EXAMINING POLICY LEVERS TO ADVANCE THE EQUITABLE DELIVERY OF MATERNITY CARE

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Executive Summary

The U.S. continues to lead high-income nations in maternal mortality, with Black birthing people bearing the greatest burden of harm.[1] California mirrors this alarming trend; stark inequities persist despite the state advancing policies to address maternal health equity. Black women and birthing people in California experience pregnancy-related mortality rates over three times higher than their white counterparts.[2] Healthcare delivery systems contribute to these inequities through embedded structural, institutional, and interpersonal racism.[2]

While California has taken steps to expand access to and improve the quality of maternal healthcare, gaps remain. To date, state legal and regulatory efforts focus primarily on interpersonal and structural drivers of inequity, with less attention to the drivers stemming from organization-level policies and practices. Interventions targeting the differential treatment and lower quality of care birthing people of color experience in the inpatient setting are largely untapped policy opportunities.

In this report, developed in partnership with the Multi-Stakeholder Engagement with State Policies to Advance Antiracism in Maternal Health (MEND) Study at the University of California, San Francisco, we identify policies that address this gap to advance maternal health equity. Informed by an academic literature review and a scan of local, state, and national maternal health policies, we conducted a policy analysis that describes, compares, and recommends promising maternal equity policies within the context of California's healthcare systems. While maternal health inequities are the product of a constellation of social and clinical factors encompassing societal, organizational, and interpersonal dynamics, we have focused this analysis on organization-level practices in the inpatient setting during and immediately following labor and delivery.

Drawing from our research, we identified four policy levers with the potential to improve the quality and equity of inpatient perinatal care. The four policy options we explore are:

1. Mandate implementation of Alliance for Innovation on Maternal Health (AIM) bundles to standardize quality improvement efforts and address clinical inequities.[3]
2. Mandate maternal quality metric reporting to a statewide equity dashboard to improve transparency and enable data-informed oversight of hospital performance.[4]
3. Establish a Medi-Cal pay-for-performance program to incentivize measurable reductions in maternal health inequities.[5,6]
4. Create pathways for inpatient models of care supporting patient advocacy and enhanced care coordination for high-risk pregnancies.[7,8]

These policies were chosen because they had the greatest evidence base, which still varies significantly even across this small group, and are representative of the four primary approaches states and organizations have taken to address maternal health equity that directly target inpatient care practices. We assessed each policy against five core criteria: efficacy in improving maternal health outcomes, ability to reduce racial inequities, fiscal efficiency, administrative

burden, and political feasibility. In cases where concrete data was not present, for example, policies without reported health outcomes or cost-benefit analyses, we noted what proxy measures have been documented that are indicative of expected impact.

We find that Policy #1 (mandated AIM bundles) and Policy #4 (pathways to patient advocacy and care management) seem to have the strongest evidence in terms of demonstrated or projected ability to reduce inpatient maternal health disparities. Conversely, Policy #2 (mandated data reporting) and Policy #3 (pay-for-performance) would be the easiest for the state to administer, as they both build on well-established existing programs. All but Policy #2 (mandated data reporting) would likely require significant financial investment from the state. However, all of these programs can be scaled over time to lessen major funding at the onset if necessary. For two reasons, we do not recommend one policy over any other in this report:

1. These policies are not mutually exclusive, so advocates and policymakers should weigh the criteria that matter most to them and consider **adopting multiple policies for maximum effect**
2. These policies should be considered **models of four routes the state can pursue**– quality improvement, data transparency, financial incentives, and care models–and **not immutable blueprints**

This policy analysis also offers a strategic plan for policy adoption in a political climate where equity-based interventions face increased scrutiny.[9–12] To succeed, policies must confront ideological pushback, navigate fiscal constraints, and remain viable under changing administrations.[2] Advocates can build bipartisan political support by framing solutions around transparency, cost-effectiveness, and patient safety.[13] A strong coalition strengthens that support by bringing together different stakeholders across issue areas, political ideology, and sectors of healthcare to align around common goals.[33,34] To achieve this, effective maternal health communications must go beyond presenting data to center shared values like fairness, effectiveness, and collective responsibility. Framing equity-based solutions through clear, solution-oriented messages helps build broader support, especially when providers and stakeholders see themselves as integral to the work.[14–16] Engaging clinicians early and aligning messages with what matters to diverse audiences builds trust, momentum, and the potential for lasting change.[17]

Our analysis came together around specific policy recommendations to address institutional-level inequities in outcomes and experience for birthing people of color. Looking forward, **the State of California and maternal health stakeholders should work to:**

1. Strengthen California's **quality improvement and data collection infrastructure**
2. Reduce healthcare fragmentation by **integrating existing programs and policies**
3. **Utilizing strategic framing** on major maternal health objectives to enhance political acceptability
4. Uniting around institutional missions and core professional values to **strengthen coalitions**.

While no single policy is likely to eliminate race-based inequities in outcomes and experience, building a comprehensive policy agenda that targets the social, organizational, and interpersonal levels at which health inequities occur can advance maternal health equity objectives.

About this report

This report was developed by four Master of Public Policy students at the University of California, Berkeley Goldman School of Public Policy (GSPP) between January and May 2025. All first-year GSPP students are required to complete a client project in order to matriculate into their second year. This project was commissioned by Dr. Sarah Garrett, Ph.D. for the University of California, San Francisco Multi-Stakeholder Engagement with State Policies to Advance Antiracism in Maternal Health (MEND) Study. Questions about this report should be directed to Dr. Garrett (Sarah.Garrett@ucsf.edu), Celia Johnson (johnson_celia@berkeley.edu), and Kirsta Hackmeier (Kirsta_Hackmeier@berkeley.edu).

Definitions

Health disparities: Differences in the burden of health status, disease, and healthcare experience across populations.[18]

Health inequities: Systematic, unjust, and preventable differences in the burden of health status, disease, and healthcare experience across populations.[19]

Perinatal care: Healthcare provided to birthing persons in the period immediately before, during, and after labor.

Structural racism: "The systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc. (adapted from Bailey et al. 2017)."[20]

Institutional racism: A form of structural racism, occurring at the healthcare system or organizational level. It is a "lack of accountability of health care systems and their providers to deliver care free from discrimination and bias."[20] Institutional racism may manifest as minoritized patients experiencing disparate treatment or outcomes due to organizational policies and practices, or a lack thereof.[21]

Interpersonal or personally mediated racism: "Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization (adapted from Jones, CP, 2000)."[20]

Discrimination: "Treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making (adapted from Smedley et al., 2003)."[20]

Project Partner

Sarah Garrett, PhD, is the principal investigator of the Multi-Stakeholder Engagement with State Policies to Advance Antiracism in Maternal Health (MEND) study at the University of California, San Francisco. The MEND study was initiated in response to California's 2019 Dignity in Pregnancy and Childbirth Act, which mandated implicit bias training for all maternal health providers. The study brings together an interdisciplinary group of stakeholders to create culturally responsive and evidence-based guidelines for these required trainings. Since its inception, the group has expanded its scope to assess other opportunities for California to enhance protections for birthing people of color. Ultimately, the project seeks to close the maternal health equity gap in California through the adoption of community-engaged policies and practices rooted in evidence and inclusion.

Dr. Garrett and other experts conducted a policy review and thematic analysis to determine if recently adopted state policies target healthcare-based drivers of maternal health inequity. The team determined that California enacted 13 maternal health laws and regulations between 2019 and 2023. They then categorized each based on what manifestation of healthcare inequity it sought to address.[22] Inspired by policy gaps identified by Dr. Garrett's work, this report clarifies how the state could take action to fill those gaps and further support women and birthing people of color.

Defining the Problem

The U.S. has the highest rate of maternal deaths of any high-income nation.[1] According to the Centers for Disease Control and Prevention (CDC), the maternal mortality rate as of September 2024 was about 19 deaths per 100,000 live births across racial and ethnic groups. However, the rate jumps to over 50 deaths per 100,000 live births among Black birthing people.[23] California, which accounts for around 10% of all births in the U.S., struggles with these inequities as well, with pronounced racial and ethnic differences in maternal health outcomes.[24] The pregnancy-related mortality rate for Black birthing people in California was 45.8 deaths per 100,000 live births, more than three times higher than the rates for Asian (15.0), Hispanic/Latino (14.8), and white birthing people (12.6).[2] Notably, a CDC analysis reveals that more than 80% of maternal deaths are preventable, highlighting the urgency of addressing persistent gaps in maternal healthcare.[25]

Underscoring these concerning statistics is the fact that trends are moving in the wrong direction. Even before the COVID-19 pandemic, maternal mortality rates in the U.S. were rising, and the pandemic only accelerated the growth.[26] Maternal deaths in California increased by 70% from 2019 to 2021.[2] While it appears that the 2021 peak has since abated, this massive swing demonstrates the significant vulnerability of this population.

