**Maryland Department of Health - Frequently Asked Questions and Answers for Medicaid's Doula/Birth Worker Coverage Implementation for MCOs**

**Issued**: March 22, 2022
<mark>**Updated**: December 13, 2022</mark>

**Description:** This document represents a compilation of questions received from MCOs around Medicaid's Doula/Birth Worker Coverage implementation, and the Department's responses in a frequently asked questions format. The questions are grouped by subject, as indicated by the Table of Contents below. A separate FAQ document has been compiled with questions received from doulas/birth workers, and will be circulated separately.

**Comments and/or questions may be directed to the Department's dedicated mailbox: mdh.medicaidmch@maryland.gov.**

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## Service Model

### Number of visits

1. **How many prenatal and postpartum visits are covered?**

    Medicaid will provide coverage for up to eight (8) perinatal visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals 8 or fewer visits per birthing parent. Each perinatal visit is broken up into 15-minute units and can last up to an hour (4 units total). Medicaid will reimburse a flat fee for attendance at delivery.

    Note: Due to the CMS designation of service codes for doulas, MDH will transition to these new codes starting April 1, 2023. Any services provided before 4/1/23 should be billed using the W codes below, and any services provided on or after 4/1/23 should be billed using the T codes below.

| Description | Service Code until 3/31/23 | Service Code Starting 4/1/23 | Per unit rate | Max Units per service |
|---|---|---|---|---|
| Prenatal service visits (15 min/unit) | W3701 | T1032 | $16.62 | 4 |
| Attendance at delivery (flat rate) | W3700 | T1033 | $350 | 1 |
| Postpartum service visit (15 min/unit) | W3702 | T1032 U9 | $19.62 | 4 |

Total possible reimbursement (assuming 4:1:4): $930.00
Total possible reimbursement (assuming 0:1:8): $977.84

### Care models

2. **Could you clarify the standard care and enhanced care models?**
    The Department is using a single, standard care model which consists of 8 perinatal visits per birthing parent, either 4 prenatal and 4 postpartum or some other combination, in addition to attendance at labor and delivery. Although the Department initially proposed an enhanced model with 12 total perinatal visits, there are system limitations that make it difficult to implement in the near term.

3. **What do the numbers refer to in the 8:1 or 4:1:4 models?**
    In both of these models, the one refers to attendance at labor and delivery, and the other number(s) refer to prenatal and/or postpartum visits per birthing parent. For

example, the 8:1 model means coverage at up to 8 prenatal and/or postpartum visits per birthing parent, in addition to attendance at labor and delivery. A 4:1:4 model specifies 4 prenatal and 4 postpartum visits per birthing parent, in addition to attendance at labor and delivery. The Department is using the 8:1 model.

**Multiple doulas**

4. **Will Maryland allow multiple doulas, i.e., will the member be limited to one doula throughout the pregnancy and postpartum period or can they see multiple doulas as long as the number of visits does not exceed the number outlined by state regulations?**
Yes, multiple doulas would be allowed, although typically the Department expects one doula would care for an individual through the entire prenatal, labor and delivery, and postpartum periods. The Department recognizes that sometimes doulas will cover for each other during an unexpected delivery, or when need arises. However, the number of visits provided is still limited by the individual birthing parent, as specified above, in the 8:1 model.

**Postpartum care**

5. **The postpartum visit is strictly for the mother, not the child?**
The services will be rendered to the birthing parent, but aspects, like lactation support, will involve the infant.

6. **Is there a timeframe which defines postpartum? We would like to see this align with NCQA, which would mean the postpartum visit would be permitted up to 84 days after delivery.**
Postpartum doula visits in the context of Medicaid's doula care benefit means after delivery and must be completed within 180 days.

**Home visits**

7. **Will doulas be making home visits for both prenatal and postpartum care?**
Yes, doulas are permitted to make home visits. Doula services may also be conducted outside of the home setting as well depending on the beneficiary's wants/needs.

8. **For pre and post services can we offer them via telehealth exclusively?**
No, a doula must offer in-person prenatal and postpartum services. Telehealth services may also be provided as an additional option. Medicaid doulas must be able to offer all three services in-person. Labor and delivery services are only permitted to be in-person,

however prenatal and postpartum services can be virtual but must have the option of being in-person.

