IssueBrief

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Doulas in Medicaid: Case Study Findings

Medicaid is a source of coverage for many pregnant individuals, funding more than 40 percent of all births in the United States. Medicaid finances more than 60 percent of all U.S. births among Black and American Indian and Alaska Native (AI/AN) women.[1] Black and AI/AN women experience higher rates of severe maternal morbidity and mortality than white women, irrespective of income (Knocke et al. 2022). There are also geographic disparities in access and health outcomes. One study found that Medicaid covers nearly half of births in maternity care deserts, counties with no maternity care centers or obstetricians, the majority of which are in rural counties (Brigance et al. 2022). Another study found that from 2011–2016, in the most rural counties, the maternal mortality ratio was 23.8 deaths per 100,000 live births compared to 14.6 in large metropolitan counties (GAO 2021).

Doulas can play a role in improving maternity care and addressing inequities in maternal and infant health outcomes. Doulas are non-clinical trained professionals who can provide emotional, physical, and informational support and guidance during the prenatal, birth, and postpartum period (NASHP 2022). Some doulas, known as full spectrum doulas, assist with additional reproductive health services, including family planning or support in the event of a miscarriage or stillbirth (Knocke et al. 2022). Doulas advocate on behalf of expecting parents, especially those from historically marginalized communities, to providers, such as midwives and obstetricians. They ensure parents' concerns and needs are addressed and facilitate access to needed prenatal and other non-clinical services (NASEM 2021).

The Biden Administration has released a blueprint of initiatives to improve maternal health; one effort is to expand and diversify the perinatal workforce, including obstetricians, midwives, community health workers, and doulas. The Centers for Medicare & Medicaid Services (CMS) is providing technical assistance to states on the ways in which doula services can be reimbursed under Medicaid (White House 2022). There is variation in Medicaid coverage for pregnant women, with some states terminating Medicaid benefits 60 days postpartum and others choosing to expand the postpartum benefit to up to 12 months postpartum (Knocke et al. 2022). The blueprint encourages states to consider ways to align this postpartum coverage extension with adoption of the doula benefit.[2] As of September 2023, 11 state Medicaid programs and the District of Columbia have implemented a Medicaid doula benefit and at least 8 states are in the implementation process (Hasan 2023, NHeLP 2023).[3]

To understand how state Medicaid programs have designed doula coverage, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with the Center for Health Care Strategies (CHCS) to conduct a document review and key informant interviews in five states (Florida, Minnesota, New Jersey, Oregon, and Rhode Island) that have implemented the benefit.[4] The case study states were selected based on a variety of criteria, including the length of time the benefit has been in place, the use of managed care organizations (MCOs), geography, and the demographic characteristics of the Medicaid population. CHCS interviewed Medicaid officials, doulas, doula organizations, and MCOs in each case study state. The interviews also included national perspectives from federal officials, maternal health experts, birth justice advocates, key stakeholders in the doula community, and doula support organizations. The interviews were designed to identify the key considerations for providing doula services in Medicaid and to assess whether states involved doulas and beneficiaries in designing and implementing the coverage. The key findings from the document review and interviews are synthesized in this issue brief.

The Medicaid coverage landscape for doulas is quickly evolving as additional states adopt this coverage and as states make changes to existing policies. This brief highlights the challenges of incorporating this non-clinical service into Medicaid, as well as the assistance doulas need to support beneficiaries. This brief begins with

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background on the role of doulas and the categories of Medicaid coverage. It then details the approaches and challenges of designing and implementing doula coverage, including benefit design, training and credentialing requirements, payment, utilization of the service, and workforce issues. It then describes states' stakeholder engagement process and efforts to provide doula administrative support.

Background

Studies have shown that doula support during pregnancy, birth, and postpartum is linked to improved maternal and infant health outcomes. For example, doula-assisted mothers were four times less likely to have a baby with low birthweight, two times less likely to experience a birth complication for the mother or baby, and significantly more likely to initiate breastfeeding (Gruber et al. 2013). Receiving care from a doula is also associated with reports of a positive birth experience (Strauss et al. 2016). Additionally, doulas can help address the health-related social needs of mothers, including assisting beneficiaires with referrals to community-based social services such as housing, food assistance, transportation services, and linkages to community health workers (Bakst et al. 2020). One study modeling the cost-effectiveness of doulas concluded that payment for doula services would likely be cost-saving for state Medicaid programs by offsetting costs associated with preterm births and cesarean deliveries (Kozhimannil et al. 2016).

In Medicaid, doula services can be covered under multiple benefit categories, including preventive services, services of licensed practitioners, clinic services, and freestanding birth center services (CMS 2021a). Preventive services are services recommended by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency (42 CFR 440.130). Such an approach provides states the flexibility in both defining who is considered a licensed practitioner as well as what constitutes a recommendation. When covered as services of licensed practitioners, doulas must be licensed, or supervised by, and bill under, a licensed practitioner. Clinics and freestanding birth centers may bill for doulas as part of their routine practice of care. MCOs can also provide doula services as value added or expanded services if they are not explicitly a state plan service (42 CFR 438.3(e)).

Of the case study states, New Jersey, Oregon, and Rhode Island cover doula services as a preventive service and allow doulas to bill for services independent of licensed practitioners. Minnesota covers doula services as a pregnancy-related service, allowing doula services to be a part of an enhanced set of services only available to pregnant people (CMS 2014).[5] Florida Medicaid gave their MCOs the option to provide doula services as an expanded benefit, which are services MCOs can offer to beneficiaries in addition to services required by the Medicaid program (AHCA 2022).

Benefit Design

States vary in the doula benefit design, but in general, the standard scope of doula services often includes prenatal, labor and delivery, and postpartum services. Doulas provide counseling, education, and emotional support throughout the pregnancy and postpartum periods and teach parents skills to care for their infant. Doulas may also be required to make connections to community-based services (NHeLP 2023). Additionally, the number of visits covered varies by state, with most of the case study states covering at least five visits from prenatal through the postpartum period. Prior authorization requirements for additional visits beyond the minimum defined benefit also vary by state. Some states engaged doulas to design the benefits and the proposed scope of services. Four states defined the scope of their doula coverage within the state plan, while in Florida, the MCOs define the scope.

