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# Community-Based Doulas and Early Relational Health:

## The Role of Public Policy and Financing

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## Partnering to Learn from Community-Based Doulas

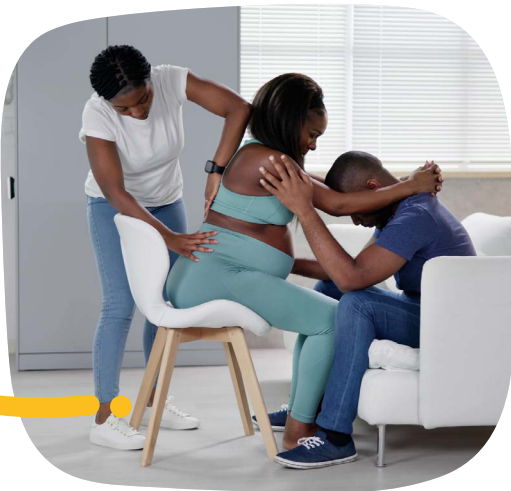
Nurture Connection has established policy goals to advance early relational health (ERH) that include priority policies to advance the development of a diverse and well-trained relational workforce that includes community health workers, doulas, home visitors, and others. (See [ERH Policy Agenda](#)). Community-based doulas, in particular, bring cultural wisdom, historical practices, and relational approaches to their work with mothers and babies.

Recognizing both the value of doulas with their relational focus in improving perinatal outcomes and the limited resources available to grow and sustain this workforce, Nurture Connection, the Center for the Study of Social Policy, and HealthConnect One joined together in partnership with community-based doulas in a two-year project designed to explore the role of doulas in advancing early relational health. This report shares some of what was learned from this partnership and offers policy recommendations to support the practice of community-based doulas. This project was funded by the Pritzker Children's Initiative, the W.K. Kellogg Foundation, and the Burke Foundation.

Through this project, the organizational partners engaged doulas in co-design of a *Community-Based Doula Early Relational Health Curriculum*, which aims to deepen the skills of community-based doulas in promoting maternal and infant well-being by strengthening relationships beginning at birth. The project included several phases of work. The work began

with a review of the components of HealthConnect One's doula training curriculum that focus on the foundational role of positive and nurturing early relationships between infants and their parents/caregivers. Next, a national survey of community-based doulas was conducted to understand the types of strategies utilized by doulas to nurture relationships with their clients and between caregivers and infants. The quantitative survey findings were synthesized with qualitative input through key informant interviews and focus groups. In addition, an Advisory Committee was formed to ground and guide the work. Together, these approaches informed the co-design of two new ERH learning modules, which highlight topics and service approaches related to peer-to-peer support, narrative sharing, building resilience, and birth equity and justice. Next, the modules were piloted and then modified based on evaluation feedback from cohorts of select doula training partner sites.

The project's quantitative and qualitative input from doulas and other key stakeholders also increased awareness and understanding of the policy, program, and practical barriers faced by community-based doulas. What was learned contributed to the knowledge base of the National Coordinating Hub on Early Relational Health, the ongoing work of HealthConnect One, and the recommendations in this policy brief.



## Understanding the Role of Community-Based Doulas in ERH

### Defining Community-Based Doulas

Doulas are trained to support people before, during, and after labor and birth by providing relational, educational, emotional, and physical support. Community-based doulas offer additional support to their clients by providing culturally reflective care that meets the unique

needs of their clients. Community-based doulas typically live in the same communities that they serve, which are often comprised of Black, Brown, Indigenous, and other people of color and which may suffer higher health risks related to racial discrimination, living in medically underserved communities, having lower incomes, and other social and structural barriers to optimal health. In contrast to traditional doula services, which often charge their clients private rates, community-based doulas frequently provide services at low or no cost and are also able to provide a range of services across the perinatal spectrum.<sup>1</sup>

## Impact of Community-Based Doula Care

In recent years, community health workers and community-based doula services have received increasing recognition for their role in improving health outcomes, reducing health disparities, and addressing the social determinants of health. Community-based doulas make up an important component of this workforce. By leveraging social capital and investing in relationships within their communities, community-based doulas have been successfully improving the maternal and infant health outcomes as demonstrated below.

National, state, and local studies point to the effectiveness of doulas in improving birth outcomes, the birthing experience, and postpartum care.<sup>2,3,4,5,6,7,8</sup> Research indicates that, in the context of births, doula care can: increase likelihood of shorter labor, vaginal births, and positive breastfeeding experiences; reduce the likelihood of Cesarean births and complications; and result in higher scores on the APGAR test measuring infant health.<sup>9,10,11,12,13</sup> Cost savings have been shown as a result of these improved outcomes and care practices.<sup>14,15,16,17,18</sup>

Community-based doulas, in particular, can play a key role in promoting health and survival of mothers and babies following a birth. They provide home and community-based services and supports for the weeks and months following a birth, when both social and medical risks can affect the health of mothers and babies.<sup>19,20,21,22,23,24,25</sup>

## Understanding Early Relational Health

As defined by Nurture Connection, ERH is the state of emotional well-being that grows from the positive emotional connection between babies and toddlers and their parents/caregivers when they experience positive and nurturing relationships with each other. These foundational early relationships support children's health and development, parents' sense of competence, and overall well-being of the family. These relationships also help to protect and/or promote healing from the harmful effects of stress.