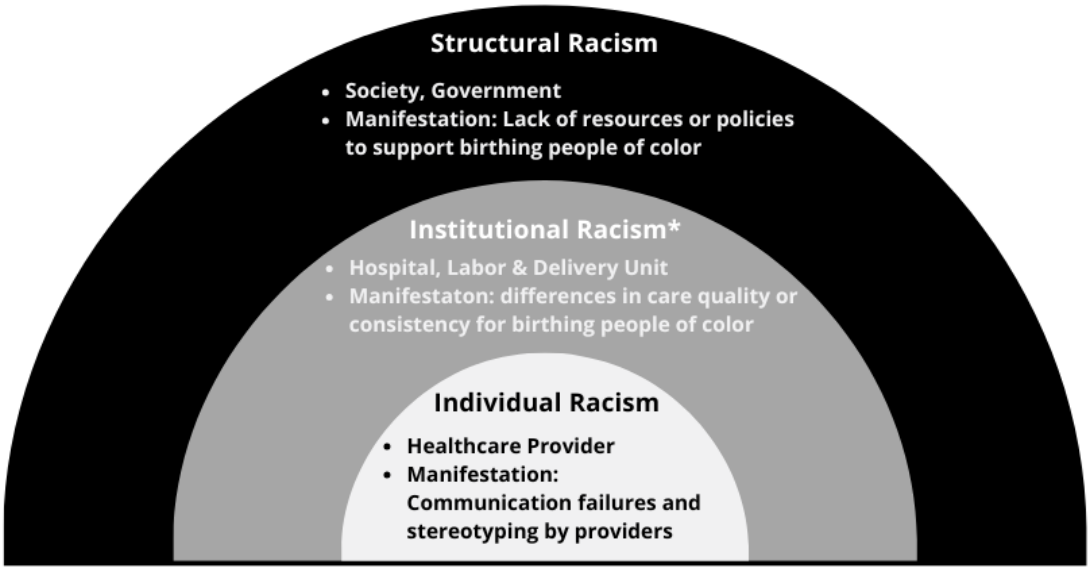
Maternal morbidity (i.e., harm or suffering that is not fatal) presents an equally pressing challenge. In California, more than one in five birthing people reported prenatal or postpartum symptoms, with the rates significantly higher for Black birthing people.[24,26] Research

consistently shows that Black people receive lower-quality care, contributing to these inequities in experience and outcomes.[1] For example, about a quarter of Black birthing people report depression symptoms during pregnancy, a higher rate than reported by other racial and ethnic groups. Studies also indicate that implicit bias among healthcare providers disproportionately impacts Black women in healthcare settings, driving care delays, miscommunication, or misdiagnosis during pregnancy and delivery.[27] While California lawmakers have mandated implicit bias training, institution-level policy interventions designed to monitor and reduce inequities effectively remain an underleveraged pathway for effecting change.[28,29]

Key Drivers of Maternal Health Inequities

An array of factors contribute to differential outcomes for birthing people of color, ranging from high-level systemic injustices to the small interpersonal decisions and interactions ofcaregivers. In 2022, the CDC Foundation convened a group of experts who developed a conceptual framework outlining three distinct forms of racism and how each manifests in healthcare.[20] Garrett et al. used this framework to categorize California's recent policy actions by the manifestation of health inequity they intend to target.[22] *Figure 1* maps these healthcare manifestations of racism onto three levels–structure, institutional, and interpersonal.

Figure 1: Three levels of racism and their manifestations



Manifestation #1: Communication failures and stereotyping by providers

The first level contributing to racial health inequities reflects interpersonal racism held consciously or subconsciously by people working in a healthcare setting. It can include victim blaming, ignoring symptoms or concerns, delaying treatment, and more.[20] California has passed two major policies in the last five years to address the issue of implicit bias in maternal care: the 2019 California Dignity in Pregnancy and Childbirth Act and 2019 Assembly Bill 845.[22] However, the current body of research cannot conclusively state that implicit bias training

reduces stereotyping and communication failures, and thus, there is no clear connection between it and improved health outcomes.[29–31] In the absence of concrete evidence, additional approaches are needed to alter and improve provider behavior.

Manifestation #2: Differential treatment for birthing people of color

The second manifestation relates to differences in care quality or consistency due to conditions at the organizational level (e.g., within a given ward, facility, or health system). Some examples of this differential treatment or experience include restrictions on social support during delivery–such as limits on patient visitors or doulas—insufficient care coordination, and care that is not culturally appropriate.[20] Only one policy has been advanced in California in the last five years to address this driver of inequity. A component of the 2019 Dignity in Pregnancy Act, this provision requires hospitals to inform patients of their rights and how to file discrimination complaints.[22] As this is a mostly unaddressed manifestation of racism in healthcare, there is a significant opportunity for state policymakers to engage with this driver of inequities.

Manifestation #3: Lack of resources or policies to support birthing people of color

The final manifestation encompasses the powerful social forces that make achieving and maintaining optimal health difficult for minoritized populations. One major contributor in this category is the fact that patients of color, particularly Black patients, deliver in different and lower-quality hospitals than white patients. Research suggests that if Black birthing people delivered in the same hospitals as white birthing people, rates of Black severe maternal mortality and morbidity (SMM) would be cut nearly in half.[32] It also includes insufficient healthcare coverage and access, as well as transportation and housing-related barriers.[20] Addressing and mitigating these social determinants of health has been a major area of focus for California health policymakers in recent years, as more than 90% of state policies target these social-structural drivers.[22]

Why is this analysis needed?

Evidence demonstrates that birthing people of color, and Black birthing people in particular, face significant barriers to equitable, high-quality, consistent maternal care. While California has taken some steps to address these issues, more policies that effectively target the differential treatment and care quality that birthing people of color receive are needed.

Scope of analysis

As discussed in the previous section, the vast majority of California's current maternal health policies target Manifestation #3 (lack of resources or policies to support birthing people of color). California has also taken major steps to try to minimize Manifestation #1 (communication failures and stereotyping by providers) with its mandated implicit bias training for maternal care providers. These two manifestations generally relate to structural and individual racism, as illustrated in *Figure 1*. Much less attention has been given to Manifestation #2, with only one policy implemented between 2019 and 2023 addressing the issue of differential treatment for birthing people of color.[22] There remains a significant need for

California to enact policies that will ensure consistent, high-quality care for all birthing populations. To do this, interventions will need to work at the institutional level, changing written and unwritten practices within the unit, department, facility, or hospital system. We denoted institutional racism and its healthcare manifestations with an asterisk in *Figure 1* as that is the level at which our policy analysis will seek to intervene.

Once we identified which manifestation of racism to target, we further scoped our analysis by focusing on one segment of the maternal care continuum. The maternal care continuum, shown in a simplified format in *Figure 2*, encompasses the care provided from conception, the months leading up to birth, the labor and delivery process, to the postpartum recovery period.[33] While health care providers play a role at each stage of this journey, the inpatient perinatal period between when a patient is admitted during labor and when they are discharged after birth represents a key moment for maternal safety. About 17% of maternal deaths take place on the day of delivery, and another 19% occur within the following six days.[34] Providers have a unique level of influence over conditions birthing people experience during their time in the inpatient setting, distinct from the prenatal and postpartum months. For this reason, we chose to focus our assessment on policies that will affect care during that relatively narrow window in the maternal health experience when a patient is laboring in the hospital and recovering after delivery. Once again, we have denoted this segment with an asterisk to further clarify the scope of our analysis.

Figure 2: The continuum of maternal care

California has the opportunity to advance policies that move beyond symbolic actions and build lasting, enforceable structures for equity in the inpatient setting. This work is necessary not only to improve outcomes but to restore trust in institutions that have long marginalized Black birthing people and other communities of color.[35,36] In looking at state-level opportunities to enact change, there are several relevant agencies with regulatory and oversight authority, described below.

Major California Policy Players in Maternal Health:

California Department of Public Health. The California Department of Public Health's Maternal, Child, and Adolescent Health Division (CDPH MCAH) conducts data surveillance on maternal deaths, pregnancy-related mortality, severe maternal morbidity, maternal substance use, and other select maternal health indicators.[37] In collaboration with the Health Resources and Services Administration (HRSA), CDPH also works with 61 local health jurisdictions (LHJs) to establish and implement strategic goals directed at improving maternal health indicators.[37] Most LHJ Title V activities are focused on mental health, prenatal care, and chronic condition management for birthing people. The California Department of Public Health also runs the Office of Health Equity (OHE), which is tasked with building partnerships to raise awareness of and address health inequities and engage the perspectives of impacted communities.[38]

Department of Health Care Access and Information. One of California's newest agencies, the Department of Health Care Access and Information (HCAI) was established in 2022 to carry out several key healthcare activities. Relevant to our analysis, HCAI is tasked with making California's healthcare system more accessible, affordable, and safe. A major component of their work involves collecting and analyzing healthcare cost and quality data. As part of that mission, HCAI will be leading the recently created Hospital Equity Measures Reporting Program, sharing public reports on a handful of health system performance measures.[39]

The California Maternal Quality Care Collaborative (CMQCC). This is a multi-stakeholder organization committed to ending preventable morbidity, mortality, and racial disparities in California maternity care. CMQCC's initiatives include the development of quality-improvement toolkits, evidence synthesis, and hospital data monitoring through the Maternal Data Center.[40]

Medi-Cal, California's State Medicaid Program. As the largest insurer of births in California, Medi-Cal regulations and coverage provisions also play a role in the provision of inpatient maternity care. About 40% of births in the state are covered by Medi-Cal.[41] Medi-Cal's policies can be broadly classified into performance and quality reporting measures, and coverage and financing mechanisms. Performance measures directly relevant to inpatient care processes include managing chronic disease (overweight/obesity and hepatitis B), as well as pay-for-performance initiatives related to long-acting reversible contraception (LARC) within 60 days of delivery.[42] Other coverage and financing of specific services relevant to the perinatal or delivery care continuum include: inpatient lactation services, mandated American College of Obstetricians and Gynecologists- and Comprehensive Perinatal Services Program-comparable risk assessments, mandated provision of care according to perinatal practice guidelines for the American Society of Addiction Medicine continuum of SUD services, and expanded delivery reimbursement to licensed midwives and freestanding or alternative birthing centers (ABCs).[42]

Methods

Policy Options

This section will outline the proposed policy options under consideration, providing a brief but clear description of each. We will also discuss similar actions that California has already undertaken and how this policy will fit into existing structures.

