DOULA IMPLEMENTATION WORKGROUP RECOMMENDATIONS

The Doula Implementation Workgroup discussed and voted on recommendations that were included in this report. The first meeting on March 14, 2025, crafted recommendations from topics discussed at prior Workgroup meetings. The second meeting on April 11, 2025, included topics brought forth from findings from the Qualitative and Quantitative analyses. Recommendations are organized by topic in Table # below.

In compliance with section 14131.24 of the Welfare and Institution Code (WIC), DHCS solicited applications for the Doula Implementation Workgroup in December 2022 from stakeholders who were involved in the previous doula workgroup to develop the benefit. DHCS selected 29 representatives from the affinity groups identified in WIC section 14132.24, including nine doulas, three health care providers, four consumer and community advocates, seven health plan representatives, four county representatives (4), and three other stakeholders with knowledge and experience in doula services. In addition, DHCS developed a Co-Design Team made up of 17 members of the Workgroup to help plan for Workgroup meetings, discuss policy, and work through concerns. The Co-Design team included seven doulas. With support from the California Health Care Foundation (CHCF), RACE For Equity (R4E) served as a meeting facilitator for the Co-Design and Workgroup meetings. CHCF also funded R4E as the meeting facilitator for the previous doula workgroup.

To allow time for the doula benefit to be implemented before discussing evaluation of the benefit, the Workgroup initially met quarterly for the first 15 months (March 30, 2023; June 23, 2023; September 14, 2023; January 31, 2024; April 12, 2025; and July 12, 2025), then met bimonthly from September 2024 through January 2025 (September 27, 2024, November 15, 2024, and January 10, 2025), and then monthly for the last three months to prepare for the report (March 14, April 11, and May 9, 2025).

While the Workgroup meetings were open to the public and all attendees could comment in the chat, only Workgroup members had the ability to speak during stakeholder meetings. Due to the time spent during the Workgroup and Co-Design meetings to discuss issues raised by Workgroup members, DHCS drafted

recommendations for the workgroup's consideration during the March 14, 2025, Workgroup meeting.

Topics for the recommendations were largely derived from discussions from the Co-Design and Workgroup meetings. To help address issues as they were raised, the Benefits, Managed Care Quality and Monitoring, Quality & Population Health Management, Provider Enrollment, Capitated Rates Development, and Fee-for-Service Rates Development divisions collaborated to address concerns, many of which concerned hospital access and implementation of the targeted rate increase. In addition, DHCS met regularly with managed care plans and began meeting with the California Hospital Association, Local Health Plans of California, California Association of Health Plans to share concerns raised by doulas and work toward resolving them. For example, DHCS worked with the California Department of Public Health (CDPH) to develop an All Facilities Letter to address doula access in hospitals, which CDPH released on March 24, 2025.

Based upon discussions at Workgroup meetings, DHCS drafted recommendations for the workgroup's review and input during the meeting on March 14, 2025. Workgroup members were able to provide comments and suggest changes via SurveyMonkey after the meeting. DHCS then revised and expanded recommendations based on stakeholder feedback and preliminary findings from the UC Berkeley's qualitative data and shared them in advance of the Workgroup meeting on April 11, 2025. DHCS updated the recommendations again based up Workgroup feedback after the meeting and additional details from UC Berkeley's research.

As requested by the Workgroup, recommendations were divided into the following areas: 1) DHCS, 2) hospitals, 3) managed care plans, and 4) legislature for funding. Since this recommendation is not able to require organizations to implement any recommendations, most of them focus on sharing best practices by hospitals and plans with other organizations and promoting the successes that have occurred since the workgroup started. These recommendations represent items to be considered and discussed and not represent an agreement or commitment from any organization to implement them.

While section 14132.24 of WIC required the report to "identify any barriers that impact access [for members] to doula services … and make recommendations to the department and the Legislature to reduce any identified barriers," DHCS recognizes that challenges doulas face as Medi-Cal providers, including receiving reimbursement, can impact members by discouraging doulas from becoming Medi-Cal providers. As such,

this report includes barriers that doulas have experienced. As noted previously in this report, doulas are initially overwhelmed by enrollment, contracting, and billing processes and can get discouraged without support, doulas may give up, which would negatively impact the number of doulas available to serve Medi-Cal members through the benefit.

