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Testimony Before the District of Columbia Council
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Public Performance Oversight Hearing: Department of Health Care Finance

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Introduction

My name is Leah Castelaz. I am a Policy Attorney at Children's Law Center and a resident of the District. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

I appreciate the opportunity to testify today regarding the Department of Health Care Finance's (DHCF's) performance over the last year. My testimony will focus on maternal health in the District and the investments DHCF has made in FY2022 and FY2023, to date.

DC has some of the worst maternal health outcomes in the United States which have only been exacerbated by the COVID-19 pandemic.[1] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic, compared with 2018 and 2019, while having the greatest impact on Black and Hispanic women.[2] Across the nation, the maternal death rate for Black or African-American (not Hispanic or Latina) per 100,000 live births increased from 44.0 in 2019, to 55.3 in 2020, and then to

68.9 in 2021.[3] In contrast, White (not Hispanic or Latina) women had death rates of 17.9, 19.1, and 26.1, respectively.[4] Additionally, the maternal death rate for Hispanic or Latina women increased significantly during the pandemic in 2020.[5]

Pregnant and postpartum people's behavioral health have not fare much better than their physical health outcomes. Prior to the COVID-19 pandemic, pregnant and postpartum people were struggling to access the care and resources they needed to address their behavioral health needs. The pandemic has only worsened behavioral health across the nation and put a greater strain on the already struggling system. Across the nation, almost 40 percent of Black parents experience perinatal mood and anxiety disorders (PMADs) — including anxiety, depression, post-traumatic stress disorder, obsessive-compulsive disorder, and bipolar illness – during the perinatal period.[6] When compared to White women, Black women are twice as likely to experience PMADs but half as likely to receive treatment.[7] There is a dearth of DC-specific PMADs data, however, we know through our work with key stakeholders that the national picture is representative of the experiences of pregnant and postpartum people in the District.

The shortage of data on PMADs in the District is why we were excited to have the Perinatal Mental Health Task Force re-introduced last budget season. The successful passage of the Task Force will help begin to close this information gap and bring attention to maternal behavioral health outcomes. Understanding the landscape and the need will

help us work to find more solutions to close the health disparities faced by the District's Black and Brown pregnant and postpartum people.

Overall, in order to best meet the physical and behavioral health needs of District residents who can become pregnant, are pregnant, or have recently given birth we must continue to incorporate and uplift the voices of key stakeholders including those with lived experiences, providers, and other community members. This testimony examines the great work that has already been done and the work that needs to continue to improve the lives of District pregnant and postpartum people as well as those who care for them both in and out of the home.

DHCF continues to make key investments in advancing positive outcomes for maternal health in the District, however, continued implementation oversight is needed

In FY2022, DHCF submitted and was approved for two State Plan Amendments (SPA) for extension of postpartum coverage from 60 to 365 days and Medicaid coverage of doula services.[8] These are critical investments in DC's pregnant and postpartum people, and we applaud the work of this Council and DHCF in moving them forward. The District, however, cannot let the momentum slow. In particular, we cannot allow the government to silo itself from the community as they implement these investments. We need continued transparency and communication between the government and community stakeholders to help move forward implementation of new and expanded maternal health supports.

There is a need for a space to provide cohesive, consistent communication regarding implementation of expanded maternal health services

The Maternal Health Advisory Group (MHAG) was a consortium of stakeholders that met monthly to help inform DHCF's work in the expansion of coverage and maternal health services in the District.[9] Together with DHCF, the MHAG and public participants provided valuable input on 365 days of postpartum coverage, doula services, and other aspects of maternal health in the District.[10]

As members of the MHAG, CLC appreciated the opportunity to converse with other participants and have a space to give attention to maternal health efforts in the District.[11] Unfortunately, the MHAG is no longer meeting since according to DHCF "the primary objectives have been completed" including submitting and getting the SPA for the doula benefit approved.[12] However, DHCF did state that they had also planned to use the MHAG to seek input on "designing outreach and training on maternal health services available through DHCF programs as well as other aspects of maternal health in DHCF programs."[13] We would consider this to be an ongoing effort and therefore, not complete.

We are concerned that during a critical point of time, implementation of the doula benefit, DHCF is no longer receiving input from those executing and utilizing the new services. Unless and until the District creates a stakeholder forum that more broadly focuses on maternal health and brings together community and government stakeholders, we ask the MHAG continue especially during this critical time of change.

