

effectively use new resources and increase attention to the prevention of addiction at both the clinical and community levels. *AJPH*

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Both authors conceptualized the content of the article and contributed to the writing of the initial draft and revisions.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State

On April 23, 2018, Governor Andrew M. Cuomo (D-NY) announced a comprehensive initiative to address maternal mortality and racial disparities in health outcomes. Alarming, the maternal mortality rate (number of maternal deaths per 100 000 live births) in New York State has increased by 44.5% from 17.3 in 2006 to 25.0 in 2015.¹ New York State is unlikely to meet its Prevention Agenda 2013–2018 goal of reducing the maternal mortality rate to 21.0 by the end of this year.² The national *Healthy People 2020* target is 11.4.³

Black women in New York State experience maternal mortality at a rate almost four times that of White women.⁴ Chronic health conditions such as hypertension and diabetes may increase risk of pregnancy complications.⁵ These health conditions are more common among Black women with pregnancy-related deaths.⁴

Governor Cuomo’s plan includes increasing access to prenatal and perinatal care through a pilot expansion of Medicaid coverage for doulas. Doulas

are trained, nonmedical birth coaches who provide continuous physical, emotional, and informational support before, during, and after childbirth. Given improved labor and delivery outcomes associated with doula services,⁶ the American College of Obstetricians and Gynecologists recommends integrating support personnel such as doulas into existing obstetric care teams.⁷

Two states expanded Medicaid coverage for doula services: Oregon and Minnesota. On the basis of lessons learned from these states and our own ongoing evaluation of a Merck for Mothers–funded community health worker (CHW) program for pregnant and postpartum women with chronic health conditions in New York City that included doula services, we offer the following recommendations to increase the pilot program’s likelihood of success: (1) provide sufficient reimbursement to doulas and an adequate number of visits for mothers, (2) fund the training and certification of a diverse doula workforce, and (3) expand the role of doulas.

SUFFICIENT REIMBURSEMENT AND NUMBER OF VISITS

Although Oregon and Minnesota pioneered the expansion of Medicaid coverage for doula services, relatively low reimbursement rates and coverage for a limited number of visits may hinder the sustainability of the doula workforce and effectiveness of the programs (Table 1). Oregon reimburses doulas \$350 per mother for four maternity support visits and the day of delivery.⁸ Minnesota reimburses doulas \$411 per mother for seven visits, one of which is for labor and delivery.^{9,10} Uptake has been minimal because reimbursement rates are below the cost for doulas to provide services.¹¹ Furthermore, this level

of reimbursement is not financially viable for low-income doulas.¹⁰

Fees for out-of-pocket doula services in New York City can range from \$400 to more than \$2000 based on the doula’s experience.¹² The high cost of these services may be a barrier for women who are most likely to benefit from having a doula. Black and publicly insured women are almost twice as likely as White and privately insured women, respectively, to report desiring but not having access to doula support.¹³

We recommend reimbursing doulas for services provided up to \$1000 per mother because of the higher cost of living in New York State and accounting for additional expenditures related to home-based support such as mileage.¹⁰ Cost-effectiveness analyses indicate that doula reimbursement at an average of \$986 would be offset by health care savings related to lower rates of preterm births (births before 37 weeks of gestation) and cesarean

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TABLE 1—Current and Recommended Doula Services: 2018

	Current Doula Services Covered by Medicaid		Recommended Doula Services Covered by Medicaid for New York State
	Oregon	Minnesota	
Reimbursement rate	\$350	\$411	Up to \$1000
Total number of visits	5	7	8
Timing of visits	2 visits before delivery Day of delivery 2 visits after delivery	6 visits across perinatal period Day of delivery	7 visits across perinatal period Day of delivery
Additional visits by authorization	No	Yes	Yes

sections.¹⁴ In addition, there is a potential reduction of unnecessary emergency department or hospital visits for women who use doula services.¹⁰

Our ongoing evaluation of the Merck for Mothers program in New York City indicates that there is an average of eight interactions per woman. These women are more likely to attend medical appointments and adhere to medication regimens with CHW or doula support. To provide sufficient care coordination to prevent and manage chronic diseases, we recommend that the state's Medicaid expansion cover at least eight visits across the perinatal period with the option for additional reimbursed visits.

