HealthConnect One Issue Brief:
Creating Policy for Equitable Doula Access
Securing Doula Access-Legislative Update

Maternal Health Landscape ................................................................. 2
  Challenges Addressing Maternal Mortality ...................................... 4
  The Role of Doula Services ............................................................... 5
  Community-Based Doula Care Programs ....................................... 6
  Community Health Workers ............................................................ 7

National and State Policy Approaches ............................................. 7
  Reimbursement Policies ................................................................. 7
  Commercial Insurance Coverage of Doula Services ...................... 8
  Medicaid Coverage Challenges ...................................................... 8
  Oregon and Minnesota Lead the Way .............................................. 10
  Other State and Federal Action ...................................................... 11
  Challenges with State and Federal Legislation ............................... 14
    Low Reimbursement .................................................................... 14
    Restrictive Requirements and Confusing Practices ...................... 14
    Overregulation of Black Birthing Professionals ......................... 15

Recommended State Policy Approaches ........................................... 15
  Ensure meaningful engagement and collaboration with women of color and community-based doulas on designing policy solutions ...................................................... 16
  Keep legislative language simple ................................................. 16
  Use Medicaid’s preventive services SPA option and embrace its flexibility ............... 16
  Ensure requirements for doulas (related to training, certification, etc.) are not overly restrictive .................................................................................................................. 17
  Consider the interplay with state definitions and regulations for Community Health Workers .................................................................................................................. 17
  Ensure adequate reimbursement for community-based doulas and engage in ongoing consultation with community-based doulas to develop effective implementation policies and procedures ........................................................................... 17
  Look for Alternate Funding Opportunities ....................................... 18

About HealthConnect One ................................................................. 18
Maternal Health Landscape

Record has it that the United States has one of the worst maternal mortality rates of any developed nation, despite spending more than any other nation on hospital-based maternal care (More than 86 Billion in 2010).\(^1\)\(^,\)\(^2\) Between 1990 and 2008, while the vast majority of countries reduced their maternal mortality ratios culminating in a global decrease of 34%, maternal mortality nearly doubled in the United States.\(^3\) The most notable disparity in mortality rates in the U.S. is defined by race: Black women die at a rate that ranges from three to four times higher than that of their white counterparts—42 deaths per 100,000 live births among black women versus 12 deaths per 100,000 live births among white women as of 2015. Black maternal mortality is more than twice in comparison to women of other races and ethnicities; this difference in risk has remained unchanged for the past six decades.\(^4\)\(^,\)\(^5\) According to the Center for Disease Control's Pregnancy Mortality Surveillance System, considerable racial disparities in pregnancy-related mortality exist. During 2015, the pregnancy-related mortality ratios were:\(^6\)

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Deaths Per 100,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISPANIC</td>
<td>11.4</td>
</tr>
<tr>
<td>WHITE NON-HISPANIC</td>
<td>13</td>
</tr>
<tr>
<td>ASIAN/PACIFIC ISLANDER</td>
<td>14.2</td>
</tr>
<tr>
<td>AMERICAN INDIAN/ALASKA NATIVE</td>
<td>32.5</td>
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<tr>
<td>BLACK</td>
<td>42.8</td>
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Attempting to unpack the epidemiology of Maternal Mortality is confounded by the vast racial and ethnic disparities associated with the phenomenon. The Maternal Health Taskforce states that:

*Women of color tend to have poorer access to high-quality reproductive health information and services than white women, as they are discriminated against in the healthcare system and experience higher rates of disrespect and abuse. Furthermore, there is evidence suggesting that the stress associated with daily experiences of racial discrimination can increase the risk of adverse perinatal outcomes including preterm birth and delivery of a low birth weight infant for women of color.*

The complexity of trying to pinpoint the cause of maternal death becomes more complex as more data become available. For instance, a 2017 investigative report from ProPublica and NPR examining maternal mortality drew national attention as it highlighted the vast disparities in New York City. This scathing report lasered in on the cavernous difference in the mortality rates of black women and all other races, summarizing:

*Regardless of their education, obesity or poverty level, black mothers in New York City are at a higher risk of harm than their white counterparts. Though Black mothers with a college education fare worse than women of all other races who dropped out of high school. The Black women of normal weight have higher rates of harm than obese women of all other races. And black women who reside in the wealthiest neighborhoods have worse outcomes than white, Asian and Hispanic mothers in the poorest ones.*

Compounding racial and ethnic disparities in maternal mortality are the persistent health disparities, including differences in access to and the quality and outcomes of maternity care. All of which can have a long-lasting impact on women, children, families, and our society. 

