# SENATE COMMITTEE ON HEALTH
**Senator Dr. Richard Pan, Chair**

**BILL NO:** SB 65
**AUTHOR:** Skinner
**VERSION:** April 5, 2021
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**CONSULTANT:** Melanie Moreno

**SUBJECT:** Maternal care and services

**SUMMARY:** Establishes the California Pregnancy-Associated Review Committee within the California Department of Public Health to continuously engage in the comprehensive, regular, and uniform review and reporting of maternal deaths throughout the state. Requires local public health agencies that participate in the Fetal and Infant Mortality Review process to investigate, track, and review at least 1% of the county's cases of term infants who were stillborn, early neonatal death, or postneonatal death, and to establish a committee for fetal and infant mortality reviews. Requires the Office of Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives to increase the number of students receiving quality education and training as a certified nurse-midwife or a licensed midwife. Extends postpartum Medi-Cal coverage from 60 days to one year. Requires Medi-Cal coverage for doulas.

**Existing law:**

1) Establishes the California Department of Public Health (CDPH) to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health and licensing and certification of health facilities, as specified. Requires CDPH to maintain a program of maternal and child health. Requires CDPH to develop a plan to identify causes of infant mortality and morbidity in California and to study recommendations on the reduction of infant mortality and morbidity in California. Requires CDPH to track and publish data on severe maternal morbidity and on pregnancy-related deaths, as specified. [HSC §131050, 123225, 123650, and 123630.4]

2) Requires each county board of supervisors to appoint a local health officer (LHO). Requires LHOs to enforce and observe orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters, orders prescribed by CDPH, and statutes relating to public health. [HSC §101000 and §101030]

3) Establishes the Office of Statewide Health Planning and Development (OSHPD) to, among other functions, collect, analyze, and publish data about healthcare workforce and health professional training, identify areas of health workforce shortages, and provide scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need. Establishes the Health Professions Education Foundation (HPEF) within the OSHPD to, among other functions, develop criteria for evaluating applicants for various scholarships and loans. [HSC §127750, et seq. and 128335]

4) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage. Makes an individual eligible for Medi-Cal, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. [WIC §14000, et seq., 1400.18, and 15840]

**This bill:**

California Pregnancy-Associated Review Committee

1) Establishes the California Pregnancy-Associated Review Committee (CPARC) within CDPH to continuously engage in the comprehensive, regular, and uniform review and reporting of maternal deaths throughout the state. Requires CDPH, in collaboration with the designated state perinatal quality collaborative, to oversee CPARC. Permits CPARC to incorporate the membership of California Pregnancy-Associated Mortality Review Committee (CA-PAMR), as it existed on December 31, 2021.

2) States that the purposes of CPARC include, but are not limited to:

    a) Identifying and reviewing all pregnancy-related deaths, including the cause, contributing factors, and disseminating findings;
    b) Analyzing common indicators of severe maternal morbidity to identify prevention opportunities and reduce near-miss experiences;
    c) Making recommendations on best practices to prevent maternal mortality and morbidity, including, but not limited to, addressing socioeconomic impacts, as well as various environmental impacts, including global warming, on pregnancy outcomes;
    d) Investigating racial disparities and making recommendations on the prevention of racial disparities;
    e) Investigating disparities experienced by lesbian, transgender, and gender-nonconforming individuals and reporting findings; and,
    f) Collecting and reviewing data from maternal death investigations and making recommendations about how to improve or streamline data collection and investigatory processes.

3) Requires CPARC investigations of maternal deaths to include, in addition to reviewing medical records, death certificates, and other pertinent reports:

    a) Voluntary interviews with pertinent surviving family members or support people present with direct knowledge of, or involvement in, the event, including the patient in cases of severe maternal morbidity. Requires CPARC to transcribe or summarize in writing any oral statements received; and,
    b) Voluntary interviews with members of the medical team who were present or involved in the deceased individual's direct care.

4) Requires CPARC to publish its findings to the public every three years as part of the publication of data on severe maternal morbidity under existing law, and requires the report to also include recommendations on how to prevent severe maternal morbidity and maternal mortality and how to reduce racial disparities.

5) Requires CPARC to be composed of a minimum of nine members, and requires members to be comprised of multidisciplinary personnel in the field of maternal mortality and morbidity, data analysis in maternal health, women's health, clinicians in maternal health, and representatives from various public health entities, as specified.

