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Advancing Perinatal Health Equity Through Medicaid Coverage of Doulas

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Health policy researchers from the American Institutes for Research investigated policy considerations for states offering or considering Medicaid coverage of doulas to advance perinatal health equity.[1] This brief:

- reviews findings from the literature on the successes and challenges of Medicaid doula coverage implementation,
- synthesizes insights on Medicaid doula coverage considerations from interviews with doula certification and advocacy organizations, and
- identifies strategies and recommendations to improve the implementation of doula coverage.

Introduction

Each year, thousands of birthing people[2] experience unexpected, and often avoidable, negative outcomes during and after childbirth that result in significant short- and long-term consequences to their health and well-being. This is particularly true for Black, Native American/Alaska Native, and Hispanic birthing individuals. Given that Medicaid finances nearly half of births in the United States each year, there is significant opportunity for the program to help advance perinatal health equity.[3]

A doula is a trained nonclinical support person who provides emotional, physical, and informational support to individuals and families during pregnancy, childbirth, and the postpartum period.

Doula care potentially provides a way to address some of these inequities while generating savings to state Medicaid programs. Community-based doula models have been shown to help address social determinants of health for underrepresented and underserved communities that are often unaddressed—and sometimes worsened—in the traditional medical model. Further, paying doulas to support pregnant individuals has been shown to save states money by avoiding unnecessary medical costs (such as unnecessary cesarean sections) and reducing poor health

outcomes (such as preterm births)—both of which are costly to Medicaid and occur most commonly among Black and Native American/Alaska Native birthing communities.[4] Despite the evidence on doula care, less than one in 10 pregnant individuals use a doula, though nearly one in three would like to use one.[5]

To better understand Medicaid's role in advancing perinatal health equity through the coverage of doula care, we (a) reviewed relevant literature[6] and interviewed doula certification and advocacy organizations[7] on successes and challenges of Medicaid doula coverage implementation, and (b) identified strategies and recommendations from the literature and interviews to improve the implementation of Medicaid doula coverage. Our findings suggest that successful and sustainable doula coverage policies should be informed by key stakeholders, including practicing doulas and doula organizations from the communities that Medicaid serves; advance awareness of doulas through state Medicaid communication campaigns and other efforts; ensure that doula care is culturally congruent and community-centered, particularly by collaborating with and investing in community-based doula programs; support flexible and inclusive training and certification requirements and supplemental training opportunities; and compensate doulas fairly to support sustainability of the profession and equitable doula access.

Perinatal Health and Medicaid

The United States has the highest rate of maternal mortality[8] of all high-income countries and is the only high-income country in which the pregnancy-related mortality ratio[9] has increased over the past decade. More than 50,000 women experience serious complications during pregnancy or birth every year, and about 700 women die.[10,11] In particular, Black and Native American/Alaska Native women experience more frequent poor birth outcomes—including higher rates of cesarean sections, preterm birth, low birth weight, and infant death—than their White counterparts. These disparities exist regardless of income, education, marital status, tobacco/alcohol use, and insurance coverage, and are consistent across time.

> The United States is the only developed country in the world where the maternal mortality rate has steadily increased over the years, and there are stark racial disparities.

There have been recent initiatives at both the federal and state levels to improve perinatal health outcomes. For example, in December 2021, Vice President Kamala Harris urged the Senate to allocate $3 billion for states to expand Medicaid coverage up to 12 months postpartum, add federal-level quality indicators for perinatal care, and invest in expanding and diversifying the perinatal workforce.[12] In June 2022, the White House released the *White House Blueprint for Addressing the Maternal Health Crisis* that calls for increasing access to and coverage of comprehensive high-quality maternal health services, tackling implicit bias and structural racism in healthcare, advancing data collection, addressing social determinants of health for birthing people, and expanding and diversifying the perinatal workforce, including doulas.[13] At the state level, Medicaid programs are expanding eligibility, simplifying enrollment, transitioning into value-based care payment arrangements, enhancing benefits such as home visiting programs and doula care, and instituting other changes.[14,15] Eight states have initiatives to address substance use or mental health services for pregnant or postpartum beneficiaries, and more than half of states have taken steps toward lengthening the postpartum coverage window beyond 60 days.