DHCS acknowledges that some stakeholders suggested some recommendations that are not included in this report or either being outside the scope of this report or not receiving full support from the represented affinity groups. One such recommendation was for a single statewide electronic medical record (EMR) and claims system to be used by all health plans. Similar proposals for a statewide or national EMR have been made over the years without success and have enormous fiscal impact to MCPs that have spent billions to customize their systems to their needs. However, this report contains other recommendations that seek to address the overall concern to provide support to doulas with submitting claims. Other requests for DHCS to provide legal protection for doulas who provide services to members who have an abortion require legislation and are outside the scope of DHCS' authority.

Recommendations to DHCS:

Scope of DHCS authority: *Medi-Cal coverage and reimbursement policies, including establishing rates. DHCS holds contracts with Medi-Cal managed care plans (MCPs) and has the authority to enforce compliance with the provisions outlined in these contracts, such as ensuring timely payments, conducting trainings, requiring a grievance and dispute process, and resolving provider disputes. DHCS can issue All Plan Letters as an extension of the MCP Contract, provide additional guidance and requirements to MCPs. DHCS does not contract with hospitals.*

Recommendation 1.1

DHCS should update the All-Plan Letter (APL) for doulas with clear, enforceable guidelines for MCP and follow-up with non-compliant MCPs.

The APL should include information about the following:

- Timely and accurate payments, including communication to contracted doulas to resolve denied or delayed payments; contact information for MCP personnel who can respond to reimbursement issues; and requirements for training doulas on submitting clean claims.
- Streamlined credentialing and contracting processes to eliminate redundancies that increase administrative burdens on doulas.

- Transparency and communication – MCPs should publish and maintain accurate information on provider portals, including contact information and number of doulas contracted with the MCP.
- Requirements concerning providing clear instructions for submitting claims to the MCP.
- Process for how doulas submit requests for providing nine additional postpartum visits and the process for approving additional visits.

On February 12, 2025, a coalition of doulas, advocates, community-based organizations, and other stakeholders sent a letter DHCS requesting immediate attention to issues that had been discussed during previous stakeholder meetings, with the most pressing concerns identified as 1) payment delays and denials, 2) credentialling process, 3) barriers to MCP contracting, and 4) provider support. Of particular concern was delays by some MCPs to pay doulas the 2024 targeted rate increase (TRI) for services provided after January 1, 2024. DHCS included doulas in the TRI for obstetric care, and issued All Plan Letter 24-007 on June 20, 2024, to require MCPs to increase rates for more than 600 billing codes used for primary/general care, obstetric care, and non-specialty outpatient mental health services used by 11 different provider types by December 31, 2024.

Many doulas reported in early 2025 that they still had not yet been paid the 2024 TRI rates, and requested that DHCS take action, including issuing Corrective Action Plans against MCPs that had not yet fully implemented the TRI. The letter stated, "[t]o resolve this situation and improve the quality of this benefit, we request that [DHCS] issue a new [APL], which addresses these concerns and establishes clear, enforceable guidelines for MCP compliance (as well as consequences for non-compliance)" with timely and accurate payments, streamlined credentialing and contracting processes, transparency and communication, and accountability and enforcement. Many topics are addressed in other recommendations.

"These compliance issues are exacerbating distrust among the doula workforce, which severely diminishes the willingness of doulas to participate in the Medi-Cal Doula Benefit despite going through the difficult and lengthy process of becoming contracted doula providers. The major concern is over how these deficits threaten the viability of the CA Doula Benefit by reducing the availability of critical perinatal support services for California families. The desired outcome is to increase access to doulas for Medi-Cal beneficiaries. However, until these matters are remedied and corrected, the opposite outcome of losing [Provider Application and Validation for Enrollment] (PAVE) approved doulas and potential doula providers become more apparent every day," according to the letter.

On November 3, 2023, DHCS issued updated APL 23-024 – Doula Services, which included guidance that MCPs must make payments in compliance with the clean claims requirements and timeframes outlined in APL 23-020 – MCP Contract and Timely Payments. In addition, timely and accurate payment requirements are part of DHCS' contract with plans. Some stakeholders requested that the doula APL reiterate the Corrective Action Plan process and what happens when a MCP is out of compliance.

