

Covering Doula Services Under Medicaid: Design and Implementation Considerations for Promoting Access and Health Equity

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TAKEAWAYS

- Many states are seeking strategies to address the maternal health crisis, including by covering doula services under Medicaid.
- Community-based doulas provide critical culturally congruent supports throughout the prenatal, labor and delivery, and postpartum period, offering promising opportunities to improve maternal and birth outcomes and reduce disparities for people of color.
- In determining how to design and implement Medicaid coverage for doulas, states should engage local and national doula stakeholders to develop strategies that will be responsive to doula and member needs and help meet Medicaid goals.
- This brief provides a practical guide for states that are pursuing doula coverage under Medicaid. It explores how six Medicaid agencies approached doula coverage decisions, including for: (1) services covered; (2) rate setting and reimbursement; (3) credentialing and enrollment; (4) training and certification; (5) managed care contracting; (6) practitioner recommendation requirements; and (7) workforce development and sustainability.

Rates of maternal morbidity and mortality are rising and more likely to impact pregnant people from marginalized and low-income communities, including individuals enrolled in Medicaid.¹ There are significant racial and ethnic disparities in maternal mortality, with Black and Indigenous women and birthing people three times more likely to die from pregnancy-related causes than white women.² These disparities stem from barriers in access to high-quality care, differences in health care quality, underlying chronic conditions, the impact of negative social determinants of health, structural racism, and implicit bias of health care providers and systems.³



Improving access to doula services is one key evidence-based approach to address the maternal mortality and morbidity crisis in the U.S. and improve maternal health equity.⁴ Doulas are community-based, non-medical trained professionals who provide emotional, physical, and informational support and guidance during the prenatal, labor and delivery, and postpartum period.⁵ Doulas can play a role in reducing the negative impact of interpersonal and institutional racism for birthing people in marginalized communities and improve overall patient experience.⁶ In some states, Black, Indigenous, and people of color (BIPOC) doulas receive training by community-based organizations to address forms of racism in hospital settings, and provide birthing individuals support to advocate for their birthing preferences.

Many states are seeking strategies to address the maternal health crisis, including by covering doula services under Medicaid. States interested in adding doula coverage to their Medicaid programs will need to submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) and consider options for implementing the new benefit.

To assist California as well as other states in adopting doula service benefits, the Center for Health Care Strategies (CHCS), through support from the California Health Care Foundation, convened stakeholders from six Medicaid agencies — **Maryland, New Jersey, Oregon, Rhode Island, Virginia,** and the **District of Columbia** — that cover doula services or are pursuing doula coverage. Through a series of virtual convenings, CHCS sought to hear from Medicaid agencies and department of health representatives about lessons states should consider when developing a SPA and implementing doula service benefits.

This resulting brief provides a practical guide for states that are designing and implementing doula coverage under Medicaid. It outlines promising practices and lessons from these six Medicaid agencies that have already, or are in the process of, incorporating doula services. The brief synthesizes actionable takeaways to guide states, focusing on:

1. [Benefit scope of services;](#)
2. [Rate setting and reimbursement;](#)
3. [Credentialing and enrollment processes;](#)
4. [Training and certification requirements;](#)
5. [Managed care contracting;](#)
6. [Practitioner recommendation requirements;](#) and
7. [Workforce development and sustainability.](#)

The brief also outlines common challenges states encounter in designing and implementing doula coverage, examples of how states addressed these challenges, and policy considerations for mitigating risks. The considerations contained in this brief reflect states' recommendations for California stakeholders and Medicaid agencies across the country that are implementing or considering Medicaid coverage of doula services.

Engaging Doulas in Design and Implementation

As a first step in designing doula service benefits, the Medicaid agencies convened by CHCS shared that it is critical to involve doulas — including solo practitioners, community-based doula organizations, and doula advocacy groups — early in the benefit design process and throughout efforts to implement the SPA. It is particularly important to build relationships with doulas who represent, and understand the needs of, the communities served. From the six Medicaid agencies brought together for this brief, many reported that strong partnerships with the doula community guided their decision-making process at each stage from benefit design through implementation. By involving doulas from the community at every design and implementation step outlined in this brief, states can ensure that the Medicaid doula service benefit will be shaped to respond to the unique needs of populations served.

California’s SPA Submission

In 2022, the California Department of Health Care Services (DHCS) engaged with doula stakeholders in the state to design its doula benefit state plan amendment (SPA). California submitted its SPA for the coverage of doula services in November 2022 and will continue to plan for implementation with the goal of launching the benefit in January 2023.