The Role of Doulas in Advancing Perinatal Health Equity

Doulas offer state Medicaid programs a high-value, evidence-based way to improve health outcomes for birthing people and their babies.[16] Research shows that paying doulas to support pregnant individuals could save states money by avoiding unnecessary medical costs and reducing poor health outcomes.[17] For example, one study found that the reduction in cesarean sections that often results from doula care could have the potential to save state Medicaid programs $2 million annually.[18]

Further, doulas provide continued support, information, resources, and guidance during the critical postpartum period—a time in which nearly one third of pregnancy-related deaths occur.[19] Mortality and complications can occur prenatally, during delivery, and throughout the postpartum period, suggesting multiple opportunities for intervention. Given their involvement throughout pregnancy and the birthing process, doulas can be an effective tool in solving the perinatal health crisis.

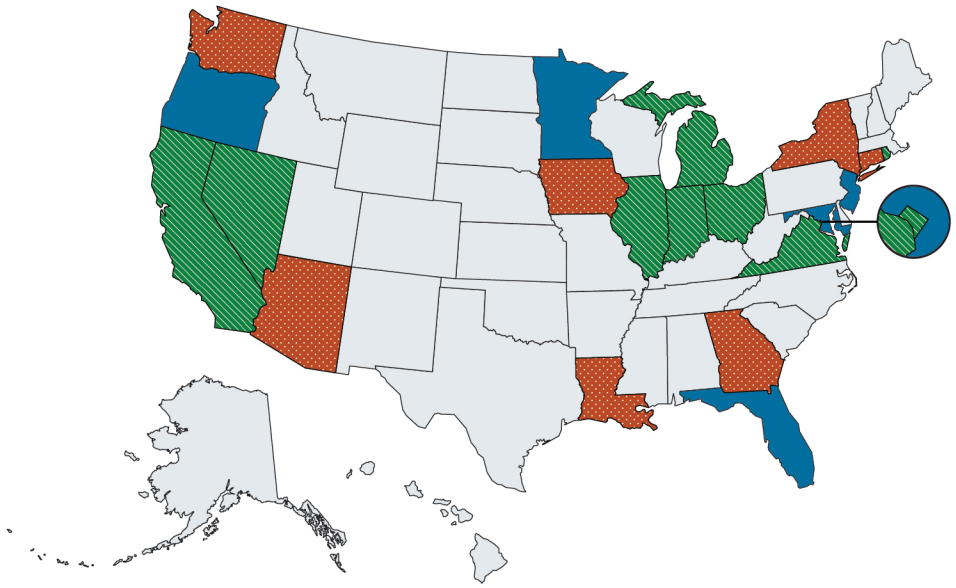
Doula care, particularly through community-based models, can help address social determinants of health that are often unaddressed, and sometimes exacerbated in the form of structural racism, in the traditional medical model.[20] For example, doulas provide childbirth and breast/bodyfeeding education; help clients navigate the medical system and encourage them to advocate for themselves; connect clients to community resources such as mental health providers and lactation consultants; help clients secure food, housing, and baby supplies; and offer education, wisdom, and companionship during the postpartum period to mitigate isolation; among other services.[21]

> The *White House Blueprint for Addressing the Maternal Health Crisis* underscores the value of a diverse doula workforce in helping to improve maternal outcomes and satisfaction for individuals served by Medicaid.

People from marginalized communities who face racism and bias in the health care system often seek doula support for added protection and care.[22] For example, Black women consistently report that their voices go unheard in medical settings,[23] and pregnant men who are transgender face discrimination when they seek care.[24] Birthing people from these communities who have engaged a doula as part of their birth team have shared that doulas help to inform them on medical topics, elevate their concerns and questions, connect them to safe and culturally appropriate care and resources, and advocate for their rights and well-being.