6) Requires CPARC to prioritize for membership members who are representative of the diversity and geographic locations of the pregnant people in populations with disproportionately high occurrences of maternal mortality and morbidity.

7) Requires the Public Health Officer (PHO) to appoint a maternal mortality expert to be a member of CPARC as the chair, and requires the chair to appoint the other members of the committee, as specified.

8) Permits CPARC to create subcommittees, as needed, to carry out its duties, and to request from any state department, division, commission, local health department, or other agency of the state or political subdivision , or any public authority, as well as hospitals, birthing facilities, medical examiners, coroners, coroner physicians, and any other facility or individual providing services associated with maternal mortality, and those individuals and entities shall provide information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records, and any other information that will help CPARC to properly carry out its functions, powers, and duties.

9) Requires all proceedings and activities of CPARC, all opinions of its members that are formed as a result of its proceedings and activities, and all records obtained, created, or maintained by CPARC, including written reports and records of interviews or oral statements, to be confidential and to not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding.

10) Prohibits CPARC from disclosing any personally identifiable information to the public, or include any personally identifiable information in a case summary or any report.

11) Prohibits CPARC members from being questioned in any civil, criminal, legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of CPARC. Specifies that nothing in this bill prohibits a CPARC member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independently of the member's participation on the committee, or as an expert witness in maternal death cases unrelated to their case review as a CPARC member.

12) Specifies that this bill does not prohibit CPARC from publishing, or from otherwise making available for public inspection, statistical compilations or reports that are based on confidential information, provided that those compilations and reports do not contain personally identifying information or other information that could be used to ultimately identify the individuals concerned. Requires CPARC to utilize standard public health reporting practices for accurate dissemination of these data elements, especially in regard to the reporting of small numbers so as to inadvertently risk a breach of confidentiality or other disclosure.

<u>Local fetal and infant mortality review</u>

13) Requires local public health agencies that participate in the Fetal and Infant Mortality Review (FIMR) to:

    a) Annually investigate, track, and review a minimum of 1% of the county's cases of term infants (36 weeks or more of gestation) who were born following labor with the outcome of intrapartum stillbirth, early neonatal death, or postneonatal death, focusing on demographic groups that are disproportionately impacted by infant death;

b) Establish a committee for fetal and infant mortality reviews led by local public health agencies, which includes members of the community, but does not include anyone employed by a law enforcement agency;
c) Conduct interviews with individuals who have experienced child loss or surviving family members of maternal or infant death who have knowledge of the event. Requires interviews to include questions to determine if the pregnant person had concerns about perinatal care during any point in their pregnancy or postpartum care, whether there were disagreements about care offered and received, and whether the pregnant person had asked for certain care that was denied or not received;
d) Conduct a report or investigation, to the degree practicable, with all medical staff involved with the event; and,
e) Offer grief counseling to surviving family members.

14) Requires counties, hospitals, birthing centers, and state entities to provide to local public health agencies death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records, and any other information that will help the local public health agency conduct the fetal and infant mortality review within 30 days of a request made in writing by a local public health agency.

Midwifery Workforce Training Act

15) Requires OSHPD to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives to increase the number of students receiving quality education and training as a certified nurse-midwife or a licensed midwife.

16) Requires OSHPD to only contract with programs that train certified nurse-midwives and programs that train licensed midwives that, at minimum, include a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and that are organized to prepare program graduates for service in those neighborhoods and communities.

17) Requires OSHPD to adopt standards and regulations necessary to carry out this bill, and permits OSHPD to accept those standards established by the licensing and regulatory bodies governing certified nurse-midwives and licensed midwives.

18) Permits OSHPD to pay contracted programs that train certified nurse-midwives and programs that train licensed midwives in an amount calculated based on a single per-student capitation formula, or through another method, in order to cover innovative special program costs.

19) Permits funds appropriated to OSHPD for purposes of this bill to be used to develop new programs, expand existing programs, or support current programs.

Postpartum Medi-Cal coverage

20) Makes an individual eligible for Medi-Cal, as though the individual was pregnant, for all pregnancy-related and postpartum services for a total of 12 months after the end of the pregnancy (instead of 60 days after pregnancy).