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Challenges Addressing Maternal Mortality

As attention to maternal mortality rates increase, so has a movement toward legislative approaches to address the issue. One such area gaining state and national legislative attention is the availability of doula services. Doula services have been gaining recognition locally and nationally for the past several years, as more women seek support services during pregnancy, delivery, and the ensuing twelve months. Evidence suggests that doula-assisted mothers were four times less likely to have a low birth weight (LBW) baby, two times less likely to experience birth complications involving themselves or their baby, and significantly more likely to initiate breastfeeding. However, recent legislative trends, while attempting to codify accessibility to doula services, are creating administrative barriers for community-based doulas, who often face insurmountable challenges to meet new licensing requirements. Even though doula services are an evidence-based practice with proven benefits, gaining access to these critical services is limited by availability, insurance coverage, integration into the health care system, and cost. Only six percent of women report the use of doula services according to a 2012 report despite the proven advantage offered by these services, including reducing the likelihood of c-section.

Policymakers recommend continuous access to doula services as an effort to prevent adverse maternal outcomes. This public health response is necessary due to the rise in maternal mortality rates among women of color in the US. Statistically, African American women are more likely to die during childbirth, compared to their white counterparts. They have an increased likelihood for preventable childbirth-related complications, one of the largest public health disparities. A study concluded that other factors contributing to the disturbing data include delayed prenatal care in the first trimester, pre-existing conditions such as hypertension, diabetes or obesity, and overall poor quality of health. Additional factors included cardiovascular disease, infections, and anesthesia complications.

An equity-focused approach to structuring access to doula services is necessary to realize the largest impact, especially for people of color.

The Role of Doula Services

The role of a doula is to provide continuous physical, emotional and informational support during pregnancy, childbirth and an agreed postpartum period. As trained professionals, doulas are categorized under nonmedical childbirth assistants, providing one-on-one advocacy for safe births. Recently, there has been an increase in doula services in maternity care facilities, as reports show improved long-term health outcomes for both mothers and infants. The community based doula-certifying organization HealthConnect One (the National Community-Based Doula Training Institute™) has trained community-based doulas and accredited community-based doula programs since 2000, and has provided peer-to-peer mentorship to over 100 community leaders through their Birth Equity Leadership Academy (BELA). In the last decade other doula-certifying organizations such as DONA International reported a significant growth in membership (750 to 5,221) and certification (31 to 2,504) in the last decade. Studies also show a correlation between the use of doulas and improved maternal and infant health, medical benefits, patient satisfaction, and cost savings. Findings also show that doula care reduces the likelihood of cesarean births and the use of epidural analgesia and postpartum depression, while increasing the possibility of shorter labors, vaginal births, higher infant Apgar scores, and healthy breastfeeding experience.

One of the key aspects of the involvement of doulas is that they provide emotional and other support by maintaining a “constant presence” throughout labor, providing specific labor support techniques and strategies, encouraging laboring women and their families, and facilitating communication between mothers and medical caregivers. Studies examining the impact of continuous support by doulas report significant reductions in cesarean births, instrumental vaginal births, need for oxytocin augmentation, and shortened the duration of labor.

