IT TAKES A VILLAGE

Pathways for Achieving Access to Doula Services for Medicaid Enrollees

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Table of Contents

Introduction

The United States is facing a maternal health crisis, and one that has a disparate impact on communities of color. The country's maternal mortality rate is more than double that of most other high-income countries, at 17 maternal deaths for every 100,000 live births.[1] Analyzing this by race reveals a striking disparity – the maternal mortality rate for Black mothers is 37.1 per 100,000, compared to 14.7 for white mothers.[2] Severe maternal morbidity affects 50,000-60,000 women each year, and Black women have a 70% greater risk of experiencing severe maternal morbidity.[3] Doulas are birth workers that support women throughout the pregnancy process, and receiving doula services has been shown to have significant positive effects on maternal morbidity and mortality and to lower overall healthcare costs. However, doula services can be cost prohibitive for low-income families, many of whom are enrolled in Medicaid.[4] Medicaid covers 42.3% of births in the country, and over 65% of births of Black women.[5] This paper will explore how grassroots advocates can leverage existing policy pathways to ensure Medicaid enrollees can access doula services.

What Doulas Do

Birth doulas are non-clinical professionals that provide emotional, physical, and informational support throughout the reproductive process.[6] Doulas do not replace medical providers; rather, doulas provide support that medical providers cannot or do not provide, typically throughout the prenatal, labor and delivery, and postpartum periods. Birthing parents who receive doula support report more positive birthing experiences and have better health outcomes, and these benefits are particularly acute for people of color and people from low-income and underserved communities.[7] These families face the greatest risks, and doulas can serve as a critical advocate

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[1] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, THE COMMONWEALTH FUND (Nov. 18, 2020) https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.

[2] *Id.*

[3] Eugene Declercq & Laurie Zephyrin, *Severe Maternal Morbidity in the United States: A Primer*, THE COMMONWEALTH FUND (Oct. 28, 2021) https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer; Kylea L. Liese, *Racial and Ethnic Disparities in Severe Maternal Morbidity in the United States*, 6 J. RACIAL & ETHNIC HEALTH DISPARITIES 790, 790 (2019) https://doi.org/10.1007/s40615-019-00577-w.

[4] Renee Mehra, *How Full-Spectrum Doula Care for Low-Income Californians During Pregnancy and Early Parenthood Can Improve Their Health and Reduce Costs to the State*, SCHOLARS STRATEGY NETWORK (Sept. 15, 2021) https://scholars.org/contribution/how-full-spectrum-doula-care-low-income;
Cara B. Safon et al., *Doula Care Saves Lives, Improves Equity, and Empowers Mothers: State Medicaid Programs Should Pay for It*, HEALTH AFFS. (May 26, 2021) https://www.healthaffairs.org/do/10.1377/forefront.20210525.295915/full/.

[5] JOYCE A. MARTIN ET AL. 68 NAT'L VITAL STAT. REP. (Ctrs. Disease Control, Nov. 27, 2019) https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

[6] *What is a Doula?*, NAT'L HEALTH L. PROGRAM (Apr. 16, 2020) https://healthlaw.org/wp-content/uploads/2020/04/WhatIsADoula_4.16.2020.pdf.

[7] Kenneth J Gruber et al., *Impact of Doulas on Healthy Birth Outcomes,* 22 J. PERINATAL EDUC. 49, 49 (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/;

for their patients' needs.[8] In addition to reducing health disparities, continuous doula support has been shown to reduce healthcare costs by avoiding expensive healthcare emergencies, like cesarean sections.[9] Despite the many demonstrated benefits of doula services, most health insurance plans do not cover doulas and having a birth doula is often seen as a luxury that low-income women cannot afford.[10]

A Brief History of Medicaid

Nearly a quarter of people in the United States are covered on Medicaid – it is the nation's largest single source of health coverage.[11] Anyone who meets a state's eligibility criteria can enroll and has the right to payment for medically necessary healthcare services.[12] Though it has always been an entitlement program, it was not initially intended to serve as robust safety net health coverage. Formed in 1965 in the shadow of Medicare, Congress created Medicaid as a program for those receiving welfare, an entitlement program for the "deserving poor": children and their parents, the elderly, blind people, and disabled people.[13] Like the rest of the United States' patchwork healthcare system, Medicaid has evolved substantially since its creation. In one of the first and most significant expansions, Congress extended Medicaid to cover children and pregnant women above the very low welfare eligibility threshold.[14] However, it was only with the enactment of the Affordable Care Act that the program was modified in an attempt to serve as an insurance program for all low-income people.[15]

The states and the Federal Government jointly administer Medicaid through a system of cooperative federalism. States are not required to participate, though all states now do. As a condition of participation, states must meet some baseline federal requirements; most substantially, states must cover a set of mandatory benefits and must cover a few mandatory

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Nan Strauss et al., *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, 25 J. PERINATAL EDUC. 145, 145 (2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6265610/pdf/sgrjpe_25_3_A3.pdf.

[8] Asteir Bey et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities,* BLACK MAMAS MATTER (Mar. 25, 2019) https://blackmamasmatter.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

[9] Katy B. Kozhimannil et al., *Potential Benefits of Increased Access to Doula Support During Childbirth*, 20 AM. J. MANAGED CARE 340, 340 (Aug. 28, 2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5538578/.

[10] *Medicaid Coverage of Doula Services in the United States,* DOULA SERIES FOOTNOTES https://doulaseriesfootnotes.com/national-overview.html (last updated July 19, 2021).

[11] *Medicaid and CHIP Enrollment as a Percentage of the U.S. Population*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (2019) https://www.macpac.gov/wp-content/uploads/2020/12/EXHIBIT-1.-Medicaid-and-CHIP-Enrollment-as-a-Percentage-of-the-U.S.-Population-2019-millions.pdf; *Eligibility,* CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/eligibility/index.html (last visited May 19, 2022).

[12] *Medicaid 101*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/medicaid-101/ (last visited May 19, 2022).

[13] Cindy Mann & Deborah Bachrach, *Medicaid as Health Insurer: Evolution and Implications,* THE COMMONWEALTH FUND (July 23, 2015) https://www.commonwealthfund.org/blog/2015/medicaid-health-insurer-evolution-and-implications.

