

MEDICAID APPROACHES TO ADDRESSING MATERNAL MORTALITY IN THE DISTRICT OF COLUMBIA

TARA WILSON\*

“...government still has an obligation to act. Just as we can’t be just a little pregnant. You either are or you are not. You cannot be a little misogynistic and racist. This is not about intentions. Lack of action is ‘unintentionally’ killing us.”<sup>1</sup> Representative, Black Mamas Matter Alliance

ABSTRACT

Maternal mortality in Washington, DC, has reached crisis levels. In a country that boasts the highest maternal mortality rate (MMR) in the developed world, DC’s MMR is double the national MMR. The closure of obstetrics units in areas of concentrated poverty has made the problem particularly acute in low-income DC communities, and most low-income residents in DC are black. This paper aims to present changes in Medicaid policy that DC City Council may take to prevent further reductions to access to obstetric care and to promote healthy pregnancies. In Part II, this paper will address contributing factors to DC’s maternal health crisis, and in Part III, the paper will argue for: (1) increased base payment reimbursement for obstetric services, (2) expanded public transportation to improve access to those hospitals with obstetrics units, and (3) the extension of Medicaid coverage to doula services to improve financial feasibility for hospitals and ensure healthy pregnancies for patients. Finally, Part IV addresses the advocacy required to implement these changes.

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\* Senior Article Editor, Georgetown Journal of Gender & the Law; J.D. Candidate, Georgetown University Law Center, expected graduation May 2019. Thank you to the editors on the Journal who put in the time and effort on my piece and gave me a platform to share my work and to Professor Peter Edelman for fostering a classroom environment that pushed students to think bigger and do better and for giving me guidance on this piece. Thank you also to “my people” for the constant support, reviewing this piece, and reminding me that I have a voice worth listening to. © 2018, Tara Wilson.

1. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, THE “MATERNAL MORTALITY REVIEW COMMITTEE ESTABLISHMENT ACT OF 2018,” at 156 (2018).

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I. INTRODUCTION

Dorothy Lee and Emma Clark, Certified Nurse Midwives in DC, were hired by their clients to assist and advocate for them through childbirth, and in doing so, they witnessed the normal, but extensive physical changes that occur through pregnancy: the enlargement of their uterus, their skeletons changing shape, organs moving aside, extreme fatigue, nausea, vomiting, and heart palpitations.<sup>2</sup> Lee and Clark worked with their clients through the “physical, emotional and psychological process” of pregnancy and childbirth.<sup>3</sup> Soon after their clients gave birth, though, Emma Clark received a call from her client’s husband: “his previously healthy partner and their unborn son had just abruptly passed away.”<sup>4</sup> Dorothy Lee’s client, after a long labor and cesarean section, passed three days later “while her husband was out getting something for her at a local pharmacy,” leaving Lee to ask herself, “what happened to make this young, vibrant woman die within the first week after birth? This woman lost her life, her husband lost a partner, and her child lost a mother. Is there a pattern? Could that have been prevented?”<sup>5</sup>

The deaths of Dorothy Lee and Emma Clark’s clients are a part of a larger, disturbing pattern nationally and within the District of Columbia. The maternal mortality rate (MMR)<sup>6</sup> in the United States is the highest of developed countries

2. *Id.* at 150, 158 (2018); Hilary Hammell, *Is the Right to Health a Necessary Precondition for Gender Equality?*, 35 N.Y.U. REV. L. & SOC. CHANGE 131, 141–42 (2011).

3. Hammell, *supra* note 2, at 143.

4. COUNCIL OF THE D.C. COM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, at 158.

5. *Id.* at 150.

6. The CDC defines maternal mortality (or pregnancy-related death) as “the death of a woman during pregnancy or within one year of the end of pregnancy from pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy.” While the World Health Organization defines maternal mortality differently, DC utilizes the CDC definition, so I will be using similar definitions and terminology here. *Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL & PREVENTION (May 2018), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm#searchTarget>; *See also* COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 6.

and rising.<sup>7</sup> The problem is particularly acute in the District of Columbia (DC): in 2016, the maternal mortality rate for Washington, DC, was forty deaths per 100,000 live births, twice the national maternal mortality rate.<sup>8</sup> Among DC residents, those who are low-income or black stand at a disproportionate risk of maternal mortality.<sup>9</sup>

Most preventable deaths and health outcomes, while influenced by medical care, are also attributable to social determinants like “conditions in the places where people live, learn, work and play.”<sup>10</sup> Beyond the hospital walls, the MMR can be caused by limited access to healthcare, which is influenced by urban policy. This note aims to propose several Medicaid policies the DC government can take to prevent MMR from increasing and improving access to care for pregnant persons,<sup>11</sup> thereby increasing the likelihood of positive outcomes.

Medicaid extends coverage to some low-income patients and is funded jointly by the state and federal governments.<sup>12</sup> This note aims to utilize this existing policy infrastructure to address maternal mortality for persons living in poverty. Because DC provides extensive benefits to make healthcare affordable for low-income pregnant persons, DC’s maternal health crisis serves as an excellent case study. The impact of DC providing low cost healthcare without making that healthcare accessible allows for an examination of potential solutions to increase accessibility. Part II will briefly place DC’s MMR within the context of the United States larger maternal health crisis. Further, Part II will describe the significant income disparity in DC and the geographic inequalities that result from this disparity and outline the significant gap in healthcare access in DC resulting from these disparities. Part III will include the following potential methods to improve access to care and support healthy pregnancies: (1) assisting hospital obstetrics units that serve low-income residents in remaining open by increasing Medicaid reimbursements, (2) improving public transportation to make these units accessible, and (3) extending Medicaid coverage to doula services to support healthy pregnancies even where access to hospitals is lacking. Finally, Part IV will address education and mobilization methods required to enact these solutions. This note does not purport to solve the crisis. Rather, the solutions proposed

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7. Nina Martin & Renee Montgane, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World* (May 12, 2017), <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world>.

8. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 2.

9. *The Social Determinants of Maternal Death and Disability*, U.N. POPULATION FUND 1, (Dec. 2012), <https://www.unfpa.org/sites/default/files/resource-pdf/EN-SRH%20fact%20sheet-Poormother.pdf>.

10. *Social Determinants of Health: Know What Affects Health*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/socialdeterminants/> (last updated, Jan, 29, 2018).

11. Consistent with the Midwives Alliance of North America, I will be referring to pregnant persons as a term inclusive of people of the female sex who do not gender identify as women. I will only refer to pregnant women when mirroring the language of relevant statistics. See *Use of Inclusive Language*, MIDWIVES ALLIANCE OF N. AM., <https://mana.org/healthcare-policy/use-of-inclusive-language>.

12. 42 U.S.C. § 1396(2014).

will suggest programs to create modest improvements and stall current trends towards increasing MMR.

## II. PROBLEM STATEMENT

Control of the female body, particularly the bodies of low-income women and women of color, has been a consistent part of US history.<sup>13</sup> Slaves were treated as breeders, with no formal rights or control over their own bodies, sexual experiences, or children: “constitut[ing] the ultimate degradation of enslaved persons and provid[ing] the very foundation of the slavery system . . . [i]n American slave society then, making such deeply intimate partnering decisions was a racial privilege.”<sup>14</sup> In the 20th century, government policy sought to control the low-income female body through welfare reform by restricting benefit eligibility based on marital status or family size.<sup>15</sup> In creating these policies, the government at a state and national level perpetuated an “otherness” of welfare recipients, making them a part of an “underclass.”<sup>16</sup> This otherness and legacy of punishing pregnant persons based on race and socioeconomic status is continued by policies restricting medical care and resulting in the death of these persons. Government action, (or inaction) that restricts persons in their choices for family, reproduction, and healthcare based on race and income represent the pattern, not the exception. Amid a national crisis in maternal health, DC’s problem stands at an extreme and the city is characterized by deep inequities related to income and race. The city is divided based on these inequities, and health disparities in DC bleed into maternal health outcomes, despite the provision of benefits for low-income pregnant persons.

### A. MATERNAL MORTALITY IN THE UNITED STATES

The maternal mortality rate (“MMR”)<sup>17</sup> in the United States reflects a problem: despite spending \$111 billion in hospital spending on childbirth expenditures, the

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13. See generally THE REPRODUCTIVE RIGHTS READER: LAW, MEDICINE, AND THE CONSTRUCTION OF MOTHERHOOD (Nancy Ehrenreich ed., 2008).

14. Rickie Solinger, *Racializing the Nation: From the Declaration of Independence to the Emancipation Proclamation, 1776-1865*, in THE REPRODUCTIVE RIGHTS READER 261, 262-65 (Nancy Ehrenreich ed., 2008). (On the Louisiana slave plantations, for instance, overwork and lack of care caused miscarriages, stillbirths and limited delay between births. As Edward De Biew, an enslaved man in Lafource Parish, described, “My ma died ‘bout three hours after I was born. . . Pa always said they made my ma work too hard. . .”).