In hospitals and maternity care facilities, doulas are often mistaken for or compared to midwives or nurses. There is a common misunderstanding about how doulas fit into the birthing experience or how their services integrate with hospital staff or midwives. Without clarity of roles, disagreements, mistakes or unprofessionalism will only take away from the mother’s birthing experience. To distinguish the roles, midwives are medically trained professionals focused on a healthy delivery, while doulas have an extended multifaceted role that begins during pregnancy and ends well after childbirth. Also, doulas work in concert with nurses, who perform clinical tasks, consult with physicians or midwives and assess for potential complications.
Community-Based Doula Care Programs

Historically, models of care in the United States have been hospital-based programs, private practice programs, and community-based doula care programs. Community-based doula programs are the most needed for underserved populations, offering culturally appropriate support to low-income communities. These programs tailor prenatal and postpartum services to the needs of the community at little to no cost. Since community-based doulas are trusted members in their communities, they are best suited to perform home visits, provide breastfeeding wellness support, recommend additional social services and offer extensive prenatal and postnatal support over an extended amount of time. Community-based doulas look like, talk like and have the same lived experiences as the families that they provide support to. This strength allows community-based doulas to be able to help families navigate the institutional racism that they face in the healthcare system and mediate the negative experiences during pregnancy, birth and in the postpartum period. This reduces stress, which is associated with poor birth outcomes.

With extensive training similar to community health workers, community-based doulas are the appropriate liaisons between clients and providers and address community-specific disparities such as race, language, and overall cultural gaps.

The aforementioned HealthConnect One in Chicago has incorporated an equity focus in their community-based doula model, which recruits and trains doulas within the communities they are serving. With a holistic approach, their community-based doulas are birth doulas, postpartum doulas, peer lactation support and birth educators. HealthConnect One's Community-Based Doula model timeline starts during pregnancy, through the birth, and at least six months after childbirth. The cultural familiarity between the doula and the mother encourages trust in their relationship and can better the birthing experience. Based on the success of this model, HealthConnect One continues to offer resources to help adapt it to other communities around the country. Similarly, immigrant and other minority populations benefit from community-based doula models that are culturally relevant and led by their “neighbors”.

Community Health Workers

Community-based doulas are classified as community health workers, a distinction from clinically trained professionals. The American Public Health Association defines a community health worker as a “frontline public health worker” who is trusted in the community and acts as an advocate for the delivery of culturally relevant services. Their role bridges health knowledge gaps and increases self-efficacy through community outreach, education and social support. Community health workers are commonly referred to by other titles such as “community health advisors, lay health advocates, promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators.”

While community-based doulas are similar to other community health workers, provide some of their services in a clinical setting, they are not clinical providers and their services are not clinical in nature. Most of the care provided takes places in homes and community settings. This distinction is important to keep in mind when policymakers are considering how to regulate and reimburse community-based doulas.

National and State Policy Approaches

Some of the most compelling attempts to tackle maternal mortality come from collaborative statewide efforts. Generally, these states have engaged local government with educational institutions and local health care providers to develop a statewide plan to address the issue, codifying efforts with policy and funding. In most instances, maternal mortality review commissions have been created to build resources and coordinate activities. Thirty-five states and the District of Columbia have already created commissions on maternal mortality. The charge of these commissions generally focuses on the measurement and collection of maternal death data.

Reimbursement Policies

Doula care can generate cost savings by reducing cesarean rates, which cost 50% more than vaginal births and lowering the use of epidural analgesia and the costs associated with anesthesia services. A 2011 study found that suboptimal breastfeeding rates have resulted in a $13 billion annual burden to the U.S. economy. Compliance with breastfeeding practices was recommended as a method of reducing the number of pediatric health complications and premature deaths. As more women seek doula services, policies for streamlining and expanding reimbursement methods need to be put in place to accommodate the demand. Currently, non-community-based doulas are paid out of pocket, an unreliable reimbursement model that may act as a barrier to care for low-income women.

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Medicaid covers almost 50% of all births, mainly serving low-income families. Thus Medicaid plays a significant role in reimbursement policies and practices in the United States. One recommendation to increase access to doula care is to utilize a Congressional mandate of the service at a federal level, and charge Centers for Medicare and Medicaid Services (CMS) with state-specific support.