[14] *Id.*

[15] *Overview of the Affordable Care Act and Medicaid,* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid/ (last visited May 19, 2022).

eligibility categories.[16] Even still, the statutory provisions governing Medicaid give states meaningful flexibility to run the program according to the state's individual preferences.[17] States can choose to cover a long list of optional benefit and eligibility categories, and each state has significant discretion over how the program is administered and how decision making authority is distributed within a state's political ecosystem.[18]

Because Medicaid is built around the needs of low-income people, it includes a broader scope of benefits than is typically found on Medicare or most private health insurance plans. For example, Medicaid covers non-emergency medical transportation and long-term care.[19] There are also flexibilities that allow for innovation around social determinants of health, for example, the Centers for Medicare and Medicaid Services (CMS) has approved pilots programs that use Medicaid funds for shelter and food costs.[20] Policymakers are beginning to recognize that in order to address the widening health disparities in our country, it is necessary to look to a person's whole health – not just access to basic healthcare services.[21]

Doula Services on Medicaid

Given Medicaid's focus on serving the distinct needs of low-income populations and the proven benefits of doula services, both in health outcomes and in costs savings, adding doula services to Medicaid seems like an obvious policy priority. However, there are many challenges to getting doula services into the hands of Medicaid enrollees. These challenges are in part due to Congressional gridlock and partisan politics. Doula services are not inherently political, but programs catered to low-income people and people of color are typically associated with liberal politics, and Republican politicians are less inclined to support these initiatives. The Medicaid program structure of cooperative federalism can also make implementing benefits difficult. Because each state's program administration is unique, advocates must learn the nuances within each state, and it can be hard to replicate success across state lines. Further, the distinct nature of

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[16] *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues,* KAISER FAM. FOUND. (Apr. 2011) https://www.kff.org/wp-content/uploads/2013/01/8174.pdf.

[17] Brietta Clark, *Medicaid Access & State Flexibility: Negotiating Federalism*, 17 HOUSTON J. HEALTH L. & POL'Y 239, 241 (Sept. 21, 2017) https://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Clark-FinalPDF.pdf.

[18] Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options,* KAISER FAM. FOUND. (Jan. 2017) https://files.kff.org/attachment/Issue-Brief-Current-Flexibility-in-Medicaid-An-Overview-of-Federal-Standards-and-State-Options.

[19] Robin Rudowitz et al., *10 Things to Know About Medicaid: Setting the Facts Straight,* KAISER FAM. FOUND. (Mar. 6, 2019) https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/.

[20] Manatt, Phelps & Phillips LLC., *Medicaid's Role in Addressing Social Determinants of Health,* ROBERT WOOD JOHNSON FOUND. (Feb. 1, 2019) https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html; Elizabeth Hinton & Lina Stolyar*, Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)*, KAISER FAM. FOUND. (Aug. 5, 2021) https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/.

[21] Press Release, Centers for Medicare and Medicaid Services, CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies, (Jan. 7, 2021) https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs.

the services that doulas provide make implementing a doula benefit challenging. Doulas are not medical providers, so states need to determine a way to certify, regulate, and reimburse them. This also poses philosophical problems for doulas, as they must consider what it means to integrate into a healthcare and public benefits system with which they may not align.

This paper will address these challenges and discuss various policy pathways that advocates can champion to get doula services to Medicaid enrollees. Regardless of what technical approach advocates pursue, it is critical that they work with doulas on the ground and center doulas' voices in advocacy efforts. Benefits need to be set up in a way that enable doulas to effectively do their work. As one doula summarized it, a state can put in tremendous effort into setting up a benefit, but it is for naught if people cannot functionally access doula services.[22]

Discussion

Advocates can pursue several pathways to enable Medicaid enrollees to access doula services; state level initiatives are more common and show greater short-term promise, but more comprehensive efforts are possible at the Federal level.

State Efforts

In order to make change, advocates need to understand the nuance of a state's policy infrastructure – knowing the process, who has decision making authority, and what the limitations are can inform the advocacy strategy and help decide where to focus lobbying efforts. There are three main ways for a state to enable Medicaid enrollees to access doulas: 1) a state plan amendment (SPA) can be submitted to CMS to formally add doula services to a state's Medicaid benefits, 2) Medicaid Managed Care Organizations (MCOs) can include doula services in enhanced benefit packages, and 3) a state can leverage federal and local grant programs.[23]

Adding Doula Benefits to Medicaid Plans

A state wanting to add doula benefits to its Medicaid program does not need to reinvent the wheel – many states have embarked on this process and can provide helpful insight. Four states have already been granted CMS approval to provide doula benefits to Medicaid enrollees:

[22] Amy Chen & Alexis Robles-Fradet, *Doulas Know Best: Lessons Learned from California's Doula Pilot Programs Panel Discussion*, NAT'L HEALTH L. PROGRAM (Mar. 2, 2022) https://healthlaw.org/resource/doulas-know-best-lessons-learned-from-californias-doula-pilot-programs-panel-discussion/.

[23] Dee Mahan, *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs,* FAMS. USA (Jun. 2012) https://www.sfdph.org/dph/files/CBHSdocs/QM2017/4Families-USA-IssueBrief2012StatePlanAmendmentsWaivers.pdf. Waivers are another way to update a Medicaid plan, but these are meant to be used when a state wants to make a change not permitted per federal guidelines. Adding doula services does not necessarily contradict Medicaid rules, and so a waiver is not generally necessary.

Oregon, Minnesota, New Jersey, and Virginia.[24] Six other states have followed suit and are in the process of implementing some type of doula benefit.[25]

A state outlines the specifics of how it will administer its Medicaid program in a state plan. This document serves as the agreement between the state and the Federal Government; the state promises to abide by federal requirements, including covering all mandatory benefits.[26] In return, the Federal Government pledges to provide allotted federal match funding. A state plan also includes details about which populations are eligible to enroll in Medicaid, which optional benefits the state will include, and how providers will be reimbursed.[27]

When a state adds a new benefit to its Medicaid program, it must submit a state plan amendment (SPA) to CMS for approval.[28] This ensures the state will receive federal match funding for the new benefit. To submit an SPA, a state must fill out Form CMS-179.[29] Once the form has been submitted, CMS returns a response within 90 days.[30] If CMS has formal questions, the clock is suspended; however, states can and should prepare necessary information ahead of time to reduce the need for back-and-forth with the agency, and it is common for states to be in communication with CMS informally throughout the submission process to address any minor questions that arise.[31] Hearings and public comment periods are not required at the federal level.