We developed these policy options by reviewing state laws, draft legislation, policy advocacy briefs, and academic literature on maternal health inequities. As we discussed in our scoping section, we chose to focus exclusively on policies or programs that specifically intervene on organization-level inpatient care processes. We looked for policies impacting how inpatient care providers interact with patients and collaborate with other care team members; where, when, and how inpatient perinatal care is delivered; and how that care may be delivered differentially by patient, provider, or hospital characteristics to contribute to health inequities. We focused on policies that could reasonably be implemented at the state level, either through legislation or

agency authority, rather than those that a private healthcare organization or private healthcare plan might implement. The scan we conducted is not exhaustive, but we believe provides a general overview of the existing incentive, regulatory, and other policy mechanisms being enacted across the U.S. to address inpatient perinatal health inequities.

Policy #1 – Mandate implementation of Alliance for Innovation on Maternal Health (AIM) bundles

The Alliance for Innovation on Maternal Health (AIM) is a partnership between the American College of Obstetricians and Gynecologists (ACOG) and the Health Resources and Services Administration (HRSA). AIM has developed core patient safety bundles to improve outcomes for birthing people, and now works to provide technical assistance and implementation support to organizations.[43] The bundles offer concrete steps that providers can follow to reduce perinatal conditions such as obstetric hemorrhage, sepsis, C-section, and more. One bundle, Reduction of Peripartum Racial and Ethnic Disparities, specifically targets maternal health inequities. This bundle has since been archived by AIM, possibly because the group has integrated racial equity more directly into each of its condition-based bundles. In *Figure 3* we provide a more detailed explanation of the AIM patient safety bundles.

This policy would scale existing actions taken by the California Maternal Quality Care Collaborative (CMQCC) by mandating select AIM bundles at low-performing hospitals, along with technical assistance and financial support to ease implementation. The state will assess which areas of maternal health the facility needs to address and assign one or more bundles based on that deficit. The state can choose to provide implementation support itself, or contract organizations with expertise to assist hospitals with the transition.

Figure 3: About the Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles

What are the Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles?

AIM is a multi-sectoral collaborative group with support from the American College of Obstetricians and Gynecologists and funding from HRSA.

"Patient Safety Bundles (PSB) are a structured way of improving the processes of care and patient outcomes. Patient safety bundles are collections of evidence-informed best practices, developed by multidisciplinary experts, which address clinically specific conditions in pregnant and postpartum people. The goal of PSBs is to improve the way care is provided to improve outcomes. A bundle includes actionable steps that can be adapted to a variety of facilities and resource levels."[3]

–Alliance for Innovation on Maternal Health

Eight Core Patient-Safety Bundles

1. Obstetric Hemorrhage
2. Severe Hypertension in Pregnancy
3. Safe Reduction of Primary Cesarean Birth
4. Cardiac Conditions in Obstetric Care
5. Care for Pregnant and Postpartum People with Substance Use Disorder
6. Perinatal Mental Health Conditions
7. Postpartum Discharge Transition
8. Sepsis in Obstetric Care

Archived Bundle: Reduction of Peripartum Racial and Ethnic Disparities

How have the AIM PSBs been used in California and other states?

Healthcare providers in California have been participating in the AIM programs since 2016.[21] Providers within the state currently use the Obstetric Hemorrhage, Severe Hypertension in Pregnancy, Safe Reduction of Primary Caesarean Birth, Care for Pregnant and Postpartum People with Substance Use Disorder, and Sepsis in Obstetrical Care bundles.[44] The AIM bundles are used in all 50 states, with states utilizing different bundles depending on their population health needs.

How do AIM PSBs relate to other policy options?

AIM bundles are one way to standardize care processes across hospitals, birthing centers, physicians, and other care providers, which can help ensure all patients are getting high-quality, evidence-based care. While the AIM bundles include outcome measures that can be used to assess quality, they also include process measures and guidance that can help hospitals and units along the change process, via education, collaboration, and feedback. Policy options such as financing mechanisms can facilitate AIM implementation; in turn, AIM can facilitate quality improvement and data collection.

Policy #2 – Mandate maternal quality metric reporting to a comprehensive state-wide maternal health equity dashboard

In 2021, California passed Assembly Bill 1204, which directed HCAI to collect and share information about hospital performance on certain equity measures.[39] The Hospital Equity Measures Reporting Program will release annual reports on about a dozen measures stratified by race, ethnicity, language, disability status, sexual orientation, gender identity, and payer. The reports cover a broad swath of structural and quality metrics, but only two of the recommended measures relate directly to maternal health:[45]

1. Cesarean birth rate (Nulliparous, Term, Singleton, Vertex)
2. Vaginal birth after Cesarean rate

While the HCAI reports will be viewable to the public, most California hospitals have been reporting maternal equity data to a centralized dashboard only visible to them for years. The CMQCC, a collaboration between the state government and many healthcare organizations, currently operates the Maternal Data Center (MDC). Participating hospitals have the option to report discharge data to MDC, which then auto-links it to existing data to generate near-real-time maternal health outcomes reports. The dashboard compares performance against peers and benchmarks, and tracks data down to the individual physician level. It also stratifies quality measures based on race and ethnicity. While participation is optional, 99% of deliveries in the state are reported to the MDC.[46] MDC auto-generates certain quality measures using Patient Discharge Data (PDD) and birth certificate data, meaning it is always reported. Many AIM measures are included in these auto-generated reports, for example, 'Cesarean Birth After Labor Induction: NTSV Cases' and 'Severe Maternal Morbidity Among Hemorrhage Cases (Inc. and Excl. Transfusions).' However, other AIM measures, such as 'Timely Treatment for Severe Hypertension' and 'Perinatal Mental Health Patient Education,' are only supplemental and thus not collected for all participating systems.[47] We do not know the rate of reporting this supplemental data. Additionally, comprehensive data is only viewable by the reporting hospital and not accessible to the public or state agencies.

This policy option would expand equity and transparency efforts initiated by Assembly Bill 1204, and consolidate disparate maternal equity efforts by making reporting to the MDC mandatory for all labor and delivery sites in California. Hospitals would have to report all AIM measures and make the data dashboard–down to the provider level–accessible to the Department of Health Care Access and Information (HCAI). Overseeing and reporting on this maternal dashboard would become a sub-stream within the larger Hospital Equity Measures Reporting Program initiative. The state will monitor the dashboard and send soft warning letters to institutions that are performing poorly in top-priority maternal health metrics.

Policy #3 - Implement a Medi-Cal Quality Incentive Pay-For-Performance Program

In a pay-for-performance (P4P) financing model, health plans, organizations, or providers are incentivized to meet certain quality or outcome benchmarks through bonus payments or

financial penalties. Fourteen states have a form of quality incentive or P4P program that provides payments for Medicaid managed care organizations (MCOs) meeting established targets. Although California utilizes P4P incentives in some condition areas, hospitals are not required to report any perinatal care continuum measures. Currently, the Department of Healthcare Services (DCHS) requires Medi-Cal MCOs to report on the CMS Core Set of maternal quality measures: timeliness of prenatal care, postpartum care, Long-Acting Reversible Contraception (LARC) at 3 and 60 Days, and Most or Moderately Effective Contraception-3 and 60 Days. DCHS implements and monitors quality improvement efforts for plans not meeting benchmark measures. Additionally, as part of the Medi-Cal Managed Care Accountability Set (MCAS), MCO plans also report low-risk cesarean delivery and postpartum depression screening and follow-up measures to DCHS, but measures are not held to a minimum performance level, nor are there incentive payment structures.[49]

This policy would expand the measures Medi-Cal plans report to DCHS to include the AIM bundle indicators described in Policy #1 (obstetric hemorrhage, sepsis, etc.) and patient experience indicators. In this policy, DHCS would monitor and initiate quality improvement plans for the existing and added benchmarks, and MCOs and providers would also be eligible for financial incentives in a structure known as a "bonus for demonstration of improvement."[48] In this payment structure, plans and providers, through pass-through payments, would receive annual bonus payments when they make significant improvements towards established benchmarks or document disparity reductions in the quality measures. There would be no financial penalties for not achieving targets, and plans that meet the established benchmark would also receive the bonus payment.

Policy #4 - Create Pathways to Expand Inpatient Models of Care and Perinatal Care Management

A wealth of states, organizations, and researchers are testing care management, interprofessional, and whole-person care models to address health inequities in outcomes and experience. California is already doing a lot of work in this space (e.g., CalAIM, Enhanced Care Management), but thus far, less attention has been paid to what this looks like in the inpatient maternity care setting–the initiatives thus far have largely focused on the prenatal and postpartum periods. We identified areas for improvement in California's existing models and other interventions that change care delivery models, which, despite promising effectiveness evidence, have yet to be scaled in California. One example of an area for improvement is the state's Medi-Cal Doula Coverage and Enhanced Care Management program, where uptake is fairly low despite high perceived need and willingness to participate.[50] This policy seeks to specifically fund care model opportunities in the inpatient setting.

This policy would create a multi-year funded program for hospitals, health systems, and other provider organizations to implement interventions, team staffing and continuing education initiatives, or other evidence-backed care models for equitable and dignified perinatal care, regardless of race or ethnicity. This funding could be integrated with the existing DHCS Providing Access and Transforming Health (PATH) Capacity and Infrastructure, Transition, Expansion, and Development (CITED) initiative (e.g., creating a similar funding model to the

Justice Involved Capacity Building program initiated in 2023).[51,52] PATH CITED provides funding, staffing, technical assistance, and data infrastructure to provider organizations implementing the state's CalAIM services, which might otherwise not have adequate resources or requisite staffing capacity to transform their service delivery model.[53] In 2024, PATH CITED distributed $147 million to organizations.[54] In creating a sustainable funding mechanism, this policy seeks to incentivize organizations to invest in transforming their care processes and staffing toward novel and evidence-based models of perinatal care delivery. Examples of such models could include mandated patient navigation or Doula support through the birthing process, nurse or social worker care coordination, use of low-interventional approaches–which are "practices that facilitate a physiologic labor process and minimize intervention for appropriate women who are in spontaneous labor at term"–or other care delivery models from the academic literature, which have yet to be scaled.[8]

Figure 4: Aligning this report with the Transforming Maternal Health (TMaH) Model

What is the Transforming Maternal Health (TMaH) Model?