Florida. MCOs determine the scope of coverage and whether doulas contract with health plans as part of a doula network, which is similar to a provider group, or as independent providers. A number of Florida MCOs contract with The Doula Network (TDN), an organization that assists doulas with credentialing and certain administrative functions (e.g., billing and reimbursement help). TDN and these MCOs have negotiated coverage that includes five visits and labor/birth support for clients served by TDN-doulas.[6] However, doulas that contract independently with MCOs may have a different visit structure. For example, in their contracts with independent doulas, two MCOs cover two prenatal visits, one visit for labor and delivery, and one postpartum visit. A number of MCOs cover unlimited doula visits for enrollees, although most require prior authorization. Interviews with selected Florida MCOs and an examination of their member handbooks found that the description of services that doulas could provide did not always align with the typical doula scope of practice. For example, two health plans described doulas, who are not clinically trained, as providing additional clinical support, such as prenatal monitoring and assessment, uterine monitoring, and gestational diabetes monitoring.

Minnesota. The Minnesota statute and the state plan describe the doula benefit as continuous emotional and physical support, as well as childbirth education, during pregnancy, labor, birth, and the postpartum period (Minnesota Legislature 2022, CMS 2014). The benefit includes up to seven visits: four prenatal visits, one birth visit, and two postpartum visits (Minnesota Legislature 2019). According to a state Medicaid official, the visit schedule is flexible. Visits can occur during the prenatal or postpartum period, and additional visits can be provided with prior authorization.

New Jersey. Coverage in New Jersey includes perinatal counseling and education (e.g., infant care), labor support (e.g., development of a birth plan), and coordination with community-based services (CMS 2021b). New Jersey uses a community-based doula model, in which the doula comes from the community that they serve and shares aspects of the lived experience of the member. The state plan also highlights that doulas provide culturally competent care that supports the racial, ethnic, and cultural diversity of members. Services are delivered within two levels of care: 1) standard care, which covers eight prenatal and postpartum visits and one labor and delivery visit; and 2) enhanced care, which is available to beneficiaries who are 19 years old or younger and includes up to 12 visits in the prenatal or postpartum period and attendance at the delivery (DMAHS 2021a, DMAHS 2021b). In both levels of care, the initial prenatal visit can be longer to allow the doula and beneficiary to establish a relationship. In addition, the timing of the visits (i.e., prenatal or postpartum) is flexible. The Medicaid agency designed this benefit based on how doulas reported they were already engaging with beneficiaries.

Oregon. Under Oregon's Medicaid benefit, doula services include non-medical support to parents during the pregnancy, childbirth, and postpartum period. Oregon provides five visits: two prenatal visits, one visit for labor and delivery, and two postpartum visits (CMS 2017). Coordinated care organizations (CCOs), which are managed care organizations in the state of Oregon, have the option to cover more visits, but it is unclear whether any currently are. In addition, Oregon requires that doulas facilitate access to community resources that may improve birth-related outcomes including supplemental nutritional benefits, transportation, housing, alcohol, tobacco and drug cessation, and intimate partner violence resources.

Rhode Island. Rhode Island Medicaid offers full-spectrum doula coverage throughout the perinatal period including up to one year after the birth of the infant or other pregnancy outcome. Medicaid covers a total of seven visits: three prenatal visits; one visit for labor and delivery; and three postpartum visits (CMS 2022). The seven visits can be distributed in a way that allows the beneficiary to access support when they choose throughout the entire perinatal period. Beneficiaries under age 21 can receive additional visits with prior authorization. MCOs can also cover extra visits. The beneficiary can receive doula support regardless of whether they experience a miscarriage, stillbirth, abortion, or other pregnancy outcome (RI General Assembly 2021). While the state plan indicates that a doula can provide linkages to services outside their scope of practice, providing community support is not a requirement (CMS 2022).

Benefit design challenges

Interviewees noted practice rules and certain scope of service requirements, including recommendations from licensed providers, supervision requirements, visit structure, and requirements to address health-related social needs as barriers to providing doula services.

Recommendations from licensed providers. Federal rules require a licensed practitioner of the healing arts to recommend preventive services, such as doula services, and give states the flexibility to determine who qualifies as a licensed practitioner and how to implement the recommendation requirement. The varying ways that states have implemented this requirement may lead to confusion and additional administrative burden for doulas and their clients. New Jersey requires doulas to secure from each beneficiary a licensed practitioner's recommendation for doula services prior to initiation of those services, and to maintain a record of the recommendations. However, doulas often misinterpret the requirement as requiring prior authorization or supervision by a clinician (DMAHS 2021a). New Jersey Medicaid created a template recommendation form and noted that a recommendation is not the same as a prescription or a medical order (NJ FamilyCare 2021).

State differences in which providers can recommend doula services can also be a source of confusion for doulas. For example, Oregon's policy permits a limited group of providers to recommend the services. In Oregon, interviewees indicated that some doulas have existing relationships with providers who submit a recommendation form for the doulas. In other instances, the recommendation comes from the pregnant individual's maternity care provider (i.e., obstetrician/gynecologist or certified nurse midwife). Rhode Island interprets licensed practitioner to include physicians, nurse practitioners and nurse midwives, as well as licensed clinical social workers and licensed behavioral health professionals. These recommendations must be documented in the beneficiary's electronic health record, but there is no standard for such documentation.

Supervision requirements. Supervision requirements, which specify that doulas must be supervised by and bill under a licensed practitioner, can be a barrier to care because doulas may have difficulty finding a willing provider. Doulas in Minnesota are required to be supervised by a physician, nurse practitioner, or other clinical provider (DHS 2020). One doula noted that physicians may not understand doula scope of services, which may contribute to the lack of medical providers willingness to supervise doulas. Her doula organization works to find willing providers, but a lack of these providers remains a barrier. Additionally, a national expert noted that there is an inherent tension between a doula's role to serve and advocate for the beneficiary and having a licensed provider oversee them. Based on feedback from doulas, Rhode Island's Medicaid program opted to forgo a supervision requirement.