We know DHCF is still engaged with some community members as illustrated by both their performance oversight responses[14] and a recent repeal of a doula enrollment requirement in December 2022. Doulas enrolling as "individual/solo" practitioners no longer have to provide a Business License or Certificate of Occupancy.[15] DHCF repealed this requirement after receiving feedback that it was impractical for many doulas and was hindering registration of "individual/solo" doulas as DHCF providers.[16] We appreciate DHCF taking this feedback and making necessary adjustments.

This example, however, highlights how crucial stakeholder input is during the implementation process. And while we appreciate there are ways to provide feedback on an individual or case-by-case basis, this is not the most effective or efficient way to ensure successful implementation. The MHAG offered a way around this piecemeal approach and allowed for DHCF to have one central touchpoint for those working on maternal health issues in the District.

Continued work on the Doula Benefit is needed to ensure access by District residents

Accessible doula care is a critical component of maternal health. Doulas have been found to help address inequities in maternal health, especially for Black pregnant and postpartum people and their infants. In DC, 90 percent of the maternal deaths happen to non-Hispanic Black women.[17] An extremely stark fact when discussing the true inequities of maternal health care in the District. Doulas, however, can help pregnant people

advocate for their personal care preferences, as well as combat interpersonal and institutional bias that occurs frequently in the maternal health care context.[18]

In 2022 the March of Dimes rated DC with a D+ for preterm birth rates, meaning that DC had a significantly higher rate than other states of babies being born at less than 37 weeks of gestation. Doula support during birth has been shown to decrease preterm births[19], lead to fewer c-sections[20], fewer emergency interventions[21], as well as increased breastfeeding rates.[22] Doulas correlate with many positive health outcomes for the parent and baby.[23]

Having a central touch point with stakeholders is especially important for the doula program. The Center for Healthcare Strategies recommends "in determining how to design and implement Medicaid coverage for doulas, states should engage local and national doula stakeholders to develop strategies that will be responsive to doula and member needs and help meet Medicaid goals."[24] This engagement was not meant to end at design. We have heard directly from other jurisdictions that having a central touchpoint to celebrate successes and address concerns would greatly benefit their doula implementation efforts by increasing transparency, communication, and access. One jurisdiction stated that when their state stopped engaging with stakeholders it negatively impacted their progress to bring on doulas.[25] State engagement with doula stakeholders can help identify and overcome barriers associated with recommendation requirements.[26]

We are concerned that right now the doula program is struggling. According to DHCF, seven doulas have started the registration process, and only two doulas have enrolled.[27] DHCF also noted that no doula reimbursement was given in FY2023 thus far, however, two doulas billed claims for reimbursement.[28] It would appear these two doulas were not reimbursed. We urge this Committee to seek clarity here and understand if this is true and if so, why that is the case. While this is the beginning of the benefit, we are concerned by the low enrollment especially given the challenges other jurisdictions have faced in implementing the doula benefit.

As of November 2022, more than half of all states are either actively providing Medicaid coverage for doula care, in the process of implementing such coverage, or are taking some statewide action related or adjacent to Medicaid coverage for doula care.[29] Reimbursement rates for doulas providing care to Medicaid enrollees was overwhelmingly the biggest issue impacting enrollment in other jurisdictions.[30] Doulas from other jurisdictions also discussed restrictive training or certification requirements and a lack of support and guidance for navigating the process to become a Medicaid provider.[31] We do look forward to learning more about DC Health's certification program and how that may impact these other concerns including growing knowledge of the program and removing barriers to becoming a doula who can bill under Medicaid.[32]

We also look forward to learning about DHCF's collaboration with Managed Care Organizations (MCOs). Once doulas have completed the enrollment process with DHCF

and are given a NPI and Taxonomy number, they are then eligible to enroll with an MCO.[33] The MCO must provide the minimum reimbursement rates using the rates outlined below but can work with doulas to provide other incentives or higher rates.[34] We ask this Committee to explore how MCOs have been integrated into this process and how they have or could be more supportive.

We do know, however, that reimbursement rates are an issue. When the reimbursement rates were released and discussed in the MHAG many providers and doulas shared concerns that the current reimbursement rates would not incentivize doulas to enroll in Medicaid.[35] Medicaid coverage of doula services has the possibility of drastically increasing access.[36] However, to attract doulas to the program, the rates must be adequate to account for the time and services a doula is providing.

The current reimbursement rate for doula support at delivery is $686.23, a one-time initial perinatal doula support visit is $97.04 (always a 2-hour visit), perinatal and postpartum support at 15-minute increment is $12.13 (typically one-hour visits for a total of $48.52 per visit),[37] and doula incentive payment for obstetric postpartum visit 7 to 84 days after labor and delivery is $100.[38] Doula services include up to twelve (12) visits for a person who is pregnant or in the six (6) months after their pregnancy ends.[39] Doulas will be expected to use the initial visit with a beneficiary to develop a Care Plan for both the perinatal and postpartum periods.

