcomes of breastfeeding exclusivity and self-efficacy. Lutenbacher et al. (2018) reported that people who received home visits from peer mentors breastfed exclusively at a higher rate and for a longer duration of time compared with the control group, who received no home visiting. The difference of the duration of exclusive breastfeeding between those who received home visiting and those who did not was a median 1.4 weeks, with 25 percent of the home-visited group exclusively breastfeeding for at least 6 weeks. Also, breastfeeding self-efficacy was higher in the intervention group at all postpartum time points – 2 weeks postpartum, 2 months postpartum, and 6 months postpartum.

Summary of findings regarding the impact of comprehensive perinatal services on breastfeeding exclusivity and self-efficacy: There is insufficient evidence from 1 RCT that comprehensive perinatal services provided by unlicensed PHWs impact breastfeeding exclusivity and self-efficacy.

Figure 18. Impact of Comprehensive Perinatal Services on Breastfeeding Exclusivity and Self-Efficacy



Summary of Findings

The *Medical Effectiveness* review examined 14 articles that assessed the impact of comprehensive perinatal services programs on birth and maternal outcomes. Eleven of these 14 studies examined the impact of comprehensive perinatal services that were provided for more than 60 days postpartum. Findings from 10 studies may not be fully generalizable to CPSP because they only enrolled low-income people or adolescents at high risk for poor birth outcomes. CHBRP did **not** find any studies that addressed Key Question #2: What is the impact of providing comprehensive perinatal services for a period of 60 days versus 12 months post-delivery following the last day of the individual's pregnancy on birth and maternal outcomes?

The *Medical Effectiveness* review reached the following conclusions regarding the impact of comprehensive perinatal services on birth outcomes:

Birth Outcomes

Low birth weight (LBW)

Study of CPSP

- There is insufficient evidence that enrollment in CPSP or the pilot project is associated with reduced risk of LBW.

Studies of interventions delivered solely by unlicensed perinatal health workers

- There is limited evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of LBW.
- There is insufficient evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of VLBW or ELBW.

Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

- There is a preponderance of evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of LBW.
- There is insufficient evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of SGA.

Preterm birth (PTB)

Studies of interventions delivered solely by unlicensed perinatal health workers

- There is inconclusive evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is associated with reduced risk of PTB.

Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

- There is limited evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of PTB.

Infant mortality

- There is insufficient evidence that comprehensive perinatal services delivered by a combination of unlicensed PHWs and licensed professionals is associated with reduced risk of infant mortality.

NICU admission

- There is insufficient evidence that comprehensive perinatal services are associated with reduced risk of NICU admission.

The *Medical Effectiveness* review reached the following conclusions regarding the impact of comprehensive perinatal services on maternal outcomes:

Maternal Outcomes

Postpartum depression

Studies of interventions delivered solely by unlicensed perinatal health workers

- There is inconclusive evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is effective in decreasing the occurrence of postpartum depression or depressive symptoms after childbirth.

Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

- There is insufficient evidence that comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs is effective in decreasing the occurrence of postpartum depression or depressive symptoms after childbirth.

Psychosocial resources

Studies of interventions delivered solely by unlicensed perinatal health workers

- There is insufficient evidence that comprehensive perinatal services delivered solely by unlicensed PHWs is effective in improving psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

Studies of interventions delivered by a combination of unlicensed perinatal health workers and licensed professionals

- There is insufficient evidence that comprehensive perinatal services delivered by a combination of licensed professionals and unlicensed PHWs is effective in improving psychosocial resources, including self-esteem, social support, mastery, locus of control, and perceived stress.

Breastfeeding initiation

- There is inconclusive evidence that comprehensive perinatal services is effective in increasing breastfeeding initiation.

Breastfeeding duration

- There is limited evidence that comprehensive perinatal services is not effective in increasing breastfeeding duration.

Breastfeeding exclusivity and self-efficacy

- There is insufficient evidence that comprehensive perinatal services is effective in increasing breastfeeding exclusivity and self-efficacy.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1930 requires coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries to be extended from 60 days to 12 months following the last day of a person's pregnancy. The bill also seeks to allow unlicensed PHWs to be reimbursed for services rendered in a nonmedical setting and change their supervision requirements.

This section reports the potential incremental impacts of AB 1930 on estimated baseline benefit coverage, utilization, and overall cost related to Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans. A large majority of Medi-Cal beneficiaries in California are enrolled in managed care plans. A brief discussion of impacts related to beneficiaries enrolled in COHS managed care or FFS is included in the discussion of expenditures.

Key Assumptions and Analytic Approach

In order to estimate postmandate utilization, CHBRP examined the provisions of the bill separately. First, CHBRP estimated the effect of expanding coverage from 0 to 60 days postpartum to 0 days to 12 months postpartum. Second, CHBRP estimated the effects of allowing unlicensed perinatal health workers (PHWs) to provide CPSP services outside of a medical setting and changes in their supervisory requirements. The analytic approach for each is detailed below. For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Assumptions Regarding Expanded Coverage in the Postpartum Period

In the absence of evidence of uptake from similar mandates or programs in California or otherwise, CHBRP assumed that utilization in the 60 days to 12-month postpartum period would increase by 5% of the current 0 to 60 days postpartum period. CHBRP made this assumption based on the following literature on current utilization of, and demand for, postpartum visits:

- There is substantial evidence finding that postpartum care is underutilized (Henderson et al., 2016), particularly in the Medi-Cal population, due to a large number of barriers. A 2016 population-based survey conducted in English and Spanish among 2,539 women who gave birth in California found that approximately 12% of women with Medi-Cal had no postpartum visit, 43% had one postpartum visit, 25% had two postpartum visits, and 20% had three or more (Sakala et al., 2018).
- There are several barriers to postpartum utilization at both the system and patient levels:
 - At the health care system level, barriers to postpartum utilization include lack of provider continuity over the course of prenatal care, discontinuity with delivery and postpartum care providers, insufficient patient information on coverage and duration of postpartum services and programs, inadequate referrals, inadequate community-based services to meet population needs, lack of transportation and child care, out-of-date patient contact information for patient visit scheduling and reminders, lack of effective processes for ensuring postpartum visits are scheduled, and lack of incentives for payers, providers, and people who have recently given birth to prioritize postpartum visits (de Bocanegra et al., 2017; DiBari et al., 2014; Henderson et al., 2016; Rodin et al., 2019; Wilcox et al., 2016).
 - Patient-level barriers include feeling overwhelmed with childcare responsibilities; lack of time for caring for self; fears of receiving bad news at follow-up appointments; perceived discrimination during the childbirth hospitalization based on race, ethnicity, cultural background or language; and dissatisfaction with care (Bennett et al., 2011; Wouk et al., 2020). Sakala et al. (2018) found that among women who did not have a postpartum visit, 36% noted that they felt they didn't need more care, 16% reported lack of time as a barrier, 11% reported not feeling well or didn't want to go, 8% reported lack of insurance coverage, and 7% reported transportation issues. DiBari et al. (2014) found similar

findings. Barriers such as lack of transportation and childcare may be alleviated with the increased availability of telehealth in the future.

- As noted in the *Medical Effectiveness* section, AB 1930 may address some of these barriers through the use of unlicensed PHWs rendering services in the nonmedical setting, but barriers to the use of PHWs also exist and are listed in the “Assumptions Regarding Use of Services Rendered by Unlicensed Perinatal Health Workers” section.
- A thorough review of the literature found that research on preferences for postpartum care, and specifically CPSP-like services, is extremely limited. A 2020 study which surveyed 300 women found that most women prefer two to three visits postpartum, and preferred for these visits to occur during the 0 to 2-month period (Peahl et al., 2020). The study focused on people who had been admitted for birth and recovery at an academic institution; most were White and had private insurance. While the respondents of the study are different from the population accessing CPSP services, this is one of the few studies specifically surveying preferences for postpartum care. The study focused on preferences for obstetrical care and not CPSP-like assessments and services; however, CHBRP assumed that preferences for CPSP services would be similar to those for obstetrical care, as many CPSP services are currently delivered alongside obstetrical care visits.
- CHBRP assumed that the provision to extend CPSP services from 60 days to 12 months postpartum would only lead to increased utilization from existing users of the CPSP program and would not lead to an increase of additional Medi-Cal beneficiaries using CPSP services. CHBRP made this assumption based on literature that finds that the strongest indicator of whether people who have given birth will utilize postpartum care is use of prenatal care (Kogan, 1990; Wouk 2020).

CHBRP assumed that the number of CPSP services provided from 60 days to 12 months postpartum would be proportional to those currently provided in the 0 to 60 days period.

Assumptions Regarding Use of Services Rendered by Unlicensed Perinatal Health Workers

At baseline, unlicensed PHWs can provide preventive services if supervised by a licensed provider and if provided in a medical site. Postmandate, unlicensed PHWs would be allowed to provide services in a setting away from a medical site and would be allowed to be supervised by a CBO, as long as a Medi-Cal provider was available for billing. CHBRP assumed that these two provisions in AB 1930 would lead to a 0.50% increase in the use of CPSP services throughout the entire perinatal period due to the allowance of unlicensed PHWs to render preventive services in nonmedical settings and changes in supervisory requirements. CHBRP made this assumption based on data on utilization in the Oregon Health Plan doula program (Bluth, 2022; Oregon Health Authority, 2018). Traditional health workers participating in the Oregon Health Plan doula program provide “nonmedical physical and behavioral health services that promote better outcomes and greater equity,” can provide services in the home, and do not have to be supervised by a physician (Oregon Health Authority, 2018). The Oregon doula program includes a package of services including two maternity support visits prior to delivery and two maternity support visits after delivery, in addition to doula support provided on the day of delivery. CHBRP assumed that utilization in the Oregon doula program would be similar to services provided before and after delivery by unlicensed PHWs participating in the CPSP program providing services in a setting other than a medical site and/or not supervised by a physician. Although traditional health workers have been eligible to serve as doulas in Oregon since 2014, Oregon paid for doulas in only 0.39% of births to Medicaid enrollees from 2018-2021 (Bluth, 2022).

CHBRP identified several potential barriers regarding PHW participation and supply in the CPSP program and utilization of the services in a nonmedical setting, which led to the 0.50% increase estimate:

- First, CHBRP identified barriers to increasing unlicensed provider supply of unlicensed PHWs, including low reimbursement rates, a high administrative burden related to data collection and reimbursement, high levels of turnover, and lack of adequate training; these barriers may lead to low participation by PHWs and low utilization of PHWs in general by CBOs and Medi-Cal

providers (George et al., 2020; Pittman et al., 2015). Although CBOs may supervise PHWs postmandate if they work with a Medi-Cal provider for billing purposes, CBOs may encounter high administrative burdens in establishing these contracts.

- Second, CHBRP identified potential barriers to services rendered by unlicensed PHWs in a non-medical setting (e.g., the home). Although perinatal programs that provide services in the home aim to reduce barriers faced by pregnant and postpartum people in attending clinic-based programs (such as lack of childcare and transportation barriers), established home visitation programs using nurses and CHWs have experienced significant challenges in retaining people and families in these programs (Boller et al., 2014). These barriers include fears that Child Protection Services may remove children from the home, lack of perceived benefit of the program, fears of criticism, and lack of connection with the CHW (Krysik et al., 2008). Similar barriers may be encountered by unlicensed PHWs participating in home visits as part of the CPSP program.

Baseline and Postmandate Benefit Coverage

Current coverage of CPSP services from 60 days to 12 months postpartum was determined by a CHBRP survey of the largest (by enrollment) providers of Medi-Cal managed care in California. At baseline, CHBRP estimates that 57% of Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans subject to AB 1930 have existing coverage for comprehensive perinatal services delivered through CPSP from 0 days to 12 months postpartum. Postmandate, 100% of eligible Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans would have coverage for comprehensive perinatal services delivered through CPSP from 0 days to 12 months postpartum. See estimates in Table 1.

At baseline, 0% of eligible Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans subject to AB 1930 have coverage of preventive CPSP services rendered by unlicensed PHWs in the home or other community setting away from a medical site. Postmandate, 100% of eligible Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans subject to AB 1930 would have coverage of preventive services rendered by unlicensed PHWs in the home or other community setting.

Baseline and Postmandate Utilization

CHBRP assumed that the underlying rates of pregnancy, abortion, miscarriage, and stillbirth will not substantially change by 2023 if the mandate is fully implemented. Underlying rates are based on 2020 administrative enrollment data and demographic data from the 2018 California Health Interview Survey.

At baseline, CHBRP estimates 69,861 Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans utilize CPSP services. Postmandate, CHBRP estimates that an additional 349 Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans are estimated to use CPSP services. See estimates in Table 1.

CHBRP estimates an increase in annual utilization of CPSP services among existing enrollees and new users of CPSP services as a result of all provisions of AB 1930 (i.e., extending the postpartum coverage period and use of services from unlicensed PHWs at a non-medical site and changes in supervision of PHWs). Annual utilization of CPSP services rendered at a medical site will increase from 82.5 per 1,000 covered Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans at baseline to 82.7 per 1,000 covered Medi-Cal beneficiaries postmandate. Annual utilization of CPSP services rendered at a beneficiary's home or other community setting away from a medical site will increase from 0 per 1,000 covered Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans at baseline to 0.4 per 1,000 covered Medi-Cal beneficiaries postmandate.