Visit structure. Some doulas reported that the visit structure, such as the number of visits as well as when these visits can be provided, does not always align with the way doulas traditionally care for beneficiaries. Doulas typically provide care based on an individual's needs and not on specified timeframes. One doula organization noted that they prefer more than two prenatal visits, one visit for labor and delivery, and two postpartum visits in Oregon and recommend more visits to ensure beneficiaries, especially Black women, receive the care they need. In New Jersey, doulas expressed the need for additional visits with some clients, especially younger beneficiaries, which led the state to cover additional visits for individuals age 19 or younger. However, one doula organization in Minnesota noted that six visits in addition to labor and delivery support can be too much; some families may be unable to participate in that many visits. Another doula organization in Florida mentioned that beneficiaries can have appointment fatigue if there are too many visits. As previously mentioned, Rhode Island offers flexibility in how the visits are distributed; if all the prenatal doula visits are not used, the beneficiary can have more postpartum visits to receive the total of seven visits.

Health-related social needs. Doulas can help connect beneficiaries to community-based services to address their health-related social needs (HRSNs), such as food insecurity or transportation, but requiring them to do so can be burdensome and out of their scope. In Oregon, both doulas and CCOs raised concerns about doulas being required to address HRSNs. They noted that doulas are trained to provide perinatal support services. The New Jersey Medicaid agency chose not to mandate that doulas make these referrals to not overburden them. Even without a requirement to do so, some doulas may provide HRSN referral services to clients. Other stakeholders noted that when doulas are providing such referrals, a billing code is needed to ensure payment for this service.

Training and Credentialing

States can specify the training and skills doulas must have to be qualified as Medicaid providers. In Minnesota, New Jersey, Oregon, and Rhode Island, a doula must complete trainings, enroll as a state Medicaid provider, receive a National Provider Identified (NPI) number, and complete a credentialing process with the state and separately with each MCO they wish to contract with. In Florida, training and certification requirements are determined by the MCO or its contracted providers.

In general, states offer two approaches to doula training requirements: completing training from a state-approved list of training programs or attending training focused on a set of core competencies. States either choose the approach or allow the doula to choose. The state-approved training may include a list of national doula training programs, such as HealthConnect One, Uzazi Village, and DONA International or state-specific trainings (MDH 2023, NJ FamilyCare 2022). Core competency focused trainings may consist of evidence-based perinatal education, birth plan development, continuous support during labor, infant feeding, trauma-informed care, linkages to community resources, or community-based or cultural competency training. Some states, such as Rhode Island and Oregon, accept doulas with significant experience but no recent formal training through legacy periods or experience pathways (Table 1).[7] In some states, doulas have multiple options to satisfy the training requirement.

States have the flexibility to establish Medicaid provider credentialing processes for doulas, which differs across states. Doulas may have to complete multiple application forms and pay application fees, undergo background checks, complete Health Insurance Portability and Accountability Act (HIPAA) compliance training and other required training (e.g., CPR, trauma-informed care training, or cultural competency training), provide documentation of required completion of trainings and certification, and pay enrollment fees. Some states also require additional trainings to complete credentialing. For example, New Jersey Medicaid requires doulas to complete supplemental community competency training that provides information about local community-based resources.

Table 1. Overview of five state approaches to doula training requirements

State	State determines training requirements	MCO determines training requirements	Approach 1: Attend state-approved trainings	Approach 2: Attend trainings to gain core competencies	Legacy periods or experience pathway[1]	Additional required trainings	Notes
Florida	No	Yes	No	No	No	No	–
Minnesota	Yes	MCOs have option to require additional training	Yes	No	No	No	–

State	State determines training requirements	MCO determines training requirements	Approach 1: Attend state-approved trainings	Approach 2: Attend trainings to gain core competencies	Legacy periods or experience pathway[1]	Additional required trainings	Notes
New Jersey	Yes	No, but all MCOs accept training process designated by the state	Yes	Yes	No	Community competency[2] Trauma-informed care	Doulas must use state approved core competency trainings
Oregon	Yes	MCOs have option to require additional training	Yes	Yes	Yes	Traditional health worker[3] Trauma-informed care	Legacy clause currently being implemented, as of 11/22
Rhode Island	Yes	MCOs have option to require additional training	No	Yes	Yes	Trauma-informed care	Core competency trainings do not need to be state approved Legacy pathway available, from 10/21-5/22

Notes: MCO is managed care organization. These training requirements reflect what was in effect at the time of the case study interviews.

[1] Legacy periods or experience pathways are options for doulas who have been providing doula care for many years and do not need formal training.

[2] Community competency training is required supplemental training that provides information about New Jersey-specific community-based resources.

[3] In Oregon, traditional health workers are defined as frontline public health workers who work in a community or clinic under the direction of a licensed health provider.

Source: Center for Health Care Strategies analysis, as of November 2022.

Training and credentialing challenges

When states are overly prescriptive of the requirements for trainings, such as training with a specific organization or the requirement to receive in-state training, doulas may struggle with timely completion based on the availability of training sessions. Rhode Island and New Jersey grant doulas the flexibility to train with national organizations. To address the difficulty of completing trainings in a timely manner, Oregon is in the process of approving a “one-stop training program” that provides the components of the traditional worker training as well as the doula training. Minnesota requires doulas to obtain training through one of nine prescribed training organizations or by an organization designated by the Commissioner of Health.

During the interviews, some doulas of color raised concerns that components of the state-approved doula training and certification organizations are not community-based, not necessarily tailored to train doulas to meet the specific needs of historically marginalized communities, and may not train doulas to meet Medicaid beneficiaries' needs. This may hinder doulas from completing these trainings and enrolling as Medicaid providers. Doulas have advocated for more local and diverse training organizations to increase the cultural competency of doulas.