Medicaid Doula Coverage: Lessons From the Field

Medicaid is an important lever to improve access to culturally sensitive and trauma-informed doula care for under-resourced communities while upholding the doula profession. In the wake of disseminated research underscoring the value of doulas, states have started integrating coverage of doula services into Medicaid programs. As of April 2022, five state Medicaid programs actively reimburse doula services: Florida, Maryland, Minnesota, New Jersey, and Oregon.[25] At least nine states (California, Illinois, Indiana, Michigan, Nevada, Ohio, Rhode Island, Virginia, and the



District of Columbia) are set to offer or are considering implementing Medicaid doula coverage starting in 2022, and many more have proposed action for future years. Other states (including Arizona, Connecticut, Georgia, Iowa, Louisiana, New York, and Washington) have implemented projects such as doula pilot programs and doula registries to test implementation of doula coverage for Medicaid beneficiaries. On the federal level, several bills have been introduced in Congress over the past year, including the Mamas First Act and the Black Maternal Health Momnibus Act, that encourage the use of doulas from pregnancy to 1 year postpartum and advocate for the inclusion of doula services under Medicaid.[26]

Though Medicaid doula coverage policies and programs vary widely from state to state, there are important lessons that are universal and can be applied across contexts. We offer a summary of key findings from the literature and interviews with national and state doula certification and advocacy organizations to provide considerations for policymakers and administrators planning or providing the coverage of doula care under Medicaid.

A Well-Trained, Diverse Doula Workforce Improves Outcomes and Experiences

One of the cornerstones of doula support is person-centered care tailored to each person's circumstances, needs, and experiences. This means that the services and support a doula provides for one person may look entirely different for the next person, requiring a diverse and nimble set of skills and expertise. Medicaid beneficiaries often have a complex set of needs that require a higher degree of coordination, advocacy, community referrals, and prompt support.

Most doula trainings and certification programs, particularly those that have been approved under Medicaid policy to date, provide baseline skills and knowledge on topics relevant to all birthing persons (such as

The lack of diversity among the doula workforce, often due to resource and Medicaid administrative barriers, is a problem, especially given studies that show having a doula with a similar racial/ethnic background improves the outcomes and experiences of the birthing person.

the physical and physiological aspects of pregnancy and childbirth, coping mechanisms for labor, and breastfeeding basics), but are not inclusive of issues that are especially relevant for marginalized communities, like culturally sensitive or trauma-informed care. Issues that are not common in the general population, such as maternal mortality and morbidity, stillbirth, and infant mortality, may be more common among vulnerable subgroups. Restricting the certification programs that Medicaid accepts may limit the skill sets of Medicaid-covered doulas, affecting the quality of care that they can offer to Medicaid beneficiaries.

Further, the cost of trainings and certification programs—which can be upwards of $3,000 and require a year of study—limits the diversity of the doula workforce. Having a doula who is part of the same community significantly improves the health and birthing outcomes and experiences of the birthing person.[27] Doulas with a similar background improve trust and the likelihood that cultural needs are met, which might otherwise be overlooked, adversely impacting the birthing experience and outcome. However, because of financial barriers, there is limited representation of communities of color among doula trainers and practitioners.

Costly training and certification requirements, coupled with low reimbursement rates as described below, may especially prevent low-income people who are disproportionately people of color from becoming doulas, who tend to be White upper-middle class people serving other upper-middle class people. More than 80% of doulas in the United States are White.[28] This lack of diversity has been repeatedly identified as an issue. The 2022 *White House Blueprint for Addressing the Maternal Health Crisis* calls out this challenge and cites studies that show that culturally congruent care could improve access to and be beneficial for people of color.[29]

Doula Certification and Licensure Requirements May Limit Doula Accessibility and Role