### Commercial Insurance Coverage of Doula Services

Currently, there are no state mandates for insurance to cover doula services. Websites about doula services often advise that there are insurers who will reimburse for doula services if a claim is submitted after a member has paid out of pocket, but that the expectation should be that doula services won’t be covered. Also, reimbursement is not standardized, and it can be challenging to find out in advance if an insurer covers the cost or not. Insurers will require a doula to have a National Provider Identification (NPI) number and also may need a doula to have gone through a specific training program. These limited types of reimbursement arrangements tend not to be accessible to or realistic for community-based doulas, nor those who would benefit from their services.

### Medicaid Coverage Challenges

As states think about how they might be able to use the Medicaid program to offer coverage for community-based health workers, including doulas, for their low-income residents. A key challenge emerges: the provider reimbursement structure in Medicaid is designed to pay for services provided by licensed practitioners whose credentials and qualifications are clearly identifiable and who have a specific scope of practice. If states cannot show that Medicaid providers meet these requirements, states will not receive federal matching funds for any services they provide under the fee-for-service Medicaid program. Medicaid managed care organizations (MCOs) also have to use the state’s fee-for-service system to screen and enroll their network providers so they face some of the same limitations. However, MCOs have additional flexibility to cover other services, such as those offered by non-licensed providers, but these aren’t always included in the MCOs’ capitated rate and may have to be included in the portion of the administrative expenses of the plans’ medical loss ratio.

There is however, a limited exception for preventive services that were added into the Medicaid statute via the Affordable Care Act in 2010 and for which the Centers for Medicare and Medicaid Services (CMS) issued final regulations in July 2013. Previously, like other Medicaid services as described above, these services had to be provided by a licensed practitioner to be eligible for reimbursement - with the revised language, they have to be recommended by a licensed practitioner.
The relevant section of the regulations is:

“Preventive services” which means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:

(1) Prevent disease, disability, and other health conditions or their progression.
(2) For Prolong life.
(3) And for the promotion of physical and mental health and efficiency. 40

In a November 27, 2013 Informational Bulletin, CMS advised states that this regulation meant that they could submit a State Plan Amendment (SPA) to allow services to be provided by non-licensed providers. For states seeking to cover services provided by non-licensed providers, the SPA would need to include a summary of practitioner qualifications and any required education, training, experience, credentialing, or registration. 41

Another challenge related to Medicaid coverage of community-based doula services is the duration of pregnancy-related coverage. While the ACA created a new category of eligibility for anyone under 138% (or $28,676 for a family of three 42) of the Federal Poverty Level, there remains an eligibility category for pregnant women - and the income eligibility level in many states is often much higher than 138% FPL. In addition, in states that have not adopted the ACA's Medicaid expansion, pregnancy eligibility is an important, and often the only, pathway for health insurance coverage during the perinatal period. However, when women qualify for Medicaid because they are pregnant, their coverage only extends to 60 days postpartum, and any care related to pregnancy generally must happen during that period of time so as to be covered by Medicaid. In states that have adopted the Medicaid expansion, many women will transition back to expansion Medicaid, but may experience disruptions in care. 43

Recent studies related to maternal mortality have demonstrated that postpartum women remain vulnerable for the first year after giving birth, and organizations like the American College of Obstetricians and Gynecologists have started to embrace the idea of the “fourth trimester,” i.e., the need for more and more extended postpartum care. 44, 45 This has led to increased interest in extending the length of Medicaid eligibility beyond 60 days postpartum. New Jersey recently became the first state to do so, expanding to six months postpartum coverage as part of the state's budget passed in June 2019. 46, 47 The community-based doula model recommends at least six months of follow-up visits postpartum, and, in some programs, the doula may remain involved with the woman and her family for up to two years.48 Unfortunately, the current confines of Medicaid may make this model difficult to adopt - or at least pay for.
Oregon and Minnesota Lead the Way

Even as the details of how to pay for non-licensed providers under Medicaid were being sorted out at the federal level, states were (and are) directly seeing the impact of disparities in maternal and infant health outcomes. Oregon and Minnesota began to move forward on the state level with the establishment of Medicaid reimbursement for doulas, with a hope that these services could help improve outcomes for women more likely to experience disparities.49

