Issue Brief: A Guide to Proposed and Enacted Legislation for Medicaid Coverage for Doula Care

By: Alexis Robles

As maternal mortality is increasingly recognized as a national health crisis, especially for women of color, providing doula services to pregnant people is being upheld as a means of reducing high rates of maternal mortality in the U.S. Although we know that maternal mortality impacts Black women at every level of education and income, doulas are particularly difficult for low-income women to afford. For this reason, the National Health Law Program has been advocating for Medicaid reimbursement for doula care, to provide low income women this method of birthing support.

Currently, Minnesota and Oregon have had doula coverage for Medicaid enrollees for several years. Minnesota covers doula care through legislation enacted in 2013 and implemented after the approval of their State Plan Amendment in 2014. Oregon enacted legislation under HB 3650 for Traditional Health Workers in 2011. A growing number of states have also been interested in this topic. In the first half of 2019 alone, 12 states introduced bills or budget items relating to Medicaid coverage of doula care, and two states – New Jersey and Indiana – have passed enacted legislation. These bills have some commonalities but vary widely in defining doulas, credentialing, reimbursement rate, and workforce issues.

Below are some of the major themes in enacted and proposed doula coverage legislation.

Doula Definition & Scope of Practice

According to DONA International, a doulas is defined as "a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and short after childbirth to help her achieve the healthiest, most satisfying experience possible." This language is mostly reflected in current bills with some differences. Most bills define doulas similar to Connecticut's SB 1078, by describing the services provided:

> 'state-certified doula' means a trained, nonmedical professional certified by the Commissioner of Public Health to provide continuous physical, emotional and informational support to a pregnant person during the antepartum and intrapartum periods.

Some bills like Arizona's HB 2605 go into more detail about the role of doulas vis-à-vis the medical staff, defining doulas as (emphasis added):

Doula definition: MA HB 1182

"A trained professional who provides physical, emotional, and informational educational support - but not medical care - to mothers before, during, and after childbirth, otherwise known as the perinatal period. Doulas also provide assistance with connecting childbearing individuals to Community-Based Organization (CBOs)."

Massachusetts' HB 1182[1] stands out in its inclusive language when defining doula support. This bill includes not only childbearing individuals but also "surrogates, foster care, and adoptive parents before, during, and after labor and childbirth." This bill also includes advocacy in the doula's scope of practice by including accompanying childbearing individuals to their health care or social services appointments and connecting them with community-based and state or federally funded resources.

As reflected in these differing definitions, doulas are not considered trained medical professionals. Doulas function as advocates and support for the childbearing person.

Credentialing & Registry

Credentialing has been a point of contention in many of the bills, because credentialing requirements can often create a barrier to working as a doula. All the bills require some type of training or certification for doulas to be eligible for Medicaid reimbursement. Some state proposals, like Illinois' HB 0004, specify that doulas must complete specific training and have a certification from a nationally recognized doula organization.

Massachusetts' HB 1182 requires doulas to have a National Provider Identification (NPI) number and have completed all required MassHealth Provider Enrollment Forms to receive reimbursement through Medicaid. Connecticut's SB 1078 requires a fee of $175 to be submitted with an application to become a certified doula for that state. In addition, both state bills require that doulas demonstrate specific competencies like completing a certain number of contact hours in education and training, attending a minimum of breastfeeding and childbirth classes, attending two births, completing cultural competency training, and completing training in client confidentiality (including HIPAA), among others. This can be demonstrated by a letter from a state, national, or international doula certification organization or by a signed attestation from the doula. By contrast Arizona's HB 2605 waives training and education requirements if a doula can provide documentation or current certification with a nationally recognized doula program. This bill does not name any specific doula program.

Massachusetts' bill is creating a doula care commission that will make recommendations for specific core competencies, and its membership must be comprised of at least three-fourths doulas. This commission seeks to include a diversity of experiences in terms of race, ethnicity, sexual orientation, gender identity, survivors of sexual or birth trauma, those with varying abilities, levels of education, residency status, and professional occupations. This commission not only seeks to develop standards for competency for doulas but also to represent the

[1] The language referenced in this issue brief is proposed and has not been updated officially as of 8/27/2019

interests of doulas, receive any grievances, oversee communications to stakeholders, and more.

In addition, completing credentialing requirements allows doulas to become part of a statewide registry of doulas. However, the registry sometimes has additional requirements like Connecticut's SB 1078 which requires doulas to go through a vetting process that includes positive client references and liability insurance. The requirements of this bill also list actions that would involuntarily exclude a doula from the registry such as conviction of a felony committed while performing doula services, "physical, mental, or emotional illness or disorder resulting in an inability to competently perform doula services."

