Andrea Williams-Muhammad, Co-Chair
443-452-7283
andnic.williams@gmail.com

Ashley Black, Esq., Co-Chair
410-625-9409, ext. 224
blacka@publicjustice.org

SB 163
Maryland Medical Assistance Program – Doulas
Hearing of the Senate Finance Committee
January 26, 2021
1:00 PM

LETTER OF INFORMATION

The Reproductive Health Equity Alliance of Maryland is a cohort of community-based birth workers, policy and legal advocates, and organizations focusing on reproductive justice, pregnancy and infant health. We aim to reduce pregnancy and infant health disparities in Maryland's Black, Brown and immigrant communities by advocating for evidence-based legislative and policy solutions that expand access to quality reproductive, pregnancy and infant health options designed to build healthy and stable families of color. Among our advocacy priorities is expanding access to community-based doulas for low-income families and people of color in Maryland. We submit this Letter of Information regarding SB 163 which would require the Maryland Medical Assistance Program to cover doula services and defines "certified doula."

During the 2020 Maryland General Assembly, Delegates Wilkins and Smith and Senator Lam introduced HB 1076/SB 914, which RHEAM strongly supported. This legislation sought to establish a doula technical assistance advisory group to study and make recommendations on the certification and reimbursement of doulas. Due to the COVID-induced, abrupt end of session, Chairs Pendergrass and Kelley sent a letter to the Maryland Department of Health (MDH) asking that they convene the group without the need for legislation. Over the past months, we have helped to identify stakeholders to sit on the technical assistance advisory group, and we are happy to report that the group had its first meeting on January 12th. Based on the guidelines outlined in the Chairs' letters to MDH, RHEAM is hopeful that MDH will be able to submit a report with policy recommendations which will move the state closer to the ultimate goal of creating an equitable reimbursement system for doulas in Maryland.

There is a significant distinction between the traditional doula model and community-based doula model. The Fiscal Note for SB 110, which was introduced during the 2020 session and is identical to SB163, indicates that the state would implement a traditional doula care model for Medicaid reimbursement. Traditional doulas, by practice, may interact only with a birthing person 1-2 times prior to the birth and attend the birth. Under this model, postpartum visits are typically provided by the doula for an additional fee. Little to no support is given for other aspects of the birthing person's life experience. Therefore, the traditional doula model does not address social determinants of health, which have been documented to have a significant impact on maternal health and positive birth outcomes. By contrast, community-based doulas provide intensive, 24/7 care to clients during

pregnancy, birth, and postpartum. Research supports that the community-based doula model has positive impact on birth outcomes and reduces maternal/infant mortality and morbidity. This type of care also has the potential to reduce racial disparities between Black and Brown birthing persons.

There are numerous doula certification programs with varying curriculums. SB 163 defines a "certified doula" as one who has received certification from The Doulas of North America, The International Childbirth Education Association, The Association of Labor Assistants and Childbirth Educators, or The Childbirth and Postpartum Professional Association. There is no one national doula certification program, and therefore, the curriculums among the existing programs vary greatly. Additionally, some programs include education on cultural competency and racial and implicit bias, while others do not. In particular, the cultural competency training within the organizations listed in SB 163 do not speak specifically to implicit bias. There are also doulas in Maryland that provide local doula training programs designed to train doulas on the unique needs of pregnant individuals in Maryland, but SB 163 does not account for these existing local trainings.

The cost of doula certification programs vary and is a barrier for low-income doulas. The costs associated with doula certification programs vary greatly and can range from $700 to $1,000. Our coalition has reached out to doulas providing care in Maryland, and we have found that many doulas are not certified and would not be eligible for reimbursement under the structure proposed by SB 163. Some doulas choose not to obtain certification due to the financial barriers but may have more experience providing doula care than a doula that has obtained certification.

Number of active doulas in Maryland. Based on our research on doula care in Maryland, the Fiscal Note for SB 110, the identical bill introduced last year, underestimated the number of active doulas practicing in the state. There currently is no Maryland registry for doulas. Doulas may work individually or as part of a collective or organization. In Maryland, there are community-based birth workers who provide doula care but identify as "perinatal community health workers." It is unclear from the fiscal note whether individuals who provide doula care, but do not use the traditional title of "doula" are included in the Fiscal Note's estimate. It is also unclear whether doulas who work individually are included in the estimate. Underestimating the number of doulas who would be eligible for Medical Assistance reimbursement greatly impacts the potential cost for SB 163.

Racial inequity in New York's doula Medicaid reimbursement rollout. SB 163 is modeled after New York's doula Medicaid legislation, which created a pilot program for specific counties, including Erie, Kings, and Onondaga counties. The pilot allows for up to 4 prenatal visits ($30 per visit), intrapartum care ($360) and 4 postpartum visits ($30 per visit) for a total of $600 for all services rendered by the doula.[1] The rate in New York is not a livable wage for community-based doulas. Further, low reimbursement rate is the most cited reason for lack of participation of doulas in states with doula Medicaid reimbursement. These rates do not account for the level of intensive services that community-based doulas provide and the amount of time that they spend with clients. In their report on New York's doula Medicaid pilot program, Bey et. al. write "the amount of time doulas spend with clients and performing unbillable responsibilities, as well as their expenses and unpredictable work hours must be taken into consideration when setting reimbursement amounts, if Medicaid doula coverage is to succeed."[2]

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[1] Bey et. al, Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities (2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

[2] *Id.*

Studying the doula landscape in Maryland is essential to determining how the state can design an equitable system for doula Medicaid reimbursement to ensure that pregnant individuals who are the most at risk for adverse birth outcomes are provided access to doulas. We appreciate the opportunity to submit this Letter of Information on SB 163 and look forward to working with the legislature to best determine how to expand access to doula care in Maryland. Please do not hesitate to contact Andrea Williams-Muhammad at 443-452-7283 or andnic.williams@gmail.com or Ashley Black at 410-625-9409, ext. 224 or blacka@publicjustice.org if you have any questions about this Letter of Information.