NATIONAL HEALTH LAW PROGRAM

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Routes to Success for Medicaid Coverage of Doula Care

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Introduction

Doulas are individuals who provide information and support for pregnant women before, during, and after childbirth. Doulas can also provide support for women during miscarriages and abortions. Doulas do not provide medical care or medical advice. Rather, they support women through in-home visits in the prenatal period, continuous support during labor and delivery, and in-home visits in the postpartum period. Doulas augment routine prenatal care for women by providing social and emotional support, individualized and culturally specific education, and strategies to reduce stress and other barriers to healthy pregnancies. Doulas help experience care that is safe, healthy, equitable, and woman-centered.

The benefits of doula care are widely recognized. Women receiving doula care have been found to have improved health outcomes for both themselves and their infants, including shorter labors, lower cesarean rates, and higher five-minute Apgar scores.[1] Babies born to mothers who had the support of a doula were less likely to have low birth weight than babies born to mothers who did not have support from a doula, and doula assistance has resulted in higher rates of initiation of breastfeeding.[2]

The potential impact of doulas on decreasing cesarean rates has been of particular interest to observers. One study found that doula support for Medicaid enrollees in Minnesota decreased the change of a cesarean delivery by 40.9%.[3] The same study estimated that state Medicaid savings from avoiding cesarean deliveries could exceed $2 million in most states.[4]

However, some advocates also caution that discussions about the benefits afforded by doula care should not rely overly on cost savings statistics and reductions in cesarean sections. So strong a focus on merely the potential measurable financial gains from doula care can mask the more fundamental social and emotional benefits that doulas afford for the women they support. This is particularly the case in the context of low-income and underserved populations that make up much of the population of Medicaid enrollees. As to reductions in cesarean rates, one author cautions that "…high cesarean rates are primarily a problem of obstetric culture and practice. The solution to this problem, then, needs to involve reforming obstetric practices from within, and cannot rest wholly on the shoulders of doulas."[5]

The author would like to acknowledge the valuable input and support provided by the following:
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[1] Meghan A. Bohren et al., Continuous Support for Women During Childbirth, 2017 COCHRANE DATABASE SYS. REV., http://www.cochrane.org/CD003766/PREG_continuous-support-women-during-childbirth.
[2] Kenneth J. Gruber, Susan H. Cupito & Christina F. Dobson. Impact of Doulas on Healthy Birth Outcomes, 22 J. PERINATAL EDUC. 49, 49 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727.
[3] Katy Backes Kozhimannil et al., Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries, 103 Am, J. Pub. Health e113, e113 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617571/pdf/AJPH.2012.301201.pdf.
[4] Id. at e117.
[5] Christine H. Morton & Monica Basile, Medicaid Coverage for Doula Care: Re-Examining the Arguments through a Reproductive Justice Lens, Part Two, SCIENCE & SENSIBILITY (April 2, 2013), https://www.scienceandsensibility.org/blog/medicaid-coverage-for-doula-care-re-examining-the-arguments-through-a-reproductive-justice-lens,-part-two. The author goes on to quote the 2012 Cochrane Report as follows: "Changes to the content of health professionals' education and to the core identity of professionals may also be important. Policy makers and administrators must look at system reform and rigorous attention to evidence-based use of interventions that were originally developed to diagnose or treat problems and are now used routinely during normal labours." (quoting Ellen D. Hodnett et al., Continuous Support for Women During Childbirth, 2012 COCHRANE DATABASE SYS. REV., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4175537/pdf/emss-58484.pdf).

While the benefits of doula care reach across all socioeconomic strata, due to limited coverage by Medicaid and private insurance, doulas work most often with clients who can afford to pay out-of-pocket.[6] Yet it is underserved populations, including women of color, immigrant women, and low-income women, who often cannot afford to pay for doula care, and who experience among the worst maternal health and birth outcomes in the United States.

Rates of maternal mortality in the United States are on the rise, in contrast to nearly every other developed country. According to the Centers for Disease Control and Prevention, the number of women dying as a result of pregnancy or childbirth in the U.S. is increasing. In 1987, an estimated 7.2 maternal deaths occurred per 100,000 live births, while in 2012 that number more than doubled to 15.9 maternal deaths per 100,000 live births.[7] The United States now has worse maternal mortality rates than every member of the Organization for Economic Cooperation and Development (OECD) except for Mexico.[8] Moreover, "[a]n American woman is about five times as likely to die in pregnancy or childbirth as a British woman."[9]

Equally troubling, the dismal maternal mortality rate in the United States masks significant race-based health disparities[10]. In general, women of color are less likely to have access to adequate maternal health care services and more likely to die in pregnancy and childbirth than white women[11]. The rates of maternal morbidity and mortality for black women and indigenous women are particularly high, and alarmingly so. Black women are three to four times as likely as white women to die of pregnancy-related complications[12]. These racial disparities in maternal mortality rates exist across all levels of income, age, and education[13] meaning that in the United States, a Black woman with a college degree is more likely to lose her baby than a white woman who has less than an eighth grade education.[14]

[6] See Bohren et al., supra note 1; Paula M. Lantz et al., Doula as Childbirth Paraprofessionals: Results from a National Survey, 15 WOMEN'S HEALTH ISSUES 109 (2005), https://www.whijournal.com/article/S1049-3867(05)00004-6/fulltext; Kozhimannil et al., supra note 3.
[7] Pregnancy Mortality Surveillance System, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 9, 2017), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.
[8] Marian F. MacDorman et al., Recent Increases in the U.S. Maternal Mortality Rate, 128 OBSTETRICS & GYNECOLOGY 447, 453 (2016).
[9] Nicholas Kristof, Motherhood is Deadlier in America, N.Y, TIMES, July 29, 2017, https://www.nytimes.com/2017/07/29/opinion/sunday/texas-childbirth-maternal-mortality.html.
[10] See Michelle Chen, Death by Birth: Race and Maternal Mortality, COLORLINES (Mar. 16, 2010), http://www.colorlines.com/articles/death-birth-race-and-maternal-mortality.
[11] AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA SUMMARY 7 (March 2010), http://www.amnestyusa.org/pdfs/deadlydeliverysummary.pdf.
[12] Pregnancy Related Deaths, CTRS. FOR DISEASE CONTROL & PREVENTION (May 9, 2018), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.
[13] See Linda Blount & Priya Agrawal, Why We Need to Pay Attention to Pregnant Women of Color, THINK PROGRESS: HEALTH BLOG (Dec. 5. 2014, 12:05 PM), http://thinkprogress.org/health/2014/12/05/3599978/disparity-maternal-health; Maternal Mortality Exceeds U.S. Goal; Age and Racial Differences Are Marked, 35 PERSPECTIVES ON SEXUAL HEALTH & REPRODUCTIVE HEALTH 189 (2003), https://www.guttmacher.org/about/journals/psrh/2003/07/maternal-mortality-exceeds-us-goal-age-and-racial-differences-are-marked. See generally GOPAL K. SINGH, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RESOURCES & SERVS. ADMIN., MATERNAL & CHILD HEALTH BUREAU, Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist 1 (2010), http://www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf.
[14] Richard Reeves, Dayna Bowen Matthew, 6 charts showing race gaps within the American middle class, BROOKINGS SOCIAL MOBILITY MEMOS, (October 21, 2016), https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class/.