1. Benefit Scope of Services

Each state has the authority to define the scope of doula coverage within its SPA.

SPA DESIGN

Within their submitted SPA, states have flexibility to customize doula service benefit details. A standard scope of covered services for doulas typically includes prenatal, postpartum, and labor and delivery care. States have decision points around what, if any, additional components to include in the benefit package. Covered services can potentially include a combination of the following components:

- Counseling and education pertaining to pregnancy, childbirth, and postpartum, which may include: (a) infant care counseling to prevent adverse outcomes; and (b) counseling on family dynamics;
- Labor support, including the development of a birth plan;
- Emotional support and physical comfort measures;
- Support for the birthing person, including for their family and loved ones;
- Information on infant feeding;
- Infant soothing and coping and skills for the new parents;
- Postpartum support and the honoring of cultural and family traditions;
- Facilitation and assurance of access to community supports that can improve birth-related outcomes, such as transportation, housing, alcohol/tobacco/drug cessation, WIC, SNAP, and intimate partner violence resources; and
- Pregnancy loss, abortion, or “bereavement” supports.

States have several considerations in designing the doula scope of services for Medicaid enrollees. States should first ensure that doulas have engaged in the process or have been able to voice their opinions on a proposed scope of services. States should structure the doula program to allow coverage of the full array of services necessary to encompass the entire perinatal period. Pregnant and postpartum clients may have a wide variation of needs depending on the course of their pregnancies, risk profiles, and preferences. It is important for the doula service benefit to be tailored to meet this wide range of needs, birth preferences, and experiences. For example, states can offer flexibility in terms of the frequency and timing of prenatal and postpartum visits to meet the preferences of women and birthing individuals. In **Rhode Island**, for example, Medicaid covers a total of seven visits (3 prenatal, 1 labor and delivery, 3 postpartum). Each visit is reimbursed at \$100, and labor and delivery at \$900.⁷ Medicaid allows different doulas to provide these services so if a doula cannot attend labor and delivery, someone else can step in and provide that service. The visits can be spread out up to 12 months postpartum.

States can also consider coverage of additional services such as assisting Medicaid enrollees in getting to and accessing needed community supports. In this extended support role, doulas may assist getting members connected to resources to address social determinants of health such as food and housing. In working closely with members, doulas may also become aware of or identify the presence of physical or emotional abuse, or other maternal mental health conditions.⁸

Expanding the doula's role beyond traditional perinatal care services to include coordination with community supports may offer potential to improve maternal health outcomes and address inequities.⁹ One important consideration is that the reimbursement rate accurately reflects an expanded scope of services. If the Medicaid benefit package requires doulas to provide care coordination services, states and stakeholders would need to evaluate if the reimbursement rates proposed in the SPA takes the expanded scope into account.

Pregnancy loss support is another service that states can add to the doula scope of benefits in their SPA. This additional benefit acknowledges that not all pregnancies result in a live birth, and pregnant women and birthing people may benefit from receiving the physical and emotional support of a doula during this experience. **Exhibit 1** (*next page*) highlights select state approaches for designing the scope of doula services within their SPAs.¹⁰

Some states explicitly list non-covered services in their SPAs, or otherwise have language indicating that if a service is not explicitly mentioned then it is not covered. As an example of non-covered services, none of the six featured states are actively reimbursing for placental encapsulation or for doulas' transportation costs.

Exhibit 1. State Examples of Scope of Services for Medicaid Doula Benefit

EXAMPLES	STATE(S)
<ul style="list-style-type: none"> • Prenatal, labor and delivery, and postpartum services covered. Flexibility related to the scope of services within the SPA, regulations, and statutory language, particularly regarding number of visits, timeline, and whether multiple doulas can support one patient.¹¹ 	MD, NJ, RI, VA
<ul style="list-style-type: none"> • Pregnancy loss support for stillbirth or other issues that arise with pregnancy loss covered.¹² Some states also cover bereavement (RI). If a member’s pregnancy does not result in a live birth, or if the member does not receive the full allotment of the benefit, the remaining can be used postpartum or for bereavement (RI). 	MD, RI
<ul style="list-style-type: none"> • Post-abortion support covered, which falls under coverage to support pregnancies that do not result in a live birth. 	RI
<ul style="list-style-type: none"> • Community supports are included in the scope of services such as helping members access community-based resources.¹³ 	NJ, OR, RI

2. Rate Setting and Reimbursement

Payment and rate setting refers to how and at what levels a doula will be compensated for the services provided to Medicaid members. Reimbursement rates may vary in the prenatal, labor, and delivery, and postpartum periods. States also have the authority to design their reimbursement approaches as a bundled payment, fee-for-service, or bonus (incentive) payment.