15. Mothers’ benefits could be terminated for living with men they were not married to. Some states chose to restrict African-American single mothers from welfare. In 1992, New Jersey enacted family cap policies to limit benefits per each additional child born, effectively requiring a choice between having a child and essential benefits. See Lucy A. Williams, *The Ideology of Division: Behavior Modification Welfare Reform Proposals*, in THE REPRODUCTIVE RIGHTS READER 288, 289 (Nancy Ehrenreich ed., 2008).

16. *Id.* at 292.

17. The CDC defines maternal mortality (or pregnancy-related death) as “the death of a woman during pregnancy or within one year of the end of pregnancy from pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy.” While the World Health Organization defines maternal mortality differently, DC utilizes

MMR rate in the United States is twenty-eight deaths per 100,000 births.<sup>18</sup> With this MMR, the US currently ranks 60th of 180 nations in rates of maternal mortality, with no sign of improvement.<sup>19</sup> In fact, from 1990 to 2013, the MMR in the United States increased by 136 percent, and over sixty percent of pregnancy related deaths are preventable.<sup>20</sup> The risk of death is particularly acute for marginalized persons and persons living in poverty.<sup>21</sup> From 2003 to 2007, for instance, the MMR was up to twice as high for persons living in poverty, and black women die at three to four times the rate of white women nationally, even when controlled for education or socioeconomic status.<sup>22</sup> In New York from 2006 to 2010 black women were twelve times more likely than white women to die from pregnancy-related causes.<sup>23</sup>

## B. MATERNAL MORTALITY IN THE DISTRICT OF COLUMBIA

The MMR in DC is twice the national average.<sup>24</sup> Consistent with patterns nationally, the MMR is likely particularly acute for residents of color and low-income residents. Relatedly, DC's poverty rate is relatively high, and the city is deeply segregated based on race and socio-economic status. Therefore, there is likely a significant overlap between MMR for low-income persons and persons of color, and this problem is exacerbated by the closure of obstetrics units in regions of DC where residents are primarily low-income and black.

### 1. *Poverty in the District of Columbia*

In the nation's capital, the poverty rate, at 18.6%, is one of the highest in the country.<sup>25</sup> There is a sharp divide between high and low income residents: the bottom fifth of DC households have only two percent of DC's total income and the top fifth of households have fifty-six percent.<sup>26</sup> DC is geographically divided

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the CDC definition, so I will be using similar definitions and terminology here. *Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL & PREVENTION (May 2018), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm#searchTarget>; COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 6.

18. Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 804–05 (2016).

19. *Id.*

20. *Id.* at 805.

21. *Id.* at 805–06; *The Social Determinants of Maternal Death and Disability*, U.N. POPULATION FUND 1, (Dec. 2012).

22. GOPAL K. SINGH, MATERNAL MORTALITY IN THE UNITED STATES, 1935-2007: SUBSTANTIAL RACIAL/ETHNIC, SOCIOECONOMIC, AND GEOGRAPHIC DISPARITIES PERSIST, DEP'T. OF HEALTH AND HUMAN SERV'S 3, 4 (2010).

23. *Id.* at 5.

24. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 2.

25. Minahil Naveed, *Income Inequality in DC Highest in the Country*, DC FISCAL POL'Y INSTITUTE (2017), <https://www.dcfpi.org/all/income-inequality-dc-highest-country/>.

26. *Id.*

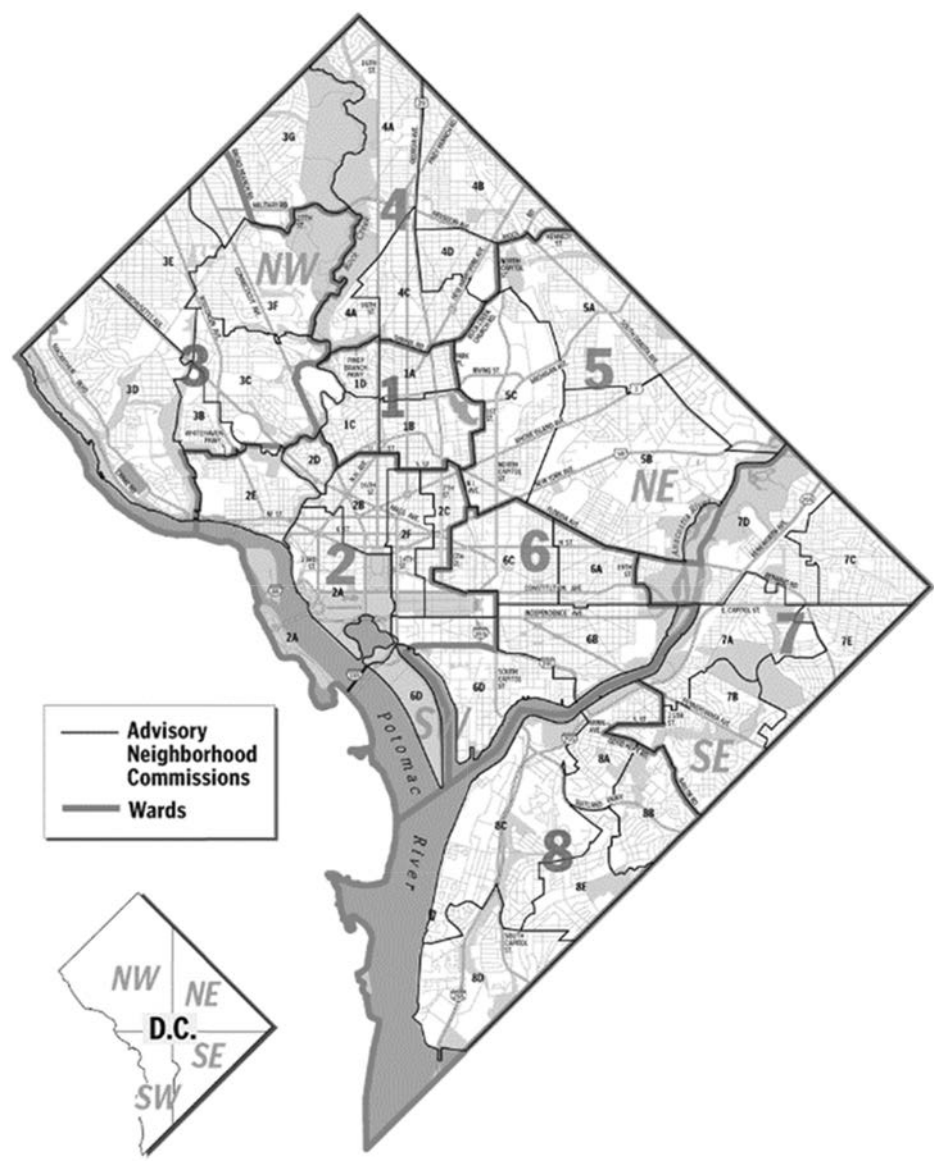


FIGURE 1. Washington DC Advisory Neighborhood Commission and Wards, The Washington Post, <https://wapo.st/1ECsTmW>

into eight wards, and the total population of the city, 647,784 from 2011 to 2015, is evenly divided between each ward, ranging from 73,290 in Ward 7 to 84,290 in Ward 6.<sup>27</sup>

The sharp divides based on income in DC results in “particular inequities for residents living in Wards 5, 7, and 8, all of which have majority racial/ ethnic minority populations.”<sup>28</sup> Income and access to resources vary based on race and socioeconomic status in DC, which is reflected in vastly different characteristics of each Ward: “DC’s black neighborhoods are nearly 10 times more likely than white neighborhoods to be areas of concentrated poverty,” and segregation of neighborhoods is only increasing.<sup>29</sup> The racial makeup of Wards 7 and 8 are ninety-three and ninety-two percent black, respectively.<sup>30</sup> On the other hand, Wards 1, 2, and 3 are forty-eight percent, sixty-three percent and seventy-six percent white, with a black population of twenty-four percent, twenty-five percent and five percent and Hispanic/Latinx population of twenty-one percent, twelve percent and nine percent, respectively.<sup>31</sup>

Socioeconomic status correlates strongly with race: the median income for a Hispanic/Latinx DC resident is \$62,631 and \$41,394 for a black DC resident, while the median income for a white resident is \$113,631.<sup>32</sup> Similarly, while the unemployment rate for white DC residents was 1.8% in 2016, black unemployment rate was thirteen percent. This translates directly into geographic divides based on income. In 2015, fourteen percent of DC families lived in poverty, and more than one out of every four of those families were concentrated in Wards 7 and 8.<sup>33</sup> Moreover, while the unemployment rate for Wards 1, 2, 3, and 6 was five percent from June to July 2017, the unemployment rate in Wards 7 and 8 was 11.8% and fifteen percent, respectively.<sup>34</sup>

Compared to the twenty-two Metro stations in Wards 2 and 6, there are only 5 metro stations in Wards 7 and 8, despite higher reliance on public transportation in Wards 7 and 8.<sup>35</sup> Even where the bus system is an available alternative, DC residents “using the DC public bus system as a low-cost alternative to the Metro. . . described the system as time-consuming, unreliable and inflexible.”<sup>36</sup> Individuals living in Ward 7 and 8 report “struggl[ing] to afford the cost of fresh produce”

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27. *Ward Snapshots: Tracking Child Well-Being in Your Ward*, Data Snapshot 12, 12–14 (Apr. 2017), [https://www.dcactionforchildren.org/sites/default/files/2016WARDSnapshots\\_FINAL\\_4\\_11\\_17.pdf](https://www.dcactionforchildren.org/sites/default/files/2016WARDSnapshots_FINAL_4_11_17.pdf).

28. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 13 (July 2017).

29. Minahil Naveed, *Economic Mobility in DC Lower Than Neighboring Counties*, DC FISCAL POL’Y INST. (2017), <https://www.dcfpi.org/all/economic-mobility-dc-lower-neighboring-counties/>.

30. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 13 (July 2017).

31. *Id.*

32. *Id.*

33. *Id.* at 15.

34. DC ECONOMIC STRATEGY, <http://dceconomicstrategy.com/>.

35. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 20 (July 2017).

36. *Id.*



### DISTRIBUTION OF METRO TRAIN STATIONS, 2015

- Metro Station
- Ward
- Water

DC Healthy Communities Collaborative  
Community Health Needs  
Assessment Appendices, 2016.



and “difficulty locating stores that stocked a decent selection.”<sup>37</sup> More than seventy-five percent of the food deserts<sup>38</sup> in DC are located in Wards 7 and 8.<sup>39</sup> Only three full service grocery stores exist in Wards 7 and 8, while all other Wards except Ward 4 have five or more full service grocery stores.<sup>40</sup> Resources, then, are more available to residents living in higher income and whiter Wards.

#### 2. Closure of Hospital Obstetric Units

Unsurprisingly, the disparities between Wards extends to hospital services; per the Washington, DC, chapter of the American College of Nurse Midwives (ACNM), DC is experiencing a “crisis level shortage” of accessible maternity

37. *Id.*

38. The DC Policy Center defines a food desert as a region meeting three requirements: (1) the walking distance to a supermarket or grocery store is more than 0.5 miles, (2) over 40 percent of the households have no vehicle, and (3) the median household income is less than 185 percent of the federal poverty level for a family of 4. Randy Smith, *Food Access in DC is Deeply Connected to Poverty and Transportation*, DC POL’Y CTR. (Mar. 13, 2017), <https://www.dcpolicycenter.org/publications/food-access-dc-deeply-connected-poverty-transportation>.

39. *Id.*

40. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 152 (July 2017).



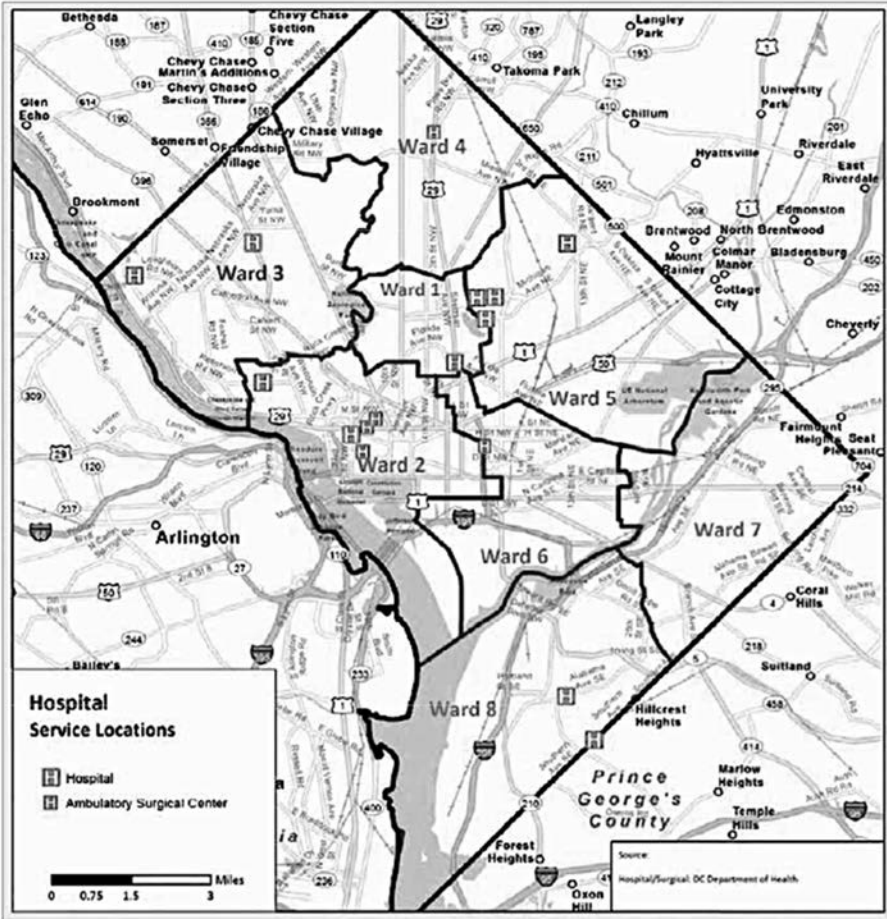


FIGURE 2. Map of hospitals (marked H in blue and red) in DC. The H’s in Ward 8 are UMC and St. Elizabeth’s, a psychiatric hospital.

care “that will have profound effects on maternal. . . mortality.”<sup>41</sup> Within the last two years, the obstetrics units of two hospitals that serve low-income patients closed, and a third hospital that cares for a high share of Medicaid patients limited the number of Medicaid patients they will extend care to. These closures and limits of services leaves low-income pregnant persons with fewer options in less accessible locations, placing them at risk for not receiving the care associated with healthy pregnancies.

41. Prince of Petworth, *Maternity Care Crisis in DC*, PoPville (Sept. 19, 2017), <https://www.popville.com/2017/09/maternity-care-crisis-in-d-c>.

Washington, DC, automatically extends medical coverage for pregnant patients through Medicaid to those up to 319% of the Federal Poverty Level for care related to pregnancy, including labor, delivery, and complications. Further, Medicaid funds prenatal care for sixty days postpartum. There are currently seven hospitals that serve adult DC residents: The George Washington University Hospital, Howard University Hospital, MedStar Georgetown University Hospital, MedStar Washington Hospital Center, Providence Hospital, Sibley Memorial Hospital, and United Medical Center (UMC).<sup>42</sup> Some hospitals take a greater share of Medicaid patients: Howard Providence and UMC predominately serve low-income DC residents, as Medicaid is the largest payer for these hospitals.<sup>43</sup> More specifically, Medicaid insured women ages eighteen through thirty-four tend to receive care from Howard, Providence and UMC.<sup>44</sup>

In October 2017, however, Providence Hospital closed their maternal and infant care department, leaving the Northeast quadrant of DC without a hospital providing maternal and infant care.<sup>45</sup> Two months later, UMC permanently closed its maternity unit due to a “drain on the hospital’s financial resource and concerns over quality of care.”<sup>46</sup> This left Wards 7 and 8 without a hospital with an obstetrics unit. In addition, Medstar Washington Hospital Center, one of the most popular hospitals for residents of Wards 7 and 8,<sup>47</sup> now does not accept two out of three Medicaid Managed Care Organizations (MCOs), leaving fewer options for low-income District pregnant persons accessing prenatal care.<sup>48</sup>

UMC closed its obstetrics unit amongst a considerable lack of transparency and conflicting information. DC government and UMC initially refused to disclose the reason for the closure of the delivery rooms and nursery.<sup>49</sup> The Washington Post reported two incidents that lead to the closure of the hospital: (1) the hospital failed to take steps to prevent HIV transmission from infected mother to newborn and (2) an obese woman who was thirty-five weeks pregnant was not properly monitored or treated, despite a history of potentially fatal blood pressure problems.<sup>50</sup> However, in January 2018, the DC Committee on the

42. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 30 (July 2017).

43. *Id.* at 34.

44. *Id.* at 35.

45. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 3.

46. *Id.* at 3–4.

47. Peter Jamison, *Hospital in Southeast Would be Half the Size of the United Medical Center*, WASH. POST (Apr. 2018), [https://www.washingtonpost.com/local/dc-politics/hospital-in-southeast-would-be-half-the-size-of-united-medical-center/2018/04/02/8fceb90-36a4-11e8-8fd2-49fe3c675a89\\_story.html?utm\\_term=.b00dafb1e1e4](https://www.washingtonpost.com/local/dc-politics/hospital-in-southeast-would-be-half-the-size-of-united-medical-center/2018/04/02/8fceb90-36a4-11e8-8fd2-49fe3c675a89_story.html?utm_term=.b00dafb1e1e4).

48. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY REP. ON B22-0524, *supra* note 1, at 4.

49. Peter Jamison and Fenit Nirappil, *Dangerous Mistakes Led to Shutdown of United Medical Center Obstetrics Ward*, WASH. POST (Aug. 14, 2017), [https://www.washingtonpost.com/local/dc-politics/dangerous-mistakes-led-to-shutdown-of-united-medical-center-obstetrics-ward/2017/08/14/5639006a-8114-11e7-b359-15a3617c767b\\_story.html?utm\\_term=.d432292adc42](https://www.washingtonpost.com/local/dc-politics/dangerous-mistakes-led-to-shutdown-of-united-medical-center-obstetrics-ward/2017/08/14/5639006a-8114-11e7-b359-15a3617c767b_story.html?utm_term=.d432292adc42).

