Testimony submitted via email.

Dear House Legislators,

Thank you for hearing my voice on HB 2015 as I have a level of knowledge on it beyond most of your constituents.

I have been involved for five years working to implement the doula services that you approved for the Medicaid population. I have been a DONA International Birth Doula Trainer for 22 years, participated on the original THW Steering Committee through public comment, sat in on RAC's, been on the THW Commission Systems Integration Subcommittee for three years, and I am on the board of the Oregon Doula Association, who is giving the state technical assistance and support. I have heavily invested my personal time and effort into establishing these doula services yet have confronted so many roadblocks it feels like trying to turn the Titanic.

Doula Services for medical assistant recipients have been a covered service since Jan 2014. To this date, providing these doula services, especially those identified with maternity care disparities, has not come to fruition, except to reimburse Providence for staff doulas providing only intrapartum care.

There are several reasons for this. One is that these services require a workforce of state registered doulas, and as of today, there are only 33 on the registry. Serving the at risk communities with culturally matched doulas has been even more of a challenge. A tremendous barrier to this has been the low reimbursement set for services, especially the intrapartum care amount of $75, which is not sustainable for the majority of doulas who wish to serve the OHP population. The assumption that doulas could make up for the low reimbursement from private pay clients, like other care providers can, is not realistic, as private insurance does not pay for doula services yet, and the market for private pay clients is low, especially within the very marginalized communities this program targets.

HB 2015 is a step in the right direction, by increasing the labor and birth care to $159 from $75. However, setting the global fee at $350 to cover that, plus the two prenatal and two postpartum home visits does so at the cost of reducing a doula's prenatal contact with her client, as prior to this bill, four prenatal home visits were recommended in the care model because of the high risk population's special needs. An investment in the prenatal component of doula care has the greatest effect on birth outcomes, as several successful programs highlighted in the final report for HB3311(Feb 2012) illustrated. This allows for adequate time to establish the therapeutic relationship that is at the core of doula care, a greater challenge with the marginalized groups the program prioritizes. It also permits time for addressing culturally specific issues, identifying client's birth needs, addressing their concerns and fears, utilizing prevention and education modalities, teaching stress relief and coping strategies, and providing empowerment support. I am strongly urging a readjustment to the bill to reinstate the two additional prenatal visits. This would set the baseline as follows:

4 prenatal visits @ $42.89 each = $172

Labor and Birth Care= $159

2 postpartum visits @ $42.89= $86

$417

A birth doula will spend, on the average, 25-30 hours per client, plus will incur business and travel expenses and taxes. Additionally, a standard of practice in our profession is to provide a back-up doula should the primary doula be unable to attend the birth due to illness, presence at another birth, or family emergency. Needing to compensate a back-up doula, thus ensuring continuity of care, was never considered in the earlier rule making process. The $75 amount would cover the cost of the backup doula meeting the clients at least once at a prenatal visit and being on call for weeks at a time. Because OAR 410-130-0015 states in section (6)(e) *only one additional payment shall be made for doula services regardless of the number of doulas providing the service,* it would be most effective to bill for and pay the total amount for doula services to the doula that attends the birth, who can then distribute the $75 payment to the back-up doula.Thus, the total billing for doula services would be $492. The cost savings by providing sufficient doula care had been documented in several bodies of research.

The second major reason for failure to serve clients is that there is lack of clarity and communication regarding the obligation for care providers, payers, and CCO's to establish doula services, especially to all of the prioritized groups. Some that do know about it believe it to be a choice. OHP clients have been asking for services and not receiving them even though state certified doulas are in their areas. Two CCO's and one payer are the only ones presently actively engaged in establishing programs. CCO representatives have, for the most part, either ignored requests to come to the table, failed to follow up as promised, or as providers at one CCO did, simply declined to pay for doula services out of the medical budget because they feel their reimbursement rates are already at an unsatisfactory rate. In light of this I am asking that stronger language regarding the health care system's obligation to provide doula services be added to the section in the amendments requiring reporting on doula services, AND if needed, additional funding made available in the maternity care global budgets.

Another issue is the unavailability of a point person within OHA/OEI who can fully and accurately answer queries for those providers and payers that are interested in providing the doula services to their members. There has been a lot of turnover there. Ideally, this person would work in concert with the THW Commission in developing a strategic plan, especially the dissemination of information, that focuses on the above mentioned barriers and other ongoing issues getting in the way of implementing the law.

Thank you for your consideration in addressing my concerns. Feel free to contact me at this email, debcatlin@aol.com or by phone at 541-912-1864.

Debra Catlin