SPA DESIGN

While Medicaid coverage may expand members’ access to doula services, without adequate payment doulas may not be able to participate in the program. States shared that to achieve sufficient levels of Medicaid participation by doulas, reimbursement rates must reflect a living wage in the region that doulas live in, and rates must be appropriate and take into consideration the nature of doula work (e.g., unpredictability in schedules that limits doulas from working other jobs, caps in the number of clients doulas are able to serve each month and still be available to all their clients). Some states, like **Oregon**, have had to re-visit their original doula reimbursement rates because initial rate setting did not support sufficient enrollment and service to communities. **Rhode Island** revised its proposed rate setting from \$850 to \$1,500 in response to feedback from doulas in the design phase.

Rates should also correlate to the scope of services, number, and length of visits, although rates may vary across states based on the range of services and visits covered. For example, some states may have higher reimbursement levels based on wider scope of services, such as assisting with referrals or linking clients to community supports.

COVERAGE IMPLEMENTATION

The six Medicaid agencies CHCS spoke to have developed a variety of methods to address payment and rate setting during coverage implementation. Some states offer incentive payments to doulas to meet quality and equity milestones. For example, in **New Jersey**, doulas receive one incentive payment if the birthing person attends a postpartum follow-up visit with their provider, and in the **District of Columbia, New Jersey, and Virginia**, one incentive payment is provided if the infant is taken to the pediatrician for a well-child visit after birth. Incentive payments may help maximize a doula’s role in improving maternal health quality goals, targeting community specific needs, and addressing equity gaps. These payments also provide additional income for doulas who go beyond providing the basic scope of services. **Exhibit 2a** (below) highlights examples of how states established rate setting and reimbursement during the design and implementation phases. **Exhibit 2b** (next page) presents additional information about select states’ rates and reimbursement plans.

Exhibit 2a. State Approaches to Rate-Setting for Doulas

APPROACHES	STATE(S)
<ul style="list-style-type: none"> Reimbursement rate correlates to the scope of services; for example, reimbursement is provided if the scope includes linkages to community-based services. Reimbursement rates must be set to adequately cover all required services. 	NJ
<ul style="list-style-type: none"> Reimbursement is provided for enhanced care. Note, in New Jersey, enhanced care is not required, but it is an option. For example, New Jersey provides additional doula visits when the client is younger than 19. 	NJ
<ul style="list-style-type: none"> To support doula care and to advance equity, Rhode Island revised the initially proposed rates to account for what a living wage would be in the state. 	RI
<ul style="list-style-type: none"> Postpartum or prenatal visit rates are adjusted to accurately reflect the work involved and expected duration of visit. New Jersey provides an increased prenatal visit rate to cover visits of longer duration to support doulas and their clients in establishing a trusting relationship. New Jersey is in the process of increasing its labor and delivery rate. Maryland has an increased postpartum visit rate to emphasize the importance of postpartum care. 	MD, NJ
<ul style="list-style-type: none"> Incentive payments are provided for doulas to support delivery of high-quality care. For example, doulas receive one incentive payment if the birthing person attends a follow-up visit to their provider after delivery and one incentive payment if the infant is taken to the pediatrician for a well-child visit after birth. 	NJ, VA
<ul style="list-style-type: none"> Collaborate with billing companies, co-operatives, or doula organizations that provide billing and reimbursement support for doulas. 	OR, RI