21) Requires the additional ten months of Medi-Cal coverage to be implemented only to the extent that any necessary federal approvals have been obtained and federal financial participation is available. Requires DHCS, in the first quarter of 2022, to seek any necessary

federal approvals to provide for implementation and any state plan amendments necessary for services provided after the end of the 60-day postpartum period in existing law.

Medi-Cal coverage for doulas

22) Requires DHCS to establish a full-spectrum doula care program for all pregnant and postpartum Medi-Cal beneficiaries in California. Requires any Medi-Cal beneficiary who is pregnant as of July 1, 2023, to be entitled to full-spectrum doula care.

23) Requires a pregnant person, for a pregnancy that is carried to term, to be eligible for at least four appointments during the prenatal period, continuous support during labor and delivery, and at least eight appointments during the postpartum period. Requires doula care to be available to any Medi-Cal beneficiary without prior authorization or cost-sharing.

24) Requires DHCS to develop multiple payment and billing options for doula care and to ensure:

    a) Any doula and community-based doula group providing services to Medi-Cal beneficiaries be guaranteed payment within 30 days of submitting a claim for reimbursement;
    b) An individual doula be able to obtain a National Provider Identifier number and be directly reimbursed; and,
    c) A community-based doula group be able to obtain reimbursement for any doula working as part of their group. Requires DHCS, if a community-based doula group employs doulas on a salaried basis, to determine appropriate reimbursement rates based on the salaries provided and not on a per-client or per-service basis.

25) Requires doulas be paid for full-spectrum doula care. Requires DHCS and Medi-Cal managed care (MCMC) plans, in setting reimbursement rates for doula care, to take into consideration the rate for any paid, community-based doula pilot programs serving the Medi-Cal population in the prior five years, the cost of living in the county, and the sustainable living wage, as calculated in the county.

26) Requires presence at a stillbirth to be reimbursed at the same rate as presence at a labor and delivery resulting in a live birth. Requires postpartum services to also be covered for a stillbirth. Requires a separate reimbursement for presence during miscarriage or abortion.

27) Requires DHCS and MCMC plans to separately reimburse for each prenatal and postpartum appointment, and requires separate reimbursement for administrative costs, including travel costs.

28) Requires DHCS to make efforts to revisit the reimbursement rate as necessary to account for inflation, cost of living adjustments, and other factors.

29) Requires DHCS to establish a centralized registry listing any doula who is available to take on new clients. Requires the registry to align with existing Medi-Cal provider directory requirements. Requires the registry to be searchable by MCMC plan, geographical area, race and ethnicity of the doula, languages spoken by the doula, and any relevant specializations, including adolescents, homeless, substance use disorder, or refugee or immigrant populations.

30) Requires MCMC plans in each county to provide information about the availability of doula care in their materials and notices on reproductive and sexual health, family planning, pregnancy, and prenatal care. Requires MCMC plans to inform all pregnant and postpartum enrollees at each prenatal and postpartum appointment about the availability of doula care, the benefits of doula care, that doula care is available in addition to other prenatal and postpartum care, and how to obtain a doula. Requires information included on the registry to be accessible by a website, an application on a smartphone, paper, and telephone.

31) Requires DHCS to convene a doula advisory board, which is required to decide on a list of core competencies required for doulas who are authorized to be reimbursed under the Medi-Cal program. Requires the board to reconvene, as deemed necessary by DHCS, at regular intervals, but no less than once every five years.

32) Requires core competencies to include, at a minimum, a demonstration of competency, through training or attestation of equivalency or lived experience, in:

    a) Understanding of basic anatomy and physiology as related to pregnancy, the childbearing process, the postpartum period, breast milk feeding, and breast-feeding or chest-feeding;
    b) Capacity to employ different strategies for providing emotional support, education, and resources during the perinatal period;
    c) Knowledge of and ability to assist families with utilizing a wide variety of nonclinical labor coping strategies;
    d) Strategies to foster effective communication between clients, their families, support services, and health care providers;
    e) Awareness of integrative health care systems and various specialties of care that a doula can provide information for in order to address client needs beyond the scope of the doula;
    f) Knowledge of community-based, state- and federally-funded clinical resources available to the client for any need outside the doula's scope of practice; and,
    g) Knowledge of strategies for supporting breast-feeding or chest-feeding, breast milk feeding, and lactation.

