CENTER FOR HEALTH INNOVATION & POLICY SCIENCE
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CHIPS Policy Brief

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The Doula Option

An Opportunity to Improve Birth Outcomes in Washington State

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doula (doo-l*uh*) *n.*
A person trained to provide information, emotional support, and physical comfort to a birthing person before, during, and shortly after childbirth.

Unlike midwives, doulas do not provide any clinical care for the birthing person or infant.

Key Points

- Medicaid reimbursement of doula services has the potential to improve outcomes of infant mortality, low birthweight infants, and cesarean birth for Washington State families.
- Two states similar to Washington in both Medicaid managed care prevalence and enrollee demographics have experience with Medicaid coverage for doulas.
- States with existing Medicaid doula programs provide useful lessons learned as Washington considers implementing Medicaid coverage of doula services.

The Center for Health Innovation & Policy Science (CHIPS) is an interdisciplinary research center that works to improve health across communities and the lifespan—through innovation, evaluation, and training in health policy and health systems science.

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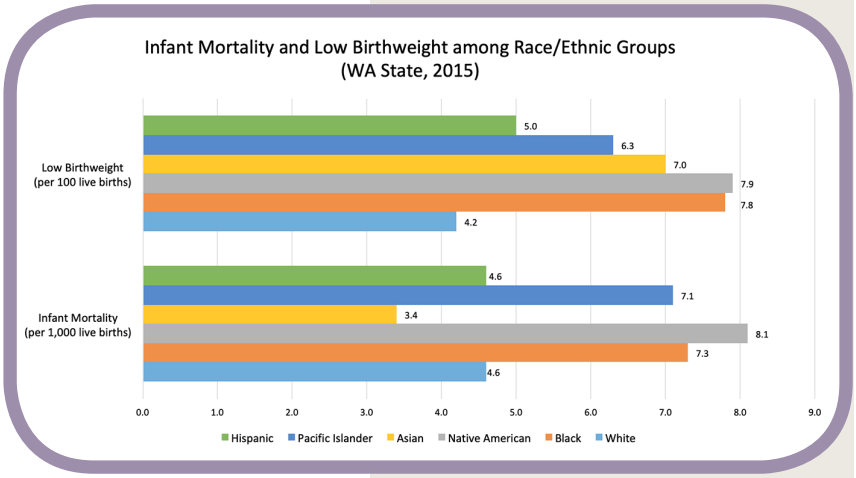
The Problem—and a Potential Intervention

Despite local and statewide efforts, perinatal health disparities persist in Washington State. Although infant mortality rates have dropped across all racial groups since 2005, Black, Native American, and Pacific Islander birthing people are still more than twice as likely to experience infant mortality compared to Asians.[1] Similar trends exist for low birthweight infants and cesarean birth, two risk factors associated with infant and maternal morbidity and mortality.[1,2] In 2015, the Governor's Interagency Council on Health Disparities recommended Medicaid coverage of doula services to address adverse birth outcomes.[3] The Governor's proposed 2019-2021 budget includes funding for doula coverage under Medicaid.



The Washington State Legislature is evaluating Medicaid coverage of doula services as a potential intervention to reduce racial disparities and improve birth outcomes for all families and children. This policy brief introduces the role and benefit of doula services, reviews Medicaid doula reimbursement programs in other states, endorses Medicaid doula coverage for Washington State, and makes implementation recommendations.

A birth doula is a trained professional who provides continuous physical, emotional, and informational support to a birthing person before, during, and shortly after childbirth.[4] Studies, including a recent Cochrane review, show that people receiving continuous labor support from a doula may be more likely to give birth vaginally without the assistance of forceps or vacuum, and report higher levels of satisfaction with their birth experience. Doula-supported individuals are less likely to have a cesarean birth, have a low birthweight infant, and give birth to a newborn with a low APGAR score (a metric used to determine if the newborn requires immediate medical attention after birth).[5,6] Furthermore, the Cochrane review found no evidence of harm from doula support, a rare finding in health care practice.[5]

Policy Implementation in Other States

Minnesota and Oregon mandate Medicaid coverage of doula services. Vermont, New Jersey, and New York have pending legislation proposing doula services for Medicaid enrollees.[6] The New Jersey and New York proposals provide limited details about their intended implementation models. However, New York launched a Medicaid doula pilot program in March 2019 as part of the governor's initiative to reduce maternal mortality and perinatal health disparities.[7]

In order for the state to receive federal matching dollars through Medicaid, a licensed clinician must submit the reimbursement claim. No states license

doulas, despite a variety of training and certification programs.[8] However, implementing and proposing states have developed various workarounds to receive federal Medicaid support for doula services. These workarounds are generally categorized into clinician intermediary and contracted billing systems.