The ERH framework brings attention to the many ways inequities—perpetuated by discrimination, racism, and poverty—can cause harm to our health and well-being. Also, it highlights how entrenched biases can make it hard to see the strengths of families that look different from our own. With a focus on ERH, we can shift toward strengths-based approaches that help families to use their intrinsic human capacities for early relationships and build upon their cultural and generational wisdom.

All parents and caregivers know that positive connections with their children matter. However, social, racial, cultural, and economic injustices and challenges can overload families and communities, often taking a toll on parents/caregivers, young children, and their relational health. Because our public policies are not designed to help families thrive, many do not have access to supports that are responsive to their needs. Adopting policies that support a diverse community-based workforce is one area ripe for improvement.

## Community-Based Doulas are Part of the ERH Workforce

Recognition is growing about the value of expanding a community-based ERH workforce in systems transformation to achieve improved child, family, and community outcomes.<sup>26,27,28</sup> In this project, the national survey of community-based doulas conducted in 2022 found that 90% of respondents (n = 140) viewed themselves as playing a role in promoting ERH.<sup>29</sup>

As discussed above, research shows the positive impact of doula care on birth outcomes and care. Studies also point to the role of community-based doulas in promoting ERH within families. Doula care is associated with reduced stress and better mental health, including reductions in perceived negative birth experiences and postpartum depression rates.<sup>30,31,32,33,34</sup> Across studies of doula care, consistent findings show increased rates of breastfeeding initiation and duration. This has positive impact not only on the long-term health of the mother and infant but, equally important, on the formation of strong mother-baby attachments associated with breastfeeding.<sup>35,36,37,38,39</sup> Beyond the mother-baby dyad, doulas have been found to positively involve partners in the pregnancy and birth.<sup>40</sup>

Using a whole-family approach supports early relationships. Having the social and relational support of a doula beginning prenatally can reduce stress levels for expecting parents and increase parental sense of empowerment and efficacy.

Last but not least, community-based doulas have shown the capacity to build trusting relationships through similarities in race, culture, and lived experience, or by providing assistance with linking the client to basic needs.<sup>41,42,43</sup> One study in the *Listening to Mothers* series found that doula support was associated with higher odds for respectful care, particularly for women of color, low-income, and other marginalized groups.<sup>44</sup>

Many experts have written about the potential role of doulas in advancing equity and reducing racial disparities in birth outcomes.<sup>45,46,47,48,49,50,51,52,53,54,55,56,57,58</sup> While doulas dedicate their efforts to addressing the social determinants of health (SDOH), reducing barriers, or empowering their clients to self-advocate, they are not immune from the negative impacts that befall them as a consequence of this work. Doulas report experiencing secondary trauma, compassion fatigue, and burnout as a result of the ongoing witnessing of institutional biases, mistreatment of clients, and the disrespect they themselves often receive from members of the health care system.<sup>59,60,61</sup>



# Inadequate Public Policies and Financing Limit Access to Community-Based Doula Care

Despite the benefits doulas can provide, data suggest that less than 10% of U.S. births involve doula services. Limitations on use of doula services are related to public policy decisions, particularly decisions in Medicaid and other health insurance. Health coverage factors include: not being approved as Medicaid providers in most states, low reimbursement rates, differences in training and certification requirements, and variation in scope and duration of the benefit. These policy decisions, in turn, affect workforce capacity and the number of doulas available to provide services to those at higher risk.<sup>62,63,64,65,66</sup>

## **STRUCTURAL AND INSTITUTIONAL BARRIERS CONTRIBUTE TO DOULA BURNOUT**

- Severity of need and conditions among clients served.
- Low compensation not reflective of the cost of living or labor demands.
- Medicaid reimbursement approaches and administrative burdens.
- Insufficient funding for community-based services and small organizations.
- Unrealistic expectations from government agencies and health care institutions.
- Experiences with racism and discrimination from health care providers and institutions.

Adapted from: *Birth Worker Burnout: Exploring Integrative Approaches to Nurturing a Healthy Doula Workforce*. Mama Glow Foundation (2023)

While research shows that community-based doula care can address perinatal health disparities, doula care in the United States has been largely limited to middle- and high-income women who can afford to pay for such services out-of-pocket, who are disproportionately White, and doulas serving these women tend to be of the same race and socioeconomic class.<sup>67</sup> People of color and those with low-incomes are at elevated risk for adverse maternal and infant health outcomes, and, at the same time, are the group most likely to want but not have affordable access to doula care.<sup>68,69</sup> “*Listening to Mothers III*,” a national survey, found that privately insured mothers were nearly twice as likely as Medicaid-enrolled respondents to be aware of doula care.<sup>70</sup>

Limited access to doula care by people of color and those living in low-income or medically underserved communities places additional workloads on community-based doulas who are in practice in those communities. More effort is required to support pregnant people and new mothers in securing health care and other concrete supports in underinvested and underserved communities with more limited resources.<sup>71</sup>

In addition, providing services that are inadequately funded or uncompensated contributes to workforce burnout.<sup>72</sup>

Moreover, while the relational nature of community-based doula practice is a key factor in the uniqueness and effectiveness of their work, those who do intensive work supporting families in times of transitions and times of need also need support to sustain their work.<sup>73,74</sup> For community-based doulas, community health workers, social workers, home visitors, and others, reflective supervision and other practice supports are essential. However, such supervision and practice supports are rarely included in financing approaches for doula care.