Doulas and others have also expressed that administrative complexity may deter some doulas from enrolling as a Medicaid provider, especially since many doulas have limited experience credentialing and contracting with the state or MCOs. These challenges increase when there are multiple plans with different requirements for doulas to fulfill. In Florida, for example, the Medicaid agency has limited involvement with how MCOs contract with doulas. The Doula Network (TDN) has an agreement with their contracted MCOs around credentialing requirements, and all TDN doulas must be credentialed before enrolling with these MCOs. Doulas who are not affiliated with TDN must learn how to contract with each individual health plan, each with differing credentialing requirements. The lack of a standardized, clear, and efficient process for independent doulas to contract with MCOs may be one cause of the limited availability of doulas who can serve Medicaid beneficiaries. In New Jersey, to ease the enrolling process for doulas and reduce cost-prohibitive credentialing requirements, doula applications and doula background checks have no fee. Given these challenges, some states, plans, and doula organizations, are providing support to doulas to fulfill these training and credentialing requirements (see Doula Supports below).

Payment

Doulas are typically paid based on a per-visit basis, with a higher payment rate for attending labor and delivery, but in some circumstances, doulas may receive a greater amount than the base payment. The base payment rates range from $350 to $1,500 for doula services (see Table 2). Some states with managed care have established a fee-for-service payment rate and permit MCOs or CCOs to pay higher rates. Payment rates may also vary depending on whether a doula contracts directly with an MCO or bills through an intermediary organization. In some cases, doulas have advocated for increased payment rates either with the state or in direct negotiations with plans.

TABLE 2. Doula payment rates in Medicaid

State	Payment rate per visit	Payment rate for labor and delivery	Total base payment	Variation from base payment rates
Florida (2022)	–	–	$850-$1,112	Payment rates vary by MCO and whether the doula contracts directly or through an intermediary organization.
Minnesota (2019)	$47 (up to six visits)	$448	$770	Some community-based organizations, billing on behalf of doulas, have negotiated higher rates, up to $900, from MCOs.
New Jersey (2021)	$99.72 (initial visit) $66.48 (subsequent visits)	$235	$800	Payment is higher (up to $1,066) for individuals age 19 or younger due to the allowance of additional visits. Doulas receive an $100 incentive payment for postpartum visit attendance.

State	Payment rate per visit	Payment rate for labor and delivery	Total base payment	Variation from base payment rates
Oregon (2017)	$50 (up to four visits)	$100	$350	CCOs typically pay higher rates, about $700-900 total. The state intends to increase the fee-for-service rate to $1,500 (total) and has submitted a state plan amendment to CMS.
Rhode Island (2022)	$100	$900	$1,500	–

Notes: MCO is managed care organization. CCO is coordinated care organization. CMS is the Centers for Medicare & Medicaid Services. These payment rates reflect what were in effect at time of the case study interviews.

Source: Center for Health Care Strategies analysis, as of November 2022.

Payment challenges

A number of payment barriers, including low payment rates and compensation that does not include the full scope of services they provide, as well as the administrative burden associated with billing, can inhibit doula participation in Medicaid.

Payment rates. Many doulas interviewed pointed to low reimbursement rates as the reason for not enrolling as Medicaid providers. In particular, interviewees raised concerns that reimbursement rates might not always provide a living wage. In some states, doulas and other stakeholders engaged state Medicaid agencies and state legislatures to increase payment rates for their services. For example, doula organizations in Rhode Island were engaged in the legislative process and pushed for Medicaid to consider reimbursement rates in the context of a livable wage for doulas. Doulas were initially concerned at the proposed rate of $850 and subsequently successfully lobbied for a $1,500 reimbursement rate (RI EOHHS 2021). Similarly, in Oregon, doula advocacy led the Oregon Health Authority to propose an increase from a reimbursement rate of $350 to $1,500 in June 2022 (OHA 2022b).

Payment for scope of services. The billing codes for doulas do not always fully reflect their scope of work or the services they are expected to provide. For example, a community-based organization in New Jersey noted that additional codes for the services doulas typically provide, such as care coordination, lactation counseling, and childbirth education, are not currently available for doulas. In New Jersey and Oregon, doulas are also expected to provide linkages to community support services, such as housing and food assistance. However, doulas are not reimbursed specifically for these additional services. In Oregon, one CCO is testing the use of a code that doulas can use to bill for care coordination services, but doulas are not currently being paid for these services.

Billing process. A number of doulas, both independent providers and those working with doula support organizations, noted difficulty in the billing process, including denied or delayed claims. For example, in Florida, one doula organization noted that the lack of Current Procedural Terminology (CPT) codes for doula services can lead to denied or delayed payments for doulas.[8] Currently, doulas use CPT codes with modifiers for doula services, and experience many denied claims. Additionally, a plan from New Jersey suggested that it may be easier for doulas to submit their claims per visit rather than as a batch after the term of service with the client has ended. This approach allows doulas to resubmit corrected claims earlier in the case of any errors and may lead to more timely payment. However, interviewees from a community-based organization in the state noted that submitting claims for each individual doula visit creates more administrative work and risk for confusion or miscommunication for the doulas. Given the complexities associated with billing, some states, plans, and doula

organizations are providing support to doulas to complete these tasks (see Administrative Support for Doulas below).

Utilization of Doula Benefit

States report utilization of doula services to be limited but were unable provide specific data. Minnesota Medicaid noted that in 2020 there was an increase in doula utilization, and that demand is high, but use of doula services remains low as a proportion of total births. Similarly, New Jersey, which began covering doula services in 2021, reported low use of the services. Factors contributing to the low utilization of doula services include lack of beneficiary awareness of the benefit and workforce issues.

Lack of beneficiary awareness

Stakeholders noted that some Medicaid beneficiaries are not familiar with what services doulas provide, that they are available through Medicaid, or how to access them. Interviewees from an MCO in Florida stated that although doulas and advocates pushed for a doula benefit, beneficiaries were not included when decisions were made. The interviewee suggested that this was a missed opportunity to engage with and receive buy-in from beneficiaries. Similar sentiments were raised in other states regarding the lack of beneficiary engagement in the discussion of covering doula services, which could lead to low utilization of the service (see Stakeholder Engagement below). Some states and stakeholders are looking to increase beneficiary awareness. For example, some MCOs in New Jersey are collaborating with doula organizations to attend health fairs, including information in beneficiary welcome packets, and launching public campaigns to increase awareness of community doulas.