In 2011, Oregon passed legislation requiring the Oregon Health Authority, the state’s agency overseeing Medicaid and other state health programs, to explore options for using doulas to improve birth outcomes for women who are at a disproportionately at higher risk of having such experience and to report back to the Legislature the following year.50 Also, in 2011, Oregon’s Joint Special Committee on Health Care Transformation proposed, and the Legislature passed a bill to transition the state’s Medicaid program away from managed care and into an Integrated and Coordinated Health Care Delivery System. One component of this system entailed seeking federal approval to provide access to “nontraditional personnel” such as community health workers.51 After the passage of this legislation, doulas were able to be classified as “traditional health workers” and received reimbursement in this role through a State Plan Amendment (SPA) that covered the services of other providers and the passage of a state administrative rule, though payment rates were low.52, 53, 54 In 2017, the state took multiple actions to increase low reimbursement rates: they passed new legislation to require review of reimbursement rates, facilitate direct payment to doulas, and require both the government and coordinated care organizations to provide more information about doulas, and they changed the structure of their SPA with CMS to include doula services under the preventive services option.55 The SPA requires that licensed health care providers will supervise doulas; lays out a scope of practice for doulas; and provides for certification and curriculum standards for doulas.56

Minnesota first passed legislation in 2009 to add the International Center for Traditional Childbearing to the list of organizations that could certify doulas and to change the definition of doula services to include continuous support during labor and birth and intermittent support during the prenatal and postpartum periods.57 The state then passed additional legislation in 2013 to require Medicaid to cover doula services provided by a certified doula and broadened the definition of doula services to include; childbirth education, emotional and physical support provided during pregnancy, labor, birth, and postpartum.58 Minnesota received approval for a SPA in 2014 that would allow the state to cover doula services as part of their state plan. Doulas must be supervised by a physician, nurse practitioner, or nurse midwife and must be certified by one of eight doula education organizations.59

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49 Oregon Health Authority Health Systems Division Medical Assistance Programs - Chapter 410, Division 130, Medical-Surgical Services, § 410-130-0015
53 Oregon Health Authority Health Systems Division Medical Assistance Programs - Chapter 410, Division 130, Medical-Surgical Services, § 410-130-0015
Other State and Federal Action

Other states have also been moving forward with legislation, as well as pilot projects, to expand Medicaid reimbursement for doula services, with significant action taking place in 2018 and 2019. In 2018, New York and New Jersey began to implement pilot projects to provide access to community-based doula services focusing on women of color in areas with particularly significant disparities in birth outcomes. 60, 61 In 2019, Indiana and New Jersey successfully also passed legislation adding doula services to Medicaid, and Washington's Legislature approved the Governor’s budget proposal to include doula services as part of the state’s package of Maternity Support Services in Medicaid. 62, 63, 64, 65 For the second session in a row, Vermont introduced legislation similar to Minnesota’s law in their state House - it is currently pending in committee. 66

New York also has pending legislation that has passed both chambers of the state Legislature and is awaiting the Governor’s signature. The bill would require doulas to complete an educational program, be certified, and pass an examination, the standards of which will be determined by the state Department of Health and would prohibit anyone who is not approved by the Department from using the title of “certified doula.” In addition, the legislation requires that doulas be “of good moral character as determined by the department.” 67 There are many concerns about this legislation from national, state and local doula groups, individual doulas, and other advocates, who don’t seem to have been consulted in the drafting of the bill. The requirements are seen as being more in line with those for clinical professionals rather than understanding the role of doulas as non-clinical support for the pregnant person. By putting in place restrictions on certification and requiring completion of an exam, the legislation may have the effect of reducing the number of doulas of color who can practice in the state. Requirements such as the one about a moral character, which is ill-defined could exclude people who have had a past conviction from doula work. 68, 69, 70