In January 2025, the Center for Medicare and Medicaid Services (CMS) announced the 15 states selected to participate in a new care innovation model designed to improve maternal health outcomes and produce government savings. California was selected for the Transforming Maternal Health (TMaH) Model, which is scheduled to last for 10 years. TMaH is designed to enhance access, experience, and outcomes for birthing people enrolled in Medicaid through targeted financial and technical support to participating states.[120]

How does the TMaH Model align with this report?

The goals of TMaH and the goals of this report are fundamentally the same–to improve maternal health outcomes and reduce disparities. While the scope of TMaH is much broader than the scope outlined in our analysis, encompassing 15 states and the entire maternal care continuum, many of the proposed interventions parallel and complement one another. TMaH encourages states to initiate quality improvement processes and support facilities in earning CMS's "Birthing Friendly" designation. Implementing AIM bundles, as outlined in Policy #1, would qualify hospitals for this new designation.[121] The model also allows states to create value-based payment structures for maternal care services; one value-based designed option is the P4P scheme outlined in Policy #3. Finally, TMaH specifically calls out increasing access to alternative providers such as midwives, doulas, and community health workers. This objective could be accomplished through Policy #4, which expands highly supportive team-based care models.

What is the future of TMaH?

TMaH was created and launched in the final days of the Biden White House, making its future under the current administration uncertain. As of publication (May 2025) President Trump's CMS has already canceled at least six current and proposed innovation models.[122] The policies and proposals contained within this report are intended to work in conjunction with or in the absence of federal assistance, like that granted via TMaH.

Analysis Criteria

Efficacy: Does the policy improve health outcomes or experience for birthing people?

We evaluated the efficacy of policies based on evidence that they can improve maternal health outcomes during or after birth. The strongest policies will have direct data demonstrating lower rates of maternal morbidity (e.g., hemorrhage, infection, unnecessary C-section, or postpartum depression) or maternal mortality. Because these outcomes can take years to manifest and are typically quite rare, especially in the case of mortality, we also looked for improvement in proxy measures. Examples of intermediate metrics included in our analysis include expert testimony, provider participation, and correlational analysis.[55,56]

Equity: Does the policy reduce the disparities in health outcomes or experience between White birthing people and birthing people of color?

While any policy will ideally improve outcomes for all birthing people, the goal of this policy analysis is to identify opportunities to shrink the inequities in outcomes for birthing people of different racial and ethnic identities. Due to the difficulty in measuring inequity directly, sometimes secondary measures are used to assess progress toward more equitable systems and outcomes. Gold-standard policies will demonstrate reduced disparities between white and non-white morbidity and mortality outcomes. As with the efficacy criteria described above, it is challenging to find significant impact data directly correlating interventions and improved equity in ultimate health outcomes. As such, we sought proxy measures that indicate progress toward greater equity. Proxy measures included in our analysis are staff awareness and engagement, provider attribution scores, and patient experience.[57,58]

Efficiency: How much will the policy cost the government and other stakeholders, and how significant is the return on that investment?

This criterion measures two separate but related measures–in absolute terms, how much additional financing will be required to implement and sustain this policy, and what is the relative return on each dollar spent in terms of efficacy outcomes described above? It will also consider who is responsible for making those payments and how heavy the burden would be for that actor. To estimate costs, we looked to public records that document investment in similar initiatives in California and other states. We also searched the literature for typical costs associated with policy compliance within hospitals and health systems.

Administrability: How much new infrastructure and how many new systems will have to be established to implement and administer the policy?

While related to cost measures, the administrability criterion is an important predictor for programmatic success and limiting unintended consequences. With this criterion, we estimate the extent to which new systems will need to be established to administer the new policy. To be

strong in this category, a policy would rely primarily on existing government infrastructure (e.g. agencies or departments, technology systems, stakeholder relationships, etc.) and competencies (e.g. professional expertise, oversight functions, etc.). Similarly, it would not require providers to take on wholly new functions with which they have no previous experience. We will explore if workforce, technological, or infrastructural investments will need to be made, and how prepared various stakeholders are to take on those new responsibilities.

Political feasibility: Is the policy likely to face pushback from powerful stakeholders?

Our final criterion assesses the level of opposition a policy is likely to face. This metric also informs the political strategy plan included later in this report. It is valuable to consider as advocates weigh the resources they are willing or able to deploy in order to overcome political barriers to a given policy. It is also indicative of whether the policy can withstand changes in leadership and shifting priorities and be sustained over the long term. The main groups we will consider in this measurement are lawmakers of different parties, industry groups that represent hospitals and physicians, and patient rights and advocacy groups. We will search for statements of opposition or support for similar policies and extrapolate likely positions based on historical group priorities.

Weighting

Because the goal of this report is to give interested parties an array of effective policy options to consider for California, none of the above criteria will be exclusionary on their own. The most important metric is the ability to reduce inequities in outcomes for birthing people of color (criterion two), with the ability to improve maternal health overall (criterion one) as a close secondary priority or consolation outcome. The other metrics will be evaluated in order to aid advocates in the process of weighing their options and developing a strategy for future action.

Results

Policy #1 – Mandate implementation of Alliance for Innovation on Maternal Health (AIM) bundles

Who has implemented the policy?

AIM bundles have primarily been implemented by individual hospitals or health systems who voluntarily sought to improve their maternal health offerings. Several states, including California and Louisiana, have developed perinatal quality collaboratives to support organizations' voluntary efforts to implement these AIM models.[40,59]

Efficacy: Does the policy improve health outcomes or experience for birthing people?

Most of the AIM bundles are broadly directed at improving maternal health outcomes for all birthing people, with the one exception being the bundle that specifically targets health equity and racial disparities. Several hospitals that have implemented these bundles have

demonstrated tangible improvements in maternal health outcomes, especially using the hemorrhage bundle. For example, after implementing the AIM hemorrhage bundle, the California Perinatal Quality Collaborative saw a reduction in severe maternal morbidity and mortality (SMM) among women with hemorrhage, falling from 22.1% to 18.5%.[60] SMM from hemorrhage also decreased from 34.1% to 26.7% at Baylor University Medical Center in Texas after they adopted the hemorrhage bundle and case review.[61]

Equity: Does the policy reduce the disparities in health outcomes or experience between White birthing people and birthing people of color?

There is significant data to validate that both the equity-specific and general AIM bundles improve care for patients of color in particular. The California Perinatal Quality Collaborative and Baylor University Medical Center reduced the racial gap in maternal hemorrhage between Black and white patients.[60,61] The University of Pennsylvania also leveraged the AIM hemorrhage bundle, alongside some other interventions as part of a broader maternal health equity push, and saw a nearly 30% decrease in maternal morbidity for Black women.[62]

In addition to these concrete outcome measures for the hemorrhage bundle, some studies have shown that the equity bundle can influence some proxy measures that are likely to improve health equity over time. Provider Attribution is a metric measuring the extent to which respondents believe that clinicians have a role in health disparities. High Provider Attribution (score of 3 or more) is considered a key step in taking personal action to address inequities. One Maryland hospital implemented the AIM equity bundle, after which scores of High Provider Attribution increased, as did the share of staff who stated that they had participated in "activities related to improving health or promoting health equity for racial and ethnic minority patients."[58]

Efficiency: How much will the policy cost the government and other stakeholders, and how significant is the return on that investment?

Studies have shown that quality improvement collaboratives, like those established by California and Louisiana that this policy seeks to expand, can be cost-effective and generate cost savings, especially when spread across large populations.[63] California's Maternal Quality Care Collaborative perinatal quality collaborative initiative to reduce severe maternal mortality and morbidity after hemorrhage was estimated to have saved $9 million, or about $18 per birth.[64]

The total cost associated with mandating AIM bundles will primarily be borne by the state. California will need to furnish technical, logistical, and administrative assistance to help hospitals successfully implement and sustain the bundles. California can do this directly or contract with an experienced organization, such as AIM or the Institute for Healthcare Improvement (IHI), to provide technical support. The state will need to hire a small number of additional staff to oversee the program, with duties to include selecting participating hospitals, assisting with their onboarding, and monitoring progress. Depending on the number of facilities mandated to participate, this could involve two to four additional full-time employees. One option for minimizing costs is to narrow the share of hospitals required to participate, for example, targeting only the bottom 10th percentile rather than the bottom 25th percentile of performers.

Even with the state financing much of the implementation and support, each hospital will also need to invest in some additional worker time to act as the facility liaison, which could be as little as one half to one full-time employee. Because the hospitals struggling in these areas typically face other financial challenges and higher-risk populations, this intervention aims to minimize any additional financial burden.

Administrability: How much new infrastructure and how many new systems will have to be established in order to implement and administer the policy?

The CDPH Center for Health Care Quality has significant experience overseeing and supporting quality improvement initiatives.[65] The state even has specific experience working with AIM bundles through the California Perinatal Quality Collaborative. There is significant existing infrastructure and institutional knowledge to ease administration efforts. Administration and continuous support become easier if the state opts to partner with expert groups, such as AIM or IHI, to assist with support functions.

All hospitals have existing quality improvement infrastructure into which AIM bundles can be integrated. AIM bundles, and the equity bundle in particular, will require some additional training and systems because they necessitate some skills and functions that have been excluded from the inpatient setting up until this point. For example, learning how to ask demographic questions, education about root causes of inequities and shared decision-making, and establishing processes for patients to report inequitable care.[66]

Political feasibility: Is the policy likely to face pushback from key stakeholders?