Baseline and Postmandate Per-Unit Cost

CHBRP estimates that the average per-unit cost will decrease slightly because on average postpartum services are less costly than prenatal services covered by CPSP. Higher estimated use of postpartum services as a result of the expanded postpartum coverage from AB 1930 will lead to an estimated lower per-unit cost. The average per-unit cost of CPSP services rendered at either a medical site or at a beneficiary's home or other community setting away from a medical site will decrease from \$15.83 to \$15.81, a 0.12% decrease.

Baseline and Postmandate Expenditures

AB 1930 applies to all Medi-Cal beneficiaries, including beneficiaries enrolled in COHS managed care as well as Medi-Cal beneficiaries associated with the Medi-Cal's FFS program. CHBRP estimates AB 1930 would increase total net annual expenditures by \$75,000 for Medi-Cal as a result of the increase in utilization of services by the approximately 8 million Medi-Cal beneficiaries enrolled in managed care through DMHC-regulated plans. Assuming a similar impact for the 1.7 million Medi-Cal beneficiaries enrolled in COHS, an additional increase of \$16,000 would be expected. A similar increase could occur for Medi-Cal beneficiaries associated with FFS, but the impact is unknown. CPSP services do not have cost sharing for enrollees, meaning the entire increase would be a Medi-Cal expenditure and would not be borne out by enrollees.

Potential Cost Offsets or Savings in the First 12 Months After Enactment

As described in the *Medical Effectiveness* section, the evidence is inconclusive or insufficient regarding maternal outcomes due to the services proposed in AB 1930. As such, CHBRP assumed no offsets or increases in additional Medi-Cal health services associated with the increase in CPSP visits. There is scant evidence examining changes in health care utilization as a result of additional postpartum assessments or home visits from unlicensed PHWs. A 2018 study by Lutenbacher et al. examining the use of peer mentors to improve maternal health and child outcomes in underserved communities found that while the program resulted in higher rates of breastfeeding, reductions in parenting stress, and improvements in social and emotional support, there were no changes in health care utilization (Lutenbacher et al., 2018). Although some research literature exists that indicates increased mental health screening and treatment prevents future health problems, it is unclear whether or how much of those prevented health problems would occur within the first year postmandate, or how much those prevented problems would have cost. Therefore, the cost offsets are unknown.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of Medi-Cal Managed Care Plans will remain proportional to the increase in expenditures. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged and to comply with the requirements of participating in CPSP, Medi-Cal Managed Care Plans will develop methods to inform pregnant women and their providers about access to CPSP services as described in AB 1930 (e.g., notifications at each visit). All DMHC-regulated health plans and CDI-regulated insurers include a component for administration and profit in their premiums. In the case of Medi-Cal Managed Care Plans, CHBRP estimates a 12% administrative/overhead rate.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in expenditures is limited to the Medi-Cal program and does not cause increases in private insurance premiums, CHBRP expects no measurable change in the number of uninsured persons due to the enactment of AB 1930.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1930.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

Untreated postpartum mental health conditions may lead enrollees to access mental health care through county-funded services, or they may pay out-of-pocket for their own mental health providers. Additionally, primary care utilization may increase, as a large proportion of mental health care is provided in the primary care setting. CHBRP cannot quantify the extent to which this is occurring, and therefore does not include these potential out-of-pocket costs in the modeling.

Long-Term Utilization and Cost Impacts

Utilization and Cost Impacts

As noted in the *Medical Effectiveness* section, given the insufficient and inconclusive evidence on CPSP or CPSP-like services on maternal health outcomes, CHBRP is unable to determine the potential long-term utilization of CPSP services and long-term cost impacts.

PUBLIC HEALTH IMPACTS

As discussed in the *Policy Context* section, AB 1930 requires coverage for specified comprehensive perinatal services for Medi-Cal beneficiaries to be extended from 60 days to 12 months following the last day of an individual's pregnancy. The bill also allows unlicensed perinatal health workers (PHWs) to be reimbursed for services rendered in a nonmedical setting and changes their supervision requirements.

This public health impact analysis includes estimated impacts AB 1930 on birth and maternal health outcomes in the short-term (within 12 months of implementation) and in the long term (beyond the first 12 months post mandate).

Estimated Public Health Outcomes

As discussed in the *Background* section, CPSP services are currently available from the date of conception through 60 days following the end of the pregnancy and must be provided by or under the personal supervision of a physician. Unlicensed PHWs (i.e., community health workers, promotoras/es, and doulas) can provide preventive perinatal services if supervised by a physician and if provided in a medical setting. AB 1930 permits these PHWs to provide services in a setting outside of a medical site and allows community based organizations (rather than physicians) to supervise PHWs as long as a Medi-Cal provider was available to facilitate billing.

As presented in the *Medical Effectiveness* section, CHBRP found varying levels of effectiveness of comprehensive perinatal services depending on the outcome measured, provider type, and setting with the strongest evidence centered on services delivered in the home setting by unlicensed PHWs (in partnership with or without licensed professionals).

There is a preponderance of evidence that home visiting interventions when delivered by a combination of unlicensed PHWs plus licensed professionals are associated with reduced risk of low birth weight and limited evidence that these services are associated with reduced risk of preterm birth and increased breastfeeding duration. When delivered solely by unlicensed PHWs, CHBRP found limited evidence of the effectiveness of home visiting interventions on low birth weight. Evidence of comprehensive perinatal services delivered by a combination of unlicensed PHWs plus licensed professionals was found to be either inconclusive or insufficient for the following outcomes: infant mortality, NICU admission, postpartum depression, psychosocial resources (including self-esteem, social support, mastery, locus of control, and perceived stress), and breastfeeding initiation, exclusivity, and self-efficacy. Evidence of comprehensive perinatal services was found to be either inconclusive or insufficient for the following outcomes when delivered solely by unlicensed PHWs: preterm birth, postpartum depression, psychosocial resources (including self-esteem, social support, mastery, locus of control, and perceived stress).

CHBRP did not identify any evidence that compared interventions that were provided for 60 days or less postpartum to interventions that were provided over a longer period of time. It is important to note that the absence of evidence is not "evidence of no effect." It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that an additional 349 Medi-Cal beneficiaries would use CPSP services postmandate, due to new access to unlicensed PHWs who may treat clients in nonmedical settings as well as changes in PHW supervisory requirements. CHBRP estimates an increase in annual utilization of CPSP services among existing users at baseline and new users of CPSP services as a result of all provisions of AB 1930 (i.e., extending the postpartum coverage period, allowance of unlicensed PHWs to render services outside of medical sites, and changes in supervision requirements). Postmandate, CHBRP projects CPSP services rendered at a medical site, a beneficiary's home, or other community setting would increase less than 1% (from 82.5 per 1,000 covered Medi-Cal beneficiaries at baseline to 83.1 per 1,000 covered Medi-Cal beneficiaries postmandate).

There are many barriers to perinatal care for Medi-Cal beneficiaries some of which would be mediated by AB 1930 and others that would remain. For example, CHBRP assumes that the use of unlicensed PHWs providing services in home settings would mediate barriers related to a client's lack of transportation or child care. However, there is some evidence that clients that could benefit from home-based services may be reluctant to participate, due to fears of Child Protection Services removing children from the home, lack of perceived benefit of the program, fears of criticism, or immigration status. Moreover, barriers affecting provider supply are likely to remain, such as low reimbursement rates and high administrative burdens for PHWs and their supervising CBOs.

CHBRP concludes that passage of AB 1930 would have no measurable short-term or long-term public health impact at the population-level, due to existing barriers to PHW supply, which would result in less than a 1% increase in CPSP services used postmandate, and lack of evidence showing the effectiveness of comprehensive perinatal services when provided more than 60 days postpartum. It is important to note that the absence of evidence is not "evidence of no effect." It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

At the individual-level, evidence of effectiveness indicates that some Medi-Cal beneficiaries who would use CPSP services postmandate, particularly home visiting interventions when delivered by a combination of unlicensed PHWs plus licensed professionals, may see improved birth outcomes, including reduced risk of low birth weight and preterm birth and increased breastfeeding duration. However, CHBRP is unable to estimate a specific number.

For these reasons, CHBRP also concludes that AB 1930 would have no measurable impact on disparities or social determinants of health for birth and maternal health outcomes.

APPENDIX A TEXT OF BILL ANALYZED

On February 17, 2022, the California Assembly Committee on Health requested that CHBRP analyze AB 1930.

AMENDED IN ASSEMBLY MARCH 16, 2022

ASSEMBLY BILL

NO. 1930

Introduced by Assembly Member Arambula

February 10, 2022

An act to amend Section 14005.185 of, and to add Section 14134.51 to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1930, as amended, Arambula. Medi-Cal: comprehensive perinatal services.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy.

This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

The bill would ~~also~~ require the department to seek any necessary federal approvals to ~~(1) cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified, and (2) specified. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization, or licensed practitioner; organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.~~

The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14005.185 of the Welfare and Institutions Code is amended to read:

14005.185. (a) (1) Notwithstanding Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual or targeted low-income child who is eligible for and is receiving health care coverage under a Medi-Cal program identified in subdivision (b) shall be eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy.

(2) (A) During the one-year postpregnancy eligibility period described in paragraph (1), as part of comprehensive perinatal services under Medi-Cal, as described in subdivision (u) of Section 14132 and in Section 14134.5, the department shall cover additional comprehensive perinatal assessments and individualized care plans and shall provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date.

(B) The department shall collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered pursuant to subparagraph (A).

(b) For purposes of this section, "Medi-Cal program" refers to any of the following programs:

(1) The Medi-Cal Access Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3.

(2) The Medi-Cal program, as described in this article.

The Perinatal Services Program, as described in Article 4.7 (commencing with Section 14148).

(c) The department shall seek any federal approvals, including under Titles XIX and XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), that it determines are necessary to extend coverage for eligible pregnant and postpartum individuals or targeted low-income children as described in this section.

(d) (1) Except as provided in paragraph (2), coverage described in this section shall commence on April 1, 2022, or the effective date or dates reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c), whichever is later.

(2) Notwithstanding paragraph (1), coverage described in this section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa) shall be effective on the date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c).

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions, without taking any further regulatory action.

(f) Implementation of this section is subject to an appropriation in the annual Budget Act, or any other act approved by the Legislature, for the purposes described in this section.

(g) (1) Except as provided in paragraph (2), this section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(2) With respect to coverage described in the section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa), the department may implement this section prior to receipt of all necessary federal approvals, so long as the department determines that federal financial participation under the Medi-Cal program is not otherwise jeopardized.

SEC. 2. Section 14134.51 is added to the Welfare and Institutions Code, to read:

14134.51. (a) As part of comprehensive perinatal services under Medi-Cal, as described in subdivision (u) of Section 14132 and in Section 14134.5, the department shall seek any necessary federal approvals to do both of the following:

(1) Cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as described in Section 1396d(a)(13) of Title 42 of the United States Code and Section 440.130(c) of Title 42 of the Code of Federal Regulations.

(2) Allow a nonlicensed perinatal health worker rendering preventive services in accordance with paragraph (1) to be supervised by ~~an~~ *either of the following*:

(A) *An enrolled Medi-Cal provider that is a clinic, a hospital, a community-based organization, or a licensed practitioner.*

(B) *A community-based organization that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.*

(b) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

APPENDIX B LITERATURE REVIEW METHODS

This appendix describes methods used in the literature review conducted for this report. A discussion of CHBRP's system for medical effectiveness grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of comprehensive perinatal services were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: PubMed Health, the Agency for Healthcare Research and Quality (AHRQ), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network. The search was limited to abstracts of studies published in English. The search was limited to studies published from 1990 to present. The majority of the identified literature about birth outcomes examined the impact of comprehensive perinatal services on low birth weight (LBW) and preterm birth (PTB). The majority of the identified literature about maternal outcomes examined the impact of comprehensive perinatal services on postpartum depression.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Medical Effectiveness Review

The medical effectiveness literature review returned abstracts for 747 articles, of which 62 were reviewed for inclusion in this report. A total of 14³⁰ studies were included in the medical effectiveness review for AB 1930.

Medical Effectiveness Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis Research Approach*.³¹ To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

³⁰ We identified one dose-response study that found each prenatal visit with a paraprofessional home visitor was associated with approximately 62 grams increase in birth weight and approximately 0.38 weeks (2.66 days) increase in gestational age at birth (Guo et al., 2016). We excluded this study because it did not directly answer our Key Questions.