The total for the initial visit, the delivery, and the postpartum visit incentive is $883.27. The total reimbursement for the other 11 visits that can be provided during the perinatal and postpartum visit can vary depending on the length of visit but if the doula spends one hour with the patient at each visit the total will be $533.72 for visit reimbursement. This means that on average doulas will receive a $1,416.99 reimbursement for services rendered. This number is subject to change and a doula may have longer visits that they reimburse for but likely a doula will not receive more than $2,000 per pregnancy. This is significantly lower than the out-of-pocket rates doulas can charge.[40] Typically, out-of-pocket costs for a doula to be present at a birth (no other appointments) is between $800 to $2,500.[41]

The District of Columbia can look at what is happening in other jurisdictions. After years of advocacy, the Oregon Health Authority announced it would be increasing its fee-for-service Medicaid reimbursement rate to $1500 per pregnancy.[42] This is one of the highest in the country. The fee covers payment for a minimum of two prenatal care visits, care during delivery and two required postpartum home visits.[43] While we support the number of visits under the District's doula benefit, a point strongly advocated for by the MHAG, we worry that the current reimbursement rate is not comparable. Doulas in the District would make only slightly more than Oregon doulas while having to do more visits.

A key lesson learned here, for states like Oregon implementing coverage, is the importance of an adequate reimbursement rate for achieving a successful benefit that can be utilized by Medicaid enrollees.[44] Doula care may indeed be a lifesaving tool for both mothers and babies, but they cannot do so if Medicaid enrollees are not actually able to access the benefit because there are not enough doulas available to provide the care due to inadequate rates.[45]

Investment in maternal health in the District must not only include physical health but also behavioral health

Across the nation, suicide is a leading cause of maternal mortality.[46] Addressing perinatal behavioral health will also begin to address the maternal mortality crisis. The recent investments in the doula benefit and extended postpartum care not only support pregnant and postpartum people's physical health but also their behavioral health. For example, retention of care for a longer period of time is vital for screening and treatment for physical and behavioral health issues like Perinatal Mood and Anxiety Disorders (PMADs).[47] Moreover, doulas can help with perinatal behavioral health like recognizing when a person may be experiencing a PMAD; have a conversation with new or expecting parents that appear to be struggling; and most importantly— refer a pregnant or postpartum person for support and treatment.[48] We, however, cannot stop here.

A recent evaluation of the vulnerability of mothers across the nation found that DC mothers had a "very high" vulnerability when it came to their behavioral health.[49] When compared to other states, DC ranked in the top 15 jurisdictions where mothers are

subject to poor behavioral health outcomes.[50] Further illustrating DC pregnant and postpartum people's struggle with behavioral health is a report by DCist and WAMU that came out little over a year ago. The report interviewed six women about their experiences of being pregnant and giving birth in the District. One woman shared, "a lot of Black women are not being listened to when it comes to their medical concerns whether it be physical or mental."[51] Another saying, "we are literally terrified of giving birth."[52] This is not the experience we want for DC's pregnant and postpartum residents.

We must look upstream at prevention and early intervention, real-time treatment and support, and out-of-box innovations. Currently, the approach is piecemeal and there is a clear need for a landscape analysis of available services to encompass the continuum of perinatal behavioral health care in the District. We appreciate Councilmember Henderson for recognizing this need during last budget season and working with Councilmember Allen to secure funding for the Perinatal Mental Health Task Force (Task Force).[53] We also appreciate Councilmember Henderson engaging with key stakeholders during the budget last year to ensure the Task Force is equipped to identify and meet the perinatal behavioral health needs of pregnant and postpartum people and their families in the District. Included in the Task Force responsibilities is a landscape analysis of perinatal behavioral health programs, treatments, and services which will include notable innovations and gaps in care and coordination and will help determine opportunities for advancement in services, partnerships, and local investments.[54] This is

an exciting opportunity to look not only at systems of care but other non-traditional innovations the District could be moving forward that support maternal health and perinatal behavioral health. For example, Strong Families, Strong Futures, the pilot program which targets new parents living in Wards 5, 7, and 8 and provides them with $900 in monthly cash assistance. Direct cash assistance programs have been shown to reduce both the stress of poverty and maternal behavioral health issues.[55] We are excited to have a cohesive, comprehensive report that captures these type of innovations as well as the many others that are happening across the District.