The most likely source of pushback for mandating AIM bundles will be from hospital and physician industry groups who generally say they are already overburdened by existing state and federal mandates, and increasing that pressure will only make their work more challenging. Both the American Hospital Association and the American Medical Association have spoken out against the growing administrative burden on providers.[67,68] And while most medical and hospital associations are generally in favor of quality improvement, especially if supplemented with government funding, physician groups are very sensitive to concerns of doctors losing autonomy over clinical decision making.[69]

Overcoming political challenges will require advocates to demonstrate that past legislative action has not been enough to correct differential treatment and navigate the political influence of powerful provider organizations.

Key advantage(s)

Quality improvement initiatives, especially AIM bundles, have the strongest evidentiary track record of virtually any inpatient maternal equity intervention. Some of the bundles have even been used broadly in California and have been shown to be effective while requiring minimal infrastructural investments.

Key disadvantage(s)

AIM bundles typically have a dozen or more steps that hospitals need to follow in order to be in compliance; the intricacy of these programs may prove challenging for providers to administer and the state to monitor.

Policy #2 – Mandate maternal quality metric reporting to a comprehensive, statewide maternal health equity dashboard

Who Implemented the Policy?

A version of state-wide publicly available hospital data reporting has been in place in Illinois for over two decades, when the state created its Illinois Hospital Report Cards. In 2023 that system was updated to make it easier for citizens to look up and compare hospitals based on cost, quality, patient experience, and more. This includes data about maternal health outcomes, among many other data points.[6]

California also has two different data reporting systems in place that collect information on inpatient maternal health outcomes and stratify them by race and ethnicity. The Maternal Data Center has been in place for years and receives reports from most maternal care sites, however, these data are only accessible to the reporting provider. The state has also begun the process of collecting hospital equity data that will eventually be available to the public, through the Hospital Equity Measures Reporting Program, but those data only include a couple maternal health measures.

Efficacy: Does the policy improve health outcomes or experience for birthing people?

A large body of evidence indicates that data transparency improves healthcare quality by lowering medical error and adverse event rates, increasing patient satisfaction, and building a "culture of patient-centered care."[24] There is also reason to believe that knowing that they are being closely monitored will motivate hospitals to engage in higher quality care practices; for example, mortality rates decrease at hospitals undergoing unannounced on-site inspections.[70] Hospitals and even individual physicians will also have the opportunity to compare performance and understand where there are areas for improvement.

The Illinois Department of Public Health's division chief for patient safety and quality, Chinyere Alu, said, "[The hospital report card] is one of the strategies that's been shown to help spur improvements by facilities…It may not necessarily be driven by patient demand. But just by even facilities really being able to compare their performance with each other and use that information to prioritize their areas of focus."[71] While California hospitals will soon be subject to report cards, the current inclusion of only three maternal health measures–one of which primarily relates to the health of the child and not the parent–may not be enough on its own to motivate the necessary maternal health consideration.

Equity: Does the policy reduce the disparities in health outcomes or experience between White birthing people and birthing people of color?

One key principle of AIM's evidence-based health equity bundle is to understand what disparities exist at a given organization, as it is necessary to first identify disparities before they can be addressed. This policy takes the data transparency component of a quality bundle like AIM and expands it to give the state further insight into health outcomes down to the provider level. Comprehensive health metrics and the demographic characteristics of the affected patients is integral to identifying discrimination or differential treatment at all levels of care.[36] Studies have shown that stratifying quality measures using race and ethnicity reduces inequities while driving efficiency. [72]

"Unless specifically measured, disparities in health and healthcare can go unnoticed even as providers, health plans, and governmental organizations seek to improve care. Stratifying quality data by patient race, ethnicity, language and other demographic variables … is an important tool for uncovering and responding to healthcare disparities."[73]
~ Using Data to Reduce Disparities and Improve Quality, Center for Healthcare Strategies

Efficiency: How much will the policy cost the government and other stakeholders, and how significant is the return on that investment?

The state government will need to support HCAI and MCQCC in collecting data for the final 1% of birth volumes not captured in current systems and integrating the fragmented efforts of the two groups. It will also need to invest in data systems and storage to expand the mandatory measures to include all AIM-suggested measures, and to host the dashboard on government servers. Much of this work is already being done as part of the Hospital Equity Measures Reporting Program, so additional investment should be minimal. The state will also need to hire a small number of staff to monitor for low performance and send follow-ups in the form of warning letters.

While all hospitals are subject to the new reporting program requirements, and most participate in the automatic data collection component of the Maternal Data Center, some will need to invest in enhanced data collection and dissemination capabilities to accommodate the expanded set of mandatorily reported measures. However, at least one recent study suggests that reporting quality metrics can be very costly and time-consuming for hospitals, though it varies by the quantity and type of metric being reported.[74]

Administrability: How much new infrastructure and how many new systems will have to be established to implement and administer the policy?

While increasing reporting requirements will take some financial investment from the state and hospitals, most of the systems are already in place to carry out this function. The largest challenge will be reporting the AIM clinical quality measures that cannot be auto-generated and thus require supplemental data. The state will need to work closely with HCAI, MCQCC, and providers to develop a streamlined system for collecting this data without creating undue pressure on hospitals.

Political feasibility: Is the policy likely to face pushback from key stakeholders?

This policy proposal is likely to face two primary forms of pushback from hospitals and providers. The first is around further expanding hospital reporting requirements. The American Hospital Association has spoken out against the current state of hospital quality reporting, which they describe as "extremely costly, time-consuming, and ever-changing" and an unnecessary drain on resources that could otherwise be directed at patient care.[75]

Many providers will also push back against individual-level data being shared with the state. Making individual provider data publicly available is fairly uncommon, as most public data is at the facility or system level; this heightened scrutiny will undoubtedly make many providers and professional groups uncomfortable

If advocates want to move this policy forward, they should look to stakeholders involved in the recently passed Hospital Equity Measures Reporting Program and the long-running Maternal Data Center for support and guidance.

Key advantage(s)

This policy can build off existing momentum and structures behind other health equity reporting systems, making administration relatively straightforward.

Key disadvantage(s)

While this dashboard would offer more information in a centralized place than other equity data centers, it is not providing a wholly new resource or tool, meaning the impact may be limited relative to the status quo.

Policy #3 - Implement a Medi-Cal Quality Incentive Pay-For-Performance (P4P) Program

Who Implemented the Policy?

Connecticut and Pennsylvania are two states with obstetrics-oriented P4P schemes. Connecticut Medicaid implemented its Pay for Performance in Obstetrics Care Program in 2013. All of the state's Medicaid providers are eligible to participate, but participation is voluntary. All pregnant Medicaid enrollees are also eligible if their provider is enrolled. The model covered an estimated 62% of Connecticut Medicaid pregnancies between August 2019 and June 2020.[56]

In Pennsylvania, the state's Medicaid program is currently implementing two racial equity value-based payment schemes in pregnancy and obstetric care. One of these, the Maternity Care Bundles Payment Model, provides bonus payments to providers for achieving benchmark measures and incentivizes disparity improvements for Black beneficiaries.[5]

Efficacy: Does the policy improve health outcomes or experience for birthing people?

Evidence for the effectiveness of P4P models in improving health outcomes across conditions is mixed.[6] Thus far, there are no formal evaluation data for the Connecticut Obstetrics P4P

program that tie the implementation of the program with ongoing Medicaid data collection efforts, although one positive indication is that provider participation has increased over time.[56] Pennsylvania's evaluation is ongoing and will assess how the program influences both access to medical care and health outcome measures.[5] In general terms, for P4P schemes, the specific focus of performance metrics may impact outcomes. Literature suggests that metrics specifically focusing on patient experience are more likely to result in improved provider collaboration and care coordination.

Equity: Does the policy reduce the disparities in health outcomes or experience between White birthing people and birthing people of color?

Absent conclusive evidence from existing state maternal P4P models, we look towards evidence for value- and performance-based models more broadly. Value-based payment models, including P4P schemes, have demonstrated mixed evidence toward improving racial health inequities. Some data suggests that financial incentives (not penalties) reduce disparities in hospital readmissions and that these models have a neutral or positive impact on equity.[76]

Efficiency: How much will the policy cost the government and other stakeholders, and how significant is the return on that investment?

The state will need to allocate funds for bonus payments to its contracted MCO plans and pass-through payments to organizations or providers. The needed amount for payments will be dependent on how easily the specific benchmarks elicit behavior changes, and the relative costs of any increases in procedures or care processes resulting from implementation. Dudley and Rosenthal (2006) describe the factors that should be considered when setting the specific amount of bonus payments.[77] These factors include organizational capabilities, relative ease of eliciting care or outcome improvements, existing incentives, and market characteristics.[77] One common benchmark for plans to elicit behavior change is 10% of physician payments, but other states have used much smaller percentages or pre-specified nonpercentage bonuses to varying effect.[48] The state might also consider additional budget allocations toward technical assistance and quality improvement programming to reduce cost burdens to hospitals or providers and to incentivize provider engagement.

Administrability: How much new infrastructure and how many new systems will have to be established to implement and administer the policy?

California has an existing P4P administrative infrastructure across its Medi-Cal managed care contracts that can be drawn upon to implement a perinatal P4P model. Integrating the P4P model into existing processes and infrastructure is particularly important for reducing administrative burden, given the complex patchwork of payers, providers, quality improvement initiatives, and data collection efforts.[29] Policymakers will need to take into account any limits on administrative data and the potential need for medical records or chart abstraction, all factors that could increase administrative burden.[77]

Several aspects of this specific policy design are intended to optimize administrability. First, standardized use of the AIM patient safety bundle measures eliminates the need for developing and validating measures that are acceptable to providers. Second, using relative improvement

benchmarks minimizes the need for additional risk adjustment structures because each entity is assessed relative to its previous performance. Risk adjustments would need to be reconsidered if there are changes in patient selection behaviors over time. Policymakers could additionally look toward the California Integrated Healthcare Association's "Align. Measure. Perform." (AMP) incentive designs in designing the bonus payment structure.[78]

Political feasibility: Is the policy likely to face pushback from key stakeholders?

