Public Comments Regarding Rule 311 – Maternal Health Providers and Remote Monitoring

Lactation Counseling/Consulting Services

1. **Several commenters noted differences in the professional preparation and scope of practice between breastfeeding and lactation *consultants* and certified lactation *counselors.* One commenter suggested removing all references to lactation consultants. Others requested that DHS create two pathways for the different lactation services provided under different credentialing.**

   Response: While we appreciate the differences between consultants and counselors in training, skill level and scope, Act 627 of 2025 specifies that "breastfeeding and lactation consultant" means both "an International Board Certified Lactation Consultant" and a "certified lactation counselor." The only difference between the two in the Act is that counselors must be supervised. Medicaid rules cannot change the requirements specified in state law.

   In addition to being contrary to the language of the Act, removing "consultant" from the policy would effectively remove these highly trained practitioners from the opportunity to enroll and bill as Medicaid providers. We believe this would be counter to the State's goal of increasing access to maternal health support.

2. **Several commenters noted that lactation consultants are considered clinical practitioners, while lactation counselors are considered non-clinical, and they objected to the use of the term "nonclinical" in the title of the manual section as it applies to lactation consultants. Several commenters noted that lactation *counselors* are non-clinical and should not be allowed or required to document treatment plans, methods used to address problems, progress made, or new problems identified.**

   Response: We appreciate the distinction between clinical and non-clinical providers and the valuable role both provide. In order to fully represent the work of each distinct maternal health provider addressed in this Manual, we are changing the title to "Supportive Maternal Health Providers."

   While we agree the lactation counselors are nonclinical, we don't believe they should be treated differently from other lactation consultants in record keeping. Additionally, the statute differentiates between consultants and counselors only for the purpose of supervision and does not single out differences in service documentation. To address the concern that lactation counselors should not be required to perform clinical services, we have updated language around the documentation of treatment plans to clarify that these are service delivery plans and are non-clinical in nature.

3. **Several commenters suggested that DHS explore a formal licensure pathway for International Board Certified Lactation Consultant, separate from lactation counselors.**

Response: Arkansas Medicaid enrolls providers to receive Medicaid reimbursement and does not license or certify health care providers. However, DHS would implement coverage for any health care providers for whom the state establishes a separate licensure and requires licensees to receive coverage.

4. **Several commenters objected to limits on the number of allowable lactation visits, the amount of time postpartum in which beneficiaries qualify for lactation services, the use of telehealth to provide services and allowable group sizes.**

   Response: We appreciate the comments seeking to lift limits on lactation services. While we understand the importance of ensuring accessibility, DMS must ensure that Medicaid Funds are distributed in a manner to ensure accessibility to ALL services. In terms of service limits, it is important to note that DMS opted against imposing a hard limit on the number of claims allowed and instead selected a soft limit that allows for an extension of benefits when medically necessary. However, we reconsidered the length of time for which beneficiaries may receive services and have opted to extend that time to twelve (12) months postpartum.

   We will keep group sizes as they are, but we will reassess after we have sufficient experience with utilization of lactation services.

   While we will continue to require the first lactation services visit to be in-person, we will allow the first visit to be provided in the hospital. Services provided in person in the hospital will be included as part of the per diem and not billed separately, but the visit, when documented in the patient's record by the lactation consultant, can serve as the first in-person visit.

5. **Several commenters noted that the International Breastfeeding Institute is not the main certifying body for lactation counselors, and that the Academy of Lactation Policy and Practice is more widely recognized.**

   Response: We appreciate commenters calling attention to the two different certifying bodies. We have examined the standards of both bodies and will accept certification from either organization to become enrolled as a lactation counselor.

6. **Several commenters suggested adding two place of service codes (02 and 10) to indicate when lactation and doula services are provided through telemedicine.**

   Response: We appreciate the commenters' suggestion to add telehealth place of service codes. We have reconsidered the list of allowable POS codes and will add the two codes to the list.

7. **Several commenters suggested that the reimbursement rates Medicaid selected for lactation services are too low.**

   Response: Arkansas Medicaid appreciates the need to set rates at a level that ensures lactation consultants can provide these services and the state can support a sufficient workforce. Based on public comments, we engaged our actuary to conduct additional research on comparable state

rates. The research examined neighboring states and comparable states, including, Kansas, Missouri Louisiana, and New Mexico. Although some of the states structured their rates differently, the reimbursement rates Arkansas selected were generally comparable to the comparison states. Therefore, we will not change the rates at this time.

Doulas

8. **Several commenters suggested allowing beneficiaries who are receiving community health worker services or who are enrolled in PASSE and those receiving Life360 HOME services to also receive doula services**. Several commenters also suggested that beneficiaries who are receiving doula services should not be prevented from also receiving services from a community health worker.

   Response: These restrictions stemmed from a concern about Medicaid reimbursing for duplicative services for care coordination or home-visiting services and the supportive services of a doula. While these services clearly differ, there is overlap. To ensure Medicaid serves as a good steward of state and federal funding, we have elected to keep most of these restrictions. However, based on the concerns expressed in public comment, we've reconsidered the distinct functions of the PASSE care coordinators and doulas, and we will allow the PASSEs the option of covering doula services for their members.

9. **Several commenters suggested that individuals dually certified as doulas and lactation consultants/counselors should be allowed to bill for both services.**

   Response: Arkansas Medicaid appreciates the additional certification these professionals have obtained and the expertise they bring to Medicaid beneficiaries. Based on this feedback, Medicaid has reconsidered this provision and will allow doulas who are also lactation consultants or counselors to bill for both service types. However, Providers may not double bill (or bill for providing both services at the same time) and records must reflect the times that each service was provided.

10. **Several commenters suggested that the reimbursement rates Medicaid selected for doula services are too low. Commenters noted that the recent experience in neighboring Oklahoma, on which Arkansas based its rates, may suggest that state's rate is too low to serve as an effective model for Arkansas. They suggested establishing a flat global rate that does not require each individual prenatal and postpartum visit to be billed separately.**

    Response: Arkansas Medicaid appreciates the need to set rates at a level that ensures access to doula services for Medicaid beneficiaries. Based on public comments, we engaged our actuary to conduct additional research on comparable state rates, and with that information we elected to maintain the structure and amount of the rates we selected. The research examined neighboring states, including Oklahoma, Kansas, Missouri and Louisiana, and showed the rates selected for Arkansas were generally comparable or better than those in surrounding states. The selected rates are higher than Oklahoma's current rates, which decreased after Arkansas selected the state's rates as a model. Louisiana does use a flat rate, but we will continue to require separate billing for each

service because it mirrors billing for other OB services. Arkansas Medicaid terminated the global OB payment in 2025 to provide greater insight (through claims analysis) into the amount and timing of prenatal services women receive and to ensure payment is provided for the level of services rendered. We elected to handle billing for doula services the same way.

11. **Several commenters noted the CMS requirement that preventive services, including doula services, must be recommended by a licensed provider. They also noted that requiring a referral from a clinical provider to access these services may limit women's access, particularly where providers are not currently familiar with doula services and may not be inclined to refer patients to them. The commenters suggested Arkansas Medicaid issue a standing referral from a physician as other states have done.**

    Response: These commenters correctly state the federal requirement. In accordance with 42 CFR 440.130(c), preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. We agree that requiring a referral may limit access to doula services, especially as clinicians begin working alongside doulas. We appreciate the commenters' suggestion that Arkansas Medicaid issue a standing recommendation from our medical director and have opted to take this approach. We will issue a standing recommendation to allow all pregnant women to access doula services.

12. **Several commenters said the limit on doula visits—four prenatal visits and two postpartum visits—created burdensome restrictions. If Medicaid needs to restrict to six visits, the commenters suggested allowing them to be used as needed, rather than limiting them to four before delivery and two after. Several commenters suggested allowing group doula visits and others suggested extending the coverage of doula services beyond 16 weeks postpartum.**

    Response: Arkansas Medicaid agrees that limiting the visits to six visits—without additional restrictions on when the visits can be used—is a reasonable accommodation. Doula services will be limited to a total of six visits per pregnancy, plus attendance at delivery. We will keep the 16 week limit, but we note that beneficiaries who need additional services may request an extension of benefits. As we begin this coverage, we have opted to provide doula services to only individuals, and not groups, but we will reassess after we have sufficient experience with utilization of doula service services.

13. **One commenter suggested Medicaid eliminate limits on ultrasounds and fetal non-stress tests as a way of increasing access to needed pregnancy monitoring.**

    Response: The commenter correctly notes that Medicaid currently limits ultrasounds and fetal non-stress tests to two per pregnancy. Based on this comment, we have reconsidered these limits in light of expanding access to fetal monitoring, particularly for women in rural areas. Medicaid will eliminate the limits on these services.

14. **Several commenters noted that the Healthy Moms, Healthy Babies Act of 2025 requires Medicaid to cover "Validated blood pressure monitoring devices, such as a blood pressure cuff and replacement cuffs, as medically necessary to diagnose or treat hypertension." These commenters noted that blood pressure cuff, A4663, was not included in the fee schedule.**

Response: We appreciate the commenters noting this oversight. We agree that the Act requires the coverage of replacement cuffs and have added A4663 as a covered code with a reimbursement rate of $25.93.

Kyle Trivedi, Regulatory Lead

Areoflow Health

Comment: On behalf of our over 1.4 million current patients nationally and our company, Aeroflow Health appreciates the opportunity to comment on Arkansas Department of Human Services' Maternal Health Providers and Remote Monitoring Proposed Rule. We appreciate the Department's recognition of the critical role lactation services play in improving maternal and infant health outcomes, and we commend the intention to broaden access to these services.

While we strongly support the proposed expansion, we respectfully submit the following concerns and recommendations to ensure the policy fully meets the needs of Medicaid beneficiaries across Arkansas:

1. Limit on Lactation Consulting Visits

The proposed policy limits breastfeeding and lactation consultant services to a maximum of three visits with the option to request an extension. While we appreciate the inclusion of an extension process, we are concerned that requiring extensions places an unnecessary administrative burden on both patients and providers. These processes can delay care, create confusion, and discourage continued engagement, particularly for vulnerable populations who may face challenges navigating additional paperwork or authorization requirements. Lactation needs are highly specific to the needs of the individual, and often evolve throughout the breastfeeding journey. For this reason, we recommend removing the visit cap altogether so lactation services can be provided based on medical necessity rather than administrative approval.

2. Requirement for Initial In-Person Visit

The proposal requires the initial lactation visit to be conducted in-person, with subsequent visits allowed either in-person or via telehealth. We recommend allowing all lactation visits, including the initial visit, to be conducted via telehealth. Telehealth removes geographic, transportation, childcare, and scheduling barriers, particularly for rural and underserved populations, and has been shown to be effective for lactation counseling and education. In addition, permitting telehealth for all visits would simplify billing requirements and eliminate the need for additional modifiers tied to visit sequencing, thereby streamlining administrative processes for providers and the Department.

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3. Group Lactation Services and Group Size Limits

The proposed policy requires that lactation services provided in a group setting be conducted in person and limits group participation to a maximum of eight individuals. We respectfully recommend allowing group lactation services to be offered via telehealth and permitting larger group sizes with HCPCS code

S9443. In practice, group lactation sessions often experience no-shows, and strict caps can limit access and reduce the efficiency of service delivery. Allowing larger group sizes would help ensure sessions remain viable, maximize participation, and expand access to peer support without compromising quality of care.

4. Place of Service (POS) Codes for Telehealth Services

As the proposed policy permits lactation services to be delivered via telehealth, we recommend explicitly allowing the use of appropriate telehealth Place of Service (POS) codes, including POS 02 (Telehealth Provided Other Than in Patient's Home) and POS 10 (Telehealth Provided in Patient's Home). Clear guidance on allowable POS codes is essential to ensure accurate billing, reduce claim denials, and support consistent implementation across providers.

We believe these changes would significantly enhance access to lactation care, promote health equity, and better support breastfeeding families throughout Arkansas. We appreciate the opportunity to provide feedback and thank the Department for its leadership and commitment to maternal and infant health.

Response: See #4 and #6 above.

Marsha Walker, RN, IBCLC, President, and

Merrilee Gober, BSN, RN, JD, NLCA Board Member

National Lactation Consultant Alliance

Comment: We, the National Lactation Consultant Alliance, appreciate the opportunity to comment on the proposed rules and State Plan Amendment for the provision of lactation services within the *Maternal Health Providers and Remote Monitoring* package. We write to you today to express several concerns within this package. Our concerns will make more sense if we first outline the lactation personnel landscape. Lactation personnel are divided into three categories[i]:

1) The International Board Certified Lactation Consultant (IBCLC) – the holder of this credential has had 14 college health science courses, at least 95 hours of lactation specific education, 300-1000 hours of supervised clinical training and has passed an independent criterion referenced board exam. The IBCLC is prepared to provide individualized clinical lactation care. The clinical work of the IBCLC includes the taking of a medical history of the mother and of the baby which also includes the labor and delivery information of the dyad; physically examining each; observing a feed, assimilating the subjective and objective data acquired; using their expert knowledge and information learned to determine the issues presented and to prioritize those issues; creating a plan of care with the family; educating the family; communicating with the primary treating physician(s) for continuity of care; documenting the encounter in a patient record; and following-up to measure the effectiveness of the plan or the need for modification of the plan.

2) Breastfeeding/Lactation Educator or Counselor – a person in this category may hold one of more than 20 different "credentials." Most of the education courses do not have any prerequisites, not even a high school diploma. The education course could be in-person, but most are now conducted online. Course work can be as little as a few days of time. There are NO supervised hands-on clinical training hours working with mother/baby dyads to develop clinical judgment, critical thinking and clinical skills. Some may have to pass an exam given by the education entity/company to receive their credential or certificate. There is no independent exam verifying knowledge. The people in this category provide education and support.

3) Breastfeeding Peer Supporter – a person in this category has to have successfully breastfed their own baby. Some additional breastfeeding/lactation education is also usually required. Generally, a high school diploma is not required. The most common groups of people in this category are WIC peer counselors and La Leche League Leaders. The people in this category are capable of conveying general breastfeeding information and providing peer support.

The Women's Preventive Services Initiative (WPSI) a coalition of multiple physician, nursing and patient advocacy organizations, led by the American College of Obstetricians and Gynecologists (ACOG) and funded by the Health Resources and Services Administration, delineates the IBCLC in the same category as physicians and nurses relative to clinical lactation care services. It identifies other lactation personnel, such as the breastfeeding and lactation counselors listed in the proposed rules and SPA, as able to provide nonclinical education, counseling and basic support, not clinical care. WPSI states:

*"Clinical lactation professionals providing clinical care include, but are not limited to, licensed lactation consultants, the IBCLC®, certified midwives, certified nurse-midwives, certified professional midwives, nurses, physician assistants, nurse practitioners, and physicians. Lactation personnel providing counseling, education or peer support include lactation counselors/breastfeeding educators and peer supporters."****[ii]***

Supervised Clinical Hours are Critical for the Provision of Clinical Care

The supervised clinical training component for all healthcare clinicians is where the critical thinking, clinical reasoning, and clinical judgment skills are developed and sharpened to prepare students to function independently with competence. The educational programs of the breastfeeding and lactation counselors identified in the proposed rules provide no clinical training. They are able to provide general breastfeeding education and support as shown in Chart 1 below (as published by the Academy of Breastfeeding Medicine).[iii] They are not trained to do physical assessments or to create a plan of care for a patient.