50. *Id.*

Judiciary and Public Safety noted that “consultants running UMC had already planned to close the unit for its alleged drain on the hospital’s financial resource and concerns over quality of care.”<sup>51</sup> DC now plans to invest approximately \$300 million in St. Elizabeth’s Hospital, located in Ward 8, to build a smaller, public hospital to replace UMC. There is no guarantee that this hospital will have an obstetrics unit.<sup>52</sup>

Of the three hospitals serving primarily Medicaid patients and accepting all MCOs, Howard is the only one still operating a unit specifically catered to maternal and infant care.<sup>53</sup> According to Wayne Moore, the formal medical director of DC Fire and EMS, Howard is considered a “dumping ground” for “the drunks and homeless and the undesirables.”<sup>54</sup> Since 2007, Howard has paid out \$27 million in malpractice or wrongful death settlements, higher than George Washington Hospital, MedStar Georgetown, Providence, Sibley, and MedStar Washington have individually paid in malpractice or wrongful death settlements.<sup>55</sup> In the last two decades, the hospital has lost accreditation for five residency programs, which typically occurs after warning, and many residents practice without license or CPR training.<sup>56</sup> More specific to maternal and infant health, on July 22, 2015, six newborns were left in the neonatal unit without supervision, in violation of the DC Nurse Practice Act.<sup>57</sup>

Of the hospitals serving patients with Medicaid, hospitals with an emergency room cannot turn away a woman in active labor.<sup>58</sup> However, the closure and limiting of obstetrics units impacts access to prenatal care, which increases the likelihood of high risk pregnancies or cesarean deliveries.<sup>59</sup> Moreover, the closure of these units may present a risk to patients in active labor.<sup>60</sup> Patients who arrive at Providence Hospital in delivery were diverted to the hospital’s emergency department.<sup>61</sup> The only training the nurses in the emergency department

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51. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY REP. ON B22-0524, *supra* note 1, at 3–4.

52. Peter Jamison, *Hospital in Southeast Would be Half the Size of the United Medical Center*, WASH. POST (Apr. 3, 2018), [https://www.washingtonpost.com/local/dc-politics/hospital-in-southeast-would-be-half-the-size-of-united-medical-center/2018/04/02/8fceb90-36a4-11e8-8fd2-49fe3c675a89\\_story.html?utm\\_term=.b00dafb1e1e4](https://www.washingtonpost.com/local/dc-politics/hospital-in-southeast-would-be-half-the-size-of-united-medical-center/2018/04/02/8fceb90-36a4-11e8-8fd2-49fe3c675a89_story.html?utm_term=.b00dafb1e1e4).

53. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 3.

54. Cheryl W. Thompson, *Howard University Hospital Shows Symptoms of a Severe Crisis*, WASH. POST (Mar. 25, 2017), [https://www.washingtonpost.com/local/howard-university-hospital-shows-symptoms-of-a-severe-crisis/2017/03/24/dc84ca34-02a5-11e7-b9fa-ed727b644a0b\\_story.html?utm\\_term=.3e96d585ceac](https://www.washingtonpost.com/local/howard-university-hospital-shows-symptoms-of-a-severe-crisis/2017/03/24/dc84ca34-02a5-11e7-b9fa-ed727b644a0b_story.html?utm_term=.3e96d585ceac).

55. *Id.*

56. *Id.*

57. *Id.*

58. 42 U.S.C. § 1395dd (2013).

59. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 3.

60. *Id.* at 3.

61. *Id.* at 3.

received was a two-hour lecture and ten YouTube videos.<sup>62</sup> Consequently, forty-five nurses in the emergency department presented hospital management with a petition demanding hands on training.<sup>63</sup>

The inequities present in DC translate directly into access to prenatal care. From 2015 to 2016, only fifty-two percent of non-Hispanic black mothers and sixty-four percent of Hispanic mothers entered prenatal care in the first trimester, while eighty-six percent of non-Hispanic white mothers accessed prenatal care.<sup>64</sup> On the other hand, most births from 2013 to 2016 were to non-Hispanic black mothers, and most live births occurred in Ward 8.<sup>65</sup>

The closure and limiting of services by hospitals that primarily serve Medicaid patients limits the obstetric care that pregnant, low-income pregnant persons in DC can receive. While birth centers can assist in childbirth and are an available alternative for some pregnancies, a hospital is the only facility that can “deliver high-risk pregnancies, provide emergency care, and perform cesarean sections.”<sup>66</sup> There are eight Federally Qualified Health Centers (FQHC)<sup>67</sup> and fifty-six FQHC look-alikes<sup>68</sup> in DC.<sup>69</sup> Though some health centers do provide on-site obstetric and midwifery services,<sup>70</sup> they are only required to provide obstetric services via referral.<sup>71</sup> No health centers can provide child delivery for high risk pregnancies or pregnancies requiring cesarean deliveries.<sup>72</sup> The services in DC are “fragmented and uncoordinated” because patients may receive care from multiple locations, including community health centers and hospitals or may be referred from one provider to another.<sup>73</sup> Per Ebony Marcelle, a midwife at Community of

62. *Id.* at 3.

63. *Id.* at 3.

64. D.C. DEP'T. OF HEALTH, PERINATAL HEALTH AND INFANT MORTALITY REPORT 23 (April 2018).

65. *Id.* at 17.

66. Atlantic Documentaries, *Why are So Many Women Dying from Pregnancy in DC?* THE ATLANTIC, <https://www.theatlantic.com/video/index/556499/maternity-desert-dc/> (last visited Nov. 13, 2018).

67. The Center for Medicare and Medicaid Services defines FHCs as “safety net providers that primarily provide services typically furnished in an outpatient clinic. . . include[ing] community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program ‘look-alikes.’” Ctr. for Medicare and Medicaid Servs., Federally Qualified Health Ctr., DEP't. of Health and Human Servs. (Jan. 2018) at 3; 42 USC § 1395x(aa).

68. FQHC look-alikes meet the requirements of an FQHC but are not receiving a grant under the Social Security Act. *See* 32 USC § 254a (§330); *see also* Center for Medicare and Medicaid Services, Federally Qualified Health Center, DEP'T. OF HEALTH AND HUMAN SERV'S. 3 (Jan. 2018).

69. DEP'T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 52 (July 2017).

70. Community of Hope and Mary's Center offer midwifery services and prenatal care. Community of Hope has a birth center targeting services to low-income DC residents. Mary's Center offers home visiting services and enrollment for Special Supplemental Nutrition Program for Women, Infants and Children (WIC). *See Birth Services*, CMTY. OF HOPE, <https://www.communityofhopedc.org/healthcare/birth-services/>; Wendy Sobey, *Prenatal Care in the Hands of Midwives*, MARY'S CTR. (Oct. 5, 2015), <https://www.maryscenter.org/blog/prenatal-care-hands-midwives>.

71. DEP'T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 52 (July 2017).

72. *Id.*

73. Atlantic Documentaries, *Why are So Many Women Dying from Pregnancy in DC?*, THE ATLANTIC, <https://www.theatlantic.com/video/index/556499/maternity-desert-dc/>.

Hope in DC, providing “complete, comprehensive care” is impossible without a hospital.<sup>74</sup>

The travel from Wards with high poverty, particularly when relying on public transportation, can be laborious, and of the hospitals still providing pregnancy related services for low-income persons in DC, appointments can be hard to find. For Amber Pierre, a low-income, African-American woman living in Southeast DC, the commute time to Medstar Washington via public transportation is over an hour, when she can get an appointment.<sup>75</sup> As she describes: “when I first got pregnant, it took me a month to actually be seen by a doctor. Always getting cancelled or rescheduled, I had to take days off of work. I was a waitress. My manager, he got upset and never put me back on the schedule.”<sup>76</sup> The inequities across DC Wards, therefore, exacerbate the inaccessibility of maternal health at DC hospitals, which has profound consequences for the health of the pregnant person.

#### C. AVAILABLE TO PREGNANT PERSONS IN THE DISTRICT OF COLUMBIA AND INITIATIVES TO SUPPORT HEALTHY PREGNANCIES

A comprehensive scheme of federal and DC benefits already exists to promote healthy pregnancies and to provide affordable healthcare. But these benefits are demonstrably inadequate without sufficient hospital services when considering DC’s high MMR. Federal law requires Medicaid coverage for pregnancy related services and for sixty days postpartum to pregnant persons with incomes up to 133% of the Federal Poverty Level.<sup>77</sup> States may choose to provide coverage beyond this requirement,<sup>78</sup> and DC provides coverage for pregnant persons who have eligible immigration status or are US citizens up to 319% of the FPL, or a monthly income of \$3227.22 for one person.<sup>79</sup> Within pregnancy related services, states have the discretion to determine the scope of maternity care benefits.<sup>80</sup> DC provides Medicaid coverage for case management, prenatal and postpartum home visits, childbirth education classes, infant care and parenting education, birth center deliveries, postpartum visits, breastfeeding education, and lactation consultation in hospitals, clinics, or at home.<sup>81</sup> Demonstrating this relatively robust Medicaid coverage, DC is one of only thirteen states that covers childbirth

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74. D.C. DEP’T OF HEALTH, PERINATAL HEALTH AND INFANT MORTALITY REPORT 23 (April 2018).

