

Methods to secure doula reimbursement approval from CMS

Engrossed Substitute Senate Bill 6168; Section 211(32); Chapter 357; Laws of 2020

December 1, 2020



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Executive summary

This report is submitted to the Legislature to comply with the requirement to provide recommendations on how to reimburse for doula services for Washington Apple Health (Medicaid). The requirement is described in Engrossed Substitute Senate Bill 6168 (2020), section 211(32):

“Within the amounts appropriated in this section, the authority shall reimburse for maternity services provided by doulas. The authority and the department of health must consult with stakeholders and develop methods to secure approval from the Centers for Medicare and Medicaid services for reimbursement for doulas. The authority will report the group's recommendations to the appropriate committees of the legislature by December 1, 2020.”

A doula is a support person, or non-medical birth coach, trained to provide physical, emotional, and informational support to pregnant persons during the antepartum, labor and delivery, and postpartum periods. Doula care is associated with increased positive birth outcomes including: reduction in low birth weight, preterm birth, cesarean sections and other medical interventions, and improvements in Apgar scores (an indicator of newborn health) and increased breastfeeding. Doula services result in increased positive outcomes for pregnant individuals who are low-income, people of color, or who experience cultural or linguistic barriers to accessing care. Research demonstrates medical cost savings associated with doula care.

In Washington, and most other states, doulas are not required to be credentialed. Typical levels of credentialing in WA through the Department of Health (DOH) include “registered”, “certified”, and “licensed”. Doula services currently are not reimbursed by Apple Health. The states that reimburse doulas with Medicaid funding have developed a credentialing process.

The Health Care Authority (HCA) and DOH formed a workgroup to consult with stakeholders and make recommendations on how to reimburse for doula services in Washington. Doulas and doula partners were an active part of the discussions during the spring and summer of 2020. The workgroup examined the two primary options from the Centers for Medicare and Medicaid Services (CMS) for doula reimbursement:

1. Non-credentialed route where doulas would need to establish a relationship with a billing and supervising provider who would bill Apple Health on the behalf of the doula; or,
2. Credentialed route where doulas would need to be credentialed through DOH allowing them to bill Apple Health directly. (DOH does not currently have an existing credentialing process for doulas).

The pros and cons of these two approaches are described in this report, along with lessons learned from other states who have implemented Medicaid reimbursement for doulas. Also discussed is a

review of the literature on doulas and the strong evidence for improved outcomes, summaries from the voices of doula partners/stakeholders, fiscal analysis related to implementation and utilization, and resources we believe are needed for successful implementation.

Our doula partners/stakeholders have shared with us their unified position to not pursue the non-credentialed route. Therefore, our recommendation for Washington aligns with the unanimous position of the Doulas for All Coalition to pursue the credentialed route for doulas. Doula credentialing would take place through DOH. Additional state funding would be necessary to create a doula credentialing program, and the estimated time to establish a new profession at DOH is 18 months.

Background

This report addresses requirements of HCA and the DOH to: (1) consult with stakeholders about developing methods to secure approval from the Centers for Medicare and Medicaid Services (CMS) for reimbursement for doulas; and (2) submit the group's recommendations to the Legislature by December 1, 2020.

The current requirements are described in Engrossed Substitute Senate Bill 6168 (2020). The budget proviso in section 211(32) of that act states:

“Within the amounts appropriated in this section, the authority shall reimburse for maternity services provided by doulas. The authority and the department of health must consult with stakeholders and develop methods to secure approval from the Centers for Medicare and Medicaid services for reimbursement for doulas. The authority will report the group's recommendations to the appropriate committees of the legislature by December 1, 2020”.

Role of the doula

A doula is a support person, or non-medical birth coach, trained to provide physical, emotional, and informational support to pregnant persons during labor, birth, and the postpartum period.

Specific job duties for doulas include:

- Prior to birth, doulas work with families to increase health literacy, knowledge, and confidence which leads to more informed health care decision making and better access to appropriate care. These activities include, but are not limited to:
 - o Discussing what to expect at the hospital, birthing center, or other desired birth location
 - o Reviewing the various health care professionals that may be interacting with the family and what their roles are

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- Talking to families about their personal and cultural preferences around childbirth and how they can prioritize them
- Providing positive reinforcement and encouragement to families for skin-to-skin care directly following birth, early breastfeeding, and other behaviors that are known to promote positive outcomes
- During labor and delivery, doulas provide continual physical comfort measures, emotional support, and informational support.
- After birth, doulas provide breastfeeding support as well as informational and emotional support related to postpartum and newborn care.

Benefits of doula care

There is strong evidence for positive maternal and infant outcomes associated with doula services. On a population level, most pregnant persons who utilize doula services show these positive effects, and, the associations between doula support and positive perinatal outcomes are larger, and in some cases statistically stronger, among persons who are low income, people of color and/or experience cultural or language barriers to accessing care.¹ This is important as we are living in a black, indigenous, and people of color (BIPOC) maternal mortality crisis and doulas have shown to be an effective strategy to address some of these large and persistent disparities in perinatal health. Unfortunately, the current reality is that individuals and families who stand to benefit the most from doula care may have the least access to it- including financially and culturally.

The following positive outcomes are associated with doula care^{2,3,4,5,6,7,8,9,10}:

- Reduced low birthweight babies
- Reduced preterm births
- Reduced cesarean sections
- Reduced labor inductions and other medical interventions (augmentation, artificial rupture of membranes, episiotomy, assisted vaginal delivery, anesthesia use)
- Higher Apgar (Appearance, Pulse, Grimace, Activity, and Respiration) scores following birth (indicator of newborn health)
- Increased breastfeeding

The peer reviewed academic literature suggests that doula services save money related to the outcomes listed above (savings cited in the literature with reasonable modeling report average savings per client ranging between \$300-1,300)^{8,9,10} and that there are many variables that impact these savings, including: states' reimbursement rates, birth volume, and current cesarean rates, among others.

Two of the leading causes of maternal death around the time of birth in the US are missed or delayed diagnoses and not recognizing warning signs of complications¹¹. Doulas offer continual

emotional and physical support during labor and delivery and empower individuals to communicate their needs to their health care team, an effective tool in preventing poor outcomes.

Given the strong evidence for the positive outcomes associated with doula services, the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine released a consensus statement in 2014 endorsing the increased use of “one of the most effective tools to improve labor and delivery outcomes, the continuous presence of support personnel, such as a doula”. Doulas effectively complement the role of healthcare professionals providing the client’s medical care.

Barriers, concerns, and doula priorities

Doulas and doula partners attended our cross-agency workgroup. Their collective voices and actions are critically important to the implementation of Apple Health reimbursement for doula services as and the expansion of doulas in the perinatal workforce. As of August 2020, HCA had four meetings with doulas and doula partners in 2020: minutes of those meetings can be found in appendix A. In addition to these meetings, HCA had multiple phone conversations with smaller groups as well as regular communication over email.

Doulas in Washington are passionate about their work being grounded in reproductive justice for all, with a focus on equity, racial justice, and social justice. Doulas want their voices heard and to be part of decisions made about their profession. They want their expertise and the human capital resources that exist in Washington to be leveraged to build a program that respectfully and appropriately serves the Apple Health population. Doulas in our workgroup voiced that they have two primary goals around establishing Apple Health-reimbursable doula services:

- 1) Make doula services accessible to more clients across Washington.
- 2) Expand opportunities for doulas.

Reports by researchers and health policy experts have identified challenges and barriers affecting doula implementation in Oregon and Minnesota¹²¹³, many of which echo the concerns identified by workgroup members as we develop doula services for Apple Health. Challenges and barriers identified by workgroup participants and mirrored in the related reports include:

- **Low reimbursement rates** – The budget-neutral Apple Health rates proposed by HCA are well below the usual private-pay rate for doula services. Doulas report their usual rates in Washington range from \$500 to \$2,500 per pregnancy. The proposed Apple Health rates do not represent a living wage for doulas, and doulas in Washington desire a payment rate from \$1,000 to \$1,500, with flexibility around the model of services (e.g., number of prenatal and postpartum visits provided along with labor and delivery support).

- **Doula services provided under the supervision of a licensed clinician** – The doula’s supervising provider also acts as the biller for Apple Health reimbursement. Doulas in our workgroup voiced concerns about lacking the infrastructure to find and align with a supervising provider. Many doulas reported not having access to, or a relationship with, an Apple Health supervising provider. In Minnesota, doulas have indeed struggled to find supervising providers, perhaps due to an unwillingness of providers to take on perceived risk. Doulas value their autonomy in providing services, so many are reluctant to work for another provider. There is also concern about how much of the doula’s reimbursement would be retained by the supervising provider to cover administrative or other costs. HCA is unable to dictate division of reimbursement, leaving it to be negotiated between the doula and their supervising provider.
- **Doula training and credentialing present a high cost barrier** – There are no universal credentialing requirements for doulas in the United States. As of 2018, there were over 100 independent organizations offering some form of doula training. Despite this large number, only eight organizations are Medicaid-approved to provide doula training in Minnesota, and only four are approved in Oregon. Doula registration in Minnesota costs \$200, in addition to training fees that cost up to \$800. Doulas in Washington desire a low-barrier, flexible approach to training and credentialing requirements. Barriers include the cost of trainings and fees, the time required to complete education and in-person training hours, and access to required education and training. Doulas also voiced concerns that credentialing-related requirements would disproportionately impact and deter doulas of color. Subsidies or fee waivers were suggested in other states to help address cost-related barriers, and doulas in Washington support this as well.
- **Lack of diversity in the doula workforce** – Doula services are not one-size-fits-all. Clients and doulas should be matched based on cultural background, race, ethnicity, languages spoken, and other shared background and lived experiences. Doulas in Washington are committed to increasing the diversity of the workforce and the diversity of families served, as this will lead to improved perinatal outcomes. Doulas want a system where partnering each family with a doula is a mutual process with agreement on both sides.
- **Topics crucial to doula care for Apple Health clients are not sufficiently covered** - Trauma-informed care, infant loss, poverty, intimate partner violence, and structural racism are not usually discussed in basic doula training. Many present-day doulas provide care primarily to middle or upper-class white clients who can afford to pay out of pocket. Doulas in Washington feel it is important to require training on cultural humility, anti-bias/anti-racism, and trauma-informed care to build a workforce that is better prepared to serve a historically underserved and disempowered population in a sensitive and strengths-based manner. A doula who is not well-versed in recognizing the challenges unique to Apple Health clients has the potential to do harm.

- **Lack of doulas in rural and remote areas** – Travel time and related costs are not part of the proposed Apple Health rate and are not reimbursable. A doula's expenditures may outweigh earnings if travel to remote areas of Washington is involved. This will limit the number of doulas willing to serve clients in non-metropolitan areas.
- **Duplication of services/services not covered by Apple Health** – Doulas in Washington expressed a desire to provide expanded services beyond the 2-1-2 visit model (two prenatal visits, labor/delivery, and two postpartum visits), particularly for clients who are the most marginalized and disempowered. One workgroup participant discussed a study using a 13-1-13 model (thirteen prenatal visits, labor/delivery, and thirteen postpartum visits), which equates to an Apple Health client seeing the doula more often than the pregnancy medical provider. Any model with an increased number of prenatal or postnatal visits needs thorough review to ensure services are not duplicated in another program, such as [First Steps Maternity Support Services \(MSS\)](#). CMS rules do not allow duplication of services provided to Medicaid enrollees, and potential overlap with MSS will limit the types of services a doula may provide for reimbursement. The [MSS program](#) serves Medicaid pregnant enrollees through 60 days postpartum and has been in existence in Washington State since 1989. HCA's existing MSS program provides enhanced services which includes, but are not limited to: education related to improving pregnancy and parenting outcomes; interventions for risk factors; basic health messages; brief counseling; case management care coordination; and referrals to community resources. These services are provided in addition to medical and prenatal care. MSS has providers located in 28 counties throughout the state and services may be provided in the office or at the client's home. Many doulas offer private-pay client assistance with tasks such as postpartum house cleaning, grocery shopping, and child care, but these tasks are not reimbursable using Medicaid funds.
- **Lack of awareness and acceptance of doulas as part of the maternal health care team** – Apple Health clients, maternity care clinicians, and health care delivery systems may not utilize doula services to the fullest extent possible, thereby minimizing the positive impact on birth-related outcomes. Doulas in the workgroup expressed concerns about how they would obtain referrals and effectively communicate with other members of the maternal health care team.
- **Doulas not familiar with Apple Health process and Managed Care Organizations (MCOs)** – Doulas are less likely to have organizational support or infrastructure to assist them with enrollment and billing requirements for Apple Health reimbursement through fee-for-service and MCOs. Doulas in Washington voiced concerns about the Apple Health provider enrollment process, how to bill Apple Health, and how to contract with each of the five MCOs serving Apple Health clients in our state. In addition, not all practicing doulas maintain chart notes about client interactions, but documentation of services is required for Apple Health reimbursement purposes.