For example, doulas who participated in the *Community-Based Doula Early Relational Health Curriculum* pilot identified the need for continuing education, additional opportunities to practice ERH skills, and support networks as resources to sustain their ERH work. In particular, as a result of the emphasis on interactive, peer-based reflective activities, evaluation findings from the curriculum pilot project showed strong interest in peer-to-peer reflective support networks. Community-based doulas in the project cohorts described “reflective supervision and networking with like-minded individuals as a beneficial mode of support as they implement ERH into their practice.”<sup>75</sup>

Overall learnings from the *Community-Based Doula Early Relational Health Curriculum* enhancement project underscored the essential role that community-based doulas play as members of the ERH workforce. While ample evidence points to the need for expanding this workforce to advance equity and well-being across communities, of equal importance is the need to invest in strategies that sustain and support those who are doing the work. The policy recommendations in this paper are based on these findings and provide strategies to ensure sustainability from the perspectives of both financial sustainability and strengthening workforce capacity.

## Accelerating an Effective Policy Response

The number of recommendations for policy change related to doula care has accelerated in recent years. Calls for changes in federal- and state-level policy to improve access to doula care—including changes in health coverage, better administrative structures, and investments in training and supervision—have been advanced in organizational issue briefs, professional journal articles, and governmental reports. More than a dozen such documents were reviewed in preparation of this brief.<sup>76,77,78,79,80,81,82,83,84,85,86,87,88,89</sup> Some of these organizations and analysts have made recommendations for federal action, while others looked specifically at state legislation related to Medicaid. Despite some differences in wording or details, these multiple sets of policy recommendations are generally consistent in their purposes. This brief builds upon these existing recommendations.



## Federal Policy Action

Maternal health has been the focus of dozens of bills introduced in Congress since 2019, by both the more than 100 members of the [Black Maternal Health Caucus](#) and other Members of Congress. The [Black Maternal Health Momnibus Act](#) alone encompasses [13 component bills in the 117<sup>th</sup> Congress](#). One aim in the Momnibus is to “grow and diversify the perinatal workforce to ensure that every mom in America receives maternal health care and support from people they trust.” This component is pending in the [Perinatal Workforce Act](#) (introduced by Representative Gwen Moore and Senator Tammy Baldwin), which would dedicate perinatal workforce grants for training, licensing, and certification of perinatal health workers, including doulas, community health workers, lactation educators, home visitors, childbirth educators, and others. (Grants also would be available for training physician assistants and midwives, and a separate section of the bill focuses on perinatal nursing.) The Perinatal Workforce Act would give priority to schools or training programs that have demonstrated commitment to recruiting and retaining students and faculty from “*racial and ethnic minority groups and other underserved populations, those who practice in health professional shortage areas, and/or who plan to practice in areas with high disparities in maternal health outcomes.*”

An analysis of the progress in Congress found that while few provisions of the pending Momnibus Act have been enacted and signed into law, many elements have been advanced through Congressional appropriations or federal agency action.<sup>90,91</sup> This includes funding for doulas through projects of the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), and the addition of doulas to the [Healthy Start program](#).

Workforce development is an equally important topic to be addressed through policy change. For example, the [White House Blueprint for Addressing the Maternal Health Crisis](#) is focused on expanding and diversifying the perinatal workforce. To address gaps in the perinatal workforce, the Blueprint Goal 4 calls for increasing:

*“...the number of physicians, licensed midwives, doulas, and community health workers in underserved communities; provide guidance to states to help them expand access to licensed midwives, doulas, and freestanding birth centers; and encourage insurance companies to improve reimbursement for and coverage of midwives and perinatal supports, such as doulas and nurse home visits.”<sup>92</sup>*

To expand the number and diversity of perinatal professionals in underserved areas, the *White House Blueprint* calls for increasing access to community health workers and doulas through programs such as the Community Health Worker Training Program. The *Blueprint* also calls for additional guidance to state Medicaid programs regarding options to finance doula care and reforms in federal employee and TRICARE coverage.

## SELECT FEDERAL INITIATIVES DESIGNED TO EXPAND ACCESS TO DOULA CARE

- **Office of the Assistant Secretary for Planning and Evaluation (ASPE)** – ASPE published an Issue Brief in December 2022 entitled [Doula Care and Maternal Health: An Evidence Review](#) that outlined challenges and opportunities for the provision of doula care, as well as existing policy efforts to strengthen and expand doula care.
- **Centers for Medicare and Medicaid Services (CMS)** – The CMS guidance is shared throughout this brief, including ways that doulas can be reimbursed under Medicaid. In addition, the CMS Maternity Care Action Plan, guidance based on findings from the [Strong Start for Mothers and Newborns Initiative](#), and other initiatives help to guide state Medicaid agency efforts.
- **Health Resources and Services Administration (HRSA)** – Because HRSA supports community health services and health professionals in underserved areas, funds maternal and child health services, and otherwise aims to increase access for underserved communities, they have multiple efforts to expand access to doula care. For example, in [2022, under the Healthy Start program](#), HRSA provided funding for 44 projects designed to support community-based doula care and expand the doula workforce. In addition, the [Rural Maternal Obstetrics Management Strategies \(RMOMS\)](#) program includes funding for doula care.
- **Department of Defense (DOD)** – The DOD has a TRICARE Childbirth and Breastfeeding Support Demonstration project underway, which provides doula and lactation services to beneficiaries.
- **Department of Labor (DOL)** – The DOL Women's Bureau convened listening sessions and prepared an [issue brief](#) about expanding and diversifying the doula workforce.
- **Department of Justice (DOJ)** – The [DOJ is contracting for doula services](#) and piloting a doula training program to better serve pregnant and postpartum people who are incarcerated in five facilities.
- **Office of Personnel Management (OPM)** – In managing the Federal Employees Health Benefits (FEHB) Program for nine million people, OPM has encouraged their health plan carriers to include coverage and reimbursement for doula services.
- **Cross agency** – In May 2022, the HHS Office of Intergovernmental and External Affairs, in coordination with CMS and HRSA, held a roundtable discussion with community-based doulas. Topics included billing and reimbursement, training and credentialing, public and provider education and awareness about doulas, and other doula supports as needed.