9. **Can pre and post services be offered in a classroom setting with two or more mothers? If yes, can this be done virtually as well?**

   No, a classroom is not an approved place of service. Additionally, a service is only billable for one Medicaid participant at a time.

10. **If we just wanted to offer pre and post services, no Labor and Delivery services is that permissible?**

    No, all doulas must make labor and delivery services available to every client. It would not be permissible for this provider type to only offer prenatal and postpartum services; labor and delivery would also need to be provided. A birthing parent may choose whether or not they wish to receive any of these services.

11. **Is it possible to bill for lactation support?**

    Lactation support is not a separately billable service for the doula provider type. As explained in our program manual, the doula would incorporate into a prenatal or postpartum doula visit (among other services indicated):

    - Provision of evidence-based information on infant feeding to supplement, but not in lieu of, the services of a lactation consultant;
    - Provision of general breastfeeding guidance and resources

    **<u>Place of Service</u>**

12. **Are MCOs required to allow doulas to attend medical appointments with members? Are they limited to home-visits only?**

    A doula may claim a prenatal or postpartum visit that is delivered at/during a medical appointment with a birthing parent. However, the total number of allowable prenatal and postpartum services delivered is limited to eight (8) service visits.

13. **If the doula accompanies the member to a prenatal visit, how is that time counted? Is only the time spent in the office with the provider counted? Or is the wait time in the office also counted?**

    The time spent with a doula and client together discussing information related to pregnancy, childbirth, the postpartum period, community support, and infant wellbeing are allowed to be billed for as specified on Policy Transmittal 37-22. These discussions may take place in a variety of locations, one of which could be the waiting room of a provider's office.

It is the Department's expectation that in order for doulas to bill for time spent with the patient in the waiting room, this time is spent discussing relevant service information with the client as described above or otherwise preparing for the appointment. Billing is still subject to the 60 minute maximum allotted time per service.

14. **Does the Department know which hospitals in MD permit doulas in the delivery area?**
The Maryland Hospital Association (MHA) confirmed that Maryland birthing hospitals currently permit doulas in the delivery area. The Department continues to work with MHA to ensure that the birthing hospital staff and providers are aware of the Medicaid doula benefit, and that policies allow access during labor and delivery support.

15. **What place of service is acceptable? In the case of doulas, should it be wherever the doula is meeting the member?**
Information on the acceptable place of service codes, and use with the telehealth modifier -GT is outlined in the Policy Transmittal 37-22 and program manual (issued on 3/22/22).

Regarding doula prenatal and postpartum services, these will usually take place in the participant's home or place of residence, but could also be in the provider's office or doctor's office if a doula is accompanying a member to an appointment. Doula services for prenatal and postpartum visits may be delivered in person or via telehealth, while the attendance at labor and delivery is required to be delivered in person. Doula attendance at labor and delivery place of service could happen at a hospital or freestanding birthing center only. Please note that Medicaid does not reimburse for home births, and doulas will not be allowed to provide this service in the participant's home or place of residence.

16. **Is telehealth permitted? Any modifier required? Or will the telehealth POS suffice?**
Yes, telehealth is permitted for prenatal and postpartum visits. Information on the acceptable place of service codes and use with the telehealth modifier -GT is outlined in the Policy Transmittal 37-22 and program manual (issued on 3/22/22).

## Credentialing/Certification

### Attestation
17. **How is the Department going to maintain the list of doula providers' attestations to being trained and certified by a Department-approved organization?**
Medicaid provider enrollment staff will review and verify the presence of required doula attestations and certification documentation as part of the ePREP enrollment process.

Only doula applicants that submit completed attestations and allowable certification documentation will be fully enrolled as Medicaid doula providers.

18. **How will the individual doula certification be captured, confirmed, and retained? Is this the responsibility of the MCO or the Department?**

    Medicaid provider enrollment staff have the responsibility of verifying the presence of a doula's attestation and valid certification documentation as part of the ePREP enrollment process. Doulas are required to update their ePREP application with new documentation should their status change.