³¹ Available at: http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

- *Clear and convincing evidence;*
- *Preponderance of evidence;*
- *Limited evidence;*
- *Inconclusive evidence;* and
- *Insufficient evidence.*

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

A grade of *limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Search Terms

Community health services	Maternal nutrition	Peri-natal care
Community health workers	Maternal welfare	Perinatal care
Comprehensive perinatal services	Medicaid	Pregnancy
	Medi-Cal	Pregnancy outcome
Fetal mortality	Outcome assessment	Pregnancy complications
Health aides	Paraprofessionals	Pre-natal care
Health education assessment	Patient education	Prenatal care
Home visits	Perinatal depression	Treatment outcome
House calls	Post-natal care	United States or USA
Maternal health	Postnatal care	
Maternal health services	Postpartum depression	
Maternal mortality		

APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.³² Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available at CHBRP's website.³³

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Current coverage of CPSP services for Medi-Cal beneficiaries was determined by a survey of the largest (by enrollment) DMHC-regulated plans enrolling Medi-Cal beneficiaries. CHBRP surveyed DMHC-regulated managed care plans, representing 77% of all Medi-Cal beneficiaries. CHBRP received responses from plans representing 44% of the Medi-Cal population. CHBRP extrapolated the responses to all Medi-Cal beneficiaries covered by DMHC-regulated managed care plans; responses to this survey are assumed to represent 57% of enrollees with health insurance that can be subject to the state benefit mandates.

CHBRP used Milliman's 2019 Consolidated Health Cost Guidelines Sources Database (CHSD) to estimate annual utilization and average cost for CPSP services in 2023. Milliman's CHSD data contains claims and encounter data from Medi-Cal Managed Care (MMC) plans, as opposed to Fee-for-Service (FFS) claims paid by Medi-Cal. The CPSP services were identified in the claims data using HCPCS (Healthcare Common Procedure Coding System) codes listed in the CPSP Provider Handbook. See Table 7 for the list of HCPCS with a description.

Table 7. Procedure Codes Used to Identify CPSP Services.

HCPCS	Description
S0197	Prenatal vitamins
Z6500	Initial combined assessment and case coordination
Z6200	Nutrition – initial assessment and development of care plan, first 30 minutes
Z6202	Nutrition – initial assessment and development of care plan, each subsequent 15 minutes
Z6204	Nutrition – follow-up antepartum reassessment/treatment/intervention, each 15 minutes
Z6208	Nutrition – postpartum assessment/treatment/intervention and development of care plan

³² CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

³³ See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2022 Cost Analyses: Data Sources, Caveats, and Assumptions*.

Z6206	Nutrition group – antepartum nutrition education/treatment/assessment/intervention
Z6300	Psychosocial – initial assessment and development of care plan, first 30 minutes
Z6302	Psychosocial – initial assessment and development of care plan, each subsequent 15 minutes
Z6304	Psychosocial – reassessment/treatment/intervention each 15 minutes
Z6308	Psychosocial – postpartum assessment/treatment/intervention and development of care plan
Z6306	Psychosocial group – antepartum treatment/assessment/intervention
Z6400	Health education – client orientation, each 15 minutes
Z6402	Health education – initial assessment and development of care plan, first 30 minutes
Z6404	Health education – initial assessment and development of care plan, each subsequent 15 minutes
Z6406	Health education – follow-up antepartum reassessment/treatment/intervention, each 15 minutes
Z6414	Health education – postpartum assessment/treatment/intervention and development of care plan, each 15 minutes
Z6408	Health education group – assessment/treatment/intervention each 15 minutes
Z6410	Perinatal education individual – antepartum or postpartum, each 15 minutes
Z6412	Perinatal education group – antepartum or postpartum, each 15 minutes
Z1032-ZL	Initial antepartum obstetric office visit performed within 16 weeks of LMP

Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Assumptions for Baseline Benefit Coverage

- The population subject to the mandate includes individuals covered by DMHC-regulated Medi-Cal Managed Care Plans, full-scope Medi-Cal, or limited scope Medi-Cal and are either pregnant or were pregnant within the previous 12 months.

- CHBRP assumed that pregnant people in Medi-Cal will continue to receive services through Fee-for-Service (FFS) or Medi-Cal Managed Care Plans based on their aid code and eligibility for partial- or full-scope benefits. While 80% of people covered by Medi-Cal are covered by a Medi-Cal Managed Care Plan (MMCP), 40% of the births paid for by Medi-Cal are covered by the FFS system (Simon, 2020a). These include people newly eligible for Medi-Cal on the basis of their pregnancy, including (1) undocumented persons and (2) persons with incomes 139% to 213% of the FPL.
- CHBRP assumed 100% of the population subject to the mandate currently offer some form of coverage for CPSP services and are subject to AB 1930. Based on responses from the survey, CHBRP assumed 57% of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans subject to the mandate currently offer CPSP services for one year postpartum.

Assumptions for Baseline Utilization and Cost

- CHBRP calculated the baseline utilization rates by first determining the total number of CPSP units in the claims data. That figure was then converted into a utilization per 1,000 enrollees, as shown in Table 1, by dividing it by the number of Medi-Cal beneficiaries in the claims data and multiplying by 1,000. CHBRP assumed a 0% annual increase in utilization of CPSP services over time.
- CHBRP calculated the baseline average cost per unit by dividing the total allowed dollars observed in the data for CPSP services by the total units observed in the data for CPSP services. CHBRP compared the average cost per unit for each HCPCS code listed above in Table 7 against the reimbursement rates found in the CPSP Provider Handbook, and generally found them to be close. CHBRP assumed a 0% annual increase in costs of CPSP services over time.
- Medi-Cal Managed Care Plans are required to execute a subcontract or memorandum of understanding with local health departments in the area of Maternal and Child Health to provide perinatal services (State of California - Health and Human Services Agency, 2012). MMCPs are required to implement a comprehensive risk assessment comparable to the standards of the American College of Obstetricians and the CPSP and must include obstetrical, nutrition, psychosocial, and health education interventions when individual risk factors are identified. assessments and services may vary from those in the CPSP. CHBRP assumed that the services covered by Medi-Cal Managed Care Plans would be very similar to those available to people with FFS coverage.

Assumptions for Postmandate Utilization

- In order to estimate postmandate utilization, CHBRP examined these two provisions of the bill separately: expanding coverage from 0-60 days postpartum and allowing unlicensed PHWs to provide CPSP services outside of a medical setting and changing their supervisory requirements.
 - CHBRP assumed that AB 1930 would lead to a 0.50% increase in the use of CPSP services throughout the entire perinatal period due to the allowance of unlicensed PHWs to render preventive services outside of a medical setting and changes in their supervisory requirements.
 - CHBRP assumed that for the 43% of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans that do not currently have coverage for the full year postpartum, utilization in the 2- to 12-month postpartum period would increase by 5% of the current first 60 days' postpartum period. This only impacted the CPSP HCPCS codes that are postpartum services. In order to model this impact, CHBRP calculated the percentages of CPSP services that are rendered within 60 days postpartum by identifying a birth in the claims data and looking at dates of service. This was done for each HCPCS code. The percentage was then applied to the total utilization for each HCPCS code in order to

capture the utilization for the beneficiaries that had births falling outside of the calendar year of the claims data.

- CHBRP assumed that new users of CPSP are only as a result of the provision regarding the use of services from unlicensed PHWs at a nonmedical site and changes in supervision of PHWs.

Assumptions for Postmandate Cost

- AB 1930 does not change the reimbursement rates for CPSP services, thus CHBRP assumes there will be no impact on cost for individual services postmandate. As seen in Table 1, the average cost of CPSP services did decrease slightly from \$15.83 to \$15.81, due to a change in the mix of services provided. The change in the mix of services is driven by the postmandate utilization assumption regarding the increase in utilization in the 2-12 month postpartum period. Since the postpartum CPSP services on average cost less than the average CPSP service, an increase in postpartum CPSP services leads to a slight decrease in average cost of CPSP services overall.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 1930 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of AB 1930 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

APPENDIX D INFORMATION SUBMITTED BY OUTSIDE PARTIES

In accordance with the California Health Benefits Review Program (CHBRP) policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by the Assemblymember Arambula's office in March 2022.

- Lennie JA, Klun JR, Hausner T. Low-birth-weight rate reduced by the obstetrical access project. Health Care Financ Rev. 1987;883-86. The impetus for enacting CPSP into law as a Medi-Cal benefit was this 3-year pilot project showing that these enhancements resulted in fewer low birth weights (a major cause of infant mortality and morbidity) as well savings to Medi-Cal.
- CMS guidance for the ARPA implementation (SHO # 21-007, Dec 7, 2021). <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>. Pp 9-10.
- <https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/>
- <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>
- MIHA Social Determinants of Health 2013-14. Source: <https://archive.cdph.ca.gov/data/surveys/MIHA/MIHAAnnualReports/MIHACountyRegionalReport2013-2014.pdf>
- A letter cosigned by multiple organizations, directed to Michelle Baass, Director of DHCS and Dr. Tomás J. Aragón, Director of CDPH dated December 10, 2021.
- An informational handout, co-signed by multiple organizations, regarding "Key Supports and Referral Services During the 12-Month Postpregnancy Period through Medi-Cal's Comprehensive Perinatal Services Program."
- A paper authored by Sarah Hollister, RN, BSN, PHN, IBCLC, West County Health Centers, and Liz George, RN, BSN, PHN, HNB-BC, IBCLC, the Sonoma County Maternal Child and Adolescent Health Coordinator, Perinatal Services Coordinator. "The Comprehensive Perinatal Services Program During Twelve Months Postpartum.

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A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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Janet Coffman, MA, MPP, PhD, Jacqueline Miller, Emily Shen, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Bruce Abbott, MLS, of the University of California, Davis, conducted the literature search. Joy Melnikow, MD, MPH, Bethney Bonilla, MA, all of the University of California, Davis, prepared the public health impact analysis. Nadereh Pourat, PhD, Michelle Keller, PhD, MPH, of the University of California, Los Angeles, prepared the cost impact analysis. Matt Schoonmaker, FSA, MAAA, of Milliman, provided actuarial analysis. Malini Nijagal, MD, MPH, of the University of California, San Francisco, and Arlene Cullum of Stanford University School of Medicine, provided technical assistance with the literature search and expert input on the analytic approach. An-Chi Tsou, PhD, CHBRP contractor prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and a member(s) of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, and Nadereh Pourat, PhD, of the University of California, Los Angeles, and Marilyn Stebbins, PharmD, of the University of California, San Francisco, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org

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California's Comprehensive Perinatal Services Program and birth outcomes

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Introduction: California's Medicaid (Medi-Cal) sponsors Comprehensive Perinatal Services Program (CPSP), a program with enhanced perinatal care for women (more education, nutritional supplements, and psychosocial counseling/support). Past evaluations of CPSP's effectiveness in birth outcomes were limited to pilot programs and yielded mixed results.

Methods: We used 2012–2016 California's statewide data about singleton live births with any receipt of prenatal care ($N = 2,385,811$) to examine whether Medi-Cal with CPSP enrollment was associated with lower odds of preterm birth (PTB), spontaneous PTB, and low birthweight (LBW) than non-CPSP births. With three binary variables of PTB, spontaneous PTB, and LBW as the response variables, three multilevel logistic models were used to compare the outcomes of participants enrolled in Medi-Cal with CPSP against those with private insurance, adjusting for maternal factors and county-level covariates.

Results: Logistic models showed that participants enrolled to Medi-Cal with CPSP [n (%) = 89,009 (3.7)] had lower odds of PTB, spontaneous PTB and LBW, respectively, as compared with those with private insurance [n (%) = 1,133,140 (47.2)]. Within the Medi-Cal sub-population, the CPSP enrollment was associated with lower odds of PTB, SPTB and LBW than Medicaid beneficiaries without CPSP [n (%) = 967,094 (40.3)].

Discussion: With statewide data, these findings revealed a robust link between CPSP enrollment and better birth outcomes. Expanding access to comprehensive prenatal services could be an important strategy to improve birth outcomes.

KEYWORDS

Comprehensive Perinatal Service Program (CPSP), Medicaid, spontaneous preterm birth (SPTB), preterm birth (PTB), low birthweight (LBW)

Introduction

Access to perinatal services is critical for maternal health and birth outcomes (1, 2), and a society's investment in evidence-based perinatal service has been shown to have favorable long-term cost-effectiveness ratio (3). The persistent racial/ethnic disparities in birth outcomes (4) have made it particularly an urgent task for public health stakeholders to identify evidence-based perinatal care models, as the negative impact of adverse birth outcomes on one's cognitive (5),

neurodevelopmental (6), and physical health outcomes (7, 8) throughout the life course indicates that the racial disparity in birth outcomes has broader significance for racial justice in a society. So far, care models for reducing preterm births (PTB) include group antenatal care (9), enhanced/targeted care for HIV-positive women (10, 11), and augmented care for women with overall elevated risk (more educational sessions, additional appointments, extended time with clinicians, etc.) (12, 13). However, relatively few prenatal service programs have been evaluated with statewide data with regard to birth outcomes such as PTB and low birthweight (LBW), both of which incur substantial burden of illness and disproportionately affect minority populations (14).