## State Policy Action

Much of the policy action has been at the state level. A landscape analysis of state legislation with the word “doula” between 2015 and 2020 found a three-fold increase in doula-related state legislation, including 58 bills introduced in 2019-2020 alone. In total, 73 bills across 24 states were studied, with 12 bills in 7 states enacted to become law. Just over half (53%) of the full set of proposed legislation and 7 of the 12 new laws focused on Medicaid reimbursement for doula care. As reported by Ogunwole and her colleagues, while many of the bills recognized health disparities in maternal and infant health, few had provisions aimed at advancing equity beyond access to Medicaid coverage for low-income people.<sup>93</sup> In addition, while some acknowledged the role of SDOH as drivers of disparate outcomes, few addressed the need to expand access to community-based doulas who might play a role in shifting negative drivers and systems barriers.

Notably, many state-level bills also have addressed the topic of workforce development, including credentialing, training, certification, cultural competency or congruence, and support for doula organizations. The lack of centralized or uniform certification or credentialing requirements for doulas in the United States creates challenges in the policy process that must be addressed on a state-by-state basis. In other words, each state has the challenge of creating rules, which avoids unnecessary burden on practicing doulas. Some states rely on credentials and experience, in combination.

In addition, lack of administrative support for providing services under health coverage plans—particularly Medicaid—can be a substantial barrier for doulas. Since many doulas operate as solo practitioners, they often lack the capacity and infrastructure to manage health plan contracting and billing requirements.<sup>94</sup> Policy and program approaches have been recommended to overcome barriers related to administration of public programs.

## WASHINGTON STATE ADOPTS HIGHEST MEDICAID REIMBURSEMENT RATE IN THE NATION

On March 7, 2024, the Washington State legislature approved the final state budget, including matching funds sufficient to support a Medicaid reimbursement rate for birth doulas up to \$3,500.00 per birth. The budget also included an additional \$200,000 to create a doula hub and referral system throughout the state. The referral system would connect birthing people, families, birth doulas, and healthcare providers who are seeking to connect with state-certified and Medicaid-enrolled birth doulas through a statewide directory or referral system.

Overall for maternal and infant health, the state's budget provided \$4.8 million in funding to: align eligibility requirements for pregnant people and children at 210% of the federal poverty level, update maternity support services, add reimbursement for services provided by doulas, support design and implementation of a doula hub and referral system, create postpartum transitional care program for people with substance use disorder, and increase rates for inpatient prospective payment hospitals participating in the Substance Using Pregnant Person program. <https://fiscal.wa.gov/statebudgets/2024proposals/Documents/co/coHSummary-Conference.pdf>

Original sponsor of the legislation, State Rep. Kirsten Harris-Talley (D-Seattle) said: "Opening up Medicaid coverage so that they also have support during birth is a huge step forward in birthing equity and making sure everyone, particularly those most marginalized and most at risk of having adverse birth outcomes, have the support they need."

[Douglas For All](#), a Black, Indigenous, People of Color (BIPOC) led birth doula coalition, has long been advocating for certification and reimbursement under Medicaid. In March 2024, the coalition celebrated the biggest milestone in their six-year journey—securing the highest Medicaid reimbursement rate in the nation for birth doulas. Senait Brown, policy director at [Surge Reproductive Justice](#), which facilitated the Douglas for All Coalition, said: "Reimbursement is not the goal. Ending the Black and Indigenous perinatal health crisis is the goal."

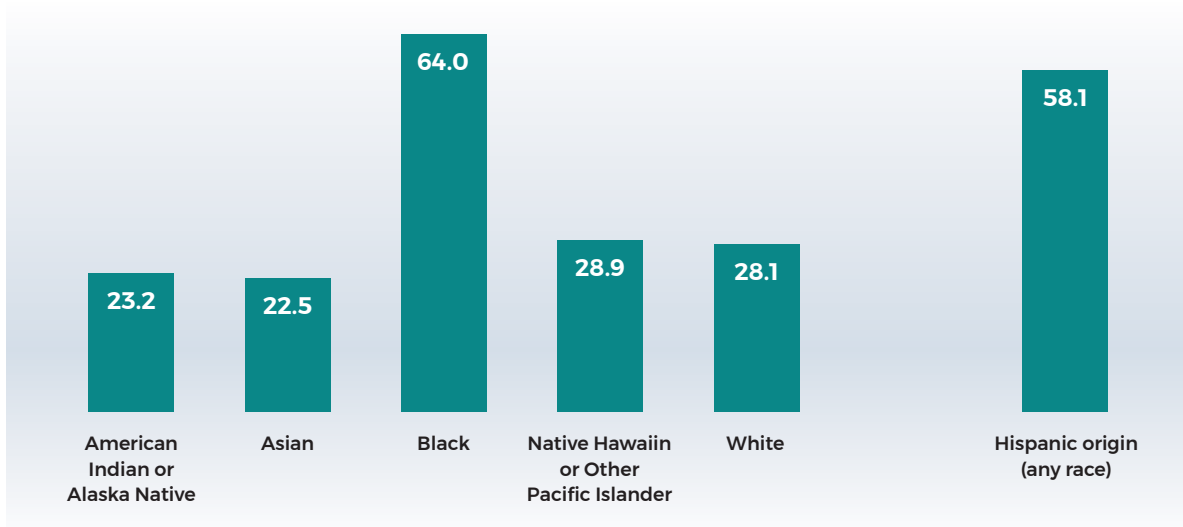
As of October 2023, the state Department of Health began accepting applications from doulas to receive their credentials at no cost to applicants [through June 30, 2025](#). As a voluntary certification, doulas only need to certify if they are planning to collect reimbursement for providing services to clients on public insurance.