Research from other states – Minnesota, Oregon, and New York

In recent years, Minnesota and Oregon became the first states to cover doula services for Medicaid clients. In 2019, New York Medicaid implemented a pilot expansion of doula coverage, with availability limited to two counties.

Oregon

When doulas were initially added to Oregon Medicaid services in 2012, a licensed health care professional was required to supervise each doula. Due to low uptake, Oregon pursued a different coverage model in 2017. The doula benefit was instead moved to Preventive Services in the State Plan, and doulas were required to become credentialed as Traditional Health Workers (THWs). THW-credentialed doulas are able to directly bill Medicaid and no longer need a supervising health care professional. Requirements to become a THW include: completion of an approved doula training program; a background check; and education about cultural competency and trauma-informed care. As of June 2020, Oregon Medicaid had 90 enrolled doulas.

Oregon's reimbursement follows a 2-1-2 doula services model (two prenatal visits, labor/delivery, and two postpartum visits). The reimbursement rate is either \$350 for all services as a bundle, or \$50 per visit plus \$150 for day of delivery. This rate has remained static since 2017. Doula services are provided through both Medicaid fee-for-service and MCOs.

Oregon MCOs have been able to use flexible funding sources to provide a higher reimbursement rate for contracted doula "hubs." For example, one MCO provides bonus payments to doulas when certain performance measures are met, such as accompanying the client to a prenatal appointment and meeting the provider responsible for the client's pregnancy medical care.

Minnesota

Minnesota implemented doula services in 2014 as part of pregnancy-related and postpartum services in the State Plan. In addition to having a supervising physician, nurse practitioner, or certified nurse midwife, doulas must be certified by an approved organization and register with the Minnesota Department of Health. As of June 2020, Minnesota Medicaid had 83 enrolled doulas.

Minnesota's reimbursement rate is most similar to a 3-1-3 model (three prenatal visits, labor/delivery, and three postpartum visits), up to a maximum of \$411.36 per pregnancy. Coverage is provided for up to seven sessions, one of which must be labor and delivery. Labor and delivery is paid at \$257.10, while the rate for the other six visits is \$25.71 each. Doulas may request authorization for additional sessions, although Minnesota has not provided specific guidance or criteria about which clients may qualify. Doula services are provided through both Medicaid fee-for-service and MCOs. A 2019 bill proposed nearly doubling the reimbursement rates for doula services to \$47 per visit and \$488 per birth, but did not become law.

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New York

New York's pilot expansion of doula services launched in March 2019. The project focuses on clients in two counties chosen for their high maternal and infant mortality rates, plus a significant number of Medicaid births. Phase 1 includes Erie County (western part of state; Buffalo, NY-area) and has 34 enrolled doulas as of June 2020. Phase 2 in Kings County (Brooklyn borough in New York City) will begin once enough doulas enroll to provide services in that area. To qualify for pilot participation, doulas must have 24 contact hours of education; classes in breastfeeding, childbirth, and cultural competency; attendance at a minimum of two births; and completion of a doula proficiency exam. Each doula must also write and submit a position paper about the role of doulas in the birthing process.

New York's reimbursement rate is based on a 4-1-4 model (four prenatal visits, labor/delivery, and four postpartum visits), up to a maximum of \$600 per pregnancy. Labor and delivery is paid at \$360, and the rate for the other eight visits is \$30 each. Doula services are provided through both Medicaid fee-for-service and MCOs.

New York Medicaid plans to evaluate the doula pilot for reach, effectiveness, and satisfaction of both doulas and clients. Doulas are surveyed after their first three claims are reimbursed and will be surveyed again at the end of the pilot. Clients using doula services are surveyed twice after childbirth, once at four to six weeks postpartum and again at three months postpartum. Claims data will be used to monitor client attendance at postpartum visits.

Doula services stakeholder group

The subsections below detail the efforts of the Doula Services Work Group to address the requirements of the budget proviso and to produce the Methods to Secure Approval from CMS for Reimbursement for Doulas Report.

Workgroup membership and process

HCA convened a Doula Services Work Group that included representatives from the following:

- State and Local Government Organizations:
 - Department of Health
 - Department of Social and Health Services/Research and Data Analysis
 - Health Care Authority
 - Snohomish Health District
 - Tacoma Pierce County Health Department
- Legal, Racial, Ethnic, and Other Population-Based Organizations:
 - American Indian Health Committee (AIHC)
 - Native American Dialogue on Infant Mortality



- Queer & Trans People of Color (QTPOC)
- Seattle Indian Health Board
- Somali Doulas
- United Indians
- Hospitals, Providers, and Professional Organizations:
 - Doulas for All Washington State
 - Midwives Alliance of WA State (MAWS) & National Association of Certified Midwives
 - NAPS Doulas
 - Neighbor Care
 - Open Arms Perinatal Services
 - PALS Doulas
 - Perinatal Social Work
 - Real Family Solutions
 - Sea Mar Community Health Centers
 - Simkin Center for Allied Birth Vocations at Bastyr University
 - Spokane Professional Doulas Association
 - Swedish Medical Center
 - Ulvenes Consulting

Appendix A contains a complete list of the Work Group member organizations and their representatives that were invited to the Work Group meetings.

The Work Group met 4 times between March and August 2020. The Work Group members:

- Defined the scope of the budget proviso requirements and the role of doula services;
- Shared information about and discussed doula reimbursement rates, payment options, and barriers and concerns;
- Drafted and reviewed the financial model based on budget neutrality;
- Achieved shared understanding about the structure for reimbursement for doula services for both the non-credentialed and the credentialed route that fulfill CMS requirements.

The Doula Services Work Group, consisting of employees of both Health Care Authority (HCA) and Department of Health (DOH), has been meeting with a group of doula stakeholders. These stakeholder meetings have been very helpful to gather information and input regarding the proposed implementation plan. Based on the current fiscal modeling, HCA is proposing up to \$650 reimbursement rate for a 2-1-2 model. This service delivery model would include two antepartum visits, labor support, and two postpartum visits. Given that HCA was not allocated any funds for doula services, the implementation needs to be cost neutral, or any associated costs must be countered by assumed cost savings.



As part of developing the fiscal model for Apple Health reimbursement, HCA asked the stakeholder group to estimate future utilization after the implementation. While there was variance, the general consensus was that utilization would increase.

Appendix B contains agendas, notes, and other materials from each Work Group meeting.

Recommendations and implementation phases

Options and analysis

Options for coverage of doula services under Apple Health include:

1. Non-credentialed doulas under Other Licensed Provider services in the State Plan
2. Non-credentialed doulas under Preventive services in the State Plan
3. Credentialed doulas through FFS/MCO
4. Credentialed or non-credentialed doulas as part of the maternity services global payment
5. 1115 Waiver, as a pilot program for non-credentialed doulas

All options require either a State Plan Amendment (SPA) or a waiver application, as well as WAC changes, ProviderOne system updates, reimbursement rate, clinical policy, and billing guide development. No matter which option is pursued, HCA must develop a robust plan to measure the health impact of doula services over time, including a baseline evaluation prior to implementation.

Non-credentialed doulas under Other Licensed Providers (OLP) services in the State Plan, and Non-credentialed doulas under Preventive services in the State Plan

A licensed provider (physician, certified nurse midwife, ARNP, licensed midwife) must supervise the doula and bill on the doula's behalf. Payment to the doula may be delayed, depending on the supervising provider's billing practices. There is no requirement for the supervising provider to pass the entire reimbursement on to the doula for services performed. A SPA under Preventive services requires more information from HCA about doula services, including detailed descriptions and list of service subcomponents, whereas a SPA under OLP services is more straightforward. Washington does not currently offer any services to Medicaid clients under the Preventive model. Minnesota uses the OLP model for doula services. During discussions with HCA staff, CMS said they would approve doulas under OLP SPA authority.

Credentialed doulas through Fee-for-Service (FFS)/MCO

Doula credentialing would take place through DOH. Additional state funding would be necessary to create a doula credentialing program, and the estimated time to establish a new profession at DOH is 18 months. Under this model, doula services would not be available to Medicaid clients until at least 2022. As discussed earlier in this report, doula training and credentialing could be high-

barrier in terms of costs, training time, and access to training. In Oregon, doulas are credentialed as Traditional Health Workers, allowing doulas to directly bill Medicaid.

Credentialed or non-credentialed doulas as part of a maternity bundle payment

The maternity bundle is a “future state” goal with an unknown implementation date. Adding doulas as a required service in a maternity bundle would result in an administrative burden and higher costs to pregnancy medical providers, who would hire and pay the doulas. How and when doulas would be paid for services is unclear, as this would be determined by the billing provider. Offering doula services as part of a maternity bundle would incentivize providers to routinely utilize doulas. Data related to doula impacts on pregnancy-related outcomes would be simpler to collect and evaluate with use of a maternity bundle.

1115 Waiver, as a pilot program for non-credentialed doulas

Implementation of doula services would be delayed until the waiver is approved by CMS, and there is no guarantee of waiver approval. Use of a pilot program would be a way to identify barriers and challenges without the cost of full implementation throughout the state, although Washington is fortunate to already have this information from the experiences of Minnesota and Oregon as discussed earlier in this report. Clients and doulas eligible for pilot participation would be limited to certain populations and/or areas. New York’s pilot program has been in operation over a year and a half and only provides services to clients in a single county. Participating New York doulas must meet stringent training and exam requirements, and both clients and doulas must respond to surveys over the course of the pilot. 1115 waivers must also include a research/evaluation component for CMS approval.

Payment rate and model recommendations

The fiscal model for the implementation of doula services was developed based on input from doula stakeholders, as well as studies supporting the cost savings associated with doula utilization. Doulas in Washington are currently serving about 650 Apple Health eligible clients per year despite receiving no Apple Health reimbursement for the service. Based on input from doula stakeholders, we estimate that about 1,100 clients would be served per fiscal year with a 10 percent yearly increase if Apple Health were to start reimbursing for the service. Studies published by the National Center for Biotechnical Information indicate that providing doulas can reduce the incidence of C-sections, inductions, and preterm births, reduce the use of anesthesia, and increase the incidence of breastfeeding. We used the current costs of C-sections, inductions, anesthesia use, and preterm births and estimated potential savings among clients with doulas. Increased breastfeeding is shown to reduce the incidence of lower respiratory tract infections, gastroenteritis, ear infections, and necrotizing enterocolitis. We assumed an increase in breastfeeding among clients with doulas and applied assumed savings based on current incidence rates and expenditures for these clients’ infants.

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In order to remain relatively cost neutral, the estimated offsets allow for a rate of \$50 per antepartum (AP) and postpartum (PP) visit plus \$450 for labor support for a model structure providing two AP visits, continuous labor and delivery support and two PP visits. This would equal a total reimbursement of \$650 per birth (Appendix C). Throughout Washington the price range for doulas ranges from \$500-\$2500 with a median rate of \$900. In order for Apple Health to pay the median rate and ensure provider participation, the Legislature would need to provide funding of about \$300,000 per year. (See Appendix D.) We would recommend flexibility in the combined four AP and PP visits where depending on client/family need and shared decision-making with the doula and maternity care team there could be variation in the timing of when these four reimbursable visits occur (i.e., three AP and one PP, one AP and three PP, or even all 4 PP, if for example the client delivers early unexpectedly and can use additional support post-delivery).

Implementation recommendation

We began the work with the Doula Services Work Group in March of 2020 following the recommendations below from HCA staff and leadership. These recommendations were developed after an analysis of options, detailed above in this report. These initial recommendations were framed as Phase 1 and Phase 2. Notably, our recommendation for implementation has changed as a result of the workgroup and doulas' position on the best way forward. Below our initial recommendation for a non-credentialed approach followed by a credentialed approach is described, and next is the current recommendation for pursuing only a credentialed route for doula care reimbursement.

Phase 1 – Non-credentialed

A non-credentialed route has the fastest timeline for making doula services available to Apple Health clients, and the OLP Service option is simpler than the Preventive option in terms of the State Plan. CMS offered Washington preliminary approval for doulas under OLP services in the State Plan. A licensed provider (physician, certified nurse midwife, ARNP, licensed midwife) must supervise the doula and bill for services on the doula's behalf. Doulas will be required to meet minimum qualifications prior to Apple Health reimbursement, and the rulemaking process to outline these qualifications has been started. The target date for implementation of Phase 1 is July 1, 2021.

Note: On August 20, 2020, the doulas in the workgroup reached out to HCA to communicate their unified preference to entirely bypass Phase 1 and move directly to Phase 2.

Phase 2 - Credentialed

In Phase 2, credentialed doulas will not need a supervising provider and will be able to bill Apple Health without an intermediary. CMS confirmed they would approve reimbursement for credentialed doulas in Washington's State Plan.



A transition period between Phase 1 and Phase 2 is recommended to prevent sudden cessation of services to clients for whom labor and delivery are imminent. After Phase 2 is rolled out, it will take time for newly-credentialed doulas to enroll as independent Apple Health providers and begin billing for services.