The state has the authority to design its Medi-Cal managed care contracts without federal waivers so long as provisions are consistent across plans and beneficiaries. However, in the case that this P4P is implemented using federal Medicaid waiver authorities (e.g., via a Section 1115(b) demonstration waiver), the state would have to consider budget-neutrality requirements. Furthermore, the current federal policy landscape could impact administrative matching payment limits, which would need to be considered when designing the policy (i.e., whether state policymakers should take a risk-averse approach to federal payment changes and incorporate additional state funding) and may face pushback from politicians citing state budgetary constraints.

Like some of the concerns voiced in previous options, this policy could also face pushback from provider groups who cite administrative burdens and impacts on independent practice. Engaging with providers in program design and implementation early and often is critical for sustained buy-in and effectiveness, with literature suggesting that inadequate consultation and top-down implementation can contribute to worse outcomes.[79] This can be mitigated through creative communication strategies and designing payments that feel "worth it" to providers. Policymakers could also consider whether bonuses could be additive so that providers can start with a few measures, rather than an all-or-nothing approach.

Key advantage(s)

P4P schemes have been implemented across many settings, and California healthcare players can look to other states' programs for implementation.

Key disadvantage(s)

The relative effectiveness of P4P schemes to improve health inequities likely hinges upon the fit of the program's design to its ultimate objectives. Poorly designed payment adjustments for performance can disproportionately impact hospitals that serve low-income or minoritized patients.[30] P4P financing can also be used as a healthcare cost-saving strategy, in which case, the objectives and strategies of the scheme may not be an effective pathway to meaningfully elicit equity improvements. Relatedly, P4P schemes open up opportunities for gaming, or, attempting to get maximum benefits with minimal change.[80] "Cream-skimming" happens when providers choose lower-risk patients or reduce the number of Medicaid patients they accept in order to reap greater rewards or reduce penalties.

Policy #4 - Create Pathways for Inpatient Models of Care Supporting Patient Advocacy and Enhanced Care Coordination for High-Risk Pregnancies

Who Implemented the Policy?

A wealth of states, organizations, and researchers are testing care management and interprofessional, team-based care models in maternity care. Three state Medicaid programs (Nebraska, Nevada, and Oregon) have care management mandates that go beyond California's existing Medi-Cal ECM program by mandating the provision or offer of specific management-related services, including case management and linkage to community health worker (CHW) services.[42] Further, evidence-based models not yet scaled in California include low-interventional intrapartum approaches (of which only one-quarter of California hospitals currently use) and the ACCURE model, which has demonstrated evidence in oncology settings, but has the potential to be implemented in maternal care.[7,8] The ACCURE model outlines a "quality improvement intervention to address structural barriers to care" and intervention components include navigator and champion roles, racial equity training, and community partnerships with the institution. ACCURE was designed to address race-based health inequities for breast and lung cancer patients and was validated by a longitudinal randomized controlled trial.[9] In addition, in California, "hospitals more likely to use low-interventional practices included those with midwife-led or physician-midwife collaborative labor management…and those in rural locations."[8]

Efficacy: Does the policy improve health outcomes or experience for birthing people?

The ACCURE model has not been evaluated in a maternal health setting, but it did show improvements in key oncology health outcomes in two cancer centers.[7] For low-interventional approaches, low-intervention hospitals had lower rates of NTSV c-sections and episiotomies compared to high-intervention hospitals in California, but this correlative study did not evaluate causal directionality.[10] According to the American College of Obstetrics and Gynecology: "Evidence suggests that, in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor. Data suggest that for women with normally progressing labor and no evidence of fetal compromise, routine amniotomy need not be undertaken unless required to facilitate monitoring."[81]

Equity: Does the policy reduce the disparities in health outcomes or experience between White birthing people and birthing people of color?

The ACCCURE model has high demonstrated efficacy in reducing inequities: "In ACCURE, (5) there was a statistically significant racial disparity in the retrospective group's treatment completion rates (79.8% for Black patients, 87.3% for white patients, $p < 0.001$). In the intervention group, this racial gap not only disappeared, but the treatment completion rates improved for both Black and white patients (88.4 and 89.5%, $p = 0.77$)."[7] Other models targeted for scale-up should demonstrate similar equity improvements.

Efficiency: How much will the policy cost the government and other stakeholders, and how significant is the return on that investment?
This policy will require significant investment from the state. Funding mechanisms (i.e. grants) will need to be created or expanded and will need to be distributed equitably. This could be achieved through the allocation of existing DCHS PATH CITED funding or through new legislative funding authorization. With the high investment comes high potential returns for population health outcomes. The cost to hospitals is expected to be moderate–hospitals may need to invest initially for programs to take hold, and may require adjustments to staffing, plus additional training investments.

Administrability: How much new infrastructure and how many new systems will have to be established to implement and administer the policy?

Implementing new processes and programs in inpatient perinatal care settings requires heavy time, personnel, and energy investments, which may be hard for providers already facing staffing and resource constraints.

Political feasibility: Is the policy likely to face pushback from key stakeholders?

This policy is likely to have support from healthcare provider organizations and advocacy groups due to its more direct, bottom-up approach to institutional care process change. Forseable pushback may stem from administrative burden or resource-constrained hospitals may feel the policy adds undue burden if funding and resources are not distributed equitably.[82]

Key advantage(s)

This policy directly intervenes on the care processes in the inpatient setting rather than through financial or administrative incentive-based mechanisms, allowing for provider buy-in and flexibility for context-specific program tailoring.

Key disadvantage(s)

This policy may require providers to hire additional personnel in an already strained healthcare workforce to realize new care models. Additionally, uncertainties in the federal policy landscape, specifically around Medicaid waiver approvals, could negatively impact the state's primary funding avenue.

Discussion

In sum, the policy options range in proven efficacy, cost, and acceptability to stakeholders. Our policies fall into four generalizable categories: quality improvement (Policy #1), data transparency (Policy #2), financial incentives (Policy #3), and care delivery models (Policy #4). We could reasonably expect California lawmakers to propose one or a combination of the analyzed policies, and believe that an omnibus approach could be more effective than a single policy. Likewise, while these policies all intervene on the same inpatient care continuum, the incentives and requirements are enacted through different players, from payers to providers to public health agencies, allowing for both political flexibility and strategic coalition building.

Mandating implementation of Alliance for Innovation on Maternal Health (AIM) bundles (Policy #1), performs strongly in the efficacy and equity criteria. AIM bundles consistently demonstrate effectiveness in inpatient perinatal care settings across a variety of provider and population contexts.[83] By mandating the bundles, the state would not only scale up evidence-based practices, but also set a more level playing field across settings and providers concerning standards for improving outcomes and reducing disparities.

Policy #2, mandating maternal quality metric reporting to a comprehensive, statewide maternal health equity dashboard, is a highly efficient option for the state to pursue. The overwhelming majority of births in the state are already reported to the MDC, and this option would reduce cross-system gaps and fragmentation in data collection and transparency. We could also imagine Policy #1 being paired with this data dashboard, to bridge the gap between implementation and the need for statewide measurement and enforcement of quality improvement initiatives.

A Medi-Cal Quality Incentive Pay-For-Performance financing model (Policy #3), utilizes the largest payer of births in the state to incentivize provider behavior change, and is therefore a highly scalable option. This policy option also incentivizes change, rather than creating a new mandate as seen in Polices #1 and #2; offering funding to providers can create opportunities for innovation and more sustainable changes, without penalizing struggling providers who are often the ones treating the most vulnerable patients. We might imagine pairing Policy #2's soft warning letters with the P4P incentives to create an even stronger incentive mechanism.

The final policy option, creating funding mechanisms to scale evidence-based or early evidence inpatient care models (Policy #4), is the most direct-to-institution policy option by facilitating bottom-up rather than top-down care and quality process changes. By expanding opportunities for institutions to test and scale up process changes, tailored to their patient populations and quality improvement needs, this policy would offer greater flexibility and reduce associated costs at the institutional level.

The largest source of political pushback we anticipate across all four policies is related to concerns about increasing administrative burden. Policy #4 is likely the most acceptable to providers as it creates a funding stream for implementing changes to the care processes. With thoughtful implementation processes and technical support, those concerns may be mitigated by the AIM and pay-for-performance policy options. Stakeholders should consider which is most important to them to balance effectiveness with relative acceptability and efficiency. If efficacy is of utmost importance, Policy #1 might be of highest priority for passage. The following section describes advocacy, messaging, and coalition-building strategies to advance these policies.

Political Strategy

Improving maternal health outcomes for women and birthing people of color requires more than just identifying effective policies to reduce inequities. Meaningful policy adoption requires political will, coordinated stakeholder engagement, and strategic planning for lasting policy

change.[32] This political strategy plan acts as a bridge between policy design and policy adoption, outlining the steps to move equity-centered maternal health policies from recommendations to tangibly advancing policy in the real world. The plan identifies supportive stakeholders, potential opposition, strategies for coalition building and policy framing, and maps out a political strategy for policy adoption.[32] In today's increasingly complex political climate, strategic planning for policy adoption is essential to advance equity-based work.

Theory of Change

This political strategy draws from the Advocacy Coalition Framework, the Multiple Streams Framework, and Institutional and Policy Framing to overcome the political challenges in adopting hospital policy reforms.[9,13,84] These approaches emphasize the importance of aligning the recognition of maternal health inequities, the identification of viable solutions like hospital-level quality improvement mandates, and the broader political climate (i.e. growing attention to health equity after COVID-19, racial justice movements, and recent federal government actions targeting Diversity Equity Inclusion (DEI) efforts).[13,84]

The Multiple Streams Framework illustrates that policy change will likely happen when the problem, solution, and political streams align, creating a "policy window."[13] By framing maternal health inequities as a vital issue within health equity and racial justice public health efforts, this strategy leverages the current political climate to advocate for reform. This alignment ensures the issue is recognized as necessary, rather than supplementary, increasing the likelihood of political support and legislative adoption. The theory suggests that when these streams converge, the political environment is perfect for action, making it a favorable time for policy change.[13]

Additionally, the Advocacy Coalition Framework highlights the significance of coalition-building among diverse stakeholders like healthcare providers, advocacy groups, and policymakers, to name a few. Successful policy change often depends on coalitions that share common beliefs and a mission, as well as putting pressure on decision-makers.[84] This long-term strategy helps overcome institutional resistance to ensure that a broad base of political and social actors supports the bill.