33) Requires at least two-thirds of the membership of the board to be composed of practicing doulas who are providing doula care to Medi-Cal beneficiaries, and requires at least two-thirds of the practicing doulas on the board to be from communities experiencing the highest burden of birth disparities in the state, including doulas who are low income, doulas of color, doulas from and working in rural communities, and doulas who speak a language other than English.

34) Requires doulas, in order to be reimbursed under the Medi-Cal program, to provide documentation that they have met the core competencies specified by the board. Permits the board to also create alternative ways to meet the core competencies, such as by providing documentation of certification through another doula certification program that meets the required core competencies. Requires a doula who has met the core competencies set by the board to receive a certificate of completion.

35) Requires DHCS to work with outside entities, such as foundations or nonprofits, to make trainings available at no cost that meet the core competencies to people who wish to become doulas who are from communities experiencing the highest-burden of birth disparities in the state, including people who are low income, people of color, people from and working in

rural communities, and people who speak a language other than English, who wish to become doulas. Requires the trainings to be available in a manner that makes them accessible to these populations.

36) Defines various terms for the mandate of Medi-Cal doula coverage under this bill, including:

a) "Community-based doula group" means a group or collective of doulas working together that prioritizes doula access for underserved populations. The doula care that is provided by community-based doula groups often goes beyond doula services provided during the prenatal and postpartum periods to encompass a broader and more holistic vision of support for the pregnant person and their family or supporting loved ones. Many community-based doula groups draw their membership directly from the communities that they serve. This often allows community-based doula groups to offer culturally congruent care, and not simply culturally appropriate care;
b) "Core competencies" means the foundational and essential knowledge, skills, and abilities required for doulas serving Medi-Cal beneficiaries;
c) "Doula" means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period. A doula provides physical, emotional, and nonmedical support during miscarriage, stillbirth, and abortion; and,
d) "Full-spectrum doula care" means prenatal and postpartum doula care, continuous presence during labor and delivery, and doula support during miscarriage, stillbirth, and abortion. Doula care includes physical, emotional, and other nonmedical care.

Human Services provisions

37) Eliminates the mandatory requirement to work or participate in welfare-to-work for pregnant people (unless exempted) and makes participation voluntary.

38) Begins aid for pregnant people based on the date of application rather than after the pregnancy is verified. Increases the pregnancy supplemental payment under the CalWORKS program from $47 to $82 per month, and indexes this amount every year. Deletes the limitation on temporary and permanent homeless assistance for households with a pregnant individual.

39) Requires the Department of Social Services to administer a program to provide a monthly stipend to low-income pregnant and postpartum people commencing at six months of pregnancy and until 24 months after birth, as specified.

40) Prohibits gross income from including monetary benefits provided to pregnant and postpartum people pursuant to 39) above. Prohibits monetary benefits provided to pregnant and postpartum people pursuant to 39) above from being considered earned income for purposes of eligibility for the California Earned Income Tax Credit.