It is important to note that racial health disparities are not due to any inherent difference between races (as there is no genetic marker for race). Researchers now theorize that these disparities can be traced to the chronic stress caused by a lifetime exposure to interpersonal and structural racism.[15] Structural racism, such as histories of redlining, discriminatory caracal practices, and income inequity have sustained these deep health inequities.[16]

Efforts to address maternal mortality rates in the United States abound. Among them, Medicaid coverage of doula care has emerged as a proposal that aims to ensure a higher quality of health care for low-income pregnant women, provide culturally appropriate and patient-centered care, and reduce the impacts of racism on pregnant women of color. Medicaid covers half of all births in the country and serves vulnerable and underserved populations, many of whom are women of color and immigrant women. Greater access to doula care for Medicaid enrollees could go a long way towards reducing health disparities by ensuring that pregnant women who face the greatest health risks during the maternal period are able to get the added support they need.

In order for doula care to become more widely available, state agencies, doula organizations, and other health care advocates must educate the public and the medical profession about the benefits and availability of doula care. Greater awareness of doulas, the benefits of doula care, and the scope of doula activities can help increase acceptance among the medical profession. Beyond providers, doulas and advocates for doula care must educate and promote doula care in communities where it is most needed. Doulas must learn to work with and recruit patients from demographics different than those who by and large currently utilize private pay doula services. Likewise, the demographics of much of the doula workforce is not an optimal culturally-sensitive match for the Medicaid patients who need them; states, agencies, and doula advocates must do more work to develop a culturally compatible workforce.

Meanwhile, a state seeking to implement Medicaid coverage of doula care must determine the best methods to include doula care as a covered medical service within their state Medicaid program. Federal guidelines have some flexibility, and Minnesota and Oregon provide examples of pathways to doula coverage that a state may take. Yet no single clear process has emerged for a state seeking to implement Medicaid coverage for doula care.

Lastly, federal requirements create potential billing and reimbursement barriers that doulas do not experience in the current private-pay model which most doulas employ. Like other providers seeking Medicaid reimbursement, must register in some way with their state. However, doulas may be less familiar with Medicaid processes than other providers, and must navigate both new professional referral patterns, as well as new models of billing and payment. Doulas may also be less likely to have access to organizational support or infrastructure to assist them with Medicaid reimbursement.

In this issue brief, we examine what we believe to be some of the most significant barriers to implementation of Medicaid coverage for doula care, focusing on workforce, payment, and billing and reimbursement issues. We then suggest potential solutions and make recommendations to overcome these barriers. We sincerely hope this work will be helpful to doulas, legislators, and state advocates and agencies in their efforts at successfully achieving Medicaid coverage of doula care.

[15] Braveman P, Heck K, Egerter S, Dominguez TP, Rinki C, Marchi KS, et al. Worry about racial discrimination: A missing piece of the puzzle of Black-White disparities in preterm birth, PLoS ONE, (2017), https://doi. org/10.1371/journal.pone.0186151.
[16] Linda Villarosa, Why America's Black Mothers and Babies Are in a Life-or-Death Crisis, NY TIMES, (April 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

How Does the Doula Fit in?

We should first say a word about the role of the doula in the context of the interdisciplinary team that provides medical care for a pregnant woman, which in addition to the doula could include physicians, midwives, and/or nurses. The doula's role as part of this team is critical to consider, since professional centrism – which occurs when one group views their profession as more central or important than that of another group – is one potential barrier to the expansion and broader acceptance of doula care. A better understanding of the services doulas can provide is important not only for the acceptance of doulas in the clinical environment, but also for gaining widespread support for Medicaid reimbursement.

The American Congress of Obstetricians and Gynecologists (ACOG) recently demonstrated affirmative support for doulas in their 2017 Committee Opinion paper, quoting the ***Cochrane Review of Continuous Support for Women During Childbirth***.[17]

Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula. A Cochrane meta-analysis of 12 trials and more than 15,000 women demonstrated that the presence of continuous one-on-one support during labor and delivery was associated with improved patient satisfaction and a statistically significant reduction in the rate of cesarean delivery. Given that there are no associated measurable harms, this resource is probably underutilized.

This committee opinion was subsequently endorsed by the American College of Nurse-Midwives and the Association of Women's Health, Obstetric and Neonatal Nurses. ACOG and the Society for Maternal-Fetal Medicine (SMFM) in a joint statement that also highlighted the benefits of doula support during labor.[18]

Nursing and doula support roles are distinct enough that individuals in both roles can respectfully collaborate for a positive birth experience and outcome for mother and infant. Nursing attitudes towards doulas will inevitably vary by the clinical setting and level of exposure to doulas, but educational efforts can solidify professional collaboration, as can certification of doulas.

[17] Committee on Obstetric Practice, Committee Opinion No. 687: Approaches to Limit Intervention During Labor and Birth, OBSTETRICS & GYNECOLOGY, e20 (2017), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Approaches-to-Limit-Intervention-During-Labor-and-Birth.

[18] American College of Obstetricians and Gynecologists, Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery, OBSTETRICS & GYNECOLOGY 693 (2014), https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery.

Table: Contrasting the Nursing and Doula Roles

Role of the Nurse	Role of the Doulas
Clinical tasks-vitals, monitoring fetal heart tones and contraction pattern, medications, intravenous access, vaginal examinations, asses for potential complications.	Supportive role - no clinical functions
Consults with physician or midwife.	No clinical responsibilities or decisions.
Intermittent presence-leaver for meal breaks, to care for other patients, and at change of shift.	Continuous presence - leaves patient's room only for bathroom breaks.
May have more than one patient.	Stays with one patient throughout labor and birth.
Keeps patient informed of the progress of labor, explains what is normal, and what to expect.	Keeps patient informed in lay terms of the progress of labor, what is normal and what to expect.
Advocated by communicating patient's desires to physician or midwife.	Advocated by helping the patient identify her questions and by helping her to communicate with health care staff. Does not offer direction regarding the womans approach to labor
Provides intermittent comfort measures and reassurance. Documentation responsibilities.	Provides one-on-one, continuous comfort measures and reassurance, including massage and touch, positioning for comfort, and to facilitate fetal rotation and descent.
Has legal responsibility for own actions.	No documentation as part of patient's chart. May keep own records or write "birth stories" for clients.
Usually no contact with patient once she is transferred to postpartum unit.	Follows a Code of Ethics; may be certified
	Follow-up postpartum visit, either in the hospital, in-home or by phone

Table 1 illustrates the distinct roles of doulas and nursing staff in the childbirth process[19]

[19] Lois Eve Ballen & Ann J. Fulcher, Nurses and Doulas: Complementary Roles to Provide Optimal Maternity Care, 35 J. OBSTETRICS GYNECOLOGY NEONATAL NURSING 304, 306 (2005).