Institutional theory is also crucial in understanding the power dynamics within healthcare systems, where established institutions like hospitals shape policy decisions or may prevent them altogether. These institutions and coalitions may support, oppose, or remain neutral on policies that are introduced depending on their interests.[85] Additionally, incrementalism suggests that introducing gradual reform, such as hospital-level quality improvement mandates, may face less opposition and be more politically feasible than extensive recommendations all at once.[86]

Lastly, Policy Framing can help ensure that our messaging for the adoption of our policy recommendations is interpreted as necessary and aligned with our goal of addressing maternal inequities rather than a politically divisive reaction. The way policies are framed and thus interpreted can instigate or assuage institutional and political pushback. Policy framing

complements the use of coalition building and the "political window" to ensure that the political strategy is set up for success.

These theories and frameworks provide insight into how policy messaging can be successful, the role of effective coalition building, and the importance of political opportunity and institutional dynamics in overcoming political challenges.

Contextualizing the Current Political Climate

California has positioned itself as a leader in progressive health and social policy, with a strong history of advancing health equity and improving healthcare access for historically marginalized communities.[87] The state's progressive political environment—with a Democratic trifecta in the Assembly, Senate, and Governor's Office, as well as a strong network of advocacy organizations—offers a promising landscape to advance equity-based maternal health interventions.[88,89] California's track record includes passage of policies that would face ideological and political opposition in other states and the federal government.[87,90]

However, progress isn't guaranteed. Structural and political barriers continue to limit how effectively maternal health policies are implemented, especially for women and birthing people of color. California's vast size, diverse geographies, and budget constraints create adoption challenges.[91–93] State agencies frequently operate in silos, and even well-crafted legislation can fall apart in practice without strategic oversight.[93] The 2024 Comprehensive Perinatal Services Program (CPSP) audit underscores this disconnect, showing how a lack of enforcement and mandated reporting mechanisms left the state with limited data on whether services improved maternal health outcomes, let alone whether they addressed racial disparities in outcomes.[94] The oversight issues with the CPSP are not a one-off occurrence; institutional accountability challenges reflect a broader problem of poorly structured accountability mechanisms and unequal implementation of policies across the state.[94–96]

Budgetary constraints also complicate the feasibility of progressive maternal health legislation. California is facing a $6.2 billion shortfall in its Medi-Cal program, making it harder to secure funding for initiatives perceived as supplementary rather than essential healthcare services.[91] In this environment, equity-focused proposals must be designed with fiscal strategy in mind.

Much of this political reaction is rooted in a shifting federal political landscape. Immediately following Donald Trump's return to the White House in 2025, his administration began drastically reversing support for equity initiatives.[97,98] This has resulted in a drastic federal policy shift: Diversity, Equity, and Inclusion (DEI) initiatives have been defunded, federal agencies have been directed to limit the use of equity-related language in research and grantmaking, and civil rights protections in healthcare are under increased threat.[97–101] These actions are part of a broader legal and political campaign to frame equity as discriminatory, creating significant risks for any state-level policies that use gender or race-explicit language or equity-based quality mandates.[97,98]

This shifting political climate may force advocates to rethink how they approach equity-based interventions. In California, this may mean that the maternal health equity work must be

designed to withstand federal hostility and political backlash. As a result, researchers, providers, and advocates are navigating a challenging policy environment.[102] Additionally, although Governor Newsom will remain in office until 2026, the state is entering a period of political transition.[89] The next California gubernatorial race will shape state leadership and may reset policy priorities for the coming years.

These dynamics highlight the importance of strategic planning amidst an ever-evolving, at times hostile, and complex political environment. California still can lead, but advancing maternal health equity will require clear goals, strong stakeholder support, and mindful political framing to withstand a volatile political environment.

Relevant Stakeholders

Supportive Legislators

Between 2023 and early 2025, California lawmakers introduced and passed several bills aimed at improving maternal health. This work demonstrates political momentum and clear legislative interest in policies that address maternal outcomes. The bills passed during this period expand access to care and highlight a core group of legislators who are already engaged in maternal health issues.[11] These legislators could serve as key allies and partners in advancing future maternal health equity-based legislation. These supportive legislators play an important role in moving a bill forward from one committee to the next. They may have existing relationships with potential opposition, which, if utilized, could hasten passage of a bill. When a legislator is committed to the goal of a bill, they can further the bill, respond to opposition, and negotiate strategically. Legislative track records can suggest who is well-positioned to lead or co-sponsor future policy efforts to improve maternal health outcomes for birthing people of color and women of color.[11]

Neutral Watchers

Some stakeholders may not outright oppose maternal health policies but still express reservations that complicate policy adoption. Rather than taking a clear stance on a policy, they remain neutral while still having concerns about the policy, and this lack of support can undermine political strategy.[11] Their neutral perspectives may negatively impact the necessary coalition building and community support to advance maternal health legislation.[11] When neutral parties are excluded from policy creation and adoption processes, their disengagement and silent disapproval can impede adoption.[11] For example, healthcare providers can engage in "micro-practices of power" through everyday decision-making that may either reinforce or undermine the goals of a given policy.[37]Anticipating these concerns can help reduce political backlash and build bipartisan support. Proactively engaging with these concerns can help prevent insurmountable political hurdles to successful policy advancement.[37]

Organizational Allies

California is home to a strong and diverse network of advocacy and political organizations, racial justice coalitions, and reproductive justice leaders who have been at the forefront of efforts to address maternal health disparities.[38] These organizations have been instrumental in shaping legislation, amplifying community voices, and holding institutions accountable to the needs of diverse communities.[11] These organizations are crucial because they bring credibility, expertise, and community backing that will strengthen legislative efforts. Their political influence and relationships with current legislators can help move legislation forward while mobilizing supporters to add public pressure for enacting policies that serve the community at large.

Organizational Opposition

Opposition to maternal health reforms takes many forms, from medical concerns to deeper ideological differences. On the medical side, organizations like the American Medical Association (AMA) and the American Hospital Association (AHA) often raise concerns about the logistics of enforcing compliance, limited administrative capacity, and the potential financial burden on healthcare providers.[11,103,104] Healthcare systems and administrators may also be cautious about legislation that introduces new government compliance mechanisms or penalties.[11,103] These organizations often oppose government intervention into healthcare practices as it can become administratively burdensome or a financial liability. When providers are expected to take on more responsibility without clear legal protections, administrative capacity development, or financial support, it can make providers less open to policy changes that affect their practice.[37] These concerns should be carefully considered and addressed to ensure that any policy changes are effective and appealing for patients and providers alike.

Other forms of opposition are rooted in deeper ideological disagreements. For example, the California Family Council (CFC) opposed AB 2319, which required implicit bias training for perinatal healthcare providers.[105] CFC argued that the legislation "misconstrues the nature of implicit bias" and imposes "harmful consequences" on medical professionals for recognizing "biological truths," such as the fact that "only females give birth."[105] For these opponents, equity-focused language, such as the use of "birthing people" and discussions of racism are often seen as politically charged and at odds with their understanding of science.[105] This reflects broader tensions over how identity, differences in care, and language should be addressed in healthcare.

Effective Coalition Building

Coalition building leads to improved community organizing and working relationships that increases access to valuable resources, organizational efforts, and heightened effectiveness and community voice.[106,107] Recruiting members with a variety of backgrounds and perspectives increases not only the legitimacy of the coalition but also the coalition's support networks and influence, improving the chances of legislative adoption and implementation.[108,109] t is important to include a diversity of lived experiences and grassroots organizations closest to the problem to ensure the coalition reflects the broader community. At the same time, the current

political climate requires thinking strategically about what will drive adoption while preserving the overall goal of maternal health equity.[106,110]

To illustrate the alignment of coalition members, *Figure 5* demonstrates three categories of partners and the role they play in advancing maternal health legislation. At times, advocates may need to partner with hospitals, public health organizations, and other institutions that oppose or avoid racial justice framing. However, these potential partners might still care about reducing maternal health mortality or improving hospital metrics. By building coalitions that include these groups, advocates can leverage unusual alliances to help move legislation forward.[110] A broad base of support will reduce resistance, create connections with shared goals, and engage potential partners in improving maternal health outcomes. An inclusive political strategy will also strengthen coalition durability and widen the area for reform for more responsive and responsible systems of power. Furthermore, it will assist in the policy implementation process at institutional settings (e.g., hospitals, clinics). Building broad support, limiting pushback, and strengthening non-policy efforts to mitigate maternal health inequities increases the likelihood of successful policy adoption.[107,108]

Figure 5: Concentric Coalition Model for advancing maternal health equity

Effective Messaging

People respond to health policy messages based largely on what they already believe, especially regarding race, equity, and what shapes health outcomes.[14,16,111] Messages that name systemic

racism, institutional bias, or structural inequities evoke varied responses across different audiences. Individuals interpret them through their political values, lived experiences, and trust in public institutions. As a result, the same message can resonate with some while prompting resistance in others.[112,113]

Policymakers rarely act on data alone. Even when advocates present compelling evidence of racial disparities in maternal health, it won't automatically lead to policy change.[114] Whether a proposal gains traction often depends on how advocates frame the issue: does it reflect policymakers' values? Do they believe the government should confront systemic racism? In many cases, policymakers acknowledge the data but may disagree with the proposed policy approaches to address it. This is why communication strategy is just as important as content.[16]

Strong public communication starts with shared values that feel relevant across communities.[15] Fairness, opportunity, shared benefit, effectiveness, and collective responsibility help people relate to complex issues and connect them to everyday concerns. In maternal health, leading with these values can build common ground and create openings for deeper engagement.