As one of the earlier state-level programs to improve maternal health and birth outcomes in the United States, the California Medicaid program (Medi-Cal) offers the voluntary enrollment Comprehensive Perinatal Services Program (CPSP) to provide enhanced services such as psychosocial counseling, nutritional supplements, and health education (15, 16). These services are provided by a team of professional which includes physicians, certified nurse midwives, certified nutritionists, social workers with a master's level training, and certified nurse educators (1). The CPSP benefit has been offered through Medi-Cal since 1987, and is an offshoot of the Obstetrical Access Project (1979–1982) that operated in 13 counties in California (17). All pregnant women eligible for Medi-Cal are eligible to receive the CPSP service (17). The income threshold for Medi-Cal eligibility is higher for pregnant women (up to 213% of federal poverty level) (17). Pregnant women without satisfactory immigration status verification may also qualify for Medi-Cal (17). All Medi-Cal managed health plans are required to ensure that their pregnant enrollees have access to the CPSP services (17). Data on the implementation and utilization of the CPSP is limited, and access to the program may not be optimal (17). For the psychosocial support part, CPSP mandates assessments of the woman's psychosocial status at baseline once prenatal care has been initiated and during each trimester, combined with a care plan to prevent or address psychosocial challenges with treatment referrals when appropriate (16). So far, evaluations of CPSP's impact on birth outcomes yielded inconclusive results (1, 18). The 1995 study demonstrating CPSP's better birth outcomes than the alternate care (18) was based upon a pilot program, not statewide sample. Hence, it is important to provide an updated assessment of CPSP's link with birth outcomes using statewide data.

In this study, we used California's Birth Statistical Master Files (BSMF) (19) 2012–2016, a source registering all live births (20), to investigate whether one's CPSP enrollment was associated with the odds of PTB and LBW. As BSMF documents whether a preterm birth case is a case of spontaneous preterm birth (SPTB), the kind of preterm that is both most prevalent and the least understood (21), we choose to examine the link between CPSP enrollment and SPTB separately, in addition to our study of the link between CPSP enrollment and PTB in general.

Methods

Data, study design and population

We conducted a pooled cross-sectional study using California's BSMF data (19) from 2012 to 2016, with ethical approvals from Clemson University, the Committee for the Protection of Human

Subjects (CPHS), and the Vital Statistics Advisory Committee (VSAC). We included women residents of California State with singleton births between 2012 and 2016 who received any prenatal care ($N=2,385,811$). We used a multilevel model in our analysis with the county as the cluster level, given the documented significant association between individual-level birth outcomes and county-level factors in the United States (22–24) [including California (24)].

Exposure

The exposure variable was the payment source for prenatal care (private insurance, Medi-Cal with CPSP, Medi-Cal without CPSP, no prenatal care, other government programs, private insurance, self-pay, other unknown/unreported source). The BSMF data for prenatal care payment source records Medi-Cal with CPSP and Medi-Cal without CPSP enrollment as separate categories.

Outcomes

We had three outcome variables: PTB (<37 weeks of gestation), spontaneous PTB [defined as a birth prior to 37 weeks of gestation with spontaneous labor or membrane rupture (14), use of tocolysis (25), or cervical cerclage (26)], and LBW (birthweight less than 2,500 grams) (27). The gestational age and birthweight were recorded by hospital staff upon birth.

Covariates

Individual-level maternal factors we used to adjust for confounding effects included race/ethnicity, age, educational attainment, pre-pregnancy and gestational diabetes, pre-pregnancy and gestational hypertension, cigarette smoking (yes/no) during pregnancy, pre-pregnancy BMI, parity (categorized as 1, 5–9, 10+ births), month of birth (as a proxy for the seasonality factor) (28), and year of birth (as a proxy for the secular trend of PTB and LBW) (29), as these individual-level factors have been documented as related with birth outcomes.

As for county-level environmental factors, we used county-level covariates including average unemployment rate for the 12 months prior to birth (30) [obtained from Bureau of Labor Statistics (31)], 5-year average proportion of foreign born population prior to year of birth (32) [obtained from County Health Ranking (33)], and 5-year average proportion of non-English speakers prior to year of birth (32) [obtained from County Health Ranking (33)], as the local unemployment rate and immigrant density are known environmental factors that influence birth outcomes (34, 35).

Statistical analyses

Descriptive statistics were calculated for the characteristics of the study population and the characteristics were compared between three prenatal care payment sources (private insurance, Medi-Cal with CPSP, Medi-Cal without CPSP). Bivariate analyses were conducted to explore the distribution of the outcomes across different sources for prenatal care. We used three multilevel logistic regression analyses

with random intercept for the cluster variable (county) to investigate the association between CPSP coverage and the outcomes: overall PTB (non-PTB as reference), spontaneous PTB (not spontaneous PTB as reference), and LBW ($\geq 2,500$ grams as reference), while the county of maternal residence was used as the Level 2 cluster (30). For the exposure variable in these three multilevel models, the cases with private insurance were used as the reference group, as private insurance beneficiaries had been shown as having relatively low prevalence of adverse birth outcomes (36).

To understand whether the association between CPSP enrollment and birth outcomes varied across racial/ethnic groups [given the racial disparity in birth outcomes (14)], we conducted multilevel analyses of the Medi-Cal-covered cases, including both those receiving CPSP and those not receiving CPSP. The exposure variable for this subsample analysis was a binary variable indicating whether the prenatal care was supported by CPSP. Additional analyses were conducted for the three multilevel models using the Medi-Cal subsample: (1) including the interaction terms between race/ethnicity and CPSP where a significant interaction term would indicate that the association between CPSP and birth outcome was different between a racial/ethnic group and the reference group of non-Hispanic White persons; (2) using inverse probability of treatment weighting [IPTW (37), treatment here is CPSP] using propensity scores to adjust for self-selection bias. The GLIMMIX procedure in SAS 9.4 was used to conduct the multilevel analyses.

Results

A total of 2,385,811 live singleton births in California from 2012 to 2016 were included (Table 1), with private insurance covering 47.5%, Medi-Cal cases without CPSP constituting 40.5%, and Medi-Cal-CPSP constituting 3.7% of the total sample. PTB made up 7.1% of the sample, with SPTB and LBW accounting for 4.5 and 5.2%, respectively. Persons from the Hispanic ethnicity made up 48.0% of the statewide sample, while other major racial/ethnic groups included persons from non-Hispanic White race (27.2%), East Asian race (6.0%), Southeast Asian race (5.1%), Black race (5.0%), South Asian race (2.4%) and mixed race (2.7%).

The crude proportion of birth outcomes significantly differed between payment sources for prenatal care (Table 2). Those with unknown/unreported source of payment for care had the highest proportions of adverse outcomes: PTB: (16.2%), SPTB: (12.6%), LBW (9.2%), Medi-Cal without CPSP (PTB: 7.6%, SPTB: 4.6%, LBW: 5.8%), those with “other” source (PTB: 6.9%, SPTB: 3.9%; LBW: 5.2%), those with “other” government programs (PTB: 6.6%, SPTB: 4.2%, LBW: 4.9%), those with private insurance (PTB: 6.4%; SPTB: 3.9%; LBW: 4.8%) and the Medi-Cal-CPSP (PTB: 6.4%; SPTB: 4.1%; LBW: 4.7%). Those with the “self-pay” category had the lowest ratio of adverse birth outcomes (PTB: 4.7%, SPTB: 3.9%, LBW: 3.6%).

Our three multilevel regressions using the full statewide BSMF sample (Table 3) showed that Medi-Cal with CPSP cases had lower likelihood of PTB [adjusted Odds ratio (aOR) = 0.89, 95% confidence interval (CI): 0.86, 0.92], SPTB (aOR = 0.89, 95% CI: 0.86, 0.92), and LBW (aOR = 0.95, 95% CI: 0.92, 0.99) than those with private insurance. The aORs for the association of Medi-Cal with CPSP and the outcomes pushed the point estimates for the outcomes of PTB (OR = 0.98, 95% CI: 0.95, 1.01) and sPTB (OR = 1.03, 95% CI: 1.00, 1.07) back against null by ~10%. The three Medi-Cal models (Table 4) suggested that Medi-Cal with CPSP had lower odds of PTB

(aOR = 0.82, 95% CI: 0.80, 0.85), SPTB (aOR = 0.86, 95% CI: 0.82, 0.89) and LBW (aOR = 0.81, 95% CI: 0.78, 0.84) than those Medi-Cal cases without CPSP (Table 4). The results for the sensitivity analyses within the Medi-Cal subgroup using inverse probability weighting for CPSP treatment selection (see Supplementary Table S1) were similar to the unweighted results in Table 4.

In both the full-sample analysis and the Medi-Cal subset analyses, persons from minority racial/ethnic groups had significantly higher risk than non-Hispanic White persons, with the exception of persons from the East Asian group who had significantly lower risk than non-Hispanic White persons in four of the six models (For the PTB outcome in full sample: aOR = 0.92, 95% CI: 0.90, 0.95; and in the Medi-Cal subgroup for all outcomes PTB: aOR = 0.78, 95% CI: 0.73, 0.84; SPTB: aOR = 0.91, 95% CI: 0.83, 0.99; LBW: aOR = 0.84, 95% CI: 0.77, 0.91).

In all our multilevel models, the random effect for county was significant ($p < 0.001$) indicating that the two-level models differed significantly from their single-level counterparts. The interaction terms between race/ethnicity and CPSP enrollment in the Medi-Cal models were all insignificant indicating that the protective effect of CPSP did not vary across these minority racial/ethnic groups. Therefore, only the main effect of CPSP has been presented in Table 4.

Discussion

Using California's statewide data, we identified a consistent protective effect of Medi-Cal's CPSP on PTB, SPTB and LBW, after adjusting for both the county-level and individual-level covariates. We strengthened the evidence from the two earlier studies whereby pilot projects of CPSP demonstrated protective effects (1, 18). Our study provided important information for stakeholders of maternal and child health, as preterm birth and low birthweight are known to be very substantial burdens for families and societies worldwide (38).

Despite the substantial differences in PTB and LBW risk across racial/ethnic groups, we found the association between CPSP and birth outcome did not vary across racial/ethnic subgroups, a finding consistent with previous evidence that increasing access to prenatal service led to better outcomes but not smaller racial disparity (39). It remained unclear how well CPSP was understood by and how accessible it was for Medi-Cal beneficiaries of minority background. In our sample, only 8.4% of the Medi-Cal cases were covered by CPSP (see Supplementary Figure S1 for CPSP enrollment across California State counties), signaling potential room for improvement in promotion and dissemination. Given the excess risk for PTB and LBW among persons from Southeast Asian and South Asian race/ethnicity groups as shown in our analyses, it might be particular importance to develop culturally and linguistically appropriate program promotion to these Asian subgroups, as a lack of cultural affinity plus the myth of Asian American persons as “the model minority” group (40) could compromise the CPSP uptake rate among Southeast Asian and South Asian persons.

It might be plausible to think that all key components of CPSP (health education, nutritional supplements and psychosocial counseling plus referrals if necessary) might have contributed to the observed risk reduction of adverse birth outcomes through their separate intervention mechanisms as documented by perinatology literature, while it could also be plausible that these different components might have produced a synergistic benefit that a standalone intervention could not produce by itself [for example, there could be a synergy between health education classes about optimal

TABLE 1 Descriptive statistics of 2,385,811 singleton births and the socio-economic environment factors in California 2012–2016.