Current recommendation for credentialed route only

As mentioned above, our doula partners/stakeholders have shared with us their unified position to not pursue the non-credentialed route, and instead focus all attention and collaboration on the credentialed route for Apple Health reimbursement for doula care. Below is language from the Doulas for All Coalition, summarizing their position and rationale.

The Doulas for All Coalition has been the primary stake holder group that has been in dialogue with the HCA and DOH. This coalition has representatives from agencies, hospital based doula programs, and independent doulas. After careful consideration and dialogue/learning with the HCA and DOH staff over the last few months the coalition broadly supports that all efforts going forward be put into implementing Apple Health reimbursement for doulas in the credentialed route. The primary reasons for the decision to not pursue the non- credentialed route are:

- Doulas across WA face multiple barriers to the non-credentialed route, in particular having access to a billing and supervising provider that meets the CMS criteria and will enter into this relationship with a doula.*
- These barriers disproportionately exist for community-based doulas across the state. Particularly because many hospitals and providers have biases towards the roles of doulas, and do not have a culture of integrating doulas into the care team.*
- Doulas have also expressed concern in that supervision under providers would undermine their ability to effectively provide advocacy and education to their clients. The credentialed route would allow doulas the ability to maintain their autonomy.*
- The Apple Health rate for a doula being paid through a billing and supervising providers is a significant concern in terms of the reimbursement reaching the doulas, the potential delays in payment to the doula, how these structures would be set up, etc. Without the HCA supporting with the administrative overhead, it makes it less likely for providers to absorb that work.*

Overall, the Doulas for All Coalition feels that the option of pursuing Phase 1 would serve a very low amount of families as it is high barrier for doulas to meet the qualifications. Pursuing the credentialed route would allow for more flexibility on the structure of the program, and increase the accessibility for doulas to participate.



Resources needed for implementation

The non-credentialed route can be implemented at a cost-neutral rate using resources at hand. However, the uptake of doula services during Phase 1 will be hampered by doulas' lack of interest, low reimbursement, and lack of readily available supervising providers. The Doulas for All Coalition does not support pursuing Phase 1.

The credentialed route would require legislative action to establish a doula credential and provide DOH rule-making authority. DOH would be obligated to establish a fee that fully covers the cost of the doula credentialing program, as required by RCW 43.70.250, which prevents DOH from considering a fee waiver. DOH has concerns about a voluntary credentialed route. Voluntary credentialing has the potential to allow doulas with disciplinary action against them to continue practicing without a doula credential.

Again, uptake of doula services will be impacted by low Apple Health reimbursement rates, this time in combination with the costs of becoming credentialed (and maintaining credentialed status). In 2020, HB 2798 proposed the creation of a voluntary doula registry but did not become law. DOH's analysis of HB 2798 indicated the cost per credential would be approximately \$100-150 per year if there was 75 percent participation by the 681 active doulas in Washington.

To ensure ongoing, successful provision of doula services to Apple Health clients, focus should be placed on the following:

- Legislative funding to provide an increased reimbursement rate for doula services. Doulas will not provide services for Apple Health clients if they are faced with overall financial loss. To provide doula services at the median private-pay rate of \$900 per pregnancy, \$300,000 in additional funding is needed each year. (See Appendix D.)
- Education for clients, providers, and the public about the benefits and availability of doula services, including targeted strategies for communities who would most benefit from doula care due to health inequities.
- Development of systems for doula referrals, as well as pathways for appropriate matching of each client with a doula.
- Funding for subsidies for costs related to training and credentialing, to reduce barriers for doulas interested in providing services for Apple Health clients.
- Development of a diverse doula workforce, including availability in rural and remote areas.
- Funding to develop training curricula for doulas serving Apple Health clients, to include the following topics: trauma-informed care; infant loss; poverty; intimate partner violence; cultural humility; and structural racism.



- Hands-on support for doulas who are new to Apple Health processes, including provider enrollment, billing through Provider One, and contracting with MCOs.

Conclusion

A doula is a trained birth companion who provides personal, nonmedical support to pregnant persons and families throughout the pregnancy, childbirth and postpartum period. This supportive care falls within the emotional, informational, and psychosocial domains with an overall goal of helping the client feel more prepared, comfortable, and safe. Doulas are an evidence-based intervention associated with improved outcomes and decreased costs across a host of metrics. Notably, the positive effects for doula services are stronger for individuals who are low-income, socially disadvantaged, or who experience cultural or linguistic barriers to accessing care, representing considerable potential to address disparities in maternal and infant outcomes.

There is substantial shared interest and support in Washington State for providing doula services to the clients/families who currently face the greatest barriers in accessing them. These barriers fall broadly under financial and cultural/linguistic umbrellas. Reimbursing doula services for Washingtonians through Apple Health meets objectives for providing evidence-based, appropriate and value-added care, for addressing health disparities, and for increasing focus on relational health and person-centered care. Apple Health reimbursement is expected to also address some of the financial and cultural barriers for pregnant and postpartum persons on Apple Health.

There is no clear example or process of how to best implement doula services as a state Medicaid-reimbursable service. Both MN and OR have struggled with utilization of doula services post-Medicaid implementation, and experienced a host of workforce issues and structural and system barriers. We have attempted to be transparent in this report as far as where we anticipate barriers will arise and acknowledge that there needs to be shared commitment in an ongoing manner between state government and policy makers, doulas and doula advocates, and the broader health care system.

As far as complying with the Legislature's request under the proviso language, we do not have short term (before 2022) plans to "reimburse for maternity services provided by doulas". This is because our statewide doula partners and stakeholders do not support the non-credentialed route for reimbursement which is the only option we believe could be functional by 2021. We are in compliance with the other two components in the proviso, to "consult with stakeholders and develop methods to secure approval from the Centers for Medicare and Medicaid for reimbursement for doulas" and to "report the group's recommendations to the appropriate committees of the Legislature by December 1, 2020". This report details much of the work that has been done with our stakeholders and CMS to date.

Our recommendation for how to reimburse doulas for their maternity services is to focus on the credentialed route and to address to the best of our shared ability, the barriers that have surfaced in other states, which were also simultaneously raised by doulas in Washington.

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Appendix A: Doula services stakeholder group roster

The table below contains the names and organizations of Work Group members who were invited to attend the Work Group meetings.

Hospitals, Providers, and Professional Organizations:	Legal, Racial, Ethnic, and Other Population-Based Organizations:	State and Local Government Agencies
Doulas for All Washington State: - Annie Kennedy - Jackie Vaughn Midwives Alliance of WA State (MAWS) & National Association of Certified Professional Midwives: - Neva Gerke - Audrey Levine NAPS Doulas: - Gwen Kiehne Neighbor Care: - Yvonne (Von) Griffin Open Arms Perinatal Services: - Dila Perera - Kate Brickell PALS Doulas: - Mariah Falin - Jamie Hunter - Tiffany Guenther Perinatal Social Work: - Anna Klastorin Real Family Solutions: - Laura Marsh Sea Mar Community Health Centers: - Kevin Proctor Simkin Center for Allied Birth Vocations at Bastyr University: - Alex Sosa - Sharon Muza	Legal Voice: - Fajer Saeed Ebrahim American Indian Health Board: - Cindy Gamble - Jan Olmstead Native American Dialogue on Infant Mortality: - Shelley Means Queer & Trans People of Color (QTPOC) Bertwerq Project:	Health Care Authority (HCA): - Beth Tinker, Clinical Quality and Care Transformation (CQCT) - Melissa Kundur, CQCT - Sarah Pearson, CQCT - Charissa Fotinos, CQCT - Jodi Kunkel, CQCT - Teresa Cooper, Medicaid Programs and Operational Integrity (MPOI) - Collette Jones, MPOI - Heather Weiher, MPOI - Stacey Bushaw, MPOI - Shellea Quillen, MPOI - Todd Slettvet, MPOI - Jessica Diaz, MPOI - Donna Mikesell, ProviderOne Operations and Services (P1OS) - Sandy Riccolo, P1OS - Robin Brake, Financial Services Division (FSD) - Ann Myers, Division of Legal Services (DLS) - Wendy Steffens, FSD - Shauna James, FSD Department of Health (DOH): - Trina Crawford, DOH - Kathy Weed, DOH - Ashley Noble, DOH - Sarah Keefe, DOH - Tiffani Buck, DOH Department of Social and Health Services

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Spokane Professional Doula Association: Swedish Medical Center: • Angie Dobbins • Jocelyn Alt Ulvenes Consulting: • Amber Ulvenes		(DSHS)/Research and Data Analysis (RDA): • Joyce Fan, DSHS/RDA • Andy Glenn, DSHS/RDA Other: • Pia Sampaga-Khim, Snohomish Health District • Lea Johnson, Tacoma Pierce County Health Department
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Appendix B: Doula services stakeholder group meetings

The Home Health Work Group held meetings on the following dates to produce this report:

- March 2, 2020
- May 20, 2020
- July 16, 2020
- August 7, 2020
- Future meetings will continue to be held

In the sections below are materials from each Work Group meeting.

Meeting on March 2, 2020

Below are the notes from this meeting.

Doula stakeholder meeting notes 3.2.20 (MK)

Annie Kennedy, Faiza Farole, Ibrahim Ahmed, Amber Ulvenes, Mariah Falin, Alex Sosa (Simpkin Center for Allied Birth Vocations at Bastyr University), Dila Perera, Trina Crawford- DOH, Lea Johnson, Jackie Vaughn (all on phone) plus HCA staff including Melissa Kundur, Sarah Pearson, Todd Slettvet, Robin Brake, Jason McGill, Beth Tinker (in room) and HCA staff on the phone were Heather Weiher, Shellea Quillen, Stacey Bushaw. Jessica with Open Arms joined later.

Beth intro – Will summarize notes then outreach to others not able to attend meeting; apologies if redundant but moving work forward; later this week, presentation of issues paper summarizing doula payment possibilities, then decision will be made on how to proceed; HCA is committed, wide recognition of value of doulas, want to see expansion; complicated to move from private payer scenario to Medicaid reimbursement; want to make it work.

Doulas for All Coalition has already put together research about other two states with doulas; info from orgs actively doing research on policies and impact on implementation; we'd be happy to cross notes with your paper (Jackie); Beth – send it and we will look at it.

Themes from meeting:

Doulas want their voices heard/ to be part of decisions made – happy to be asked/included.

Need to use resources we already have in WA St to build out program- training, expertise in this work, focus on low income families.

Concern that expanding doula services to more Medicaid clients requires thoughtful attention to doulas who have not been serving this population and to the future workforce.

Want system where partnering family with doula is a mutual process and agreement- relationship is important (do not want system where for example doulas are chosen/assigned).

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Doulas want as much flexibility as possible in future credentialing with DOH, feel that criteria in OR for example on training, hours, fees have been prohibitive.

From this group- not a strong consensus on credentialed vs non-credentialed model (pros/cons voiced).

Agreement that bundled payment would likely be prohibitive as doulas would have to wait for episode trigger (likely birth) to receive payment for earlier visits.

Questions bolded below were posed to the group-

What qualifies doula to provide services?

Open Arms provides doulas to Medicaid eligible families exclusively x 22 years, min requirement is level of training as a doula, no certification; also weigh personal experience and other types of experience, such as language or cultural concordance with community/community need; screening process to ensure other skills needed, like cultural responsiveness, families affected by poverty, health disparity/inequity.

Health Doulas (PALS Doulas?) – predate DONA; look at training exclusively but in process of changing to competency based; work in progress, group meeting twice a month to build it, toughest part is coming up with a competency evaluation for it; we are facilitating the conversation but open to community at large even if not part of PALS.

Doulas for All – we are working on supporting PALS, doing outreach and engagement; MN, OR, and NY their certification process so limited (as in stringent/inflexible) that created barriers for low-income doulas and doulas of color to meet standards; in coalition, discussed that we are lucky in WA to have community-based doulas that provide training; we are hoping HCA and DOH can look at resources we already have in place to meet training and certification requirements; other states made it so strict on where you can obtain training.

Beth- we realized there have been barriers in other states, utilization lower than what anticipated, want to build on what other states have done.

Alex – current curriculum based on competencies from DONA International training curriculum; we spend 3 hours talking about cultural competency; 32 hour training, earn certificate, able to work in WA or around the world.

Beth – who should we reach out to about this question, missing voices; we are reaching out to tribes but other contacts helpful; Delia recommends Daybreak Star doulas, which is part of United Indians of All Tribes Foundation, Delia can pass on the name of the contact, Heather Weiher has it as well. Over 400 doulas in state of WA.

Annie – queer trans people of color doulas, QTPOC, she will forward info.

Payment models and pros/cons – per visit vs bundled – thoughts and concerns?

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Delia – difficult to know without knowing more about bundle payment and what is included; on some levels bundle could be easier for implementation but wondering what minimums would be; we find three antenatal, three postpartum, plus L&D (3-1-3 model) results in better outcomes than 2-1-2 model; if influencing outcomes, what are minimum requirements?, would like to know more about it.