Workforce issues

The limited number of doulas available to serve the population may also hinder access and some states are invested in developing a doula workforce. In Rhode Island, the Office of the Health Insurance Commissioner required each MCO to make a financial investment in either the perinatal or doula workforce by supporting doula workforce development and training (OHIC 2022). New Jersey is also focused on workforce development to build a doula network. As part of this effort, the New Jersey Department of Health is partnering with foundations and community-based organizations to train new cohorts of doulas to continue to build the community doula workforce, particularly in communities in maternity care deserts (Brewington et al. 2022). However, challenges still remain in increasing doula participation in the Medicaid program and developing a workforce that is culturally representative of the population they serve.

Limited doula participation in Medicaid. Doulas expressed challenges to participating in state Medicaid programs including difficulties contracting with MCOs, low payment rates, and the administrative burden of enrolling as a Medicaid provider. For example, doulas in Florida noted that difficulty in contracting with MCOs may limit the number doulas who can serve Medicaid beneficiaries. Oregon increased the payment rate and CCOs are working with doulas and doula hubs, a connection point for doulas to receive support in becoming a Medicaid provider, to remove administrative barriers in hopes of increasing the workforce. Doulas interviewed in Minnesota indicated that demand for doula services is high among Medicaid beneficiaries, but that there are not enough doulas who accept Medicaid. The state is engaging in early conversations with doulas and doula organizations to address this issue.

Representative doula workforce. Many doulas and national experts interviewed expressed the need for racial, ethnic, and linguistic congruency between doulas and Medicaid beneficiaries. Studies have shown that when patients and providers share the same race or ethnicity, for example, patient perception of treatment decisions improves (Saha and Beach 2020, Wilbur et al. 2020). An interviewee from the Oregon Health Authority underscored the need for cultural congruency. They intentionally enroll doulas who have both cultural

concordance with the members and reside in the same communities as members. In Rhode Island, Medicaid officials shared that in the coming years they intend to track utilization, race, ethnicity, and outcomes data, and they are exploring ways to track racial concordance between doulas and beneficiaries. One national subject matter expert expressed not only the need for a pipeline to recruit doulas who are representative of the members they are serving, but for other stakeholders to respect doulas' methods and practices.

Stakeholder Engagement

States engaged with stakeholders, including doulas and MCOs, in varying ways and at different points during benefit design and implementation to promote buy-in from the doula community and encourage their participation in Medicaid. In addition, states found that an iterative engagement process with doulas and doula organizations allowed for the identification of potential barriers to participation and the development of policy solutions at the outset. For example, Rhode Island Medicaid and doula organizations credited their strong partnership in implementing coverage and establishing their $1,500 payment rate. In New Jersey, Medicaid officials convened a stakeholder group of doulas, officials from the Department of Health, and MCOs to help define the doula benefit. This group of stakeholders continues to meet to assess implementation. Some states also found it valuable to engage organizations led by doulas from historically marginalized backgrounds, especially doulas that serve Black and AI/AN beneficiaries that have high rates of negative maternal and infant health outcomes. In Rhode Island, Oregon, and Minnesota, state officials noted that organizations led by Black, AI/AN, or people of color were instrumental in moving forward efforts to cover doula services under Medicaid. Engagement and input from MCOs varied across the states. In New Jersey, MCOs were engaged and provided feedback to the state early in the benefit design stage.

Input from Medicaid beneficiaries and clinical providers were not formally included in most states' design and implementation efforts. Some states used doulas as a proxy for beneficiaries as they felt that doulas represented beneficiaries' wishes, and other states intend to involve beneficiaries moving forward. Oregon stated that while it already communicates with doulas and welcomes input from beneficiaries, the agency will prioritize beneficiary engagement going forward to gather input on what changes could be made to increase access to doula services. In the states interviewed, clinical providers and the obstetric community did not have a formal role in the doula benefit design process.

Administrative Support for Doulas

Doulas experience challenges with certain administrative requirements that may be relatively new to them. These may include enrolling as a Medicaid provider, contracting with health plans, and submitting claims and billing. In addition, doula organizations report that the provider enrollment and credentialing processes established for licensed clinical providers are difficult to navigate and may include components that are not applicable to them. To address this challenge, one doula organization in Oregon worked with a CCO to streamline credentialing requirements for doulas, reducing the credentialing paperwork from 40 pages to 8. Doulas, who historically have been paid directly by private clients, may not have experience billing for services or contracting with insurers and may find these administrative processes particularly challenging. States, MCOs, and other organizations have efforts underway to support doulas in navigating these administrative tasks to encourage their participation in Medicaid.

States

Some states provide direct assistance to doulas in completing administrative tasks associated with training, certification, credentialing, enrollment, contracting, and billing. For example, New Jersey created paid state positions (known as doula guides) within the Medicaid agency to provide one-on-one support for doulas enrolling as a Medicaid provider. New Jersey is also facilitating a doula learning collaborative that brings together national

doula organizations and doulas for peer-to-peer support, especially around the administrative tasks required to enroll as a Medicaid provider and to receive payment (DOH 2021). Oregon Medicaid assisted in the creation of doula hubs, which help doulas obtain the required trainings and credentialing, contract with CCOs, and submit claims and receive reimbursement (Platt and Kaye 2020).

Two states require MCOs to designate a staff resource for doulas trying to enroll as providers. Oregon requires each CCO to have a traditional health worker liaison who assists doulas in navigating their relationships with the CCO and in adhering to the various state and CCO requirements (Doula Series Footnotes 2021). In New Jersey, all MCOs must identify a dedicated contact person to support doulas with the credentialing, contracting, and billing processes. For example, a representative from one plan reaches out to doulas who are enrolled as fee-for-service Medicaid providers to request their participation in the plan and assist with the application.