Recommendation 1.2

DHCS should form a new doula stakeholder workgroup to continue to work with stakeholders on their concerns to monitor implementation of recommendations. The new workgroup would share recommendations and best practices with stakeholders, including plans and hospitals. The workgroup would meet for two years and then be evaluated to determine if it would continue to meet.

As recently as March 2025, workgroup members expressed frustration that topics they have raised are still being worked on, including timely payments, hospital access, and time and difficulties with the credentialing processes, among other concerns. DHCS acknowledges that despite many successes that have already occurred through collaborative work, there is still additional work needed to implement and monitor many of the recommendations, and a desire for DHCS to be transparent about the status for these issues. Therefore, DHCS remains committed to work with doulas and other stakeholders to address topics raised in the following recommendations. This recommendation calls for a two-year commitment, at which time DHCS and the stakeholders will evaluate the need for additional ongoing meetings.

The size and makeup of the new workgroup and meeting frequency would be jointly developed by DHCS and stakeholders.

Recommendation 1.3

DHCS should clarify its policy regarding doula services after unconfirmed pregnancies that ended in miscarriage or abortion.

While postpartum doula services are available to members for pregnancies that ended in miscarriage or abortion, the UC Berkeley's research identified challenges that some doulas have receiving reimbursement if a licensed provider never documented that the Medi-Cal member was pregnant, so that the Medi-Cal MCP cannot confirm if the

member is eligible for doula services. Documentation of pregnancy is an important protection against potential fraud so that DHCS or a MCP can confirm whether a member is eligible for doula services up to one year of postpartum care and even when the year-long eligibility period ends. While there are billing codes for abortion services that can confirm the member was pregnant, there might not be documentation of a pregnancy that ended in spontaneous miscarriage. To address this issue, the Workgroup recommends that DHCS consider how to address postpartum care for members whose pregnancy was not documented by a licensed provider. Some stakeholders also requested that DHCS identify steps will take to protect members from being "criminalized for spontaneous or chosen pregnancy conclusions." However, providing legal protections is outside the scope of DHCS' authority and rests with the Legislature and Governor.

Recommendation 1.4

DHCS should work with stakeholders to develop and distribute a new Frequently Asked Questions (FAQ) document about the available dispute resolution process and other options available to doulas to when there is a dispute concerning payment or they seek technical assistance submitting claims.

Workgroup members frequently discussed difficulties they faced when a MCP denies a claim and how to resolve a dispute. Although DHCS updated the FAQ for reimbursement on March 14, 2025 with information about the requirement for MCPs to have a provider dispute resolution mechanism and how to escalate the complaint to DHCS if they continue to face challenges, more information should be readily available to doulas who seek to resolve a denied claim, including different options available to them when plans are not being responsive or they request technical assistance with submitting claims. In addition, since MCPs are contractually required to have a dispute resolution process, some plans expressed concern about violating their own dispute resolution process if doulas do not first seek to resolve the dispute with the MCP.

Recommendation 1.5

DHCS should work with MCP associations and individual MCPs to make up-to-date contact information for MCPs easily available regarding contracting and credentialing process, reimbursement, and claim denials.

"Transparency & communication" was one of the key recommendations in the February 12, 2025, Coalition Letter. DHCS has maintained a contact list on the doula provider webpage, but doulas have noted that contact information can become outdated, or they do not hear back from MCPs regarding applications they submitted, the credential

process, claim denials, and status of implementation of the targeted rate increase, among other issues. MCP associations and individual MCPs have also noted that their websites are usually member-focused and contain contact information for their members, and suggested sharing contact information for doulas through different venues. Some MCPs have designated email mailboxes or doulas and/or staff to work directly with their contracted doulas. In addition, some representatives who attended workgroup meetings provided their contact information in the chat so that doulas who raised concerns about specific MCPs could reach out to them. DHCS also continues to work with MCP associations (i.e., Local Health Plans of California (LHPC) the California Association of Health Plans (CAHP)) as well as individual MCPs on the ways to collect and distribute this information in an efficient and timely manner. Note: This recommendation supports Recommendation No. 3.3 for MCPs.