Workforce Barriers to Doula Coverage

Licensure, Certification, and Credentialing

Matching federal Medicaid funds are almost always dependent on the service either being provided by or recommended by a licensed provider.[20] In 2013, the American Medical Association (AMA) established a definition for a qualified health care professional in terms of which providers may report medical services:

A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.[21]

From a state licensing authority perspective, and one that would be accepted by the Center for Medicare and Medicaid Services (CMS), licensing means that an individual meets educational, training, and professional standards of conduct. Many licensed qualified health care professionals have various certifications which demonstrate they have a specialized area of competence within the scope of their license.[22] Credentialing assures any hospital- or clinic-based health care worker meets certain requirements for entry into the facility.[23]

There are currently no formal mandatory licensure, certification, or credentialing requirements for doulas in the United States. As of mid-2018, there were over 100 independent organizations offering some form of doula training and certification, principal among them are four large-scale training organizations:

- The Association of Labor Assistants and Childbirth Educators (ALACE)
- DONA International
- Childbirth International (CBI)
- Childbirth and Postpartum Professional Association (CAPPA).[24]

A single national certification or set of guidelines adopted consistently by the states would provide uniformity for doula standards, but such does not presently exist. Regardless, any certification requirement either instituted by individual states or at a national level should not constitute an undue burden to entry, particularly for community-based doulas who have socially and culturally specific skills to most effectively serve the Medicaid population. Accordingly, doulas and doula advocates have proposed that states requiring doula certification and registration fees offer waivers for low-income would-be doulas, and that approved certifying and training organizations include a range of socially and culturally varied programs.

Since doulas offer non-medical support and work alongside doctors, midwives, and nurses rather than supplanting them, doulas as a profession have not sought licensing by state medical boards. This has enabled doulas to operate more flexibly than their more stringently regulated medical counterparts. Equally importantly, it has also allowed doulas to enjoy autonomy from the medical system, which in turn gives them credibility as more independently minded patient advocates. However, the lack of licensure has in some cases also limited doulas' ability to be compensated directly with federal funds.

[20] Renee Dustman, Define a Qualified Healthcare Professional, AMERICAN ACADEMY OF PROFESSIONAL CODERS BLOG, Jan. 1, 2015, https://www.aapc.com/blog/28964-define-a-qualified-healthcare-professional.
[21] Id.
[22] Id.
[23] See generally THE JOINT COMMISSION, https://www.jointcommission.org.
[24] List of Doula Certification & Training Programs compiled in July 2018, available at National Health Law Program Los Angeles Office.

The two states that have introduced Medicaid coverage for doula services – Minnesota and Oregon – have adopted a registration approach for doulas who seek reimbursement from Medicaid. Both states require that doulas seeking to serve Medicaid enrollees obtain some form of certification recognized by the state, as well as satisfy background checks and other requirements.

Federal matching funds for Medicaid spending currently apply only to payments to licensed providers.[25] States have the option to either add doulas to current licensing agencies, or to use a State Plan Amendment to allow licensed professionals to bill on behalf of non-licensed professionals for services recommended by the licensed provider. Both Minnesota and Oregon's State Plan Amendments designating doulas as Medicaid providers specify that the doulas must practice under the supervision of a licensed professional; however, as of 2018 Oregon doulas may bill directly for their services.[26] Requiring doulas to bill under licensed professionals can create a significant barrier to doulas seeking to serve Medicaid enrollees, as they must find a licensed provider to work with, bill for, and pay them.

In the Medicaid managed care context, federal law requires that all managed care network providers be enrolled in and screened by the state's fee-for-service system, including any applicable licensing or certification requirements.[27] As such, the same barriers described above in a fee-for-service Medicaid context continue to apply under Medicaid managed care.

Managed care plans can contract with alternative providers such as doulas to serve their members, but expenditures on such providers would not always be included in the development of the capitation rate that plans receive, and may count as an administrative expense in the plan's medical loss ratio.[28] This in turn could make plans less likely to include these providers. Still some health plans do choose to cover doula services, hoping that use of these cost-effective providers will lower costs.

[25]42 C.F.R. § 440.130(c); Social Security Act §1905(a)(13), 42 U.S.C. 1396d.
[26]"2014 Minnesota Approved State Plan Amendments." https://mn.gov/dhs/assets/14-07-spa_tcm1053-270737.pdf; "Oregon Approved State Plan Amendment." https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-12-007.pdf; "Permanent Administrative Order." Oregon Health Authority. https://www.oregon.gov/oha/HSD/OHP/Policies/130-0015-04022018.pdf.
[27]Social Security Act §1902(a)(78), 42 U.S.C. 1396d.
[28]Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed.Reg. 27527 (2016).

Diversity, Workforce Development, and Other Challenges

As several studies have observed and as noted above, present-day doula care has been largely limited to middle-class white women who can afford to pay for such services out-of-pocket.[29] The doulas serving these women also tend to be of the same socioeconomic class, and often approach doula work as a part-time occupation. To supplement the limited and sometimes irregular income stream from providing doula care, many doulas also conduct childbirth and doula education classes.

For doulas to be effective in providing culturally appropriate and patient-centered care for Medicaid enrollees, they must be recruited and trained in greater numbers from the same communities in which their services are most urgently needed. Researchers have found that doulas desire more training to better serve the Medicaid population. The standard doula curriculum lacks sufficient coverage on such topics as the social determinants of health, trauma-informed care, and other issues relevant for those serving Medicaid enrollees.[30] Additionally, the doula profession will need to provide sufficient pay to attract candidates who can make a sustainable living from providing this type of care.

Trained professional doulas often provide a certain amount of volunteer care in which their usual fees are waived or lowered. Many volunteer with community organizations to provide free doula care to low-income women. Other community-based organizations have also partnered with doulas to help serve their communities. HealthConnect One, for example, has worked with over 50 community health care sites in 20 states to train local doulas and assist in the development of doula programs for lower-income communities.[31]

The state examples that follow show in more detail how these workforce barriers have played out in Minnesota and Oregon.