**FISCAL EFFECT:** This bill has not been analyzed by a fiscal committee.

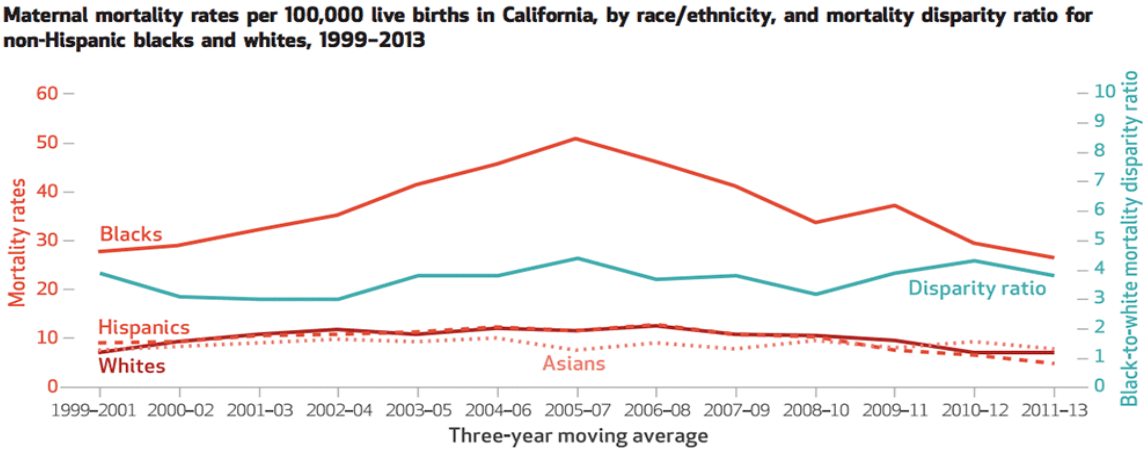
**COMMENTS:**

1) *Author's statement.* According to the author, the United States is failing birthing people and babies – particularly women and babies of color. More birthing people and babies die in this country than in any other high-income countries– and many of these deaths are preventable. This bill takes a comprehensive approach to improve outcomes for birthing parents and

babies by closing racial disparities in maternal and infant death and near-death experiences. It accomplishes this by requiring comprehensive investigations into maternal and infant mortality and morbidity, improving data collection and research on socio-economic factors that contribute to negative birth outcomes, expanding postpartum health care for parents and babies, and improving access to health options like doulas and midwives which have been proven to improve birthing outcomes for women and babies of color.

2) *Disparities in maternal morbidity and mortality.* According to the California Birth Equity Collaborative (CBEC), an initiative at Stanford University's California Maternal Quality of Care Collaborative (CMQCC), maternal mortality rates nearly doubled in California between 1999 and 2006. Since CMQCC was founded in 2006, California's maternal mortality rate has declined by 55% while the national maternal mortality rate has continued to rise. The expectation was that widespread adoption of CMQCC's clinical safety bundles would reduce the gap in the number of maternal deaths among black women. However, the difference in outcomes for black mothers has persisted. Further analysis revealed that clinical safety bundles and social support interventions done in isolation, without an integrated approach, did not produce the desired outcomes. Data shows that even in the absence of risk factors such as age over 35 years, lack of health insurance, inadequate or no prenatal care, and less than high school education, the U.S. system of health care is not protecting black mothers. According to CBEC, increasing evidence points to racism within and across multiple levels, and not race, as a key cause of these birth disparities. Data also show variations in the quality of care and outcomes across hospitals in California highlighting opportunities for advancing equity in quality improvement. A 2017 study published in Seminars in Perinatology, *Improving hospital quality to reduce disparities in severe maternal morbidity and mortality,* found that growing research suggests that hospital quality may be a critical lever for improving outcomes and narrowing disparities. This study stated that with black women three to four times more likely to die from pregnancy-related causes than white women, this represents the largest disparity among all the conventional population perinatal health measures. Among other things, the study suggested that team training is an important step to providing coordinated care, and that implementation of a disparities dashboard, which stratifies quality metrics by race and ethnicity, is a useful tool which allows hospitals to become aware of disparities.

The chart below is from a November 2018 article in Public Health Post, *Disparities in Maternal Mortality in California:*



3) *CA-PAMR and CDPH maternal morbidity and mortality reporting.* CA-PAMR is a comprehensive statewide maternal mortality examination that aims to identify pregnancy-related deaths during pregnancy or within one year of the end of pregnancy, their causes, factors that contributed to the death, and improvement opportunities in maternity care and support, with the ultimate goal to reduce preventable deaths and associated health disparities. CA-PAMR is a collaborative effort between CDPH's Division of Maternal, Child and Adolescent Health, Stanford University's California Maternal Quality of Care Collaborative, and the Public Health Institute. Funding comes from the federal Title V Maternal Child Health Block Grant. In a review of maternal deaths from 2002-2007, CA-PAMR found that:

   - 41% of pregnancy-related obstetric deaths had a good-to-strong chance of preventability;
   - Cardiovascular disease is the leading cause of pregnancy-related death;
   - Racial and ethnic disparities persist, with African-American women continuing to experience higher risk of a pregnancy-related death;
   - Multiple patient, facility, and health care provider factors contributed to pregnancy-related deaths; and,
   - Case reviews informed public health prevention programs and led to the development of maternity care quality improvement strategies, known as California Toolkits to Transform Maternity Care.