Doula support organizations

Organizations, typically run by doulas, provide a range of administrative support. Some of these organizations focus on billing, while others provide broader administrative support, such as providing training, contracting with managed care organization, billing, and providing practice supports.

Training. Some doula organizations provide training that is designed to meet the state requirements. For example, in Oregon, the Community Doula Alliance provides a training program that includes preparing doulas to work with Medicaid beneficiaries who may have complex health and social needs. The Doula Training Center, also based in Oregon, provides support and training on meeting the state certification requirements and connects new doulas to doula mentors who can help them meet the state requirement for attending three initial births.[9]

Managed care contracting. Doula organizations in Florida, such as Black Birthworkers Rock (BBWR), Soul Sista Birth Services (SSBS), and The Doula Network (TDN) help doulas enroll as a Medicaid provider and contract with MCOs. BBWR and SSBS focus on teaching doulas of color how to contract independently with an MCO, rather than going through an intermediary doula organization. BBWR and SSBS also help doulas complete the Medicaid provider application. A number of Florida MCOs contract with TDN, an organization that assists doulas with credentialing and provides administrative support for billing and payment.

Billing assistance. Some intermediary organizations provide billing and claiming assistance to doulas, including independent, sole proprietor doulas, who can face significant challenges with these tasks. In some instances, the organizations assess an administrative fee ranging from 8 to 20 percent, which is deducted from the payment rate, or in some cases charged to the MCO. Some doulas work with a cooperative that collects membership fees to provide administrative and billing support. In this approach, doulas receive the full Medicaid payment. For example, the Rhode Island Birthworkers Co-op charges doulas a monthly fee that covers the cost of software used to store beneficiary information and for billing services, including checking Medicaid eligibility, submitting claims, and claim denials and error follow-up. These organizations may also negotiate with plans for higher payment rates and facilitate contracting with MCOs.

Practice supports. Some organizations help connect doulas to recommending or supervising providers, as well as potential clients. For example, in Minnesota, Everyday Miracles has established relationships with providers and hospitals. It helps to match doulas with a required supervising provider needed to practice and bill Minnesota Medicaid as well as connects doulas and beneficiaries to initiate services.

Conclusion

This case study examined five states at different stages of implementing coverage for doula services in 2022. Officials from the five study states report that doula coverage is an important intervention to improve maternal health. While all states cite the need for evaluation and are collecting data, some are further along in

implementing a strategy to do so. States with low utilization of doula services report that collecting robust data has been challenging. Some states and doula advocates are exploring ways to increase utilization, including efforts to publicize the availability of the benefit and to build the doula workforce.

Endnotes

[1] MACPAC uses the term pregnant women as this is the term used in the statue and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[2] As of September 2023, 37 states and the District of Columbia have expanded postpartum coverage to 12 months (KFF 2023). States can cover doula services to support parents during the postpartum period.

[3] The 11 states covering doula services are California, Florida, Maryland, Michigan, Minnesota, Nevada, New Jersey, Oklahoma, Oregon, Rhode Island, and Virginia. The eight states that are in the process of implementing a doula benefit are Connecticut, Delaware, Illinois, Louisiana, Massachusetts, New York, Ohio, and Pennsylvania (Hasan 2023, NHeLP 2023).

[4] These interviews occurred in the spring and summer of 2022.

[5] Under 42 CFR 440.210(2) states may provide pregnancy-related services and services for other conditions that might complicate the pregnancy only to pregnant individuals. A service limited to pregnant people must be tied to a benefit under §1905(a) of the Social Security Act. Minnesota's state plan does not cite a specific benefit category, but the state's supervision requirement is consistent with benefit categories that allow licensed practitioners to bill for services they supervise or direct, as permitted by state law (e.g., physician services, other licensed providers, nurse practitioner services, nurse-midwife services, and more restrictive applications of the preventive services rule).

[6] These managed care organizations are Aetna Better Health of Florida, Florida Community Care, Molina Health, Simply Healthcare/Clear Health Alliance, Sunshine Health, United Health Care, and Vivida Health (AHCA 2022).

[7] In Rhode Island, from October 5, 2021 through May 5, 2022, the state accepted any training that doulas had received in the past as acceptable, allowing experienced doulas to avoid having to re-train. After this period ended, training is required to take place within three years prior to the date of application (RI Certification Board 2022). In Oregon, the legacy clause refers to an individual who has never been certified with Oregon Medicaid and receives recognition for certification as a result of their prior training and work experience (OHA 2022a).

[8] CPT codes are used for coding medical services and procedures to streamline reporting and billing, increase accuracy and efficiency, and improve the chances that payment will be rendered for services delivered (AMA 2022).

[9] Both the training provided under The Community Doula Alliance and The Doula Training Center were in the process of becoming a state-approved training program when our interviews were conducted.

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Appendix A: Case Study Details

TABLE A-1. Florida Medicaid Doula Coverage

Element	Program details
Effective date	2019
Authority and benefit category	Doula services included in statewide Medicaid managed care as an optional expanded benefit.
Services covered	Managed care organizations (MCOs) can determine which services are covered: • services to support pregnant individuals during the prenatal, labor and delivery, and postpartum periods • number of visits varies by MCO • most MCO require prior authorization
Training	The Doula Network (TDN) accepts trainings from most certifying organizations. TDN also requires doulas to have CPR, First Aid, and HIPAA training. Requirements may differ among MCOs and by how doulas are contracted with the MCO (independently vs. intermediary organization).
Certification requirements	To be certified by TDN, doulas must submit: • application form • background check • certificates of completion for required trainings • letter of reference • proof of liability insurance (if the doula also sees clients independently) Requirements may differ for independent doulas who are subject to the requirements of each MCO they contract with.
Licensing	There is no state licensing requirement.
Incurred costs to become a Medicaid provider (beyond training costs)	There may be costs incurred to become a Medicaid provider with TDN, including liability insurance and a device for secure charting.