Even more so than has been seen to date in other states, the conversation around New York’s legislation has laid bare the tension around how certification, which can be a facilitator for payment and reimbursement, could also be a barrier for the community-based doulas best positioned to serve low-income women of color who would benefit most from having a doula. This is an essential tension that states and advocates will be grappling with going forward as they continue in figuring out how to structure Medicaid reimbursement for doulas. Recommendations for how best to do this are included in the next section.
While not exactly the same as Medicaid reimbursement for doula services, several states have also either introduced and/or passed legislation that would provide information about and make doula services available to incarcerated women. However, these programs often have limited impact because they do not provide public funding, requiring the services to be provided at no cost or for the women themselves or outside organizations to fund them. States that have passed such legislation include Minnesota, Oklahoma, and Washington, and states that have introduced it include Wisconsin. Other states have proposed legislation to provide Medicaid reimbursement for doula services and require certification, those states include Arizona, Connecticut, Illinois, Massachusetts, Rhode Island, Texas, Wisconsin, and Washington DC, however at the time of this writing, these legislations are still under review.

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Currently there are two pieces of federal legislation that would or have the potential to support coverage of doula services. The MOMMIES Act (S1343), sponsored by Senator Cory Booker in the Senate, and the Healthy MOMMIES Act (HR2602), sponsored by Representative Ayanna Pressley in the House, would authorize pregnancy medical home demonstration projects in the states where one of the goals would be improving the integration of perinatal support services, including doula services. The legislation would also require the Medicaid and CHIP Payment and Access Commission (MACPAC) to produce a report on increasing access to doula care for Medicaid beneficiaries and would need MACPAC to consult with individuals and organizations representing doula care providers, including community-based doula programs. Within one year of the MACPAC report, CMS will be required to issue guidance to states on how to increase access to doula services in Medicaid.73

The Maternal CARE Access and Reducing Emergencies Act (S1600), sponsored by Senator Kamala Harris in the Senate, and the Maternal CARE Act (HR2902), sponsored by Representative Alma Adams in the House, would also authorize pregnancy medical home demonstration projects in the states and would require states to work with relevant stakeholders, including community-based doulas, to develop and carry out their programs.74 This could provide an avenue for the inclusion of community-based doula services in the demonstration projects and ultimately full coverage under Medicaid. Unfortunately, both bills have so far seen no movement in this Congress.

Federal action could also be helpful in other areas beyond legislation. In particular, one of the most impactful actions that could happen would be if the U.S. Preventive Services Task Force undertook a study and recommended doula services as a preventive service that should be covered under the ACA’s preventive services mandate. This would ensure that doula services would be provided at no cost-sharing, even when provided by a non-licensed provider, under private insurance and for many Medicaid enrollees.75, 76 CMS could also help by providing additional guidance to state Medicaid agencies about the appropriate codes to use for reimbursement for doula services, as well as how they can use the preventive services SPA that allows coverage of services provided by non-licensed providers for payment for doula services.77 Additional federal collaborations that have been recommended are for community-based doulas to be able to bill Medicaid through federally-qualified health centers and greater integration with the Maternal, Infant, and Early Childhood Home Visiting Program and other Maternal and Child Health Bureau programs.78

Challenges with State and Federal Legislation

Low Reimbursement

Despite Oregon and Minnesota efforts to expand coverage of doula services, doulas in both states still struggle with low reimbursement. In 2012, Oregon’s Medicaid program began coverage of birth by doulas through the same “non-traditional health workers” reimbursement category used for community health workers. However, uptake has been minimal because reimbursement rates are currently set well below the costs for doulas to provide services.\(^7^9\) Currently, most doulas are white upper-middle-class women, and most doulas practice in metropolitan areas.\(^8^0\) To increase the diversity of the doula workforce to reflect the population of Medicaid beneficiaries giving birth, and to expand the workforce to rural areas, states may want to consider granting programs to subsidize doula training for women from culturally diverse backgrounds and from the rural communities. Doula training, certification, and registration are costly, generally ranging from $800–$1200, and many low-income women and women from communities of color have limited financial access to the training required to become a doula.\(^8^1\) Additionally, establishing a fee waiver process for fees for doula certification and registration for low-income applicants is an important policy consideration and would likely contribute to diversifying the doula workforce.\(^8^2\)