   According to CDPH, once the changes being made to CA-EDRS are in place, it will be able to track maternal mortality through data collected on the death certificate. With regard to maternal morbidity, CDPH uses hospital discharge data from the Office of Statewide Health Planning and Development to track maternal morbidity. Maternal mortality and morbidity are reviewed, validated, and released within about two years of collection. Analysis of both maternal mortality and morbidity relies on active reporting by licensed health facilities, but the statute's provisions only require reporting up to 42 days post-delivery. CDPH states that comprehensive assessment of maternal mortality and morbidity would require reporting of all maternal mortality and morbidity events that occur within one year post-delivery.

4) *Black Infant Health (BIH) Program*. BIH is one of the programs within CDPH's Division of Maternal, Child, and Adolescent Health. The goal of BIH is to improve African-American infant and maternal health, as well as decrease black-white health inequities and social inequities for women and infants. BIH serves African-American women who are 18 years or older and up to 30 weeks pregnant at the time of enrollment. According to the CDPH's BIH website, "within a culturally affirming environment and honoring the unique history of African-American women, BIH aims to help women have healthy babies. Participants learn proven strategies to reduce stress and develop life skills. This is accomplished through a group-based approach with complementary case management." BIH services are provided by family health advocates, group facilitators, public health nurses, and social workers. BIH participants report stronger positive connections to their heritage and the African-American community, increased empowerment to make behavior changes that lead to living a healthier life, and better understanding of effective stress-reduction strategies.

5) *California Perinatal Equity Initiative (PEI).* AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018), the health trailer bill, established the PEI at CDPH and appropriated $8 million from the General Fund to expand the scope of interventions provided under BIH. The PEI is intended to foster Community Centers of Excellence in perinatal health and promote

the use of interventions designed to fill gaps in current programming offered through BIH. Under the PEI, CDPH is required to allocate funds to up to 15 county health departments, to work collaboratively with state and local BIH programs, for the purposes of improving back infant birth outcomes and reducing infant mortality. The county health departments are required to use the funds to develop local Community Centers of Excellence at hospitals, federal qualified health centers, clinics, or community-based organizations that have demonstrated capacity to work with public health and health care systems as well as within the black community. Recipients of local grants are required to implement or expand two of five types programs: evidence-based group prenatal care that has shown promise in reducing the incidence of adverse birth outcomes; pregnancy intentionality and preconception programs; fatherhood or partnership initiatives; evidence-based home visiting programs inclusive of case management to increase advocacy and empowerment for black women and to ensure linkages to prenatal care; or, a different strategy that is justified based on local needs and resources, if a county determines that the strategy is evidence-based in related to reducing adverse birth outcomes.

6) *State Loan Repayment Program (SLRP).* OSHPD's SLRP seeks to increase the number of primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and mental/behavioral health providers practicing in federally designated California Health Professional Shortage Areas (HPSA). The award maximum is $50,000, but the actual amount awarded depends on actual student debt. Since 2018, SLRP has awarded $218,400 to certified nurse midwives (two awards each in 2018 and 2020, and three awards in 2019).

7) *FIMR.* According to CDPH, FIMR is a community-based program that reviews the contributing factors to fetal and infant deaths within a local health jurisdiction. FIMR is a national program, and according to CDPH's website, there are currently 16 counties (both rural and urban) that participate in California's FIMR program. According to Alameda's FIMR program, FIMR collects and presents data from a variety of sources regarding the loss of a fetus or infant. The data is presented to providers throughout Alameda County. A review team identifies factors to help decide what changes can be made in the community, to individual behavior, and the health care system. The team of providers meets twice a year to review specific infant death cases, learn more about the causes of early and untimely deaths, and identify gaps in the health care system such as access to insurance and care. The goal is to reduce disparities and fetal and infant deaths.