Exhibit 2b. State Examples of Medicaid Doula Rates and Reimbursement Plans

RATES AND REIMBURSEMENT PLANS	STATE(S)
<ul style="list-style-type: none"> • Up to \$900 for clients with up to eight service visits, and up to \$1,166 for clients with 12 service visits. Each perinatal service visit will be billed for and reimbursed separately. <ul style="list-style-type: none"> - All visits are reimbursed at units consisting of 15-minute increments at \$16.62 per unit rate. - An initial prenatal visit has a maximum unit capacity of six units to account for assessment while all other visits have a maximum capacity of four units. - Reimbursement for attendance during delivery is set at a flat rate of \$235. • During the postpartum period, there is a \$100 additional value-based incentive. Payment is made to the doula if the doula performs at least one postpartum service visit, and the client is seen by an obstetric clinician for one postpartum visit after a labor and delivery claim. 	NJ
<ul style="list-style-type: none"> • Maximum doula reimbursement for services per pregnancy is \$1,500. <ul style="list-style-type: none"> - Includes three prenatal and three postpartum visits at \$100 each. - Labor and delivery services at \$900. - Multiple doulas may provide services and be reimbursed. 	RI
<ul style="list-style-type: none"> • Up to \$859 for up to eight prenatal/postpartum visits plus labor and delivery, and \$100 in incentive payments. <ul style="list-style-type: none"> - Doula services may be reimbursed from the date of confirmed conception through 180 days (six months) after delivery, contingent on the client maintaining Medicaid eligibility. - Virginia will reimburse up to eight prenatal/postpartum visits and attendance at birth. - Prenatal/postpartum visits are billed and reimbursed separately. A unit of service is 15 minutes. - An initial prenatal visit has a maximum unit capacity of six units to account for assessment while all other visits have a maximum capacity of four units. - During the postpartum period, an additional value-based incentive payment will be made if the doula performs at least one postpartum service visit, and the client is seen by an obstetric clinician for one postpartum visit after a labor and delivery claim. - A second additional value-based incentive payment will be made if the doula performs at least one postpartum service visit (this may be the same postpartum visit used for the first value-based payment) and the newborn is seen by a pediatric clinician for one visit after a labor and delivery claim. 	VA
<ul style="list-style-type: none"> • Up to \$1,950.71 for 12 visits during the perinatal and postpartum period, as well as attendance at labor/delivery. The perinatal period lasts before, during, and up to six weeks after delivery. <ul style="list-style-type: none"> - The doula postpartum period begins on the last day of pregnancy and ends at the end of the month in which 180 days (six months) after the end of the pregnancy falls. - Different doula services are available and reimbursable during the perinatal and doula postpartum period. - Reimbursement for prenatal visits is \$97.04 per visit, regardless of length of time. - Reimbursement for labor/delivery is \$686.23. Reimbursement for postpartum services is billed and reimbursed separately at a per-unit rate and billed in 15-minute increments of \$12.13. There is also a one-time incentive payment of \$100 for doulas whose clients attend a postpartum appointment between 7 - 84 days after labor/delivery. 	DC

3. Credentialing and Enrollment Processes

Once the SPA has been approved, Medicaid agencies will prioritize getting doulas credentialed and enrolled into the Medicaid provider network. In most states, doulas are required to submit proof of training certification, get a National Provider Identifier (NPI) number,¹⁴ attest to having liability insurance, and pass a criminal background check.

The Medicaid credentialing, enrollment, and contracting processes are new and unfamiliar territory for doulas. There is a significant need for administrative support to help doulas navigate the process, which can be provided in different ways including through one-on-one support, trainings, toolkits, and peer-to-peer learning collaboratives. In **Oregon**, the state supports “doula hubs” that help doulas get the necessary credentialing, enroll to be a Medicaid provider, and contract with Community Care Organizations (CCOs).

States report facing challenges around credentialing, such as:

- **Helping independent doulas navigate enrollment processes** because the procedure is complex and unfamiliar, and independent doulas who are not a part of a doula organization are trying to navigate on their own.
- **Assisting doulas to present proof of certification**, as well as certificates for competency/topic areas.
- **Supporting doulas to navigate liability insurance challenges** and ensuring they have the appropriate coverage.
- **Helping to address bottlenecks with third-party vendor agencies.** For example, the fingerprinting process has posed a delay to enrollment in some states, and turnaround time for third party vendors can be long which leads to lags in enrollment.

COVERAGE IMPLEMENTATION

Medicaid agencies can work with doula stakeholders to craft mutually agreed upon certification requirements. This collaborative approach may help reduce the barriers that doulas have experienced in some states when trying to become credentialed and enroll as a Medicaid provider. From a health equity standpoint, using certification organizations that can help doulas overcome enrollment barriers may help support a more robust workforce. For example, **Rhode Island** outsourced doula certification to the Rhode Island Certification Board.¹⁵ The Board, along with Medicaid, the Department of Health, and doula stakeholders, worked together to create Rhode Island’s doula credentialing requirements. Eliminating fees for credentialing and/or to enroll as a Medicaid provider will also enable more doulas to complete the process.

Enrollment challenges can create a bottleneck in the process for doulas to become credentialed, contract with managed care organizations (MCOs), and provide services. To alleviate these challenges, states may consider housing the tracking and processing of credentialing and enrollment within a centralized “hub,” within their department of health or Medicaid, to follow each doula’s enrollment and contracting status. To support doulas to make it through the enrollment process without dropping out, state officials have realized

the importance of providing support through multiple points of contact that occur throughout the different stages of enrollment.

