



*Testimony before the Human Services Committee
Kathleen Brennan, Deputy Commissioner
March 21, 2019*

Good morning, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathleen Brennan, and I am the Deputy Commissioner of the Department of Social Services (DSS).

I am pleased to appear before you today to offer remarks on two of the bills on today's agenda.

SB 1078 - AN ACT CONCERNING DOULA CERTIFICATION AND MEDICAID REIMBURSEMENT FOR DOULA SERVICES

The Department of Social Services (DSS) strongly supports the intent of this bill. We do have some technical concerns as the Medicaid agency about navigating federal requirements, and suggestions for language changes, as covered below. But, overall, we applaud and share the commitment of the bill's proponents to improving birth outcomes for mothers and babies.

First, a quick mention of how Connecticut is addressing the maternal health of our Medicaid members. DSS has taken steps to improve maternal and neonatal outcomes, including the pay-for-performance program for obstetrical providers (obstetricians and certified nurse-midwives). This program incentivizes early and frequent prenatal care, natural births without unnecessary medical intervention, and on-time post-partum care. We are further developing a maternal outcomes program that will address each of the frequent causes of adverse maternal outcomes – eclampsia and pre-eclampsia, hypertension, vascular occlusion and maternal substance use.

Consistent with these aims and should this initiative go forward as legislation, DSS must seek approval of a State Plan Amendment (SPA) from the Centers for Medicare and Medicaid Services to gain federal financial participation.

In order for DSS to submit a request for a SPA to approve Medicaid payments for doula services, several issues must be addressed:

- As the state Medicaid agency, federal requirements mandate that DSS ensure that services under the Medicaid program are of high quality and are medically necessary.
- The Department must be able to determine and to tell CMS exactly who is a qualified doula.
- The SPA must demonstrate that the state has procedures to ensure that providers of doula services have met objective criteria and standards for training and experience.
- The SPA must also delineate a doula's scope of practice, i.e., the specific services doulas are authorized to provide.

Consistent with those expectations and requirements, the Department strongly recommends that an entity representing doulas submit a scope of practice request to the Department of Public Health (set forth in Connecticut General Statutes, sections 19a-16d through 19a-16f). The scope of practice process provides professions seeking to establish a scope of practice a mechanism to work with the Department of Public Health, and other interested parties, to review and evaluate the request and provide a comprehensive report to the Legislature. The scope of practice process includes an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

There are some important caveats. First, we are aware of only two states that have received CMS state plan approval for doula services (Minnesota and Oregon). Our understanding is that other states which do reimburse for doula services do so through managed care or other waivers. Although this limited experience in other states can help inform our analysis in Connecticut, we must still be prepared to undergo extensive CMS scrutiny of our proposal if and when that time comes, hence the importance of preparing our proposal thoughtfully and collaboratively.

Second, a large percentage of the services provided by doulas are at least in part educational in nature – training mothers and families to be best prepared for the birthing process and beyond. While these services are laudable and valuable, they can only be reimbursable under Medicaid if CMS determines that they fall within the federal definition of “medical assistance.”

Several details of the current language are problematic, including an unprecedented and excessive level of detail regarding coverage and payment for a Medicaid service. This level of detail, especially specific payment ranges and mandated sub-components of coverage, is inappropriate because it would undermine DSS’s ability to administer the Medicaid program by removing necessary flexibility to adapt to changing clinical standards, comply with federal requirements, and account for other unique circumstances.

DSS must retain the flexibility to ensure that all covered services are clinically appropriate and comply with state and federal requirements. That flexibility is especially important in this context because not all the specific services described in this section are coverable under federal Medicaid requirements (such as administrative tasks). Moreover, because this coverage would be for a certified provider type, DSS would need to be able to ensure compliance with very specific federal Medicaid requirements under the preventive services benefit category.

DSS also needs the flexibility to calculate appropriate payment rates to comply with federal requirements that all Medicaid payment rates must be economic and efficient, as well as to be careful stewards of the state funding appropriated in the state budget adopted by the General Assembly. It is not appropriate to codify any specific level of payment in statute. It is also unnecessary to do so because federal requirements already mandate that the state ensure that payment levels are sufficient to achieve comparable access to services as for the general population.

Finally, there are a number of additional steps that need to happen before adding coverage for any new service in Medicaid. These include performing a fiscal analysis to determine the impact on the state’s budget, developing an appropriate rate and finding appropriate billing code(s), making

operational changes to the Department’s payment systems, and developing necessary guidance and requirements for providers.

For these reasons, DSS is unable to support this bill in its current form. However, we strongly encourage and support further study of how doula services for Medicaid members could potentially be part of our ongoing efforts to improve maternal and neonatal outcomes.

In that spirit, if this bill moves forward, we provide additional comments on specific sections of the legislation, which appear below.

Section 1: The bill needs to clearly define who is a doula, who is not a doula, and what a doula would be authorized to do (and not authorized to do). The current definitions are too vague to be able to establish clear professional standards.

Section 2: This section is vague and not rigorous enough to ensure certified doulas would be qualified to provide services to receive Medicaid payment. First, the standards should be more rigorous, clear, and detailed. Second, as in some other licensing statutes, this language could include certification (including verification of certification) by a recognized professional association approved by DPH with rigorous standards as a precondition for state certification. As currently written, any “state, national or international doula certification organization” is too vague and does not include criteria for DPH to evaluate if a specific association has appropriate standards and certification procedures. The current language allowing an individual simply to attest that the requirements were met should be removed, so that every individual seeking certification would need to receive external verification that the requirements are met. Finally, this section should add appropriate requirements for ongoing training after initial certification.

Section 8: As described above, DSS is unable to support adding Medicaid coverage for doula services at this time until more analysis is done regarding a doula’s role in addressing maternal and neonatal birth outcomes. Specific language mandating coverage is unnecessary because DSS is already authorized to add appropriate coverage for appropriate services that are not required to be covered by federal Medicaid requirements. The current language would require DSS to add coverage for services provided by doulas without any criteria for DSS to ensure that the type and extent of coverage was clinically appropriate, would likely lead to improved outcomes, and be cost-effective for the state.

SB 1080 - AN ACT CONCERNING A TWO-GENERATIONAL INITIATIVE

This bill would include the Department of Social Services on a newly created Two-Generational Family Economic Success Cabinet. This bill removes the Department from the existing Two-Generational Advisory Council.

The Department recognizes the importance of supporting two-generational efforts that assist families with reaching their full potential and has worked to integrate the two-generational model into program delivery as an effective way to increase the overall security and quality of life for families, children and communities.

To this end, the Department appreciates the opportunity to continue supporting these efforts.