Clinician Intermediary Billing for Doula Services

In 2013, Minnesota submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) allowing licensed clinicians (physicians, nurse practitioners, nurse-midwives) to bill for recommended services provided by non-licensed professionals. As a result, Minnesota doulas seeking Medicaid reimbursement must work under the supervision of a licensed clinician, who then submits billing for the doula's services under their National Provider Identifier (NPI) number. In addition to developing a professional partnership with a licensed clinician, Minnesota doulas seeking Medicaid reimbursement must be certified with a state-approved doula organization and be listed on the statewide doula registry.[8]

Vermont's proposed system is very similar to Minnesota's. If the legislation is approved, Vermont will also submit a State Amendment Plan to allow certified doulas to receive Medicaid reimbursement through a supervising licensed clinician. The Vermont bill includes additional doula requirements, such as documentation of training to work with special populations, which would require further definition if the legislation passes.[9]

Contracted Billing for Doula Services

When Oregon first approved doula reimbursement in 2012, its system shared many features with Minnesota's. In 2018, Oregon revised the state's reimbursement process for doulas to bill directly with their own NPI number. Doulas now contract, independently or as part of a community organization, with one or more of Oregon's 16 coordinated care organizations (CCOs). Similar to Minnesota, their services must be recommended by a licensed clinician and documented in the patient's medical record. CCOs are required to reimburse non-contracted doulas, however contracted doulas receive a higher reimbursement rate in an effort to attract and retain diverse and experienced practitioners to serve Medicaid enrollees.[8,10]

Most (92%) of Oregon's Medicaid enrollees are CCO members. The remaining 8% are fee-for-service clients. For these clients, the doula reimbursement system is very similar to the Minnesota model. Fee-for-service enrollees are primarily Native Americans and people who choose to give birth with direct-entry midwives. Under the Oregon model, doulas must be trained and registered as an Oregon Traditional Health Worker and attend a state cultural competency course. Like Minnesota, Oregon doulas must be certified by an approved doula organization and be listed on the state doula registry.[8,10]

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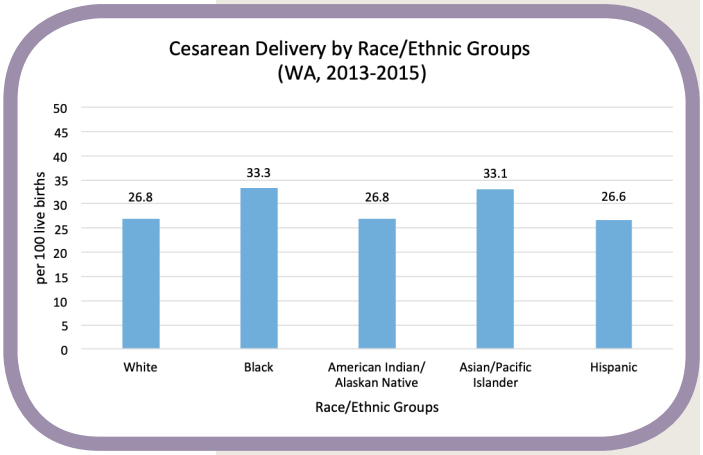

Similar to the updated Oregon model, doulas participating in the New York State Doula Pilot Program may apply for an NPI number and enroll as a New York State Medicaid provider. Doulas then contract with at least one of the state's Managed Care Organizations (MCOs). Unlike other states, New York only requires documentation of doula training, not certification. The New York State Doula Pilot Program currently partners with 11 of the 16 MCOs serving the two designated pilot counties. Doulas working in these counties may submit claims for Medicaid reimbursement beginning March 2019. Assessment of the pilot project will occur in 2021.[7]

Challenges

Both workaround models have been criticized for low reimbursement rates, excessive barriers for community-based doulas, insufficient training regarding issues critical to serving Medicaid populations, and misinformation about the new benefit within the existing healthcare system.[6,8,11] Low reimbursement rates disincentivize many doulas from caring for Medicaid patients. Those wanting to work with this population are frequently limited in the number of Medicaid patients in their care, as the doula must often prioritize patients who can pay out-of-pocket in order to sustain their practice.[11] New York's pilot program encountered this obstacle; one county did not launch due to low enrollment among doulas. Local doulas cited a reimbursement rate that was insufficient to cover the county's cost of living as a primary deterrent to participation.[12]