Some states are leveraging the partnerships between state Medicaid and public health agencies to mitigate some of these challenges. States may consider separating the credentialing and enrollment processes into different state agencies, e.g., the department of health manages the credentialing certification process while Medicaid manages the Medicaid enrollment side. **Virginia** found it helpful to have the support and collaboration between Medicaid and public health agencies around credentialing and enrollment.

New Jersey’s Medicaid and Department of Health worked together to develop the doula Medicaid benefit and various components for training, credentialing, and enrollment. **Exhibit 3** (below) outlines approaches states are implementing to increase the number of doulas who complete the credentialing and enrollment processes

Exhibit 3: State Approaches to Facilitate Doula Credentialing and Enrollment as Medicaid Providers

APPROACHES	STATE(S)
<ul style="list-style-type: none"> • Waive or minimize state application fees for doulas to enroll as a Medicaid provider. 	NJ, VA
<ul style="list-style-type: none"> • Encourage training organizations to offer sponsorships for doulas to complete training and credentialing. • Recruit and retain doulas through MCO investments. For instance, a plan may support a training initiative if it is trying to recruit doulas into a specific region. 	NJ, VA
<ul style="list-style-type: none"> • Create flexible enrollment processes that enable doulas to enroll as an individual or with a group to allow for more doulas to go through the process. 	NJ, RI
<ul style="list-style-type: none"> • Develop a process to add new state-approved certifying organizations. 	MD
<ul style="list-style-type: none"> • Offer education initiatives, e.g., how-to workshops for doulas on the Medicaid enrollment process that include information on fingerprinting and liability insurance, so that when doulas initiate the process there are no surprises related to requirements and timing expectations. It is important to do this especially for independent doulas. 	NJ, VA
<ul style="list-style-type: none"> • Work closely with doula organizations to ensure doulas receive hands-on support to assist them through credentialing and enrollment. 	VA
<ul style="list-style-type: none"> • Fund a technical assistance group or peer to peer learning collaborative run by doula champions to educate and assist doulas with enrollment. 	NJ
<ul style="list-style-type: none"> • Create a role or designated staff member at Medicaid to help doulas navigate the process. • New Jersey’s “doula guides” are Medicaid staff and help doulas enroll and obtain an NPI number. • In Oregon, the state requires CCOs to have a “liaison” specifically dedicated to assisting traditional health worker doulas. 	NJ, OR
<ul style="list-style-type: none"> • Work with the state's contracted provider enrollment vendor to troubleshoot common enrollment issues and increase successful applications. 	MD, VA

4. Training and Certification Requirements

States must determine the specific doula training and certification requirements to incorporate into their SPA. Working with doula stakeholders who represent the population served by Medicaid to help identify best mechanisms for training and certification can help ensure that training approaches are responsive to the needs of Medicaid members. There are key health equity considerations related to the types of training organizations that can be used and the ability of doulas, particularly those of color, to access and feel comfortable attending trainings. For example, states may want to consider: (1) developing a list of training organizations that reflect the cultural and linguistic aspects of communities most in need; (2) ensuring that options include BIPOC-led doula training organizations; and (3) providing accessible trainings to a wide range of doulas, e.g., trainings are affordable or offered at no-cost, and may be virtual or conducted throughout the state to increase doula participation.

SPA DESIGN

States are taking a variety of approaches to designing the training requirements that doulas must meet to become certified. Some states list or approve specific training organizations in their SPA that will satisfy the requirements, while other states list a set of doula core competencies in their SPAs determined by the state in communication with doula stakeholders, which serve as the training requirements.¹⁶ For instance, **New Jersey’s** Medicaid benefit is specifically a “community doula” service benefit, which requires additional training in delivering culturally competent care and community-based resources. **Exhibit 4** (below) highlights examples of state doula training requirements.

Working with doula stakeholders to determine the list of training organizations offered or gaining consensus on core competencies that reflect regional cultural and community aspects are important but can be challenging. Many of the national training organizations required for credentialing are typically white-led and may not offer training to meet the needs of diverse communities. To address this challenge, states are considering doula training approaches that are culturally reflective of the communities served, and accessible to a wide range of doulas. Considerations include training costs, duration, and number of and location of trainings. For example, doula stakeholders and state officials in **New Jersey, Oregon,** and **Rhode Island** have focused on the development and promotion of BIPOC-led community-based trainings.