Beth – what we've seen in historical documents is 2-1-2 or 1-1-1; looking at what is reasonable across the doula spectrum, 3-1-3 not feasible for hospital or not the way they're practicing.

Mariah – hospital-based v community-based doula, we flexibly go back and forth inside and outside hospitals, best model is 13-1-13.

Swedish minimum recommendation is 1-1-1 but even in that system most provide 2-3 visits prior to delivery, to build trust.

Not necessarily that hospital based program can't do more than 1-1-1, it has to do with their preference for the model they're using; it is based on the scheme used to set up the program; recommendation is to do more than 1, we are wanting to focus on outcomes.

Deb PALS board and Open Arms doula – across clients (OA and private pay), even private is 3-1-3; my concern is bundle with those requirements, what happens if we don't meet those requirements; if client having second or third baby, often don't want two or three visits ahead of time; bundle model in place needs to allow flexibility; ideal is 3-1-3 but don't want to go without compensation if our clients make a different choice.

Faisa with GPS – we provide doula services and labor support; model is typically 2-1-2, usually get moms in last trimester, some moms need more support during postpartum, so there are times when all four non-L&D visits postpartum, this flexibility is important; training is different, visits are different.

How are patients referred to doulas and who makes the referral?

Mariah – majority find me on their own, word of mouth, or referral from health care provider; variable provider types, in-hospital OBs and midwives out-of-hospital; often based on having worked with them previously.

Jen – echo what Mariah is saying, when move through community and work with different providers, some will jive with our style of doing things; it comes up organically. Self-referrals, also get referrals from public health nurses, neighbor care nurses, low-income clinics; we provide doulas that speak various languages.

Open Arms – 70 percent of referrals from 30 different referral providers; PHNs, SWs, community health clinics; self-referred 30 percent including returning clients.

Annie – CBE often refer to doulas, independent doulas often have websites, also doulamatch.net. Beth-could referrals be improved, made more robust, how work best to ensure equitable access to doulas?



Mariah – more community education about what doulas are, what we do, how we help; so often we sit down with families, not sure what a doula does; beautiful dream scenario would be more on the ground education for communities at large.

Jen- family medical leave act in WA, they have interfaced with our staff a ton, thumbs up to them for getting the info out.

Used to work with WIC in LA, hospital-based breastfeeding program; important to connect with community partners; with breastfeeding data, WIC partnered with hospitals and nonprofits to provide services and recruit individuals who look like clients we are serving and speak the language; issue of trust, can't emphasize that part enough.

Delia – when past reimbursement for doulas through Medicaid in past, health departments and PHNs connected people to doulas; some kind of mechanism where they can refer to doulas; King County unique in structure, not sure feasible in smaller counties; want to echo what Alex said; we don't simply assign a client to a doula; we do an intake to look at client wants and needs, including cultural/linguistic and others, then go through process of matching them to a person; would not like to see a client matched to someone based on name or availability; to be effective, need process of matching; also helps with follow up and retention; also speaks to screening process for doulas, don't want to screen out people who are most representative of the communities they serve and screen in only people who present as most qualified.

Documentation – Medicaid requires for evaluation, audit, and other purposes; how do doulas document currently?

Attendee with GPS – labor support we have paper form documentation; doula has to return back to us prior to getting payment; simple form with check offs; e.g., client signs agreement, HIPAA form, section for notes about how it went; use “Maternity Neighborhoods”, an online charting system that all of the doulas use.

Jessica with Open Arms and First Doula Services – used to use paper forms, now electronic “Apricot”; forms for prenatal plus postpartum plus L&D; is there potential for separate payments?

Beth – yes potential for both scenarios, trying to figure out what best.

Jessica – use Apricot database, maybe we could use that to trigger submission for payment.

Mariah – Swedish uses “Mind-Body”, submission of documentation is required prior to additional payout to the contractors.

Beth – does anyone know of doulas who are using paper documentation?

This is Jen Hamilton, with private pay clients do sometimes use a paper form but partnering with community group that uses online portal called “IntakeQ” that is HIPAA compliant.

PALS has asked all doulas to do paper documentation and send them in, but can't make mandatory; DONA standards are to keep paper documentation on all clients a doula has worked with.



Todd-our MSS/ICM providers require care plans which we audit sometimes but does not have to be submitted for payment.

Open Arms has good template.

A lot of doulas choose not to write anything down because don't want misplaced or don't want others to have it; not required to comply with HIPAA.

Most private doulas are sole proprietors and don't have access to funds to pay for one of those systems; 98 percent of us work out of the back of our cars.

Medicaid clients B- Open Arms serves Medicaid clients; for others, what are opportunities and barriers for expanding services to Medicaid clients?

Jen – one of the huge things ties into training, and who is going into the community; to be blatantly honest, we potentially face a real issue with white saviorism and there is a format for how to qualify to work with Medicaid families; to be transparent, I am white and I am an Open Arms doula, I had to go through a certain amount of training and an interview process; we have talked about this at PALS as well; discussion about ensuring cultural competence is an important piece moving forward.

Alex – wearing lactation hat; need more training and guidance about what are billable codes; it got really complicated, such as if you were helping the baby latch on, was it billable under the baby or under the mother; it was messy.

Annie – doulas are unable to serve the great majority of Medicaid clients, huge opportunity.

Faiza - the difference in payment has been a barrier, between private pay and Medicaid, reimbursement too low.

Beth – no amount set, no decision made on that, but we are aware that perceived low reimbursement has caused low uptake and utilization; we want program to work.

Credentialing – for CMS, there are two options: 1) credentialing through DOH, makes doulas payable directly via NPI, 2) non-credentialed, can only pay through another licensed provider.

We've had this conversations a lot in our coalition, whether our state has doula credential or licensed provider; Oregon and Minnesota have both options; we are firm that we don't want a licensure process, we would want a certification process; dig deep into doula and birthwork community; stricter certification processes narrow the options, that's an item we are having community outreach and discussions on.

Beth – when you talk about barriers for licensure, do financial components of training/credentialing come up as significant, or are they secondary to training pieces?

What makes Oregon's process so high barrier, seems simple but community health worker training and then a certified doula training either internationally or nationally recognized; community

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health worker training in Oregon is \$800; doula training is \$800-2,000; couple those high costs with the low reimbursement; you would have to do 4-5 births just to pay for the trainings; also plays out in NY and MN; low-income doulas and doulas of color drop off; in WA, many agencies offer free doula trainings and stipend, that is way to reduce the barriers; provide scholarships, provide stipends rather than just marrying to DONA and expensive programs.

Delia – with model of going through a licensed provider for NPI number, would vary with organization; for Open Arms, to contract with an ARNP to provide referrals has cost implications, as they would part of the team; difficult for someone independent to contract with someone like that.

Beth – credentialing route has a long timeline, that gap is the driver for these conversations; thoughts about interim non-credentialed while move toward credentialing, what are your thoughts?

Mariah – want to echo Jen; credentialing and certification not a guarantee of anything, but have a concern of people jumping quickly onto this ship and doing harm to communities we are trying to help; think minimum standard is important; PALS is working to update certification standards that we are using; over 125 organizations training and certifying doulas right now; some cost as little as \$100; what are they getting for that, prepared to not do harm to communities?

Delia – would like the option of going through a provider; would like to have both, rather than only one; then some flexibility; discussion about making the provider route more accessible.

I would worry more about providers having to refer to doulas; some providers do not see the value of doulas, downplay or provide negative feedback.

Alex – how important is certification? once attended any doula training in WA, are they able to provide the services; what does certification look and sound like?

Todd – need multiple meetings with DOH, what would program look like; then HCA would make the case with CMS that certification is the same as licensure.

Mariah – if certification is looked at as minimum standard, is there value or more barriers to ask a certified doula to go through cert process again.

Trina from DOH – depends on legislation; there may be a grandfather clause; discuss three types of licensure; registration has no education requirement, but still considered a credential; then certification, which is vocational school like nursing assistants, medical assistants; then licensed like doctors, nurses, more of a positive education requirement; DOH using “certification” in a different way than being nationally certified.

Can doulas come under an organization like GPS, if it meets one of these requirements, to bill for them – discuss this, Mariah - it’s more than billing it’s also supervision/liability.

Beth – we’ve discussed this amongst ourselves too, it may work well for some organizations but not others, it’s complicated.



Jen – it's all great for folks connected with an association but many doulas choose not to do that because they do value their independence; doulas are able to get an NPI number (discuss NPI, taxonomy not in P1).

How long until doulas get paid? Trina – usually within the week after submit to P1; Mariah – delay if pay other provider, and turn around to pay doula.

Heather – with bundle can't bill until after that last visit, may not be feasible compared to billing after each visit.

I think the majority of doulas don't have financial space to put off receiving payment for services provided for 3-6 months, will eliminate a lot of doulas from being able to do this.

Jessica – I agree; not uncommon for doulas to invoice after each service for that exact reason because no capacity to financially float until all services are done.

Secondary logistical question – since they're billing, does that show up as income for the licensed midwife (we don't know, maybe accountant or tax lawyer).

Robin – in WA would increase gross revenue of provider and would have to pay B&O tax on that. Please send all the questions out and we can share them with others.

Beth – will not use names on it unless okay with everyone; what if we send out first to just this group and give a week to look it over, then revise and send out broadly? OK.

Typical/customary costs to clients, or range.

Mariah – I reached out to Sara, Swedish charges \$500-2500 for someone not certified all the way to someone who is experienced, in tiers; doulamatch has info on charges so it is financially stable for doulas.

Open Arms - \$500 for newer doulas in a fellowship program, \$1000 for doulas who have been with us for a year or more.
Faisa - \$800-1000.

Beth – shared new proviso language, includes info about leg report due in December 2020.

Coalition – rolling out this spring and summer, doing outreach to doulas and birthworkers for their ideas on what this will look like; can use info from today when doing this.

Delia – back to using NPI from a provider, could a local public health department use that process to provide doulas; would government be able to do something like that?

Beth – I believe it's specific to an NPI and an institution doesn't meet the criteria.
Not sure, would need discussion with health districts.

DONA - Any interest in members from HCA or DOH sitting in on current meetings to look at our certification process?

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Beth – makes sense but not sure about the timing.

Trina – interested in being part of conversation, start to what this credentialing might look like; we don't want to move forward with just one approved training program.

Meeting on May 20, 2020

Below are the notes from this meeting.

Doula Stakeholder Meeting Notes 5.20.20

HCA: Sarah Pearson, Beth Tinker, Melissa Kundur, Robin Brake, Teresa Cooper, Shauna James, Sandy Riccolo, Heather Weiher, Wendy Steffens, Todd Slettvett,

RDA: Joyce Fan, Andy Glenn,

DOH: Trina Crawford, Kathy Weed, Tiffani Buck

Doula Stakeholders: Amy Coleman, Dila Perera, Drew Alt, Sharon Muza, Jackie Vaughn, Vaughn Griffin, Gwen Keeney, Amber Ulvenes, Jocelyn Alt, Faisa Farole, Pia Sampaga-Khim, Katie Wilhite Brickell, Fuad Mohamed, Jon Pielemeier, Alex Sosa, Jen Hamilton, Mariah Falin

Summary of concerns and issues from stakeholders:

- Rate is inadequate but current economic climate makes additional legislative funding unlikely
- Challenges with Phase 1 model, including 1) impact on doula autonomy and doula-client relationship, and 2) how to establish a relationship with supervising professional
- Stricter criteria in Phase 2 could affect number of doulas available to clients on Medicaid
- Doulas serving clients on Medicaid need additional training to provide quality services

To-do items:

- Beth and Jackie to work on doula survey to address barriers to supervising professional relationship
- Robin to explain analysis leading to rate determination
- Jackie requests 30 minutes on next meeting agenda to discuss Doulas for All points

Beth: Introduction and our agenda. We want to listen and hear from you.

1. Payment Model
2. Phase 1 Steps
3. Comments and Concerns
4. Phase 2 Steps

Legislative Proviso Language: Within the amounts appropriated in this section, the authority shall reimburse for maternity ((support)) services provided by doulas. The authority and the

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department of health must consult with stakeholders and develop methods to secure approval from the centers for medicare and medicaid services for reimbursement for doulas. The authority will report the group's recommendations to the appropriate committees of the legislature by December 1, 2020.

Phase 1: Non-credentialed doula services. Does not require legislative funding if we can be budget neutral. Quicker timeline.

Phase 2: Credentialed doula services. DOH – Would require legislative funding. Different timeline.

Jackie – Doulas for All Coalition - Overarching pieces of the policy that they would like to talk about. Plans for what this means and to continue to build this with input from the doulas. How HCA could support doulas in community.

Beth – Email sent: This is needed to help us with the fiscal modeling and future utilization.

- Based on your data for the number of clients you/your agency serve each year, how much growth do you project you would see in WA St if doula services were reimbursed as a Medicaid service (ideally in terms of over 3-5 years)?

Feedback summary – several groups talked about 50 percent increase in utilization. The largest was 100 percent (doubling). This was in the rural areas. Lower end 20 percent increase in utilization. Expected variability, but helpful for us to do the fiscal modeling.