To receive reimbursement under the Medicaid program, states must first establish a process for doulas to obtain licensure or certification. Currently, no states have a licensure program for doulas. However, states take a variety of approaches regarding the certification or credentialing of doulas. For example:

- In Florida, the state delegates both credentialing procedures and the determination of the benefit structure to each Medicaid managed care plan. Several managed care plans in Florida have delegated doula credentialing to the National Doula Network.
- In New Jersey, doulas must be at least age 18 and complete a doula training module, which includes core competencies (perinatal counseling, infant care, labor support) and community-based/cultural competency training, Health Insurance Portability and Accountability Act training, and adult/infant CPR certification. The New Jersey Department of Human Services, in consultation with the New Jersey Department of Health, must approve any doula training. Doulas must also pass a fingerprint-based criminal background check and have liability insurance.

- In Maryland, participating doulas must maintain certification through a doula certification program and must obtain adequate liability insurance.
- In Minnesota, doulas must be certified by one of the following organizations: International Childbirth Education Association; DONA International; Association of Labor Assistants and Childbirth Educators; Birthworks; Childbirth and Postpartum Professional Association; Childbirth International; International Center for Traditional Childbearing; or Commonsense Childbirth Inc.
- In Oregon, to be certified as a birth doula an individual must complete required training specified by the Oregon Health Authority through an authority-approved training program, complete an authority-approved oral health training, be CPR-certified, and document attendance at a minimum of three births and three postpartum visits.

Some doula organizations believe that certification requirements limiting the list of accepted certification programs places a barrier to entry for highly qualified doulas who have not trained with an approved organization and may limit the diversity of doulas who are eligible for reimbursement.

Despite efforts to move toward licensure for doulas, many doula organizations and individual practitioners have highlighted the drawbacks in doing so. Some groups have gone even further, speaking out against any type of doula certification. Typically, concerns with proposed licensure or certification requirements relate to how they define and regulate doulas rather than the expansion of doula services to the low-income population. For example, licensure may place limits around the role that the doula may play. Some birthing people elect to give birth with the assistance of a doula to help them navigate the birthing process with their medical doctors or nurses. Limiting the role a doula can play during the birthing process could potentially take away the benefit of doula support. Licensure may also insert a formal, government-regulated structure around a role that is inherently family and community based.

There is concern among some doulas and doula organizations that unnecessary and unvetted credentialing and licensure requirements will impose a formal, government-regulated structure around a role that is inherently family and community based.

A Living Wage Helps to Ensure Sustainability of Doula Coverage Programs

Low reimbursement rates and complex billing are a significant barrier to entry for doulas and an obstacle to doula retention. A living wage helps to ensure equitable access to doula services and encourages a sustainable workforce.

For sustainability of doula coverage programs, Medicaid reimbursement rates for doula services must offer doulas a living wage. Across states and pilot programs that have implemented doula coverage, low reimbursement rates have been shown to be a significant barrier to entry for doulas and an obstacle to retention of doulas. Evidence from Oregon and Minnesota, for example, shows that both states set initial reimbursement rates for doula services too low to attract enough doulas to serve Medicaid beneficiaries.[30] Oregon reported an increase in participating doulas following a rate increase.

To further illustrate, in Minnesota, doulas are reimbursed $770 for a complete package covering continuous labor support and six prenatal and postpartum visits.[31] In New Jersey, doulas are reimbursed $800 for a complete package covering continuous labor support and up to eight prenatal and postpartum visits. In Oregon, doulas are reimbursed $350 for continuous labor support and up to four prenatal and postpartum visits. In the case of a 24-hour labor, which is not uncommon for first-time parents, this means that doulas are reimbursed anywhere from $12 to $25 an hour. After

accounting for administrative costs and other expenses (e.g., travel time, parking, gas, time offering support via phone or coordinating care with other providers), the pocketed hourly rate is much lower.