One of the challenges of submitting an SPA is that despite the lack of substantial federal requirements, the form requires an analysis of federal budgetary impact.[32] This means that before an SPA is submitted, the scope of the benefit must be fully ironed out – including the number of visits that will be covered per patient, the Medicaid reimbursement rate, and the estimated enrollee utilization. Arriving at these specifics can be a complicated and time intensive process, so the submission of an SPA often comes after a state has taken many intermediate steps.

There are varying strategies advocates can pursue to get the SPA process rolling. This choice will largely depend on the particular state's politics, the structure of its Medicaid program, and who has authority to make change. In states that have had early success, the initial driving force

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[24] *Medicaid State Plan Amendments*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html?search_api_fulltext=doula&field_approval_date%5Bmin%5D=06%2F01%2F2001&field_approval_date%5Bmax%5D=05%2F17%2F2022&field_effective_date%5Bmin%5D=12%2F31%2F2000&field_effective_date%5Bmax%5D=05%2F17%2F2024&sort_by=field_approval_date&sort_order=DESC&items_per_page=10#content (last visited May 19, 2022) (linking approved state plan amendments for doula services).

[25] *Doula Medicaid Project,* NAT'L HEALTH L. PROGRAM https://healthlaw.org/doulamedicaidproject/ (last updated April 2022).

[26] *State Plan,* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/state-plan/ (last visited May 19, 2022).

[27] *Id.*

[28] *Medicaid State Plan Amendments*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid-state-plan-amendments/index.html (last visited May 19, 2022).

[29] The agency that operates the state's program must have submitted the requested change to the governor for approval, and comments from the governor should be included in the submission to CMS. CTRS. FOR MEDICARE & MEDICAID SERVS., FORM CMS-179, OMB NO. 0938-0193, https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS179.pdf.

[30] 42 C.F.R. § 430.16(a)(1) (2022).

[31] 42 C.F.R. § 430.16(a)(2) (2022).

[32] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 26.

has come from the state side, either from either the governor, the legislature, or the Medicaid agency itself. These policymakers then sought out feedback from the local birth worker communities. However, this dynamic is changing, and grassroots coalitions are now driving the change in many states. This is aided by the fact that people across the country are gaining familiarity with doulas, in part because of celebrity endorsements, but also due to the increasing awareness around health disparities and the maternal health crisis.[33] This awareness has spurred additional research that shows how effective doulas can be, both in bettering health outcomes and in decreasing healthcare costs.[34] Armed with this information, it is now easier for grassroots initiatives to make the case about doula benefits when asking policymakers to champion this within their state.

One unique challenge is that even though doulas have a large historical significance, especially in communities of color, doulas do not have a history of organizing and lobbying.[35] Doulas often work as solo practitioners or in small collectives, and most states do not already have an existing network of doulas that can be easily rallied to put political pressure on local politicians. Some nationally recognized doula organizations do exist, for example, DONA and the National Black Doulas Association, but they do not have the political capital that other medical professional associations do.[36] Advocates can start to develop such a network, but, in some cases, doulas have had negative experiences working within the medical and political establishments and are reluctant to be further entrenched in these systems. These dynamics are delicate, and healthcare advocates from outside the doula community must approach with humility.

For advocates and coalitions that want to engage in the political process and lobby for a doula Medicaid benefit, one strategy is to put pressure on state lawmakers to first pass legislation that forms a commission or some related body to explore doula services. Oregon's 2011 House Bill 3311 provides an example of such legislation: "The Oregon Health Authority . . . shall explore options for providing or utilizing doulas in the state medical assistance program to improve birth outcomes for women who face a disproportionately greater risk of poor birth outcomes."[37] The bill further required the Authority to report to the state legislature on its findings.[38] Connecticut is pursuing a similar strategy; in 2021, as part of legislation aimed at equalizing comprehensive access to mental, behavioral, and physical health care in response to the pandemic, Connecticut outlined that the Commissioner of Public Health must conduct a scope of practice review to look into doula services.[39] The state health department put together a working group that included doulas and representatives from other professionals that are interested in doula benefits.[40] This type of legislation brings policymakers' attentions to the topic and provides an opportunity to

[33] See e.g., Sarah Aswell, *These Celebrities Hired a Doula to Help Them Through Childbirth,* SHEKNOWS (Oct. 21, 2018) https://www.sheknows.com/entertainment/slideshow/9962/celebrities-who-hired-a-doula/.
[34] Cara B. Safon, *supra* note 4.
[35] *The Historical Significance of Doulas and Midwives,* SMITHSONIAN NAT'L MUSEUM OF AFRICAN AM. HIST. & CULTURE (Jan. 31, 2022) https://nmaahc.si.edu/explore/stories/historical-significance-doulas-and-midwives.
[36] DONA INTERNATIONAL, https://www.dona.org/ (last visited May 19, 2022); NAT'L BLACK DOULAS ASS'N, https://www.blackdoulas.org/ (last visited May 19, 2022).
[37] H.B. 3311, 76th Leg. Assemb., Reg. Sess. (Or. 2011).
[38] *Id.*
[39] Pub. Act No. 21-35 (Conn. 2021).
[40] *Id.*

demonstrate the benefits of doula services, explore potential coverage strategies, and get people comfortable with the idea before making any initial changes.