Importantly, the Task Force is giving attention to a topic that is widely overlooked. In a search for reporting on the state of perinatal behavioral health in the District there was little to be found.[56] The Task Force has a long list of other responsibilities aside from the landscape analysis that it hopes to complete in time to provide a report on October 1, 2023.[57] We want to note that the Task Force did not hold its first meeting until January 31, 2023.[58] We are concerned the timeframe may be too limited to complete a thorough, useful report that will inform recommendations to resolve inequities in perinatal behavioral health care access, coverage, and coordination. The Task Force is vital to ensure pregnant and postpartum people and their families have affirming and sustainable support for their behavioral health during the perinatal health period and beyond. We would appreciate the opportunity in partnership to consider how the Task Force may continue this work beyond the 10-month period.

Finally, stakeholder participation is critical to creating systemic reform. We are concerned that after the Task Force dissolves there will be no convening of stakeholders regularly with government officials to move forward solutions for maternal health in the District.[59] We hope in partnership we can find a solution that will continue to engage perinatal health professionals, health service organizations, affected community members, and the government and allow for collaboration to resolve inequities in maternal health.

Conclusion

Thank you for the opportunity to testify. I look forward to any questions.

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[1] Over a five-year period, 2014-2018, DC's maternal death rate was 23.1 deaths per 100,000 live births as compared to the US, the maternal mortality rate during those years was 20.7 per 100,000 live births. According to data from the United Health Foundation, in 2019 the maternal mortality rate in the District of Columbia was 35.6 per 100,000 live births as compared to a national rate of 29.6. Additionally, the five-year DC pregnancy-related mortality rate for 2014-2018 was 44.0 deaths per 100,000 live births. In the United States overall, the five-year pregnancy-related mortality rate during 2014-2018 was 28.4 deaths per 100,000 live births. *See* Maternal Mortality Review Committee, 2019-2020 Annual Report, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf. *See also* United States Government Accountability Office, Report to Congressional Addressees, *Maternal Health, Outcomes Worsened and Disparities Persisted During the Pandemic*, October 2022, *available at*: https://www.gao.gov/assets/gao-23-105871.pdf.

[2] United States Government Accountability Office, Report to Congressional Addressees, Maternal Health, Outcomes Worsened and Disparities Persisted During the Pandemic, October 2022, available at: https://www.gao.gov/assets/gao-23-105871.pdf. As a note, although we use the term women here and in other points in our testimony, we recognize that not everyone who carries a pregnancy is a woman, and we respect the diversity of all people who have given birth. However, much of the data we refer to utilizes the term women and we wish to stay to fidelity of the research and data collection. At points where it makes sense to utilize inclusive language, when we are more broadly discussing this population who people who can be pregnant, have been pregnant, or have recently given birth, we have chosen to

utilize the term pregnant and postpartum people to encompass those who do not identify as a woman but can and do become pregnant and give birth.

[3] United States Government Accountability Office, Report to Congressional Addressees, *Maternal Health, Outcomes Worsened and Disparities Persisted During the Pandemic*, October 2022, *available at*: https://www.gao.gov/assets/gao-23-105871.pdf. In terms of DC's racial disparities working off the 2019-2020 Maternal Mortality Review Committee report, found that while Non-Hispanic Black women made up 90% of the city's pregnancy-related deaths, white residents reported no pregnancy-related deaths, despite comprising 30% of all births in the city. Additionally, DC experienced geographic disparities amongst words with Wards 7 and 8 residents comprising 70% of pregnancy associated deaths, while residents of Wards 2 and 3 reported no pregnancy-associated deaths in the reporting period. *See* Maternal Mortality Review Committee, 2019-2020 Annual Report, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf

[4] Maternal Mortality Review Committee, 2019-2020 Annual Report, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf

[5] *Id.*

[6] *Fact Sheet: Maternal Mental Health: Black Women & Birthing People*, November 2021, *available at*: https://www.mmhla.org/wp-content/uploads/2021/11/Black-Women-Birthing-People.pdf. *Black Maternal Mental Health: The Challenges Facing Black Mothers,* UPMC, July 23, 2020, *available at*: https://share.upmc.com/2020/07/black-maternal-mental-health/#:~:text=Black%20mothers%20are%20much%20more%20likely%20than%20white,than%20double%20the%20rate%20for%20the%20general%20population.

[7] Taylor, J. and Gamble, C.M., Suffering in Silence: Mood Disorders Among Pregnant and Postpartum Women of Color, Center for American Progress, November 17, 2017, *available at*: https://www.americanprogress.org/wp-content/uploads/2017/11/MaternalMentalHealth-report1.pdf; Kozhimannil KB, Trinacty CM, Busch AB, Huskamp HA, Adams AS. Racial and ethnic disparities in postpartum depression care among low-income women. Psychiatr Serv. 2011 Jun;62(6):619-25. doi: 10.1176/ps.62.6.pss6206_0619. PMID: 21632730; PMCID: PMC3733216.