Chart 1

TABLE 1. LACTATION CARE SPECIALISTS BY EDUCATION,CREDENTIAL, AND SCOPE

Breastfeeding and Lactation Specialist Type	Supervised Clinical Education	Credential or Designation	Hands-on Training Requirement	Clinical Lactation Assessment and Plan of Care	Diagnosis and Treatment of Medical Issues
BFLM Provider	Undergraduate and Graduate Medical Education (6-8 years), Medical Residency (3-6 years) OR Advanced Supervised Clinical Training or Practicum (e.g., NP: 500 hours, CNM: 2-3 years)	Board certification varies by country and specialty NABBLM-C FABM	Yes	Yes	Yes
Community Supports (e.g., LLL, CHW)	Varies	None	Personal breastfeeding experience, mentorship	No	No
IBCLC®	95 didactic hours plus 300-1000 clinical hours	IBCLC®	Yes	Yes	No
Peer Counselor (e.g., WIC)	Varies	None	Personal breastfeeding experience, mentorship	No	No
Other (country-specific)	Varies	CLC®/CLE® Champion Counselor	Varies	No	No

BFLM, breastfeeding and lactation medicine; CLC, certified lactation counselor; CLE, certified lactation educator; CNM, certified nurse midwife; CHW, community health worker; FABM, Fellow of the Academy of Breastfeeding Medicine; IBCLC, International Board Certified Lactation Consultant; LLL, la leche league; NABBLM-C, North American Board of Breastfeeding and Lactation Medicine; NP, nurse practitioner; WIC, women, infant and children.

Clinical patient care inherently has risk of harm—clinical lactation care is no different. S.U. v. N.Y. Univ. Langone Med. Ctr., 144 N.Y.S. 3d 837 (N.Y. Sup. Ct. 2021) aptly demonstrates that risk—a lawsuit where the family asserted that there was an inadequate lactation assessment and inadequate follow-up instructions which led to the infant becoming dehydrated, developing severe jaundice and permanent brain damage. Moreover, when not properly/timely assessed and cared for, a woman's breasts during lactation are also subject to permanent physical damage and disfigurement when abscesses occur.

Since these proposed rules at the outset indicate that they are for Nonclinical Maternal services, the IBCLC does not belong in these rules. Comingling the clinical services of IBCLCs with those of breastfeeding and lactation counselors creates confusion for families, physicians and hospitals and puts patients at risk of harm. Clear lines of demarcation need to be established between clinical and nonclinical services to optimize the delivery of risk-appropriate care for families.

Thus, with that preamble of information, we recommend the following edits to the proposed rules and SPA: 200.100

A. "Breastfeeding and lactation counselor ~~consultant~~" means:

1. ~~An International Board Certified Lactation Consultant certified by the International Board of Lactation Consultant Examiners~~ A Certified Lactation Counselor certified by the Academy of Lactation Policy and Practice (a.k.a. Healthy Children Project, Inc.); or

2. A Certified Breastfeeding Counselor certified by the International Breastfeeding Institute.

A certified breastfeeding or lactation counselor must be supervised….

B. "Breastfeeding and lactation consultant counselor services means ~~medically~~ general education and support ~~appropriate~~ outpatient services or hospital services, or both, provided by a breastfeeding

and lactation consultant counselor during pregnancy and through the first six months of the infant's life ~~to aid in milk expression or infant nutrition~~;

Through the remainder of this document, in every place where there is the term "consultant," we suggest changing it to "counselor."

220.500 Documentation Requirements –since lactation and breastfeeding counselors are not clinicians, are not qualified to perform individual assessments and create care plans, and these services are titled "Nonclinical Maternal Care," we believe that it is inappropriate, and perhaps dangerous, to have clinical criteria as part of the required documentation. Therefore, we suggest deleting A. 4., 5, 6, and 8.

With regard to the draft SPA (on page 20), we offer the following edits:

Breastfeeding and Lactation ~~Consultants~~ Counselors:

A breastfeeding and lactation ~~consultant~~ counselor ~~is a trained professional specializing~~ specializes in providing ~~medically general breastfeeding education and support services. appropriate care to aid in milk expression or infant nutrition~~. Breastfeeding and lactation ~~consultants~~ counselors are non-clinical and do not provide medical care, although some breastfeeding and lactation ~~consultants~~ counselors hold licenses as other healthcare professionals. When only certified to provide breastfeeding and lactation ~~care~~ counselor services, they cannot replace the services of licensed and trained medical professionals including, without limitation, physicians, physician assistants, advanced practice registered nurses, and certified nurse midwives.

Breastfeeding and lactation ~~consultant~~ counselor services are ~~medically appropriate~~ general education and support outpatient services or hospital services, or both, provided by a breastfeeding and lactation ~~consultant~~ counselors during pregnancy and through the extended postpartum period. ~~to aid in milk expression or infant nutrition~~.

Eligibility Requirements for breastfeeding and lactation ~~consultants~~ counselors are:

• Breastfeeding and lactation consultants counselors must be at least eighteen (18) years of age and have an NPI number and

• Meet one of the following certifications:

o ~~An International Board-Certified Lactation Consultant~~ A Certified Breastfeeding Counselor; or

o A Certified Lactation Counselor;

♣ Certified Breastfeeding and Lactation Counselors are required to be supervised by a Medicaid

enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:

A. An agency led by an International Board-Certified Lactation Consultant;

B. A physician, advanced practice nurse, or physician assistant

C. A local health unit or

D. A hospital

Thank you for your consideration of these changes to protect the safety of Arkansas' mothers and babies. We would be happy to speak to you or any of your staff, by zoom or a call, if you desire any further resources or other information.

Citations:

[i] For more detail on Lactation Personnel, see the attached NLCA Knowledge Brief *Orientation to Lactation Personnel*, also found at https://nlca.us/resources/publications/

[ii] Women's Preventive Services Initiative. (2022). *Breastfeeding services and supplies*. https://www.womenspreventivehealth.org/recommendations/breastfeeding-services-and-supplies/

[iii] Rosen-Carole, C.B., Prieto, E., AlHreashy, F., et al. (2025). Current scope of practice for breastfeeding and lactation medicine physicians and providers: Description of an emerging subspecialty. *Breastfeeding Medicine, 20*(9), 601-614.

Comment:

NLCA
NATIONAL LACTATION CONSULTANT ALLIANCE

Knowledge Brief

Orientation to Lactation Personnel

Introduction

The need to protect, promote, and support breastfeeding has been at the forefront of maternal and child health interventions for decades. While breastfeeding may be a natural process, education, support, and clinical lactation care are needed for the successful initiation of breastfeeding and to address challenges to the breastfeeding and lactation process. The lactation field is replete with a bewildering array of personnel who fulfill these roles, but their titles can be confusing to parents, policy makers, legislators, insurers, employers, hospitals, and the healthcare system.1 The National Lactation Consultant Alliance (NLCA) recognizes the following three catagories of lactation personnel, each with specific qualifications based upon the extent of their education and training:[1]

LACTATION CONSULTANT

International Board Certified Lactation Consultant (IBCLC®) provides clinical lactation care, especially in high-risk or complex cases

BREASTFEEDING/LACTATION EDUCATOR OR COUNSELOR

There are approximately 20 designations in this category providing basic breastfeeding education and counseling (Table 1)

BREASTFEEDING PEER SUPPORTER

Mother-to-mother support personnel who provide basic support and encouragement

The US Women's Preventive Services Initiative (a joint program between the US Health Resources and Services Administration (HRSA) and led by the American College of Obstetricians and Gynecologists (ACOG) defines lactation personnel as follows:

> *"Clinical lactation professionals providing clinical care include, but are not limited to, licensed lactation consultants, the IBCLC®, certified midwives, certified nurse-midwives, certified professional midwives, nurses, physician assistants, nurse practitioners, and physicians.*
>
> *Lactation personnel providing counseling, education or peer support include lactation counselors/ breastfeeding educators and peer supporters."* [2]

The Academy of Breastfeeding Medicine also provides a clear line of demarcation identifying only IBCLCs as allied healthcare lactation personnel who are able to perform clinical lactation assessment and plan of care.[3]

Recommendations

1. NLCA recommends that legislators and policy makers exercise specificity in defining lactation personnel when writing legislative bills or policies. The three categories of personnel are not equivalent in preparation and are not interchangeable. Co-mingling lactation personnel increases the risk for harm.
2. The healthcare system including hospitals, clinics, insurers, and physician offices should be aware of the differences among lactation personnel such that risk appropriate lactation services are provided.
3. Understand the difference between education, support, and clinical care.

    - Education involves providing basic breastfeeding and lactation teaching
    - Support involves offering encouragement
    - Clinical care involves:
        - Taking an individualized maternal, child, and feeding history
        - Performing clinical assessments related to breastfeeding and human lactation through the systematic collection of subjective and objective information
        - Analyzing data using critical thinking, clinical reasoning, and clinical judgment skills acquired through precepted clinical experience
        - Developing a lactation management and child feeding plan with demonstration and instruction to parents
        - Providing lactation and feeding education
        - Recommending and training on the use of assistive devices
        - Communicating to the primary health care practitioner(s) and referring to other healthcare practitioners, as needed
        - Conducting appropriate follow-up with evaluation of outcomes
        - Documenting the encounter in a patient record

Table 1

CATEGORY		
International Board Certified Lactation Consultant®	**IBCLC®** **PREPARATION** • 14 Allied healthcare core college courses, 95 hours of lactation-specific education, and 300-1000 clinical lactation care training hours with patients. • Pass an independent, psychometrically validated board certification exam.	**SERVICE** Evidence-based clinical lactation care, education, and support
Breastfeeding and Lactation Educator or Counselor	**Advanced Lactation Consultant (ALC) Advanced Nurse Lactation Consultant (ANLC) Baby Café Breastfeeding Counselor (BCBC) Blactation Educator (BE) Breastfeeding Counselor (BC) Breastfeeding Counselor (BFC) Breastfeeding Educator Certification (BEC) Certified Breastfeeding Counselor (CBC) Certified Breastfeeding Educator (CBE) Certified Breastfeeding Specialist (CBS)**	**Certified Lactation Educator (CLE) Certified Lactation Educator Specialist (CLES) Certified Lactation Counselor (CLC®) Certified Lactation Specialist (CLS) Community Lactation Educator (LE(C)) Indigenous Breastfeeding Counselor (IBC) Lactation Education Counselor (LEC) Lactation Educator (LE) Military Lactation Counselor (MiLC)**

	PREPARATION • Array of lactation-specific education requirements. • May need to pass an exam given by the education entity/company to receive their credential, certification, or certificate. • Most have no requirement of high school diploma, General Education Diploma (GED), college courses, or clinical care training. • There is no universal, independent exam verifying knowledge and skill.	**SERVICE** Breastfeeding and lactation education and counseling
Breastfeeding Peer Supporter	**Breastfeeding Counselor (BC)** **Breastfeeding Heritage and Pride Program (BHP Peer Counselor)** **Breastfeeding Peer Counselor (BPC)**	**La Leche League Leader (LLLL)** **Reaching Our Sisters Everywhere, Community Transformer (ROSE CT)** **Women, Infants, and Children Breastfeeding Peer Counselor (WIC BFPC)**
	PREPARATION • Required to have personal breastfeeding experience and variable hours of education, some of which may be self-study. • No requirement of high school diploma, GED, college courses or clinical care training. • There is no universal, independent exam verifying knowledge and skill.	**SERVICE** Breastfeeding education and peer support.

Source Footnote 1

CITATIONS:

1 Strong, G., Gober, M., & Walker, M. (2023). Speaking the same language: A call for standardized lactation terminology in the United States.

Journal of Human Lactation, 39(1), 121-131.

2 Women's Preventive Services Initiative. *Breastfeeding services and supplies.* https://www.womenspreventivehealth.org/recommendations/ breastfeeding-services-and-supplies/

3 Rosen-Carole, C.B., Prieto, E., AlHreashy, F., et al. (2025). Current scope of practice for breastfeeding and lactation medicine physicians and providers: Description of an emerging subspecialty. https://www.bfmed.org/assets/DOCUMENTS/PositionStatements/Final_Org_ ScopeofPracticePaper.pdf

Response: See #1-2 above.

Amy Tedrow, Director of Supportive Services

Arkansas Doulas

Comment: On behalf of Arkansas Doulas, one of Arkansas's longest-serving and largest doula agencies providing maternal support services to families across urban and rural communities statewide, we

appreciate the opportunity to submit public comment regarding the proposed rules for lactation services within the Nonclinical Maternal Health Services package.

Our agency supports families in hospital settings, private homes, and community-based programs throughout Arkansas. We work in collaboration with physicians, nurses, WIC programs, and lactation professionals to ensure families receive coordinated, risk-appropriate care.

We strongly support expanding access to breastfeeding education and postpartum support. Both non-clinical lactation counseling and clinical lactation care are essential components of comprehensive maternal health services.

Within our agency, several doulas hold Certified Lactation Counselor (CLC) credentials and provide general breastfeeding education, encouragement, and foundational troubleshooting. These services are valuable and often sufficient for families with straightforward feeding questions.

However, when concerns move beyond education and into clinical territory, such as suspected inadequate milk transfer, dehydration risk, latch trauma, mastitis, jaundice risk, or feeding complications involving maternal or infant medical history, we refer families to an International Board Certified Lactation Consultant (IBCLC). This referral structure works because there is a clear understanding of scope:

- CLCs provide education and general support. CLCs do not have clinical training.
- IBCLCs provide clinical assessment, hands-on evaluation, individualized care planning, and coordination with medical providers when indicated. IBCLCs have clinical training and extensive education.

This distinction protects families and strengthens continuity of care.

For this reason, we are concerned that classifying IBCLCs solely within a “Nonclinical Maternal Care” framework may unintentionally blur established scope boundaries. In hospital and healthcare environments, clinical designation influences credentialing standards, liability coverage, supervision requirements, and interdisciplinary integration.

From a doula agency perspective, regulatory clarity is not about hierarchy, it is about patient safety, coordination, and appropriate escalation of care.

Families depend on us to recognize when education is sufficient and when clinical evaluation is necessary. Clear regulatory separation between non-clinical lactation support services and clinical lactation care ensures that this tiered system continues to function effectively across hospitals, WIC programs, public health partnerships, and private practices.

We respectfully encourage the Department to establish distinct regulatory pathways that reflect the different levels of training, scope, and responsibility within lactation services.

Arkansas families deserve a maternal health system that supports education, peer support, and clinical expertise, each operating within clearly defined parameters.

Thank you for your thoughtful consideration and for your continued commitment to strengthening maternal health services across our state.

Response: See #2-3 above.

Sondra Rodocker, IBCLC, CLD, CPD

Arkansas Breastfeeding Clinic

Comment received by email on February 25, 2026

Comment: I appreciate the opportunity to submit public comment regarding the proposed rules for lactation services within the Nonclinical Maternal Health Services package.