Exhibit 4. State Approaches to Doula Training and/or Core Competency Requirements

APPROACHES	STATE(S)
<ul style="list-style-type: none"> A list of training programs is provided to reflect the communities most in need. Maryland and New Jersey both have nine approved training organizations and Virginia has 12 approved training organizations. 	MD, NJ, VA
<ul style="list-style-type: none"> Rhode Island uses core competencies instead of requiring a list of approved training organizations. Rhode Island Medicaid does not specify training requirements, instead it requires that doulas be certified by the Rhode Island Certification Board. Based on doula feedback, the certification process uses a core competencies model whereby doulas must obtain training hours relevant to specific perinatal doula domains, such as birth care, postpartum care, and cultural competency. 	RI

COVERAGE IMPLEMENTATION

There are several ways to structure training and certification requirements. Medicaid agency staff CHCS spoke with expressed the need to balance rigorous training and certification requirements that ensure doulas are well-positioned to help Medicaid members with the need to streamline processes to alleviate any barriers to doulas' participation in the Medicaid program.

Some states may choose to permit a “legacy pathway” or “experience pathway,” which is a way to credential doulas who have significant experience but do not have recent formal training. In **Oregon**, for example, the state established a way for doulas to demonstrate their experience through documentation of “attending 10 births and providing 500 hours of work supporting birthing persons and families as a birth doula.”¹⁷ If a doula provides this information to the state, they do not need a certificate from a training organization to become a credentialed provider. Key considerations in establishing legacy pathway requirements include assessing how long states will hold “pathway periods” or the time frame they have to submit their previous professional experience as a necessary qualification. States must also decide if the requirements must be adjusted for those with short-term previous professional experience.

Some Medicaid agencies are also considering partnering with other state agencies, such as the state department of health, to manage the training requirements for doulas. For instance, **New Jersey's** Medicaid agency leveraged an existing doula pilot housed in the state's Department of Health to develop and tailor its training requirements.

5. Managed Care Contracting

After enrolling in Medicaid, doulas will need to contract with MCOs to provide services to plan members. The contracting process can be difficult for doulas to navigate. Integrating doulas through managed care, particularly independent doulas, has been a challenge and has resulted in networks that are inadequate to meet Medicaid member demand. Other Medicaid providers usually work for health systems or large organizations that help them through the contracting process. However, doulas are a new Medicaid provider type and have little to no experience contracting with health plans. In addition, because most doulas are private pay, they do not have experience navigating health insurance.

In some states, doulas must fulfill multiple credentialing requirements for both state Medicaid and MCOs, which can add significant administrative time and complexity. Each MCO is likely to have a different credentialing process, which can hinder doula completion of the process, particularly for independent, sole-proprietor doulas. To alleviate this burden, MCOs in **Maryland** and **Virginia** agreed to accept state certification and do not ask for further credentialing or requirements, reducing a significant barrier and streamlining the contracting process.

COVERAGE IMPLEMENTATION

Building partnerships between states and MCOs allows for information sharing and developing opportunities to simplify implementation from both the MCO and doula perspectives. By offering MCOs guidance about key topics — such as rate-setting, contracting, and workforce — Medicaid agencies can clarify expectations so MCOs understand the processes necessary to implement doula coverage, as well as areas where there may be more flexibility and discretion. States can benefit from MCO input on the practical challenges of integrating a new provider type and benefit.

In **New Jersey**, each of the state’s five MCOs identify a plan-level point of contact to assist with contracting and claims help. States and MCOs have taken several strategies, outlined in **Exhibit 5** (*below*), to smooth the contracting process for doulas.

Exhibit 5. State Approaches to Streamline Managed Care Contracting for Doulas

APPROACHES	STATE(S)
<ul style="list-style-type: none"> Build strong state/MCO partnerships to help doulas through the contracting process. Some states have had extensive conversations with Medicaid MCOs to prepare and set expectations. 	MD, NJ, VA
<ul style="list-style-type: none"> Offer guidance that established rates are the minimum, and not necessarily the only rate that MCOs may use. States can clarify that MCOs have the flexibility to implement higher reimbursement rates if necessary to secure contracts with enough doulas to meet member demand. Most states explained that it was too early for MCOs to consider going above the minimum contracted reimbursement rate, but that it helps to keep the discussion open. 	OR
<ul style="list-style-type: none"> Communicate with MCOs about how to approach contracting and workforce demand from a network adequacy standpoint. 	MD

6. Practitioner Recommendation Requirements

Most states have adopted Medicaid coverage of doulas under CMS’ “preventive services” regulations,¹⁸ which requires that services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law.¹⁹ In these states, doulas do not need to be supervised by or receive a formal “referral” from a licensed maternity care provider, they only need to obtain a recommendation from a licensed provider. When using the preventive services authority, there are decision points about how best to implement the recommendation requirement, in terms of how the recommendation is secured and documented. CMS has not issued any public guidance on this requirement and states have some latitude on how best to implement the practitioner recommendation in a way that does not create additional barriers to accessing doulas.