[29] Paula Lantz et al., supra note 6; Kozhimannil et al., supra note 3.
[30] KATY B. KOZHIMANNIL, CARRIE A. VOGELSANG, RACHEL R. HARDEMAN, MEDICAID COVERAGE OF DOULA SERVICES IN MINNESOTA: PRELIMINARY FINDINGS FROM THE FIRST YEAR 9 (2015), https://static1.squarespace.com/static/577d7562ff7c5018d6ea200a/t/5840c791cd0f683f8477920a/1480640403710/FullReport.pdf.
[31] HEALTH CONNECT ONE, ANNUAL REPORT 2016 (2016), https://www.healthconnectone.org/wp-content/uploads/bsk-pdf-manager/HC1_Annual_Report_2016_FINAL_(11_23)_34.pdf.

Addressing Workforce Barriers in Minnesota and Oregon

State Example: Minnesota Doula Coverage

Doulas in Minnesota seeking to serve Medicaid enrollees must comply with state-level certification and registration requirements in order to receive Medicaid reimbursement.

First, doulas must be certified by an approved organization and register with Minnesota's doula registry.[32] The registry verifies doulas' certification and lists their location, certifications, contact information, and criminal history.

As of August 2018, the registry listed fewer than 60 individual doulas, and has been criticized for not listing doula organizations, which would better support efficient searching and potentially ease contracting with payers.[33]

At present, doula registration in Minnesota costs $200, in addition to training and certification fees that can range up to $800.[34] Certification and registration costs have been cited as hurdles that deter Medicaid-serving doula workforce growth in Minnesota.[35]

Additionally, doulas seeking Medicaid reimbursement must practice under supervision of a physician, nurse practitioner, or certified nurse midwife enrolled as a Minnesota Medicaid provider, in compliance with Minnesota's State Plan Amendment supervision guidelines. The supervising professional bills Minnesota Medicaid for the doula's services, and payment is rendered to the professionals National Provider Identifier (NPI) number.[36] Different arrangements may be developed if a doula practices as staff at a hospital.[37] Generally, it is not believed that billing providers take an administrative or other fee from the doulas' reimbursement.[38]

State Example: Oregon Doula Coverage

To serve Oregon Medicaid enrollees, doulas must first become a certified and registered Traditional Health Worker, which involves completing an Oregon Health Authority (OHA) approved curriculum and enrolling into the state registry. Oregon doulas must complete an $800 OHA-approved training program or receive equivalent credit from a national or international training program to be certified, and must also complete a cultural competency course.[39]

[32] Minnesota Doula Registry Frequently Asked Questions, MINNESOTA DEPARTMENT OF HEALTH http://www.health.state.mn.us/divs/hpsc/hop/doula/doulafaq.html.
[33] Kozhimannil et al., supra note 27, at ii.
[34] Minnesota Doula Registry, MINNESOTA DEPARTMENT OF HEALTH, http://www.health.state.mn.us/divs/hpsc/hop/doula/index.html; SMC Full Circle Doula Training, SHAFIA MONROE CONSULTING/BIRTHING CHANGE, https://shafiamonroe.com/doula-training-education/full-circle-doula/.
[35] Kozhimannil et al., supra note 27, at i.
[36] Id. at 20.
[37] Telephone Interview with D. Reis, Minnesota Department of Human Services, (Sep. 20 2017).
[38] Id.
[39] "OHA-Approved Traditional Health Worker (THW) Training and Continuing Education Unit (CEU) Programs," Oregon Health Authority, available at http://www.oregon.gov/oha/OEI/Pages/THW-Approved.aspx
"Full Circle Doula Training," International Center for Traditional Childbearing (ICTC), http://ictcmidwives.org/sample-page/full-circle-doula-training; "Traditional Health Worker Training Requirements for Certification." Oregon Health Authority, available at https://www.oregon.gov/oha/OEI/Pages/THW-Training.aspx.

In contrast to Minnesota, once registered the doula must obtain a unique NPI, enroll as an Oregon Medicaid provider, and enroll with or become a state-approved Medicaid billing provider.

In written testimony, Raeben Nolan, President of the Oregon Doula Association, noted that understaffing and underfunding of the OHA Office of Equity and Inclusion has complicated doulas' timely approval onto the state registry.[40] Advocates have also said they would like to see the functionality of the state registry expanded to include the extent to which a given doula is culturally specific and a doula's availability for a patient's due date, along with the doula's contact information.

As of August 2017, there were approximately 40 doulas enrolled in Oregon's state registry providing services across several Oregon counties.[41] The Oregon Doula Association reports that many doulas are still awaiting more data regarding Medicaid enrollees' utilization of doulas before investing in the lengthy certification and registration process, but anticipates that with their new ability to bill directly, more doulas will become Medicaid providers.

Workforce Barriers: Lessons Learned and Recommendations

There are substantial hurdles to developing a doula workforce that is both capable of serving the needs of the Medicaid population and is in a position to access payment streams, should they be made available. These include licensing and credentialing concerns, as well as identification and training of community-based doulas to meet socially and culturally specific needs. Yet these hurdles also point us to opportunities.

First, some form of qualification or credentialing is desirable for doulas to be uniformly accepted into the birthing environment and for insurers (be they private or Medicaid) to be in a position to pay claims for doula services. In order to facilitate the identification and payment of doulas through state Medicaid programs, states, doula organizations, partnering medical professionals, and health advocates should work together to develop a common set of criteria for doula qualification.

[40] Raeben Nolan, President, Oregan Doula Association, Testimony on HB 2015, https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/114889.
[41] Traditional Health Worker Registry, OREGON HEALTH AUTHORITY, https://traditionalhealthworkerregistry.oregon.gov/Search (select "Birth Doula" under certification type, then click "Search").

These qualifications could be implemented on a national basis. States should include a path to a basic, non-medical doula qualification to avoid excluding would-be doulas who cannot afford the financial or time burdens of many training programs.

Second, the inability for doulas to receive Medicaid payments directly in most states is a barrier that, in lieu of direct payment opportunities, can only be overcome with some form of nationally recognized licensure. The doula community has not embraced licensing in the past. However, in many locations at present the only alternative to licensing is to continue to be required to bill through and be reimbursed by licensed medical providers.

Finally, there is an opportunity for state departments of health and Medicaid managed care organizations to work with local and national organizations to develop the doula workforce within their states, focusing on identifying and training a robust doula workforce from within the communities in which services are most needed. For example, two managed care organizations in Oregon have funded grants to specifically certify doulas from diverse backgrounds, identify referrals from prioritized populations for care, and provide doula services accordingly.