While I strongly support expanding access to breastfeeding education and support, it is essential that the Department establish separate regulatory pathways for non-clinical lactation support services and clinical lactation care.

National standards clearly distinguish between clinical lactation care and non-clinical education/support services.

The Women's Preventive Services Initiative (WPSI), led by the American College of Obstetricians and Gynecologists (ACOG) and supported by HRSA, identifies International Board of Certified Lactation Consultants (IBCLCs) alongside licensed healthcare providers when delivering clinical lactation care. These standards recognize IBCLCs as clinicians who perform individualized assessment, clinical decision-making, care planning, documentation, and coordination with other medical providers.

In contrast, lactation counselors and peer supporters are recognized as providing general education and support services.

Maintaining this distinction is critical for regulatory consistency and patient safety. Since lactation counselors and lactation consultants are not interchangeable, intermingling the two interferes with the delivery of risk-appropriate care.

Placing IBCLCs within a "Nonclinical Maternal Care" framework materially alters how care can be delivered in hospital, public health, and private practice settings.

Clinical lactation care involves:

- Physical assessment of the lactating mother and infant
- Hands-on evaluation of latch and milk transfer
- Identification of complications such as dehydration, jaundice risk, nipple trauma, mastitis, or insufficient intake
- Development of individualized plans of care

- Clinical documentation and provider communication

If IBCLCs are formally classified as non-clinical providers under Medicaid regulation, this designation may restrict or complicate their ability to perform hands-on clinical assessments within hospital systems and other healthcare environments. Hospitals rely on clearly defined clinical roles when credentialing staff, determining scope of practice, and establishing liability coverage.

Reclassifying IBCLCs as non-clinical under state rule could:

- Create confusion within hospital credentialing departments
- Affect how IBCLCs are integrated into inpatient postpartum care
- Impact WIC programs that collaborate with clinical providers
- Disrupt private practices that provide clinical lactation assessment under medical referral
- Introduce liability ambiguity for facilities employing IBCLCs

In practical terms, this classification may unintentionally limit the full scope of clinical lactation care that hospitals and health systems are currently able to provide. Even routine elements of clinical lactation practice — such as performing a physical assessment or hands-on latch evaluation — depend upon recognition of the provider as functioning in a clinical capacity.

The proposed rules also require elements such as treatment planning, problem identification, progress documentation, and diagnosis coding. These are hallmarks of clinical care. If services are defined as non-clinical, documentation requirements should align with education and support functions.

If the intent is to include clinical lactation services within Medicaid coverage, then IBCLCs should be regulated within a clinical framework consistent with national standards and their scope of preparation.

I respectfully urge the Department to:

1. Establish separate regulations for non-clinical lactation education/support services and clinical lactation care. Additionally, the Department may wish to explore a formal licensure pathway for IBCLCs in the future, as licensure would provide regulatory clarity, formal scope recognition, and a clear distinction between clinical lactation providers and non-clinical support personnel.
2. Clearly define the scope and documentation expectations for each provider category.
3. Ensure alignment with national standards recognizing IBCLCs as clinical lactation providers.

Clear delineation protects:

- Mothers and infants
- Hospitals and healthcare system

Response: See 1, 2 and 3 above.

Sondra Rodocker, IBCLC, CLD, CPD

Comment Received by email on March 9, 2026

Comment: Thank you for the opportunity to submit public comment regarding provisions proposed for inclusion in the Community-Based Doula Provider Manual. On behalf of Arkansas Breastfeeding Clinic, we appreciate the state's efforts to expand maternal health services and strengthen the perinatal workforce serving Arkansas families.

As a clinical lactation practice serving mothers and infants across Arkansas, we work closely with obstetric providers, pediatricians, nurses, community programs, and doulas to support families during pregnancy and the postpartum period. We strongly support initiatives that increase access to non-clinical maternal support services, including community-based doulas, as part of a comprehensive maternal health system.

Research has consistently shown that doula support during pregnancy and childbirth improves maternal experiences and birth outcomes. In our experience working with families across the state, doulas often play an important role in helping families prepare for birth, navigate the postpartum transition, and access additional resources when concerns arise.

For this reason, we support efforts to ensure that community-based doula services remain accessible to families who may benefit from this support, including those participating in programs such as PASSE and Life 360 Home. Individuals enrolled in these programs often experience complex medical, social, or behavioral health challenges, and additional perinatal support may help mitigate risks during pregnancy and the postpartum period.

We also recognize the importance of reimbursement structures that allow doulas to sustainably provide continuous support to families, particularly in rural and underserved areas of Arkansas where maternal health resources are limited.

Fee Schedule

The current proposal reimburses a maximum total of $933.20 for prenatal visits, postpartum visits, and birth support. Once contracted rates are negotiated, the effective reimbursement may be further reduced. At this level, the proposed structure does not reflect the scope of work required for doulas to provide continuous, high-quality care.

Most doula organizations in our state charge fees that range from $1,300 and $1,800 for base service package depending on the doulas experience. Doulas spend approximately 90 minutes with clients during prenatal visits and two to three hours during postpartum visits. In addition, doulas remain on call for weeks leading up to labor and often provide many hours of continuous support during birth.

Regardless of the birth outcome, doulas remain with families throughout labor and continue providing support immediately following birth.

To better align reimbursement with the realities of a practices needs and to compensate the doulas fairly and support workforce sustainability, we recommend the following: • A flat birth support reimbursement of $900 • 64 billable 15-minute units at $20 per unit for prenatal and postpartum visits, allowing families flexibility in determining how services are used. This structure supports both family autonomy and the practical realities of doula care.

Lactation Services

We would also like to address the intersection between community-based doula services and lactation support.

Many doulas provide breastfeeding education as part of their perinatal support role, and some hold additional credentials such as Certified Lactation Counselor (CLC). These providers offer valuable early breastfeeding education, encouragement, and support for families initiating infant feeding.

Within our clinical practice, we frequently receive referrals from doulas when breastfeeding concerns extend beyond general education and require clinical evaluation. This collaborative referral model works well for families because it allows non-clinical support providers and clinical lactation consultants to function within clearly defined scopes of practice.

International Board Certified Lactation Consultants (IBCLCs) are trained to conduct comprehensive maternal and infant feeding assessments, evaluate milk transfer, identify complications such as dehydration risk, jaundice, latch trauma, mastitis, and other feeding challenges, and coordinate care with pediatricians, obstetric providers, and nursing staff when clinical concerns arise.

As outlined in the formal public comment previously submitted by Arkansas Breastfeeding Clinic regarding lactation services, we respectfully reiterate the importance of maintaining a clear distinction between non-clinical breastfeeding education and clinical lactation care.

Hospitals, WIC programs, and healthcare providers rely on clearly defined clinical roles when determining credentialing standards, scope of practice recognition, and interdisciplinary care coordination. Maintaining regulatory clarity between non-clinical lactation support and clinical lactation care helps ensure that families receive risk-appropriate services and that referral pathways between doulas, lactation professionals, and medical providers remain strong.

We appreciate the Department's continued efforts to strengthen maternal and infant health services across Arkansas and thank you for considering the perspectives of providers working directly with families during pregnancy and the postpartum period.

Response: See #1, 7, 9 and 10 above.

Sondra Rodocker, IBCLC, CLD, CPD

Public hearing held remotely 02/25/26 @ 9:30 AM CST

Comment: Thank you. I have submitted my comment via email, but I wanted to speak out today as well just so my voice can go with this when you guys are reviewing this.

Dear Ms. Pitman, I appreciate the opportunity to submit public comments regarding the proposed rules for lactation services within the Nonclinical Maternal Health Services packages. While I strongly support expanding access to breastfeeding education and support, it is essential that the Department establish separate regulatory pathways for non-clinical lactation support and clinical lactation care. National standards clearly distinguish between clinical lactation care and non-clinical education/support services.

The Women's Preventive Services Initiative led by the American College of Obstetricians and Gynecologists and supported by HRSA, identifies International Board-Certified Lactation Consultants alongside licensed healthcare providers when delivering clinical lactation care. These standards recognize IBCLCs as clinicians who perform individualized assessment, clinical decision-making, care planning, documentation, and coordination with other medical providers. In contrast, lactation counselors and peer supporters are recognized as providing general education and support services. Maintaining this distinction is critical to regulatory consistency and patient safety. Since lactation counselors and lactation consultants are not interchangeable, intermingling the two interferes with the delivery of riskappropriate care.

Placing IBCLCs within a "Nonclinical Maternal Care" framework materially alters how we can deliver care in hospital, public health, and private practice settings. Clinical lactation care involves physical assessment of the lactating mother and infant; hands-on evaluation of latch and milk transfer; identification of complications such as dehydration, jaundice risk, nipple trauma, mastitis, or insufficient intake; development of individualized plans of care and clinical documentation and provider communication. If IBCLCs are formally classified as non-clinical providers under Medicaid regulation, this designation may restrict or complicate their ability to perform hands-on clinical assessments within hospital settings and other healthcare environments. Hospitals rely on clearly defined clinical roles when credentialing staff, determining scope of practice, and establishing liability coverage. Reclassifying IBCLCs as nonclinical under state rule could: create confusion within hospital credentialing departments; affect how IBCLCs are integrated into inpatient postpartum care; impact WIC services that collaborate with clinical providers; disrupt private practices that provide clinical lactation assessment under medical referral; and introduce liability ambiguity for facilities employing IBCLCs.

In practical terms, this classification may unintentionally limit the full scope of clinical lactation care that hospitals and health care systems are currently able to provide. Even routine elements of clinical lactation practice such as performing a physical assessment or hands-on latch evaluation depend upon recognition of the provider as functioning in a clinical capacity.

The proposed rules also require elements such as treatment planning, problem identification, progress documentation, and diagnosis coding. These are hallmarks of clinical care. If services are defined as non-clinical, documentation requirements should align with education and support functions. If the intent is to include clinical lactation services within Medicaid coverage, then IBCLCs should be regulated within a

clinical framework consistent with national standards and their scope of preparation. I respectfully urge the Department to: One, establish separate regulations for nonclinical lactation education and support services and clinical lactation care.

Additionally, the Department may wish to explore a formal licensure pathway for IBCLCs in the future, as licensure would provide regulatory clarity, formal scope recognition, and a clear distinction between clinical lactation providers and non-clinical support personnel; clearly define the scope and documentation expectations for each provider category and ensure alignment with national standards recognizing IBCLCs as clinical lactation providers. Clear definitions protect mothers and infants; hospitals and healthcare systems; WIC and public health programs; private clinical practices and the integrity of Medicaid reimbursement.

With thoughtful revision, Arkansas can expand access to lactation services while preserving public safety, workforce stability, and regulatory clarity. Thank you for your careful consideration of this important matter.

Response: Please see #1-3 above.

Katie Atkins, Owner

Arkansas Lactation

Comment: I am the owner of a private, multidisciplinary lactation practice in Arkansas that employs 12 International Board Certified Lactation Consultants (IBCLCs) and serves more than 350 mother–infant dyads each month across outpatient, and community settings. Our practice also includes mental health therapists, occupational therapists, dietitians, and a nurse practitioner, allowing us to provide coordinated, comprehensive care to families with both routine and complex needs. I strongly support expanding access to breastfeeding education and lactation support for families in our state. However, I am deeply concerned about the placement of IBCLCs within a non-clinical regulatory framework and the potential consequences this may have for patient care, provider integration, and healthcare systems.

In daily practice, IBCLCs provide clinical lactation care, not general education alone. Our work routinely involves physical assessment of both the lactating parent and infant, hands-on evaluation of latch and milk transfer, identification of medical complications such as dehydration, jaundice risk, nipple trauma, mastitis, or insufficient intake, and the development of individualized plans of care. We document clinically, communicate with referring providers, and coordinate care within our multidisciplinary team and with external medical providers when intervention is needed. These services require clinical judgment, accountability, and integration within healthcare systems. In practice, this level of clinical lactation care helps prevent avoidable emergency department visits and hospital readmissions, while supporting early intervention and more efficient use of healthcare resources.

National standards recognize this distinction. IBCLCs are identified alongside licensed healthcare providers when delivering clinical lactation care, while lactation counselors and peer supporters are

appropriately recognized as providing non-clinical education and support. These roles are both valuable, but they are not interchangeable. Treating them as such interferes with the delivery of risk-appropriate care, particularly for medically complex dyads.

From a practical standpoint, classifying IBCLCs as non-clinical under Medicaid regulation would significantly alter how care can be delivered in real-world settings. Hospitals and health systems depend on clearly defined clinical roles for credentialing, scope-of-practice determinations, and liability coverage. In my experience, any ambiguity around whether IBCLCs are functioning in a clinical capacity creates immediate barriers to hospital access, inpatient care integration, and collaboration with medical providers.

This classification could also disrupt established care models in Arkansas by creating confusion within hospital credentialing departments, complicating partnerships with WIC and public health programs, and undermining private practices like mine that deliver clinical lactation services within interdisciplinary and medically integrated models of care. Even routine elements of lactation care—such as performing a physical assessment or hands-on feeding evaluation—depend on recognition of the provider as operating in a clinical role.

Additionally, the proposed rules include requirements such as treatment planning, problem identification, progress documentation, and diagnostic coding. These are hallmarks of clinical care. If lactation services are defined as non-clinical, documentation and regulatory expectations should reflect education-based support rather than clinical service delivery. As written, the rules create a mismatch between how services are defined and what is required of providers.

If the intent of these rules is to meaningfully include clinical lactation services within Medicaid coverage, then IBCLCs must be regulated within a framework that aligns with national standards and accurately reflects their education, training, and scope of practice. I respectfully urge the Department to establish separate regulatory pathways for non-clinical lactation education and support services and for clinical lactation care, clearly define scope of practice and documentation expectations for each provider category, and ensure alignment with national standards recognizing IBCLCs as clinical lactation providers. In the future, the Department may also wish to explore a formal licensure pathway for IBCLCs to provide additional regulatory clarity and formal scope recognition.

Clear delineation protects mothers and infants, supports hospitals and healthcare systems, strengthens multidisciplinary care models, preserves collaboration with WIC and public health programs, safeguards private clinical practices, and supports the integrity of Medicaid reimbursement. With thoughtful revision, Arkansas can expand access to lactation services while maintaining patient safety, workforce stability, and regulatory clarity.

Thank you for your time and consideration of this important issue.

Response: See 2-3 above.

Tanya Smith, BA, IBCLC

Comment: Provider Impact Statement for Arkansas Medicaid Coverage for Breastfeeding and Lactation Consultant Services

My name is Tanya Smith, and I am an International Board-Certified Lactation Consultant (IBCLC) with a community-based practice in Central Arkansas. The proposed rules and fee schedule establishing Medicaid reimbursement for breastfeeding and lactation consultant services represent an important step forward for maternal and infant health in Arkansas. However, several provisions, particularly the misclassification of International Board-Certified Lactation Consultants (IBCLCs) as nonclinical providers, inadequate reimbursement levels, and restrictive visit limits and timeframes—are likely to significantly limit provider participation and reduce beneficiary access if not revised.