State	**Washington** non-FQHC / FQHC	**Oregon** FFS / CCO	**Minnesota**	**New York**	**Vermont**
Reimbursement rate	$688 / $1606	$350 / $600-800	$411	$510	Up to $750
Number of visits, plus birth attendance	5	5 / 7	7	8	Up to 6 hours, plus birth attendance
% of Medicaid population enrolled in managed care[a]	92%	93%	84%	77.2%	N/A
% of Medicaid population who are non-white[b]	46%	35%	44%	67%	12%
Current program status	Proposed	Mandated	Mandated	Pilot study	Proposed

[a]2018, Kaiser Family Foundation
[b]2017, Kaiser Family Foundation

Another barrier is the challenge of developing the mandatory intermediary relationships with licensed clinicians or contracted relationships with Medicaid payers.[8,11] Beyond establishing professional connections, becoming a Medicaid-reimbursed doula requires several steps, including certification, additional trainings, and state registration. The complexity and associated costs of these steps is viewed as a significant barrier for new, low-income, or community-based doulas who most resemble the Medicaid population.[6,8,11]

Furthermore, Minnesota doulas have reported needing training in topics such as trauma, infant loss, poverty, intimate partner violence, and structural racism to effectively support Medicaid enrollees.[11] Most doula certification training fails to sufficiently address these topics. Finally, few Medicaid managed care plans and licensed clinicians fully understand the Medicaid benefit and fail to share accurate program information with their Medicaid patients. As a result, some eligible Medicaid enrollees who want doula support are unable to access these services, despite doulas being available in their region.[6,8] As Washington considers Medicaid reimbursement for doula services, it should reflect upon these lessons learned from Minnesota, New York, and Oregon.

Recommendations

Washington should cover doula services under Medicaid to help improve birth outcomes and reduce perinatal disparities. The state continues to observe adverse perinatal health outcomes and gaping disparities, particularly for Black, Native American, and Pacific Islander families. In an effort to curb these trends, the Washington State Health Care Authority requested, and the Governor's 2019-2021 proposed budget included, funding to add doula services under the existing Maternity Support Services program. This novel approach to doula Medicaid reimbursement may mitigate many of the challenges experienced in other states. We recommend the following additional considerations for implementing a Medicaid doula program in Washington State:

- Ensure sufficient reimbursement rates necessary to attract and retain doulas. Washington's proposal may be more successful than the existing programs in Minnesota and Oregon, as it incorporates a reimbursement rate that is more closely aligned with the typical payment doulas receive. This decision is supported by the results of a cost-effectiveness study of Medicaid coverage of doula services among ten Midwestern states. The study concluded that the cost equivalency point, where the service costs were offset by the savings, ranged from $929 to $1,047.[13] Another cost-benefit analysis conducted by the Washington State Institute of Public Policy found that continuous support for women in labor from a doula, nurse, or volunteer moderately reduces the likelihood of a cesarean delivery, but the benefits do not exceed the costs.[14] However, this analysis is limited by only considering the costs and benefits of cesarean delivery. The benefits of a Medicaid doula program would likely exceed the costs by helping to minimize racial disparities linked to infant and maternal mortality, including low birthweight.
- Train doulas in topics relevant to serving the Medicaid population. The Health Care Authority should design and implement trainings on trauma, infant loss, poverty, intimate partner violence, and structural racism. These topics were identified as gaps in standard doula training by the Minnesota program. Washington doulas should be required to complete these trainings in order to receive Medicaid reimbursement.
- Fully educate Washington physicians, midwives, and insurance payers about the coverage and benefits of doula services. This would require engaging industry stakeholders in program design and outreach. A strategic, organized, and well-resourced roll-out and education campaign would ensure that all professionals receive accurate information.
- Develop diversity among the doula workforce. Registration fee waivers and training scholarships should be provided for low-income or racially diverse individuals who want to enter the doula profession or become eligible for Medicaid reimbursement. Several studies have discussed the importance of developing diversity among the doula workforce.[6, 8, 11] Washington's program should create a referral system so that Medicaid enrollees are paired with a doula who shares their cultural background or community.

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In Summary

Medicaid reimbursement of doula services has the potential to improve outcomes of infant mortality, low birthweight infants, and cesarean birth for Washington State families. The Health Care Authority's proposal provides a unique opportunity to expand the services of an existing state program while adding a new approach to the national conversation on improving perinatal health.

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