    **Certification Organizations**

19. **What are the current doula certification organizations accepted?**

    The following organizations are approved by the Department. For each, all of the required trainings are listed:

    (1) Doula Trainings International: Birth Doula, and Postpartum Doula Certifications;

    (2) The Childbirth and Postpartum Professional Association (CAPPA): Certified Labor Doula, Certified Postpartum Doula, and Certified Community Lactation Educator Certifications;

    (3) Black Doula Training (BDT), formerly the International Black Doula Institute: Pregnancy & Childbirth Doula Certification, Postpartum & Newborn Certification, and Lactation/Breastfeeding Certificate of Completion;

    (4) Ancient Song Doula Services: Full Spectrum Labor & Postpartum Certification;

    (5) Mamatoto Village: Community Birth Worker Certification;

    (6) Doulas of North America (DONA): Birth Doula, and Postpartum Doula Certifications;

    (7) International Childbirth Education Association (ICEA): Birth Doula, and Postpartum Doula Certifications;

    (8) Childbirth International (CBI): Birth Doula, and Postpartum Doula Certifications; or

    (9) MaternityWise: Labor Doula, and Postpartum Doula Certifications.

20. **Are you considering more certifying organizations to be added to your list?**

    Yes, we are considering a process for reviewing additional certification organizations as part of Phase 2.

    **Credentialing**

21. **Do MCOs still have to credential doulas?**

    Yes, as with all other provider types, MCOs still have credentialing responsibilities.

22. **How do we monitor or recredential these provider types? Is there any recertification we should be looking for during the recredentialing process?**
A key task for phase 2 includes developing standards for recertification or recredentialing, and the process for updating this in ePREP. More information will be shared as soon as it becomes available.

23. **Please clarify that for contracting with the MCOs, the doula would be expected to be credentialed at the individual level and not at the organization level. Also, by credentialing at the individual level we would require the CAQH application to be used.**
Doulas will be enrolled in ePREP at the individual level, whether offering services as an individual or as part of a group. For contracting with MCOs, it is at the discretion of the MCO as to what credentialing they will require.

### Enrollment
24. **Will ePREP enrollment be at the individual or facility level?**
All doulas will be required to have a Type 1 NPI and TIN to enroll in ePREP to obtain an MA Provider ID. Individuals doulas can then bill MCOs directly for services under their individual Type 1 NPI. Group doula practices will be required to have a Type 2 NPI and TIN to enroll in ePREP, and then can enroll doulas as rendering providers using the individual doulas' Type 1 NPI. Group practices can then be reimbursed for services provided by their rendering providers. All doulas or doula group practices will need to submit an addendum attesting to having met the conditions of participation as part of ePREP enrollment.

25. **Will enrolled doulas require a site visit?**
No.

26. **Understanding that ePREP enrollment will be available beginning January 1, 2022, has the Department considered a separate deadline for loading codes and rates into MCO systems? There are concerns about the systems being ready for a January 1, 2022 deadline as there will not be time to test configuration until providers are loaded. If it takes a few months for ePREP and contracting, it is possible for system set-up to be delayed.**

January 1 is the earliest date available for doula enrollment. Some lag time in 2022 is expected for enrollment and contracting due to proximity of dates. The Department is ready to accept the test files. Doulas themselves are able to bill for services rendered on

or after February 21, 2022 if fully enrolled with ePREP, and if serving a HealthChoice member, they are also contracted with that member's MCO.

### Recertification

27. **How often is the training/recertification required?**
    Recertification standards and processes will be developed in phase 2, which starts after the initial effective date for the doula benefit.

### Validation

28. **Will MCOs be required to validate certifications for credentialing purposes or simply validate state enrollment status as meeting those requirements?**
    MCOs will be required to validate state enrollment status through ePREP. Additional validation of doula certification is an MCO business decision.

29. **Will encounter edits be deployed? If so, what will those edits involve in terms of validation of services?**
    Yes, encounter edits are expected to validate that the doula is an enrolled provider at the time of service and that they are using the allowable codes for doula services.

### Liability insurance

30. **Is liability insurance required?**
    Yes.

31. **Who ensures that doulas have liability insurance?**
    As part of the ePREP enrollment process, Medicaid provider enrollment staff will review and approve doula attestations, which require the doula to confirm that liability insurance is in place.

32. **Our standard liability insurance is $1mil/$3 mil. Is it a concern if our requirements do not match the Department's?**
    This level of liability insurance aligns with the Department's expectations for level of liability insurance held by a doula.