Clarification of IBCLC Clinical Status

The proposed rules classify breastfeeding and lactation consultants, including IBCLCs, as nonclinical providers. This characterization is inaccurate and creates unnecessary regulatory and reimbursement barriers.

IBCLCs are clinical providers who deliver medically necessary, evidence-based lactation and infant feeding care within a recognized clinical scope of practice. Their services include clinical assessment, intervention, care planning, and coordination with licensed medical professionals. While IBCLCs may not be independently licensed under state law, their services constitute clinical care, not nonclinical support.

IBCLCs undergo extensive education, supervised clinical training, and ongoing recertification. Reimbursement at the proposed levels may:

- Undermines professional credibility
- Creates ambiguity regarding scope of practice
- Contributes to undervaluation in reimbursement methodologies
- Discourages provider enrollment and retention

IBCLC services are recognized as clinical services by the Centers for Medicare & Medicaid Services (CMS) when included in state Medicaid plans as preventive or diagnostic services, commercial payers, and multiple state Medicaid agencies. Classifying IBCLCs as nonclinical creates inconsistency with how IBCLC services are treated nationally.

Accurate classification is essential to ensure appropriate integration of IBCLCs into Arkansas's maternal and infant healthcare system.

Reimbursement Adequacy

The proposed fee schedule reimburses lactation consultant services at approximately $61.88 per hour, regardless of visit complexity or clinical acuity. After accounting for non-billable time, documentation requirements, travel for home visits, professional liability insurance, certification maintenance, and administrative overhead, this reimbursement level is not sufficient to support sustainable independent or community-based IBCLC practice.

Inadequate reimbursement may discourage Medicaid enrollment, limit participation, and reduce access in rural communities. Without adequate provider participation, beneficiaries may have longer wait times, fewer provider options, or limited access to services.

Visit Limitations and Timeframes

The proposed limit of three lactation visits per pregnancy and three visits per infant within six months of life does not reflect the clinical realities or standards of lactation care.

The standard of care supports continued breastfeeding with appropriate clinical support for at least 12 months and is in line with limitations in other states with Medicaid coverage for lactation. Many common breastfeeding challenges such as low milk supply, infant feeding dysfunction, return-to-work transitions, multiple gestation, and post-NICU discharge support occur after six months and require ongoing clinical follow-up.

Restrictive visit limits and timeframes may:

- Prevent delivery of clinically appropriate care
- Increase administrative burden through extension requests
- Place providers in ethically challenging situations when medically necessary care is not reimbursable
- Discourage providers from accepting high-acuity or complex cases

Additionally, limiting telehealth to follow up visits only makes lactation care available only to those who live in large metro areas and leaves a large portion of the state without care.

Summary of Recommendations

1. Correct the classification of IBCLCs to reflect their role as clinical providers delivering medically necessary care
2. Increase lactation reimbursement rates to align with national Medicaid benchmarks and account for differences between clinical and nonclinical providers.
3. Expand visit limits or allow additional visits based on medical necessity. If a limitation is necessary, six visits would reduce administrative burden for exceptions. Limiting coverage to 12 months would account for medical challenges during later stages of lactation.
4. Align documentation requirements with the provider's scope of practice and reimbursement Level.
5. Consider allowing telehealth for initial visits for underserved/rural areas to improve network adequacy.

Thank you for the work you are doing to improve the health of Arkansas mothers and babies.

Response: See 2,4 and 7 above.

Dave Oberembt, State Government Relations Director for Arkansas

American Heart Association

Comment: The American Heart Association (AHA) appreciates the opportunity to submit comments on the proposed Maternal Health Providers and Remote Monitoring rules and fee schedule.

The AHA believes everyone should have access to quality and affordable healthcare coverage. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we strongly support sustainable and impactful policy solutions that help prevent maternal death and ensure all mothers can live healthy lives before, during, and after giving birth.

Hypertension disorders in pregnancy are a leading, largely preventable threat to maternal health during pregnancy and later in life, and is one of leading causes of maternal death in the US.[1] Self-measured blood pressure devices and services provide a convenient and easy to use option for patients and clinicians to monitor and manage blood pressure for individuals at risk of, or with, pregnancy hypertension. The AHA supported passage of the Healthy Moms, Healthy Babies Act in 2025, and now supports Arkansas's proposed rules (with one requested addition) to implement self-measured blood pressure coverage for pregnant and postpartum women enrolled in Medicaid.

The AHA was pleased to see Current Procedural Terminology codes 99453, 99454, 99457, 99458, and 99091 included in the Maternal Health Providers and Remote Monitoring Fee Schedule as part of the proposed rules. These remote physiologic monitoring codes will allow clinicians to support patients as they monitor their blood pressure at home.

The AHA also appreciates the inclusion of code A4670, which ensures coverage of the necessary automatic blood pressure monitor for patients. However, the AHA notes that code A4663, which provides coverage for blood pressure cuffs to be used with a blood pressure monitor, is not included in the fee schedule.

The Health Moms, Health Babies Act (SB 213 2025) specifically states that "a blood pressure cuff and replacement cuffs" are included in covered self-measured blood pressure monitoring services. The extra blood pressure cuff is necessary to ensure proper fit for accurate blood pressure monitoring. Many people with hypertension have arm sizes too large or too small to ensure accurate readings with commonly used devices, with incorrect cuff sizes resulting in both under and overstating blood pressures.[2] We respectfully request that code A4663 be added before the rules and fee schedule are finalized to align with the directives of the legislation and ensure accurate readings for patients.

The AHA truly appreciates Arkansas's commitment to supporting the health of mothers and their babies.

CITATIONS:

[1]Hypertension in Pregnancy and Postpartum: Current Standards and Opportunities to Improve Care
[2]AMA: For millions with hypertension, home BP cuffs aren't a good fit

Response: See #14 above.

Hunter Young, Head of State Government Relations

ATA Action

Comment: On behalf of ATA Action, I am writing to comment on the Arkansas Department of Human Services' (the Department's) proposed Nonclinical Maternal Care Provider Manual establishing coverage and reimbursement rules for certified community-based doulas and breastfeeding and lactation consultants under the Arkansas Medicaid Program. We write to raise concerns about a requirement in the proposed rule that is not contained in the authorizing statute and that would unnecessarily restrict access to these vital services.

ATA Action is the affiliated trade association of the American Telemedicine Association and is committed to ensuring that all individuals have permanent access to telehealth services across the care continuum, regardless of geography, income, or ability. Through our Virtual Foodcare Coalition, we have brought together stakeholders across sectors to advocate for policies that expand access to evidence-based nutrition interventions, especially through innovative, patient-centered care delivery models like telehealth, including virtual lactation consulting.

We strongly support the establishment of Medicaid coverage for certified community-based doulas and breastfeeding and lactation consultants. Breastfeeding is foundational to the health of mothers and infants and studies have shown that prenatal lactation support and education significantly improve breastfeeding initiation and duration[1], reduces postpartum depression[2], and decreases healthcare costs.[3] Doula support similarly has well-documented benefits for maternal and infant health outcomes, particularly in underserved communities. Arkansas has made a meaningful commitment to maternal health through the legislation underlying this rule.

Concern: In-Person Initial Visit Requirement Exceeds the Authorizing Statute

Despite our overall support, we urge the Department to reconsider the requirement in Sections 210.400(B) and 220.400(B) of the proposed rule that requires the initial visit for doula services and lactation consultant services, respectively, to be conducted in person. The proposed rule states:

> "The initial visit must be in person, and at least one (1) visit must take place in the client's home." (Section 210.400(B))
>
> "The initial visit must be in person. After the initial visit, subsequent visits may be conducted in person or via telehealth." (Section 220.400(B))

This in-person initial visit requirement does not appear in the authorizing legislation, Act 627 of 2025.[4] Imposing it through rulemaking goes beyond the Department's statutory mandate and introduces an access barrier that the legislature did not intend. Mandating an in-person first visit can delay the initiation of care, add costs to services, and deter engagement with services altogether. Studies have shown that virtual care is effective in lactation consulting and is particularly important for patients in rural areas or those facing time or mobility constraints.[5]

Arkansas has significant rural and underserved populations who stand to benefit most from the flexibility of telehealth. Requiring an in-person first visit before telehealth access is permitted effectively penalizes

patients who cannot easily travel to a provider's office, a hospital, or another approved service location. This runs counter to the legislature's evident intent in establishing these new benefits.

The proposed rule itself acknowledges the value of telehealth for subsequent visits and for prenatal and postpartum care coordination. Sections 210.400(C) and 220.400(B) permit telehealth after the initial visit. We see no clinical or policy rationale for restricting telehealth only at the initial visit stage, particularly given that the authorizing statute imposes no such restriction.

Concern: Billing and Place of Service Code Clarity

We also urge the Department to provide explicit guidance on the Place of Service (POS) codes applicable to telehealth-delivered doula and lactation consultant services. Arkansas Medicaid's general telehealth reimbursement policy already provides a clear framework for how telehealth services are billed, and the rules implementing these new provider types should reflect the same clarity. Specifically, the Department should confirm the use of appropriate telehealth POS codes, including POS 02 (Telehealth Provided Other Than in Patient's Home) and POS 10 (Telehealth Provided in Patient's Home), to ensure that providers can bill accurately, reduce unnecessary claim denials, and support consistent implementation across the state.

We respectfully recommend that the Department amend Sections 210.400(B) and 220.400(B) to remove the in-person initial visit requirement, and instead allow all visits, including initial visits, to be conducted either in person *or* via telehealth, at the mutual determination of the beneficiary and provider. The Department should also include explicit guidance on applicable telehealth POS codes in the final rule.

These changes would align the rule with Act 627 of 2025, maximize access for Arkansas Medicaid beneficiaries, and support clear and consistent billing by providers.

We urge the Department to finalize these rules in a manner that fully unlocks access to doula and lactation consultant services for all eligible Arkansas Medicaid beneficiaries, including through telehealth from the very first visit. The VFC and ATA Action appreciate the Department's leadership on maternal health and stand ready to assist in the implementation of this important coverage expansion. Please feel free to contact me at hyoung@ataaction.org with any questions.

CITATIONS:

[1] McFadden A, Gavine A, Renfrew MJ, Wade A, Buchanan P, Taylor JL, Veitch E, Rennie AM, Crowther SA, Neiman S, MacGillivray S. Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database of Systematic Reviews 2017, Issue 2. Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub5. Accessed 13 November 2025.

[2] Figueiredo B, Canário C, Field T. Breastfeeding is negatively affected by prenatal depression and reduces postpartum depression. *Psychological Medicine*. 2014;44(5):927-936. doi:10.1017/S0033291713001530

[3] Mavranezouli, I., Varley-Campbell, J., Stockton, S. *et al.* The cost-effectiveness of antenatal and postnatal education and support interventions for women aimed at promoting breastfeeding in the UK. *BMC Public Health* 22, 153 (2022). https://doi.org/10.1186/s12889-021-12446-5

[4] HB1333 - To Mandate Coverage for Breastfeeding and Lactation Consultant Services. https://arkleg.state.ar.us/Bills/Detail?id=hb1333&ddBienniumSession=2025%2F2025R

[5] Uscher-Pines, L., Lawrence, R., & Waymouth, M. (2023). Telehealth for Breastfeeding Support and Lessons for Digital Equity. *JAMA health forum*, *4*(3), e225464. https://doi.org/10.1001/jamahealthforum.2022.5464

Response: See #2 and #6 above.

Nirvana Manning, MD, NCMP, FACOG, Chair and Professor of Obstetrics and Gynecology, Director of the Arkansas Center for Women and Infants' Health, Service Line Director of Women's Health Service Line

Department of Obstetrics and Gynecology, University of Arkansas for Medical Sciences

Comment: I am writing in support of the proposed addition allowing non-stress tests (NSTs) to be covered without arbitrary limits when accompanied by an appropriate medical diagnosis under the most recent DHS proposed changes on Maternal health Providers and Remote Monitoring.

Non-stress testing is a critical, evidence-based tool used to monitor fetal well-being in high-risk pregnancies. Limiting the number of covered tests can create unnecessary barriers to appropriate care and may place mothers and babies at avoidable risk. Clinical decisions regarding frequency should remain between the provider and patient, based on medical necessity.

Allowing coverage in an unlimited format, when supported by proper documentation and diagnosis, aligns with best practices in obstetric care and promotes healthier outcomes for Arkansas families. This is a prudent, patient-centered policy change that supports safe, high-quality maternal care across our state.

Response: See #13 above.

Liyah Wasson Executive Director

Doula Alliance of Arkansas

Comment: Thank you for the opportunity to present public comment on provisions that will be included in the community-based doula provider manual. We acknowledge all of the collaborative time and effort that has been dedicated to creating the current proposed rules. The Doula Alliance of Arkansas has shared the proposed rules across our board of directors and membership of active doulas. Interest has peaked surrounding reimbursement rates for a sustainable doula workforce, access to care, and scope

of practice considerations. Studying the national growth of doulas in Medicaid combined with direct feedback from local doulas led to the following feedback:

- Create a more comparable and flexible fee schedule that centers patient accessibility and doula workforce sustainability - Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount could be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge an average of $1300 for packages comparable to what the benefit outlines. The federal Medicaid "equal access" requirement mandates that states set provider reimbursement rates high enough to ensure access to care to the extent generally available in the area. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Postpartum support with a doula is not just a visit to check in; it is an extended time with the client spent offering emotional support, mental and physical health observation, resource stabilization, newborn education, and assistance with recovery after birth. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Supporting a family through a cesarean birth sometimes happens after hours of laboring and requires more intensive postpartum care. Doulas carry families through the in-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload.

  While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, Louisiana offers 90-minute limits for prenatal and postpartum visits, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. *To align reimbursement with established doula practices and ensure a sustainable workforce, we propose adopting a flat rate birth fee of $750 and offering more flexible prenatal and postpartum visit options.* Rather than setting a set amount for prenatals and a set amount for postpartum visits, a limited combination of either or both can be used in the way families decide best for themselves. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both.

  DA-AR is happy to help support DHS in exploring solutions that are both reasonable and adaptable.

- Reduce referral barriers through a statewide standing recommendation as implemented in other states for doula services - We understand the intent of referrals from providers to doulas to facilitate a team approach and care coordination, but we are concerned, especially in the early stages of implementation, that this could make it more difficult for women to access community-based doula services. Medical Directors, Commissioners of Health, and Chief Medical Officers of other agencies in eight states have implemented statewide standing recommendations to decrease

barriers. More information on which states have implemented standing recommendations can be found through The National Health Law Program's Doula Medicaid Project "Best Practices for Medicaid Coverage of Doula Care". This especially benefits those in parts of the state considered maternity care deserts, where early care needs may be met at local health units and sometimes not at all. Access to community-based doulas early on can help support increased facilitation to proper, specialized medical care. *We recommend a statewide standing recommendation stating that all pregnant and postpartum women are automatically recommended to be eligible for community-based doula services.*

- Less restrictive access to Community Health Workers and Community-Based Doulas - 210.100, Scope, A. "All Arkansas Medicaid beneficiaries who are pregnant or within sixteen (16) weeks postpartum and are not enrolled in a PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas."