Recommendation 1.6

DHCS should distribute funding to MCPs, in a method similar to the California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Incentive Payment Program, for redistribution to community-based organizations (CBOs) and independent doula providers through ramp-up funding. This funding will be utilized to build infrastructure, train additional Medi-Cal doulas, provide technical assistance with the Medi-Cal provider enrollment online application and MCP enrollment and billing solutions.

As highlighted in UC Berkeley's qualitative research, CBOs played an important role in doula services even before it became a Medi-Cal benefit, and have continued to support doulas with training on becoming providers and submitting claims, but they have struggled with ongoing funding and some CBOs have reduced or eliminated their technical support for doulas. However, doulas noted their important value in assisting doulas with training to become Medi-Cal providers and how to enroll and submit claims for reimbursement. Medi-Cal does not separately reimburse providers for time spent on administrative duties.

The CalAIM Incentive Payment Program (IPP) supports the implementation and expansion of ECM, Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal MCPs. The incentives are orientated around the goals of member engagement and service delivery, including reaching new members, building sustainable infrastructure and capacity, promoting program quality, and creating equitable access for ECM Populations of Focus.

Recommendation 1.7

DHCS should develop and publish on its website a dashboard with input from doulas and other stakeholders that publicly shares key performance indicators measuring the success of benefit implementation, including number of doulas contracted with each MCP, disaggregated data for members, as well as information identified in Recommendation 3.6.

After the presentation of the quantitative data during the workgroup meeting on April 11, 2025, stakeholders requested that DHCS regularly publish information on doula utilization that would report on the number of Medi-Cal members using the benefit, the frequency with which members access services, the number of enrolled doulas, and the number of doulas contracted with MCPs. Stakeholders would work with DHCS to determine the elements and presentation of the data.

Stakeholders also requested that DHCS disaggregate the utilization demographic data for Medi-Cal so that they can better evaluate whether vulnerable populations like American Indian/Alaskan Native, are being adequately represented by enrolled doulas. Stakeholders also requested that DHCS disaggregate data to account better for people of mixed races. In publishing enrollment figures, DHCS publicly reports enrollment by the following race/ethnicity categories: African-American, American Indian/Alaskan Native, Asian/Pacific Islander, Hispanic, White, and Not Reported. As part of the enrollment application, applicants can select from additional categories – Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, and other. Individuals who are of Hispanic, Latino of Spanish origin can also select one or more of the following: Mexican, Mexican American, and Chicano; Salvadoran, Guatemalan, Cuban, Puerto Rican, or Other Hispanic, Latino, or Spanish Origin. Applicants who are members of a federally recognized American Indian or Alaska Native tribe can also list the name of their tribe.

Recommendation 1.8

DHCS should issue a standing order to pre-authorize additional postpartum visits because Medi-Cal members should be able to determine for themselves whether they want continued care for the first year after a pregnancy conclusion.

The standing recommendation issued by Dr. Karen Mark, DHCS Medical Director, authorizes services during labor and delivery as well as an initial visit, eight visits during either the prenatal or postpartum visit, and two extended postpartum visits, it does not include nine additional postpartum visits that are available with a new recommendation from a licensed provider. Medi-Cal members can use the Medi-Cal Doula Services

Recommendation form that can be signed by any licensed provider to authorize the additional postpartum services. This form can be signed before the member gives birth. However, some stakeholders said that there is confusion about this form and some doulas are unsure about which form to use, if the MCP needs to approve it first, and other whether it's even needed. Some stakeholders said this is "an additional burden on postpartum families to complete and submit yet another form" that should be eliminated. However, data for the first 18 months of the benefit showed that no members used all eight of the perinatal visits authorized by the standing order.

Recommendation 1.9

DHCS should create a campaign to make more Medi-Cal members aware of the doula benefit.

The statute requires the workgroup to consider "making recommendations for outreach efforts so that all Medi-Cal recipients within the eligible and other target populations are aware of the option to use doula services." As the qualitative research revealed, not all Medi-Cal members are aware of the benefit, particularly for Spanish-speaking members.