### Training

33. **Will the doula need to be certified in both prenatal/birth and postpartum care?**
    Yes, the Department will require doulas to have training that qualifies them to provide services throughout the entire perinatal period including prenatal, labor and delivery, and postpartum care. Since each certifying organization has its own requirements for

training, what these certifications consist of and how they are broken down will vary by organization.

### Preferred providers

34. **Are MCOs responsible for finding and contracting doulas on their own or will the Department create a list of preferred providers?**
Doulas approved in ePREP will be included in the provider master file sent every Tuesday evening to MCOs. As soon as doulas are approved in ePREP, MCOs will be able to use the information in the master file to contact them and begin contracting.

35. **Would the Department consider mandating participation with all MCOs? This would expedite contracting.**
The Department is not planning to mandate participation with all MCOs at this time.

### Credentialing Organizations

36. **Will Aperture be required to credential doulas at the MCO level?**
The doula will need to submit an attestation at time of enrollment into ePREP. The MCOs will still be expected to credential doulas once they have been successfully enrolled with Medicaid via ePREP; this credentialing process will be determined by each MCO.

## Timeline

### Phase 1 vs. Phase 2

37. **What is the tentative timeline for phase 1 vs. phase 2?**
Phase 1 started midway through 2021, lasting until early 2022, culminating with regulations being promulgated, effective February 21, 2022. Phase 2 is currently underway. Depending on MCO and stakeholder feedback, changes could be made as early as July 1, 2022, or thereafter.

38. **What is the anticipated date of the start of services?**
Services may begin now that doula regulations are effective and certified doulas may bill for services rendered on or after February 21, 2022, if they are enrolled in ePREP and if servicing a HealthChoice member, contracted with that member's MCO. Enrollment of doulas in ePREP is available now and as soon as doulas are approved in ePREP, MCOs may begin the contracting process. The Department understands that additional time may be needed for MCOs to complete configuration and other operational changes needed to implement the benefit.

**Cost structure**

> **Billing and Contracting**

39. **How many doulas are in Maryland?**
   Due to a lack of an official credentialing organization, the exact number of doulas in the state of Maryland is unknown. The Department estimates approximately 250 doulas are in Maryland.

40. **Will doulas only bill through claim submission or is invoice an option?**
   Doulas will bill only through claims submission.

41. **Is the billing system overly complicated, especially for some doulas with little billing or technology experience?**
   Doulas will need to submit claims for services rendered in order to get reimbursed. The intention is to make the process as streamlined and supportive of doulas as possible, knowing that doulas will not be experienced with billing Medicaid. The Department anticipates that technical assistance will be required to get doulas enrolled, contracted with MCOs, and able to submit claims.

42. **Will the services be required to bill within a certain timeframe, i.e. first postpartum visit must occur within six weeks of delivery?**
   The Department has not established a required timeline for these visits at this time. Birthing parents have a variety of needs that may necessitate some flexibility in terms of visit timing. Should a time frame for billing be established, additional subregulatory guidance will be provided.

43. **In terms of the "approved organizations" – we want to make sure we're understanding this correctly – these organizations only train/provide the required certifications to doulas in this area, therefore as long as we partner with an organization who is accredited/trained by these organizations, we are in the clear, correct? For example, we discovered that *Maryland State Doulas* employ staff who are certified by a number of the approved organizations: DONA, ICEA, etc. We want to ensure that if we partner with *Maryland State Doulas*, that the doula's will be accepted as long as they have accreditation from the approved organization list. We recognize this may be a silly question, but want to be clear on the requirements of contracting with individuals who are accredited by the approved organizations but are employed by local entities.**
   Yes, if a doula organization is enrolled as a Medicaid doula provider, then an MCO could contract with them to provide doula services to members. The individual rendering doula's who are part of this group should also be enrolled through ePREP as long as they

meet the requirements. If the doula group has doula's on staff but they do not meet the Medicaid Requirements, they cannot enroll and should not be rendering services to Medicaid Participants for the group to seek reimbursement for.

44. **We also discovered that Ancient Song Doulas is a NY organization and doesn't support/train/work with doulas in the MD area. Our contracting team was told this when outreaching them, and didn't know if you've heard differently?**
While Ancient Song does not currently hold trainings in Maryland, there are several doulas in the state who indicate that they have been certified by Ancient Song; for that reason, their certification program was included as part of the Medicaid doula certifying organizations review.