Estimated rate: \$550 - \$700 based on 2-1-2 model. 2 antepartum, labor and delivery, 2 postpartum

Faiza Farole – Sent feedback. Talked about the rate. This is on the lower end of what doulas receive. Questions around this with the coalition.

Beth – Fiscal modeling is preliminary, but the rate will most likely still be in this range. There currently is no legislative funding. There is a possibility for funding in the future, but right now with Covid-19 there are considerable budget cuts. Forecast for additional funding not promising. Phase 1 would need to be budget neutral. Savings achieved by doula services will equal the cost.

Robin – The rate has to be set at an amount that will be budget neutral. Limits how high the rate can be. Have to base that off of utilization. Outlook is dim with budget cuts with reduced revenue from Covid. Unlikely that legislature will fund a new program during this time when HCA will be struggling to provide required programs.

Jackie – Utilization will impact reimbursement then?

Robin – It's all proportional. Finding the balance between how high we can pay and how much realistic savings we will see.

Faiza - How did you land at this particular starting rate?



Robin – Started from knowing project would not receive much money, if any at all. Looked at other states and the rates they pay. Looked at private pay rates. We look at possible offsets of savings for the cost.

Beth - Review doula evidence on effectiveness. Cost savings, etc.

Jocelyn – Have you been able to include any savings from breastfeeding savings? Powerful for finding savings.

Robin – Hard to tie a dollar amount to breastfeeding savings. Money comes out of rates paid to other providers. WA breastfeeding rates higher than for other states, including for Medicaid population. Not including in the offset in order to be conservative. If we overestimate and pay too high of rate, then end up in a budget shortfall and have to cancel the program down the road. Need offsets that we can count on.

Dila – Phase 2 will focus on credentialing. Understand the explanation. If the credentialing process is stricter and more limiting, there would be less doulas qualified. It would affect the organization's ability to serve as many clients. Would affect uptake of the program.

Beth - Need all the factors to work together. Tricky to project supply and demand. Foundation to build trajectory and doesn't create barriers. Not having dedicated funding is a barrier. We want to work with what we have and start somewhere and be open about what the future will look like. There is a lot of support for doulas. Fiscal forecast has put us in a position that we didn't think we would be in for this next session.

Beth reviewed Phase 1 Steps: Non-credentialed doula services

1. Projected rate – Fiscal modeling. Determine implementation date.
2. Implementation date and fiscal modeling for Tribal (90 days) and Public notice.
3. SPA – need CMS formal approval.
4. SPA amendment.
5. Update WACS.
6. MCO Contract.
7. Update Provider Guides.
8. System Updates.
9. Communication.
10. Implementation – Ability to bill.

Jackie – We sent research from various organizations and policy think tanks. Doulas for All Coalition. High barrier for doulas to have agreements with providers who could bill on their behalf, due to lack of infrastructure for doulas. A lot of places have it both ways. Will Phase 2 be locked into the Phase 1 rate?

Beth – We have discussed issue related to supervising professional. What are the solutions for that? How would we query the potential supervisors? Is it up to HCA or up to the doulas? Critically

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important but could create difficulties. We want to hear from doulas. Partner in how to do this and how to work through this.

Jackie - Is this moving too fast then? Survey would be good. Needs to be recognition that we have organizations but also many individual doulas as well. High barrier for low-income doulas, doulas of color, doulas who do not traditionally have those relationships with providers who could bill on their behalf.

Beth – Happy to work on a survey. Have Jackie help. Anyone else willing to help? What does it look like for individual doulas?

Mariah – Independent doula but also president of PALS Doulas, which is a certification organization in WA. Need to increase access and decrease barriers. Many doulas do not want to work for an organization. Language like supervising provider may push doulas away from this type of work. This is why we encourage alignment with certification or credential so supervisor not telling doula how to serve families. Comes down to who is telling doulas to do their jobs. If not doing it the way provider tells them, then are they not able to work?

Melissa – Language. Cannot pay the doulas directly.

Mariah - State of Washington did this previously.

Melissa – Yes, CMS told us to stop. Not acceptable. If I remember correctly, MSS did not have someone to take responsibility for the supervising the doulas.

Heather – No certification through DOH. Were able to keep community health workers, but could not keep doulas.

Jen Hamilton – Independent doula and also contractor for Open Arms. Reimbursement tragically low for the clientele will be serving. Idea of supervising presents another level of problems when the reimbursement is so low. These are my clients that I am involved with for months after birth for DV support, housing assistant, case management. It looks very different to support a Medicaid client that has been marginalized than to support a private client. Add the layer of needed supervisor to bill on our behalf. \$550-700 is ridiculously low and not a sustainable livelihood. Then the billing provider will take some since they need to get paid. Don't know how we can do it this way. Real concerns.

Beth – We recognize the doula community is diverse. We do not have to try for Phase 1 non-credentialed route. A lot of varying opinions. Reasons we are engaging with you all is to find out what makes sense.

Dila – Level of need and intensity of work for the clients that would be served through this is a real thing. We actually ask for 3-1-3. 99 percent of the time doulas do much more than this. 6-8 visits on either side. Perhaps stagger the modeling and reduce the number of clients who would be served, in favor of increasing the reimbursement. Then it will build demand over time. Model adjusted to

reflect ramp-up. There is a side of me that wonders if better to focus on the credentialing part and get that sorted first. Reimbursement in place sooner without credential, but then need structure for referral/relationship with provider for billing. Potentially something intended to be a bandaid would be in place for 4-5 years.

Beth / Robin – There is assumed ramp up over time. The biggest problem are the offsets that we can account for. We can't assume everyone would have had a c-section and that we were able to prevent it because of a doula. Offsets are still low percentage-wise. It is really going to be difficult to change the rate regardless of utilization without funding. If we think the rate is a huge factor and we can't implement without a certain rate, we can put that into the report.

Beth – Hears the dissatisfaction about rate. Originally thought getting phase 1 going and then working on phase 2. Next session likely limited for funding. It would be 2 years from now if economy recovers. Seems like a long way away.

Mariah - \$550-700 seems like a lot but doulas commit to being on call 24/7. Work is not sustainable at that rate. Group in WA currently working on a new avenue for certification. Underway and mostly finished. Hard to keep people invested and engaged. Offering a service and then not having quality doulas show up is what we are pushing ourselves toward. We need people who know what they're doing and how to support families. Potential for more harm, trauma, and worse outcomes. Additional training needed outside usual doula training. Health Connect shows demonstrable outcomes with higher contact, like 13-1-13. There is more training that goes into community-based programs so can show up for those families in a way not covered in traditional/original doula training. When a doula cannot pay for additional training, then they go in with blinders on and cannot see where bias is and where trust breaks down. Don't think any of us want that. We want stronger, healthier families.

Dila – A lot that goes into the match of the doula with the client. A lot goes into identifying what that client needs and finding a doula that is the right fit for them. There needs to be the customization. Not just given a name.

Jackie – One thing we discuss heavily in Doulas for All is that lower rate impacts the quality of services because it is not sustainable. Won't be able to get doulas from the communities that you are serving. That is part of the equity piece of this policy. Folks that can afford to accept the lower reimbursement rate may not have the shared background and experiences. Doula work includes lived experiences and we want to value that. Lower reimbursement rate does not get us there.

Faisa – Echo what everyone else is saying. I'm a licensed midwife as well. Went through schooling a few years ago and remember some preceptors saying they didn't advertise themselves for Medicaid recipients because Medicaid doesn't pay much. Medicaid recipients are most vulnerable and need the longer visits. People throw around the fact that there's inequity and disparity. This is not really stepping up to the plate and showing that we as a state want to step up and do something about this. Discouraging. Discourages doulas from doing what they need to do to make a dent in what this country is facing. I get so appalled I don't have the words. Doula work is not just assigning a doula

to a birthing person. Doula herself also has support she can turn to for reflective supervision or other resources. The rate the state is offering, it's insulting.

Beth – I hear that. Get back to Dila's question about if we implement phase 1, are we locked into the rate. No. Can go to the legislature to get funding. However, there could be issues. Don't know how difficult it would be to increase the rate. Might be strategy if try to get funding up front rather than later. Argument could be made that they're providing the services at this rate already. Asked Amber if she was on the line and asked her opinion on political strategy. Acknowledgement of current budget crisis.

Amber – There is some risk to it. Rates are built and have actuarial basis behind them. Once they are built, there are factors that go into if you are able to increase or decrease the rate. There is not a lot of departmental flexibility. It has taken work in the past to get rate changes, especially dramatic ones. Two ways efforts have been successful. One was to provide a basis for assumptions that should be underlying, getting a legislatively appropriated addition through the budget. Definitely a political component. Could get additional money from legislature to increase the rate, but could also see the argument for pausing to work on a rate that feels at least sufficient to the group before actually putting that down in ink. See the argument for either way. If you do agree on a rate, it is not easy to change.

Dila – Not surprised by what Amber says. Maybe need to unpack more that rate that has been proposed and how arrived at, since strong reactions to it. Thinking out of the box. If rate is \$550 for 2-1-2, could there be different tiers for clients receiving higher levels of support like what MSS providers do, with additional visits available? The hard place is the budget climate we are in.

Beth – Interest in a future meeting for Robin to go through more detail?

Robin – Needs to be vetted through her department before it is public. Risk – if the rate is set low, it will be harder to get a higher rate later on.

Delia – Need to understand the fiscal model better.

Robin – Offsets are based on savings from reduction of C-section, anesthesia, pre-term births, and inductions. Take utilization we anticipate and assume the normal percentage of those factors happening, then compare to what we expect to see with doulas. Look at the difference and convert it into a dollar amount. Apply the same methodology for all of those factors. Utilization is not the driving factor.

Mariah – I would challenge that those rates are different. It is our low-income populations that feel like they don't have options or feel able to ask about other options. Will see a much higher positive impact than those numbers.

Robin – Based on studies, plus input from HCA staff doctors and what they feel is realistic for offsets.

Dila – Preterm birth savings sufficient alone to offset costs. Hospitalization, NICU stays, etc. Open Arms pre-term birth rate is 4 percent vs. 9 percent for the state.

Robin – Preterm birth is most significant cost offset we have. We estimated 7.5 percent of our clients have a preterm birth. Study we found, there would be 1.6 percent reduction. Savings is \$30,000 for each averted preterm birth.

Kate – Reason why postpartum offsets are not included? Breastfeeding and postpartum mood disorders.

Robin – Not included because tied to monthly rate we pay our plans. Breastfeeding decreases sicknesses and visits by baby over course of their life. We look at budget offset within a two-year budget term. When savings spread out over the life of a newborn, can't estimate the savings. Eventually may not be a Medicaid client, so no longer our savings to see.

Kate – Could you use the more short term items, such as decreased visits in that population?

Robin – Yes. Can have data people look these up.

Mariah – I get that those are long-term but would affect the outcomes and the finances.

Attendee from Swedish – People of color, immigrants, refugees with lack of distrust in hospital system. May reduce trust in doula if doula answers to doctor rather than client.

Jackie – Wants to discuss the Doulas for All points; wants designated time on the agenda for next meeting. Wants to do community outreach and engagement on these questions. Even the conversation today there are a lot of questions and red flags. Requests 30 minutes on agenda.

Sarah – We can set up another meeting soon. Will wait until Robin is ready for the updated fiscal modeling.

Meeting on July 16, 2020

Below are the PowerPoint presentations and notes from this meeting.