Payment Barriers to Doula Coverage

Private Insurance Examples

In a private health care setting, the majority of doulas charge their clients directly based on services rendered, and discuss their fees up front. Payment is typically set to reasonably cover the doula's expertise, time, and travel expenses. Insurance does not typically cover these costs. Doula charges vary widely between different health care markets, and on the high end can reach up to several thousand dollars in some areas. Many doulas offer a sliding fee scale.

Private insurance companies typically detail the requirements necessary for health providers allowed to submit charges and receive payment. The insurance company has a credentialing process, billing requirements, and fee schedules. The current billing codes applicable to doula care apply to physician fee schedules only. Some private insurance companies may retroactively reimburse patients who have purchased doula services out-of-pocket on a case-by-case basis. In those instances, it is the patient who submits the claim for reimbursement and not the doula.

There is also some precedence for private insurance plans to include some level of doula care as part of the package of services they offer to their members. For example, Blue Cross and Blue Shield of Rhode Island (BCBSRI) implemented a pilot program for limited doula care, through which members of the health plan who delivered at Women and Infant's Hospital of Rhode Island received postpartum-only doula support.[42] The doulas were certified nursing assistants who received doula training. BCBSRI paid the hospital's Visiting Nurse Association (VNA) to train, manage, and pay those doulas. The pilot was limited in the scope of typical doula services and was discontinued due to lack of funding. The project was originally funded under the direction of leadership that has since left BCBSRI, thereby demonstrating that strong internal leadership is critical to add doula services in the private insurance market. Also, the number of plan enrollees who took advantage of doula services was fewer than originally expected, thereby demonstrating a greater need for both the health plan and individual physician providers to have marketed the doula services to plan enrollees and patients.

[42] Telephone Interview with Blue Cross & Blue Shield of Rhode Island (Aug. 21, 2017).

Preventative Services

The Affordable Care Act (ACA) mandates that all new health plans cover certain preventive services without cost sharing:

- items or services that have a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force;
- immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices;
- preventive care and screenings for infants, children, and adolescents contained in guidelines supported by the Health Resources and Services Administration (HRSA); and
- additional preventive care and screenings not provided for in recommendations of the United States Preventive Services Task Force, as well as additional guidelines supported by the HRSA.[43]

After the ACA was enacted, HRSA commissioned the Institute of Medicine of the National Academies (IOM) to recommend specific women's preventive health services.[44] HRSA subsequently adopted all of the IOM recommendations.[45]

Where a mandated preventive service is recommended by a licensed provider, most private insurers must allow coverage of that service without cost sharing, including instances where the service is provided by a non-licensed provider.[46] This would include coverage for doula care, if it were to be identified as a mandated preventive service.

[43] 42 U.S.C.A. § 300gg-13(a).
[44] Women's Preventive Services Guidelines, U.S. DEP'T OF HEALTH & HUMAN SERVS. HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/womens-guidelines-2016/index.html.
[45] Id.
[46] Early and Periodic Screening, Diagnostic, and Treatment, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

In the case of Medicaid coverage of preventive services, states have the option to cover the full slate of recommended adult preventive services. If they offer these services without cost sharing to all populations, they may receive a 1% increase in federal matching funds for those preventive services.[47] At least eight states (California, New York, Nevada, Minnesota, Oklahoma, West Virginia, New Jersey, and New Hampshire) have taken up this option.[48] In these states, adding doula services to the list of recommended preventive services would automatically result in coverage of doula services without cost sharing for pregnant women.

Notably, in all states, the recommended preventive services must be covered for all Medicaid expansion adults without cost sharing. Moreover, covered pregnancy-related services provided to pregnant women in Medicaid may not be subject to cost sharing.[49]

CMS regulations allow state Medicaid programs to create a charge and payment structure for covered services provided by licensed providers. For additional services that are not provided directly by licensed providers, a state may submit a Medicaid State Plan Amendment to include these preventive interventions as part of covered services so long as they are "recommended by a physician or other licensed practitioner within the scope of their practice under State law," thereby allowing Medicaid to pay for services provided by non-licensed providers such as doulas.[50] This is the payment method that both Minnesota and Oregon originally utilized for their Medicaid payments to doulas.

Regardless of how a state chooses to cover doula services, under the current framework, many doulas must still align with a licensed provider who recommends their services, and under some structures the licensed provider is still responsible for billing for the services and providing payment to the doula. For such a system to work, all health providers would need to be educated on the option of doula care for their patients, and state agencies, health plans, and health systems would need to develop efficient billing systems and paths of referral.

[47] 29 C.F.R § 2590.715.2713.
[48] Alexandra Gates, Usha Ranji, and Laura Snyder, Coverage of Preventive Services for Adults in Medicaid, KAISER FAMILY FOUNDATION, https://www.kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/view/print.
[49] Social Security Act §1916A(b)(3)(B)(iii), 42 U.S.C. 1396o-1.
[50] Cindy Mann, CMS Informational Bulletin: Update on Preventive Services Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, Nov. 27, 2013, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf; 42 C.F.R. § 440.130(c); Social Security Act §1905(a)(13), 42 U.S.C. 1396d.

Case Study: San Francisco

In January of 2019, San Francisco will begin an innovative program to provide community-based doula pregnancy care, to serve a priority population: Black and Pacific Islander communities accessing Medi-Cal. Grant funds from the San Francisco Department of Public Health to a community-based doula network, SisterWeb, will build, grow, and evaluate an innovative program model, supporting healthy births for populations in San Francisco experiencing significant health inequities. Urgency for the program was driven by a city-wide collective advocating for healthy births, Expecting Justice.

Community Partnership

SisterWeb (https://www.sisterweb.org) is a San Francisco network of community-based doulas of color. SisterWeb formed in 2018 as a way to organize doulas who were facing similar barriers; mainly low pay, lack of support, and challenging interactions on the labor and delivery floors of hospitals. SisterWeb will lead program delivery.

Program Components

- Direct doula services: SisterWeb will accept referrals from Medi-Cal prenatal providers, social service providers, and self-referrals. SisterWeb will match pregnant people with a doula. Doulas will provide 3 prenatal visits, support during labor, delivery, and postpartum periods, and 3 postnatal visits.
- SisterWeb will train and mentor doulas. SisterWeb anticipates training 20-30 women to become doulas in the first 6 months of the program, as well as training medical staff at San Francisco hospitals to work with doulas.
- The primary focus of the first year of funding is to build, grow, and evaluate the program.