Within this context, one barrier to doula practice pertains to confusion regarding a doula’s role in the care setting and whether licensed providers are willing to recommend doula services to patients. States report that doula stakeholders are anxious about the possibility of an obstetrics office not wanting to provide recommendations for doulas because providers have misconceptions or fears about practicing with doulas.

Provider awareness and education can be integral to creating more supportive care environments for doulas to provide services.

SPA DESIGN

Within the design of coverage, states can reduce barriers to practice for doulas by clarifying and simplifying the recommendation process, as well as allowing flexibility regarding the type of “licensed provider” who can recommend doula services. Some states allow for a wide range of licensed practitioner or clinician types who can recommend doula services, such as licensed clinical social workers. This flexibility makes it easier for patients to receive the recommendations necessary to obtain covered doula services. State engagement with doula stakeholders can help identify and overcome barriers associated with recommendation requirements.

COVERAGE IMPLEMENTATION

To better support doulas in providing services under Medicaid, Medicaid agencies can educate maternity providers about the recommendation process and provide clarity around the difference between a referral and a recommendation. It is also essential for states to educate health providers about the role of a doula, the evidence showing the benefits of doulas to birthing people, and the coverage components of the Medicaid benefit. For example, in **New Jersey**, the state’s hospital association educated providers about doulas, and the state reports seeing success in shifting culture. States have used different approaches to minimize barriers to using doulas, including those listed in **Exhibit 6** (*below*).

Exhibit 6. State Approaches to Implement Recommendation Requirements

APPROACHES	STATE(S)
<ul style="list-style-type: none"> Require documentation that a licensed practitioner recommended a doula. Documenting the recommendation in the patient’s electronic health record is sufficient as it allows for tracking. Doulas may also choose to obtain and then retain in their own records a written document from a licensed practitioner stating that the practitioner recommends doula services for a patient. Standing orders and/or protocols by licensed practitioners are also acceptable documentation. 	RI
<ul style="list-style-type: none"> Allow doulas to submit a doula recommendation form, or help facilitate a recommendation, using a paper form from the state website. In this case, a doula has already identified a client who is seeking service and the client would be given the form to take to their clinical provider for a “recommendation” signature. Doulas must obtain the form prior to service and include it for submission of claims. In this approach, providers are prevented from becoming a barrier to access. 	VA
<ul style="list-style-type: none"> Allow multiple ways of securing a recommendation, e.g., use a paper form or other documentation that doulas can maintain in their records or use a “perinatal risk assessment” form where a provider can check a box to recommend a doula. There is an option to refer through this route or provide a recommendation outside of that form. 	NJ
<ul style="list-style-type: none"> Allow a diagnosis of pregnancy to automatically create a recommendation for doula care. Maryland’s SPA approved that pregnancy itself constituted a “referral” for doula services, but the state is allowing MCOs to require prior authorization for doula services. 	MD

7. Workforce Development and Sustainability

Workforce development and sustainability refers to creating a well-trained doula workforce that is ready to meet the demand from Medicaid members.

COVERAGE IMPLEMENTATION

Most states reported that they would not be advertising the doula benefit until there was a sufficient enrollment to meet demand. Workforce development and expansion is also tied to the many aspects of SPA design and implementation as discussed in this brief, such as proper rate setting and reimbursement levels, administrative support for credentialing, enrollment, billing, and claims processing, as well as increasing provider education around the role of a doula. With an intentional approach across all of these elements of coverage, a diverse, well-trained, and sustainable doula workforce is possible.

One unique component of keeping doulas engaged as part of the Medicaid workforce lies in ensuring that doulas have access to hospitals for labor and delivery. States heard from doulas who expressed some concerns about their abilities to practice in hospitals among other care team members. During COVID, many hospitals tightened their visiting policies. One state shared that there were reported incidents of doulas not being allowed into an emergency department or labor and delivery floor because they were being counted as the friend or family member accompanying the birthing person into delivery. Counting doulas against allowed visitors during labor and delivery results in barriers for members to access the care they need. States have addressed these challenges by working to shift the culture around doulas and increase provider education.