  The scope of Community Health Workers (CHWs) is defined as liaisons between health and social services and the community. Studies have shown that CHWs improve health outcomes in their role by increasing access to care, reducing stress, and fostering better communication between patients and providers. Although there may be some overlap, this differs from the scope of Community-Based Doulas; trained to support women and families through pregnancy, birth, and postpartum. Continuous and consistent support of doulas in birth is directly related to decreased cesarean rates; decreased rates of pain medication, vacuum-, and forcep-assisted births; shorter labor times; decreased complications during childbirth; and increased breastfeeding initiation. *Honoring the differing scopes of practice of CHWs and Community-Based Doulas serves the "access, infrastructure, & workforce" pillar as well as the "whole-person care delivery" pillar of the Transforming Maternal Health Grant, reducing overall rates of maternal and infant mortality and morbidity, and increasing overall quality care amongst underserved communities.*

- PASSE and Life 360 Home Program participants should be priority candidates for community-based doula support - Doula support can help mitigate the potential exasperation of poor health outcomes and behavioral health during the perinatal period for participants under these programs. *People participating in PASSE or Life 360 Home should not only be eligible, but should be considered priority candidates for community-based doula support.*

- Payment for dual roles of community-based doulas who also offer specialized lactation support - *In recognition of the overlap in perinatal support services, we recommend that any provider who holds both a Certified Community-Based Doula credential and an IBCLC or CLC credential be permitted to bill for lactation support services in accordance with Act 627 of 2025*. Holding a doula certification should not limit or interfere with the provider's ability to bill for eligible lactation care services under Act 627, so long as those services are provided within the scope and standards of the lactation certification. This bill specifically states that coverage for breastfeeding and lactation consultant services does not diminish or limit benefits otherwise allowable under a health benefit plan. This provision supports integrated care, acknowledges the dual roles many providers play in the perinatal workforce, and reduces administrative barriers for clients receiving services from trusted, culturally responsive professionals.

Once again, thank you for the opportunity to provide feedback on the community-based doula provider rules. We would love the opportunity to support DHS in this phase of implementation by discussing these recommendations further.

Response: See #8-11 above.

Whitney Hardie

Certified Full-Spectrum Doula, CLE, Founder

Bentonville Birth Services

Comment: I appreciate the opportunity to provide feedback on the proposed rules and reimbursement rates for community-based doulas accepting Medicaid. This is an exciting and important time for Arkansas to make meaningful change in addressing the maternal mortality crisis.

I know many doulas are eager for our services to be more accessible to populations facing the greatest risk of mortality and morbidity in our state. I have worked with birthing families for 14 years across multiple states. After relocating to Northwest Arkansas with my family in 2021, I became aware of the great need for professional, evidence-based doula care that creates a positive impact for mothers and infants. I founded Bentonville Birth Services and began building a team of certified doulas in 2023. We are now a group practice of 12 certified doulas with multiple years of experience and expertise between us. Our team provides childbirth education, birth doula services and postpartum doula care.

We serve birthing women all over Northwest Arkansas and are intimately acquainted with the rewards and challenges of this career. Our desire to make doula work sustainable for communities and also for birth workers is what informs the following suggestions:

1. Create a flat rate for labor and birth support that is sustainable for doulas. The current proposed reimbursement rates reflect a model of value-based care that is unnecessary for doulas. We are inherently motivated to pursue vaginal birth, as avoiding unnecessary c-sections is one of the most popular reasons people seek our services. The $325.45 rate proposed for Cesarean delivery fails to take into account a situation that doulas have experienced multiple times: after providing many hours of hands-on physical and emotional labor support (12-14 hours on average), a client may require a necessary c-section. The proposed reimbursement rate is simply too low and will discourage doulas from working with Medicaid clients. Because doula work is on-call and requires a very flexible and unpredictable schedule, professional doulas on our team only contract 2-3 clients per month. The continuous support we provide, no matter the circumstances of the birth, means that we charge a flat rate for services, regardless of outcome. This allows stability in pricing and doula income, which helps offset the unpredictably long hours and heavy physical and

emotional workload. It is far more appropriate to offer a flat reimbursement rate for labor/birth support of $800.

2. Allow for flexibility in prenatal and postpartum visits. Rather than dictating how many visits can happen prenatally and how many can occur post-birth, we suggest using a number of visits (or hours) to be used either prenatally or in the postpartum period and allowing the family to decide the best use of these visits. Knowing that most deaths occur in the postpartum period, it may benefit women to have extended services from their doula after the birth to provide ongoing education, emotional support, and referrals to community and mental health resources. 6-8 hours of support outside of labor and delivery is very common for the doulas on our team. I think the proposed rate for prenatal and postpartum support is fair, but families will benefit from more flexibility in how these hours are used.

3. Protect Medicaid recipients' access to Community Health Workers. While doulas and Community Health Workers are both important members in the ecosystem of care, we are not trained in the same scope and skills. It would do a disservice to the goals of improving maternal health outcomes to force families to choose between working with one or the other. While my care as a doula is focused on a person's experience in pregnancy, birth, and postpartum, there are often multiple social determinants of health impacting a client's wellbeing. These clients are greatly served by the work of CHWs in navigating a broader medical system and being connected with resources beyond the targeted focus of doula care.

4. Do away with the required provider referral for doula support. The proposed regulations currently state that no formal referral is needed for breastfeeding and lactation consultant services. The same should be true for doula services. The wide-reaching benefits of doula support have been well researched and documented in multiple academic studies and across government organizations. (Evidence on: Doulas, The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review) With such an overwhelming body of evidence citing doula support as a beneficial intervention with no risk to the patient, a referral from a medical provider is unnecessary and adds complication to the documentation process. Anecdotally, we have occasionally heard from clients whose medical providers "were not fans of doulas" and insisted "doulas really aren't necessary." If a referral from OB-GYN or CNM providers is required, Medicaid recipients may be unable to access support in situations where a doula's advocacy is potentially needed the most.

5. Provide clarity regarding options for group prenatal doula visits. As the owner of a business that works with many families each month and balances the schedules of multiple doulas, I have sat with the regulations and reimbursement rates and tried to envision how I could continue to pay a livable wage to doulas on my team AND accept Medicaid covered clients. One option we would like to explore is offering group prenatal care for 1-2 of the covered prenatal visits. This would be especially beneficial for teaching labor and birth preparation — as group settings not only allow us to serve multiple clients at once, but also encourage stronger social connections and community support among a peer group of doula clients.

Thank you again for reading this feedback and giving the public an opportunity to shape provider rules that will impact many of the professional doulas in our state. I am available to discuss the above

recommendations and am happy to provide insight into ANY questions you may have as you continue to refine and implement Medicaid reimbursement for these vital services.

Response: See #8 and #10-12 above.

Robin Butler

Certified Birth Doula Member

Doula Alliance of Arkansas

Comment: Thank you for the opportunity to provide public comment on the proposed Community-Based Doula Provider rules. I appreciate the Department of Human Services' effort to expand access to doula care for pregnant families across Arkansas!

I am a practicing birth doula serving families in rural Arkansas (Carroll County), and I strongly support Medicaid coverage for doula services. I am writing to encourage the department to reconsider the proposed reimbursement rates to reflect the scope of work required to provide quality doula care.

Many Arkansas women already are seeking doula services, and have the means to pay for them. Our schedules are full of these women, and we love serving them. They are paying an average of $1300 for doula services, which is on the low/moderate end nationally.

Doulas in Arkansas (particularly in my region) are busy. We don't have enough doulas. I often receive calls from families being turned away by other doulas whose schedules are full. Frankly, those schedules are filled by many of these families who have the means to pay for doula care.

But many Medicaid recipients need doula care for life-and-death reasons. They have gaps in services, live far from services, and lack the time, energy and resources to access quality healthcare and maternity care. They need intensive coaching, instruction and encouragement. These are the families intended to benefit from these new maternal health laws and efforts! You want us to serve these women!

If reimbursement is less than the average—which is already on the low end nationally—who will be left out? Yes, the women and families who need support the most.

Labor support can last many hours or even days, and postpartum visits often involve extended time for answering a myriad of questions about newborn health, addressing postpartum struggles, and easing emotions. Doulas remain on call for weeks leading up to labor and communicate extensively with families throughout pregnancy. We leave our own families for days and recovery periods are lengthy and intense. The families with the greatest needs require the doulas to spend the most time. We love to do this, and we also need adequate compensation.

If we're doing this, let's do this well. Let's start strong. I promise, you have our dedication and our hearts and souls. We do this work because we love women, we love families, and we love our state.

Thank you for your consideration, your committment to improving health in our beloved Arkansas, and for the hope and inspiration we are all feeling.

Response: See #10 above.

Jessica Donahue, RN IBCLC

Baptist Health

Comment: Baptist Health commends Arkansas Medicaid for revising its rules to include coverage for Lactation consulting. We anticipate that these rule changes will significantly support our ongoing statewide initiatives to enhance maternal and infant healthcare by boosting breastfeeding rates throughout Arkansas. Our specific comments and suggestions are detailed below.

Recommendation**:** Revise Section 220.400(B) to allow the initial visit to be conducted either in person or via telehealth at the discretion of the beneficiary and the consultant.

The proposed rule currently states: *"The initial visit must be in person, After the initial visit, subsequent visits may be conducted in person or via telehealth"*. Baptist Health is asking that the Division of Medical Services (DMS) remove the requirement for the initial visit to be conducted in person for the following reasons:

- Immediate Clinical Need:

  Breastfeeding and lactation consultant services are often required urgently to address issues such as infant nutrition or milk expression. Requiring an in-person initial visit can create a barrier to care for beneficiaries who need immediate support but lack transportation or live in rural areas.

- Consistency with Subsequent Care:

  The proposed rule already acknowledges that "subsequent visits may be conducted in person or via telehealth." If telehealth is an effective medium for follow-up lactation support, it should also be permitted for the initial assessment to ensure the most "appropriate service location" is chosen based on the beneficiary's specific needs.

- Alignment with Modern Healthcare Delivery: Allowing the initial visit to occur via telehealth aligns with the flexibility provided for other nonclinical maternal services and ensures that the "minimum visit length" of fifteen minutes can be utilized efficiently to "best meet the needs of the beneficiary" without the delay of travel.

Response: See #4 above.

Amy Tedrow, Director of Supportive Services

Arkansas Doulas

Comment: Thank you for the opportunity to submit public comment regarding provisions proposed for inclusion in the Community-Based Doula Provider Manual. Our team at Arkansas Doulas has reviewed the proposed rules with our 25 actively working doulas who are serving families across the state. We appreciate the state's efforts to expand maternal health services and strengthen the perinatal workforce. In reviewing the proposed policies, our doulas have expressed particular interest in issues related to scope of practice, access to care, and reimbursement structures necessary to sustain a doula workforce that can effectively serve Arkansas families. Drawing on national research regarding Medicaid doula programs, as well as direct feedback from doulas working within Arkansas communities, we respectfully offer the following comments.

Community Health Workers – Section 210.100, Scope

Section A states: "All Arkansas Medicaid beneficiaries who are pregnant or within sixteen (16) weeks postpartum and are not enrolled in a PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas."

Community Health Workers (CHWs) serve an important role as liaisons between healthcare systems, social services, and the communities they serve. Research consistently shows that CHWs improve health outcomes by increasing access to care, reducing barriers, and strengthening communication between patients and providers. While some areas of support may overlap, the scope of Community-Based Doulas differs in meaningful ways. Doulas are specifically trained to provide continuous support during pregnancy, labor, birth, and the postpartum period. Extensive research demonstrates that the presence of doulas during childbirth is associated with decreased cesarean rates, reduced use of pain medication, fewer vacuum- or forceps-assisted births, shorter labor duration, fewer complications, and increased breastfeeding initiation. Allowing families access to both Community Health Workers and Community-Based Doulas without unnecessary restrictions supports the "Access, Infrastructure, and Workforce" and "Whole-Person Care Delivery" pillars of the Transforming Maternal Health Grant.

Expanding access to both roles strengthens care coordination and contributes to improved maternal and infant health outcomes, particularly in underserved communities.

PASSE and Life 360 Home Program Eligibility

Individuals participating in PASSE or Life 360 Home programs often experience complex medical, social, or behavioral health challenges. Doula support during pregnancy and the postpartum period can help mitigate many of the risks associated with these conditions.

For this reason, we recommend that individuals enrolled in PASSE or Life 360 Home programs remain eligible for Community-Based Doula services and be considered priority candidates for this support.

Referral Requirements

We understand the intent behind requiring provider referrals for doula services in order to encourage care coordination. However, particularly during early implementation of the program, referral requirements may unintentionally create barriers to access.

Several states have addressed this challenge by implementing statewide standing recommendations that allow pregnant and postpartum individuals to access doula services without requiring a separate referral for each client. This approach reduces barriers, particularly in areas of Arkansas designated as maternity care deserts, where individuals may have limited access to obstetric providers early in pregnancy.

Access to doula services early in pregnancy can help connect families to appropriate medical care, encourage earlier engagement with prenatal services, and strengthen support networks.

We recommend the adoption of a statewide standing recommendation recognizing that all pregnant and postpartum Medicaid beneficiaries are eligible to receive Community-Based Doula services.

Fee Schedule

The current proposal reimburses a maximum total of $933.20 for prenatal visits, postpartum visits, and birth support. Once contracted rates are negotiated, the effective reimbursement may be further reduced. At this level, the proposed structure does not reflect the scope of work required for doulas to provide continuous, high-quality care.

Within our organization our fee ranges is $1,300 and $1,800 for our base service package depending on the doulas experience. In our practice, doulas spend approximately 90 minutes with clients during prenatal visits and two to three hours during postpartum visits. In addition, our doulas remain on call for weeks leading up to labor and often provide many hours of continuous support during birth. Regardless of the birth outcome, our doulas remain with families throughout labor and continue providing support immediately following birth. To better align reimbursement with the realities of a practices needs and to compensate the doulas fairly and support workforce sustainability, we recommend the following:

- A flat birth support reimbursement of $900
- 64 billable 15-minute units at $20 per unit for prenatal and postpartum visits, allowing families flexibility in determining how services are used.

This structure supports both family autonomy and the practical realities of doula care.

While Arkansas has looked to Oklahoma's Medicaid doula model, it is worth noting that the Oklahoma Health Care Authority has consulted with the Doula Alliance of Arkansas regarding challenges within its program. Arkansas may benefit from examining models in neighboring states with stronger reimbursement structures. For example, Missouri reimburses up to $800 for labor and birth support, and Kansas allows prenatal and postpartum services to be billed in 15-minute increments.