A similar strategy involves advocating for initial legislation that sets up a process for doula certification and registration. In order to be reimbursed, most states require that doulas abide by some level of state regulation. Setting up this process before formally adding doula benefits to Medicaid can allow a smoother transition to statewide coverage of doula services, and the initial stage of creating a doula registry or certification procedure does not require large outlays of money so it is easier to convince lawmakers to vote for such bills. It also initiates helpful relationships between doulas and state policymakers. Many states have taken this approach, for example, in June 2021, Louisiana passed a bill creating a Louisiana Doula Registry Board within the Department of Health to allow for health insurance reimbursement of doula services.[41] The Board includes one doula for each of the nine regions in the state, someone with lived experience using a doula, and representatives from maternity care service and advocacy organizations.[42] The Board was charged with creating criteria for registration, reviewing applications, and approving registrations of doulas.[43] Though this does not create a doula benefit under Medicaid, it sets the stage by encouraging relationships between relevant stakeholders and developing a workforce of doulas that can serve Medicaid enrollees if a benefit is added in the future.

These policies are typically pursued via standalone legislation – individual bills brought to the floor by state representatives. In most states, there are multiple opportunities throughout the year for state lawmakers to introduce a bill. Even if there is little hope of passage, bill proposals can serve as important messaging items. For instance, a group of state senators in North Carolina have introduced multiple bills requiring the state's Department of Health and Human Services to conduct a statewide analysis of doula services and then partner with doulas to develop standards and submit a state plan amendment to add doula services to Medicaid.[44] The legislation has not progressed, but it has served to bring knowledge of doula services to state representatives and constituents.

Proposing a bill requires a strategy decision on whether to introduce sparse legislation that gives authority to a specified group to determine details, or, alternatively, whether the legislation itself should dictate program specifics – everything from fee schedules to qualification requirements. If a legislative body knows they want to move forward with providing doula benefits, even if the details of such a benefit are not yet ironed out, they may choose to pass barebones legislation. In New Jersey, the bill requiring coverage of doula care on Medicaid took the form of a simple amendment that added "doula care" to the existing list of covered maternity health services.[45] The state health department then issued follow-up newsletters detailing how doulas were to be certified and reimbursed.[46] Rhode Island took the opposite approach, detailing the scope of practice and the reimbursement rate directly in the legislation.[47] Including details in legislation

[41] H.B. 190, Reg. Sess. (La. 2021).
[42] *Id.*
[43] *Id.*
[44] S.B. 732, Gen. Assemb., (N.C. 2019).
[45] S.B. 1784 (N.J. 2019).
[46] Doula Care, STATE OF N.J. DEP'T OF HUM. SERVS., https://www.state.nj.us/humanservices/dmahs/info/doula.html (last visited May 19, 2022).
[47] S. 484A, Gen. Assemb., Jan. Sess. (R.I. 2021).

more clearly sets out program goals and expectations, but it leaves the Medicaid agency with less authority, and it is more difficult to amend. This may make sense when doula groups are involved in crafting the legislation from the start, as was the case in Rhode Island.[48] However, Rhode Island has already had to amend the bill to provide for a higher reimbursement rate, and any future changes will need to go through the legislative process.[49] If the state is not as well connected with on the ground doulas, it may be better to pass simple legislation that allows for more flexibility. Doula voices can then be integrated in the subsequent regulatory process.

Rather than passing standalone legislation directing the state to take action, advocates can lobby for the state budget bill to include funds to be used towards doula services or other doula programming.[50] Advocates are often wary of the seemingly impenetrable budget process, but leaning the specifics of a state's budget cycle and working with health subcommittees to include doula provisions in the budget can be very effective. Virginia used its state budget process to provide doula benefits to its Medicaid population, and California is currently in the middle of benefit implementation initiated by a budget bill.[51] In Missouri, the 2022 state budget includes funds for a doula training program.[52] Even though this does not fund an actual benefit, building the doula workforce within communities can be a critical first step, and a standalone bill for this may not have had the momentum to move forward.

As demonstrated in Missouri, one benefit to pursuing inclusion of doula services within a larger state budget is that budgets generally must pass, so lawmakers can use the political process to their advantage. State budgets are generally very large and include many specific provisions, and legislators must pick and choose their battles. However, lawmakers face less backlash for striking a line item in a budget as compared to voting down a bill. Also, there are less opportunities for budget advocacy because a budget is passed only once a year, or sometimes even less, depending on the state's budget cycle.

Even when pursuing doula services through more typical legislative advocacy, engaging in budget advocacy can still be important because budgets include funding, and funding is critical for success. In 2019, the Indiana state legislature passed a bill allowing doulas to be reimbursed under Medicaid.[53] However, funds for this were stripped from the budget, and even though there is a law on the books, currently no doulas are funded through Medicaid directly.[54]

Regardless of the ultimate policy vehicle, advocates and legislators need to determine the scope of the benefit and how it will be administered. It is particularly important that advocates and

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[48] *Id.*
[49] *Public Notice of Proposed Amendment to Rhode Island Medicaid State Plan*, STATE OF R.I. EXEC. OFF. OF HEALTH & HUM. SERVS. (Sept. 27, 2021) https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-09/21-0013-clean-to-post-revised-notice-to-public_doula-6.29.21.pdf.
[50] *State Budget Advocacy Issue Brief,* MENTAL HEALTH AM., https://www.mhanational.org/issues/state-budget-advocacy-issue-brief (last visited May 19, 2022).
[51] H.B. 1800 (Va. 2021); A.B. 128 (Ca. 2021).
[52] H.B. 3010, 101st Gen. Assemb., 2nd Reg. Sess. (Mo. 2022).
[53] S.B. 416, 121st Gen. Assemb., Reg. Sess. (Ind. 2019).
[54] Jill Sheridan, *Funding for Doulas Cut Out of Budget*, NAT'L PUB. RADIO (Apr. 26, 2019) https://indianapublicradio.org/news/2019/04/funding-for-doulas-cut-out-of-budget/.

policymakers work directly with doulas when developing these benefit parameters, as the long-term success of a benefit depends largely on ensuring doulas continue to engage with the system.