Exhibit 7. State Approaches to Support and Sustain the Doula Workforce

APPROACHES	STATE(S)
<ul style="list-style-type: none"> Identify Medicaid staff to assist with fielding doula questions. Staff guided the first pool of doulas and worked with them to obtain feedback and develop FAQs and tip sheets that have been incorporated into all state doula presentations.²⁰ 	VA
<ul style="list-style-type: none"> Connect with doulas through listservs or Facebook groups to learn about doula pain points and assist doulas with workforce challenges. 	DC
<ul style="list-style-type: none"> Work with stakeholder groups, particularly “legacy doulas” who have significant experience, to establish core knowledge areas for “experience pathways” or legacy trainings. 	VA

Looking Ahead

Providing doula coverage for Medicaid populations offers promising opportunities to improve maternal and birth outcomes and reduce disparities for people of color. Many states, including California, are seeking to ensure doula access for Medicaid members and provide more culturally congruent support throughout the prenatal, labor and delivery, and postpartum period.

Involving community-based doulas in developing a SPA and launching the Medicaid doula benefit can help ensure that services are responsive to the needs of community members. In California, the Department of Health Care Services worked closely with doula stakeholders to inform development of the state's SPA application that was submitted to CMS in November 2022 with the doula benefit potentially set to go into effect in January 2023 pending CMS approval. California and other states can learn from states across the country that are in various stages of designing and implementing Medicaid coverage of doula services. Bringing together early adopter states as well as those that have more recently approved coverage to share successes and barriers to implementation provides key strategies for other states to consider.



ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

ENDNOTES

¹ Centers for Disease Control and Prevention, Working Together to Reduce Black Maternal Mortality. Available at <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>.

² Ibid.

³ Ibid.

⁴ K. J. Gruber, S.H. Cupito, and C.F. Dobson, C. F. "Impact of Doulas on Healthy Birth Outcomes," *Journal of Perinatal Education*, 2013, 22(1), 49-58. Available at: <https://doi.org/10.1891/1058-1243.22.1.49>.

⁵ Ibid.

⁶ "Doula Care Saves Lives, Improves Equity, And Empowers Mothers. State Medicaid Programs Should Pay For It," *Health Affairs Blog*, May 26, 2021. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20210525.295915/>.

⁷ For more information on Rhode Island's State Plan Amendment (SPA), see: Centers for Medicare & Medicaid Services. Available at: <https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0013.pdf>.

⁸ "Doula Care Saves Lives, Improves Equity, and Empowers Mothers. State Medicaid Programs Should Pay For It," op cit.

⁹ C. Bakst, J. Moore, K. George, K. Shea. *Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid*. Institute for Medicaid Innovation, May 2020. Available at:

https://www.medicaidinnovation.org/images/content/2020-IMI-Community_Based_Maternal_Support_Services-Report.pdf.

¹⁰ National Academy for State Health Policy. *State Medicaid Approaches to Doula Service Benefits*. October 2022. Available at:

<https://www.nashp.org/state-medicaid-approaches-to-doula-service-benefits/>.

¹¹ Ibid.

¹² Most states do not include SPA language that specifically states “miscarriage” or “pregnancy loss” support, however, states shared that the benefit does provide doula support for pregnancy loss in prenatal, labor and delivery care, or postpartum care. Only Rhode Island distinctly provides “bereavement” support after an outcome that does not result in a live birth.

¹³ State Plan Amendment (SPA) #: 17-0006, Oregon. Available at: <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf>.

¹⁴ The National Provider Identifier (NPI) number is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. For more information, see: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProviderStand#:~:text=The%20NPI%20is%20a%20unique,financial%20transactions%20adopted%20under%20HIPAA>.

¹⁵ Rhode Island Certification Board. For more information, see: <https://www.ricertboard.org/certifications>.

¹⁶ National Academy for State Health Policy. *State Medicaid Approaches to Doula Service Benefits*. October 2022. Available at:

<https://www.nashp.org/state-medicaid-approaches-to-doula-service-benefits/>.

¹⁷ For more information on how to become a traditional health worker in Oregon, see: Oregon Health Authority. Available at

<https://www.oregon.gov/oha/OEI/Pages/How-to-Become-a-THW.aspx>.

¹⁸ United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, Informational Bulletin, Update on Preventive Services (November 27, 2013). Available at: <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>.

¹⁹ Ibid.

²⁰ Virginia Medicaid. Department of Medical Assistance Services. Community Doula Program. Available at:

<https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/community-doula-program/>.