75. *Id.*

76. Atlantic Documentaries, *Why are So Many Women Dying from Pregnancy in DC?*, THE ATLANTIC, <https://www.theatlantic.com/video/index/556499/maternity-desert-dc/>.

77. 42 U.S.C. § 1396a(e)(5).

78. 29 D.C. MUN. REGS. Tit. 29, § 9500 (2015).

79. 29 D.C. MUN. REGS. Tit. 29, § 9506.3 (2015).

80. Kathy Gifford, et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, THE HENRY J. KAISER FAM. FOUND. (April 2017).

81. *Id.* at 4.



and parenting education.<sup>82</sup> DC does not provide coverage, however, for home births and doula services.<sup>83</sup>

Aside from Medicaid, several programs are available in DC to support healthy pregnancies: Special Supplemental Nutrition Program for Women, Infants and Children (WIC), support from community health centers, Maternal, Infant and Early Childhood Home Visiting, Preventative Health and Chronic Disease Control, and DC Quitline Pregnancy Program.<sup>84</sup> In addition, in response to the high rates of maternal mortality in DC, DC City Council established the Maternal Mortality Review Committee (MMRC). The bill, passed by City Council, is currently under congressional review.<sup>85</sup> The committee functions include: compiling data, examining circumstances surrounding maternal mortality, changing rules and procedures, recommending system improvements, and creating frameworks for improving outcomes.<sup>86</sup> The MMRC must also create an annual report with updated findings and suggested reforms.<sup>87</sup> The MMRC consists of voting members from the following categories: an obstetric registered nurse, obstetrics and gynecological representatives from the District's birthing hospitals, a member of the American Congress of Obstetricians and Gynecologists, a certified nurse midwife from a District birthing center, doula serving District residents, a representative from a pediatric hospital, three representatives from community organizations specializing in women's health, teen pregnancy or public health, and a district resident community member.<sup>88</sup>

### III. PROPOSED POLICY SOLUTIONS

Viewed in combination with the closure of obstetrics units, programs and medical care for healthy pregnancies are available but are not accessible. The aim of the following proposals is to prevent further erosion of services provided to low-income, pregnant persons, improve access to remaining obstetrics units and prenatal care available in DC, and to improve healthy pregnancies outside of hospital centered care. This can be accomplished by: (1) improving Medicaid reimbursements to hospitals for pregnancy related care, (2) increasing access to hospitals that accept Medicaid to improve patient choice, and (3) extending Medicaid coverage for doula care to reduce risk of pregnancies where hospital care is inaccessible. In focusing on reforms DC government may enact to combat the increasing MMR, these proposals assume consistent federal funding for Medicaid.

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82. *Id.*

83. *Id.*

84. D.C. DEP'T OF HEALTH, PERINATAL HEALTH AND INFANT MORTALITY REPORT 23 (April 2018).

85. 65 D.C. Reg. 6786 (June 22, 2018).

86. COUNCIL OF THE D.C. COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, at 7–8; *FAQ-Frequently Asked Questions*, COUNCIL OF D.C. <http://dcclims1.dccouncil.us/lims/faq.aspx>.

87. *Id.* at 23.

88. *Id.* at 23–24.

### A. MAINTAINING AND INCREASING ACCESS TO OBSTETRIC UNITS

To reduce maternal mortality amongst low-income persons in DC, the DC government must maintain and increase access to obstetric care at area hospitals. Despite solidifying a partnership with The George Washington University to create and manage a \$300 million hospital in Southeast DC to replace University Medical Center, DC officials only “hope” this hospital, including an obstetrics unit, will be complete by 2023.<sup>89</sup> Even with the construction of a new obstetrics unit, the long-term financial stability of this unit requires a change in Medicaid financing. To maintain the obstetrics units in hospitals that see a large share of Medicaid patients, DC must renegotiate reimbursements to cover a larger share of the cost of childbirth. Without a change in Medicaid reimbursements, the underlying problem remains, and the new hospital will still face significant financial strain from low Medicaid reimbursements for childbirth. Further, at least until a new hospital is constructed in or near Wards 7 and 8, DC must invest in quality transportation to allow for access to these hospitals that are continuing to provide services to Medicaid patients and more evenly distribute the number of Medicaid patients each hospital sees. Pregnant persons will still be dying due to lack of accessible healthcare from now to 2023.

#### 1. *Increasing Medicaid Base Payments*

In closing the obstetrics units at UMC and Providence and limiting the number of MCOs accepted at MedStar, hospitals cited cost as the cause for these closures.<sup>90</sup> These hospitals primarily serve patients on Medicaid, so when patients receive services from the hospital, Medicaid pays the hospital a base payment for the services rendered.<sup>91</sup> In determining these reimbursements, state governments negotiate with Medicaid for what the hospitals may charge for services.<sup>92</sup> Therefore, when a patient arrives at a hospital in DC to give birth, the cost of a live birth or cesarean is predetermined based on the negotiations between DC government and Medicaid.

However, the base payments from Medicaid may fall below what the hospitals charge private insurers or individuals for the services or cost of providing these services, leaving a shortfall for the hospitals.<sup>93</sup> Therefore, while treating uninsured patients is more expensive than treating patients covered by Medicaid, if reimbursement costs for Medicaid are inadequate, a hospital may lose money by treating primarily Medicaid patients. In general, Medicaid reimbursements fail to

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89. Peter Jamison, *George Washington University Hospital Tapped to Run New Southeast DC Hospital*, WASH. POST (Aug. 10, 2018), [https://www.washingtonpost.com/local/dc-politics/george-washington-university-tapped-to-run-new-southeast-dc-hospital/2018/08/09/a1287d90-9c1a-11e8-843b-36e177f3081c\\_story.html?utm\\_term=.42c7f3e99fa9](https://www.washingtonpost.com/local/dc-politics/george-washington-university-tapped-to-run-new-southeast-dc-hospital/2018/08/09/a1287d90-9c1a-11e8-843b-36e177f3081c_story.html?utm_term=.42c7f3e99fa9).

90. See discussion *supra* Section II.B.ii.

91. *Id.*

92. PETER CUNNINGHAM, ET AL., UNDERSTANDING MEDICAID HOSPITAL PAYMENTS AND THE IMPACT OF RECENT POLICY CHANGES 2–3 (THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED 2016).

93. *Id.* at 4.



rise along with increasing costs of care, and even during periods of economic growth, states are lowering or maintaining reimbursement prices.<sup>94</sup>

The shortfall may cost hospitals even with additional funding the hospital receives from Medicaid: states may choose to provide supplemental payments to hospitals beyond the base rate, including Medicaid Disproportionate Share Hospital (DSH) payments for hospitals serving a high share of Medicaid patients.<sup>95</sup> DC allocates DSH supplemental payments to hospitals treating a higher than average share of Medicaid patients whose low-income utilization rate is over twenty-five percent.<sup>96</sup> In 2016, DC paid approximately \$385.1 million to hospitals in supplemental Medicaid payments, or 17.7% of total Medicaid costs, and of that, \$33 million were DSH payments.<sup>97</sup> Hospitals with a high share of Medicaid patients often rely on supplemental payments to offset the shortfall of low Medicaid reimbursements.<sup>98</sup>

Even with supplemental payments, the financial unsustainability of Medicaid reimbursements is particularly true for obstetrics units, as further demonstrated by rural hospitals. From 1984 to 2002, the rate of non-metropolitan counties lacking hospital-based obstetric services rose from twenty-four to forty-four percent.<sup>99</sup> Low Medicaid reimbursements made it financially impossible to continue providing obstetric services.<sup>100</sup> Consequently, these rural hospitals often cited a high proportion of Medicaid patients as a reason for closure.<sup>101</sup> In DC, the reimbursement rate for vaginal deliveries is \$1,943.54 and \$2,156.67 for cesarean deliveries.<sup>102</sup> However, the cost to private insurers for childbirth in DC in 2016 and 2017 is \$6,388 for vaginal delivery and \$7,439 for cesarean deliveries.<sup>103</sup> In other words, the Medicaid reimbursement for childbirth is approximately thirty percent of the reimbursement from private insurance. Though private insurance reimbursement does not necessarily reflect the actual cost of childbirth, as private insurance reimbursements are negotiated between the hospitals and insurance companies, the disparity reflects the significant loss incurred by hospitals taking primarily Medicaid patients as compared to those patients with private insurance.

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94. *Id.* at 4-5.

95. *Id.*

96. 57 D.C. Reg. 012203 (Dec. 24, 2010).

97. *Medicaid Supplemental Payments to Hospital Providers by State*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION 2017, <https://www.macpac.gov/publication/medicaid-supplemental-payments-to-hospital-providers-by-state/>.

98. *Our View: Essential Hospitals Rely on Medicaid Supplemental Payments*, AMERICA'S ESSENTIAL HOSPITALS 2016, <http://essentialhospitals.org/wp-content/uploads/2016/03/Our-View-Supplemental-Payments-March-2016.pdf>.