Visit Structure and Postpartum Support

According to the Arkansas Maternal Mortality Review Committee, approximately 70 percent of pregnancy-related deaths occur during the postpartum period. Suicide, homicide, and overdose are leading causes of death after the first 28 days following birth. Postpartum doulas provide non-medical support focused on maternal recovery, newborn care education, and family adjustment. They also help families recognize early warning signs of complications and seek appropriate clinical care when needed. This role is particularly important in rural areas where individuals may live far from the providers who delivered their babies. Postpartum depression can persist for more than seven months in 25–50 percent of affected women, and cardiovascular complications such as hypertension may emerge months after delivery. For these reasons, postpartum support is a critical component of maternal health care. Because Arkansas reviews pregnancy-related deaths through 365 days postpartum, an ideal benefit would allow coverage of doula services throughout the first year after birth. Flexible structures allowing families to determine how prenatal and postpartum visits are distributed would better reflect the diverse needs of Arkansas families and support shared decision-making in care.

Lactation Services

We also wish to address the intersection between community-based doula services and lactation support.

Many doulas provide breastfeeding education as part of their perinatal support role, and some doulas hold additional credentials such as Certified Lactation Counselor (CLC). These doulas are trained to provide foundational breastfeeding education, encouragement, and early postpartum troubleshooting. Allowing doulas who hold a CLC credential to bill for lactation education and support services within the scope of that certification would recognize the valuable role they play in helping families initiate breastfeeding and access early support. This approach would also align with the intent of House Bill 1333 (2025), which expanded access to breastfeeding and lactation support services for Arkansas families and emphasized the importance of increasing the availability of qualified lactation care providers.

At the same time, it is important to recognize that clinical lactation care is distinct from general breastfeeding education. International Board Certified Lactation Consultants (IBCLCs) are trained to conduct comprehensive maternal and infant feeding assessments, identify complications such as ineffective milk transfer, dehydration risk, latch trauma, mastitis, jaundice concerns, and other medical feeding challenges, and coordinate care with pediatricians, obstetric providers, nurses, and other healthcare professionals when clinical intervention may be necessary. Within our practice, doulas who provide initial breastfeeding education refer families to a local IBCLC when concerns extend beyond general support and require clinical evaluation.

Maintaining a clear distinction between non-clinical lactation education and clinical lactation care is important for families and for the healthcare systems that serve them. Hospitals, WIC programs, and healthcare providers rely on clearly defined clinical roles when determining credentialing standards, scope of practice, and interdisciplinary care coordination.

For this reason, we respectfully encourage regulatory language that both allows doulas who hold CLC credentials to provide and bill for appropriate breastfeeding education and support, while also recognizing the distinct clinical scope of IBCLCs within Arkansas' maternal health system.

Maintaining this distinction strengthens referral pathways, protects families receiving care, and supports a collaborative perinatal workforce in which education, support, and clinical expertise each function within clearly defined roles.

Thank you for your time and consideration as Arkansas continues to strengthen maternal health services. We appreciate the opportunity to contribute feedback and look forward to ongoing collaboration to support healthy outcomes for mothers and infants across the state.

Response: See #8-12 above.

Cora Crain, Owner at Balanced Mama, MMT, CD(DONA), SpAP

Doula Alliance of Arkansas

Comment: My name is Cora Crain, I have been a certified doula practicing in the state of Arkansas for over 20 years. I am also Vice-President of the Doula Alliance of Arkansas and have worked hard to help this doula bill become law and succeed in our state. I whole-heartedly agree with all of DA-AR's comments regarding the distinction between community health workers and doulas, as well as access to care. However, most of my feedback concerns the reimbursement rates.

Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount will be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge between $1000-1500 for packages comparable to what the benefit outlines. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Doulas carry families through the in-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family for hours, sometimes even days, through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload. While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. To align reimbursement with established doula practices and ensure a sustainable workforce, we propose

adopting a flat rate birth fee of $750 and offering 64 billable 15-minute units at a fee of $18 per unit available to be used for any combination of prenatals and postpartum visits to be decided by the client based on their family needs. A flat rate fee for birth better supports community-based doulas in their scope of work encompassing intensive patient education, family stabilization services, continuous support, and time for administrative tasks. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both.

Again, it's important to look at surrounding states where this is succeeding. Doulas will not participate if we have to take a huge paycut. Being on call and present for an undetermined amount of time during a birth is the primary source of our value and compensation. The proposed rate is not sustainable for success because it is based on a surrounding state with few, if any, participating doulas. We have all worked too hard on this for it to fail!

Thank you for the opportunity to provide feedback on the community-based doula provider rules. We appreciate your collaboration!
Response: See #10 above.

Keesa Smith-Brantley, Executive Director and

Camille Richoux, Health Policy Director

Arkansas Advocates for Children and Families

Comment: Arkansas Advocates for Children and Families (AACF) appreciates the opportunity to submit comments on the proposed maternal health providers and remote monitoring rules and fee schedule. AACF is a statewide, nonprofit child and family policy research and advocacy organization whose mission is to ensure that every child and family has the resources and opportunities needed to live healthy, productive lives.

AACF is strongly supportive of the investments that the Healthy Moms, Healthy Babies Act is making to address our maternal health crisis. Our feedback intends to ensure implementation of the provisions that most effectively move the needle. Our suggestions to consider are as follows:

- Revise the fee schedule to be more competitive and flexible to support workforce sustainability. As the state has recently begun implementing its Rural Health Transformation Program, a stated goal is to recruit and retain a robust health workforce. The proposed doula benefit would reimburse $933.20 at the highest fee for prenatal and postpartum services, which may limit provider participation if rates are not competitive. Comparable states such as Oklahoma have experienced challenges recruiting and retaining providers when reimbursement rates are too low, and Arkansas's proposal appears to cover two fewer visits

than what has been discussed in other state models.

- Adopt a statewide standing recommendation to satisfy the federal requirement for doula services without requiring individual written referrals. This approach would meet the requirement[1] that preventive services be recommended by a licensed practitioner while removing an administrative step that can delay or impede access to care. Reducing this barrier may be especially important during early implementation and in maternity care deserts, where access to prenatal providers may be limited and timely access to community-based doulas can help connect patients to needed care.
- Allow reimbursement for doulas who are also certified to provide lactation support. Providers who are licensed as IBCLC or CLC and also certified as Community-Based Doulas should be able to be reimbursed for both types of services during visits, as applicable. These are distinct health services that are commonly provided by professionals with integrated, multidisciplinary certifications, and our reading of the law does not indicate that reimbursement for both services should be prohibited.
- Revise the limit on lactation consultant services to allow additional visits and extend eligibility beyond six months postpartum. Guidance from the Centers for Disease Control and Prevention, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics supports breastfeeding for up to two years, and many states provide more flexible coverage for lactation support.
- Expanding the number of covered visits and the postpartum timeframe would ensure mothers who experience challenges later in the breastfeeding period can still access needed support.
- Add a code for replacement blood pressure cuffs to the fee schedule. Hypertension and cardiovascular-related conditions are major drivers of maternal morbidity and mortality in Arkansas. The Healthy Moms, Healthy Babies Act specifies coverage of both a blood pressure monitor and replacement cuffs as part of self-measured blood pressure monitoring services. Including this code would align the fee schedule with the statute and help ensure patients can access appropriately sized cuffs to obtain accurate blood pressure readings during pregnancy and the postpartum period.
- Provide clarification on the exclusion of Life360 and PASSE participants from these services. It is unclear why beneficiaries enrolled in Life360 or PASSE programs are not included in the proposed coverage for these maternal health services. Additional clarification on the rationale for this exclusion and how these beneficiaries are expected to access comparable services would be helpful.

CITATIONS:

1 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.130

Response: See #4 and #8-11 and #14 above.

Judy I. Pile, EdD, Executive Director

Arkansas Community Health Worker Association

Comment: On behalf of the Arkansas Community Health Worker Association (ARCHWA), we submit the following for your consideration:

Proposed Language:

"All Arkansas Medicaid beneficiaries who are pregnant or within sixteen weeks postpartum and are not enrolled in PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas."

Comment:

The scope of practice, focus, and client goals of Community Health Workers (CHWs) and community-based doulas are distinct and unique. Requiring clients to discontinue services with a trusted CHW to engage a doula during the pregnancy, birth, and postpartum periods would negatively impact Arkansas families.

ARCHWA strongly recommends that clients be permitted to access both a trusted CHW and a trusted community-based doula before, during, and after childbirth.

Response: See #8 above.

Katlyne Gilliam

Certified Community Based Doula

Comment: My name is Katlyne Gilliam. I am a Certified Community Based Doula. I am writing to share the sentiments that DA-AR proposed -- the distinction between community health workers and doulas, as well as access to care.

Thank you for the opportunity to present public comment on provisions that will be included in the community-based doula provider manual. There has been explicit Interest amongst birth workers, surrounding reimbursement rates for a sustainable doula workforce, access to care, and scope of practice considerations.

Studying the national growth of doulas in Medicaid combined with direct feedback from local doulas led to the following feedback:

● Create a more comparable and flexible fee schedule that centers patient accessibility and doula workforce sustainability - Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount could be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge an average of $1300 for packages comparable to what the benefit outlines. The federal Medicaid "equal access" requirement mandates that states set provider reimbursement rates high enough to ensure access to care to the extent generally available in the area. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Postpartum support with a doula is not just a visit to check in; it is an extended time with the client spent offering emotional support, mental and physical health observation, resource stabilization, newborn education, and assistance with recovery after birth. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Supporting a family through a cesarean birth sometimes happens after hours of laboring and requires more intensive postpartum care. Doulas carry families through the in-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload. While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, Louisiana offers 90-minute limits for prenatal and postpartum visits, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. To align reimbursement with established doula practices and ensure a sustainable workforce, we propose adopting a flat rate birth fee of $750 and offering more flexible prenatal and postpartum visit options. Rather than setting a set amount for prenatals and a set amount for postpartum visits, a limited combination of either or both can be used in the way families decide best for themselves. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both. DA-AR is happy to help support DHS in exploring solutions that are both reasonable and adaptable.

● Reduce referral barriers through a statewide standing recommendation as implemented in other states for doula services - We understand the intent of referrals from providers to doulas to facilitate a team approach and care coordination, but we are concerned, especially in the early stages of implementation, that this could make it more difficult for women to access community-based doula services. Medical Directors, Commissioners of Health, and Chief Medical Officers of other agencies in eight states have implemented statewide standing recommendations to decrease barriers. More information on which states have implemented standing recommendations can be found through The National Health Law Program's Doula Medicaid Project "Best Practices for Medicaid Coverage of Doula

Care". This especially benefits those in parts of the state considered maternity care deserts, where early care needs may be met at local health units and sometimes not at all. Access to community-based doulas early on can help support increased facilitation to proper, specialized medical care. We recommend a statewide standing recommendation stating that all pregnant and postpartum women are automatically recommended to be eligible for community-based doula services.

● Less restrictive access to Community Health Workers and Community-Based Doulas - 210.100, Scope, A. "All Arkansas Medicaid beneficiaries who are pregnant or within sixteen (16) weeks postpartum and are not enrolled in a PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas." The scope of Community Health Workers (CHWs) is defined as liaisons between health and social services and the community. Studies have shown that CHWs improve health outcomes in their role by increasing access to care, reducing stress, and fostering better communication between patients and providers. Although there may be some overlap, this differs from the scope of Community-Based Doulas; trained to support women and families through pregnancy, birth, and postpartum. Continuous and consistent support of doulas in birth is directly related to decreased cesarean rates; decreased rates of pain medication, vacuum-, and forcep-assisted births; shorter labor times; decreased complications during childbirth; and increased breastfeeding initiation. Honoring the differing scopes of practice of CHWs and Community-Based Doulas serves the "access, infrastructure, & workforce" pillar as well as the "whole-person care delivery" pillar of the Transforming Maternal Health Grant, reducing overall rates of maternal and infant mortality and morbidity, and increasing overall quality care amongst underserved communities.

● PASSE and Life 360 Home Program participants should be priority candidates for community-based doula support - Doula support can help mitigate the potential exasperation of poor health outcomes and behavioral health during the perinatal period for participants under these programs. People participating in PASSE or Life 360 Home should not only be eligible, but should be considered priority candidates for community-based doula support.

● Payment for dual roles of community-based doulas who also offer specialized lactation support - In recognition of the overlap in perinatal support services, we recommend that any provider who holds both a Certified Community-Based Doula credential and an IBCLC or CLC credential be permitted to bill for lactation support services in accordance with Act 627 of 2025. Holding a doula certification should not limit or interfere with the provider's ability to bill for eligible lactation care services under Act 627, so long as those services are provided within the scope and standards of the lactation certification. This bill specifically states that coverage for breastfeeding and lactation consultant services does not diminish or limit benefits otherwise allowable under a health benefit plan. This provision supports integrated care, acknowledges the dual roles many providers play in the perinatal workforce, and reduces administrative barriers for clients receiving services from trusted, culturally responsive professionals.

Response: See #10-12 above.

Desiree Girard-Baxter, Certified Postpartum Doula (DONA), Certified Birth and Bereavement Doula (Stillbirthday)

Advanced Lactation Consultant (ALPP, Healthy Children Project)

Comment: My name is Desiree Girard-Baxter. I am a full-spectrum doula (birth, postpartum, bereavement), and lactation consultant in Central Arkansas. I have been working as a doula here for 10 years. I am also the founder and director of the non-profit, "Everyone Deserves a Doula", a 501c3 organization focused on supporting Arkansas families with no and low cost education, support, and services in the birthing year.

I whole-heartedly agree with all of DA-AR's comments regarding the distinction between community health workers and doulas, as well as access to care. However, most of my feedback concerns the reimbursement rates.

Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount will be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge between $1000-1500 for packages comparable to what the benefit outlines.

In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Doulas carry families through the in-between spaces of life transitions, and are on call and in contact with clients for weeks leading up to labor and birth. They also provide close contact and care after birth, often traveling to their client’s home.

Regardless of outcomes, doulas show up to provide direct support to a family for hours, sometimes even days, during labor and delivery, and then stay by their side beyond the birth experience. This is especially true for families who experience birth complications, fetal diagnosis, or postpartum and breastfeeding complications. The proposed fee structure does not reflect the reality of a doula’s workload.

To align reimbursement with established doula practices and ensure a sustainable workforce, I agree with DA-AR’s proposal of adopting a flat rate birth fee of $750 and offering 64 billable 15-minute units at a fee of $18 per unit available to be used for any combination of prenatal appointments and postpartum visits to be decided by the client based on their family needs.

A flat rate fee for birth better supports community-based doulas in their scope of work encompassing intensive patient education, family stabilization services, continuous support, and time for administrative tasks. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care and support.

Doulas will not participate if we have to take a huge paycut. Being on call and present for an undetermined amount of time during and after a birth is the primary source of our value and compensation.

We have all worked too hard on this to fail! Arkansans deserve doula care, and Arkansas leadership has an amazing chance to step up in strong support for Arkansas families and Arkansas birth workers!

Thank you for the opportunity to provide feedback on the community-based doula provider rules. We appreciate your collaboration!

Response: See #10 above.

Almetria Turner, Owner/Full Spectrum Doula, Certified Health CoachRoots and River Wellness

Comment: As a seasoned doula but new doula to the rural Arkansas community, I want to address several concerns.

•It is my belief that people shouldn't have to choose between having a community health worker or a doula because both are vital in providing holistic wraparound support and services in the continuum of care.