Medi-Cal members that UC Berkeley interviewed suggested some best practices that could be implemented by DHCS, MCPs, hospitals, and licensed providers, including that health care providers should verbally inform members about doula services early in their pregnancy and give them fliers; hospitals and clinics could display posters on their walls about doula services; MCPs could share information about doula services via mail, email, phone calls from health educators or nurses, and provide information on the MCP's website and web-based apps; hospitals and MCPs could host events that allow pregnant members to meet doulas; and posters could be posted in county social service offices and at Women, Infants, and Children offices.

DHCS has already taken various steps to make members aware of the doula benefit:

- DHCS mailed a member notice all Medi-Cal members in the first quarter of 2025 regarding the doula benefit.
- DHCS published a flier, "Doctors, Midwives, and Doulas: Finding the Right Care Team for Your Pregnancy," on its website in February 2025 for members and providers about maternity care that spotlights doulas. This flier is available for providers to print and distribute to Medi-Cal members. It is available in English, Spanish, Traditional Chinese, Simplified Chinese, Korean, Tagalog, and Vietnamese.

- Member handbooks are given annually to all Medi-Cal members in managed care that includes information about doula coverage.
- DHCS is adding doula coverage to the MyMedi-Cal pamphlets that are given to all newly enrolled members. The updated MyMedi-Cal pamphlet will be available later this year.
- DHCS is currently developing a social media campaign.

Recommendation 1.10

DHCS should continue to work with MCP associations and individual MCPs to identify and promote commonalities to streamline operations and reduce administrative burden for submitting claims and credentialing doulas.

A number of doulas have commented on the challenges navigating different claims systems used by MCPs as well as different credential processes, and have expressed a desire for a statewide standard. However, as noted by the MCP associations – CAHP and LHPC – "provider networks need to reflect the needs and goals of the plans' community and that varies in a state as diverse as California." In addition, MCPs have developed their billing systems that work with their electronic medical records system. The MCP associations noted that MCPs continue to look for efficiencies in their credentialing and claims processes, and DHCS could further explore opportunities for better supporting MCPs in their efforts to streamline operations and reducing administrative burdens on doula providers.

Recommendation 1.11

Explore adding doulas as providers of ECM and Community Support services provided by MCPs under Cal-AIM and what would be necessary for doulas to provide these services, including training.

ECM and Community Supports are provided by MCPs through CalAIM to Medi-Cal members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services, while community supports are services that help address members' health-related social needs.

Recommendations for Hospitals

Scope of authority for California Hospital Association (CHA): *CHA and other hospital associations represent more than 400 hospitals throughout California and*

advocate for better, more accessible health care for all Californians. They do not have the authority to require hospitals to follow specific guidance.

Recommendation 2.1

Best practice: Hospitals should create admission policies with doulas that treats doulas as part of the care team and does not count doulas toward the number of visitors that patients are allowed for access to hospitals, including labor & delivery, triage areas, operating rooms, post-op, postpartum units and other areas necessary for the doula to accompany members. Hospitals should share this information with all staff with whom pregnant and postpartum individuals and doulas come in contact.

Hospital access was one of the first issues raised by doulas when the workgroup began meeting. Stakeholders said they experienced barriers that include, but are not limited to, doctors who did not want doulas in the labor and delivery room, staff not knowing what a doula was or that it was a covered Medi-Cal benefit, hospitals excluding doulas by counting them as visitors and limiting how many visitors Medi-Cal members could have, limited space in labor and delivery as well as operating rooms, and waiting in visitor lines while accompanying the Medi-Cal member into the facility. Some hospitals issue a doula specific badge to bypass security lines, although not all doulas support being issued badges. Some doulas recommend that if a member states that an individual is their doula, then the hospital should not require identification from the doula; however, there are legal requirements pertaining to privacy and security that would need to be observed and appropriately balanced.

Some steps have already been taken to improve access. CHA developed and delivered a live, interactive training on June 6, 2024, titled, "Doula Access in Hospitals: What the Law Requires." Peggy Wheeler, vice president of Policy for the CHA and one of the training's presenters, is a member of the workgroup. The presentation included information about what services doulas provide, the benefits of using a doula, and information on Medi-Cal coverage of doulas. The presentation stated that, with very limited exceptions, hospitals are required to allow patients to have doulas them in the hospital. In addition, the California Department of Public Health (CDPH) issued All Facilities Letter (AFL) 25-13 on March 24, 2025, titled, "Benefits of Doula Support and Recommendations to Accommodate Doula Services and Foster a Doula-Friendly Environment."