Restrictive Requirements and Confusing Practices

There is an urgent need to address non-medical, social determinants of health so as to stem the rising perinatal care costs in a time of increasing fiscal pressures on health care systems and state Medicaid budgets.\(^8^3\) Yet, doula legislation has created more barriers for community-based doulas and the women they serve. Legislation often limits the number of patient visits to just four (prenatal and postnatal), a number far too few to effectively offer care and adequately support marginalized women of color who are at high risk of experiencing inequities during the pregnancy, birth and postpartum period. The legislation also requires registration as a Medicaid provider, or requires clinician referral and oversight, creating administrative barriers to community-based workers who often work for a community-based organization/nonprofit, therefore limiting the ability for these doulas to participate.

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Overregulation of Black Birthing Professionals

The US has a traumatic history of regulation, especially for Black birth professionals and Black women. This history has served to discourage and limit participation in service delivery from community-based health workers. The history of the community-based birthing traditions starts with slavery, and is likely rooted in West African religious and medical practices. However, by 1920s, state legislators intensified efforts to control practicing midwives with the long-term goal of elimination. Due to new regulations, midwives were required to obtain permission slips from licensed doctors to provide pre and post-natal care and hospital births became the standard as policies regulating the practice of medicine and who could provide child birthing services prohibited midwives from practicing. And by 1975, less than 1 percent of all births occurred outside of a public hospital and were attended by a midwife.

Overregulation, onerous certification and licensing standards discourages valuable diversity in labor support. Independent doulas tend to be higher-educated, more affluent, white women, and community-based doulas are community members who have been trained and educated, are generally lower-income, and are usually people of color who come from the communities they serve. These differences mean that independent doulas are more accepting of certification and licensing processes which could inhibit participation by community-based doulas who may not be able to afford licensing fees or meet the licensing requirements.

Recommended State Policy Approaches

In the current political and policy climate, opportunities for coverage of community-based doula services are most likely at the state level. There are several options for coverage, including through fee-for-service Medicaid; managed care Medicaid; private insurance; and more innovative payment and delivery reforms that can happen in the context of either Medicaid or private insurance. Additional federal collaborations that have been recommended are for community-based doulas to be able to bill Medicaid through federally qualified health centers and greater integration with the Maternal, Infant, and Early Childhood Home Visiting Program and other Maternal and Child Health Bureau programs. The following recommendations are offered for fee-for-service Medicaid; recommendations for the other types of coverage will be provided in Issue Brief #3.

Ensure meaningful engagement and collaboration with women of color and community-based doulas on designing policy solutions.
The most crucial step that states can take is to collaborate with women of color and others who are experiencing and at risk for negative maternal and infant health outcomes and the community-based doulas who are already providing care to them to make sure their voices are part of the conversation. In particular, community-based doulas can provide valuable information about how to make any necessary state requirements about doula qualifications, referral arrangements, and payment practices workable, not just in theory, but in practice, so that pregnant women can actually have access to these services.

Keep legislative language simple.
Given that including doula services in Medicaid will require the state to submit a state plan amendment, the legislation does not need to be detailed. While Minnesota and Oregon both passed legislation that was more detailed, in part because they began the process before the SPA process was clarified, New Jersey and Indiana have shown that the legislation itself can be as simple as adding doula services to the list of services that Medicaid will cover and authorizing the state to apply for a SPA. However, depending on the state, legislators may wish to have more input over the process and include more details in legislation. It is also important to note that in Washington, legislation wasn’t used at all - the Governor included adding doula services to Medicaid in his budget, and the Legislature passed the budget with that language included. The exact word needed to add these services to Medicaid will vary state by state, but there is usually a part of the state’s Medicaid law that covers pregnancy services, where doula services can be added. The definition of doula services should be broad enough to include education and emotional and physical support provided during the prenatal, labor, birth, and postpartum periods.