	Total sample		Private insurance		Medi-Cal with CPSP		Medi-Cal without CPSP		<i>p</i> ^e
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
County level variables									
Unemployment ^a (%)	8.7	3.2	8.3	3.0	9.8	3.6	9.2	3.2	–
Foreign born ^b (%)	27.1	7.4	27.4	7.4	21.7	7.6	27.0	7.3	–
Non-English speakers ^c (%)	44.1	10.9	43.6	10.7	37.4	12.6	45.1	10.6	–
Individual level variables									
Maternal age (years)	29.2	6.1	31.0	5.4	26.9	6.0	27.2	6.1	<0.001
Pre-pregnancy BMI (kg/m ²)	26.2	6.2	25.5	5.9	27.4	6.6	27.1	6.4	<0.001
Birth weight (grams)	3327.4	538.0	3349.1	532.9	3347.1	529.6	3299.9	546.8	<0.001
Gestational age (days)	275.1	18.3	275.8	18.1	275.9	17.7	274.3	18.0	<0.001
	N	% (column percent)	N	% (column percent)	N	% (column percent)	N	% (column percent)	
Race/ethnicity									<0.001
Non-Hispanic White	649,512	27.2	448,051	39.5	19,025	21.4	127,733	13.2	
Black	118,365	5.0	40,115	3.5	4,586	5.2	61,836	6.4	
American Indian	8,029	0.3	2,716	0.2	835	0.9	3,541	0.4	
Other/unknown/refused	56,184	2.4	35,497	3.1	914	1.0	15,306	1.6	
Pacific islander ^d	9,079	0.4	3,839	0.3	416	0.5	4,008	0.4	
Mixed race	64,068	2.7	37,981	3.4	2,593	2.9	18,891	2.0	
Asian other	13,778	0.6	9,042	0.8	508	0.6	3,375	0.4	
Asian-South	57,769	2.4	46,744	4.1	739	0.8	7,586	0.8	
Asian-South-East	120,486	5.1	76,952	6.8	2,848	3.2	34,171	3.5	
Asian-East	142,410	6.0	79,375	7.0	749	0.8	15,712	1.6	
Hispanic	1,146,131	48.0	352,828	31.1	55,796	62.7	674,935	69.8	
Maternal age (years)									<0.001
<20	135,601	5.7	23,456	2.1	9,135	10.3	93,719	9.7	
20–24	450,578	18.9	116,979	10.3	25,817	29.0	269,676	27.9	
25–29	635,013	26.6	279,439	24.7	25,726	28.9	274,936	28.4	
30–34	685,773	28.7	414,288	36.6	17,506	19.7	197,600	20.4	
35–29	380,120	15.9	238,789	21.1	8,606	9.7	102,478	10.6	
40+	98,726	4.1	60,189	5.3	2,219	2.5	28,685	3.0	
Maternal educational attainment									<0.001
No formal education	6,925	0.3	315	0.0	1,046	1.2	5,346	0.6	
8th grade or less	112,242	4.7	6,830	0.6	8,344	9.4	93,520	9.7	
9th grade through 12th grade – no diploma	277,624	11.6	30,968	2.7	16,908	19.0	215,209	22.3	
High school graduate or GED completed	584,464	24.5	177,355	15.7	31,315	35.2	332,376	34.4	
Some college credit – no degree	467,771	19.6	219,743	19.4	18,152	20.4	191,023	19.8	
Associate degree	150,082	6.3	92,503	8.2	4,470	5.0	38,215	4.0	
Bachelor's degree	436,961	18.3	340,088	30.0	4,380	4.9	44,044	4.6	
Master's degree	184,179	7.7	156,745	13.8	773	0.9	8,042	0.8	
Doctorate or professional degree	62,140	2.6	56,159	5.0	136	0.2	2,005	0.2	
Unknown or not stated	103,423	4.3	52,434	4.6	3,485	3.9	37,314	3.9	

(Continued)

TABLE 1 (Continued)

	Total sample		Private insurance		Medi-Cal with CPSP		Medi-Cal without CPSP		p^e
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Types of payment sources for prenatal care									
Medi-Cal without CPSP support services	967,094	40.5							
Other government programs	77,994	3.3							
Private insurance company	1,133,140	47.5							
Self-pay	83,190	3.5							
Medi-Cal with CPSP support services	89,009	3.7							
Other	24,961	1.1							
Unknown/unreported pay source	10,423	0.4							
Pre-pregnancy smoking									<0.001
None	2,328,650	97.6	1,121,971	99.0	84,174	94.6	930,912	96.3	
≥1 cigarettes/day	41,395	1.7	8,649	0.8	4,265	4.8	25,110	2.6	
unknown smoking status	15,766	0.7	2,520	0.2	570	0.6	11,072	1.1	
Parity									<0.001
One	937,737	39.3	505,957	44.7	30,185	33.9	320,043	33.1	
2–4	1,332,884	55.9	601,621	53.1	52,435	58.9	572,897	59.2	
5–9	109,522	4.6	24,416	2.2	6,239	7.0	71,966	7.4	
10+	1,993	0.1	349	0.0	93	0.1	1,418	0.2	
unknown	3,675	0.2	797	0.1	57	0.1	770	0.1	
BMI (kg/m ²)									<0.001
<18.5	90,736	3.8	42,044	3.7	2,983	3.4	33,807	3.5	
18.5–24.9	1,088,545	45.6	583,334	51.5	33,349	37.5	372,966	38.6	
25–29.9	595,503	25.0	264,714	23.4	24,145	27.1	266,019	27.5	
30–34.9	510,583	21.4	204,522	18.1	24,797	27.9	253,853	26.3	
unknown	100,444	4.2	38,526	3.4	3,735	4.2	40,449	4.2	
Pre-pregnancy diabetes									<0.001
No	2,373,190	99.5	1,128,022	99.6	88,565	99.5	960,719	99.3	
Yes	12,621	0.5	5,118	0.5	444	0.5	6,375	0.7	
Gestational diabetes									<0.001
No	2,254,142	94.5	1,069,686	94.4	83,099	93.4	912,549	94.4	
Yes	131,669	5.5	63,454	5.6	5,910	6.6	54,545	5.6	
Pre-pregnancy hypertension (Chronic)									<0.001
No	2,367,991	99.3	1,123,242	99.1	88,282	99.2	960,798	99.4	
Yes	17,820	0.8	9,898	0.9	727	0.8	6,296	0.7	
Gestational hypertension (PIH, Pre-eclampsia)									<0.001
No	2,306,837	96.7	1,093,080	96.5	86,320	97.0	935,175	96.7	
Yes	78,974	3.3	40,060	3.5	2,689	3.0	31,919	3.3	
Month of birth									<0.001
January	194,797	8.2	90,277	8.0	7,423	8.3	81,050	8.4	
February	180,461	7.6	84,970	7.5	6,765	7.6	74,298	7.7	
March	196,742	8.3	94,380	8.3	7,451	8.4	78,895	8.2	
April	187,562	7.9	90,654	8.0	6,994	7.9	74,834	7.7	
May	195,627	8.2	95,154	8.4	7,443	8.4	77,278	8.0	

(Continued)

TABLE 1 (Continued)

	Total sample		Private insurance		Medi-Cal with CPSP		Medi-Cal without CPSP		<i>p</i> ^e
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
June	191,982	8.1	92,382	8.2	7,100	8.0	76,656	7.9	
July	206,366	8.7	98,361	8.7	7,671	8.6	83,336	8.6	
August	216,292	9.1	102,632	9.1	7,774	8.7	87,997	9.1	
September	212,966	8.9	100,814	8.9	7,961	8.9	86,403	8.9	
October	208,180	8.7	98,419	8.7	7,726	8.7	84,853	8.8	
November	195,555	8.2	92,146	8.1	7,052	7.9	79,724	8.2	
December	199,281	8.4	92,951	8.2	7,649	8.6	81,770	8.5	
Year of birth									<0.001
2012	485,301	20.3	225,220	19.9	19,168	21.5	205,907	21.3	
2013	475,179	19.9	222,536	19.6	19,242	21.6	195,683	20.2	
2014	483,116	20.3	229,982	20.3	17,308	19.5	192,945	20.0	
2015	472,648	19.8	228,360	20.2	16,261	18.3	188,411	19.5	
2016	469,567	19.7	227,042	20.0	17,030	19.1	184,148	19.0	

California county-level averages of the ^aunemployment rate in the 12-months prior to birth, ^bproportion of foreign born population in 5-year period prior to birth year, ^cproportion of non-English speaking population in the 5-year period prior to birth year. ^dPacific Islander group includes Hawaiian, Guamanian, and Samoan groups. ^eP-values compare the private insurance, Medi-Cal with CPSP, and Medi-Cal without CPSP prenatal care payment source groups.

TABLE 2 Frequencies (%) of outcomes by payment source for prenatal care.

	Medi-Cal without CPSP	Other govt. progs.	Private insurance	Self-pay	Medi-Cal with CPSP	Other	Unknown/unreported source	<i>p</i>
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)	
Preterm	73,163 (7.6%)	5,135 (6.6%)	72,746 (6.4%)	3,895 (4.7%)	5,662 (6.4%)	1,714 (6.9%)	1,690 (16.2%)	<0.001
Spontaneous preterm	43,526 (4.6%)	3,178 (4.2%)	43,483 (3.9%)	2,498 (3.1%)	3,581 (4.1%)	931 (3.9%)	1,254 (12.6%)	<0.001
Low birthweight	55,696 (5.8%)	3,843 (4.9%)	54,146 (4.8%)	3,015 (3.6%)	4,217 (4.7%)	1,299 (5.2%)	946 (9.2%)	<0.001

For each outcome, each N (%) figures represents positive cases for the outcome within the insurance subgroup.

nutritional intake during pregnancy and the actual delivery of nutritional supplements to those who have received nutritional health education (41)]. So far, the evidence of health education's protective effect against adverse birth outcomes seems to be the strongest in the field of antenatal nutritional education: a 2015 review found that nutritional education programs with the aim of increasing energy and protein intake among pregnant women appears to be effective in reducing the risk of PTB (two trials, 449 women) and LBW (one trial, 300 women) (41). The effectiveness of psychosocial support on reducing LBW, meanwhile, has been supported by a 2015 meta-analysis about four trials among psychosocial interventions among teenage pregnant women (42). The evidence for the effectiveness of psychosocial interventions alone on the PTB outcome and birth outcomes among women of other age groups remain inconclusive. As a possible piece of circumstantial evidence for the effectiveness of health education and psychosocial support in lowering PTB and LBW, it has been noted that the low level of PTB and LBW observed in "birth centers" [a holistic midwifery model of care (43)] might be attributable to its substantial time to education and psychosocial support, to an extent typically unavailable in usual prenatal visits (43).

Compared with CPSP's service in health education and psychosocial support, its delivery of nutritional supplements to the pregnant women has more direct support from epidemiological literature with high level of evidence strength. For example, a 2018 meta-analysis of randomized controlled trials (4,193 women) summarized that prenatal supplementation of Omega-3 fatty acid led to a 58% reduction of early preterm birth risk and 17% reduction of any premature birth risk compared to those in the placebo groups (44), and its subgroup analysis found that these protective effects did not vary by women's risk status, dosage of supplement or timing of the intervention. As for the outcome of LBW, a systematic review of 30 trials concluded that supplementing pregnant women with vitamin D alone probably reduces the risk of LBW but not PTB (45), while a meta-analysis shows that balanced energy and protein supplementation reduce the risk of infants born small-for-gestational age (Relative risk: 0.79, 95% CI: 0.69–0.90, 4,408 women, moderate-quality evidence) (41). Furthermore, a meta-analysis of prenatal iron use has been found to reduce the risk of LBW (Relative risk: 0.81, 95% CI: 0.71–0.93, 13 trials) but not PTB. These results, however, need to be interpreted with caution since a modification of the proven nutritional supplementation intervention might actually change

TABLE 3 Multilevel logistic regression results for the association between CPSP and birth outcomes in California.

	Preterm birth		Spontaneous preterm birth		Low birthweight	
	OR (95% CI)	<i>p</i>	OR (95% CI)	<i>p</i>	OR (95% CI)	<i>p</i>
Source of prenatal care (private insurance as reference)						
Medi-Cal + CPSP	0.98 (0.95, 1.01)	0.152	1.03 (1.00, 1.07)	0.077	1.01 (0.98, 1.05)	0.454
Medi-Cal–no CPSP	1.17 (1.16, 1.18)	<0.001	1.17 (1.16, 1.19)	<0.001	1.21 (1.19, 1.22)	<0.001
Other public	1.03 (1.00, 1.07)	0.031	1.10 (1.06, 1.14)	<0.001	1.05 (1.02, 1.09)	0.004
Self-pay	0.71 (0.68, 0.73)	<0.001	0.77 (0.74, 0.81)	<0.001	0.75 (0.72, 0.77)	<0.001
Other	1.07 (1.02, 1.12)	0.011	0.98 (0.92, 1.05)	0.501	1.08 (1.02, 1.14)	0.009
	aOR (95% CI)	<i>p</i>	aOR (95% CI)	<i>p</i>	aOR (95% CI)	<i>p</i>
Source of prenatal care (private insurance as reference)						
Medi-Cal + CPSP	0.89 (0.86, 0.92)	<0.001	0.89 (0.86, 0.92)	<0.001	0.95 (0.92, 0.99)	0.007
Medi-Cal–no CPSP	1.05 (1.04, 1.07)	<0.001	1.01 (0.99, 1.03)	0.307	1.14 (1.12, 1.16)	<0.001
Other public	1.04 (1.00, 1.07)	0.029	1.03 (0.99, 1.07)	0.105	1.05 (1.01, 1.09)	0.007
Self-pay	0.81 (0.78, 0.84)	<0.001	0.82 (0.78, 0.85)	<0.001	0.83 (0.80, 0.87)	<0.001
Other	1.02 (0.97, 1.08)	0.367	0.91 (0.85, 0.97)	0.005	1.03 (0.98, 1.10)	0.253
Race/ethnicity (Non-Hispanic Whites as reference)						
Black	1.61 (1.57, 1.64)	<0.001	1.51 (1.47, 1.56)	<0.001	2.33 (2.27, 2.39)	<0.001
Hispanic	1.21 (1.19, 1.23)	<0.001	1.24 (1.21, 1.26)	<0.001	1.30 (1.28, 1.33)	<0.001
Asian-East	0.92 (0.90, 0.95)	<0.001	0.99 (0.95, 1.02)	0.510	1.09 (1.05, 1.12)	<0.001
Asian-Southeast	1.50 (1.47, 1.54)	<0.001	1.56 (1.52, 1.61)	<0.001	1.87 (1.82, 1.92)	<0.001
Asian-South	1.31 (1.26, 1.36)	<0.001	1.21 (1.15, 1.26)	<0.001	2.31 (2.23, 2.39)	<0.001
Asian Other	1.22 (1.14, 1.31)	<0.001	1.30 (1.20, 1.42)	<0.001	1.55 (1.44, 1.67)	<0.001

County of maternal residence was used as the Level 2 cluster. Individual-level maternal covariates included race/ethnicity, age, education, pre-pregnancy/gestational diabetes, pre-pregnancy/gestational hypertension, cigarette smoking during pregnancy, pre-pregnancy BMI, parity, birth month, birth year. County-level covariates included average unemployment rate for the 12 months prior to birth, 5-year average proportion of foreign-born prior to year of birth year, and 5-year average proportion of non-English speakers prior to birth year.