As stated in AFL 25-13, both CDPH and DHCS acknowledge that there is sensitivity around doulas being considered "visitors," particularly when a doula accompanies a birthing individual into the hospital, and that CDPH and DHCS are only using this term

to describe the category within written hospital policies and procedures that doulas can reference to better understand individual hospital practices. As such, the AFL recommends the following best practices for hospital patient visitation policies and procedures to "to maintain patients' rights and foster a positive environment for birthing individuals, babies, and their families:"

- Review patient visitation policies and procedures and update if necessary to specifically address doulas.
- Exclude doulas from the visitor limit if the policies and procedures contain a restriction/limit on the number of visitors (e.g., if the hospital has a limit of two visitors, a doula should not count toward the visitor/support person limit).
- Ensure FAQs for visitation policies are easily accessible (e.g., easy to locate on the hospital website and post or make copies available on hospital premises).
- Provide training to hospital staff of all levels (e.g., administrative, clinical, and executive staff) on patient visitation policies and procedures to ensure appropriate implementation and to avoid any unnecessary restrictions/limitations on patients' visitation rights, including access to doulas in hospitals.

Recommendation 2.2

Best Practices: Hospitals should adopt and share best practices that have already been created and shared by doula advocates that support the integration of doulas into maternity care settings and ensure that staff and providers are aware that doulas are part of the birth team to care for the member. Hospitals should join perinatal coalitions and partner with patients, doulas, doula collectives, and community-based organizations to create or update best practices documents for access.

In addition to sharing best practices for hospital access, the Workgroup recommends that hospitals that develop policies and best practices for integrating doulas into maternity care settings more broadly. For example, some hospitals hosted meet-and-greets where doulas were able to get to know hospital staff prior to accompanying a pregnant member to the hospital. Others launched a doula convening where doula providers were brought on site to the MCP headquarters and were provided with key information and resources critical to the success of all network providers. At the convening, doula providers were also provided with the opportunity to connect with the Maternal Mental Health Team and the Health Education Team that provide information about the services and resources that their teams provide, including an overview of ECM services for members. Some hospitals offer tours so that doulas could meet hospital staff and so hospital staff can better understand what services doulas provide; hosted "meet the doula" events; provided direct lines of communication between doulas and

hospital leaders; and promoted doula services at childbirth education classes and/or postpartum support groups. Doula workgroup members strongly urge hospitals to get feedback from community stakeholders, such as Medi-Cal members and doulas, to build on those original recommendations.

This can include quarterly meetings between doulas, midwives, physicians, perinatologists, nurses, etc. In fact, Workgroup members said hospitals that have lower uptake of the doula benefit and high rates of perinatal mortality and morbidity should be required to create some sort of community accountability workgroup to address how community members can be better supported.

Recommendations for Managed Care Plans

Scope of Authority for LHPC: *LPHC is an association that represents and works on behalf of all 17 local, not-for-profit* ***MCPs*** *that serve 70 percent of Medi-Cal managed care enrollees in California. LHPC supports* ***MCPs*** *though policy development, advocacy, and education.*

Scope of Authority for CAHP: *CAHP is a statewide trade association that represents and works on behalf of public and private MCPs in California that provide coverage for more than 26 million Californians and supports MCPs through policy development, advocacy, and education.*

Recommendation 3.1

Best practice: MCPs should work with doulas and plan associations to create Medi-Cal doula-specific contracts to simplify and speed up the process for doulas to contract with plans. Plans are also encouraged to share best practices regarding onboarding and technical assistance for contracting.

In order for doulas to contract with a MCP, they must first enroll through the Medi-Cal provider enrollment online application or a MCP's enrollment process and then go through the plan's credential process, as required by federal law, before they can contract with the MCP. This entails three distinct processes, each with its own requirements. However, doulas frequently commented that the contracts were often dozens of pages long, and written in technical language for licensed providers with sections that did not apply to doulas.