45. **In partnering with doulas, we know the level of contracting (individual vs. group practice) is at our discretion, but in terms of claims, who will receive the funding if we contract with the group practice? Will the organization receive the payment, or will the MCO receive the payment and cut the check for the organization so they can pay the associated doula?**
The doula organization would contract with the MCO, and would bill the MCO for services rendered by the Medicaid-enrolled individual doula. The organization would then pay the associated doula.

46. **Will the claim need the organizational NPI and the individual NPI if we contract with an agency?**
Yes. The claim would include the organizational NPI, as well as the doula's individual NPI as the rendering provider.

47. **Please confirm how the Department encounters will set the provider type in the MMIS system for encounters to be accepted.**
The provider type should be assigned based on the provider's NPI type: Individuals: 30 – Individual; Groups: 35 – Group.

**Fee schedule**

48. **When will the final fee schedule and amounts be released to MCOs for testing?**
The fee schedule is included in Policy Transmittal 37-22. MCOs may begin testing with the proposed rates now. The finalized fee schedule can be found on our Medicaid Provider Information website under the billing guidance, fee schedule, and preauthorization section.

49. **Are the proposed rates a minimum amount?**
Yes, the rates in the proposed regulations would be the minimum reimbursement amount for the MCOs.

50. **Will these new codes be added to the Medicaid fee schedule?**
<mark>Yes. The codes W3700, W3701, and W3702 were added to the Medicaid fee schedule and the codes are active as of February 21, 2022. The new CMS-designated codes T1032 and T1033 (see question 1) will be added to the fee schedule 4/1/23.</mark>

**Codes**

51. **Is there a diagnosis code requirement for billing?**
Providers should use the diagnosis code Z32.2, which stands for 'encounter for childbirth instruction,' when billing for any and all of their services, along with the designated CPT code.

52. **How were these codes selected? Why do they differ from those chosen by other states for their doula benefits?**
In developing the Maryland doula and HVS codes, the Department was aware of the codes neighboring states have selected. That being said, it was necessary to consider what codes would accurately meet the definitions of the services provided in the proposed model structure. This was to accommodate both the new doula and HVS provider types in addition to working within Maryland's MMIS system. After several meetings with the provider enrollment and MMIS coding teams, local codes were selected for doulas in the near term and eventually the necessary steps will be taken to request permanent codes through CMS.

It should be noted that several MCO questions relating to the use of modifiers have been submitted, such as GT for telehealth and place of service and this information is further outlined in the doula Policy Transmittal 37-22.

53. **Is the modifier -U7 (Medicaid level of care 7, as defined by each state) appended on the 99600 code in addition to –HD (pregnant/parenting women's program) considered an informational modifier or pricing?**
The Department will not be including those modifiers in the reimbursement model due to system limitations.

54. **Has the Department finalized the selection of Code 99600? If so, please consider the following factors. It is an unlisted procedure code, meaning it is non-covered and not**

**on the state fee schedule. Additionally, the other proposed code 99199 is on the FS as REPORT. If the Department adds the codes to the FS, changes will need to be made to benefit and pricing configuration. Code 99600 will require a code editing update to exclude from unlisted edit.**

Yes, the Department does not intend to use 99600 for doula services because it is being used for the separate Home Visiting Services coverage initiative. This code has been added to the fee schedule to be used by only the designated Home Visitor provider type at the designated service unit rate. The Department also worked with colleagues on the fee-for-service side to ensure that this code was added as a reimbursable code.

55. **Is the HD modifier only used for doulas?**

The Department has elected not to use the HD modifier for doulas.

56. **Will a CMS 1500 professional claim be required for reimbursement?**

Yes.

**Incentive payments**

57. **Would Maryland consider making incentive payments to doulas if they provide a visit within 6 weeks postpartum and the member completes a clinical visit with an obstetrician during the same period, as other states do?**

Because of system limitations, the Department has decided against providing an incentive payment as other states have included, but instead has increased the unit rate reimbursement for the postpartum doula visits, as compared to the prenatal doula visit unit rate.

58. **Would the Department require a minimum rate to be paid?**

Yes, the rates outlined in Policy Transmittal 37-22 in our reimbursement model are the minimum rates that could be paid for a prenatal or postpartum doula visit, or for doula labor and delivery support.