TABLE 4 Multilevel logistic regression results for the association between CPSP and birth outcomes in California (Medi-Cal subgroup analyses).

	Preterm birth		Spontaneous preterm birth		Low birthweight	
	OR (95% CI)	<i>p</i>	OR (95% CI)	<i>p</i>	OR (95% CI)	<i>p</i>
Source of payment for prenatal care (Medi-Cal without CPSP as reference)						
Medi-Cal + CPSP	0.82 (0.79, 0.85)	<0.001	0.86 (0.83, 0.89)	<0.001	0.82 (0.79, 0.85)	<0.001
	aOR (95% CI)	<i>p</i>	aOR (95% CI)	<i>p</i>	aOR (95% CI)	<i>p</i>
Source of payment for prenatal care (Medi-Cal without CPSP as reference)						
Medi-Cal + CPSP	0.82 (0.80, 0.85)	<0.001	0.86 (0.82, 0.89)	<0.001	0.81 (0.78, 0.84)	<0.001
Race/ethnicity (Non-Hispanic Whites as reference)						
Black	1.46 (1.41, 1.51)	<0.001	1.40 (1.34, 1.46)	<0.001	2.10 (2.02, 2.17)	<0.001
Hispanic	1.08 (1.05, 1.11)	<0.001	1.12 (1.09, 1.16)	<0.001	1.11 (1.08, 1.15)	<0.001
Asian-East	0.78 (0.73, 0.84)	<0.001	0.91 (0.83, 0.99)	0.032	0.84 (0.77, 0.91)	<0.001
Asian-Southeast	1.24 (1.18, 1.29)	<0.001	1.33 (1.26, 1.41)	<0.001	1.48 (1.41, 1.55)	<0.001
Asian-South	1.14 (1.05, 1.25)	0.002	1.02 (0.91, 1.15)	0.695	1.61 (1.47, 1.75)	<0.001
Asian other	1.06 (0.94, 1.21)	0.353	1.13 (0.97, 1.32)	0.127	1.29 (1.12, 1.48)	<0.001

County of maternal residence was used as the Level 2 cluster. Individual-level maternal covariates included race/ethnicity, age, education, pre-pregnancy/gestational diabetes, pre-pregnancy/gestational hypertension, cigarette smoking during pregnancy, pre-pregnancy BMI, parity, birth month, birth year. County-level covariates included average unemployment rate for the 12 months prior to birth, 5-year average proportion of foreign-born prior to year of birth year, and 5-year average proportion of non-English speakers prior to birth year.

the intervention's protective effects into net harm: the same review that found the benefit of balanced energy and protein supplementation also found that high-protein supplementation may be harmful to the fetus (41), while the review that found the benefits of Vitamin D supplementation also found that supplementation with vitamin D plus

calcium may increase the PTB risk (Relative risk: 1.52, 95% CI: 1.01–2.28; 5 trials, 942 women, low-certainty evidence) (45). For the specific context of our study about California's CPSP service, though, the fact that CPSP's prenatal assessment/reassessment and individualized care plan included screening questions about the woman's iron and vitamin

intake is a clue why CPSP enrollment might be associated with lower risk for PTB and LBW.

Our study is limited in that no causal inference can be drawn from the observed link between CPSP and outcome due to the voluntary nature of CPSP participation. In other words, women who decided to enroll in CPSP could have certain protective factors that reduced risk for preterm births and low birthweight, factors that might not be available from our observational data. Moreover, the BSMF dataset did not have the frequency of CPSP service utilization and therefore we could not test the effect of the CPSP utilization frequency on the outcomes. Also, details about the type of CPSP service (education, nutritional supplements, and psychosocial counseling plus referrals if necessary) utilized were not available, and therefore we were unable to tell which component of the CPSP played a significant role in PTB and LBW risk reduction. Also, there is a lack of data on the extent to which the program was implemented in healthcare settings. It is possible that some women may not have enrolled due to lesser access to the program (17). Therefore, more in-depth detailed study (such as survey questionnaires with more specific questions about care utilization behavior among the CPSP enrollees as well as non-CPSP enrollees) is needed to understand which CPSP component might have contributed to outcome improvement.

Finally, while it might be a promising sign to see the significantly negative association between CPSP enrollment and spontaneous PTB, the type of preterm births that has been known as hard to understand and thus difficult to prevent, it is also important to note that the classification of preterm subtype from birth registries such as California's BSMF might not be perfectly accurate as the methodology of accurately categorizing types of preterm births is still under development (46) and has yet to reach perfection.

Nevertheless, it is encouraging to see that the CPSP cases had better birth outcomes than those covered by private insurance after adjusting for confounding factors. As the evidence for Medicaid expansion's benefits on birth outcome remained inconclusive as of 2022 (47), population health stakeholders might consider strengthening the reach of comprehensive perinatal services like CPSP so that insurance coverage could have a stronger benefit on vitally important health outcomes such as preterm birth and low birthweight.

Data availability statement

The county level data used in this study is from publicly accessible sources (Bureau of Labor Statistics: <https://www.bls.gov/> and County Health Ranking: <https://www.countyhealthrankings.org/>). Other data analyzed in this study is subject to the following licenses/restrictions: The California Birth Data used in our study is restricted and the authors in this study do not have permission to share it. Requests to access these datasets should be directed to <https://www.cdph.ca.gov>.

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Ethics statement

The studies involving humans were approved by Clemson University IRB; the Committee for the Protection of Human Subjects (CPHS); and the Vital Statistics Advisory Committee (VSAC). The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation was not required from the participants or the participants' legal guardians/next of kin in accordance with the national legislation and institutional requirements.

Author contributions

SL: Conceptualization, Data curation, Formal analysis, Writing – original draft, Writing – review & editing. AS: Writing – review & editing. LC: Writing – review & editing. JL: Writing – review & editing. LM: Conceptualization, Funding acquisition, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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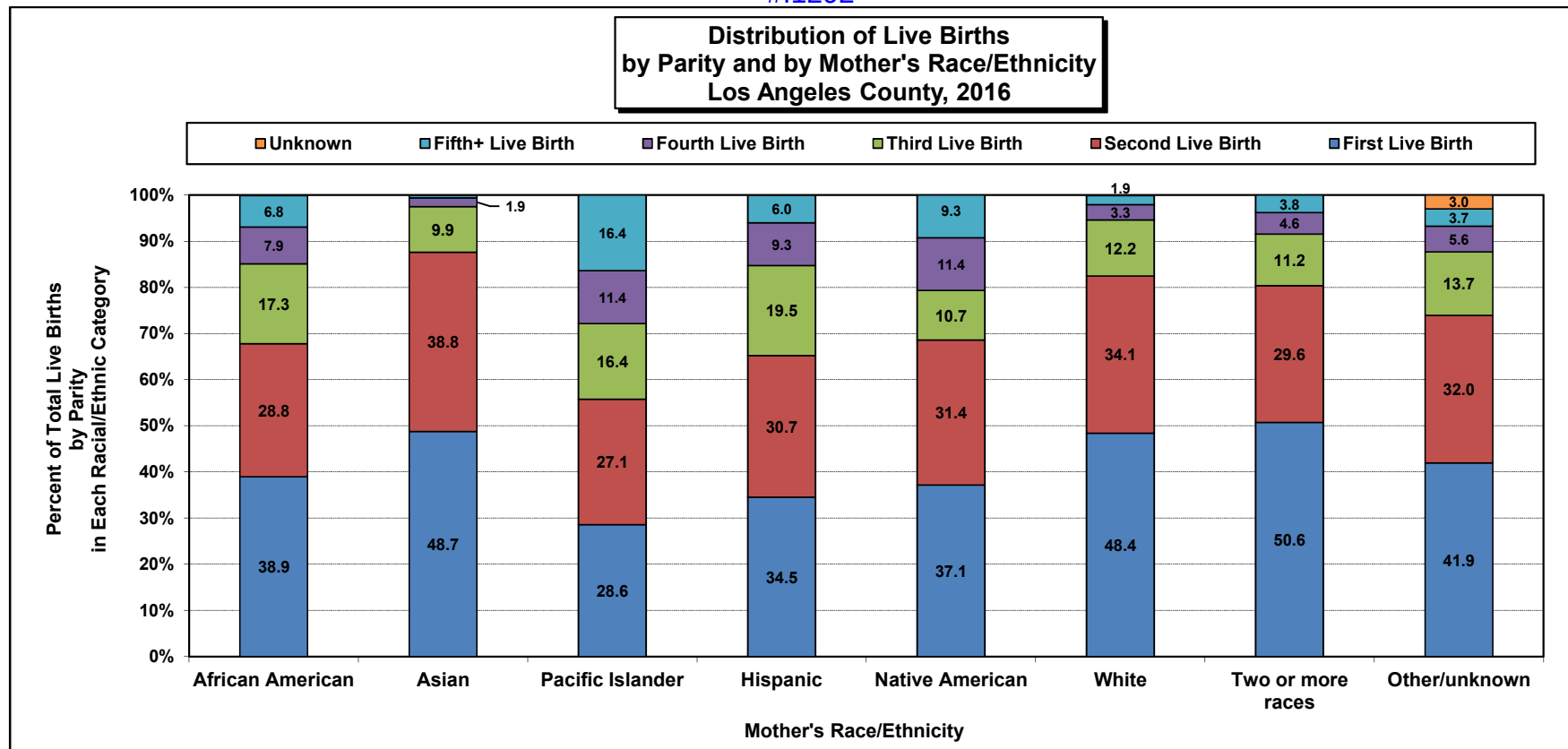
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Supplementary material

The Supplementary material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpubh.2023.1321313/full#supplementary-material>

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EXHIBIT F



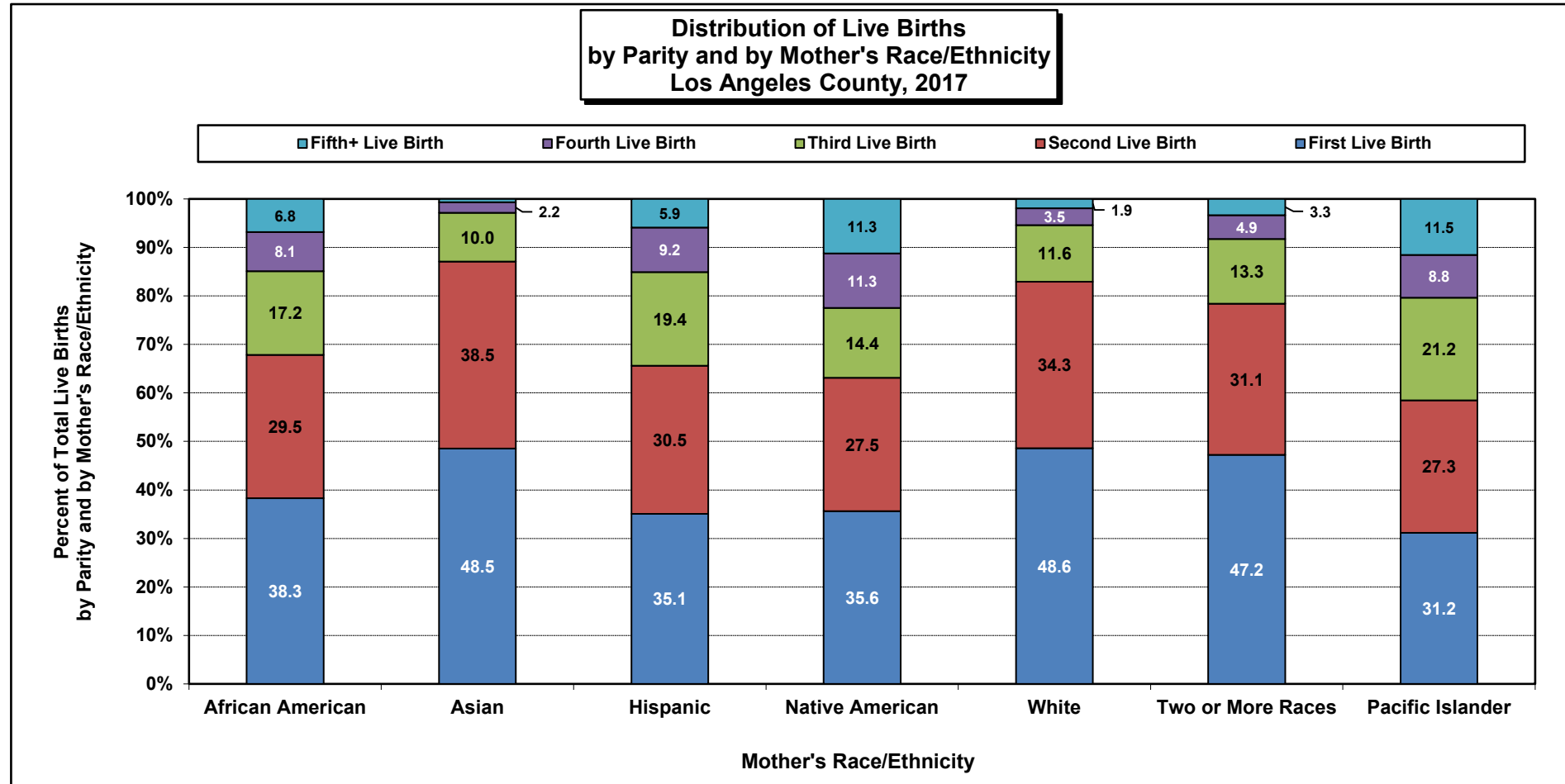
Los Angeles County, 2016												
Mother's Race/Ethnicity	Parity											
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
African American	3,281	38.9	2,428	28.8	1,460	17.3	667	7.9	577	6.8	12	0.1
Asian	9,558	48.7	7,615	38.8	1,940	9.9	370	1.9	112	0.6	13	0.1
Pacific Islander	80	28.6	76	27.1	46	16.4	32	11.4	46	16.4	<5	N/C
Hispanic	23,345	34.5	20,763	30.7	13,210	19.5	6,262	9.3	4,060	6.0	26	0.0
Native American	52	37.1	44	31.4	15	10.7	16	11.4	13	9.3	<5	N/C
White	11,032	48.4	7,768	34.1	2,774	12.2	757	3.3	440	1.9	37	0.2
Two or more races	1,015	50.6	594	29.6	224	11.2	93	4.6	77	3.8	<5	N/C
Other/unknown	842	41.9	643	32.0	276	13.7	112	5.6	75	3.7	61	3.0
Total	49,205	40.0	39,931	32.5	19,945	16.2	8,309	6.8	5,400	4.4	151	0.1