Timeline

December 2018: Grant money to be distributed to SisterWeb
January 2019: Recruitment for new doulas from prioritized populations will begin
March 2019: Established SisterWeb doulas will begin seeing patients
March 2019: Training for newly recruited doulas to begin

Funding

The initial funding period is December 2018-June 2019, with a focus on sustainability from the San Francisco Department of Public Health. Total funding is $460K through a grant from the CPMC Innovation Fund, administered by the San Francisco Department of Public Health along with the San Francisco Foundation.

Questions?

For more information on this program, please contact Zea Malawa, Program Manager for Expecting Justice, **zea.malawa@sfdph.org**.

Medicaid Managed Care

Medicaid managed care (MMC) plans must provide all preventive services as defined above. MMC plans may also cover additional services not otherwise covered in their Medicaid State Plan benefit package "in lieu of" services explicitly authorized under the State Plan, as long as these services are deemed medically appropriate and cost effective by the state.[51] The capitated payment rate that plans receive would take into account the use of this service.[52] To the extent that a state agrees that doula services meet these standards, MMC plans in that state would have the option to cover doula services and would be reimbursed for the provision of those services.

Similarly, MMC plans may opt to spend their capitation payments to provide "value added" services not otherwise covered by the state. Unlike "in lieu of" services, these "value added" services are not accounted for in the calculation of capitated payments to plans. MMC plans may nonetheless choose to provide these services anyway because they improve care or reduce costs.

Medicaid Value-Based Payment Models

Many states are currently implementing broader care delivery and payment reforms as part of Medicaid demonstration projects, or Section 1115 waivers. Under these models, the risk-taking entity – a provider, accountable care organization (ACO), or managed care organization – has increased flexibility and incentives to deliver services that might decrease the overall cost of care provided to their patients, such as doula care. The risk-bearing entity typically agrees to provide a set of services for Medicaid enrollees for a set budget or within specific payment parameters, thereby taking on financial risk for the total cost of the set of services provided. In Medicaid managed care states, the state may require plans to participate in these innovative models.

Under a bundled payment model, providers are at risk for the costs of all care to treat a clinically defined episode of care over a specified length of time. Rather than tying reimbursement to specific services, a principal accountable provider is responsible for managing care within target costs for bundle. All services to treat that condition are reimbursed in one payment. Arkansas, for example, is implementing a bundled payment model for perinatal care which includes prenatal care related to labor and delivery, and postpartum care under a single budget.[53] While these models hold promise of more comprehensive and inclusive care and more flexibility to provide doula services, the inclusion of doula services in such a model depends highly on the design and services included in the bundle. These are decisions typically made by the state. The bundled payment model for perinatal care in Arkansas, for example, includes services that are typically reimbursed in the fee-for-service Medicaid program, which does not include doula services.

Under a global budget model, health care spending made by a risk-bearing entity is retroactively measured against an actuarially developed budget based on the expected costs of care. Providers must later return some or all of spending in excess of the budget. These models could, by design, include doula services as part of the overall package of services provided within the budget, and doing so could make care more cost-effective for the risk-bearing entity. However, doulas would need to individually negotiate such an arrangement with the risk-bearing entity that receives the state payments and manages the budget.

[51] "In lieu of services" are defined in managed care rules (42 C.F.R. § 438.3) as medically appropriate and cost effective services that a plan may substitute for a covered service or setting. Plans cannot require enrollees to use this alternative service, and these services are authorized and identified in a plan's contract with the State and offered at a plan's discretion.
[52] 42 C.F.R. § 438.3(2).
[53] Sarah Lally, Transforming Maternity Care: A Bundled Payment Approach, INTEGRATED HEALTHCARE ASSOCIATION 4 (2013), https://www.iha.org/sites/default/files/resources/issue-brief-maternity-bundled-payment-2013.pdf.

Under these models, providers are often able to negotiate gainsharing agreements with the risk-bearing entity to share in any savings created under the model. Doulas, given their demonstrated ability to create savings, could potentially negotiate to be included in these gainsharing agreements with providers or payers.

Medicaid Delivery System Reform Incentive Payment (DSRIP) Waivers

In several state Section 1115 waivers, CMS has approved additional funding directed at providers to help them transition to a more integrated delivery system and/or new payment models. These are known as Delivery System Reform Incentive Payment (DSRIP) waivers. DSRIP waivers list specific projects that participating providers must implement and meet specified performance metrics on in order to qualify for funding.

Providers participating in DSRIP waivers could spend their waiver funding to support innovative care models, including doula care. However, because payments are tied to outcomes and performance measures, waivers typically do not define how the recipients of these waivers must spend the funding.

Addressing Payment Barriers in Minnesota, Oregon and Private Insurance

State Example: Minnesota Doula Coverage

Doula services in Minnesota are covered for eligible Medicaid fee-for-service and Medicaid managed care enrollees pursuant to legislative directive and as codified in a 2014 Medicaid State Plan Amendment.[54] Medicaid will reimburse for doula services for up to seven prenatal or postpartum sessions with a Medicaid enrollee, one of which must be labor and delivery.[55]

As of 2015, Medicaid reimbursement per birth, including labor and delivery, was allowable up to $411.[56] There is no allowable reimbursement for travel. This rate was developed via the state's standard rate-setting methodology, which reduces the Medicaid reimbursement rate by a standardized percent to account for provider type.

[54] See MINN, STAT. § 256B.0625 (2017); Minnesota State Plan Amendment, TN: 14-07, https://mn.gov/dhs/assets/14-07-spa_tcm1053-270737.pdf.

[55] Doula Services, MINNESOTA DEPARTMENT OF HUMAN SERVICES, www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_190890#AR.

[56] In the 2017-2018 legislative session, proposed legislation was introduced to increase the reimbursement rate to $47 per prenatal or postpartum visit, up to a total of six visits; and $488 for attending and providing doula services at a birth. Minn. H. F. 2178, 90th Leg. (2017-2018), https://www.revisor.mn.gov/bills/text.php?number=HF2178&version=latest&session=90&session_number=0&session_year=2017.

While some consider Minnesota's Medicaid reimbursement rate for doula care to be low, others have pointed out that it is comparable to similar services paid to other Medicaid providers in the state.[57] However, the literature has cited the reimbursement amount as "an obstacle to sustainability and retention of doulas serving Medicaid beneficiaries, and a financial feasibility challenge for doula program administrators."[58] Licensed providers affiliated with hospital-based doulas, who do not see patients throughout their pregnancies, may only bill for services provided during labor and delivery, and are thus further limited in Medicaid reimbursement. One hospital doula program reported that the effort to obtain reimbursement through licensed providers on behalf of the program's employed doulas would outweigh the financial benefit derived from billing Medicaid.[59] In general, Minnesota's reimbursement rate, coupled with the administrative difficulties in seeking reimbursement, is a major barrier for doulas in the state seeking to serve Medicaid enrollees.