This policy change had wide support among birth doulas. [A survey of doulas](#) in Washington State showed that 8 out of 10 agreed that Medicaid reimbursement for birth doulas will positively impact the doula workforce and 9 out of 10 believe that the policy will benefit low-income people who are giving birth.

## Opportunities in Medicaid

Medicaid policy change may offer the greatest opportunities to finance more doula care for birthing people with low incomes and with higher social or medical needs. Data from birth certificates reported by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics provide some details about the distribution of births by race/ethnicity. (See Figure 1.) Neither the federal nor state governments collect consistent and comparable data on Medicaid births at the state level and Medicaid managed care data are even less likely to be available.<sup>95</sup>

**FIGURE 1. PERCENTAGE OF BIRTHS WITH MEDICAID FINANCING BY MATERNAL RACE AND HISPANIC ORIGIN, US, 2021**



Note: Data shown by racial group data are for non-Hispanic people. Hispanic people may be of any race.

Source: Valenzuela CP, Osterman MJK. *Characteristics of mothers by source of payment for the delivery: United States, 2021*. NCHS Data Brief, No. 468. National Center for Health Statistics. 2023. <https://dx.doi.org/10.15620/cdc:127266>

As shown in Figure 1, Black and Hispanic mothers are significantly more likely than mothers of other races/ethnicities to have Medicaid coverage. More than two-thirds (64%) of Black mothers and more than half (58%) of Hispanic mothers had Medicaid coverage reported on birth certificates in 2021. This high rate of Medicaid participation is related to the greater likelihood of Black and Hispanic mothers having low income and/or employment that does not include health coverage. (Note that the role of Medicaid is less for Indigenous women due to tribal care and Indian Health Service arrangements.) Younger mothers were also more likely to have Medicaid coverage, with more than three quarters (78%) of teen mothers under age 20 having Medicaid financing for a birth. These data point to the vital role of Medicaid in reducing disparities in birth outcomes and to the importance of Medicaid financing for care from the

full range of perinatal providers—whether women need services of doulas, nurse midwives, obstetricians, maternal fetal medicine specialists, or others.

With the option for [Medicaid extended postpartum coverage](#) adopted and implemented in 45 states and the District of Columbia as of March 2024, the role of Medicaid coverage for doula care is particularly important.<sup>96</sup> If every state adopts postpartum coverage extensions from 60 days to one full year, an estimated 720,000 additional women will gain coverage and approximately 2 million mother-baby pairs will have a full year of continuous coverage.<sup>97,98,99,100</sup>

The Medicaid postpartum coverage extensions create opportunities not only to finance doula birth-related services but, equally important, to finance community-based doula services for mothers and babies throughout the first year following a Medicaid-financed pregnancy.<sup>101,102</sup> For example, the “California Momnibus” bill (SB 65), signed into law in October 2021, includes language to cover full-spectrum doula services, including in cases of pregnancy loss.<sup>103</sup>

The federal Centers for Medicare and Medicaid Services (CMS) has encouraged states to use their options to include doulas as providers of perinatal services to mothers and babies covered by Medicaid during the pregnancy and postpartum periods. In 2023, the [CMS Maternity Care Action Plan](#) encouraged state Medicaid programs to cover community-based maternity services, such as those furnished by doulas and community health workers, stating: “*State Medicaid programs can cover community-based maternity services, such as those furnished by doulas and community health workers.*”<sup>104</sup> CMS also pledged to work with states and sister agencies to identify opportunities to expand and improve access to a diverse maternity care workforce that includes community-based practitioners such as doulas and community health workers.

States have several options for adopting Medicaid financing of doula services. In a 2021 letter with guidance to states regarding Medicaid postpartum coverage extensions, CMS encouraged states to finance doula services as one opportunity to improve maternal and infant health.

*“States may also consider building on person-centered models of perinatal care to support individuals in the prenatal, delivery, and postpartum periods, such as doula services and home visiting. Doula support, which can be delivered in a home setting, is associated with improved health outcomes including decreased likelihood of postpartum depression and near-universal breastfeeding among low-income individuals. Coverage of doula services may be effectuated through multiple benefit categories, including, but not limited to, preventive services, services of licensed practitioners, clinic services, and freestanding birth center services.”*<sup>105</sup>

While they have several options, most Medicaid agencies covering doula services are using a State Plan Amendment (SPA) for preventive services. The SPA for preventive services is more permanent, more flexible for doulas, and less burdensome for the state than adding doula services to a waiver or other benefit category. (See box regarding doulas and preventive services benefit.)