Fiscal Model for Doula



Guidelines for Developing a Cost Neutral Program

- Offsets must be within the same biennium
- Offsets must be within HCA's budget
- Offsets must be based on actual current expenditures with HCA data that substantiates

Assumptions within our Model

- Doula services include 2 antepartum visits and 2 postpartum visits at \$50/visit and labor support at \$450
- Phase 1 would require doulas to be supervised by a licensed provider
- Utilization based on current and estimated uptake per doula feedback with an assumed 10% increase per year
- 10% decrease in c-section rate among clients with doula care
- 12.2% increase in breastfeeding resulting in reduction of lower respiratory tract infections, gastroenteritis, otitis media, and NEC
- 9% reduction in the use of anesthesia, 1.6% reduction in preterm births, 12% reduction in inductions

Maternal and Infant Services for Select Washington Births to Medicaid Mothers 2018

FEE FOR SERVICE + ENCOUNTER PAYMENTS BY CONTRACTED MANAGED CARE PLANS

(DOES NOT INCLUDE MEDICAID PAYMENTS TO CONTRACTED MANAGED CARE PLANS (PREMIUMS, ENHANCEMENTS, ETC))

Type of Service	Single Live Preterm Birth				Single Live Term Birth			
	(N)	%	Ave. \$/Client	Med. \$/Client	(N)	%	Ave. \$/Client	Med. \$/Client
MATERNAL SERVICES								
Prior to Initial Assessment								
Outpatient	1,336	43.8%	\$ 395	\$ 92	12,603	35.3%	\$ 200	\$ 61
Inpatient	7	0.2%	6,176	5,987	15	0.0%	4,353	3,317
Prenatal Visits; OB Services	2,978	97.6%	2,507	1,843	35,072	98.4%	2,160	1,607
Maternity Support -	1,363	44.7%	280	200	16,053	45.0%	275	184
Prior to Delivery -								
Outpatient	2,051	86.2%	1,559	361	30,943	86.8%	810	289
Inpatient	600	19.7%	5,660	3,034	2,502	7.0%	4,801	2,089
Delivery	2,921	95.7%	7,736	5,577	34,162	95.8%	4,629	4,807
Postpartum -								
Outpatient	2,646	86.7%	854	457	28,346	79.5%	781	428
Inpatient	93	3.0%	10,115	5,262	437	1.2%	6,180	3,675
Unknown								
Outpatient	2,657	87.1%	490	87	29,273	82.1%	246	54
Inpatient	25	0.8%	15,553	7,464	129	0.4%	8,430	6,638
TOTAL MATERNAL	3,052	100.0%	\$ 14,097	\$ 9,857	35,650	100.0%	\$ 8,601	\$ 7,919
INFANT SERVICES (Liveborn Infants)								
During the first year of life (timespan may vary)*								
Outpatient	2,925	98.3%	\$ 3,027	\$ 1,628	34,657	99.3%	\$ 1,662	\$ 1,178
Inpatient	2,077	69.8%	24,534	2,497	30,771	88.1%	2,882	1,023
Neonatal/Ped. Critical Care	1,653	55.5%	26,761	3,767	2,392	6.9%	5,238	889
During the first 60 days of life								
Outpatient	2,887	97.0%	566	378	33,752	96.7%	437	327
Inpatient	1,996	67.0%	20,223	2,070	30,683	87.9%	2,342	1,021
Neonatal/Ped. Critical Care	1,041	35.1%	25,803	3,743	2,254	6.5%	5,231	819
Infant Case Management -	751	25.2%	128	80	7,671	22.0%	96	40
TOTAL INFANT CARE	2,977	100.0%	\$ 34,951	\$ 5,872	34,917	100.0%	\$ 4,549	\$ 2,223

Methods to secure doula reimbursement approval from CMS
December 1, 2020

State of Washington

11/9/2019/dal MC1

Maternal and Infant Services for Select Washington Births to Medicaid Mothers 2018

FEE FOR SERVICE + ENCOUNTER PAYMENTS BY CONTRACTED MANAGED CARE PLANS

(DOES NOT INCLUDE MEDICAID PAYMENTS TO CONTRACTED MANAGED CARE PLANS (PREMIUMS, ENHANCEMENTS, ETC))

Type of Service	Single Live Cesarean Birth				Single Live Vaginal Birth			
	(N)	%	Ave. \$/Client	Med. \$/Client	(N)	%	Ave. \$/Client	Med. \$/Client
MATERNAL SERVICES								
Prior to Initial Assessment								
Outpatient	3,828	38.4%	\$ 257	\$ 68	10,153	35.1%	\$ 205	\$ 64
Inpatient	14	0.1%	3,888	2,644	10	0.0%	6,057	5,416
Prenatal Visits; OB Services	9,813	98.5%	2,430	1,863	28,547	98.1%	2,103	1,343
Maternity Support -	4,500	45.8%	289	200	12,910	44.7%	270	180
Prior to Delivery -								
Outpatient	8,761	87.9%	1,042	349	24,901	86.2%	807	279
Inpatient	887	8.9%	6,576	3,160	2,227	7.7%	4,332	1,955
Delivery	9,547	95.8%	6,838	6,840	27,662	95.8%	4,195	4,525
Postpartum -								
Outpatient	8,597	84.3%	757	406	22,700	78.6%	799	442
Inpatient	231	2.3%	6,824	3,821	304	1.1%	7,012	3,693
Unknown								
Outpatient	9,181	92.2%	330	74	22,859	79.1%	241	50
Inpatient	52	0.5%	12,557	7,668	102	0.4%	8,072	6,256
TOTAL MATERNAL	9,963	100.0%	\$ 11,719	\$ 10,311	28,888	100.0%	\$ 8,105	\$ 7,418
INFANT SERVICES (Liveborn Infants)								
During the first year of life (time span may vary)*								
Outpatient	9,685	99.2%	\$ 2,100	\$ 1,299	28,031	99.2%	\$ 1,654	\$ 1,174
Inpatient	8,302	85.7%	7,309	1,099	24,598	87.0%	3,203	1,015
Neonatal/Ped. Critical Care	1,774	18.2%	19,193	2,172	2,294	8.1%	10,055	1,119
During the first 60 days of life								
Outpatient	9,458	96.9%	481	331	27,311	96.6%	436	325
Inpatient	8,273	84.8%	5,778	1,091	24,517	86.7%	2,636	1,010
Neonatal/Ped. Critical Care	1,730	17.7%	18,681	2,164	2,188	7.7%	10,129	1,055
Infant Case Management -	2,220	22.7%	111	60	6,233	22.0%	94	40
TOTAL INFANT CARE	9,700	100.0%	\$ 11,835	\$ 2,659	28,271	100.0%	\$ 5,243	\$ 2,202

Methods to secure doula reimbursement approval from CMS
December 1, 2020

Cost Savings for Anesthesia

	Total (N)	Total Cost	Ave Cost
ENC	12,193	\$5,688,773.17	\$452.39
FFS	2,386	\$1,044,136.91	\$428.28
All	14,579	\$6,732,910.08	\$448.47

Cost Savings for Induction

Fee-for-Service or Encounter Payment	Total Women (N)	Total Cost	Ave Cost
FFS	247	1315179.86	574.565
ENC	734	3511818.78	570.935

Savings Due to Increased Breastfeeding

	Gastro	Resp	Entero	Otitis
Total Clients 0-2	4,245	12,873	115	12,230
Total \$ Paid	\$ 2,041,239	\$ 18,295,092	\$ 6,173,849	\$ 4,549,400
Avg \$/Client	\$ 481	\$ 1,421	\$ 53,686	\$ 372
Projected # Clients where Mother Has Doula (3% of pop)	127	386	3	367
Additional Clients Expected to Breastfeed	15.5	47.1	0.4	44.8
Maximum Potential Savings per Year based on Odds Ratio	\$ 2,689.54	\$ 18,748.81	\$ 9,490.44	\$ 8,325.40
			Total/Year	\$ 39,254.19

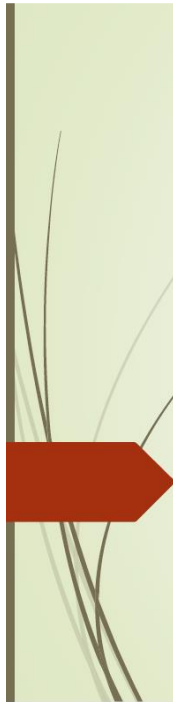
Cost Savings Attributed to Doula Use

	SFY2021 (Jan '21-Jul'21)	SFY2022	SFY2023	SFY2024
Total Clients with Doula Services	550	1,210	1,331	1,464
Expected # C-Sections	141	310	341	375
# of Reduced C-Sections (10% reduction)	14	31	34	37
Cost Savings from Reduced C-Sections	\$ 143,700	\$ 316,141	\$ 347,755	\$ 382,531
Expected Use of Anesthesia	235	517	568	625
# Reduced Use of Anesthesia (9% reduction)	21	47	51	56
Cost Savings from Reduced Anesthesia	\$ 9,481	\$ 20,858	\$ 22,944	\$ 25,238
Expected # of Inductions	133	292	321	353
# Reduced Inductions (12% reduction)	16	35	39	42
Cost Savings from Reduced Inductions	\$ 9,093	\$ 20,005	\$ 22,005	\$ 24,206
Expected # Preterm Births	41	91	100	110
# of Reduced Preterm Births (1.6% reduction)	1	1	2	2
Cost Savings from Reduced Preterm Births	\$ 23,692	\$ 52,122	\$ 57,334	\$ 63,067
Cost Savings from Decreased Illness due to Bf	\$ 19,627	\$ 39,254	\$ 43,180	\$ 47,498
Total Cost Savings from Doulas	\$ 205,593	\$ 448,380	\$ 493,218	\$ 542,539

Total Net Cost of Doula Implementation

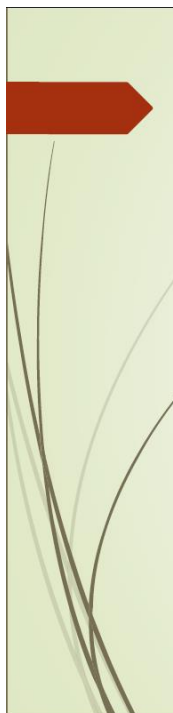
Total Medicaid Births/year	39,695	%		
Total Managed Care Births/Year	32,222	81%		
Total FFS Births/Year	10,536	19%		
	SFY2021 (Jan '21-Jul'21)	SFY2022	SFY2023	SFY2024
Utilization of Doula Services	1%	3%	3%	4%
Total Clients with Doula Services	550	1,210	1,331	1,464
Ante/Postpartum Visits (4 visits/client @ \$50/each)	\$ 110,000	\$ 242,000	\$ 267,000	\$ 293,000
Labor Services (\$450/client)	\$ 248,000	\$ 545,000	\$ 599,000	\$ 659,000
Total Cost	\$ 358,000	\$ 787,000	\$ 866,000	\$ 952,000
Total Savings	\$ (206,000)	\$ (449,000)	\$ (494,000)	\$ (543,000)
Net	\$ 152,000	\$ 338,000	\$ 372,000	\$ 409,000

PowerPoint Presentation – Items for Review and Discussion



Items for review/discussion

Doula partner meeting/HCA/DOH
7/16/20
1-2pm



Legislative report – due by 12/01/20

- 2019 Legislative proviso language –
“Within the amounts appropriated in this section, the authority shall reimburse for maternity services provided by doulas. The authority and the department of health must consult with stakeholders and develop methods to secure approval from the centers for medicare and medicaid services for reimbursement for doulas. The authority will report the group's recommendations to the appropriate committees of the legislature by December 1, 2020.”
- Components of the legislative report
 - Executive Summary
 - Background
 - Stakeholder Workgroup
 - Key Definitions
 - Role of the Doula
 - Payment Methodology
 - Phase 1 Recommendations and Implementation Timeline
 - Phase 2 Recommendations and Implementation Timeline
 - Conclusion
- Legislative Report Process
 - Review and Feedback
 - Report Timeline: Upcoming due date – 9/15/20 – 1st draft due to LAA (Legislative Affairs and Analysis)

Methods to secure doula reimbursement approval from CMS
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Payment methods/options

Payment rate – set by HCA. MCOs must reimburse at least this amount but rates can be negotiated with plans

Payment models – fee-for-service or bundled. Our plan is to recommend fee-for-service in leg report based on doula feedback regarding concerns with delaying payment

Non-credentialed route – Medicaid payment must flow through supervising/billing provider. Few examples here:

- Swedish Doulas – Supervised by Dr. X at Swedish, Swedish bills HCA, HCA pays Swedish.
- Doulas for All Doulas – Supervised by Midwife, Midwife bills HCA, HCA pays Midwife, Midwife pays Doula.
- Community Doula – Create a relationship with OB/GYN, OB/GYN bills HCA, HCA pays OB/GYN, OB/GYN pays Doula.

Credentialed route – Doulas can be paid directly from Medicaid.

Credentialing process- focus of 8/7 meeting

Department of Health (DOH) will lead/facilitate conversation around credentialing

Please send specific questions you have and would like addressed in this meeting to Sarah Pearson at sarah.pearson@hca.wa.gov

Notes

Notes/minutes from doula partner/stakeholder meeting on 7/16/20 1-2pm. Skype

Planned agenda:

Methods to secure doula reimbursement approval from CMS
December 1, 2020

Welcome & Introductions	Sarah	5 min.	
Review Updated Fiscal Model	Robin	20 min.	Inform the stakeholders of the updated fiscal model.
Stakeholder Discussion	Jackie Vaughn	30 min.	Gain input and answer stakeholder questions.
Next Stakeholder Meeting	Sarah	5 min.	Holding 8/7/20 (1-3 p.m.) and 8/25/20 (1-3 p.m.) Topics: DOH Credentialing Others Topics?

Attendees: Wendy Steffens, Sandra Riccolo, Jodi Kunkel, Sarah Pearson, Melissa Kundur, Charissa Fotinos, Joyce Fan, Beth Tinker, Teresa Cooper, Robin Brake, Shauna James, Heather Weiher, Trina Crawford, Kathy Weed, Jodi Kunkel, Ashley Noble, Sarah Keefe

Mariah Falin, Jen Hamilton, Sharon Muza, Jackie Vaughn, Amber Ulvenes, Cindy Gamble, Jasmyne Bryant, Jazmin Williams, Jocelyn Alt, Kate Wilhite-Brickell, Susan Siphon, Melanie Florshare, Faisa Farole, Jon Pielemeier, Annie Kennedy, Camie Goldhammer (joined about 1:30).