99. Lan Zhao, WHY ARE FEWER HOSPITALS IN THE DELIVERY BUSINESS?, NORC - Health Policy & Evaluation Division, iii (2007).

100. *Id.* at vi.

101. *Id.* at 14.

102. *Interactive Fee Schedule*, D.C. GOV., <https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleInquiry> (last visited Oct. 14, 2018).

103. Elizabeth O'Brien & Pratheek Rebala, *Find Out How Much it Costs to Give Birth in Every State*, TIME (Oct. 30, 2017), <http://time.com/money/4995922/how-much-costs-give-birth-state/>.

The disparity between Medicaid and private insurance reimbursement is demonstrative of the financial loss occurring by taking primarily Medicaid patients; as is, obstetrics units taking primarily Medicaid patients are financially unsustainable.

For hospitals that serve large numbers of Medicaid patients, changes in base payment reimbursement rates have a significant financial impact.<sup>104</sup> To operate hospitals located closer to Wards 7 and 8 that primarily serve patients living in poverty the DC government must make the operation of these hospitals financially feasible. As demonstrated by the closure of obstetrics units in hospitals primarily serving Medicaid patients, the current reimbursement rate for pregnancy related care, even combined with additional grants and funding support, is insufficient. Moreover, as demonstrated by increasing in funding for primary care, higher Medicaid reimbursement rates may lead to the increasing availability of appointments for Medicaid patients, lower overall wait times for appointments, and, therefore, increased access to prenatal care.<sup>105</sup>

Funding, however, presents a major barrier to change. As of 2016, Medicaid accounted for \$2.8 billion of DC spending. For 2019, the gross budget is \$14.4 billion, and Medicaid spending increased by \$70.2 million over the 2018 fiscal year, partially due to increased payments to Medicaid providers.<sup>106</sup> While DC receives federal assistance in Medicaid spending, Medicaid spending totals to approximately twenty percent of the total budget.<sup>107</sup> Increasing base payments would only increase Medicaid spending as a share of the overall budget unless accompanied by an overall increase in DC revenue. Further, as of January 2018, DC's chief financial officer states that DC did not even have sufficient funds to cover the MMRC, which would cost a total of \$372,000 over four years.<sup>108</sup> If this is the case, DC elected officials are unlikely to invest in increased in Medicaid base payments. Assuming the 7,870 births funded by Medicaid from 2015 to 2016<sup>109</sup> were all vaginal births, the cost for increasing Medicaid reimbursement to forty percent of private insurance reimbursements would be \$4,813,764.20 per year, and considering the relatively high rate of cesarean deliveries,<sup>110</sup> this is an underestimation of the cost of increasing base payments.

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104. PETER CUNNINGHAM ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UNDERSTANDING MEDICAID HOSPITAL PAYMENTS AND THE IMPACT OF RECENT POLICY CHANGES: ISSUE BRIEF 2–3 (Jun. 2016).

105. Daniel Polsky et al., *Appointment Availability after Increases in Medicaid Payments for Primary Care*, 372 NEW ENG. J. OF MED. 541, 543 (2015).

106. COUNCIL OF D.C., FY 2019 PROPOSED BUDGET AND FINANCIAL PLAN GOVERNMENT OF THE D.C. 30, 58 (2018).

107. *Medicaid in the District of Columbia*, KAISER FAM. FOUND., (2018), <http://files.kff.org/attachment/fact-sheet-medicaid-state-DC>.

108. COUNCIL OF D.C., Memorandum from Jeffrey S. DeWitt, Chief Financial Officer, to the Honorable Phil Mendelson, Chairman, (January 18, 2018).

109. D.C. DEP'T. OF HEALTH, PRENATAL HEALTH AND INFANT MORTALITY REPORT 26 (2018).

110. AM. C. OBSTETRICIANS & GYNECOLOGISTS & SOC'Y FOR MATERNAL-FETAL MED., OBSTETRIC CARE CONSENSUS: SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY 2 (2014, *aff'd* 2016).

DC plans to invest nearly \$300 million to build a new hospital in Southeast DC by 2023, which would increase access for residents in Wards 7 and 8.<sup>111</sup> But, the proposed new hospital in Ward 8 does not address the underlying problems that led to the closure of UMC's obstetrics ward. If the hospital includes an obstetrics unit and serves patients primarily on Medicaid, the hospital will operate at a significant shortfall if there is no change to Medicaid. This investment also demonstrates that DC could instead or concurrently invest one to five percent of this amount in Medicaid reimbursements. Though, DC City Council demonstrated the political will to address hospital financing by creating the MMRC to address maternal mortality, the committee includes providers specializing in maternal and infant care, but the committee does not include any officials involved in hospital administration and finance.<sup>112</sup> The failure to include a voting member involved in hospital finance prevents the committee from incorporating hospital financing into long term reforms, thereby evidencing that shortfalls from Medicaid reimbursement will not be prioritized in MMRC considerations.

## 2. *Improving Access to Hospitals to Reduce the Impact of Medicaid Shortfalls*

In lieu of access to a hospital in Wards 7 or 8, hospitals must be made accessible to patients to receive pregnancy related care, which requires either building a hospital near Wards 7 and 8 or increasing the reliability and efficiency of public transportation. This may also more evenly distribute the share of Medicaid patients amongst hospitals. If no hospital takes on a disproportionate share of Medicaid patients, they are not experiencing a greater shortfall, and consequently, they are not experiencing a disproportionate financial burden. However, the concentration of poverty in DC and lack of reliable public transportation ensures that patients will be restricted to hospitals or health centers located near Wards 5, 7 and 8 for continuous care during and after pregnancy.

DC faces highly concentrated poverty correlated with high racial segregation: as of 2015, "94 percent of DC neighborhoods with majority white populations have less than 10 percent of their families living below the poverty line, compared with 22 percent of majority black neighborhoods."<sup>113</sup> Without a significant overhaul in DC housing to reduce the concentration of poverty, hospitals with obstetrics units must be made accessible to low-income residents through reliable and efficient transportation. Though bus services and public transportation are available to individuals living in Wards 5, 7 and 8, there are fewer metro stations and the bus system is often unreliable. Low-income DC residents who were

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111. Andrew Giambrone, *Bowser and Gray Square Off Over New Hospital Project*, WASH. CITY PAPER (Mar. 25, 2018), <https://www.washingtoncitypaper.com/news/loose-lips/blog/20997944/bowser-and-gray-square-off-over-new-hospital-project>.

112. COUNCIL OF THE D.C., COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, attach. A, at 3–4.

113. Stuart M. Butler and Jonathan Grabinisky, *Segregation and Concentrated Poverty in the Nation's Capital*, BROOKINGS (Mar. 24, 2015), <https://www.brookings.edu/blog/social-mobility-memos/2015/03/24/segregation-and-concentrated-poverty-in-the-nations-capital/>.

interviewed “spoke about the tremendous burden of distance and travel time experiences when attempting to access care. Many conveyed passionate stories about having to travel more than an hour to see their preferred provider.”<sup>114</sup>

DC must invest in improving the reliability and efficiency in public transportation to improve access to hospitals with obstetrics units, which are all located outside of wards with the highest concentration of persons living in poverty. In addition to providing greater access to care, improved transportation will also give pregnant persons the dignity of choice in their care. Rather than being restricted based on form of health insurance and access to public transportation, improved public transportation will increase access to multiple providers, and increased choice and control in healthcare decisions is related to more positive recollections of birth experiences.<sup>115</sup> For pregnant persons in DC, this could allow access to prenatal care and a healthier pregnancy.

Already, the Fiscal Year Budget Proposal for 2019 explicitly cites “safe, efficient and reliable Metro systems” as a policy priority.<sup>116</sup> The proposed investments include \$178.5 million annually for WMATA and \$269 million for circulators and streetcars.<sup>117</sup> The improvements, however, seem to be restricted to current rail networks and expanding on H Street, so Wards 7 and 8, without the same level of access to transportation, may not be the beneficiaries of this funding.<sup>118</sup> Therefore, DC City Council must ensure that the individuals who rely on public transportation have access to efficient and reliable means of public transportation.

#### B. MEDICAID COVERAGE FOR DOULAS

Where access to hospitals with obstetrics units is limited, DC must support healthy pregnancies through alternative avenues. Efforts to create hospital alternatives may operate concurrently or separately with efforts to improve access to hospital care; these efforts must help reduce the risk of high-risk pregnancies and cesarean sections, thereby reducing the need for accessing hospitals.<sup>119</sup> The presence of a doula is “one of the most effective tools to improve labor and delivery outcomes,” including better patient satisfaction and reduced rate of cesarean delivery.<sup>120</sup> In conjunction with programs to increase access to hospital services,

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114. DEP’T OF HEALTH, DISTRICT OF COLUMBIA HEALTH SYSTEMS PLAN 2017 59 (July 2017).

115. Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women’s Childbirth Experiences*, J. PERINATAL EDUC. 158, 161–65 (2012).

116. *FY 2019 Proposed Budget and Financial Plan, Vol. 1*, Government of D.C. 2018, at 30, 59.

117. *Id.* at 59–60.