More than half of states are either actively providing Medicaid financing for doula care, are in the process of implementing such coverage, or are taking some statewide action related or adjacent to Medicaid coverage for doula care. While some states are using pilot projects, most are implementing policies that include doulas as Medicaid providers.<sup>106,107</sup>

### **DOULAS AND MEDICAID PREVENTIVE SERVICES COVERAGE**

The Affordable Care Act changed Medicaid law related to preventive services, giving states the option to submit a State Plan Amendment (SPA) that would allow preventive services to be provided by non-licensed providers with the recommendation of a licensed provider (Social Security Act, 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130(c) (2013)). Most states covering doula services now use this preventive services SPA approach. This policy requires that services be recommended by a physician or other licensed practitioner within the scope of their practice under state law. In other words, direct supervision by a physician or other licensed practitioner is no longer required. In a 2013 Informational Bulletin, CMS advised states that preventive services SPAs should include a summary of practitioner qualifications and any required education, training, experience, credentialing, or registration (CMCS Informational Bulletin: Update on Preventive Services Initiatives. November 27, 2013) <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf>).

Within the preventive services SPA, states can define and clarify doula service benefit details. For example, while a standard scope of covered services for doulas typically includes prenatal, postpartum, and labor and delivery care, states might specify coverage for other aspects of care such as prenatal health education, development of a birth plan, support for pregnancy loss, postpartum counseling and education, information on parenting and infant care, and support for access to other services such as nutrition, mental health, tobacco cessation, or housing supports. Many additional services beyond support for prenatal and birth services are often part of community-based doula care.

As shown in Table 1, a growing number of states have used one of their options to provide Medicaid reimbursement for doula services. Most are using an SPA for preventive services benefits as their approach. A smaller number are using expanded maternity care benefits or other benefit categories. In some states proposals are pending and in others progress in implementation has been slow. About a dozen states have adopted and fully implemented Medicaid financing for doula services. Notably, some are limited to birth doulas and may not include coverage of the range of services provided by community-based doulas or full-spectrum doulas.<sup>108</sup>



**TABLE 1. STATE MEDICAID FINANCING FOR DOULA SERVICES**

State	Approach	Benefit Category	Effective date
California	SPA	Preventive Services and Freestanding Birth Center (professional service)	January 1, 2023
Connecticut		Maternity Bundle Payment	Proposed for 2024.
Delaware			Implementation in progress. Proposed effective date 1/1/2024 (delayed).
District of Columbia	SPA	Preventive Services	October 1, 2022
Florida	MCO	Managed Care Expanded Benefits	2019
Illinois			Implementation in progress. Proposed effective date 2/1/2024 (delayed).
Louisiana	MCO	Managed care maternity care benefit includes doulas.	Implementation in progress in some MCOs.
Maryland	SPA	Preventive Services	January 1, 2022
Massachusetts	SPA	Preventive Services	December 8, 2023
Michigan	SPA	Preventive Services	January 1, 2023
Minnesota	SPA	Pregnancy-related Services	July 1, 2014; Statewide standing recommendation January 9, 2024.
Nevada	SPA	Preventive Services	April 1, 2022
New Jersey	SPA	Preventive Services	January 2, 2021
New York	SPA	Preventive Services	January 1, 2024
Ohio		Broader maternal and infant health initiative, not statewide benefit	Implementation in progress. Proposed effective date 7/1/2024.
Oklahoma	SPA	Preventive Services	July 1, 2023
Oregon	SPA	Preventive Services	May 1, 2017
Pennsylvania	MCO		Implementation in progress. Proposed effective date October 3, 2024.
Rhode Island	SPA	Preventive Services	July 1, 2021
Tennessee	MCO		Implementation in progress.
Virginia	SPA	Preventive Services	April 1, 2022

Sources: National Academy for State Health Policy tracking table available at <https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/> and National Health Law Program updated table as of January 2024 available at <https://healthlaw.org/doulamedicaidproject/#:~:text=artist%20statement%C2%A0here.-Current%20State%20Doula%20Medicaid%20Efforts.-The%20National%20Health> and issue brief available at <https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/>

Another aspect of using Medicaid to finance doula services is the fact that more than 70% of all Medicaid beneficiaries are enrolled in Medicaid managed care arrangements, with women of childbearing age and children most likely to be enrolled in managed care. A recent analysis of maternal health provisions in Medicaid-managed care contracts conducted by Rosenbaum and her colleagues found overall that most states do not have specific contract language to address the full continuum of reproductive and maternal health services.<sup>109</sup> This analysis included Medicaid contracts from all states that used comprehensive managed care in 2022 (39 states and the District of Columbia). The researchers conducted an extensive literature review of [maternal health "best practices" from pre-pregnancy through postpartum](#) as the basis for contractual review.

This analysis found that [only 9 states had Medicaid managed care contract language](#) addressing doulas as providers (FL, MD, MN, NJ, NV, OR, PA, RI, and VA). This generally corresponds to the number of states who had adopted policies for doula reimbursement in Medicaid. This group of contract provisions typically provided definitions and, less often, details about the expectations for MCOs. New Jersey is a notable exception, with a somewhat more detailed definition and expectations set out in their managed care contract specifications. (See box below.)