The first decision is determining which benefit category doulas fall into – typically, either maternal care or preventive care. Medicaid has very little patient cost-sharing, and pregnant women are exempt from most Medicaid cost-sharing requirements, so the benefit category is less relevant to enrollees (least as compared to most other insurance plans where preventive services are much more affordable than other care).[55] However, the benefit category does have large implications for the doulas themselves. Including doula services as part of the maternal care benefit requires that doulas work under the supervision of a Medicaid provider, since care must be furnished under the direction of a licensed practitioner.[56] Minnesota was one of the first states to include a doula benefit on Medicaid. It chose to offer doula services as a maternity benefit, but the supervision requirement hindered the benefit rollout.[57] Providers were hesitant to agree to supervise doulas due to a lack of familiarity with the services they provide as well as a concern for their malpractice insurance, and doulas were concerned with what this would mean for their independence.[58]

Doula services can also be included as a preventive care benefit. In 2013, CMS updated the Medicaid preventive services regulation to allow for reimbursement for preventive services when provided by non-licensed service providers, as long as services are recommended by a licensed Medicaid provider.[59] This was intended to allow for a more robust set of preventive services benefits and broader access to care.[60] Some states initially interpreted the "recommended by" language very narrowly, wanting to replicate a supervision requirement. CMS has since approved New Jersey and Virginia's SPAs including doulas as preventive care benefit without specific supervision requirements, indicating that the recommendation requirement can be interpreted broadly. Leveraging this regulatory flexibility and including doula benefits as preventive care can allow doulas to practice more freely, sidestepping some of the issues found in Minnesota.

States will also need to set up pathways for doula certification and registration. Advocates need to balance the administrative needs of the state with the burdens that requirements place on doulas, as the willingness of doulas to engage depends in part on how difficult it is to meet state requirements. Many states have proposed the requirement that doulas choose from a list of

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[55] Out-of-Pocket Cost Exemptions, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/cost-sharing/out-pocket-cost-exemptions/index.html (last visited May 19, 2022).
[56] 42 C.F.R. § 440.210 (2022).
[57] Taylor Platt & Neva Kaye, *Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid,* NAT'L ACAD. FOR STATE HEALTH POL'Y (July 13, 2020) https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/#toggle-id-4
[58] *Id.*
[59] 42 C.F.R. § 440.130(c) (2022); *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, NAT'L P'SHIP FOR WOMEN & FAMS (Jan. 2016) https://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicaid-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf.
[60] *Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment*, 78 Fed. Reg. 42159, 42227 (July 15, 2013) (codified at 42 C.F.R. § 440).

standard doula training programs. Doulas in California raised the issue that many of these national doula training and certification organizations are not well tailored to the needs of Medicaid populations and underserved communities.[61] They instead recommended that states set out a list of core competencies that doulas must meet, as was initially proposed in Massachusetts.[62] These core competencies cover a lot of the same material that one would learn from a national doula organization's program, but a core competency requirement allows for more flexibility and more community-based training. Further, many doulas have been practicing for years and do not necessarily need to go through a full new training process. One potential solution is to include a legacy pathway for such doulas, where an established community doula can demonstrate expertise without needing to go through a training program. Balancing the state's desire to regulate with the needs of doulas can be tricky and takes time, but setting this up appropriately from the start can be the key to long-term success.

The success of a doula benefit also depends on the billing rates and benefit structure set out by the state. Doula rates vary across the country, as all wages do, but it has been challenging for public programs to agree to pay doulas equitable reimbursement rates. Doulas should be paid a living wage. Doulas can only take on a few clients at a time, and it is emotionally taxing work that requires around the clock availability – it is unfair to require doulas to offer services at rates that require them to seek multiple sources of income.[63] Doula reimbursement rates are also impacted by how many visits are included in a benefit, and if services are billed per visit or as a bundled package. Most states have proposed billing for bundle that includes between 6-8 visits, split between prenatal and postpartum visits, as well as attendance at labor and delivery.[64] Bundling creates less administrative work for both the state and for the doula.

Even once payment details are agreed upon, it can be logistically difficult to reimburse doulas through our traditional health insurance system. Doulas are non-clinical providers, so they are not already part of the larger healthcare infrastructure. States can choose to enroll doulas as Medicaid providers that can bill Medicaid directly, or they can set up a way for doulas to bill via an already licensed provider.[65] Reimbursing doulas directly requires that doulas obtain provider identification numbers and learn billing systems, which places significant administrative burdens on doulas. Some states allow doulas to join collectives that function as practice groups that handle billing procedures. Alternatively, a state may require that a clinical provider bill for doula services and then pass along reimbursement to the doula. Though this may be enticing because there is less up-front cost for the state, it subjects doulas to the whim of clinicians and is more likely to be met with resistance from doulas, shrinking the population willing to provide services to Medicaid enrollees.

Once a state has worked with stakeholders to iron out the benefit logistics, the SPA can be submitted. State laws vary significantly in what must happen in order to submit an SPA; this

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[61] Letter from Co-Sponsors of SB 65, California Momnibus to California Department of Health Care Services (Sept. 30, 2021) (on file with author).
[62] H. 2372, 192nd Gen. Ct. (Ma. 2021).
[63] Asteir Bey et al., *supra* note 8, at 17.
[64] NAT'L HEALTH L. PROGRAM, *supra* note 31.
[65] Amy Chen, *Routes to Success for Medicaid Coverage of Doula Care,* NAT'L HEALTH L. PROGRAM (2018) https://healthlaw.org/wp-content/uploads/2018/12/NHeLP-PTBi-Doula-Care-Report.pdf.

information can typically be found in the state's code within the section focused on medical assistance programs, or sometimes more generally within a section about designation of authority to state agencies.[66] It is not always clear from a statute what is required, and this is a fluid area of law, so advocates should work with state Medicaid agencies to ensure they have the most up to date and accurate knowledge.

In a small handful of states, state law requires legislative approval in order to submit an SPA.[67] Depending on the state's political philosophy, this may be either to increase transparency into the Medicaid process, or it may stem from a desire to control the Medicaid agency more tightly. Other states require that the legislature be notified and be given the opportunity to review any changes, likely for similar reasons, but specific approval is not required. Some states hinge approval requirements on the amount of necessary appropriation, which allows the Medicaid agency to have discretion on budget neutral or low budget changes, but requires broader government involvement when larger budgetary decisions are in play.[68] In other states, approval is required by some other entity, whether that be a board, committee, council, etc.[69] This may similarly be to control the Medicaid agency, or to ensure that relevant decisionmakers are informed of and have the ability to influence these decisions. Many states require some type of public notice, and states that have substantive Medicaid provisions in regulations may require notice-and-comment rulemaking to make an update to benefits. Advocates should work with local government officials to understand the nuances of the process in their state and ensure all necessary procedures are followed.