Element	Program details
Practice restrictions	The state does not require doulas to be supervised by other licensed health care professionals. MCOs can require supervision.
Billing and payment	Billing structure: • If registered with TDN, the network submits the claim on the doula's behalf. • Doulas can also bill managed care plans directly if contracted independently.
	Payment structure: • Global reimbursement is negotiated with each plan with rates varying from $450 to $1,110 for prenatal, labor and delivery, and/or postpartum services. • Doulas can also be reimbursed per visit. • Once TDN receives payment from the health plan, they pay the doula via direct deposit. TDN takes a 10-15% administrative fee from the MCO (i.e., does not come out of the doula's pay).

Notes: The Doula Network is an organization that assists doulas with credentialing and certain administrative functions. Payment rates reflect what were in effect at time of the case study interviews. CPR is cardiopulmonary resuscitation. HIPAA is the Health Insurance Portability and Accountability Act.

Source: Center for Health Care Strategies review of public documents and interviews with key stakeholders, spring 2022.

TABLE A-2. Minnesota Medicaid Doula Coverage

Element	Program details
Effective date	9/2014
Authority and benefit category	State plan amendment, as an extended pregnancy-related service.
Services covered	Prenatal, labor and delivery, and postpartum services, including education and emotional and physical support services. The state covers up to seven visits: four prenatal visits, one birth visit, and two postpartum visits. The state allows for additional visits with a prior authorization request.
Training	Doula-related training must be obtained through one of the nine training organizations (listed below) or by an organization designated by the Commissioner of Health. These organizations include: • Association of Labor Assistants and Childbirth Educators • BirthWorks • Childbirth and Postpartum Professional Association • Childbirth International • Commonsense Childbirth, Inc. • Doulas of North America • International Center for Traditional Childbearing • Modern Doula Education • The International Childbirth Education Association
Certification requirements	Doulas must be certified and register on the doula registry with the Minnesota Department of Health to bill Medicaid. To be certified, doulas must submit: • application fee • application form • state-issued background check • certificates of completion for required trainings
Licensing	There is no state licensing requirement.
Incurred costs to become a Medicaid provider (beyond training costs)	There is a $200 application fee to become a Medicaid provider.

Element	Program details
Practice restrictions	Doulas must be supervised by one of the following Minnesota Medicaid-enrolled providers: physician, nurse practitioner, or certified nurse-midwife.
Billing and payment	Billing Structure: • Doulas bill through a licensed clinical provider who bills Medicaid directly.
	Payment structure: • Fee-for-service: Payment is up to a total of $770. This includes up to six prenatal and postpartum visits paid at $47 per session and labor and delivery services paid at $488.

Notes: Payment rates reflect what were in effect at time of the case study interviews.

Source: Center for Health Care Strategies review of public documents and interviews with key stakeholders, spring 2022.

TABLE A-3. New Jersey Medicaid Doula Coverage

Element	Program details
Effective date	1/2021
Authority and benefit category	State Plan Amendment, as a preventive service
Services covered	Prenatal, labor and delivery, and postpartum services, including: • perinatal counseling and evidence-based education, including infant care, to prevent adverse outcomes • labor support, including development of a birth plan • coordination with community-based services Doula services are delivered within two levels of care: • standard care, which covers eight prenatal or postpartum visits and one labor and delivery visit • enhanced care, which is available to beneficiaries who are 19 years old or younger and includes up to 12 visits in the prenatal or postpartum period and attendance at the delivery
Training	Doula-related trainings must include: • core competency training including evidence-based perinatal education, birth plan development, continuous support during labor, and infant feeding • community-based/cultural competency training that addresses delivering person-centered and trauma-informed care, and facilitating access to NJ-specific community-based resources • HIPAA training • adult/infant CPR certification Doulas may complete training from one of these New Jersey Medicaid-approved training organizations, all of which provide training based on the national HealthConnect One and Uzazi Village models: • Children's Futures • Children's Home Society of New Jersey • Community Doulas of South Jersey Doulas may complete training at other national training organizations, but then must also complete New Jersey-approved supplemental community competency training: • Ancient Song Labor Doula Certification

Element	Program details
	• CAPPA Labor Doula Certification • DONA International Birth Doula Certification • HealthConnectOne Community Based Doula training • Uzazi Village Perinatal Doula training Additional training only if doulas received doula-related training from non-New Jersey Medicaid approved organization: • CPR certification • HIPAA certification • community health workers (CHW) Competency Training • CHW Doula Competency Training module.
Certification requirements	To enroll as a provider with New Jersey Medicaid, doulas must submit: • individual National Provider Identifier • fee-for-service application • background check • proof of liability insurance • certifications of completed approved doula training and CPR for adults and infants as well as completion of HIPAA training
Licensing	There is no state licensing requirement.
Incurred costs to become a Medicaid provider (beyond training costs)	Liability insurance
Practice restrictions	Doulas are independent providers and do not need to be supervised by other licensed health care professionals. Beneficiaries must receive a recommendation for doula services from a licensed provider.
Billing and payment	Billing Structure • Doulas bill Medicaid or MCOs directly.
	Payment structure: • Fee-for-service payment for standard care is provided up to a total of $800.08. This includes the initial prenatal visit of $99.72, up to seven prenatal and postpartum visits at $66.48, and labor and delivery services paid at $235. • Fee-for-service payment for enhanced care (i.e., for beneficiaries age 19 and younger) is provided up to a total of $1,066. This includes the initial prenatal visit of $99.72, up to 11 prenatal and postpartum visits at $66.48, and labor and delivery services paid at $235.

Element	Program details
	• Doulas receive an additional $100 incentive if the beneficiary has a doula visit and a clinical follow up appointment with their provider within six weeks postpartum.

Notes: Payment rates reflect what were in effect at time of the case study interviews.

Source: Center for Health Care Strategies review of public documents and interviews with key stakeholders, spring 2022.