### **NEW JERSEY MEDICAID MANAGED CARE CONTRACT SPECIFICATIONS REGARDING DOULA SERVICES**

*“Doula—A doula is an individual who meets the community doula training requirements for doula core and community-based/cultural competencies established by DHS in consultation with DOH. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a trained, licensed medical professional, and cannot perform clinical tasks” (p. 11, Article 1, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).*

*“G. Doula care. The Contractor shall provide access to doula care to all pregnant, birthing, and postpartum individuals regardless of their medical complexity. The Contractor shall not require prior authorization for doula care. Doula care is available from conception until 180 days from the birth event. Doula care can be provided in the community, in clinical offices, or in the hospital. Doula care does not include reimbursement for transportation. Prior to the initiation of visits, doula care must be recommended by a licensed practitioner. Doula care must be provided by a community*

*Continued on next page.*

*doula, defined as a doula with trainings in doula core competency and community-based/cultural competency that are among those approved by the New Jersey Department of Human Services in consultation with NJ Department of Health. All in-network doulas must be enrolled as fee-for-service providers and have the ability to serve fee-for-service members...The Contractor shall allow doulas to contract as individual providers and/or as providers affiliated with groups with the following specialties: doula-only agency, physician practices, midwifery practices, advanced nurse practitioner practices, and independent clinics. The Contractor must give DMAHS 90 days' notice prior to any changes to the doula care fee schedule” (p. 31, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).*

To learn more about Medicaid managed care contract language and maternal health, see: Rosenbaum et al. *The road to maternal health runs through Medicaid managed care*. Commonwealth Fund (Blog). May 22, 2023. <https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care>

Multiple challenges have been identified in the context of Medicaid financing for doula services. These include, but are not limited to: lack of engagement with doulas in design of policies, insufficient reimbursement rates, restrictive or confusing rules related to training levels and certification, burdensome billing and other administrative procedures, and complex relationships with managed care plans.<sup>110,111,112,113,114,115,116,117</sup> Some of these challenges are common among Medicaid providers of multiple types (e.g., physician concerns about low reimbursement rates); others are more directly related to the practice of doulas (e.g., certification). In addition, when community-based organizations and small independent practices shift from grant or out-of-pocket payments into Medicaid billing arrangements, the administrative burden and “learning curve” is generally seen as burdensome.<sup>118</sup> The recommendations in this Nurture Connection brief and many other reports are designed to overcome some of these challenges.

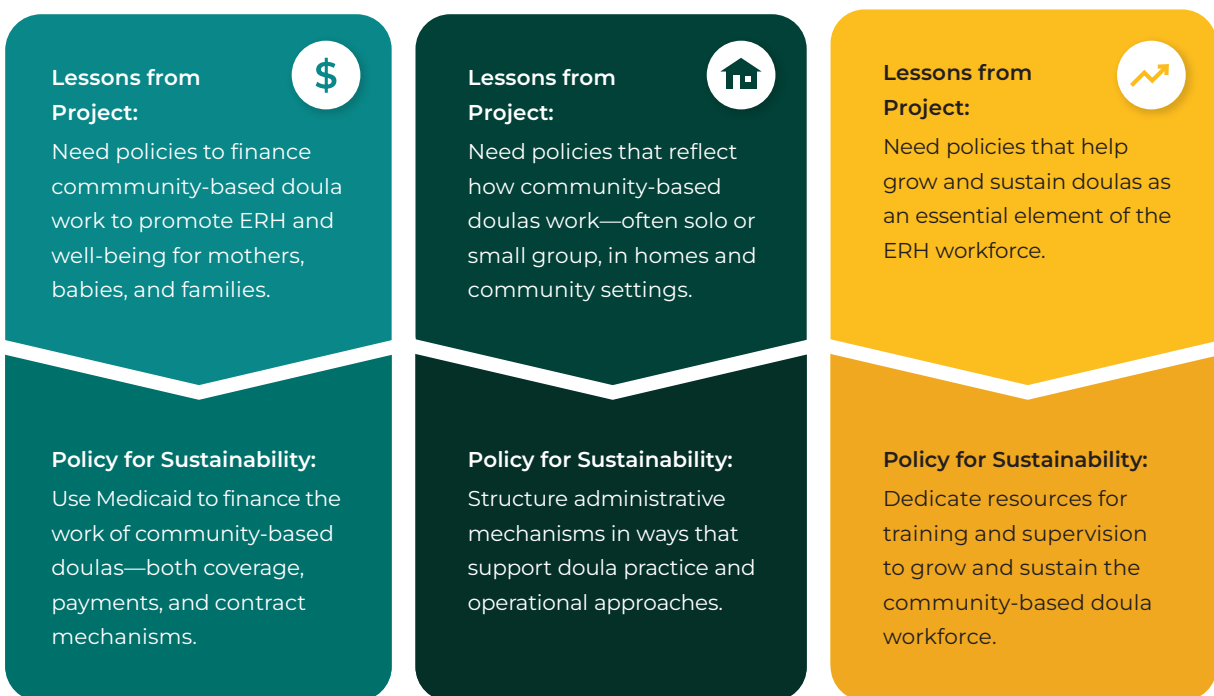
# Policy Recommendations in Support of Community-Based Doula Services

Nurture Connection and HealthConnect One have been learning from community-based doulas about their skills and capacity to provide relational care to pregnant people and new mothers and babies. Our project engaging, training, and listening to community-based doulas has policy implications.

As shown in Figure 2, the policy implications from the partnership focus on three types of policies that can sustain the community-based doula workforce and their role in promoting ERH and well-being for mothers, babies, and families: 1) use of Medicaid, 2) administrative mechanisms to support practice, and 3) public funding to ensure community-based doulas have access to training, ongoing professional development, and reflective supervision/consultation.