State Example: Oregon Doula Coverage

Oregon also has a Medicaid State Plan Amendment to cover doula services for eligible Medicaid fee-for-service and managed care enrollees.[60] Doulas are reimbursed through one of two pathways depending on whether a patient is enrolled in fee-for-service or one of Oregon's 16 coordinated care organizations (CCOs).[61]

Medicaid reimbursement of doula services for fee-for-service and CCO enrollees are set well below the costs for doulas to provide services.[62] A doula spends an average of 25-30 hours on each client, and in addition incurs business and travel expenses and taxes related to their work.

For fee-for-service enrollees, Oregon Health Plan (OHP) pays a $350 global rate that includes two prenatal support visits, continuous birth attendance beginning at the client's request through the immediate postpartum period, and two postpartum support visits.[63] If billed as partial services, fee-for-service reimbursement is $150 for attending the labor and delivery and $50 for each support visit. However, many stakeholders argue that Oregon's reimbursement rate still does not adequately compensate doulas' costs, which some have calculated to be at least $492 in total billing.[64]

[57] Telephone Interview with D. Reis, Minnesota Department of Human Services, (Sep. 20, 2017).
[58] Katy Kozhimannil & Rachel Hardeman, How Medicaid Coverage For Doula Care Could Improve Birth Outcomes, Reduce Costs, And Improve Equity, HEALTH AFFAIRS BLOG, July 1, 2015, https://www.healthaffairs.org/do/10.1377/hblog20150701.049026/full.
[59] Kozhimannil et al., supra note 27, at 16.
[60] Oregon State Plan Amendment, TN: 17-0006, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf.
[61] In 2012, Oregon implemented CCOs, a managed care model consisting of a network of health care providers who are paid a single global budget and can earn incentive payments based on quality metrics. In December 2016, total CCO enrollment reached approximately one million. OREGON HEALTH AUTHORITY, OREGON HEALTH SYSTEM TRANSFORMATION: CCO METRICS 2016 FINAL REPORT 15 (2017), http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf.
[62] Alice Taylor, Bright Eyes Midwifery and Wild Rivers Women's Health, Testimony on HB 2015, https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/114189.
[63] Oregon Medicaid reimbursement for doula services, OREGON HEALTH AUTHORITY, https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20reimbursement%20for%20doula%20services.pdf.
[64] Debra Catlin, Testimony on HB 2015, https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/114197.

For CCO enrollees, doula services are reimbursed out of the CCO's global budget. CCOs must pay doulas not contracted with the CCO the fee-for-service rate, but are generally expected to contract with doulas as managed care providers at a higher reimbursement rate.[65] As a result, a uniform reimbursement rate is not specifically outlined. The Oregon Doula Association advocates for a higher CCO reimbursement rate as compared to the fee-for-service reimbursement rate, so as to attract and retain a diverse and experienced doula workforce.[66]

There have also been broader issues arising from the CCOs. Although Oregon has defined billing codes for reimbursement of doula services, CCOs in some cases have failed to come to the table to negotiate contracts and reimbursement rates. Similarly, doulas have found some CCOs to be noncompliant with doula provider legislation.

Debra Catlin, a board member of the Oregon Doula Association, noted a lack of clarity in legislation, contract language, and communication regarding providers, payers, and CCOs' obligation to establish and utilize doula services.[67] Though some CCOs have worked closely with key doula representatives to address systematic issues, Oregon Doula Association members have had difficulty contacting other CCOs to discuss coverage of doula services, or have found CCOs to be noncompliant with current legislation.[68] Some Medicaid patients have reported requesting doula services but not receiving them, even though there are Medicaid certified doulas available in their region.

Payment Barriers: Lessons Learned and Recommendations

Doulas and their advocates often focus on payment issues, and point out that increasing reimbursement rates would lead to increased participation of doulas in Medicaid in both Minnesota and Oregon and others. Unfortunately, Medicaid payments for many services and provider types – not just doulas – are well below private rates and provider costs. Increasing payment, while a justifiable goal, will likely face state resistance and could result in competition for already limited Medicaid funding on the part of other provider groups.

That being said, states could opt to develop doula reimbursement rates based instead on the amount of time spent one-on-one with a patient, rather than using a standard rate-setting methodology. Such an approach would provide doulas with more equitable compensation based on the amount of time that they invest in their patients. It would also likely increase the number of doulas willing to enroll as Medicaid providers.

The examples of Minnesota and Oregon, both of which opted to develop a payment structure for doula services via a State Plan Amendment, serve to demonstrate the payment barriers that can exist to Medicaid doula coverage. In Minnesota, the Medicaid payment rate and other barriers to reimbursement have so far not resulted in significant participation: at present fewer than 70 doulas appear to participate in the Medicaid program. Meanwhile, in Oregon the payment pathway for doulas has only recently been operationalized, and successful instances of doulas billing directly for their services are still rare.[69]

The payment barriers to successful Medicaid coverage of doula care are substantial but not insurmountable. We can share some recommendations that would facilitate payment for a state seeking to implement Medicaid doula coverage.

[65] Communication with Oregon Doula Association, July 31, 2018.
[66] See Or. Admin. R. 410-130-0015 (2017); OREGON DOULA ASSOCIATION, http://www.oregondoulas.org/update-on-oregon-state-doula-care-program.
[67] Oregon Medicaid reimbursement for doula services, supra note 60.
[68] Communication with Oregon Doula Association, July 31, 2018.
[69] Id.

First, a state should streamline and organize the payment pathway for doula services. States pursuing doula payment in Medicaid should provide clear guidance to plans and providers on reimbursing doula services, including the codes to be used for reimbursement, prompt pay, and other payment standards which typically apply to other covered services.

Second, to the extent possible, states and advocates should push for doula services to be classified as preventive services under the USPSTF or HRSA and IOM Committee on Women's Clinical Services. Designating doula services as a preventive service would require every state to cover doulas under Medicaid.[70] Of note, a review of 41 birth practices in the American Journal of Obstetrics and Gynecology in 2008, using the same methodology as that used by the USPSTF, concluded that doula support was among the most effective of all those reviewed. In fact, it was one of only three services to receive an "A" grade.[71]

Third, states should explore ways to increase their flexibility to pay for doula services. States may be able to utilize innovative payment models and DSRIP waivers to provide funding for Medicaid doula care. In doing so, advocates for doula services must work closely with their state and relevant state agencies to both advocate for and ensure inclusion of doula care in the bundle of services to be provided.