Total Live Births
8,425
19,608
280
67,666
140
22,808
2,005
2,009
122,941

Notes: Parity = number of pregnancies resulting in live births to a woman.

Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.

Source: California Department of Public Health, Birth Statistical Master File, 2016

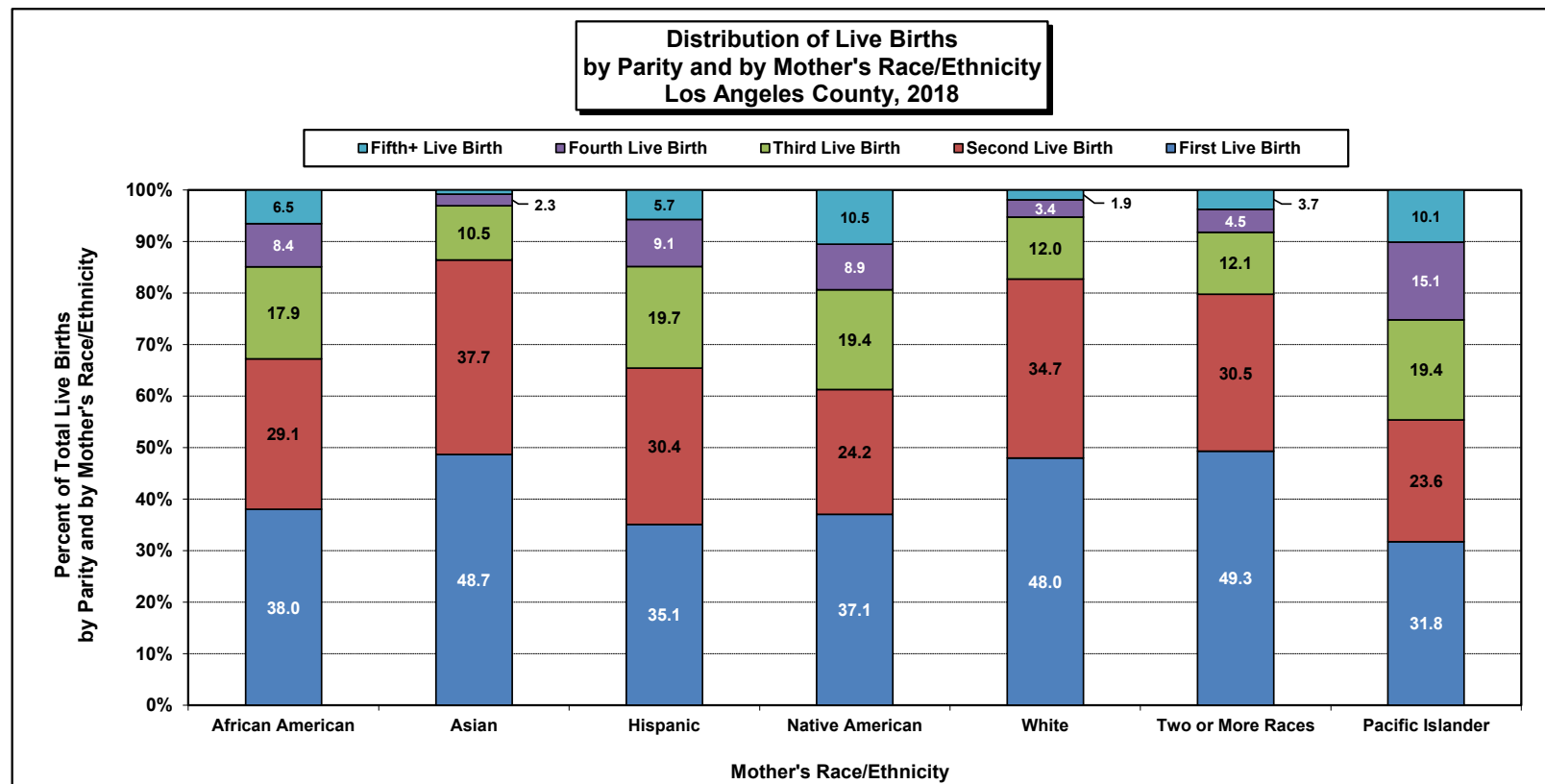


Los Angeles County, 2017													Total Live Births
Mother's Race/Ethnicity	Parity												
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
African American	3,087	38.3	2,382	29.5	1,390	17.2	650	8.1	549	6.8	6	0.1	8,064
Asian	8,975	48.5	7,126	38.5	1,851	10.0	403	2.2	130	0.7	5	0.0	18,490
Hispanic	22,476	35.1	19,542	30.5	12,404	19.4	5,876	9.2	3,774	5.9	19	0.0	64,091
Native American	57	35.6	44	27.5	23	14.4	18	11.3	18	11.3	<5	N/C	160
White	10,780	48.6	7,617	34.3	2,580	11.6	771	3.5	429	1.9	8	0.0	22,185
Two or More Races	976	47.2	644	31.1	276	13.3	102	4.9	69	3.3	<5	N/C	2,069
Other/unknown	678	44.3	489	31.9	197	12.9	62	4.0	62	4.0	43	2.8	1,531
Pacific Islander	81	31.2	71	27.3	55	21.2	23	8.8	30	11.5	<5	N/C	260
Total	47,110	40.3	37,915	32.4	18,776	16.1	7,905	6.8	5,061	4.3	83	0.1	116,850

Notes: Parity = number of pregnancies resulting in live births to a woman.

Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.

Source: California Department of Public Health, Birth Statistical Master File, 2017



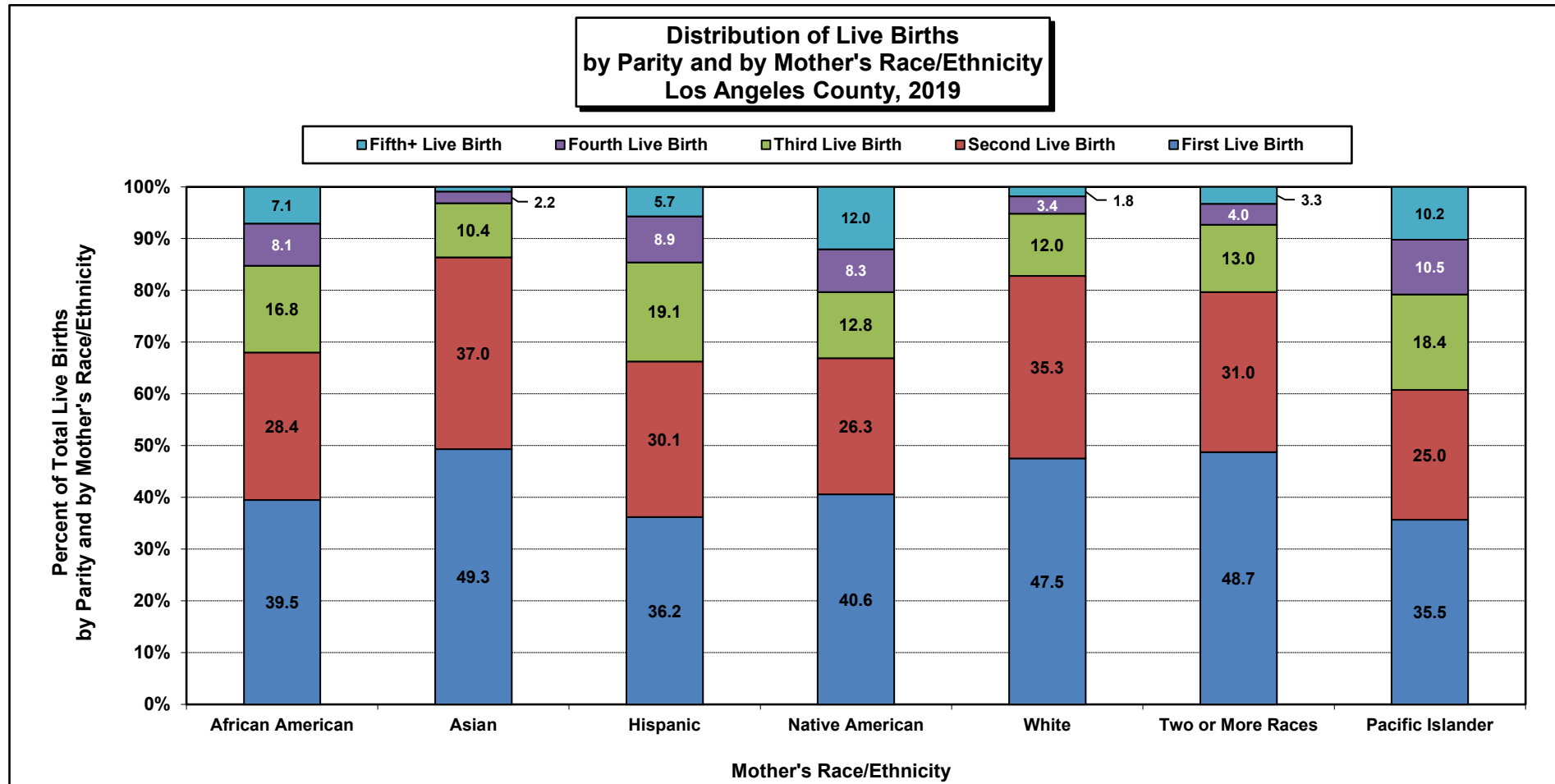
Los Angeles County, 2018												
Mother's Race/Ethnicity	Parity											
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
African American	2,953	38.0	2,260	29.1	1,389	17.9	650	8.4	502	6.5	7	0.1
Asian	8,050	48.7	6,238	37.7	1,737	10.5	375	2.3	130	0.8	2	0.0
Hispanic	21,113	35.1	18,256	30.4	11,844	19.7	5,476	9.1	3,433	5.7	11	0.0
Native American	46	37.1	30	24.2	24	19.4	11	8.9	13	10.5	<5	N/C
White	10,357	48.0	7,492	34.7	2,592	12.0	734	3.4	400	1.9	6	0.0
Two or More Races	941	49.3	581	30.5	230	12.1	85	4.5	71	3.7	<5	N/C
Other/unknown	731	45.8	442	27.7	187	11.7	96	6.0	86	5.4	54	3.4
Pacific Islander	82	31.8	61	23.6	50	19.4	39	15.1	26	10.1	<5	N/C
Total	44,273	40.3	35,360	32.2	18,053	16.4	7,466	6.8	4,661	4.2	80	0.1

Total Live Births
7,761
16,532
60,133
124
21,581
1,908
1,596
258
109,893

Notes: Parity = number of pregnancies resulting in live births to a woman.

Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.