8) *CHBRP analysis of Medi-Cal doula benefit*. AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed the mandate that Medi-Cal cover doula benefits pursuant to AB 2258 (Reyes, Bonta, Limon, McCarty) of 2020, which would have required Medi-Cal coverage for doulas under a pilot project in 14 counties. Key findings include:

   a) Coverage impacts: No enrollees in Medi-Cal that would be subject to AB 2258 have coverage for full-spectrum doula services as proposed in AB 2258. Postmandate, 100% of enrollees in the 14 counties would have coverage for doula care through the pilot program.

b) Medical effectiveness. The medical effectiveness review examined the impact of doulas on a multitude of maternal and neonatal and infant outcomes. Findings across outcomes varied.
c) Public health. AB 2258 would produce an unknown but positive impact on birth experiences, including improved agency for pregnant Medi-Cal enrollees, especially among the racial and ethnic minority populations that access community-based doula care in the first year, postmandate.
d) Long-Term Impacts. The reduction in cesarean deliveries among Medi-Cal managed care enrollees is unlikely to be reflected in prospectively set payments in the short-term. After 2 to 3 years when rates are recalculated, reductions in caesarian deliveries could be reflected in the payments made to plans, which may result in savings to the Medi-Cal program.
e) Utilization: Postmandate, CHBRP estimates approximately 20% of the almost 204,000 eligible pregnant women who experience live birth, abortion, miscarriage, or stillbirth would use the doula services offered by the pilot. As a result, vaginal deliveries would increase by 3,441 (2.44%), while cesarean deliveries would decrease by the same number (which represents a 5.84% decrease because the number of vaginal deliveries exceeds the number of cesarean deliveries in Medi-Cal).
f) Expenditures. Total net annual Medi-Cal expenditures in the 14 pilot counties would increase by $32,495,448, or 0.08%.

9) *Double referral.* This bill has been double referred. Should it pass out of this committee, it will be referred to the Committee on Human Services.

10) *Related legislation.* SB 492 (Hurtado) renames the CA-PAMR as the Maternal Mortality Review Committee (MMRC), and requires the MMRC to be composed of a minimum of nine members, as specified. Requires the purpose of MMRC to be collecting and reviewing data from maternal death investigations, as specified, and making recommendations about how to improve or streamline data collection and investigatory processes. *SB 492 is set to be heard in this Committee on April 14, 2021.*

11) *Previous legislation*. SB 464 (Mitchell, Chapter 533, Statutes of 2019) requires hospitals and alternative birth centers to implement an implicit bias program for all health care providers involved in the perinatal care of patients within those facilities, including requiring these healthcare providers to complete initial basic training through the implicit bias program and a refresher course every two years thereafter. Requires CDPH to track and publish data on maternal death and severe morbidity. Adds, to the list of written information a hospital is required to provide to each patient upon admission, information on how to file a discrimination complaint with CDPH or the Medical Board of California if the patient feels they were discriminated against.

AB 2258 (Reyes, et al.) would have required DHCS to establish a full-spectrum doula care pilot program to operate for three years for pregnant and postpartum Medi-Cal beneficiaries residing in 14 counties that experience the highest burden of birth disparities in the state, and would have entitled any pregnant Medi-Cal beneficiary residing in a pilot program county to doula care. *AB 2258 was not heard in the Assembly Health Committee.*

12) *Support*. A coalition letter from the sponsors of this bill states that although California has reduced the rates of maternal mortality over the past 30 years, mortality and morbidity for Black and Indigenous/Native American pregnant people, women, and infants remain considerably higher than the state's average. Research points to structural racism, as well as socioeconomic factors, contributing to the racial and geographic disparities seen in birthing outcomes of people of color. In addition, although we have not gotten updated data at the state level in several years, county data suggest that the racial disparities are widening, with deaths for Black birthing people ticking back up here in California. Between 2011 and 2013, the ratio of death for Black women was 26.4 per 100,000, almost 3.8 times higher than that for white women. In certain counties, the disparities are even greater. In Los Angeles County, the largest county in California, the rate of maternal death for Black women is over 4.5 times higher than the County overall rate for women. According to the Los Angeles County Office of Women's Health Indicators for Women in Los Angeles County 2013 report, the ratio of Black maternal mortality in Los Angeles was 58.6 per 100,000. In the 2018 version of the report, the number was 85.8 per 100,000. LA County's ratio for all women in the 2018 report was 17.9 per 100,000.