118. *Id.* at 185.

119. Atlantic Documentaries, *Why are So Many Women Dying from Pregnancy in DC?* THE ATLANTIC, <https://www.theatlantic.com/video/index/556499/maternity-desert-dc/> (last visited Nov. 12, 2018).

120. AM. C. OBSTETRICIANS & GYNECOLOGISTS & SOC’Y FOR MATERNAL-FETAL MED., OBSTETRIC CARE CONSENSUS: SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY 13 (March 2014, reaffirmed 2016); *see generally* MA Bohren, et al., CONTINUOUS SUPPORT FOR WOMEN DURING CHILDBIRTH, COCHRANE DATABASE SYST. REV. (July 2017).

extending Medicaid coverage to doulas may function to further promote healthy pregnancies and reduce the overall cost to hospitals taking higher shares of Medicaid patients. Were hospitals still to remain as unavailable to low-income pregnant persons in DC, Medicaid coverage of doulas would also function to alleviate the impact of reduced access to hospitalized prenatal care by creating an alternative to hospital care.

A doula is a non-clinical person who provides emotional, physical, and emotional support for pregnant persons before, during, and after birth.<sup>121</sup> The services offered include: comfort measures, resources or referrals for health or social services, and information on childbirth and breastfeeding.<sup>122</sup> Doulas facilitate productive communication between pregnant persons and their provider to help “articulate their preferences and values.”<sup>123</sup> At the state’s option, Medicaid may cover preventative services provided by physicians, licensed practitioners, and unlicensed practitioners recommended by a physician or licensed practitioner.<sup>124</sup>

States may define what preventative services fall within Medicaid coverage, within outer bounds set by federal requirements, allowing states to extend Medicaid coverage to doula services.<sup>125</sup> Only three states currently provide Medicaid coverage for doulas: Minnesota, Oregon, and Wisconsin.<sup>126</sup> DC does not provide Medicaid coverage for doulas, leaving low-income pregnant persons to pay out of pocket.

Minnesota’s implementation of Medicaid coverage of doula services provides potential problems and benefits to the program. Minnesota hosts significant disparities in maternal mortality based on race and ethnicity. These disparities are partially caused by lack of access resulting from the extensive travel necessary to receive obstetric services.<sup>127</sup> Consequently, Minnesota chose to provide Medicaid coverage for doula care to improve birth outcomes and reduce “the number and types of interventions and cesarean rates” to increase parity amongst birth outcomes.<sup>128</sup>

The outcomes could be significant and result in significant savings. Based on 1,079 births, utilizing doula care in Minneapolis and Minnesota, the cesarean

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121. National Partnership for Women and Families, *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, Issue Brief, at 3 (Jan. 2016).

122. *Id.*

123. *Id.*

124. 42 C.F.R. § 440.130(c); Cindy Mann, *Center for Medicaid and CHIP Services Informational Bulletin: Update on Preventative Services Initiative*, DEP’T. OF HEALTH & HUMAN SERV’S. (November 27, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf>.

125. Center for Medicare & Medicaid Services, *Medicaid Preventative Services: Regulatory Change*, DEP’T. OF HEALTH & HUMAN SERV’S. (April 2014) <https://www.medicaid.gov/medicaid/benefits/downloads/preventive-webinar-presentation-4-9-14.pdf>.

126. *Id.* at 1.

127. Katy B. Kozhimannil et al., *Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year at \*1* (Jul. 2015), <https://static1.squarespace.com/static/577d7562ff7c5018d6ea200a/t/5840c791cd0f683f8477920a/1480640403710/FullReport.pdf>.

128. Minn. Stat. § 256B.0625(28b) (2017).

delivery rate dropped nearly forty percent.<sup>129</sup> Nationally, cesarean deliveries cost fifty percent more than vaginal births, and as of 2010, cesarean deliveries add \$4,459 in Medicaid payments per birth in the US.<sup>130</sup> Using these statistics, the study measured potential cost savings to Medicaid.<sup>131</sup> For a 22.3% cesarean deliveries rate and a reimbursement rate of \$200, nearly half of all states would save \$2.5 million.<sup>132</sup> With a cesarean delivery rate of 40.9% and the same reimbursement rate, nearly all states would save approximately \$2 million per year.<sup>133</sup> Therefore, while Medicaid coverage of doula services would increase costs to states' budgets, the increase would be offset by reduced reimbursement to hospitals and providers for obstetric complications and cesarean deliveries. The rate of cesarean sections in DC in 2010 was 33.1%, higher than twenty-eight states, so increasing vaginal deliveries may function to reduce overall cost to Medicaid in DC.<sup>134</sup> In terms of increasing base payments in DC for Medicaid, the increased rate of vaginal deliveries will drive down the overall costs of Medicaid.

The Minnesota program also provides perspective on potential problems if DC were to implement Medicaid coverage for doula care. A year after Minnesota implemented the change, the service was not utilized to the full extent possible because many pregnant people were unaware of doula services.<sup>135</sup> Therefore, the provision of these services would require additional support from providers, community health centers and other locations to inform low-income patients of the additional option.

Moreover, individuals in Minnesota noted the value of having a doula who shared their cultural background.<sup>136</sup> The Center for Disease Control and Prevention further recognizes the value of developing a strong relationship between the community and provider to "improve the quality and cultural competence of service delivery."<sup>137</sup> Medicaid coverage of doulas, then, should not have barriers to practice for doulas who are low-income or from underrepresented communities in order to mirror some characteristics of their patients. This may include allowing a fee waiver process for doula verification and registration.<sup>138</sup>

Despite the potential benefits of the doula program, DC will incur a cost to implement the program, which includes the cost of Medicaid reimbursements

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129. Katy Backes Kozhimannil et al., *Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries*, AM. J. OF PUB. HEALTH e113, e114 (2013).

130. National Partnership for Women and Families *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, Issue Brief, at 1 (Jan. 2016).

131. Kozhimannil, et al., *supra* note 129, at e113.

132. *Id.* at e116.

133. *Id.*

134. AM. C. OBSTETRICIANS & GYNECOLOGISTS & SOC'Y FOR MATERNAL-FETAL MED., *Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery*, 4 (2014).

135. Katy B. Kozhimannil et al., *supra* note 127, at 7.

136. *Id.* at 9.

137. CTR. FOR DISEASE CONTROL, *Technical Assistance Guide: States Implementing Community Health Worker Strategies*, DEP'T. HEALTH & HUMAN SERV'S. 3 (Dec. 2014), [https://www.cdc.gov/dhdspp/programs/spha/docs/1305\\_ta\\_guide\\_chws.pdf](https://www.cdc.gov/dhdspp/programs/spha/docs/1305_ta_guide_chws.pdf).

138. *Id.* at ii, 9.



and any outreach programs. However, the cost of the program may be alleviated by reduced need for cesarean delivery and less complicated pregnancies. Doulas can also ensure that low-income pregnant persons are aware of the resources available to them and assist them in accessing these resources to promote healthy pregnancies. Moreover, the makeup of voting members of the MMRC evidences that DC City Council may be receptive to extending coverage to doulas. The MMRC requires that one of the voting members is a doula.<sup>139</sup> This reflects a recognition of the value of doula care for pregnant residences, and the expansion of continuous care with doula services may become a priority of the committee.

#### IV. STRATEGY FOR IMPLEMENTATION

Though media coverage has brought significant attention to the national maternal mortality crisis,<sup>140</sup> stakeholders in DC are perplexed by the lack of momentum in reducing maternal mortality in DC. According to Dr. Michal Young, a neonatologist at Howard University Hospital: “It’s hard for me to believe that a city with a woman for a mayor would think it’s okay to leave those without any kind of delivery services.”<sup>141</sup> Despite the creation of the MMRC and DC government’s complicity in allowing this crisis to develop, Dr. Young noted that progress is “moving slow.”<sup>142</sup> In other words, the creation of a committee is not enough to tackle this crisis; greater reform will likely require greater pressure placed on councilmembers. This requires education and mobilization of DC voters.

The glacial pace of reform within DC is not for lack of awareness from policy makers: Mayor Bowser held the first Maternal and Infant Health Summit on September 12, 2018 “to develop a nationwide agenda that addresses the disproportionately high rates of maternal mortality experienced by people of color in Washington, DC, and across the nation.”<sup>143</sup> Both the mayor and city councilmembers have expressed support for the construction of a new hospital in an effort to reduce health, including obstetric health, disparities<sup>144</sup> and the MMRC passed by

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139. COUNCIL OF THE D.C., COMM. ON THE JUDICIARY & PUB. SAFETY, REP. ON B22-0524, *supra* note 1, attach. A at 4.

140. See Linda Villarosa, *Why America’s Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES (Apr. 11, 2018), <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>; Nina Martin & Renee Montagne, *The Last Person You’d Expect to Die in Childbirth*, PRO PUBLICA & NPR (May 12, 2017), <https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system>; Betsy McKay & Paul Overberg, *Rural America’s Childbirth Crisis: The Fight to Save Whitney Brown*, WALL ST. J., <https://www.wsj.com/articles/rural-americas-childbirth-crisis-the-fight-to-save-whitney-brown-1502462523>; Ester Bloom, *America’s Pregnancy Care Paradox: Paying More for the Same Bad Results*, THE ATLANTIC (Nov. 10, 2015), <https://www.theatlantic.com/business/archive/2015/11/americas-pregnancy-care-paradox-paying-ever-more-for-the-same-bad-results/415032/>.