Enhanced Managed Care Benefits

If a state does not want to formally add doula services via a state plan amendment or cannot garner the political support to do so, Medicaid enrollees can still access doula care if Medicaid Managed Care Organizations (MCOs) choose to offer these services as part of an enhanced or expanded benefits package. Nearly all Medicaid beneficiaries are enrolled in some type of managed care plan, so this can be an effective way to reach most eligible people without going through a formal administrative process.[70] States can encourage this benefit inclusion as a health equity measure. This can be particularly beneficial in a state that understands the importance of doulas for addressing poor maternal health outcomes but does not want to propose legislation and launch a political fight over its Medicaid program. MCOs may also want to do so on their own volition as a cost-effectiveness tool or to create a competitive edge. Beneficiaries typically pick from a list of potential MCOs in which to enroll, and including doula services can make a plan more enticing.

A downside to using MCOs is that the state government has little control over the benefit administration. Even if the state health department monitors implementation efforts, they

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[66] See e.g., Mo. Rev. Stat. § 208.001 (2021).
[67] *Role of State Law in Limiting Medicaid Changes*, NAT'L HEALTH L. PROGRAM & NAT'L ASSOC. OF CMTY. HEALTH CTRS. (July 2006) https://healthlaw.org/wp-content/uploads/2018/09/role-of-state-in-limiting-medicaid-changes.pdf.
[68] *Id.*
[69] *Id.*
[70] *Managed Care,* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/topics/managed-care/ (last visited May 19, 2022).

generally do not have substantial power to require program specifics – for example, each plan can determine who is eligible to receive expanded services and which doulas are able to work with their enrollees. Because each MCO can determine its own scope of benefits, access to services depends on which MCO an enrollee chooses, which can lead to inequality of access amongst a state's beneficiary population. Perhaps most critically, MCO enhanced benefits are not part of the formally mandated Medicaid plan and therefore can be easily rescinded.

Florida implemented doula benefits using this method; the state's Agency for Healthcare Administration (AHCA) included doula services in its expanded benefits for Medicaid Managed Care. Most plans chose to adopt doula services as a plan benefit, but AHCA has limited control over implementation and has not released any guidance, so the success across plans varies dramatically.[71] Some plans have done outreach and education about the benefit, but other plans have enacted restrictions on access, such as only providing doula care for high-risk pregnancies.[72] There is no standard fee schedule, so reimbursement is negotiated with each plan, which can be very time consuming and inequitable.[73]

Though only Florida has taken this approach to date, it will likely become more common – especially in states that have more moderate politics, as this is a solution that leverages the private market and consumer choice. However, even if an MCO declares that it offers doula benefits, access will be limited if the benefit is structured in such a way that restricts the doula workforce or makes it difficult for enrollees to express interest in receiving services. As this practice becomes more prominent, it is imperative to investigate ways that states can ensure the benefit is robust even without being able to directly control MCOs. One method is for state health departments to issue guidance; even though guidance is not binding, suggested best practices for MCOs can be help to reduce the amount of variability among plans. There are also potential mechanisms that states can employ to hold MCOs to minimum rates for doula services, for example CMS regulations allow a state to require that MCOs adopt a minimum fee schedule for network providers.[74] Doulas must be in the provider network, and, in some circumstances, this also may require federal approval. Even though the minimum fee schedule would be mandatory, neither states nor the Federal Government have a good way to enforce this requirement. The primary enforcement mechanism is the blunt instrument of cutting off funding, which ultimately hurts the intended beneficiaries. As MCOs become a larger presence in the Medicaid space, the government should consider creating more nuanced enforcement mechanisms.

Grant Programs

Grant programs, both at the federal and state levels, can be a great way to more quickly get doula services into the hands of citizens without requiring legislative action or federal agency approval. Grants do not guarantee doula services for all Medicaid enrollees and are not permanent, but they are promising options for states that will have a harder time getting stakeholder engagement in the SPA process and where MCOs are less willing to engage. Grant programs can also serve as

[71] NAT'L HEALTH L. PROGRAM, *supra* note 31.
[72] *Id.*
[73] *Id.*
[74] 42 C.F.R. § 438.6(c) (2022).

opportunities to pilot community doula programs that can then be leveraged into permanent Medicaid benefits.

The Federal Government makes Title V Maternal and Child Health Services Block Grants available to states to address current and emerging maternal and child health challenges.[75] These grants can be used for a wide array of activities, and some states have used this as a pathway to getting doula services to eligible families. For example, in 2017 a $2.1 million Title V grant was awarded to an Indiana organization that provides access to doulas to communities with high infant mortality rates.[76] The grants are federal-state partnerships, requiring three dollars of state or local matching funds for every four dollars of federal spending.[77] The joint funding requirement means that the state is at least partially on the hook. It can sometimes be harder to get state buy-in because of this funding requirement, but there is a long history of states leveraging Title V grants, so most states are comfortable with this arrangement. Leveraging Title V grants can be a great way for grassroots organizations to get funding to expand the reach of doula services without needing the support of the political process – for example, Indiana is governed by Republican politicians, who are more hesitant to fund doula initiatives. When Indiana passed a bill allowing doulas to be reimbursed under Medicaid, funds for this were stripped from the budget, and currently no doulas are funded through Medicaid.[78] Federal grants, however, remain unaffected.