59. **How will the Department pay MCOs for the doula services?**

Doula services will be built into capitation rates. The program is effective as of February 21, 2022, and some lag time should be expected to get doulas enrolled and contracted with MCOs; therefore, in 2022, the Department expects to implement a mid-year rate adjustment.

**Contracting**

### Authorization

60. **Will the Department mandate authorization for doula services? Will authorization or referral be required on any of the services?**

   No. The Department is not requiring prior authorization for any doula services, nor a referral from a licensed practitioner. MCOs may still direct beneficiaries to doula services as a part of their care coordination.

### Referrals

61. **Will doula services be considered self-referred if the member started prenatal care prior to enrollment with MCO? If yes, non-par pricing and benefit configuration will need to be considered.**

   No, doula services will not be considered self-referred. If a beneficiary began services with a doula who was not in the MCO's network, the doula would have to work with the MCO to become an in-network provider or the beneficiary would need to find an in-network doula provider to continue services.

62. **Will the benefit be self-referral based or subject to network requirements?**

   The benefit will be subject to network requirements and not be self-referral based.

63. **Will providers be educated on the need to ensure they are part of the MCO network?**

   Yes. Resources related to enrolling into ePREP and how to enroll with each MCO can be found on the [Doula Provider Information](#) website.

### Coverage

64. **If a pregnancy does not result in a live birth, will the remaining allotted benefit amount be allowed to be used towards postpartum and/or bereavement support, as is outlined in Rhode Island's proposal?**

   Yes, if a member's pregnancy does not result in a live birth, the number of visits that have not been utilized from the amount of visits allocated to prenatal and postpartum services can be used towards postpartum and/or bereavement support.

**Miscellaneous**

### Evidence Base

65. **What are take up rates in other states?**

   Nationally, 6 percent of births are attended by doulas. There is currently insufficient data to report from other states with a similar Medicaid doula benefit, largely due to small

pilot populations and program newness. Using the national uptake rate of 6-percent, an estimated 1,500 Maryland Medicaid pregnancies could be attended by doulas annually.

66. **What is the evidence for doulas?**

Doula-attended pregnancies have been demonstrated to significantly reduce the number of preterm births, infants of low birth weight, and cesarean births, in addition to increasing breastfeeding initiation. This trend has been seen across the country and in a wide array of populations. In fact, the relationship between doula care and improved health outcomes is particularly pronounced in disparate populations. For further reading on the subject, see the following:

- Kozhimannil, K. B., Attanasio, L. B., Jou, J., Joarnt, L. K., Johnson, P. J., & Gjerdingen, D. K. (2014). Potential benefits of increased access to doula support during childbirth. The American Journal of Managed Care, 20(8), e340–e352.
- Kozhimannil, K. B., Attanasio, L. B., Hardeman, R. R., & O'Brien, M. (2013). Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of Midwifery & Women's Health*, *58*(4), 378–382. https://doi.org/10.1111/jmwh.12065
- Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. *Birth (Berkeley, Calif.)*, *43*(1), 20–27. https://doi.org/10.1111/birt.12218
- Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C. (2013). Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries. *American Journal of Public Health, 103(4): e113–e121. doi: 10.2105/AJPH.2012.301201*
- Kozhimannil, K. B., Vogelsang, C. A., Hardeman, R. R., & Prasad, S. (2016). Disrupting the Pathways of Social Determinants of Health: Doula Support during Pregnancy and Childbirth. *Journal of the American Board of Family Medicine : JABFM*, *29*(3), 308–317. https://doi.org/10.3122/jabfm.2016.03.150300
- Thomas, M. P., Ammann, G., Brazier, E., Noyes, P., & Maybank, A. (2017). Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. *Maternal and child health journal*, *21*(Suppl 1), 59–64. https://doi.org/10.1007/s10995-017-2402-0
- Kozhimannil, K. B., Attanasio, L. B., Hardeman, R. R., & O'Brien, M. (2013). Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of midwifery & women's health*, *58*(4), 378–382. https://doi.org/10.1111/jmwh.12065
- Everson, C. L., Cheyney, M., & Bovbjerg, M. L. (2018). Outcomes of Care for 1,892 Doula-Supported Adolescent Births in the United States: The DONA International Data Project, 2000 to 2013. *The Journal of perinatal education*, *27*(3), 135–147. https://doi.org/10.1891/1058-1243.27.3.135

67. **In the research your team has conducted, what is the evidence around doulas improving the health care and the overall costs of a pregnancy?**

As a result of the improved birth outcomes associated with doula-attended pregnancies,

the cost of the care has been shown to be cost effective or result in a cost-savings. This effect is in large part due to the high healthcare costs associated with preterm births and infants of low birth weight, in addition to cesarean births.