Review Updated Fiscal Model

Robin Brake – went through and discussed PowerPoint slides focused on fiscal model and HCA parameters for cost neutral fiscal modeling.

Following slides there was time for Q&A with Robin – slides will be available to participants after the meeting.

Cindy Gamble - asked for clarification on the breastfeeding savings in the model – was it initiation, 3 months, or 6 months?; Robin – used incidence ratio in study, hard to have an exact application of offsets, this was best case scenario where we could substantiate with data we have available; breastfeeding is hardest piece to find actuarially sound dollars to attribute to it

Jackie Vaughn asked for clarification on the utilization #'s. Robin explained the #'s were loosely based on responses HCA received from 6 people on current and projected utilization among Medicaid clients. Open to hearing more feedback. Jackie explained that these #'s might be low as

Methods to secure doula reimbursement approval from CMS
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many Medicaid clients are currently turned away from doula services due to inability to pay and doulas can only support so many pro bono clients. Robin also acknowledged typo in utilization table where first 6 month period is represented as 18mo- she will fix this.

Jen Hamilton asked for clarification on the assumed decrease in preterm birth (1.6 percent), wondering if it should be more than this? Robin explained that the preterm birth rate in WA is already relatively low compared to national statistics and with the N that we have projected this # is relatively low. Robin also emphasized that preventing preterm birth has the associated largest cost savings. Jackie asked if it can be show that doulas can gave greater impacts on c-section and preterm births in WA, can we come back to the board and look at model? Robin - If we can implement and collect data and better evaluate cost savings with real time data we could re-evaluate and apply additional offsets in the model. Potentially this could increase the rate (Jackie asked this f/u question).

Jocelyn asked for clarification around how projected doula utilization impacts the associated rate in a cost neutral model. Would higher projected utilization increase or decrease the rate that could be paid for the services? Robin explained that it doesn't really make a difference as there is a net cost to the HCA in this model, so that higher utilization would just project out over time. Not a driver for higher pay rate for doulas at this point.

Stakeholder Discussion

Sarah introduced Jackie to lead this part of the meeting and introduced/presented 3 slides that the HCA put together on topics that Jackie and the coalition had raised in email exchanges prior to this meeting. 1) legislative report 2) payment structure and options 3) meeting focused on credentialing with DOH as lead on this topic

Jackie, Jasmyne, and Jazmin facilitated this next portion of the meeting.

Jackie summarized some key priorities for the coalition and related these back to lessons learned from doula implementation in MN, OR and NY. Also, findings from the National Health Law Partnership.

Certification and what that will look like is a priority issue for doulas. They are concerned that certification not be too rigid/inflexible or in other ways high barrier for doulas. It was problematic in other states that there have been very limited options for doulas on where they could get certification (e.g., only through DONA or other national or international organizations or in OR doulas are required to complete both the doula certification through one of these orgs and also the state CHW certification). They recommend certification requirements be "low barrier and flexible".

Doula coalition prioritizes that the implementation be useful for both individual doulas and for community doulas. Mentioned barriers and structure for doulas is varied. Policy at rollout needs to be useful for all doulas.

There are 700 doulas on doulamatch.net in WA. Think about how many clients are being turned away for inability to pay for a doula. Think of a way to tap into how many Medicaid clients could potentially be served, I think the number would potentially be higher.

Fee-for-service versus bundled payments – Bundled payments can only be billed annually. Jackie shares that in other states there have been complaints around the FFS model which is inflexible. Complaints from doulas when not able to attend labor and delivery, as biggest payment is attached to that. Locks doulas into a rigid method for serving clients. Agrees that a bundled payment with a delayed reimbursement to the doula could be problematic.

Jackie summarized that barriers in other states have been around certification, rate and payment structure.

Jasmyne B- shared there are 2 goals – make doula services more accessible to clients and give doulas more clients. Shared that she is trained and practices but is not certified currently. Would not be included as someone who could get a reimbursement. Medicaid clients are referred to her and other uncertified doulas who offer free or reduced-cost services to obtain certification. Barriers and hoops harm doulas' ability to serve community and advocate for our own reimbursement. Viewing certain entities as more valid than others creates issues, need to be creative. Also shared that the coalition has input to core competencies that would be required for certification. Pushing doulas into an organization where we have to work to get reimbursed will cause loss of individuality and diversity. Give attention to Black and Indigenous workers and rural areas, avoid being Seattle-centric.

Jackie shared in chat “if we’re able to have greater flexibility and options on the list of certification organizations we can reduce barriers for doulas to qualify while still maintaining parameters around defining scope of practice and accountability and assurance for clients”.

Charissa – In the studies I’ve reviewed in the past, there are clearly benefits with doulas but most of the reduction in adverse outcomes have come from doula attendance during the labor itself. Asked if there is literature/data on patient outcomes for doulas who are providing AP and/or PP support but not labor/intrapartum support? If so, can you pass along to us so we can review it? That would be important for us to have. Also gave a brief overview of value based payments and that there is potentially opportunity to look at what a VBP for doula services would look like –where payment is tied to patient outcomes as opposed to payment being tied to specific services provided.

Jackie – It would be helpful in the future to have information around the different payment models.

Jackie – You all speak of Phase 1 and then Phase 2. The phased approach is not the direction we want to go. Want to work on both but biggest lift will be credentialed route. Credentialed route is where we’d see more families be able to access this benefit. More questions about non-credentialed. I see the examples you have (in slides) like doulas could be matched up to licensed providers. Lots of doulas not connected to Swedish doulas or Doulas for All. How would they get matched up? It seems like there would not be funding attached to compensate supervising

providers for their overhead. How would doulas get matched up and what amount would go to those providers?

Kate via message – “think the discussion of the doula missing the birth and payment, would be that they could provide additional pre- or post-natal support to still access additional payment. For example: now in COVID, doulas are being kept out of some birthing spaces, so they could provide additional postnatal support to make-up that payment differential.”

Next meeting 8/7, 1-3pm. DOH will talk about credentialing. Sarah asked for questions around credentialing be sent to her via email so that we can try to address the priorities from the group.

Meeting on August 7, 2020

Below is the PowerPoint presentation and notes from this meeting.

PowerPoint Presentation



Credentialing

What We Do:

DOH regulates 86 different health professions, in doing so the initial application and renewal process includes:

- Complete an initial review and record information for approximately 4,650 new applications per month
- Complete approximately 20,800 renewals per month
- Complete about 4,700 Washington State Patrol background checks each month
- Complete about 840 FBI Fingerprint background checks per month
- Roughly 20,000 applications are pending during any given month
 - Various reasons for a pending application: transcript verification, background check, insufficient information on the application, awaiting exam results, etc..
 - Will hold a pending application for up to one year

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Different Credential Types

There are three types of credentials which DOH processes:

- **Registration**

A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession and, if required, the location, nature and operation of the healthcare activity practiced.

- **Certification**

A type of credential. Certifications may be a voluntary process by which the state grants recognition to an individual who has met certain qualifications. Some certifications are required before the person can practice a healthcare profession. The qualifications for each certified profession are set in law.

- **License**

A method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health profession. The qualifications are set by law and without a license the practice of the specific health profession would be unlawful. Licensure protects the scope of practice and the healthcare professional's title.

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Sunrise Act/Requirements for regulation

The Sunrise Act (RCW 18.120.010) says a healthcare profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public...
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.
 - If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive method, consistent with the public interest.

<https://www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance/SunriseReviews>

Washington State Department of Health | 4

House Bill 2798: DOH comments

During the 2020 legislative session, HB 2798 was introduced as a voluntary registration for doulas. DOH had the following comments/concerns with the bill:

- State law requires health profession programs to be fully self-supported by fees
 - The smaller number of doulas who choose to become credentialed would increase the cost for each doula that does get credentialed
- Credentialing healthcare professionals ensures a specified standard of care is met and protects the public:
 - Background checks are required for new applicants
 - Can include denial of an application or an agreement to practice under certain conditions
 - Disciplinary action taken when unprofessional conduct is founded
 - Provider credential search available to the public

<https://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch>

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House Bill 2798: DOH comments

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- State law requires health profession programs to be fully self-supported by fees
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 - Provider credential search available to the public
- <https://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch>

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Credentialing and Fees

Based on research from HB 2798, DOH reported the following:

- Assumption that approximately 75% of doulas would become credentialed (408)
- Cost per credential would be approximately \$100-\$150 per year
- Secretary of Health should have the authority to establish requirements through rule writing (WAC)
 - Takes approximately 18 months to implement
 - Includes stakeholder meetings to gather input and help propose requirements
 - Concludes with a public hearing and filing with the Code Reviser
 - Only includes what is authorized by statute (RCW)

Washington State Department of Health | 7



Fee Support

Credentialing fees collected by the Department provides:

- Credentialing/customer service unit support
- Health profession program unit support
- Disciplinary investigations and legal service support
- Case Management and Compliance unit support
- Policy staff support
- Media and Communications support
- Facility rent and other logistics
- IT support
- And more...

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Voluntary Credentials

There are only a few health professions in which credentialing is considered voluntary:

- Licensed SLP/Audiologists: RCW 18.39.195, **This chapter does not prohibit or regulate:**

(c) The practice of audiology or speech-language pathology **by persons certified by the Washington professional educator standards board as educational staff associates**, except for those persons electing to be licensed under this chapter. However, a person certified by the board as an educational staff associate who practices outside the school setting must be a licensed audiologist or licensed speech-language pathologist.

- Licensed Midwives: RCW 18.50.010

Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her newborn up to two weeks of age or who shall advertise as a midwife by signs, printed cards, or otherwise. **Nothing shall be construed in this chapter to prohibit gratuitous services.** It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the newborn.

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Voluntary Credentials Continued

Certified Home Care Aides: RCW 18.88B.041

(1) The following long-term care workers are not required to become a certified home care aide pursuant to this chapter..

(c) An individual provider caring only for the individual provider's biological, step, or adoptive child or parent.

(d) A person working as an individual provider who provides twenty hours or less of care for one person in any calendar month.

(f) A long-term care worker providing approved services only for a spouse or registered domestic partner.

WAC 246-980-025

- (1)(e) A direct care worker who is not paid by the state or by a private agency or facility licensed by the state to provide personal care services.

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New Profession Implementation

- The law (RCW) and rules (WAC) will set the credentialing requirements for each profession
- The RCW sets the effective date for each profession. No new licenses will be issued before that date
- The target timeline to issue a new credential is 10 business days from when a complete application is received.

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Department of Health Contacts

Office of Health Professions Executive Director:

Trina Crawford trina.crawford@doh.wa.gov 360- 236-4890

Credentialing Section Manager:

Diane Young diane.young@doh.wa.gov 360-236-4666

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Notes

Doula Stakeholder Meeting Notes 8.7.2020 1-2pm (meeting concluded about 1:45)

Attendees: Teresa Cooper, Joyce Fan, Melissa Kundur, Sarah Pearson, Sandra Riccolo, Elizabeth Tinker, Heather Weiher, Amber Ulvenes, Gwen Kiehne, Cindy Gamble, Jackie Vaughn, Jazmin Williams, Kate Wilhite Brickell, Mariah Falin, Trina Crawford, Dila Perera, Faiza Farole, Sharon Muza, Jen Hamilton, Shellea Quillen, Shamso (Global Perinatal Services), Ann Hawker (sp?)

Trina Crawford from the Department of Health and PowerPoint presentation (slide deck shared post meeting from Sarah Pearson at the HCA):

1 of 5 executive directors in Health Professions at DOH, one of her programs is midwifery

Registration – work under supervision of another professional, such as a dental assistant

Certification – typically requires training and often exam, examples include Home Care Aide 75 hours of training and exam, also NAC 85 hours and exam; some require associate and up to a bachelor's degree

License – medical doctor, dentist; can't call self a doctor unless credentialed with DOH

Doula profession has not gone through sunrise review process yet, so can't say yet what appropriate credential type is. Birthing assistants went through sunrise review in 2017, no credential recommended.

Jackie – Is sunrise review required for certification? Trina – up to legislature, typically how new professions certified, not required but helps determine scope of practice

Methods to secure doula reimbursement approval from CMS

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State law requires professions to be self-supported, no offsets or extra state funds. Voluntary registration - If only five doulas desire credentialing vs. 500, then those five have to bear the cost of whole profession.

Rule-writing for new profession is guided by legislature, follows what is in bill and statute.

Dila – When you say fee of \$100-150 per year, estimate based on 408 people? Trina – Yes, estimate of 600 or so doulas in WA, estimated 75 percent would become credentialed. The fee would vary if there are more or less doulas credentialing than this estimated number of 408.

Kate – Flexibility in renewal process being spaced out to every two or three years? Trina – Could be flexibility. Fee would be less if more doulas but more if less doulas. For first year or two until we know where numbers are at, it would be annual requirement and then perhaps the renewal cycle could be adjusted.