State level grants are another way to get doula services to beneficiary populations, but these require a state to come up with full program funding, whereas a state can receive federal funds when it enacts Medicaid benefits or applies for federal grants. Grantmaking processes vary dramatically, so understanding if this could be a useful tool requires digging into the budget and grant making process of an individual state. This information is not readily available and applying for grants requires a significant amount of work, but this could be worthwhile in states with difficult political situations that make other options untenable. In Ohio, all branches of government are run by Republican politicians, but the Department of Medicaid chose to provide grants to cover doula services through its Maternal Infant Support Program.[79]

Grant programs for doula services can lay the groundwork for further investments in this area. Grants can be a great method for building an evidence base in the state; data can be collected on the effectiveness of doulas for a state's specific population, which can help make a more persuasive case to the state legislature in the future. Additionally, many of the decisions required for legislative action must still be made – for example, how to reimburse doulas and what certification requirements are required – so this can be a good strategy to get administrative details ironed out before transitioning to a statewide Medicaid benefit. This has been the case in

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[75] *Title V Maternal and Child Health (MCH) Block Grant,* HEALTH RES. & SERVS. ADMIN., https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant (last updated Mar. 2022).
[76] Ben Middelkamp, *Speak Life: Pregnancy Outreach Program Launches in Cass County,* PHAROS TRIBUNE (Mar. 9, 2018) https://www.pharostribune.com/news/local_news/article_a4fba591-e44a-5f7b-b2c1-d31a8adf583b.html.
[77] *Id.*
[78] *Id.*
[79] *Doula Services*, OHIO DEP'T OF MEDICAID (June 23, 2021) https://medicaid.ohio.gov/static/Families%2C+Individuals/Programs/MISP/Doula-Services-June23-15Jun21.pdf.

Maryland, where the governor introduced a four-year state funded doula pilot, and the Department of Health is now using this as a starting point for an SPA.[80]

The biggest drawback to implementing benefits via a grant program is the lack of permanence. Title V grants need to be reapplied for every year;[81] state grant programs may have longer horizons, but they are not unlimited. As such, grant programs should be used strategically. In states where the Medicaid agency is averse to expanding benefits, it may make more sense to focus on Title V and independent grants that can be used to fund doula organizations directly. In states where the legislature does not want to engage in the SPA process, lobbying the governor to set aside funds for doula services might be a better strategy. In states where there is more play in the joints, using a grant program to set up the infrastructure for an eventual doula benefit can be highly beneficial and can help get a future benefit off the ground much more quickly.

Federal Efforts

The Federal Government jointly administers Medicaid with the states, so in addition to state tactics, advocates can champion federal policy tools to expand access to doula services. The most direct and effective way is for Congress to pass a bill that adds doula benefits to the Medicaid program, but other actions could help to lay the groundwork for access to doula services.

Federal Legislation to Add Doula Benefits to Medicaid

In 2013, an expert panel on improving maternal and infant health outcomes convened by CMS recommended that Congress add doula services to Medicaid benefits as a strategy to enhance maternal health.[82] Despite this recommendation, limited movement has been seen towards Congress passing legislation to add doula services, either as an optional or mandatory Medicaid benefit.

Legislation making doula services a mandatory Medicaid benefit would ensure that all enrollees across the country could access doula care; however, Congress does not frequently add mandatory benefits because the political will necessary to pass such legislation is often lacking. It is unpopular to force states' hands, and politicians are wary because recent trends in healthcare litigation have limited the Federal Government's ability to dictate program specifics – cases have instead turned in favor of state control and flexibility.[83] This is epitomized by *NFIB v. Sebelius*, where the Supreme Court deemed that the ACA's provision that states must expand Medicaid

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[80] *Governor Hogan Announces Launch of $72 Million Maternal and Child Health Care Initiative*, OFF. OF GOV. LARRY HOGAN (July 6, 2021) https://governor.maryland.gov/2021/07/06/governor-hogan-announces-launch-of-72-million-maternal-and-child-health-care-initiative/; S.B. 166 (Md. 2021).

[81] *Title V Maternal and Child Health Services Block Grant to the States Program: Guidance and Forms for the Title V Application/Annual Report - Appendix of Supporting Documents*, U.S. DEP'T HEALTH & HUM. SERVS. (Dec. 1, 2020) https://www.hhs.gov/guidance/document/title-v-maternal-and-child-health-services-block-grant-states-program-guidance-and-forms-2#:~:text=As%20one%20of%20the%20largest,special%20needs%2C%20and%20their%20families/.

[82] Mary Applegate et al., *Improving Maternal and Infant Health Outcomes in Medicaid and the Children's Health Insurance Program,* 124 OBSTETRICS & GYNECOLOGY (2014) https://pubmed.ncbi.nlm.nih.gov/24901270/.

[83] Brietta Clark, *Medicaid Access & State Flexibility: Negotiating Federalism*, HOUSTON J HEALTH L. & POL'Y 239, X-Y (2017) https://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Clark-FinalPDF.pdf.

was coercive; expansion became optional.[84] The Court did not define the contours of what it means for a policy to be coercive and what Congress can properly tell states to do, leaving an ambiguous gray area of Congressional authority. Though adding a single mandatory benefit is unlikely to be so coercive as to be unconstitutional, a mandatory benefit could be a riskier strategy to pursue. Doula coverage does not generally garner Republican support and some liberal advocates want to avoid partisan policies that could attract litigation. Even still, it is not impossible to add mandatory benefits. In 2018, Congress added a mandatory benefit related to opioid treatment, but this was packaged within a broader opioid bill that had broad bipartisan support, so there was less risk of backlash.[85]

Congress could also pass legislation making doula services an optional Medicaid benefit, but this does not differ dramatically from the current landscape: if states want to engage, they can, but there is no incentive or requirement for states that are not independently interested. Nevertheless, adding an optional benefit signals an official endorsement from the Federal Government and could set a helpful precedent for coverage, and it does reduce some administrative hurdles by providing a clearer pathway to inclusion. It is also unlikely to be litigated. However, an optional benefit still requires Congress to pass a bill, and the marginal utility of adding doula services as an optional benefit may not be worthwhile considering the political energy required to pass legislation.

One benefit to Congressional legislation – either for mandatory or optional benefits – is that this would spur CMS to issue guidance on how to translate this benefit into accessible services. Legislation is generally sparse, and so agencies publish federal guidance that helps to establish uniform standards and expectations. Guidance can be issued to states fairly quickly after a bill is enacted because it does not require public comment. Rather than requiring states to go through the process of making decisions regarding the scope of the doula benefit, CMS would issue recommendations for how doulas should be licensed, regulated, and reimbursed.[86] States are not legally required to follow guidance, but most states choose to leverage federal recommendations rather than explore all the nuances of a new benefit from scratch.