Some best practices that MCPs have developed include the following:

- Developed contracts specifically for doulas as Medi-Cal providers, which involves internal, external, and regulatory participation and ensuring legal and compliance considerations.
- Developed a modified contract addendum that outlines the legal requirements in layman's terms.
- Created a "Requirements for Doulas document" that reviews all necessary documents needed for contracting, as well as the contact information for their Provider Services and Credentialing Department and posted this information on the MCP's website.
- Publicly posted a Doula Benefit Overview that supports doulas through the contracting.
- Developed training for onboarding that is specific to doulas.
- Designated people at the MCP who could provide technical assistance to walk doulas through the contracting process if they experienced problems.
- Developed and posted a New Provider Orientation PowerPoint deck detailing timely access, services, provider portal, authorization, and member benefits. The MCP has also created a Provider Manual and Claims resource page on their website that reviews claim submission.
- Provided a doula scholarship to help ease any financial burden of becoming a Medi-Cal provider and any administrative burdens during the contracting & credentialing process.

Recommendation 3.2

Best practice: Each MCP should make easily accessible training that is tailored for doulas on how to submit a clean claim. MCPs are encouraged to revisit training series requirements for applicable participation by doulas, including review of denied claims, to tailor their trainings.

By contract and as outlined in All Plan Letter 23-020, MCPs are required to pay providers within 30 days of receipt of a "clean claim, which is defined in federal law as a claim that can be processed without obtaining additional from the provider or a third party. Doulas noted that they are new submitting claims and, unlikely many other provider types, often must fill out claims and submit them themselves, while other providers frequently hired billers to submit claims for them. While CBOs have sometimes been able to fill this gap, it would be helpful if MCPs developed training for their own processes that tailored specifically to doulas.

Recommendation 3.3

For increased responsiveness, MCPs should designate staff who serve as contacts to assist doulas with questions regarding credentialling, contracting,

reimbursement, and denied claims in a timely manner. MCPs should establish expectations for how frequently designated email boxes are checked and the time frame when MCP staff are expected to respond to emails.

This recommendation supports Recommendation 1.5 for DHCS to make up-to-date contact information readily available to doulas. As noted previously, some doulas have had challenges finding the right person at a MCP to answer their questions regarding credentialling, contracting, reimbursement, and denied claims. To address these concerns, some MCPs have implemented best practices that include dedicated email mailboxes for doulas; assigning two specific staff people who are responsible for addressing concerns raised by doulas; setting up a dedicated claims que that processes claims submitted by doula; including doula claims in their regular internal audit rotation to ensure that claims are paid on time and if any issues arise, the MCP''s Claims team collaborates closely with Provider Services to provide feedback and additional education to support proper billing practices.

Recommendation 3.4

Best Practice: MCPs should not require doulas to resubmit the same documentation for their credentialing process that they submitted to DHCS to enroll through DHCS' online application portal.

Before a doula can provide services to a Medi-Cal member of a MCP, they need to enroll with DHCS through the Medi-Cal provider enrollment online application (or the MCP, if the plan sets up its own enrollment process); fulfill the MCP's credential process, as required by federal law, the National Committee for Quality Assurance, and DHCS; and enter into a contract with the MCP. When enrolling with DHCS, doulas must submit required documents that demonstrate they have fulfilled DHCS' criteria to enroll through either the training or certificate pathway. Doulas have commented that their enrollment with DHCS should be sufficient for the MCP that they met enrollment requirements and are qualified to provide doula service, and they should not need to resubmit the same documents to the MCP during the credential process.

Recommendation 3.5

Best Practice: MCPs with high doula benefit utilization should share best practices with other MCPs for connecting members with doulas.

Some MCP representatives noted that supporting non-traditional providers like doulas was new for MCPs and remains a work in process. Some MCP providers have been

meeting with peers at other MCPs to share successful implementation strategies. In addition, Health Net, Molina, L.A. Care Health Plan, and Anthem jointly published a joint letter, "Health Plans Expect Network Hospitals to address the Role of Doulas in Birth Care Policies," on how maternity care policies and practices can respect the important role that doulas serve. The letter includes resources that hospitals can use to effectively integrate doulas in their care teams.