In addition to the project findings, in preparation for this brief, a review and synthesis of existing policy reports and recommendations was undertaken to ground our work in what other experts and organizations have recommended. Existing recommendations fall into three major categories: 1) use of Medicaid to finance doula services, 2) administrative mechanisms to support doula practice (e.g., practical certification rules, technical assistance, organizational hubs, etc.), and 3) resources to provide training and supervision to grow and sustain the workforce. **Nurture Connection supports policy change in all three areas.**

**FIGURE 2: LESSONS THAT POINT TO POLICY OPPORTUNITIES**



## Recommendations for Increasing Use of Medicaid to Finance Doula Services

### COVER DOULA SERVICES

- **Use one of the state options to provide Medicaid reimbursement for birth and community-based doula services.** Using a State Plan Amendment (SPA) for preventive services is the most frequently used approach.
- When the state is using preventive services benefits, **clarify and simplify the rules and process for having doula services recommended by a physician or other licensed practitioner of the healing arts.** Specify that a referral is not required. In a small number of states, a state health officer, Medicaid medical director, or similar physician in government have issued a “blanket” recommendation for doula care under Medicaid.

### USE PAYMENT APPROACHES THAT ARE FAIR AND FUNCTIONAL

- **Set Medicaid reimbursement rates for doula services at a level that is fair and sufficient to cover costs,** corresponding to the scope of services (e.g., birth only, community-based services) and reflecting the level of work (e.g., number and duration of visits and type of services provided).
- Align Medicaid and managed care organization expectations by including **clear specifications in Medicaid MCO contracts** (e.g., state credentialing, payment rates, networks, scope of benefit).
- **Create fiscal incentives for quality care and performance** (e.g., pay for performance when postpartum visit is completed).
- **Consider various payment approaches.** While a global payment might work for birth doula services, a rate set per visit or based on time might be more appropriate for community-based doula services.
- **Include doula services based in federally qualified health centers (FQHC)** as part of setting rates in prospective payment systems (PPS) or alternative payment mechanisms (APM) in Medicaid.
- Develop alternative payment models and value-based payment arrangements that **incentivize the use of team-based maternal health care delivery models** which include doulas, midwives, and others in the perinatal workforce.

## Recommendations for Administrative Mechanisms to Support Doula Services

- Provide administrative structures and technical assistance that **support doulas as they navigate the Medicaid provider enrollment, contracting, and billing processes**, including technical assistance related to administrative requirements for becoming a Medicaid provider. This support might be offered through a technical assistance hub, one-on-one support, training sessions, peer-to-peer learning collaboratives, and/or other approaches. Resources might include Medicaid administrative claiming, Title V Maternal and Child Health Services Block Grant, and state appropriated special funds.
- **Structure mechanisms for Medicaid billing that reduce administrative burden**, particularly for independent doulas and community-based organizations. For example, this might include streamlined billing processes or centralized billing via a doula collective group or another organization (e.g., freestanding birth center, department of health, federally qualified health center, Healthy Start grantee).
- When requirements to be a provider of Medicaid reimbursable doula care include training and certification criteria, these should **align with other state requirements and use approaches built on competencies**, rather than a list of approved organizations. Also, use common criteria enrollment under managed care and fee-for-service. Competency in ERH might be included, as appropriate.
- **Ensure that community-based doulas and others can be reimbursed for services delivered in-home or community settings**. This is an integral part of the delivery and design of effective community-based doula care. Nothing in federal Medicaid law prohibits the provision of services in community or home settings.
- **Collect data and fund evaluative studies to show impact** of doula services on birth outcomes. These might be funded by special dedicated state funds, Title V Maternal and Child Health Service Block Grant, or other public health program dollars.

## Recommendations to Ensure Ongoing Training and Supervision to Grow and Sustain the Workforce

- Ensure state overall and Medicaid **requirements for training certification of doulas are not overly or unnecessarily restrictive**.
- Support a **variety of training programs that reflect the different types of doula care**, including community-based and full-service doula models of care.
- **Offer trainings at low-cost, no-cost, or on a sliding-scale basis**. Resources might include Title V Maternal and Child Health Services Block Grant, public health or workforce funds, and/or dedicated state appropriations for training.

- **Provide financing for reflective supervision and support.** This typically would be using non-Medicaid funding, such as grants using public health funding. Permit use of and provide funding for reflective consultation models in the form of **peer-to-peer networks** of support.
- Offer **support and information that can grow a diverse doula workforce** such as a list of training organizations that reflect the cultural and linguistic needs of the birthing population and include BIPOC-led doula training organizations.

For any and all policy action related to doulas, Nurture Connection recommends engaging doula providers, their organizations, and the people they serve. Throughout the policy development and implementation process, such engagement may take several forms, including: key stakeholder meetings, formal appointment of doulas and their organizations to advisory groups, focus groups and interviews with doulas and patients, and/or sharing policy proposals for review and comment. Ensuring meaningful engagement of doulas and patients, particularly women of color who have been historically marginalized, is essential to development of sound public policy.

This brief calls for further federal and state policy action in development, adoption, and implementation of policies to grow and sustain doulas in their various roles as an essential component of the perinatal and ERH workforce. As our national crisis on maternal and infant mortality continues, with widening racial/ethnic disparities, now is the time for policy action.<sup>119</sup>



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