To build broader support, maternal health equity can be framed around shared goals: making policies effective, ensuring resources reach communities with the greatest need, and supporting everyone's ability to thrive. Decision-makers respond to messages that focus on solutions and emphasize fairness.[15,111] This includes being clear about where policies should begin and why, based on need and impact. When we ground messaging in values like community well-being, human potential, and mutual responsibility, we bring more people into the conversation and build momentum for change.[15,111]

Messages that name the problem while highlighting the possibility of progress tend to engage more effectively than those that center on crisis. This approach doesn't ignore the severity of disparities. It creates space for people to understand what's driving them and how change can happen. Framing maternal health this way helps build support and encourages dialogue focused on solutions. Certain approaches to communication can unintentionally create distance, while others help build clarity, trust, and momentum.

What to Avoid in Messaging[111]:

- Jumping straight to who's affected or how bad it is, without explaining what's driving the problem.
- Assuming the data on health disparities speaks for itself.
- Framing it as a problem that only affects historically marginalized communities, which can unintentionally distance people from the issue.
- Leaning on moral outrage like "This is unacceptable" without naming what needs to change or how.
- Calling for sweeping change right now without grounding the ask in what's possible or actionable.

What to Advance in Messaging[111]:

- Focus on root causes and what outcomes systems are producing.
- Frame the problem as one of a system that's supposed to serve everyone but isn't.
- Use data to show how the system is operating, not just that people are suffering.

- Show that what's happening is not only unjust but also inefficient, unsustainable, or failing by its standards.
- Point to real, workable solutions. Name what could be better, how to get there, and who benefits when we do.

To build lasting support for maternal health equity, we need to shift how we frame the issue.[111] Instead of focusing only on disparities, we can connect the work to shared goals and practical improvements.[15] Framing maternal health as a collective priority means emphasizing outcomes that matter to everyone: improving health, supporting clinicians in providing excellent and equitable care, and ensuring all communities have the resources they need to thrive.

Leading with values does not mean abandoning equity; it lays the foundation for people to understand why equity matters and what achieving it requires. While equity is the goal, it's not always the most effective starting point. This approach encourages participation by helping people see their stake in the issue and the role they can play in addressing it. Everyone should have the opportunity to thrive, and we all share responsibility for creating systems that make that possible. When we root our communication in shared values and focus on achievable solutions, we expand the conversation and strengthen support for lasting change.[14]

This includes how we engage the clinical community.[114] When engaging medical professionals and organizations like the AMA or AHA, advocates should reflect values that already guide those communities, such as advancing public health, improving care quality, and ensuring fairness. The AMA's mission is "to promote the science and art of medicine and the betterment of public health."[116] Framing maternal health equity as part of that mission reinforces alignment, deepens shared goals, and reduces resistance to policy change.

We also need to treat providers as essential partners in maternal health reform.[116,117] They play a central role in delivering care and shaping how it is experienced. Policymakers and advocates should invite providers into the process early, respond to clinical realities, and propose changes that respect medical expertise. Effective policy doesn't treat providers as passive recipients of regulation—it builds with them. Messaging that highlights collaboration, practical insight, and shared purpose builds trust.[17] When providers see themselves reflected in the solutions, they're more likely to support and help carry the work forward.

To drive meaningful change in maternal health, we need to be intentional about how we communicate. Our messaging should reflect the kind of policy reform we're aiming for: practical, inclusive, and grounded in shared goals.[14,15,111] When we lead with values, focus on what's possible, and involve providers and other stakeholders early, we are more likely to build the trust and alignment needed to make progress.[14,111,119] Equity-focused reform depends not just on what we say, but on who sees themselves as part of the work. Thoughtful, values-based messaging helps make that possible.

Policy Recommendations

In the preceding sections, we analyzed policy opportunities that California could pursue to improve the quality and outcomes of inpatient maternal care, ranging from data transparency

and care models to quality improvement initiatives and financial incentives. Here we bring together those insights with lessons from political implementation theory to describe concrete policy recommendations stakeholders can leverage to advance a maternal health equity agenda in California.

First, to address institutional-level inequities in outcomes and experience for birthing people of color, California should pursue both legislative and regulatory policies. Specific recommendations the state should consider to enhance the likelihood of policy success include:

- **Pursue multiple policy approaches for maximum effect across political objectives.** The four major policy approaches we highlighted in this report (i.e., quality regulation, data transparency, financing, and care model transformation) can be utilized in combination to enhance policy effectiveness and acceptability.
- **Strengthen California's independent quality improvement and data collection infrastructure.** Policymakers should ensure continuity of the collaborative evidence-generation and dissemination process demonstrated by the Alliance for Maternal Health (AIM). This could be facilitated via state-level funding in the scenario of federal funding disruptions.
- **Reduce healthcare fragmentation by integrating existing programs and policies.** California healthcare and public health systems already have robust administrative, financing, and oversight capabilities. New policies should be adapted to integrate with existing systems and reduce administrative burden when possible.

Second, birthing and health justice advocates already working in the maternal health equity space should pursue a political strategy focusing on broad coalition building and strategic framing. Specific recommendations include:

- **Enhance political acceptability by utilizing strategic framing on major maternal health objectives.** Communications should evoke broadly unifying goals of improving outcomes and supporting clinicians in providing excellent, equitable, and dignified care to all birthing people in California.
- **Strengthen coalitions by creating a united front around institutional missions and core professional values.** Facilitate coordination with hospital institutions by reminding them of their missions and actively engaging healthcare professionals throughout the policy development and implementation process. Collaborate with institutions to secure bipartisan support and establish feasible goals that advance maternal health equity policies.

Conclusion

This report outlines potential policy mechanisms–both incentives and mandates– that could move the needle on inequities in outcomes or patient experience for birthing populations within inpatient perinatal care settings. Thus far, California has few policies to create institutional change that specifically intervene in this important phase in the maternity care continuum. There are, however, numerous groups and individuals generating knowledge and evidence for maternal health equity programs and interventions. We synthesize those opportunities here and

present a policy agenda for California policymakers and maternal health advocates to draw upon. Policymakers might consider expansion of proven quality programs, greater data sharing and transparency, and funding for care model initiatives with demonstrated evidence.

Appendix

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Appendix B: Literature Review Search Strategy

Databases and Search Engines	PubMed, Google Scholar
Question	**Inclusion Criteria Used for the Review Process**
1. What metrics or frameworks exist to validate equity interventions across condition categories?	Does the theory or framework advance equity in maternal or other health outcomes?
2. Which care processes across the continuum of maternal healthcare are associated with inequitable outcomes?	Does the project identify interactions, care processes, quality measures, or systemic distributions of healthcare resources that may contribute to inequitable outcomes?
3. What criteria should be used to evaluate policies?	Does the project identify outcome- or quality-based data that measured the scale, scope, or reduction of inequitable maternal care outcomes and processes?
4. Where may policies that affect how clinicians and/or clinical teams do their work be implemented across California's healthcare landscape?	Does the source identify agencies, regulatory mechanisms, legislative provisions, funding sources, or organizations where policies may be implemented that aim to advance maternal health equity?
5. Are there emerging interventions not yet translated to policy?	Does the project contain an intervention that has been implemented? Does the intervention seek to reduce maternal health inequities, interpersonal biases or racism and discrimination, or improve care quality processes or health outcomes?

Appendix C: Policy Scan Methods and Findings

Key Sources:	State Policies to Improve Perinatal Health Outcomes | Commonwealth Fund. Accessed March 5, 2025. https://www.commonwealthfund.org/publications/maps-and-interactives/state-policies-improve-perinatal-health-outcomes	
Objectives	Key Questions	Actions
Identify existing policies and strategies through gathering federal, state, and local policies that address maternal health inequities, particularly those influencing provider behavior, care quality, and accountability.	What policies or programs exist at the federal, state, or local level that address maternal healthcare quality and provider accountability? What policy mechanisms are used (e.g., regulation, financial incentives, procedural mandates)?	Compile a list of existing maternal health policies and programs at the federal, state, and local levels. Include policies that impact broader health equity and provider accountability. Identify policies that directly target improvements in clinical care, provider behavior, and healthcare delivery for marginalized communities and those who face poor maternal health outcomes.
Describe and categorize policies and interventions that improve maternal health outcomes for women of color and birthing people of color.	What are the characteristics of successful and unsuccessful interventions? How do different policies incentivize or enforce equitable care delivery? How do policies vary by type (e.g., legislative mandates vs. voluntary guidelines)? Do policies target specific populations or healthcare settings (e.g., hospitals serving historically marginalized communities, Medicaid-funded programs, programs specifically targeting maternal health, programs targeting co-morbidities that unintentionally impact maternal health outcomes)? How do policies differ across states, and what lessons can be drawn from states with lower maternal health disparities?	Develop a framework for evaluating policies based on effectiveness, enforcement, and feasibility for California. Categorize policies by type (e.g., legislation, regulation, voluntary programs) and level (federal, state, local). Categorize policies based on their mechanisms (e.g., financial incentives, provider training mandates, reporting requirements).

Policy scan note: Identifying inpatient maternal health policy solutions proved challenging, in part because many effective interventions such as those targeting diabetes management, hypertension, or hospital safety practices are not explicitly labeled as maternal health reforms. This highlights the need for future research to look beyond explicitly branded maternal health policies and examine in-patient interventions that may indirectly improve maternal health outcomes. Additionally, while our initial scan included a wide array of local, state, and national programs, the breadth of geographies and jurisdictions made it difficult to fully evaluate all possible interventions within our timeline.