[8] Department of Health Care Finance, *Maternal Health Projects, available at*: https://dhcf.dc.gov/maternalhealthprojects#:~:text=The%20maternal%20health%20projects%20were%20in%20the%20following,transportation%20benefits%20to%20pregnant%20and%20postpartum%20Alliance%20beneficiaries.

[9] Department of Health Care Finance, Maternal Health Advisory Group and Related Stakeholder Outreach, December 17, 2021, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MDL-21-07-Maternal-Health-Advisory-Group.pdf.

[10] Department of Health Care Finance, Maternal Health Advisory Group and Related Stakeholder Outreach, December 17, 2021, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MDL-21-07-Maternal-Health-Advisory-Group.pdf. Maternal Health Advisory Group meetings can be review at Department of Health Care Finance, *Maternal Health Projects, available at*: https://dhcf.dc.gov/maternalhealthprojects#:~:text=The%20maternal%20health%20projects%20were%20in%20the%20following,transportation%20benefits%20to%20pregnant%20and%20postpartum%20Alliance%20beneficiaries.

[11] Department of Health Care Finance, DHCF Maternal Health Advisory Group Roster – 2022, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/List%20of%20Maternal%20Health%20Advisory%20Group%20Members%20012822.pdf.
[12] FY2023 DHCF Performance Oversight Responses, response to Q57, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AACOn8Enbisk7hSKkH1NjzFga/COH%20Performance%20Oversight/DHCF/Agency%20Responses?dl=0&subfolder_nav_tracking=1.
[13] *Id.*
[14] According to performance oversight responses, "DHCF does send occasional communications to the group for assistance in conducting outreach for participating in doula enrollment training and other DHCF requirements pertaining to doula training." FY2023 DHCF Performance Oversight Responses, response to Q57, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AACOn8Enbisk7hSKkH1NjzFga/COH%20Performance%20Oversight/DHCF/Agency%20Responses?dl=0&subfolder_nav_tracking=1.
[15] Department of Health Care Finance, Transmittal 22-39 – Repeal of Business License Certificate of Occupancy Requirement for Individual/Solo Doula Practitioners, December 22, 2022, *available at*: https://dhcf.dc.gov/node/1635886.
[16] Those registering doula groups as a DHCF provider are still subject to the requirement to have a Certificate of Occupancy or Business License. *See* Department of Health Care Finance, Transmittal 22-39 – Repeal of Business License Certificate of Occupancy Requirement for Individual/Solo Doula Practitioners, December 22, 2022, *available at*: https://dhcf.dc.gov/node/1635886.
[17] Grablick, C., *Black People Accounted For 90% Of Pregnancy-Related Deaths In D.C., Study Finds*, DCist, April 28, 2022, *available at*: https://dcist.com/story/22/04/28/dc-maternal-mortality-study-2022/.
[18] Safon, C.B., et al, Doula Care Saves Lives, Improves Equity, And Empowers Mothers. State Medicaid Programs Should Pay For It, Health Affairs, May 26, 2021, *available at*: https://www.healthaffairs.org/do/10.1377/forefront.20210525.295915/; Gruber KJ, Cupito SH, Dobson CF. Impact of doulas on healthy birth outcomes. J Perinat Educ. 2013 Winter;22(1):49-58. doi: 10.1891/1058-1243.22.1.49. PMID: 24381478; PMCID: PMC3647727.
[19] Sharon Muza, *The Doula Difference: Lowering Cesarean Rates*, DONA International, (March 28, 2017), *available at*: https://www.dona.org/cesarean-rates/#:~:text=Depending%20on%20the%20study%20or,)%20for%20full-term%20births; *See also* Guillermo Font et al., *Doula Programs Improve Cesarean Section Rate, Breastfeeding Initiation, Maternal and Perinatal Outcomes [11P],* Obstetrics & Gynecology, (April 26, 2020), *available at*: https://journals.lww.com/greenjournal/Abstract/2020/05001/Doula_Programs_Improve_Cesarean_Section_Rate,.602.aspx
[20] Gruber, Kenneth et al., *Impact of Doulas on Healthy Birth Outcomes*, The Journal of Perinatal Education, (Winter 2013), *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/; *See also* Guillermo Font et al., *Doula Programs Improve Cesarean Section Rate, Breastfeeding Initiation, Maternal and Perinatal Outcomes [11P],* Obstetrics & Gynecology, (April 26, 2020), *available at*: https://journals.lww.com/greenjournal/Abstract/2020/05001/Doula_Programs_Improve_Cesarean_Section_Rate,.602.aspx
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] Center for Health care Strategies, *Covering Doula Services Under Medicaid: Design and Implementation Considerations for Promoting Access and Health Equity,* December 2022, *available at*:

https://www.chcs.org/resource/covering-doula-services-under-medicaid-design-and-implementation-considerations-for-promoting-access-and-health-equity/.