Mariah – How set are those renewal fees? Trina – Set on data we received. This is the fee for 408 doulas. If more doulas or data showing higher credentialed number, then cost could decrease. There's a lot that goes into supporting a new profession. Every two years, we review the fee to determine if too high or too low.

Amber – With what goes into fees for a health profession, it's just whatever it takes an agency to create and regulate a profession. I also represent midwives. Really interested to see what goes into licensing fees. Midwives' fees quite high, not a lot of them so the mandatory self-supporting costs are not spread out. Also issues with people practicing unlicensed midwifery as it costs credentialed people a lot of money. It varies from profession to profession, relying on what it takes to regulate your particular profession.

Jackie – With voluntary credentialing, I hear from doulas that some doulas may want to bill Medicaid but others who are not interested in billing Medicaid because of strings attached and what it means for individual practice. What happens if decide not to become credentialed? Trina – Segues into next slide. Trina shared example of Certified Home Care Aides. A direct care worker does not need to be certified by DOH to get paid under Home Care Aide rules if private pay only, there is a carve out for private pay. But, cannot advertise yourself as a Home Care Aide unless you are credentialed by the DOH, still a title protection with the profession. Might be an interesting concept for the doula profession. If doula certification, do you still allow people who don't get certified to call themselves a doula? I don't have the answer, just something to consider. Jackie – We'll have to brainstorm on what that means, because don't want to force this on folks who don't want to bill Medicaid.

Sarah – Yesterday sent out first draft of legislative report to group, request feedback by COB on 8/21. Will also have final draft that we send around for final review and response.

Dila – Thank you for all of the work on it. Haven't sent comments in yet but thank you for giving us the time to review it.

Sarah – Currently hold on internal calendars for another stakeholder meeting end of August, but may be moved out further. Any other questions/comments? Dila – Please share the slides. Sarah – Attached to meeting request but will also mail them out.

Appendix C: Original doula services coverage model

Below is the original doula services coverage model.

Doula Services Coverage Model



Financial Services Division

Doula Services Coverage

Date: 6/25/2020

Prepared by: Robin Brake

Overview:

HCA is proposing the coverage of doula services for pregnant women covered by Medicaid.

Data Used:

Medicaid Births & Maternity Support Services Utilization, Data Source: Z. Joyce Fan, RDA
Cost Comparisons for C-Sections, Preterm Births, Induction from Dorothy Lyons, RDA

Assumptions:

- Phase 1 Effective Date of January 1, 2021.
- Phase 1 would require supervision by a licensed provider but no DOH certification
- Phase 2 effective date of XXX
- Phase 2 would require certification through DOH

For both models:

- Doula services include 2 antepartum visits and 2 postpartum visits at \$50/visit and labor support
- Labor support reimbursement is a flat fee of \$450 per birth and not eligible for encounter rates
- FMAP from June-18 MFSR for Deliveries
- Utilization estimated based on estimates from doula organizations plus a 10% yearly increase
- SPA/WAC changes would be required and CMS approval
- 10% Reduction in C-Sections for clients with Doulas per Dr. Fotinos
- Doulas expected to decrease # of preterm births by 1.6%, 9% reduction in use of anesthesia, and 12% reduction in inductions. % based on studies
- Doulas expected to increase breastfeeding by 12.2% in clients resulting in savings through reduced lower respiratory tract infections, gastroenteritis, otitis media, and NEC

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Doula Services Coverage Model

Model

Total Medicaid Births/year	39,695	%
Total Managed Care Births/Year	32,222	81%
Total FFS Births/Year	10,536	19%

	SFY2021 (Jan '21-Jul'21)	SFY2022	SFY2023	SFY2024
Utilization of Doula Services	1%	3%	3%	4%
Total Clients with Doula Services	550	1,210	1,331	1,464
Ante/Postpartum Visits (4 visits/client @ \$50/each)	\$ 110,000	\$ 242,000	\$ 267,000	\$ 293,000
Labor Services (\$450/client)	\$ 248,000	\$ 545,000	\$ 599,000	\$ 659,000
Total Cost	\$ 358,000	\$ 787,000	\$ 866,000	\$ 952,000
Total Savings	\$ (206,000)	\$ (449,000)	\$ (494,000)	\$ (543,000)
Net	\$ 152,000	\$ 338,000	\$ 372,000	\$ 409,000

	SFY2021	SFY2022	SFY2023	SFY2024
Total MC	\$ 124,000	\$ 275,000	\$ 302,000	\$ 333,000
Total FFS	\$ 29,000	\$ 64,000	\$ 71,000	\$ 77,000
General Fund - State	\$ 57,000	\$ 125,000	\$ 137,000	\$ 151,000
General Fund - Federal	\$ 97,000	\$ 215,000	\$ 237,000	\$ 260,000

	Federal	State
FMAP for MC	63.6%	36.4%
FMAP for FFS	62.6%	37.4%

1.6%, 9% reduction in use of anesthesia, and 12% reduction in inductions. % based on studies



Doula Services Coverage Model

Cost Savings Calculations

	SFY2021 (Jan '21-Jul'22)	SFY2022	SFY2023	SFY2024
Total Clients with Doula Services	550	1,210	1,331	1,464
Expected # C-Sections	141	310	341	375
# of Reduced C-Sections (10% reduction)	14	31	34	37
Cost Savings from Reduced C-Sections	\$ 143,700	\$ 316,141	\$ 347,755	\$ 382,531
Expected Use of Anesthesia	235	517	568	625
# Reduced Use of Anesthesia (9% reduction)	21	47	51	56
Cost Savings from Reduced Anesthesia	\$ 9,481	\$ 20,858	\$ 22,944	\$ 25,238
Expected # of Inductions	133	292	321	353
# Reduced Inductions (12% reduction)	16	35	39	42
Cost Savings from Reduced Inductions	\$ 9,093	\$ 20,005	\$ 22,005	\$ 24,206
Expected # Preterm Births	41	91	100	110
# of Reduced Preterm Births (1.6% reduction)	1	1	2	2
Cost Savings from Reduced Preterm Births	\$ 23,692	\$ 52,122	\$ 57,334	\$ 63,067
Cost Savings from Decreased Illness due to Bf	\$ 19,627	\$ 39,254	\$ 43,180	\$ 47,498
Total Cost Savings from Doulas	\$ 205,593	\$ 448,380	\$ 493,218	\$ 542,539

Methods to secure doula reimbursement approval from CMS
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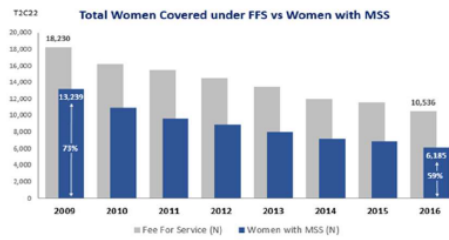
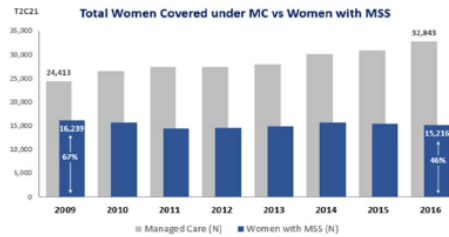


Doula Services Coverage Model

Utilization Data

WA Women who gave births in WA State

	2016		2017		2018	
Total Medicaid Births/year	43,379	%	41,463	%	39,695	%
Total Managed Care Births/Year	32,843	76%	33,573	81%	32,222	81%
Total FFS Births/Year	10,536	24%	7,890	19%	7,473	19%



DSHS | Financial Service Administration | Research and Data Analysis Division • APRIL 2018

Created by
Z. Joyce Fan, PhD
Financial Service Administration, Research and Data Analysis Division
Maternal and Child Health
23-Apr-18

Methods to secure doula reimbursement approval from CMS
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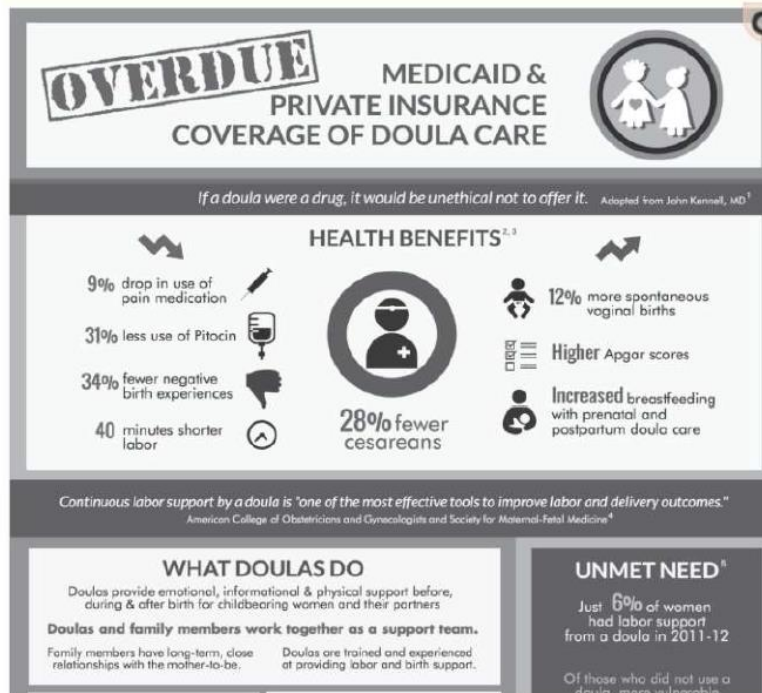
Doula Services Coverage Model

Savings Stats

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC265610/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC544530/>

<https://www.swedish.org/services/doula-services/research-on-doulas>



Appendix D: Updated doula services coverage model

Below is the updated doula services coverage model

Doula Services Coverage Model

Model at \$900

Total Medicaid Births/year	39,695	%
Total Managed Care Births/Year	32,222	81%
Total FFS Births/Year	10,536	19%

	SFY2021 (Jan '21-Jul'21)	SFY2022	SFY2023	SFY2024
Utilization of Doula Services	1%	3%	3%	4%
Total Clients with Doula Services	550	1,210	1,331	1,464
Ante/Postpartum Visits (4 visits/client @ \$50/each)	\$ 110,000	\$ 242,000	\$ 267,000	\$ 293,000
Labor Services (\$700/client)	\$ 385,000	\$ 847,000	\$ 932,000	\$ 1,025,000
Total Cost	\$ 495,000	\$ 1,089,000	\$ 1,199,000	\$ 1,318,000
Total Savings	\$ (206,000)	\$ (449,000)	\$ (494,000)	\$ (543,000)
Net	\$ 289,000	\$ 640,000	\$ 705,000	\$ 775,000
Net at \$650	\$ 152,000.00	\$ 338,000.00	\$ 372,000.00	\$ 409,000.00
Difference	\$ 137,000.00	\$ 302,000.00	\$ 333,000.00	\$ 366,000.00

	SFY2021	SFY2022	SFY2023	SFY2024
Total MC	\$ 235,000	\$ 520,000	\$ 573,000	\$ 630,000
Total FFS	\$ 55,000	\$ 121,000	\$ 133,000	\$ 146,000
General Fund - State	\$ 107,000	\$ 235,000	\$ 259,000	\$ 285,000
General Fund - Federal	\$ 184,000	\$ 407,000	\$ 448,000	\$ 492,000

	Federal	State
FMAP for MC	63.6%	36.4%
FMAP for FFS	62.6%	37.4%

1.6%, 9% reduction in use of anesthesia, and 12% reduction in inductions. % based on studies

Methods to secure doula reimbursement approval from CMS
December 1, 2020



Appendix E: End notes

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- ¹ Hodnett E, Gates S, Hofmeyr G, et al. Continuous support for women during childbirth. *Cochrane Database Syst Rev*; 2013(7):CD003766.
- ² Vonderheid S, Kishi R, Norr K, et al. *Reducing Racial/Ethnic Disparities in Reproductive and Perinatal Outcomes*. New York: Springer Science and Business Media, 2011.
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- ⁴ Gruber KJ, Cupito SH, Dobson CF. Impact of Doulas on Healthy Birth Outcomes. *J of Perinat Educ*. 2013; 22(1):49-58.
- ⁵ Sauls DJ. Effects of labor support on mothers, babies, and birth outcomes. *J ObstetGynecolNeonatNurs*. 2002; 31(6):733-741.
- ⁶ 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.
- ⁷ Kozhimannil KB, Attanasio LB, Jou J, Joarnt LK, Johnson PJ, Gjerdingen DK. Potential benefits of increased access to doula support during childbirth. *Am J Manag Care*. 2014; 20(8):e340-e352.
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- ¹⁰ Greiner KS, Hersh AR, Hersh SR, et al. The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model. *J Midwifery Womens Health*. 2019;64(4):410-420.
- ¹¹ Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017. *MMWR MorbMortal WklyRep*. 2019;68:423-249.
- ¹² Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year, Interim Report to the Minnesota Department of Human Services, July 2015.
- ¹³ Routes to Success for Medicaid Coverage of Doula Care, National Health Law Program, December 2018.