While some of their support might overlap, doulas spend an exorbitant amount of time with clients throughout the perinatal period from being on call weeks at a time, addressing concerns throughout the day and night, as well as offering uninterrupted hours of in person hands-on holistic support that CHW's can't and don't offer. It's this type of hands-on support that reduces inductions, interventions, worries and c-sections amongst our clients and families.

•All families should have access to doulas without the referrals of physicians especially within the rural communities due to maternal deserts, limited obs/gyns, nurse practitioners, maternal fetal medicine specialists, dietitians, lactation consultants, other perinatal providers and the drivers of health. Referrals can prolong access to prenatal care, evidence based education and support.

•Also, many doulas are also lactation counselors and consultants who already have established a relationship with our clients, provide lactation education, make sure a proper latch has been established after birth, and we resolve nonclinical issues and concerns in postpartum. Doulas who are also lactation counselors/consultants should be able to bill for lactation services in addition to providing doula support. Doulas refer out to IBCLCs when medically necessary.

•Doulas should also be paid a sustainable wage in addition to a 10% incentive to serve rural communities. Doulas can only take on 3-5 clients per month and sometimes less if this isn't their full time job. Most doulas work a 9-5, have children of their own and households to run. A minimum of $1500 per client regardless of the type of birth with 5 flexible pre/postnatal visits should be the base because of doulas provide time, effort and resources unaccounted and paid for beyond the visits and birth. We can't take on 30-40 clients per month like obs as it's not humanly possible and it compromises care.

With there being so many maternal deserts, a lack of providers serving many counties, and the need to build up the workforce while trying to reduce our maternal and infant mortality statistics, a 10% rural incentive should be given per client to encourage people to become doulas within those areas as well as current doulas to go out and serve potential clients to cover extra time away from our own families, gas, and wear/tear on our cars.

There are so many benefits to having doulas covered under Medicaid and I hope the state of Arkansas will take these considerations to heart to help build up our perinatal workforce, address health disparities, bridge health equity gaps and reduce the maternal and infant mortality rates for our fellow Arkansans.

Response: See #8-10 above.

Jenny Kincannon

Comment: Dear Director Pittman and Deputy Director Smith: Thank you for the opportunity to present public comment on provisions that will be included in the community-based doula provider manual. We acknowledge all of the collaborative time and effort that has been dedicated to creating the current proposed rules. The Doula Alliance of Arkansas has shared the proposed rules across our board of directors and membership of active doulas. Interest has peaked surrounding reimbursement rates for a sustainable doula workforce, access to care, and scope of practice considerations. Studying the national growth of doulas in Medicaid combined with direct feedback from local doulas led to the following feedback:

Create a more comparable and flexible fee schedule that centers patient accessibility and doula workforce sustainability - Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount could be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge an average of $1300 for packages comparable to what the benefit outlines. The federal Medicaid “equal access” requirement mandates that states set provider reimbursement rates high enough to ensure access to care to the extent generally available in the area. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Postpartum support with a doula is not just a visit to check in; it is an extended time with the client spent offering emotional support, mental and physical health observation, resource stabilization, newborn education, and assistance with recovery after birth. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Supporting a family through a cesarean birth sometimes happens after hours of laboring and requires more intensive postpartum care. Doulas carry families through theIn-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload.

While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, Louisiana offers 90-minute limits for prenatal and postpartum visits, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. *To align reimbursement with established doula practices and ensure a sustainable workforce, we propose adopting a flat rate birth fee of $750 and offering more flexible prenatal and postpartum visit options.* Rather than setting a set amount for prenatals and a set amount for postpartum visits, a limited combination of either or both can be used in the way families decide best for themselves. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both. DA-AR is happy to help support DHS in exploring solutions that are both reasonable and adaptable.

Reduce referral barriers through a statewide standing recommendation as implemented in other states for doula services - We understand the intent of referrals from providers to doulas to facilitate a team approach and care coordination, but we are concerned, especially in the early stages of implementation, that this could make it more difficult for women to access community-based doula services. Medical Directors, Commissioners of Health, and Chief Medical Officers of other agencies in eight states have implemented statewide standing recommendations to decrease barriers. More information on which states have implemented standing recommendations can be found through The National Health Law Program's Doula Medicaid Project "Best Practices for Medicaid Coverage of Doula Care". This especially benefits those in parts of the state considered maternity care deserts, where early care needs may be met at local health units and sometimes not at all. Access to community-based doulas early on can help support increased facilitation to proper, specialized medical care. *We recommend a statewide standing recommendation stating that all pregnant and postpartum women are automatically recommended to be eligible for community-based doula services.*

Less restrictive access to Community Health Workers and Community-Based Doulas - 210.100, Scope, A. "All Arkansas Medicaid beneficiaries who are pregnant or within sixteen (16) weeks postpartum and are not enrolled in a PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas." The scope of Community Health Workers (CHWs) is defined as liaisons between health and social services and the community. Studies have shown that CHWs improve health outcomes in their role by increasing access to care, reducing stress, and fostering better communication between patients and providers. Although there may be some overlap, this differs from the scope of Community-Based Doulas; trained to support women and families through pregnancy, birth, and postpartum. Continuous and consistent support of doulas in birth is directly related to decreased cesarean rates; decreased rates of pain medication, vacuum-, and forcep-assisted births; shorter labor times; decreased complications during childbirth; and increased breastfeeding initiation. Honoring the differing scopes of practice of CHWs and Community-Based Doulas serves the "access, infrastructure, & workforce" pillar as well as the "whole-person care delivery" pillar of the Transforming Maternal Health Grant, reducing overall rates of maternal and infant mortality and morbidity, and increasing overall quality care amongst underserved communities.

PASSE and Life 360 Home Program participants should be priority candidates for community-based doula support - Doula support can help mitigate the potential exasperation of poor health outcomes and

behavioral health during the perinatal period for participants under these programs. *People participating in P ASSE or Life 360 H*ome should *not only be eligible, but should be considered priority candidates for community-based doula support.*

Payment for dual roles of community-based doulas who also offer specialized lactation support - *In recognition of the overlap in perinatal support services, we recommend that any provider who holds both a Certified Community-Based Doula credential and an IBCLC or CLC credential be permitted to bill for lactation* support services *in accordance with Act 627 of 2025*. Holding a doula certification should not limit or interfere with the provider's ability to bill for eligible lactation care services under Act 627, so long as those services are provided within the scope and standards of the lactation certification. This bill specifically states that coverage for breastfeeding and lactation consultant services does not diminish or limit benefits otherwise allowable under a health benefit plan. This provision supports integrated care, acknowledges the dual roles many providers play in the perinatal workforce, and reduces administrative barriers for clients receiving services from trusted, culturally responsive professionals. Once again, thank you for the opportunity to provide feedback on the community-based doula provider rules. We would love the opportunity to support DHS in this phase of implementation by discussing these recommendations further.

Response: See #8-11 above.

Laura Langley

Credentials or organization

Comment: I am writing as a board member of Everyone Deserves a Doula and a forever client of Cora Crain and Desiree Girard-Baxter of Balanced Mama. My husband and I are certain that we would not have had the birthing and postpartum experience that we would were privileged to have without our beloved doulas. They prepared us, supported us through, and held us in community after the most transformative and challenging transition of our lives. And, we were fortunate to not have to worry about the financial burden of the services our doulas provided. We firmly believe that *all* Arkansas families deserve access to birthing and post-partum support so that they are prepared and supported mentally and physically during the massive transition that is childbirth.

Create a more comparable and flexible fee schedule that centers patient accessibility and doula workforce sustainability - Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount could be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge an average of $1300 for packages comparable to what the benefit outlines. The federal Medicaid "equal access" requirement mandates that states set provider reimbursement rates high enough to ensure access to care to the extent generally available in the area. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Postpartum support with a doula is not just a visit to check in; it is an extended time with the client

spent offering emotional support, mental and physical health observation, resource stabilization, newborn education, and assistance with recovery after birth. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Supporting a family through a cesarean birth sometimes happens after hours of laboring and requires more intensive postpartum care. Doulas carry families through the in-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload.

While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, Louisiana offers 90-minute limits for prenatal and postpartum visits, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. To align reimbursement with established doula practices and ensure a sustainable workforce, we propose adopting a flat rate birth fee of $750 and offering more flexible prenatal and postpartum visit options. Rather than setting a set amount for prenatals and a set amount for postpartum visits, a limited combination of either or both can be used in the way families decide best for themselves. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both. DA-AR is happy to help support DHS in exploring solutions that are both reasonable and adaptable.

Reduce referral barriers through a statewide standing recommendation as implemented in other states for doula services - We understand the intent of referrals from providers to doulas to facilitate a team approach and care coordination, but we are concerned, especially in the early stages of implementation, that this could make it more difficult for women to access community-based doula services. Medical Directors, Commissioners of Health, and Chief Medical Officers of other agencies in eight states have implemented statewide standing recommendations to decrease barriers. More information on which states have implemented standing recommendations can be found through The National Health Law Program's Doula Medicaid Project "Best Practices for Medicaid Coverage of Doula Care". This especially benefits those in parts of the state considered maternity care deserts, where early care needs may be met at local health units and sometimes not at all. Access to community-based doulas early on can help support increased facilitation to proper, specialized medical care. We recommend a statewide standing recommendation stating that all pregnant and postpartum women are automatically recommended to be eligible for community-based doula services.

Less restrictive access to Community Health Workers and Community-Based Doulas - 210.100, Scope, A. "All Arkansas Medicaid beneficiaries who are pregnant or within sixteen (16) weeks postpartum and are not enrolled in a PASSE or Life 360 Home program and are not receiving community health worker services are eligible for services provided by certified community-based doulas." The scope of Community Health Workers (CHWs) is defined as liaisons between health and social services and the community. Studies have shown that CHWs improve health outcomes in their role by increasing access to care, reducing stress, and fostering better communication between patients and providers. Although

there may be some overlap, this differs from the scope of Community-Based Doulas; trained to support women and families through pregnancy, birth, and postpartum. Continuous and consistent support of doulas in birth is directly related to decreased cesarean rates; decreased rates of pain medication, vacuum-, and forcep-assisted births; shorter labor times; decreased complications during childbirth; and increased breastfeeding initiation. Honoring the differing scopes of practice of CHWs and Community-Based Doulas serves the "access, infrastructure, & workforce" pillar as well as the "whole-person care delivery" pillar of the Transforming Maternal Health Grant, reducing overall rates of maternal and infant mortality and morbidity, and increasing overall quality care amongst underserved communities.

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Payment for dual roles of community-based doulas who also offer specialized lactation support - In recognition of the overlap in perinatal support services, we recommend that any provider who holds both a Certified Community-Based Doula credential and an IBCLC or CLC credential be permitted to bill for lactation support services in accordance with Act 627 of 2025. Holding a doula certification should not limit or interfere with the provider's ability to bill for eligible lactation care services under Act 627, so long as those services are provided within the scope and standards of the lactation certification. This bill specifically states that coverage for breastfeeding and lactation consultant services does not diminish or limit benefits otherwise allowable under a health benefit plan. This provision supports integrated care, acknowledges the dual roles many providers play in the perinatal workforce, and reduces administrative barriers for clients receiving services from trusted, culturally responsive professionals.

Response: See #8, 10 and 11 above.

Anna Strong, MPH, MPS Executive Director Arkansas Chapter,

American Academy of Pediatrics

Comment: On behalf of the Arkansas Chapter of the American Academy of Pediatrics Foundation (ARAAP), I am pleased to submit comments on the proposed rule for Maternal Health Providers and Remote Monitoring. ARAAP represents approximately 500 member pediatricians and pediatric trainees statewide. Pediatricians care deeply about maternal and infant health and are pleased to see the addition of new team members who can support positive health outcomes for mothers, newborns, infants, and families.

ARAAP deeply appreciates that this rule includes the ability for pediatricians to bill Medicaid and ARKids First for the child's nutrition through breastfeeding in addition to the mother's breastfeeding needs.

Often, pediatricians are the only health care provider a mother-baby dyad sees in the critical initial weeks after delivery, and having lactation support available at a place the family is already going for well-baby care improves access tremendously. Since pediatricians do not typically bill for mothers' care, this allows them to employ lactation providers for their pediatric patients. ARAAP also appreciates that referrals are not required for lactation services.

We see a few opportunities to strengthen these rules prior to promulgation.

1) Change CLC Certifying Body**.** Most importantly, the certifying body for Certified Lactation Counselors (CLCs) should be the Academy of Lactation Policy and Practice. The International Breastfeeding Institute listed in the proposed rule is not the widely recognized training and certification body for CLCs. Please note the term is "lactation" counselor not "breastfeeding" counselor as written in 200.100 A.2 and in other areas throughout the rule. The terms used in the actual SPA on pages 20 and 24 of the posted PDF are correct. This recommendation aligns with Act 627 of 2025.

2) Extend length of service availability**.** In its Policy Statement "Breastfeeding and the Use of Human Milk," the American Academy of Pediatrics recommends breastfeeding exclusively for six months and continued breastfeeding through two years or beyond if mutually desired by the mother and child. This recommendation is echoed by the Centers for Disease Control and Prevention (CDC). ARAAP recommends lactation support be available through Medicaid as long as the dyad is using human milk for nutrition. Throughout this time, breastfeeding support may be needed for a variety of reasons, including a transition to pumping during mother's workday, changes in supply due to a subsequent pregnancy, changing milk supplies due to introduction of food, etc. This limitation is referenced in 200.100 B and 220.100 B.

3) Allow both lactation and doula support from the same provider. Many lactation providers are also certified to provide additional supports for mother-baby dyads. We advise removing the second sentence in 210.600 that prohibits doulas from billing for breastfeeding and lactation services for their doula clients. Typically, doulas' breastfeeding support includes initial latch and limited support immediately following childbirth. Following that, lactation support would provide higher levels of specialized breastfeeding support during the entire period of breastfeeding. We also encourage allowing same-day support for primary care visits and lactation visits as well as doula and lactation visits for those dually-certified providers. This may be noted in 220.600.

4) Ensure lactation providers are clinical and able to bill independently. This rule lists lactation providers as non-clinical. IBCLCs are clinical providers, and IBCLCs are concerned this may limit their scope of services and ability to bill independently. Defining them as clinical would ensure IBCLCs are not negatively impacted, but it could require separate rules. IBCLCs have submitted more detailed comments on this topic.

5) Remove referral reference. Section 220.500 A.9 requires documentation of a referral source, but referrals are not required for lactation support.

6) Clarify service locations. Section 220.400 outlines service locations that "may" be included, but those differ slightly from the Place of Service codes in 230.200. Improved alignment is needed. Telemedicine should be one of the service locations that is allowed, which it seems to be per 220.400 B.

7) Improve rates. The proposed rates will not be sufficient to ensure access to highly-trained

lactation consultants (IBCLC). Given the training differential for IBCLC and CLC providers, higher rates should be offered for IBCLCs.

8) Ensure coverage is available for extenuating circumstances. In 220.400 sections D and E, ARAAP would like to ensure that lactation support for surrogates, milk donors, and other less-common situations will be covered.

Response: See #2, #4-7 and #9 above.