[25] Notes on file with the Children's Law Center.

[26] Oregon continues to work closely with the Oregon Doulas' Association providing funding for a statewide needs assessment as well as the development of guidelines and protocols defining how hospitals can work with birth doulas. Minnesota also continues to discuss policy options with doulas. In Nebraska, the MCO conducted community focus groups to help staff decide what services to propose as value-added services but did not work directly with doulas or the agency that administers the foster care system. MCO staff cited this as one reason few doula services were being provided, thereby underscoring the need for active engagement of doulas in policy development. *See*, Platt, T. and Neva, K., *Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid*, National Academy for State Health Policy, July 13, 2020, *available at*: https://nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/. *See also* Center for Health care Strategies, *Covering Doula Services Under Medicaid: Design and Implementation Considerations for Promoting Access and Health Equity*, December 2022, *available at*: https://www.chcs.org/resource/covering-doula-services-under-medicaid-design-and-implementation-considerations-for-promoting-access-and-health-equity/.

[27] FY2023 DHCF Performance Oversight Responses, response to Q59, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AACOn8Enbisk7hSKkH1NjzFga/COH%20Performance%20Oversight/DHCF/Agency%20Responses?dl=0&subfolder_nav_tracking=1.

[28] *Id.*

[29] Chen, A., *Current State of Doula Medicaid Implementation Efforts in November 2022,* National Health Law Program, *available at*: https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/.

[30] *Id.*

[31] *Id.*

[32] DHCF has stated, "We expect knowledge of and interest in the program to increase with the start of the creation of doula certification through DC Health and after Certification and training standards are established by DC Health. " *See* FY2023 DHCF Performance Oversight Responses, response to Q59, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AACOn8Enbisk7hSKkH1NjzFga/COH%20Performance%20Oversight/DHCF/Agency%20Responses?dl=0&subfolder_nav_tracking=1.

[33] Department of Health Care Finance, Transmittal 22-34 – Doula Benefit, Provider Qualifications and Enrollment, Rates, and Reimbursement Standards, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf

[34] *Id.*

[35] Department of Health Care Finance, *Maternal Health Projects, available at*: https://dhcf.dc.gov/maternalhealthprojects#:~:text=The%20maternal%20health%20projects%20were%20in%20the%20following,transportation%20benefits%20to%20pregnant%20and%20postpartum%20Alliance%20beneficiaries.

[36] Prior to the SPA, Medicaid did not cover the costs associated with doula care making it inaccessible to many low-income District residents who rely on Medicaid for their health coverage. Hiring a doula was an out of-pocket expense for most Medicaid beneficiaries. With high fees the cost is prohibitive for most Medicaid beneficiaries. *See* Sharra E. Greer, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 28, 2022), *available at*:

https://childrenslawcenter.org/wp-content/uploads/2022/02/SGreer_Childrens-Law-Center-Testimony-for-Feb.-28-2022-DHCF-Oversight-Hearing_FINAL..pdf.

[37] In the transmittal for the Doula Benefit does not list out perinatal visit and only lists postpartum visit rate. However, at a MHAG presentation in August, DHCF shared a separate rate for perinatal and postpartum visits. *See* Department of Health Care Finance, Transmittal 22-34 – Doula Benefit, Provider Qualifications and Enrollment, Rates, and Reimbursement Standards, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf. *See also* Maternal Health Advisory Group, Department of Health Care Finance, *Doula Services Enrollment, Billing, and Training,* slide 17, August 8, 2022, *available at:* https://dhcf.dc.gov/sites/default/files/u23/Slides%20Maternal%20Health%20Advisory%20Group%20Enrollment%20and%20Billing%20Meeting%20080822.pdf.

[38] Department of Health Care Finance, Transmittal 22-34 – Doula Benefit, Provider Qualifications and Enrollment, Rates, and Reimbursement Standards, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf.

[39] Doula services are separated into two (2) periods: perinatal period (before, during, and up to six (6) weeks after delivery) and the doula postpartum period (beginning on the last day of pregnancy and extending through the end of the calendar month in which one hundred eighty (180) days after the end of the pregnancy falls). *See* Department of Health Care Finance, Transmittal 22-34 – Doula Benefit, Provider Qualifications and Enrollment, Rates, and Reimbursement Standards, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf.