141. Telephone Interview with Michal Young, neonatologist, Howard University (April 24, 2016).

142. *Id.*

143. Executive Office of the Mayor, *Mayors from Across the Country to Join Mayor Bowser for DC’s First Maternal and Infant Health Summit*, D.C. GOV. (Aug. 29, 2018), <https://mayor.dc.gov/release/mayors-across-country-join-mayor-bowser-dc’s-first-maternal-and-infant-health-summit>.

144. Jamison, *supra* note 89.



a unanimous vote of city council.<sup>145</sup> Councilman Charles Allen, who represents Ward 6, introduced the Maternal Mortality Review Committee Establishment Act in 2017, and stated that “maternal mortality rates in the District indicate nothing short of a maternal health crisis.”<sup>146</sup> The Councilmember for Ward 7, Vincent Gray, also publicly criticized obstetric health inequities in DC, noting that “the people on the East End of the city are seen as not sufficiently worthy to have available to them one of the most important services a population can have.”<sup>147</sup> Additionally, Councilmembers Nadeau, Cheh and White from Wards 1, 3 and 8, respectively, introduced the Patient Centered Maternal Care Program Act of 2018 in April to require “the Department of Health Care Finance to select an entity to... deliver preventative health and perinatal educational services to Medicaid eligible, high-risk expectant mothers residing in Wards 7 and 8.” A vote on the bill is pending. Beyond this, however, no councilmembers have any mention of maternal mortality on their websites or have publicly spoken out on maternal mortality.

These existing responses are largely inadequate. The Mayor’s Summit, while bringing further attention to the national maternal health crisis, does little to address DC-specific policy changes that must occur to reduce maternal mortality.<sup>148</sup> The MMRC fails to incorporate members with knowledge of hospital financing to avoid future closures of hospitals that serve low-income DC residents, and there is no guarantee action will accompany MMRC reports and recommendations.<sup>149</sup> Finally, the construction of a new hospital does little to address the underlying problem that caused the closure of obstetrics units near Wards 7 and 8.<sup>150</sup> DC must engage in policies that mitigate the ongoing harm to pregnant persons and to create sustainable, affordable and accessible care.

Because elected officials are aware of the problem, but failing to levy a crisis level response, constituents must be fully educated to ensure they are armed with this information and may act to change elected official’s political calculus. Segregation divides DC on lines of race and class, ensuring that these individuals are limited in their interactions and shared experiences.<sup>151</sup> Consequently, many residents of DC may be unaware of the lack of access to obstetrics units and prenatal care for low-income persons and persons of color. Therefore, they are

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145. See Cameron Thompson, *D.C. Council Approves Creation of Maternal Mortality Review Committee*, DCW50 (Mar. 2018, 11:47 PM), <http://dcw50.com/2018/03/06/d-c-council-approves-creation-of-maternal-mortality-review-committee/>.

146. Murugi Thande, *A Matter of Life or Death: DC Has Highest Maternal Mortality Rate in the US*, WUSA9 (Mar. 2018), <https://www.wusa9.com/article/news/local/dc/a-matter-of-life-or-death-dc-has-highest-maternal-mortality-rate-in-us/65-522514786>.

147. Anne Branigin, *Washington, DC’s Only Public Hospital Just Decided to Close Its Maternity Ward*, THE ROOT (Dec. 2017), <https://www.theroot.com/d-c-s-only-public-hospital-just-decided-to-close-its-ma-1821302306>.

148. See Executive Office of the Mayor, *supra* note 143.

149. See *supra* Section III(A)(i).

150. See *id.*

151. See *supra* Section II(A).

unable to utilize this information to advocate to their elected officials and push for reform, and to achieve a majority in City Council, councilmembers beyond those acutely affected by the closures of obstetrics units and lack of services must be pressured to act with the sense of urgency that this crisis requires.

Education requires a detailed illustration of the problem in DC, including both the outcomes (MMR) and the process (barriers to accessing care). Just the same as broadcast television motivated white audiences during the Civil Rights movement,<sup>152</sup> and cell phones sparked national attention to police brutality,<sup>153</sup> people in DC who are not living in or near poverty must *see* the impact of limited health-care and what this means in practice. Where the problem is not obvious, stakeholders such as physicians, midwives, doulas, reproductive rights organizations, and organizations devoted to racial justice are charged with bringing the public's attention to this problem through press attention. Videos and articles must show constituents that the limited access to care means long travel times, financial insecurity, and has adverse impacts on health, which not just a problem of health, but one of income and race. Litigation, too, may assist in drawing public attention to the stories of low-income pregnant persons in DC.<sup>154</sup> The audience may be receptive to increased investments and expansion of Medicaid because DC residents in 2016 overwhelmingly voted for Hillary Clinton, who supported strengthening Medicaid programs.<sup>155</sup>

Education means nothing without action to create change. As of June 2018, over half the members of the DC City Council are up for re-election.<sup>156</sup> Voters must be informed and motivated to push their elected officials to act. Assuming awareness of the problem is not enough to motivate constituents to act and to demand change, organizations and affected constituents must combine education efforts with efforts to motivate action through social media campaigns, petitions, and lobbying of elected officials.

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152. See Alexis C. Madrigal, *When the Revolution Was Televised*, THE ATLANTIC (Apr. 1, 2018), <https://www.theatlantic.com/technology/archive/2018/04/televisions-civil-rights-revolution/554639/>.

153. See Alyssa Rosenberg, *The Complicated History of Capturing Racist Violence on Film*, WASH. POST (July 23, 2015), [https://www.washingtonpost.com/news/act-four/wp/2015/07/23/the-complicated-history-of-capturing-racist-violence-on-film/?utm\\_term=.3a2c6cacf169](https://www.washingtonpost.com/news/act-four/wp/2015/07/23/the-complicated-history-of-capturing-racist-violence-on-film/?utm_term=.3a2c6cacf169).

154. Litigation played a role in raising awareness of the impact of public health policy on HIV and tobacco and shifted the political balance to create change. See Wendy E. Parmet, *Tobacco, HIV, and the Courtroom: The Role of Affirmative Litigation in the Formation of Public Health Policy*, 36 HOUS. L. REV. 1663, 1694 (1999).

155. See *District of Columbia Results*, N.Y. TIMES (Aug. 1, 2017), <https://www.nytimes.com/elections/results/district-of-columbia> (Hillary Clinton received 90.9 percent of DC votes); *Snapshot of Where Hillary Clinton and Donald Trump Stand on Seven Health Care Issues*, HENRY J. KAISER FAM. FOUND. (Sept. 23, 2016), <https://www.kff.org/health-reform/issue-brief/snapshot-of-where-hillary-clinton-and-donald-trump-stand-on-seven-health-care-issues/#healthinsurance>.

156. See *Councilmembers*, COUNCIL OF D.C., <http://dccouncil.us/council> (City council members up for election in 2019 include Phil Mendelson, Kenyan R. McDuffie, Anita Bonds, Elissa Silervman, Brianna Nadeau, Mary Cheh, and Charles Allen; city council members up for election in 2021 are David Grosso, Robert C. White, Jack Evans, Brandon T. Todd, Vincent Gray and Trayon White).

## V. CONCLUSION

Pregnant, low-income persons in DC face a higher health risk than persons with higher incomes. Persons living in low-income wards face a higher risk than people living in higher income wards. Pregnant people of color, particularly black persons, face a higher risk than white persons. Existing policies and practice in DC are killing low-income pregnant persons. The current scheme of Medicaid reimbursements, coverage, and healthcare access is clearly unsustainable.

These proposed policies will require political will and financing. The impact, though, will be to counter the lack of access contributing to DC's high MMR. The provision of higher Medicaid reimbursements will reduce cost cutting measures and increase the sustainability of obstetric units, particularly for hospitals receiving a relatively larger share of Medicaid patients. Accompanied with expanded public transportation, low-income pregnant persons will be granted the dignity of choice and have access to pregnancy-related care that is vital for healthy pregnancies. Further, extending Medicaid coverage to doulas, in addition to or in lieu of measures to increase access to hospital care, will increase the number of healthy pregnancies, driving down the ultimate cost to Medicaid and hospitals and mitigating the impact of limited access to hospitals.

The closure of obstetrics units, limiting of available services and incidents at DC hospitals demonstrate that various factors beyond Medicaid reimbursement and healthcare financing contribute to MMR.<sup>157</sup> The reforms proposed are relatively modest and immediate in the face of a significant, ongoing problem. However, the problem and solutions proposed also show that this problem is not restricted to individual behaviors or interactions between doctors and patients. City policy action, or lack thereof, directly contributes to access to prenatal care and has a significant impact on pregnancy outcomes. This is particularly for those who rely on public infrastructure for healthcare and transportation. DC officials have a responsibility to act and act immediately with the sense of urgency that this issue requires.

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157. See *supra* Section II(B)(ii).