Low pay often means that doulas either choose not to work with Medicaid or limit the number of clients they take through Medicaid, requiring them to seek clients outside of the communities that they are committed to serving. Further, complex billing requirements and paperwork can mean that a doula does not receive compensation until weeks, sometimes months, after care is completed. In these cases, doulas often seek other sources of income, limiting their ability to support Medicaid-covered birthing individuals.[32] Sufficient and timely reimbursement rates are needed to ensure equitable access to doula services and encourage more interest among new and established doulas in serving the Medicaid population.

Lack of Awareness, Cost, and Barriers to Entry for Doulas Limit Doula Access Among Medicaid Beneficiaries

Despite the growing evidence on doulas' role in improving outcomes and experiences, pregnant Medicaid beneficiaries are less likely to know about doulas than other populations. In fact, Medicaid beneficiaries are 50% less likely to know about doula care than those who are privately insured.[33]

> Many barriers limit doula access to birthing people who need them, including general unawareness of doulas, unawareness of Medicaid coverage options, and a limited pool of diverse doulas.

Even if birthing people are aware of doulas, they may not be aware that doulas may be covered through their state Medicaid program. Because cost is a significant barrier to accessing doulas—fees can range from a few hundred dollars to $2,800 and more—doula support is typically limited to birthing people who can afford to hire them.[34] In fact, cost is the most significant barrier to obtaining doula care—one study found that among birthing people who faced challenges obtaining doula care, 88% cited cost as a barrier; this same study found that 40% of doulas in private practice sometimes turned clients away because of cost issues.[35] Therefore, awareness of Medicaid coverage of doula care is important to a successful program.

As described above, doulas may also choose not to participate in Medicaid due to low reimbursement rates or costly training and certification barriers. Even if people are aware of doulas and Medicaid coverage options, availability of doulas is another barrier that limits access to care, especially in under-resourced and historically marginalized communities. For example, some states that cover doula care or that may be considering providing doula care under state Medicaid (e.g., Louisiana) have established doula registries, and a subset of these states require that doulas be on the registry to receive Medicaid reimbursement. Requirements for inclusion on the registry vary across states and include stipulations that doulas must be certified, submit an application, submit to a background check, and meet an annual verification of certification, all which require a fee paid by the doula. Further, as noted above, Medicaid reimbursement rates tend to be low, which poses a significant barrier to entering the profession. In addition, there are fewer practicing doulas in rural areas as compared to urban and suburban areas, which further limits availability of doulas for some Medicaid beneficiaries.[36,37]

Strategies to Advance Medicaid Doula Coverage Policy

Doulas are a potential way to reduce health care costs and improve perinatal health equity and experiences for under-resourced and marginalized birthing people and their families. Medicaid—as the prime source of health coverage for birthing people of color—is poised to play a critical role in advancing perinatal health care through doula coverage. Federal and state policymakers and stakeholders can consider the following measures to adopt and improve doula coverage policies in state Medicaid programs.

1. **Federal policymakers should consider providing more guidance to states and Medicaid managed care plans regarding Medicaid coverage options for doula care.** Guidance could include case studies of other states that have successfully implemented such coverage; for example, Indiana is using a Title V Maternal and Child Health Block Grant, Minnesota is paying through Medicaid, and in Nebraska, a Medicaid managed care organization pays for doula care as a value-added service.[38]

2. **Federal policymakers should consider investing in examination and evaluation of doula coverage policies.** More evidence is needed on impactful and sustainable approaches to doula coverage across implementing states, including, but not limited to, models of community-based doula integration, certification and licensure requirements, and payment rates. Such information could illuminate promising practices and lessons learned for states covering or considering coverage of doulas under Medicaid.

3. **State policymakers should consider seeking more direct input and feedback from relevant stakeholders before making decisions about the structure of Medicaid coverage for doula care.**[39] State policymakers should engage doula and patient advocacy organizations, program administrators, practicing doulas, and patients in a conversation about how best to structure Medicaid coverage for doula care. Nuances to be considered include licensing and certification requirements, including an analysis of how best to structure fulfillment of those requirements, and potential reimbursement pathways.