Use Medicaid’s preventive services SPA option and embrace its flexibility.
The SPA option to cover preventive services by non-licensed providers is likely to provide the most flexibility for states, helping them create requirements for doulas that aren’t overly restrictive and hopefully allowing for broad participation. As previously mentioned, in this model, these services can only be covered if they were recommended by a licensed professional, and the SPA would need to include a summary of practitioner qualifications and any required education, training, experience, credentialing, or registration. While Oregon and Minnesota have set up their doula services so they are supervised by a licensed professional, the SPA only requires that they are recommended by a licensed professional. Depending on how doula practice is set up in a particular state, the maternity care community should discuss if supervision makes more sense or if the state could set up a system of documented recommendations and referrals from licensed professionals to individual doulas and community-based doula programs, which would meet this requirement.
Ensure requirements for doulas (related to training, certification, etc.) are not overly restrictive. States should also work with the doula community, and ensure that community-based doulas from a variety of communities are part of these conversations. This is to make sure that any required qualifications, education, training, experience, credentialing, and registration are not overly restrictive and do not have the effect of significantly limiting the pool of available doulas, particularly in those communities most in need of doulas. Especially since there isn’t one accepted certification or training entity for doulas, states should consider receiving a wide variety of training, as well as a pathway based on experience. There should also be consideration about waiving any required fees for certification or registration based on financial need.

Consider the interplay with state definitions and regulations for Community Health Workers. States should consider if they already have policies or definitions in place that address the role of community health workers and how these may be able to facilitate access to doulas. The National Academy for State Health Policy provides an interactive resource map for states to find out about community health worker models in place in states across the country.89

Ensure adequate reimbursement for community-based doulas and engage in ongoing consultation with community-based doulas to develop effective implementation policies and procedures. Consultation with the doula community should also discuss options for billing and whether they would prefer to bill through another provider or to be able to bill on their own and what support each option would require. While low reimbursement rates are a common problem in Medicaid, states should work to ensure that reimbursement for doula services is at a level that these services are actually available for enrollees, especially considering the cost savings and improved outcomes doulas provide.

As with any new service, often problems and issues arise during the implementation process. States should ensure that there is a feedback loop with community-based doulas who are providing services so that they can correct challenges that arise, keeping it feasible for doulas to offer their services and for pregnant women to access them.

Look for Alternate Funding Opportunities
Exploring opportunities to reimburse for Doula services include some nontraditional approaches. Other programs that may offer reimbursement for Doula services are Early Head Start, SAMHSA (Substance Abuse and Mental Health Services Administration), USDA (WIC), and Dept of Education. These nontraditional programs are exploring ways to better support women during pregnancy, childbirth, and the ensuing months. The Early Head Start (EHS) program creates strong partnerships with service agencies that come into contact with pregnant women. Thereby increasing the exposure of EHS in the community and develop formal agreements for collaboration which might include agreements with programs such as WIC, La Leche League, Healthy Start, and a local mental health center, as well as OB/GYN physicians, midwives, doulas, and clinicians. The WIC program routinely covers lactation support that can cover access to a Doula or lactation specialist. Finally, SAMHSA provides resources and best practices for opioid addicted mothers and their health care providers on the benefits of using Doula services.

About HealthConnect One
Since 1986, HealthConnect One has worked with community clinics, Federally Qualified Health Centers, tribal organizations, and numerous other community groups. Rooted in the belief that communities know what they need but often require support to get it, we work with communities to co-create programs, initiatives and services that support moms, babies and families. Always collaborative, our work continues to raise breastfeeding rates, lower c-section rates, and increase parent-child bonding.

HealthConnect One is a national leader in advancing equitable, community-based, peer-to-peer support for pregnancy, birth, breastfeeding and early parenting. Our vision is to see that every baby, mother, and family thrive in a healthy community. We work to achieve this vision through an equity focused approach supporting the first 1000 days for birthing families.

For more information please visit www.healthconnectone.org
This brief was developed in collaboration with Cross Health Care Solutions www.CrossHCS.com