Allison Hupp

Comment: My name is Allison Hupp, I am a certified and practicing doula here in the state of Arkansas. I whole-heartedly agree with all of DA-AR's comments regarding the distinction between community health workers and doulas, as well as access to care. most of my feedback concerns the reimbursement rates.

Currently the proposed doula benefit would reimburse a maximum total of $933.20 for prenatal visits, postpartum visits, and the current highest proposed fee for supporting a birth. This amount will be reduced further once contracted rates are negotiated. This structure is not sustainable for community-based doulas to provide continuous quality care. Across Arkansas, doulas typically charge between $1000-1500 for packages comparable to what the benefit outlines. In practice, doulas spend between 90 minutes - 2 hours with clients during prenatal visits and 2-4 hours during postpartum visits. Doulas do not charge a differing fee based on varying birth outcomes and are not just there at the moment of birth. Doulas carry families through the in-between spaces of life transitions, on call and in consistent contact with clients for weeks leading up to labor and birth. Regardless of outcomes, doulas show up to provide direct support to a family for hours, sometimes even days, through labor and then stay by their side beyond the birth experience. The proposed fee structure does not reflect this workload. While Arkansas has modeled its proposal on Oklahoma's system, it is important to note that the Oklahoma Health Authority has sought consultation from DA-AR to address challenges in its doula program. This signals that the model may not be functioning effectively, and Arkansas would be better served by looking to nearby states with stronger, more successful doula benefits. Looking at the surrounding states, reimbursement for doula labor and birth support is as high as $800 in Missouri, and Kansas doula Medicaid reimburses for prenatal and postpartum services in 15-minute increments. To align reimbursement with established doula practices and ensure a sustainable workforce, we propose adopting a flat rate birth fee of $750 and offering 64 billable 15-minute units at a fee of $18 per unit available to be used for any combination of prenatals and postpartum visits to be decided by the client based on their family needs. A flat rate fee for birth better supports community-based doulas in their scope of work encompassing intensive patient education, family stabilization services, continuous support, and time for administrative tasks. Flexible increments of billing time for prenatal and postpartum visits offers families autonomy to decide if they need more prenatal care - such as a first time mom preparing for labor and birth - more postpartum support, which may better suit a family welcoming multiples, or a balanced combination of both.

Again, it's important to look at surrounding states where this is succeeding. Doulas will not participate if we have to take a huge paycut. Being on call and present for an undetermined amount of time during a birth is the primary source of our value and compensation. The proposed rate is not sustainable for success because it is based on a surrounding state with few, if any, participating doulas. We have all worked too hard on this for it to fail!

Thank you for the opportunity to provide feedback on the community-based doula provider rules. We appreciate your collaboration and your listening ear!

Response: See #10 above.

Kyndall Rogers, Impact Management Group, for

Dave Oberembt

Comment: As I mentioned, the proposed rules for Self-Measured Blood Pressure monitoring from Healthy Moms and Healthy Babies is out. But codes in the fee schedule do not line up with what the AMA suggests for coverage. Attached is the full AMA document and screenshot of the codes in question. Maybe there is more than one way to skin to skin a cat. But the proposed fee schedule does not mention covering an additional cuff, which in the Healthy Moms; Healthy Babies act I copy/pasted below is expressly stated.

Can we do a soft touch with DHS about the possibility or remedying this?

(a) The Arkansas Medicaid Program shall provide coverage and 2 reimbursement for self-measurement blood pressure monitoring services for 3 pregnant women and postpartum women. 4 (b) Self-measurement blood pressure monitoring services shall include: 5 (1) Validated blood pressure monitoring devices, such as a blood 6 pressure cuff and replacement cuffs, as medically necessary, to diagnose or 7 treat hypertension; 8 (2) Patient education and training on the set-up and use of a 9 self-measurement blood pressure measurement device that is validated for 10 clinical accuracy, device calibration, and the procedure for obtaining self-11 measurement readings; and 12 (3) Collection of data reports by the patient or caregiver for 13 submission to a healthcare provider to communicate blood pressure readings 14 and create or modify treatment plans.

Response: See #14 above.

Tanya Smith, BA, IBCLC

Public hearing held remotely 02/25/26 @ 9:30 AM CST

Comment: Hello, my name is Tonya Smith and I'm an International Board-Certified Lactation Consultant with a community-based practice in Central Arkansas. The proposed rules and fee schedule establishing Medicaid reimbursement for lactation consultant services are an important step forward for maternal and infant health in Arkansas. There are three provisions that are likely to significantly limit provider participation and reduce beneficiary access if not revised. First the proposed rules classify IBCLCs as non-clinical providers. This is inaccurate and creates unnecessary regulatory and reimbursement barriers. IBCLCs are clinical providers who deliver medically necessary evidence-based lactation and infant feeding care within a recognized clinical scope of practice. Our services include clinical assessment, intervention, care planning, and coordination with licensed medical professionals. Our services constitute clinical care not non-clinical support. Misclassifications of IBCLCs may undermine our professional credibility, create ambiguity regarding steps of practice which could have legal and malpractice insurance implications for us; contribute to undervaluation and reimbursement policies; discourage provider enrollment; conflict with hospital credentialing, and privileging standards; and increase the risk of inconsistent claims review and audit interpretations. Accurate classification is essential to ensure appropriate and intergradation of IBCLCs into our health care system. Second, the proposed fee schedule reimburses lactation consultants services at approximately $61 per hour regardless of visit complexity, clinic acuity or provider type. After accounting for nonbillable time, documentation requirements, travel, professional liability insurance, certification maintenance, and administrative overhead reimbursement level is not sufficient to support sustainable independent or community based IBCLCs process. It is also significantly lower than other states with similar coverage. Reimbursement at the proposed level may discourage Medicaid enrollment and limit participation to hospital-based settings and reduce access in rural and underserved communities. Lastly, the proposed limit of three lactation visits does not reflect the clinical realities of lactation care. Common breastfeeding challenges often require ongoing clinical follow-ups. Restricted visit limits may result in incomplete care, increase administrative burden, ethical challenges when medically necessary care is not reimbursable and reduced willingness among providers to accept complex cases. To my knowledge, none of the states that provide lactation care for Medicaid beneficiaries have a visit limit other than medical necessity. Further, the only time constraint is in one State and that limit is 12 months. Thank you for listening to my concerns and I'm available to discuss the profession further if it would be helpful drafting these rules.

Response: See #2, 4 and 7 above.

Sondra Rodocker, IBCLC, CLD, CPD

Public hearing held remotely 02/25/26 @ 9:30 AM CST

Comment: Thank you. I have submitted my comment via email, but I wanted to speak out today as well just so my voice can go with this when you guys are reviewing this. Dear Ms. Pitman, I appreciate the opportunity to submit public comments regarding the proposed rules for lactation services within the Nonclinical Maternal Health Services packages. While I strongly support expanding access to

breastfeeding education and support, it is essential that the Department establish separate regulatory pathways for non-clinical lactation support and clinical lactation care. National standards clearly distinguish between clinical lactation care and non-clinical education/support services. The Women's Preventive Services Initiative led by the American College of Obstetricians and Gynecologists and supported by HRSA, identifies International Board-Certified Lactation Consultants alongside licensed healthcare providers when delivering clinical lactation care. These standards recognize IBCLCs as clinicians who perform individualized assessment, clinical decision-making, care planning, documentation, and coordination with other medical providers. In contrast, lactation counselors and peer supporters are recognized as providing general education and support services. Maintaining this distinction is critical to regulatory consistency and patient safety. Since lactation counselors and lactation consultants are not interchangeable, intermingling the two interferes with the delivery of riskappropriate care. Placing IBCLCs within a "Nonclinical Maternal Care" framework materially alters how we can deliver care in hospital, public health, and private practice settings. Clinical lactation care involves physical assessment of the lactating mother and infant; hands-on evaluation of latch and milk transfer; identification of complications such as dehydration, jaundice risk, nipple trauma, mastitis, or insufficient intake; development of individualized plans of care and clinical documentation and provider communication. If IBCLCs are formally classified as non-clinical providers under Medicaid regulation, this designation may restrict or complicate their ability to perform hands-on clinical assessments within hospital settings and other healthcare environments. Hospitals rely on clearly defined clinical roles when credentialing staff, determining scope of practice, and establishing liability coverage. Reclassifying IBCLCs as nonclinical under state rule could: create confusion within hospital credentialing departments; affect how IBCLCs are integrated into inpatient postpartum care; impact WIC services that collaborate with clinical providers; disrupt private practices that provide clinical lactation assessment under medical referral; and introduce liability ambiguity for facilities employing IBCLCs. In practical terms, this classification may unintentionally limit the full scope of clinical lactation care that hospitals and health care systems are currently able to provide. Even routine elements of clinical lactation practice such as performing a physical assessment or hands-on latch evaluation depend upon recognition of the provider as functioning in a clinical capacity. The proposed rules also require elements such as treatment planning, problem identification, progress documentation, and diagnosis coding. These are hallmarks of clinical care. If services are defined as non-clinical, documentation requirements should align with education and support functions. If the intent is to include clinical lactation services within Medicaid coverage, then IBCLCs should be regulated within a clinical framework consistent with national standards and their scope of preparation. I respectfully urge the Department to: One, establish separate regulations for nonclinical lactation education and support services and clinical lactation care. Additionally, the Department may wish to explore a formal licensure pathway for IBCLCs in the future, as licensure would provide regulatory clarity, formal scope recognition, and a clear distinction between clinical lactation providers and non-clinical support personnel; clearly define the scope and documentation expectations for each provider category and ensure alignment with national standards recognizing IBCLCs as clinical lactation providers. Clear definitions protect mothers and infants; hospitals and healthcare systems; WIC and public health programs; private clinical practices and the integrity of Medicaid reimbursement. With thoughtful revision, Arkansas can expand access to lactation services while preserving public safety, workforce stability, and regulatory clarity. Thank you for your careful consideration of this important matter.

Response: See #1-3 above.

COMMENTS, QUESTIONS AND GUIDANCE RECEIVED FROM OTHER AGENCIES

Centers for Medicare and Medicaid Services

Informal Comments for AR-26-0004
Preventive Services

Form 179

Attachment 3.1-A, Page 6a1 and Attachment 3.1-B, Page 5d1
Attachment 3.1-A, Page 6a1G and Attachment 3.1-B, Page 5d1G

1. The state advises CMS that it is moving Rehabilitative Services from pages "Attachment 3.1-A, Page 6a1" and "Attachment 3.1-B, Page 5d1" to "Attachment 3.1-A, Page 6a1G" and "Attachment 3.1-B, Page 5d1G", respectively.

The Rehabilitative Services pages beginning on "Attachment 3.1-A, Page 6a1" and "Attachment 3.1-B, Page 5d1" are multiple pages long and describe in detail the component services covered under Rehabilitative Services. Please clarify through the submission whether the state intends to move all Rehabilitative Services pages to the new "Attachment 3.1-A, Page 6a1G" and "Attachment 3.1-B, Page 5d1G." The current submission only appears to move the first page of Rehabilitative Services.

The state does not intend to move all Rehabilitative Services pages.

The strikethrough content from Attachment 3.1-A, Page 6a1 will be moved to Attachment 3.1-A, Page 6a1G, as indicated in our SPA submission. The remainder of the Rehabilitative Services section will continue unamended, with extant Page 6a2 immediately succeeding Page 6a1G.

The strikethrough content from Attachment 3.1-B, Page 5d1 will be moved to Attachment 3.1-B, Page 5d1G, as indicated in our SPA submission. The remainder of the Rehabilitative Services section will continue unamended, with extant Page 5d2 immediately succeeding Page 5d1G.

Attachment 3.1-A, Page 6a1A and Attachment 3.1-B, Page 5d1A

1. In accordance with 42 CFR 440.130(c), preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Please add similar language to the following on the state plan page "Services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice."

Attachment 3.1-A, Page 6a1C and Attachment 3.1-B, Page 5d1C

2. In accordance with 42 CFR 440.130(c), preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Please add similar language to the following on the state plan page "Services must be

recommended by a physician or other licensed practitioner of the healing arts within their scope of practice."

3. Please clarify any component services that the state is proposing to cover under breastfeeding and lactation consultants.
4. Under the last paragraph describing Eligibility Requirements, the state requires breastfeeding and lactation consultants, to either be an "International Board-Certified Lactation Consultant" or a "Certified Lactation Counselor." Are "Certified Lactation Counselors" licensed? If not, please summarize on the state plan page the qualifications for "Certified Lactation Counselors," including the education/degree, training, and experience the state requires, and any additional general information related to credentialing or registration.

Response:

1. DHS will issue a standing recommendation drafted by our medical director and we will address this approach with revisions to our SPA.
2. DHS will issue a standing recommendation drafted by our medical director and we will address this approach with revisions to our SPA.
3. Breastfeeding and lactation consultant services" includes medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the first twelve (12) months of the infant's life to aid in milk expression or infant nutrition. DHS intends to cover S9443 (lactation class) in 15-minute increments with rates for individual and group services.
4. Certified Lactation Counselors are not licensed. However, two bodies certify them. The International Breastfeeding Institute certifies "breastfeeding counselors," and the Academy of Lactation Policy and Practice (ALPP) certifies "lactation counselors." We have added this certifying body as acceptable certification to enroll as a Medicaid provider. We will include both breastfeeding counselors, as certified by the International Breastfeeding Institute, and lactation counselors, as certified by ALPP.

Bureau of Legislative Research

1. Ark. Code Ann. § 17-108-301 states that a certified community-based doula shall perform only certain listed services. Section 210.000 of the Nonclinical Maternal Care manual also lists services a doula may provide, but it includes additional items. Specifically, the manual lists "pregnancy, childbirth, and parenting education" rather than "childbirth education" and includes "assessment for health-related social needs" and "development of a birth plan", which are not listed in the statute. Where do these additional items come from? (I see that these items are also included in the lists in the SPA.)

2. Section 220.000 of the manual limits breastfeeding and lactation consultant coverage to beneficiaries who are pregnant or within 6 months postpartum, or infants up to six months of age. Is there a specific source for the six-month timeframe?

3. The SPA refers to a “Certified Lactation Counselor” while the definitions section of the manual refers to a “Certified Breastfeeding Counselor”. Are these two terms referring to the same thing?

1. **Response**: We have reviewed the language and have adjusted to ensure the provider manual mirrors the language in the Act.
2. **Response**: Other states that offer Medicaid coverage for lactation support extend coverage to 90 days (Kansas) and six months (Colorado). We originally selected the six-month timeframe and planned to allow additional services when medically necessary through an extension of benefit. Based on concerns expressed during public comment, we reconsidered this limit and opted to extend the limit to 12 months to provide the requested accommodation.
3. **Response**: Yes. The Act specifies a “certified lactation counselor” but doesn’t specify the certifying body. We selected the International Breastfeeding Institute, which certifies “breastfeeding counselors”. One commenter said the most used certifying body is the Academy of Lactation Policy and Practice (ALPP), which certifies “lactation counselors.” We have added this certifying body as acceptable certification to enroll as a Medicaid provider. We will include both breastfeeding counselors, as certified by the International Breastfeeding Institute, and lactation counselors, as certified by ALPP.