[40] Maternal Health Advisory Group, Department of Health Care Finance, *Doula Services Enrollment, Billing, and Training,* slide 17, August 8, 2022, *available at:* https://dhcf.dc.gov/sites/default/files/u23/Slides%20Maternal%20Health%20Advisory%20Group%20Enrollment%20and%20Billing%20Meeting%20080822.pdf.

[41] Weiss, R.E., *The Cost of Hiring a Doula for Your Pregnancy,* November 28, 2022, *available at*: https://www.verywellfamily.com/how-much-does-a-doula-cost-4123633; Masters, M., *What is a Doula and Should You Hire One for Your Baby's Birth?,* April 19, 2022, *available at*: https://www.whattoexpect.com/pregnancy/hiring-doula.

[42] Chen, A., *Current State of Doula Medicaid Implementation Efforts in November 2022,* National Health Law Program, *available at*: https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/; Guarnizo, T. and Clark, M., *Doula Services in Medicaid: Pathways and Payment Rates (Part 3 in a series),* Georgetown University Healthy Policy Institute Center for Children and Families, October 6, 2022, *available at*: https://ccf.georgetown.edu/2022/10/06/doula-services-in-medicaid-pathways-and-payment-rates/.

[43] Oregon Health Authority, Notice of intent – OHA will amend the Medicaid State Plan to increase fee-for-service reimbursement for doula services, June 8, 2022, *available* at: https://www.oregon.gov/oha/HSD/OHP/Announcements/Doula-Rates0622.pdf.

[44] Guarnizo, T. and Clark, M., *Doula Services in Medicaid: Pathways and Payment Rates (Part 3 in a series),* Georgetown University Healthy Policy Institute Center for Children and Families, October 6, 2022, *available at*: https://ccf.georgetown.edu/2022/10/06/doula-services-in-medicaid-pathways-and-payment-rates/.

[45] *Id.*

[46] Chin K, Wendt A, Bennett IM, Bhat A. Suicide and Maternal Mortality. Curr Psychiatry Rep. 2022 Apr;24(4):239-275. doi: 10.1007/s11920-022-01334-3. Epub 2022 Apr 2. PMID: 35366195; PMCID: PMC8976222. 20/20 Mom, Maternal Suicide, *available at*: https://www.2020mom.org/maternal-suicide.

[47] In 2019, 12.3% of postpartum people with a recent live birth reported experiencing depressive symptoms. When perinatal mood disorders are left undiagnosed or untreated, the results can be deadly. Suicide is a leading cause of maternal death for women with postpartum depression. Therefore, being able to access screening and treatment through extended coverage can have positive impact on postpartum people. These services have been shown to lead to a decrease in suicidal rates amongst postpartum people. *See* America's Health Rankings, Health of Women and Children, *available at*: https://www.americashealthrankings.org/learn/reports/2021-health-of-women-and-children/state-summaries-district-of-columbia; See also Jamila Taylor, et al., *Suffering in Silence*, Center for American Progress, November 17, 2017, available at: https://www.americanprogress.org/article/suffering-in-silence/.

[48] Bellenbaum, P., *The Important Role Doulas Play in Recognizing Perinatal Mood and Anxiety Disorcers,* Every Mother Counts, September 24, 2018, *available at*: https://everymothercounts.org/on-the-front-lines/the-important-role-doulas-play-in-recognizing-perinatal-mood-and-anxiety-disorders/#:~:text=Doulas%20need%20the%20basic%20skills%20to%20do%20the,professional%20mental%20health%20provider%20to%20recognize%20a%20PMAD; *Doulas & Recognizing PMADs,* The Motherhood Center of New York, *available at*: https://www.themotherhoodcenter.com/blogindex/2018/10/2/the-important-role-doulas-play-in-recognizing-perinatal-mood-and-anxiety-disordersnbsp.

[49] *Maternal vulnerability in the US – A Shameful problem for one of the world's wealthiest countries,* Surgo Ventures, *available at*: https://mvi.surgoventures.org/.

[50] The other states with maternal vulnerability in mental health and substance abuse include Pennsylvania, West Virginia, Kentucky, Indiana, Missouri, Tennessee, Louisiana, Mississippi, Alabama, South Carolina, and Florida. *See Maternal vulnerability in the US – A Shameful problem for one of the world's wealthiest countries,* Surgo Ventures, *available at*: https://mvi.surgoventures.org/.

[51] Dwyer, D. and Barthel, M., *'We Are Literally Terrified Of Giving Birth': The Road To Motherhood Is Different For Black Women Around D.C.*, DCist, October 20, 2021, *available at*: https://dcist.com/story/21/10/20/black-mothers-dc-motherhood-birthing-health-disparities/.