Reimbursement

Reimbursement of doula services also varies greatly. Currently, doulas range from volunteers who do not charge their clients, to doulas who charge up to $2,500 or more for their services. The state bill proposals typically include a range or a cap for Medicaid reimbursement. The minimum reimbursement in the Massachusetts' bill is $1,250 for labor and delivery support, and $100 per visit in the prenatal period. Massachusetts also will allow for billing up to one year following birth, stillbirth, miscarriage, or loss. In addition, ongoing postpartum doula care will be reimbursed at $25 per hour. Finally Massachusetts covers postpartum doula services up to 320 hours except in cases of premature birth, traumatic birth, or loss which does not a have specific reimbursement rate. The Connecticut bill includes a reimbursement range of $900 to $1,500 per pregnancy, depending on the services provided. These services include: prenatal visits, physical and emotional support, telephone or virtual communications, time on call for a birth, time spent on support during a birth, postpartum visits, and time spend on administrative tasks. This bill does not specify the rates of each service.

Vermont's reimbursement fees

"$25 per hour for prenatal visits, not to exceed four hours; a flat fee of $550 for physical and emotional support for the entire course of the mother's labor, and delivery, which shall include unlimited telephone and e-mail contact and the doula's commitment to be available on an on-call basis; $25 per hour for postpartum visits, not to exceed two hours; and up to $50 for administrative expenses."

Vermont's H 219 details the total allowed reimbursement for specific activities and caps their reimbursement at $750:

Low rates of reimbursement are especially concerning for doulas, particularly for full-time doulas, as the hours worked and reimbursement may not amount to minimum wage. One alarming example of low reimbursement rates occurred in New York's Medicaid doula pilot program which paid only $30 for each prenatal and postpartum visit with up to four of each and $360 for birth attendance with a maximum reimbursement of $600. Furthermore, the initial low reimbursement for doulas in Minnesota and Oregon after their implementation is a potential cause of the slow uptake in those states.

Whether doulas can get reimbursed for post-partum care is another issue. Connecticut does not establish a time limit for postpartum care. Rhode Island, specifies that doulas may be reimbursed up to one year postpartum. Massachusetts' bill is the most specific and generous in that doulas can be reimbursed for up to a year following birth, stillbirth, miscarriage, or loss and not to exceed 320 hours except in specific cases.

Workforce

With respect to workforce issues, doulas and midwives are sometimes seen as trendy and exclusive. Certainly, the cost can give the perception that they are a luxury instead of a necessity. The natural birth movement has largely been spearheaded by white and middle to upper-class individuals to serve a population of white and middle class pregnant people, without addressing the needs of non-dominant populations.

People of color, immigrants, low-income, and LGBTQ+ people have often struggled for adequate access to doula care. In addition, racism has an insidious and enduring effect on health, which is particularly noticeable in the high rates of black maternal mortality. Recent research described in ADVANCING BIRTH JUSTICE: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities by Ancient Song Doula Services, Village Birth International, and Every Mother Counts, highlights the importance of culturally competent, linguistically accessible community based doulas. Community-based doulas are doulas who come from or are familiar with, and are situated in, the communities they serve. Community-based doula programs often provide more holistic support for comprehensive care like more in-home visits and referrals to other programs. In the context of Medicaid coverage for doula care as a method for increasing services to underserved populations, community-based doulas are ideal.

Some bills have included language to promote this level of cultural competency in their reimbursement models. For example, Massachusetts' H 1182 specifies that doulas are required to complete cultural competency training but does not specify other ways of supporting community-based or bilingual doulas. One example of supporting a community-based doula program is the Los Angeles based Health Net Community Doula Program which is an initiative of Health Net and The Association for Holistic and Newborn Health. This program seeks to provide doula support to African-American/Black families in Los Angeles County. They seek to model a program that has doulas from the same community as the pregnant people they support with cultural competency and linguistic capabilities, understanding and empathy when pregnant people experience discrimination and stress, and have a longer relationship than usual with support from early pregnancy to postpartum. The San Francisco Department of Public Health, Expecting Justice, and a community doula network called SisterWeb are collaborating on a Bay Area-based pilot program that is also making strides to support community based doulas and communities of color. In this program, SisterWeb trains, mentors, and supports doulas from the communities with high maternal mortality rates to provide culturally competent care. SisterWeb is working with San Francisco General Hospital on a pilot program of eight births with Latina mothers. Doulas are brought on as independent contractors and will be mentored and financially supported throughout the program. Ultimately, this program will be evaluated by University of California, Berkeley

researchers in the hopes of demonstrating the value of continued funding for programs like these.

Conclusion

State bills that seek to address maternal mortality by providing coverage for Medicaid enrollees should be cautious not to create more barriers for community based doulas in their credentialing and reimbursement policies. States should also consider being more intentional in building up community-based doula models for providing care to Medicaid enrollees that are culturally competent and linguistically accessible, so as to fully support communities that are most impacted by birth disparities. Moreover, doulas offer an important path to address maternal mortality, but they are not a panacea. Racism, economic barriers, and more continue to contribute to rising rates of maternal mortality and morbidity, especially for women of color.

For more information on the National Health Law Program's work on Medicaid coverage for doula care, please see our Doula Medicaid Project page, which includes trackers for state and federal bills relating to Medicaid coverage for doula care, as well as publications and resources on the topic from both NHeLP and others.