4. **Federal and state policymakers and program administrators should consider increasing awareness of doulas through communications campaigns.** The Centers for Medicare & Medicaid Services could provide state Medicaid offices and Medicaid managed care plans with communications toolkits for states to use with example messaging and images for different audiences, communication formats, and venues.

5. **State policymakers and program administrators should seek to diversify the doula workforce and strive to provider culturally congruent and community centered care.** This includes collaborating with and investing in community-based doula programs. Community-based doula programs operate in and aim to support individuals in marginalized communities using evidence-based person-centered practices[40] to ensure that doulas enrolled in Medicaid coverage programs are well equipped and supported to serve communities of color and low-income communities.

6. **State policymakers and program administrators should consider supporting flexible and inclusive training and certification requirements and supplemental training opportunities.** State policymakers can incorporate flexibility to their approved training and certification programs, especially programs that attract diverse doula

trainees. State policymakers and program administrators should also provide funds or establish a grant program to train and certify doulas from underserved low-income communities, rural communities, communities of color, and communities facing linguistic or cultural barriers. Further, state policymakers and program administrators should provide funds to supplement doula certification (or licensing) requirements to include education on trauma-informed care and on social and structural determinants of pregnancy and childbirth care.

7. **State policymakers and program administrators should consider compensating doulas more fairly and in a timely fashion to support sustainability of the profession and equitable doula access.** This includes ensuring reimbursement rates allow doulas to have the opportunity to earn a living wage and allowing payment for travel mileage. It also includes simplifying billing requirements so doulas receive compensation in a timely manner.

Areas for Future Research

There are many opportunities to further explore the role of doulas in equity-focused initiatives and shine light on strategies to improve perinatal health equity within Medicaid by optimizing doula coverage. Areas for future research may include:

- evaluating the effectiveness of doula support in improving maternal health outcomes in states with Medicaid coverage of doulas, with a particular focus on the outcomes of Medicaid-covered Black, Native, and Hispanic birthing individuals;
- exploring strategies to increase the racial/ethnic, geographic, and socioeconomic diversity of the Medicaid doula workforce and to sustain diversity over time;
- examining how doulas can help support and improve maternal mental health (e.g., by connecting individuals who need specialized support with mental health providers);
- exploring ways to improve standardized data collection on doula care activities across state Medicaid programs by systematically collecting data on doula service provision and developing quality measures for doula care;
- examining approaches to certification and licensure that uphold the community- and family-focused nature of doula work while ensuring high-quality care for all individuals and families;
- assessing varying approaches to Medicaid doula coverage, including community-based models, with the aim of reducing health disparities;
- exploring successes and challenges of Medicaid doula coverage programs from the perspective of a wide range of stakeholders, including providers, issuers, state Medicaid administrators, and beneficiaries; and
- examining doulas' role in addressing social determinants of health for underserved and underrepresented Medicaid communities.

Endnotes

1 For this brief, we define "perinatal health" as the health of birthing people and child before, during, and after birth.

2 We use inclusive terms, such as "birthing person," in recognition that not all individuals who become pregnant and give birth identify as women.

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7 We interviewed (or received written comments from, in one case) leaders from four national and state-based doula certification and/or advocacy organizations with diverse programs and focuses. The state-based organizations were in states in which Medicaid is reimbursing doulas or is designing policies to do so. Conversations were about 30 minutes in length and included questions about their perspectives on Medicaid coverage of doulas and observed successes and challenges with implementation of coverage.

8 Maternal mortality is defined as the number of women that die during pregnancy, child delivery, or within 42 days of giving birth.

9 A pregnancy-related death is defined as the death of a birthing person while pregnant or within 1 year of the end of the pregnancy from any cause related to the pregnancy.

10 To maintain accuracy, the American Institutes for Research uses the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth. Where possible, we use more inclusive terms in recognition that not all individuals who become pregnant and give birth identify as women.

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