    Meanwhile, California's infant mortality rate is 4.2 per 1000 live births, lower than the national average of 5.7. However, a closer look at the numbers demonstrates sharp racial disparities. Indigenous/Native American infants in California die at a rate of 11.7 per 1000 live births, followed by Black infants who die at a rate of 8.7 per 1000 live births. Higher numbers of Black and Asian and Pacific Islander pregnant and postpartum people report unfair treatment, harsh language, and rough handling during their labor/delivery hospital stay, as compared to white pregnant and postpartum people. Higher numbers of pregnant and postpartum people who speak an Asian Language or Spanish at home also report unfair treatment during their labor/delivery hospital stay, as compared to pregnant and postpartum people who speak primarily English at home. In addition, California is heading towards a maternal health crisis, with critical shortages in maternity providers predicted by 2025. Currently, California has nine counties that do not have a single OBGYN. California only has two nurse-midwifery programs in the entire state, and only one direct-entry midwifery program, approved by their respective state licensing boards. It is becoming increasingly difficult for these programs to expand the midwifery workforce in California to meet the demand in maternity care deserts and low access areas.

13) *Policy comments on FIMR provisions*. Currently, it is optional for counties to participate in FIMR, and only 16 counties choose to do so. This bill places investigative, tracking, and review requirements on those counties that voluntarily participate in FIMR. This may create a disincentive for counties to participate in FIMR, or for counties to standup new programs, which is counter to the author's objectives.

    Additionally, this bill would impose a mandate to annually investigate, track, and review a minimum of 1% of the county's cases of infant deaths. According to the CDC, in 2019, there were a total of 1,879 infant deaths statewide. If 1% of all of those deaths were investigated, it would only involve 19 infant deaths. Even in a county as large as Los Angeles, with approximately 25% of the state's population, a review of 1% of the infant deaths in that county would still likely only involve a handful of cases. In small counties, 1% could amount to one or less cases per year.

14) *Technical amendments.*

In Section 3 of this bill, delete "local public health agency" and insert "local health department"

On page 55, delete lines 22-24 and insert: **Full spectrum doula care is a covered benefit.**

On page 55, beginning on line 25:
(2) Any Medi-Cal beneficiary who is pregnant as of July 1, 2023, shall be entitled to full-spectrum doula care **provided by a doula or a community based doula group pursuant to this section**. For a pregnancy that is carried to term, a pregnant person shall be eligible for at least four appointments during the prenatal period, continuous support during labor and delivery, and at least eight appointments during the postpartum period.

On page 56, beginning on line 1:
(ii) An individual doula shall ~~be able to~~ obtain a National Provider Identifier number and be directly reimbursed by the department.
(iii) A community-based doula group shall be able to obtain reimbursement for any doula working as part of their group. If a community-based doula group employs doulas on a salaried basis, the department shall determine appropriate reimbursement rates based on the salaries provided and not on a per-client or per-service basis. **A contracting community-based doula group shall provide the department with doula salaries for purposes of this section.**

On page 56, delete lines 34-38.

**SUPPORT AND OPPOSITION:**

**Support:** Black Women for Wellness Action Project (co-sponsor)
California Nurse Midwife Association (co-sponsor)
March of Dimes (co-sponsor)
NARAL Pro-Choice California (co-sponsor)
National Health Law Program (co-sponsor)
Western Center on Law and Poverty (co-sponsor)
Access Reproductive Justice
ACLU California Action
BreastfeedLA
Business & Professional Women of Nevada County
California Coalition of Welfare Rights Organizations
California League of Conservation Voters
California Pan-Ethnic Health Network
California Women's Law Center
Center on Reproductive Justice at Berkeley Law
Children Now
Children's Specialty Care Coalition
Citizens for Choice
Coalition of California Welfare Rights Organizations
Consumer Watchdog
Courage California
Disability Rights Education and Defense Fund
Empowering Pacific Islander Communities
Essential Access Health

Every Mother Counts
Health Access California
If/When/How: Lawyering for Reproductive Justice
In Our Own Voice: National Black Women's Reproductive Justice Agenda
LA Best Babies Network
Los Angeles County Board of Supervisors
Maternal and Child Health Access
National Association of Social Workers, California Chapter
National Center for Youth Law
Plan C
Planned Parenthood Affiliates of California
Providence
Public Law Center
Religious Coalition for Reproductive Choice
SBCC-Strength Based Community Change
TEACH
The Birth Equity Advocacy Project
The Birthworkers of Color Collective
The Children's Partnership
The Coalition of 100 Black Women, Los Angeles Chapter
The Praxis Project
Time for Change Foundation
Training in Early Abortion for Comprehensive Healthcare
Three Individuals

**Oppose:** None received

**-- END --**