In a comparison of 10,000 simulated Medicaid-funded deliveries with and without doula support, a cost-savings occurred in 73.3-percent of births and 25.3-percent of births were designated cost-effective.

For further reading on the subject, see the following:

> Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. *Birth (Berkeley, Calif.)*, *43*(1), 20–27. https://doi.org/10.1111/birt.12218

68. **In the research your team has conducted, what is the utilization rate range you all have seen in other states offering the services through Medicaid managed care?**
Over the course of 6 years, Minnesota reimbursed for 850 births whereas Oregon reimbursed for 200 births. Oregon has roughly 60 doulas in their state registry and both states have a similar number of Medicaid deliveries per year as Maryland (approximately 25,000 births).

Nationally, doula utilization is closer to 6% for the general population; however, the states that have rolled out Medicaid doula services have experienced significant issues due to low rates and unclear billing guidance. Both Oregon and Minnesota have made changes in the past year that may not be reflected in utilization data rates yet. New Jersey, which would operate most similarly to Maryland's program, does not yet have utilization data available.

While the range for other states appears to be roughly 30-150 Medicaid participants per year, the Department hopes through implementing the program with competitive level rates and making efforts to provide TA surrounding billing, utilization will be closer to serving 1,500 Medicaid participants per year. This is an early estimate, however, and may be subject to change.

**Network adequacy**
69. **Will there be network adequacy requirements?**

The Department is not going to subject doulas to time and distance standards or any network adequacy requirements at this time. The Department will re-evaluate this at a later time, if needed.

### Bundles

70. **If the initial postpartum visit occurs in the hospital, will the doula claim be separate from the postpartum/hospital claim bundle?**

Yes, a doula postpartum service visit would need to be submitted as a separate claim from the postpartum/hospital claim bundle.

### Reporting

71. **Will there be reporting or tracking required by the state, such as reporting on the total amount of beneficiaries eligible to receive doula services vs. the actual uptake of doula services?**

The Department will track doula utilization through claims; no additional reporting from MCOs is anticipated at this time.

### Member Communication

72. **Are the MCOs required to document that they are offering the program to members through a mass marketing effort?**

MCOs should let members know this is a new benefit; how they choose to do this may be through their handbooks/manuals, or targeted to pregnant enrollees, for example.

73. **Would doulas be required to be published in our directories? If so, do we know if doulas have a business address or if they would use their home address?**

Decisions on how to inform their members about contracted doulas in their network will be left to the MCOs. Based on experience to date, most doulas have a professional or business address.

### Ongoing Monitoring

74. **How will the Department address the need for OB acceptance?**

The Department issued Policy Transmittal 37-22 to inform providers (*e.g.,* OB/GYNs) and key stakeholders of the new Medicaid covered benefit for doula services. Labor and delivery policies at the hospital level regarding acceptance into the delivery room will still be managed by each individual hospital. The Department is working with the Maryland Hospital Association around hospital-related implementation issues.

75. **What is the process for reviewing and monitoring quality improvement issues?**

MCOs are expected to use existing processes when needing to submit a grievance. The new doula benefit will be treated in the same manner that MCOs review and monitor their network providers.

76. **What is the expectation of the doula to communicate with the MCOs? Are the MCOs able to establish this type of communication requirement?**
MCOs may design communication protocols with contracted doulas to encourage coordination of services and track/monitor referrals for qualified members. The Department encourages MCOs to examine any existing protocols they may have in this regard for their other provider types when determining any requirements for communication.

**Further questions**

77. **Is the Department working on a provider communication/manual to specifically educate providers on the enrollment requirements and benefit structure?**
Yes. The Department has developed a program manual (issued 3/22/22) intended to educate doula providers on the enrollment requirements and benefit structure. This program manual (issued 3/22/22) will be updated as needed, posted on the Department's doula webpage, and distributed to the doula provider community.