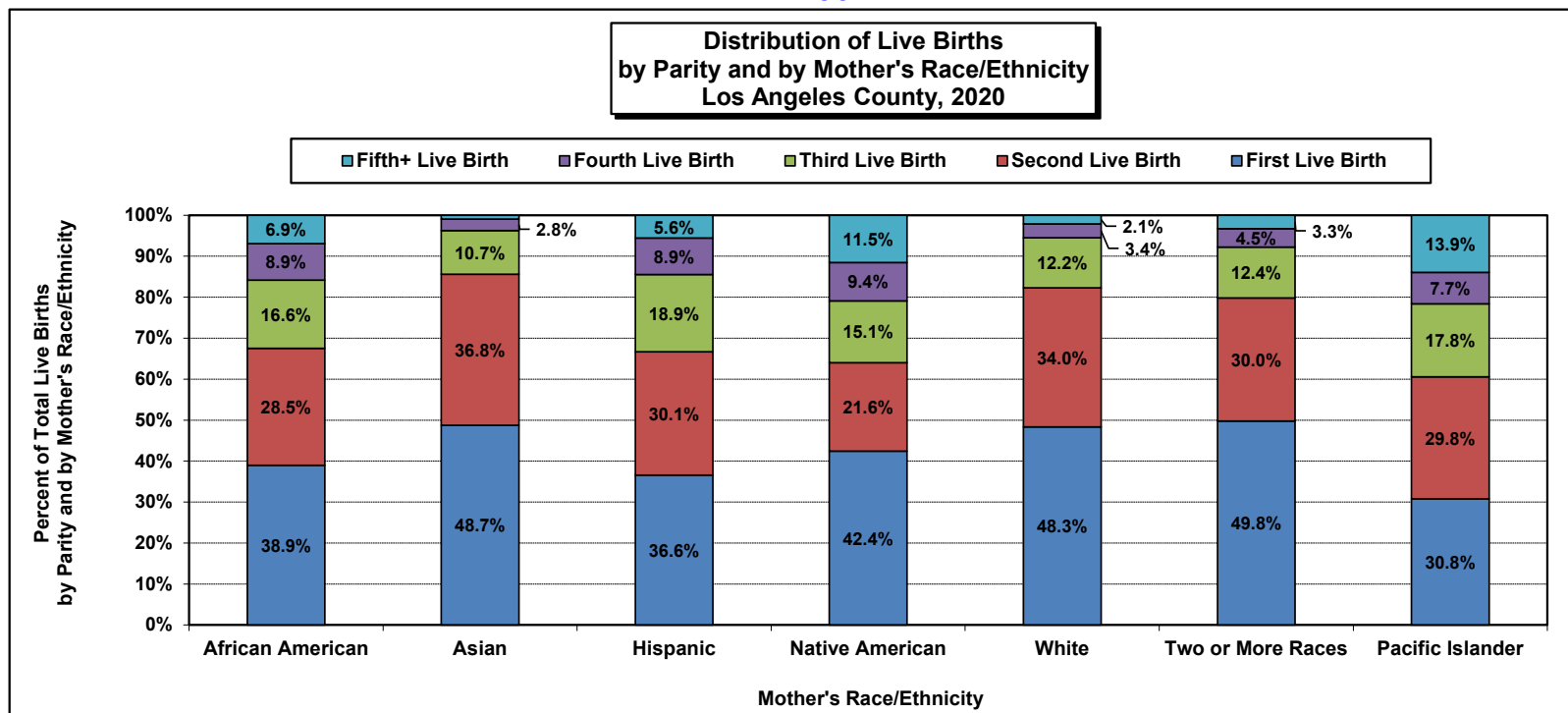
Source: 2018 birth records downloaded from the Vital Record Business Intelligence System (VRBIS) on 02/04/20



Los Angeles County, 2019													Total Live Births
Mother's Race/Ethnicity	Parity												
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
African American	2,977	39.5	2,144	28.4	1,264	16.8	614	8.1	533	7.1	7	0.1	7,539
Asian	8,072	49.3	6,061	37.0	1,707	10.4	366	2.2	151	0.9	2	0.0	16,359
Hispanic	20,823	36.2	17,332	30.1	11,008	19.1	5,122	8.9	3,269	5.7	7	0.0	57,561
Native American	54	40.6	35	26.3	17	12.8	11	8.3	16	12.0	<5	N/C	133
White	10,298	47.5	7,643	35.3	2,606	12.0	733	3.4	393	1.8	6	0.0	21,679
Two or More Races	867	48.7	551	31.0	231	13.0	72	4.0	58	3.3	<5	N/C	1,779
Other/Unknown	863	45.5	525	27.7	242	12.8	135	7.1	81	4.3	50	2.6	1,896
Pacific Islander	91	35.5	64	25.0	47	18.4	27	10.5	26	10.2	<5	N/C	256
Total	44,045	41.1	34,355	32.0	17,122	16.0	7,080	6.6	4,527	4.2	73	0.1	107,202

Notes: Parity = number of pregnancies resulting in live births to a woman.
Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.

Source: California Integrated Vital Records System 2019

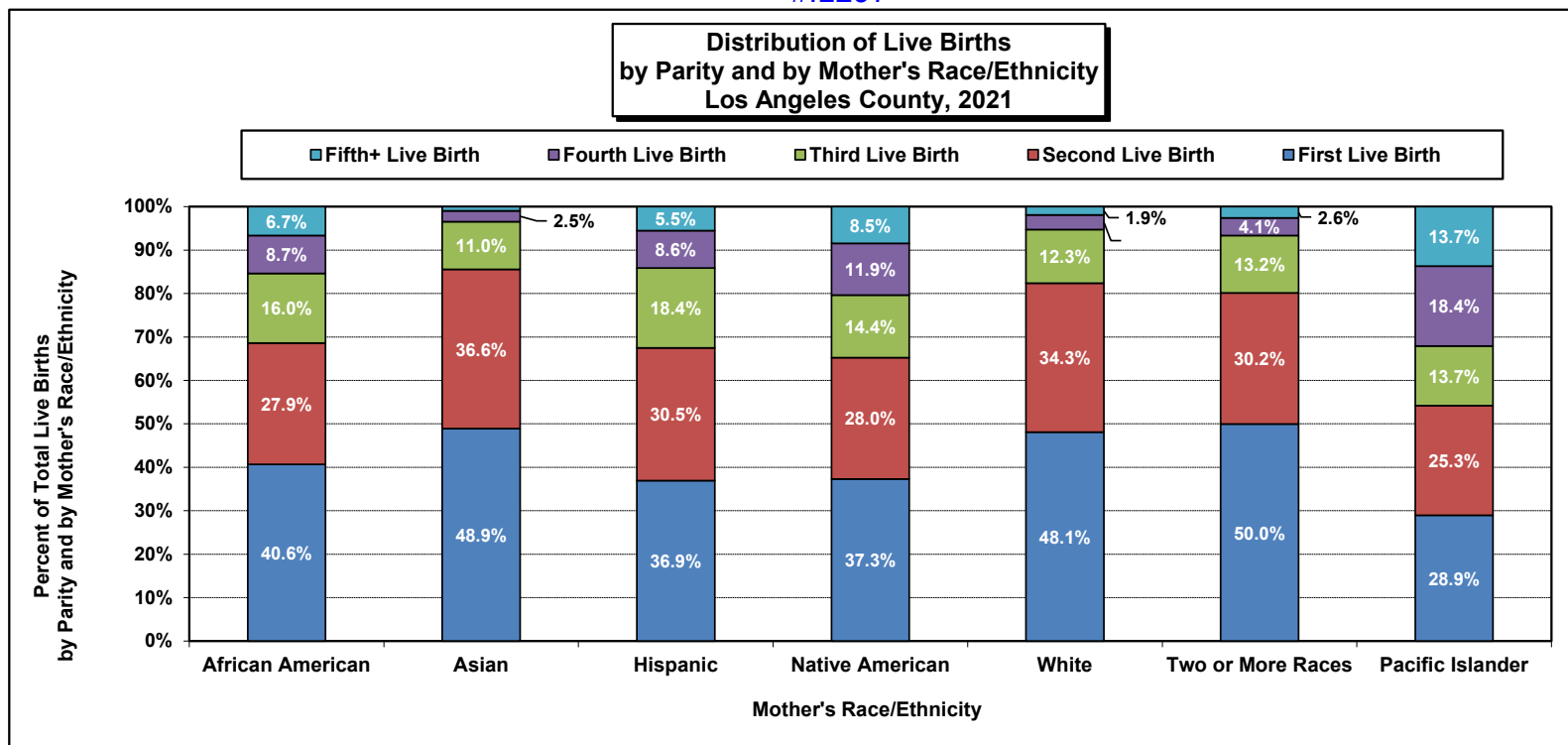


Los Angeles County, 2020													Total Live Births
Mother's Race/Ethnicity	Parity												
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
African American	2,758	38.9	2,022	28.5	1,176	16.6	633	8.9	487	6.9	9	0.1	7,085
Asian	6,361	48.7	4,813	36.8	1,394	10.7	364	2.8	121	0.9	9	0.1	13,062
Hispanic	19,594	36.6	16,132	30.1	10,127	18.9	4,753	8.9	2,986	5.6	12	0.0	53,604
Native American	59	42.4	30	21.6	21	15.1	13	9.4	16	11.5	<5	N/C	139
White	9,768	48.3	6,872	34.0	2,469	12.2	683	3.4	421	2.1	9	0.0	20,222
Two or More Races	853	49.8	515	30.0	213	12.4	77	4.5	56	3.3	<5	N/C	1,714
Other/Unknown	860	43.3	587	29.5	287	14.4	116	5.8	117	5.9	20	1.0	1,987
Pacific Islander	64	30.8	62	29.8	37	17.8	16	7.7	29	13.9	<5	N/C	208
Total	40,317	41.1	31,033	31.7	15,724	16.0	6,655	6.8	4,233	4.3	59	0.1	98,021

Notes: Parity = number of pregnancies resulting in live births to a woman.

Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.

Source: California Integrated Vital Records System, 2020



Los Angeles County, 2021													Denominator: Total Live Births
Mother's Race/Ethnicity	Parity												
	First Live Birth		Second Live Birth		Third Live Birth		Fourth Live Birth		Fifth+ Live Birth		Unknown		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
African American	2,858	40.6	1,964	27.9	1,129	16.0	611	8.7	469	6.7	8	0.1	7,039
Asian	5,704	48.9	4,275	36.6	1,281	11.0	294	2.5	113	1.0	3	0.0	11,670
Hispanic	19,463	36.9	16,104	30.5	9,703	18.4	4,535	8.6	2,914	5.5	14	0.0	52,733
Native American	44	37.3	33	28.0	17	14.4	14	11.9	10	8.5	<5	N/C	118
White	9,807	48.1	6,987	34.3	2,516	12.3	684	3.4	390	1.9	9	0.0	20,393
Two or More Races	848	50.0	512	30.2	224	13.2	69	4.1	44	2.6	<5	N/C	1,697
Other/Unknown	1,094	45.8	701	29.3	312	13.1	153	6.4	114	4.8	16	0.7	2,390
Pacific Islander	55	28.9	48	25.3	26	13.7	35	18.4	26	13.7	<5	N/C	190
Total	39,873	41.4	30,624	31.8	15,208	15.8	6,395	6.6	4,080	4.2	50	0.1	96,230

Notes: Parity = number of pregnancies resulting in live births to a woman.
Numbers fewer than 5 are shown as "<5". Rates are not calculated (N/C) if number is fewer than five.
Source: California Integrated Vital Records System, 2021

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8 **UNITED STATES DISTRICT COURT**
9 **CENTRAL DISTRICT OF CALIFORNIA**
10

11 ERICA JIMENEZ, individually and on
12 behalf of a class of similarly situated
13 individuals,

14 Plaintiff,

15 v.

16 DR. ERICA PAN, in her official capacity
17 as Director of the California Department of
18 Public Health, et al.,

19 Defendants.
20

Case No. 2:26-cv-03500-SPG-SP

**[PROPOSED] ORDER GRANTING
PLAINTIFF'S MOTION FOR CLASS
CERTIFICATION [ECF NO. #]**

21 On September 18, 2026, Plaintiff Erica Jimenez filed a Motion for Class
22 Certification and Appointment of Class Counsel, seeking certification of a proposed class
23 consisting of all persons who met, meet, or will meet the race-neutral eligibility
24 requirements for participation in the California Black Infant Health Program, but who
25 were, are, or will be ineligible for participation because they are not or do not identify as
26 black; and appointment of her counsel to serve as class counsel.
27

28 The Court, having considered Plaintiff's Motion and finding good cause therefore,
hereby GRANTS the Motion and ORDERS as follows

1. Pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(2), the Court certifies
the following class:

1 All persons who met, meet, or will meet the race-neutral
2 eligibility requirements for participation in the California Black
3 Infant Health Program, but who were, are, or will be ineligible
4 for participation because they are not or do not identify as black.

5 2. The Court appoints Plaintiff Erica Jimenez as representative of the certified class
6 pursuant to Federal Rule of Civil Procedure 23(a); and

7 3. Pursuant to Federal Rule of Civil Procedure 23(g), the Court appoints counsel of
8 Pacific Legal Foundation as Class Counsel.

9
10
11 IT IS SO ORDERED.

12
13 Dated:

14 _____
15 HON. SHERILYN PEACE GARNETT
16 UNITED STATES DISTRICT JUDGE
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