Adding Doula Benefits to Other Federal Programs

Adding doula benefits to other federally administered health programs could set the stage for future Medicaid coverage of doula services. The Department of Defense (DOD) recently began a five-year pilot program to provide doulas and lactation support on Tricare, the health insurance program for active-duty military members and their families.[87] This is in recognition of the fact that, given the nature of military careers, one parent is often not able to be present at the birth of

[84] Nat'l Fed. of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).
[85] SUPPORT for Patients and Communities Act, H.R. 6 , 115th Cong. §1006(b) (2018); Letter to State Health Officials from the Centers for Medicare and Medicaid Services regarding Mandatory Medicaid State Plan Coverage of Medication Assisted Treatment (Dec. 30, 2020) https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf.
[86] CMS could also issue this guidance independent of Congressional action as an aid to help states that want to request SPAs.
[87]The program will cover up to six prenatal and postpartum doula visits, as well as doula support at labor/delivery and will reimburse doulas certified by a list of specified organizations. Establishing a TRICARE Childbirth and Breastfeeding Support Demonstration, 86 Fed. Reg. 60006 (Oct. 29, 2021).

a child. Doulas can provide particularly beneficial support to this population.[88] DOD has said that if maternal and infant health outcomes improve, they will consider making doula care a permanent benefit. Though this is distinct from Medicaid, this shows federal support for and understanding of the particular kinds of services that doulas can offer. This sets a strong precedent for future coverage of doula services on other federal programs, and the government can use learnings from the pilot regarding the scope of the benefit and how to reimburse doulas.

The government could also appropriate funds to the Indian Health Service (IHS) to include doula services as part of its health service offerings. Given the benefits of doula support for minority women, this could be particularly beneficial for IHS patients. However, the IHS is fairly small and independent, and so it has less influence on other federal health programs. Medicare and the Veterans Health Administration are larger programs that are generally more influential, but these programs historically served very few people giving birth, so they do not cover maternity care as extensively. It is unlikely that the government will explore adding doula benefits to these programs before extending it to Medicaid.

Including Doulas as an Essential Health Benefit

Including doula services as an essential health benefit (EHB) on individual marketplace plans would also set the stage for Medicaid coverage of doula care. The ACA requires that all individual marketplace plans cover ten categories of EHBs, one of which is "pregnancy, maternity, and newborn care."[89] The ACA grants the Secretary of HHS clear authority to define EHBs.[90] HHS could promulgate rulemaking to establish a definition that explicitly includes doula services in the maternal health category. This would not require any congressional action – it is fully within the administration's ability to take such an action. Including doula services as an EHB would not enable Medicaid beneficiaries to access doula services, but it would still serve to benefit many low-income healthcare consumers, considering 86% of marketplace enrollees receive premium tax credits, meaning a large majority of enrollees are under 400% of the federal poverty level.[91] Adding doula services as an EHB would also demonstrate the administration's belief in the benefit, and it would force CMS to set up an infrastructure for reimbursing doula services. Once in existence, this infrastructure could be leveraged by the Medicaid program.

Creating Standardizing Billing Codes for Doula Services

Even if the Federal Government does not want to take action to formally add doula benefits to Medicaid, CMS could create the underlying infrastructure for providing doula services by creating standardized billing codes. CMS maintains and updates a list of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that

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[88] *Id.* at 60010.
[89] *What Marketplace Health Insurance Plans Cover,* CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last visited May 19, 2022).
[90] 42 U.S.C. § 18022(b)(1).
[91] *Marketplace Effectuated Enrollment and Financial Assistance,* KAISER FAM. FOUND. (2021) https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

identify all items and services for which providers can bill.[92] States that currently allow for doula reimbursement on Medicaid are using a variety of different methods to capture doula services on provider bills. Some states use a generic "unlisted" CPT code, and others have created state-specific temporary codes. A universally acceptable code would lift this administrative burden from states and allow for uniform billing, making it easier for both the states and for doulas. Publishing codes would also symbolically show that the Federal Government supports the inclusion of doula services as high standard of medical care.

Issuing an Executive Order

In April 2021, President Biden issued a press release detailing initial actions his administration had taken to address the maternal health crisis in the United States.[93] The President could issue an additional press release or executive order advocating the Administration's support of doula services on Medicaid. While this would not serve to actually get benefits to people, it would raise awareness of doulas generally and signal to CMS and Congress that it is time to act.

Conclusion

There are a number of pathways that have been and can continue to be leveraged to provide doula services to Medicaid enrollees, ranging from a variety of options at the state level to sweeping federal policies. Success with any strategy requires dedicated advocates who are willing to dig into the specifics of state policy and work with both policymakers and local doula communities; thankfully, those advocates are already out there starting to do this work.

The most effective option for country-wide access to doula services would be for Congress to pass legislation adding doulas as a mandatory Medicaid benefit. However, in light of Congress's inability to pass even the most limited social legislation with a democratic majority in both chambers of Congress and control of the executive branch, this seems like an increasingly unlikely outcome.

Given this, lobbying state governments to submit state plan amendments is ultimately the most powerful and achievable pathway to getting Medicaid beneficiaries doula services. This process can be labor intensive, but research proving the benefits of doula services is abundant and draft legislation from pioneer states exists. Rather than starting from scratch, state advocates should focus on forming coalitions of doulas on the ground, modifying existing materials to tailor them to the distinct needs of their state, and then approaching appropriate decisionmakers in order to begin implementation. This requires understanding specific state processes and knowing which decisions will have to be made, and the benefits and drawbacks of various approaches as described in this paper. This is hard work, but Medicaid enrollees should be able to access doula services and experience healthier, happier births.

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[92] *List of CPT/HCPCS Codes,* CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021) https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral.

[93] White House Fact Sheet, Biden-Harris Administration Announces Initial Actions to Address the Black Maternal Health Crisis, (Apr. 13, 2021) https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/13/fact-sheet-biden-harris-administration-announces-initial-actions-to-address-the-black-maternal-health-crisis/.