FUNDS TO TRAIN AND CERTIFY DIVERSE WORKFORCE

Historically, doulas have primarily been White, well-educated, married women with children.¹⁵ Yet doulas provide support that low-income, racially diverse women need to have healthy pregnancies.¹⁰ Our interviews with various stakeholders in New York City indicate that strengths of having staff that reflect the diversity of the community include, “women connect with you in a real way, because you're either from their country or you speak their

language, or you just look like them.” By having multilingual doulas, pregnant women's barriers to care can be overcome, and interactions between women and health care and social service professionals can be improved.

On the basis of our findings and the implementation of Medicaid reimbursement for doulas in Minnesota,¹⁰ we recommend that New York State provide funds for training doulas in communities of color and low-income communities and for doula certification for low-income women.

EXPAND THE ROLE OF DOULAS

Throughout the country, CHW initiatives have been successfully implemented to address myriad health conditions.¹⁶ The CHWs are trusted members of the community who bridge the divide between health and social services and the communities they serve. Through outreach, health education, and advocacy, they improve health knowledge and self-sufficiency of individuals. The CHWs we interviewed noted that women have a multitude of social and medical needs and “extra support is needed.” Therefore, we recommend expanding the role of doulas, by training them to perform the functions of CHWs so that

pregnant women may also benefit from better navigation of health care and social services systems, as well as long-term support to address ongoing financial, housing, and transportation needs, and guidance to initiate and maintain healthy behaviors. The scope of practice, competencies, and training and certification of CHWs in New York State require standardization¹⁷; thus, doulas would take on the evolving role of CHWs. Our recommended reimbursement rate accounts for this expanded role.

PRIORITIZING PREVENTION TO REDUCE DISPARITIES

While it is important to fund provision of doula services, particularly for women at high risk for poor pregnancy outcomes, it is also essential to fund programs that prevent comorbid conditions. Chronic health conditions affect a growing number of pregnant women in the United States, resulting in higher health care costs and poorer pregnancy outcomes.^{5,18} Therefore, we also recommend increasing access to pre- and interconception care to identify and address maternal health risks to optimize pregnancy outcomes.

Increasing maternal mortality rates are a national trend.¹⁹ Thus,

other states should also consider expanding Medicaid coverage for doula services. New York State could assist in establishing best practices for this expansion by effectively implementing recommended standards and practices²⁰ and rigorously evaluating its pilot program. In particular, research is needed to determine which reimbursement mechanism best incentivizes quality of care.

Despite the highest health spending per capita, the United States has the worst maternal and child outcomes among high-income countries.²¹ Causes of adverse outcomes and persistent racial and ethnic health disparities across the perinatal period are multifactorial. Appropriately reimbursing, funding training and certification of a diversity of women to serve as, and expanding the role of doulas will improve outcomes, particularly for high-risk women. Provision of doula services, in conjunction with routine prenatal care, is a cost-effective solution to reduce disparities and meet the triple aim (better care, improved outcomes, and lower cost) in maternal health.²² **AJPH**

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HUMAN PARTICIPANT PROTECTION

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Vaccine Trials in Schools: We Must Not Ignore Progress

The article by Schupmann¹ and the accompanying editorial by Baker² accurately describe three vaccine trials carried out in schools during the 20th century and provide a context for their procedures and practices, which are not presently considered acceptable. However, they inadequately contextualize the situations,³ seem biased toward presentism (typically defined as an attitude toward the past dominated by present-day values and experiences), and insufficiently acknowledge the continuing evolution of efforts to provide protection to participants in clinical trials.

Schupmann seems to hold an exclusively negative view of peer-to-peer influences; that is, he treats them as if they are only unduly persuasive. He does not entertain the notion that they might offer a different context—even if there are inherent pressures or influences—for discourse, deliberation, and dialogue about these complex and socially important decisions.

The starting point for the three cases was not moral neutrality. These diseases all deserved efforts to control them and prevent them, and therefore it must be conceded that each of the efforts was ethically

warranted in a fundamental way. That point somehow seems to get submerged.

NEWER CHALLENGES

We have come a long way from the research situations they describe. Neither author described the “ideal” situation for clinical trials. Some research challenges may be impossible to avoid. For example, if people

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