[52] *Id.*

[53] Office of the Budget Director, *Certification of the Report and Recommendations of the Committee on Health on the Fiscal Year 2023 Budget and Financial Plan for Agencies Under Its Purview* (April 29, 2022), *available at*: https://lims.dccouncil.gov/downloads/LIMS/49081/Committee_Report/B24-0716-Committee_Report5.pdf; B24-0716 - Fiscal Year 2023 Local Budget Act of 2022.

[54] § 7-1234.02(Perm), Perinatal Mental Health Task Force, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Establishment%20Legislation%20%281%29.pdf.

[55] Floyd, I.F., *Cash Supports Should be Integrated into the Maternal-Infant Health Policy Agenda,* GBPI, August 29, 2023, *available at*: https://gbpi.org/cash-supports-should-be-integrated-into-the-maternal-infant-health-policy-agenda/; Duong Le, T, *Maternal depression and anxiety exacerbate hardships – How to help the mothers in your life,* Children's Health Watch, August 11, 2022, *available at*: https://childrenshealthwatch.org/maternal-depression-and-anxiety-exacerbate-hardships-how-to-help-the-mothers-in-your-life/.

[56] For example, the DC Health Needs Assessment report recommends that "in order to ensure women in the District have an equitable opportunity to access mental health resources, DC Health must be mindful

of funding services that diversify the workforce as well as placement of services." *See* DC Health, *Five-Year Maternal and Child Health Needs Assessment Summary 2021-2025*, September 2020, *available at*: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/MCH%20Five%20Year%20Needs%20Assessment%20Summary%202020_FINAL.pdf. However, the Needs Assessment does not provide any sort of meaningful data or explanation of the landscape of perinatal mental in the District. The Needs Assessment provides this short paragraph in regard to maternal mental health, "The mental health of women emerged as an important finding as women often prioritize the needs of their family before their own. According to 2018 BRFSS data, 13% of women in the District reported experiencing 14 days or more of their mental health not being good compared to 12.1% of men." This egregiously limited as well as a biased data point. *Id.* There has been no publicized follow-up on this Needs Assessment to check progress or amend. Through the Task Force there is an opportunity to connect with those who are collecting the data like hospitals, Managed Care Organizations, and community-based providers and to begin to compile a greater understanding of the gaps and need for perinatal mental services in the District like the Needs Assessment suggests. Understanding if, and when mothers are being screened and treated for maternal mental health disorders, for example, are critical data points for ensuring mothers get the timely and appropriate care they need. *See* Britt, R., and Burkhard, J., *U.S. Maternal Depression Screening Rates Released for the First Time Through HEDIS*, November 14, 2022, *available at:* https://www.2020mom.org/blog/2022/11/14/us-maternal-depression-screening-rates-released-for-the-first-time-through-hedis.

[57] § 7-1234.02(Perm), Perinatal Mental Health Task Force; B24-0964 - Perinatal Mental Health Task Force Temporary Amendment Act of 2022.

[58] Department of Health Care Finance, Perinatal Mental Health Task Force, *available at*: https://dhcf.dc.gov/publication/perinatal-mental-health-task-force.

[59] There are so many great resources and happenings going on in the District and across the nation, it is very difficult to find a central touchpoint for all this information. Therefore, having regular convenings means more information sharing and more solution making. We appreciate organizations like Mind the Gap who share extremely relevant and useful information relating to maternal health and found their work through collation with partners. We have linked several of their newsletters that provide excellent resources for policymakers as well as research that supports the need for greater attention and investment in many aspects of maternal health. Mind the Gap Newsletter, February 2023, *available at*: https://myemail.constantcontact.com/Mind-the-Gap-Monthly--February-2023-.html?soid=1131354207938&aid=25FGGOfikxE; Mind the Gap Newsletter, December 2022, *available at*: https://myemail.constantcontact.com/Mind-the-Gap-Monthly--December-2022--.html?soid=1131354207938&aid=_ILSftmqgf8; Mind the Gap Newsletter, November 2022, *available at*: https://myemail.constantcontact.com/Mind-the-Gap-Monthly--November-2022--.html?soid=1131354207938&aid=BLSeHbnKpGw; Mind the Gap Newsletter, October 2022, *available at*: https://myemail.constantcontact.com/Mind-the-Gap-Monthly--October-2022--.html?soid=1131354207938&aid=-85KTfIGMko; and Mind the Gap Newsletter, September 2022, *available at*: https://myemail.constantcontact.com/Mind-the-Gap-Monthly--September-2022--.html?soid=1131354207938&aid=gdDsZMz2dzE.