Billing and Reimbursement Barriers to Doula Coverage

Requiring doulas to work under a licensed Medicaid provider who is willing to bill on their behalf naturally creates barriers by adding an intermediary to the billing and reimbursement process for Medicaid doula care. Additionally, when doulas or the licensed providers who bill on their behalf contract with MMC plans, rather than contracting directly with a state Medicaid program, billing practices and requirements will likely vary between individual plans. As such, billing in the context of Medicaid managed care may be more administratively burdensome for doulas than in the context of Medicaid fee-for-service.

Addressing Billing Barriers in Minnesota and Oregon

State Example: Minnesota Doula Coverage

There are limited pathways to Medicaid managed care provider enrollment or supervisory relationships for doulas in Minnesota. This has prevented doulas from establishing successful relationships with licensed Medicaid providers for billing purposes and has served as a further deterrent to serving Medicaid patients. Most independently practicing doulas lack the infrastructure to align with a medical professional who can bill Medicaid, and even nonprofit doula organizations with more robust infrastructure lack sufficient billing guidance from the state.[72]

Doulas have struggled to find licensed billing supervisors in Minnesota, perhaps in part due to unwillingness on the licensed providers' part to take on the perceived risk associated with an additional provider.[73] Supervisory oversight is a stipulation of Minnesota's State Plan Amendment that allows for doula reimbursement, and thus cannot at this time be altered. Discussions have occurred within the doula community about whether doulas should seek to become direct licensed Medicaid providers, which would allow doulas to forgo the need of a billing intermediary.[74] However, there has not been consensus around licensure, and in the near future it seems unlikely this is a path that the broader doula community would advocate.

[70] 29 C.F.R. § 2590.715-2713.
[71] Vincenzo Berghella, Jason K. Baxter & Suneet P. Chauhan, Evidence-Based Labor and Delivery Management, 199 Am. J. Obstetrics & Gynecology 445 (2008).
[72] Kozhimannil et al., supra note 27, at 15.
[73] Telephone Interview with official of Minnesota Department of Human Services (Sept. 20, 2017).
[74] Id.

State Example: Oregon Doula Coverage

With the implementation of direct doula billing, Oregon doula billing services must now enroll into each CCO's system. Because doula services may be provided only at the request of the practitioner and be specifically noted in the patient's medical records, provider education and a coordinated referral system are needed to support doula service take-up. This process demands close collaboration between the doula and other Medicaid providers. State certified doulas in counties or regions of the state are beginning to form groups or "hubs" to work together for billing purposes, streamlining referrals and back-up, and peer support. Their challenge is now to be able to reach the providers in a coordinated and efficient way to create such collaboration.[75]

The Oregon Doula Association is currently promoting a billing structure to serve CCO patients in which CCOs contract with doula businesses or community-based organizations which have a group National Provider Identifier, are enrolled as a billing provider, and can submit claim forms and reimburse doulas. Several entities are currently following this approach and many more are in the process of applying to do so. The Association expects billing through doula businesses and community-based organizations to be the primary pathway to reimbursement for both fee-for-service and CCO enrollees.[76]

Greater awareness and acceptance of doulas as part of the team providing maternal health care appears to be the most significant barrier to identifying licensed providers willing to work with doulas. According to the Oregon Doula Association, Oregon providers have widely varying experience with doulas. While many are supportive of doula care, others have very limited exposure.[77] A primary concern of many providers is the perception that doulas unduly influence a patient's medical decisions.[78] Furthermore, The Oregon Doula Association also notes that Oregon providers are often not knowledgeable about the state's doula program and services that doulas offer. To address this situation, the Association has convened a doula learning collaborative and drafted provider materials on utilizing doulas to be distributed once billing and payment structures are in place with the CCOs.[79]

Billing and Reimbursement Barriers Lessoned Learned and Recommendations

Unless doulas are permitted to bill Medicaid directly or otherwise pursue licensing, doulas will not be able to universally obtain payment directly from Medicaid, and will have to continue to rely on a licensed Medicaid provider to serve as a billing intermediary. Such relationships between doulas and providers can be successful if there is mutual understanding and professional respect between doulas and the billing providers they work with. However, thus far, health care professionals and entities have been slow to incorporate doulas into their care plans. Broader public education efforts about doulas and doula care can go a long way towards greater understanding, awareness, and acceptance of doula services.

It is also important for doulas and advocates for doula care to spread greater awareness about doula services to payers who are unused to reimbursing for doula services. Embedding themselves into the wider health care delivery system will allow doulas to emphasize the value of their services and encourage more Medicaid enrollees to utilize the valuable services that doulas provide.

[75] Communication with Oregon Doula Association, July 31, 2018.
[76] Id.
[77] Telephone Interview with Oregon Doula Association (Aug. 22, 2017).
[78] Id.
[79] Id.

Conclusion and Tailoring It to Your State

As detailed in the graphic below, navigating Medicaid payment and coverage rules is a formidable task, given the immense variation between each state's program and between different plans and delivery models within each state. Advocates for expanded doula services must tailor their messages to different states depending on current reimbursement practices, the presence and practices of Medicaid managed care plans, state participation in new and innovative payment models and waivers, state licensure and certification rules, state benefit mandates, and a host of other program design factors. Doulas and advocates for doula care must also pursue better integration of doulas into the health care system as a whole so as to effectively advance Medicaid coverage for doula services. The formation and sustainability of these relationships are in some cases beyond control of State Medicaid Agencies, and instead will depend on doulas, advocates for doula care, and the broader community of health care providers.

The interest and involvement of state legislatures is also important to implementation of doula coverage. In both Minnesota and Oregon, the state legislatures served as the initial impetus for Medicaid coverage of doula services. Thus, state advocates focused on gaining Medicaid coverage for doula services could look to state legislation as a key starting point to aligning stakeholders and gaining momentum for their efforts.

Finally, national pathways to increased doula coverage in Medicaid must not be overlooked. Gaining USPSTF designation of doula care as a preventive service would result in automatic coverage of doula services without cost-sharing in Medicaid in many states and in most private insurance plans, representing immense promise in increasing access to doula services.[80]

"We need black doulas. There is a crisis with black women having babies in America. Black women and their babies are dying at alarming rates. And we need other black women to stand beside them and help them survive. One of the ways you can do that is through doula work, birth work, becoming a midwife or an obstetrician."

-Marna Armstead, Doula and Co-founder of SisterWeb,
San Francisco

[80] 29 C.F.R § 2590.715.2713; Coverage of Preventive Services for Adults in Medicaid, KAISER FAMILY FOUNDATION, https://www.kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/view/print.

Paths to payment for services are dependent on a combination of Medicaid mandates for a services, licensure or certification, and referrals.