Recommendation 3.6

MCPs should report to DHCS for the dashboard on how many doulas have contracted with the MCP, submitted claims, and been paid for services provided; how many members have requested a doula, and how many utilized services. Plans should also share with DHCS and stakeholders on the types of challenges doulas have shared with the plans, and the MCP's strategy and approach for resolving these challenges.

This recommendation supports recommendation 1.7 for DHCS to create and maintain a dashboard and additional information that is not available through claims or encounter data, as well as the fact that MCPs regularly inform DHCS on how many doulas with whom they have contracted with and how many contracts are pending approval.

Recommendations for the State Legislature

Scope of authority for the Legislature and Governor: *They develop and enact state laws and the state budget.*

Recommendation 4.1:

The state legislature should authorize funding pilot programs for and grants to organizations, including community-based organizations (CBOs), for training individuals to become doulas and submit claims to increase capacity in geographic areas with fewer doulas and for populations with the greatest health disparities. Funding for pilot programs should be prioritized for CBOs that work with families with high needs, particularly in counties with the worst perinatal outcomes and/or lest access to perinatal care.

As noted extensively earlier in this report, CBOs have played an important in the provision of doula services before Medi-Cal added doula services as a benefit, and they played an important role in implementation of the benefit by providing outreach and technical assistance to doulas, but they face difficulties in sustaining this support due to

limited funding. The need is increasing as more doulas enroll as providers and with growing public awareness of the benefits doulas provide. CBOs who enroll as group doula providers can assist individual doulas by submitting claims on their behalf, but separate Medi-Cal funding is not for administrative tasks or technical assistance.

With additional financial support, CBOs could help increase the number of trained doulas statewide and in areas of the state with fewer doulas, trained doulas who speak Spanish, and doulas who are American Indian or African American to work with populations that experience the greatest maternal health disparities, particularly in light of reports that American Indians who wish to become doulas have expressed challenges in meeting the enrollment requirements. Stakeholders also recommended funding for pilot programs to examine delivery of services that could improve perinatal outcomes and access to care.

Recommendation 4.2

The legislature should authorize funding for DHCS to create a web-based doula directory that includes obstetricians and midwives on its website that is user-friendly and that allows members to sort doulas can be sorted by language, county, managed care plan, and specialties.

While the March 10, 2021, version of Senate Bill (SB) 65 included a requirement for DHCS to develop a directory of enrolled doulas and identified required elements for the directory, the enrolled version of SB 65 did not include a requirement for a directory. However, DHCS worked with the first doula workgroup to identify elements that should be included in a doula directory, including counties where they provide services, ethnicity, languages spoken, specialties, and areas of focus. DHCS first published a PDF version of the directory on the doula webpage on April 21, 2023. Since many of the elements for the directory are not collected when doulas enroll through the Medi-Cal provider enrollment online application, including permission to publish contact information, DHCS emails each newly enrolled doula and requests their permission to include them in the directory along with data elements for the directory. About two-thirds of doulas respond and are included in the directory. DHCS seeks to update the directory on a monthly basis.

In response to requests that the directory be sortable by the different category, DHCS began publishing the directory as a sortable Microsoft Excel document in late 2024. However, UC Berkeley's research identified that the directory is not user-friendly and not everyone has access to Excel, so DHCS now publishes the directory in PDF and Excel formats. Enrolled doulas are also listed in the Open Data Portal maintained the

California Health and Human Services, but it does not contain contact information nor the requested data elements that can help members choose a doula that best meets their needs. Starting July 1, 2025, DHCS will also start publishing a directory of enrolled fee-for-service providers, as required section 5123 of the Consolidated Appropriations Act and described in State Health Official letter #24-003 for state Medicaid programs to have "accurate, updated, and searchable provider directories." This directory, however, will have the data elements currently available in the DHCS doula directory.

In addition, while some MCPs have directories for doulas, they may not include ethnicity, language spoken by the doula, or their specialty, which in some cases has required MCP staff to do more hands-on work, which they note is not sustainable.

In order for DHCS to develop a user-friendly, web-based version of the directory that supports the original vision in SB 65 and the mutually-agreed upon data elements, DHCS would need additional state funding for the staffing build a web-portal that could both collect and display data elements for doulas who agree to be included. Workgroup members suggested that the portal also include obstetricians, nurse midwives, and licensed midwives for an integrated approach to the care team.