TABLE A-4. Oregon Medicaid Doula Coverage

Element	Program details
Effective date	1/2014
Authority and benefit category	State Plan Amendment, as a preventive service
Services covered	Prenatal, labor and delivery, and postpartum services, including: • prenatal counseling and assisting the woman in preparing and carrying out birth plan • evidence-based information on general health practices pertaining to pregnancy, childbirth, postpartum, newborn health, breastfeeding, infant feeding, infant soothing, and family dynamics • emotional support, physical comfort measures, and helping the woman get the information she needs to make informed decisions pertaining to childbirth and postpartum; • postpartum support and honoring cultural and family traditions • facilitating and assuring access to resources that can improve birth-related outcomes including transportation, housing, alcohol, tobacco and drug cessation, WIC and SNAP benefits, and intimate partner violence resources The state covers five visits: two prenatal visits, one labor and delivery visit, and two postpartum visits.
Training	Doula-related training includes at least 28 hours of in-person education that includes any combination of childbirth education and birth doula training either through an Oregon Health Authority (OHA)-approved Birth Doula Certification Organization or doula training in the following core competencies: • anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding • labor coping strategies, comfort measures and non-pharmacological techniques for pain management • the reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth • emotional and psychosocial support of women and their support team • birth doula scope of practice, standards of practice, and basic ethical principles • the role of the doula with members of the birth team

Element	Program details
	• communication skills, including active listening, cross-cultural communication, and inter-professional communication • self-advocacy and empowerment techniques • breastfeeding support measures • postpartum support measures for the mother and baby relationship • perinatal mental health • family adjustment and dynamics • evidence-informed educational and informational strategies • community resource referrals • professional conduct, including relationship boundaries and maintaining confidentiality • self-care
	Additional training: • at least six hours of cultural competency training • at least six contact hours total in one or more of the following topics as they relate to doula care: one hour of inter-professional collaboration, one hour of HIPAA training, and/or four hours of trauma-informed care training • an OHA-approved oral health training
Certification requirements	Doulas must be enrolled as a Traditional Health Worker (THW) and be certified and registered on the doula registry with Office of Equity and Inclusion (located within OHA) with approved curricula used to train birth doulas. To be certified and added to the state registry, doulas must complete and submit: • application form • background check • Birth Doula State Registry Certification Checklist • certificates of completion for required training • CPR for children and adults • document of attendance at a minimum of three births and three postpartum visits
Licensing	There is no state licensing requirement.

Element	Program details
Incurred costs to become a Medicaid provider (beyond training costs)	There are no costs incurred to become a Medicaid provider.
Practice restrictions	Doulas are independent providers and do not need to be supervised by other licensed health care professional. Beneficiaries must receive a recommendation for doula services from a licensed provider.
Billing and payment	Billing Structure: As of 2018, doulas have two options to bill services: • doulas may apply to become an approved Individual Billing Provider • use doula "hubs" which provide doulas the ability to bill as groups
	Payment structure: • Global payment for the standard doula benefit package of two prenatal, two postpartum visits, and labor and delivery services can be billed for a total of $350. • If a doula provides some, but not all, services included in the standard doula benefit: the rate is $50 for a prenatal or postnatal visit; and $150 for doula services provided on the day of delivery only. • The state intends to increase the fee-for-service rate to $1,500 (total) and has submitted a state plan amendment to the Centers for Medicare and Medicaid Services.

Notes: WIC is the special supplemental nutrition program for women, infants, and children. SNAP is the supplemental nutrition assistance program. Payment rates reflect what were in effect at time of the case study interviews.

Source: Center for Health Care Strategies review of public documents and interviews with key stakeholders, spring 2022.

TABLE A-5. Rhode Island Medicaid Doula Coverage

Element	Program details
Effective date	7/2021
Authority and benefit category	State Plan Amendment, as a preventive service
Services covered	Prenatal, labor and delivery, and postpartum services, including: • services to support pregnant individuals, improve birth outcomes, and support new mothers and families with culturally specific antepartum, intrapartum, and postpartum services, referrals, and advocacy • advocating for and supporting physiological birth, breastfeeding, and parenting for their client • supporting the pregnancy, labor, and birth by providing emotional and physical support with traditional comfort measures and educational materials, as well as assistance during the transition to parenthood in the initial postpartum period • empowering pregnant people and new mothers with evidence-based information to choose best practices for birth, breastfeeding, and infant care • providing support to the laboring client until the birth of the baby • referring clients to their health care provider for medical advice for care outside of the scope of doula scope of practice • working as a member of the client's multidisciplinary team • offering evidence-based information on infant feeding, emotional and physical recovery from childbirth, and other issues related to the postpartum period The state covers a total of seven visits: three prenatal visits, one visit for labor and delivery, and three postpartum visits.
Training	Doula-related training includes 20 hours of relevant education or training in the Certified Perinatal Doula domains: • birth care • postpartum care • loss, bereavement, and termination • advocacy • cultural competency • communication, interpersonal, and professional skills • safety and self-care • professional and ethical responsibility

Element	Program details
	Process for legacy training: • During the legacy period, there was no time frame for when doula education and training had to be obtained. • After the legacy period ended on May 5, 2022, education and training must have occurred within the last three years prior to the date of application. Additional training: • SafeServ training for meal preparation
Certification requirements	Doulas must be certified with the Rhode Island Certification Board to bill Medicaid. To be certified, doulas must submit: • application fee • application form • background check • certification of completion for required training or legacy training documentation • proof of CPR for adults and infants • HIPAA
Licensing	There is no state licensing requirement.
Incurred costs to become a Medicaid provider (beyond training costs)	There is a $50 application fee to become a Medicaid provider.
Practice restrictions	Doulas practice independently and are are not required to be supervised by other licensed health care professionals.
Billing and payment	Billing structure: • Doulas bill the MCOs directly for individuals enrolled in managed care (the vast majority of individuals). • For individuals not enrolled in managed care, doulas bill Medicaid directly.
	Payment structure: • Fee-for-service payment is provided up to $1,500. This includes three prenatal and three postpartum visits at $100 each, and labor and delivery services at $900.

Notes: Payment rates reflect what were in effect at time of the case study interviews.

Source: Center for Health Care Strategies review of public documents and interviews with key stakeholders, spring 2022.