Elevance Health | Public Policy Institute

Doula Access Through Medicaid Managed Care Improves Maternal Health

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Key Takeaways

- Doula support to women during the prenatal, birthing, and post-partum periods can improve maternal health outcomes, especially among women at higher risk for maternal morbidity and mortality.
- Compared to women without doula care, women with doula care demonstrated lower prevalence of cesarean section (C-section), higher prevalence of vaginal births after C-section, higher prevalence of postpartum visit attendance, and lower prevalence of postpartum anxiety or depression when doula care started in the first trimester.
- This evaluation concludes with lessons learned from multiple Elevance Health-affiliated Medicaid managed care plans and considerations to help inform Medicaid programs interested in implementing a future doula benefit.

Overview

For many years, the maternal mortality rate in the United States (U.S.) has exceeded that of other developed countries, and these rates have only worsened in recent years, exacerbated by the COVID-19 pandemic.[1]

In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births, compared to a rate of 23.8 in 2020 and 20.1 in 2019.[2] As with maternal mortality, the prevalence of severe maternal morbidity (SMM) has steadily increased in the U.S. with one study finding a 22.5 percent increased prevalence in SMM from 2008 to 2021 among hospital-based births.[3] Further, maternal mortality and morbidity rates are disproportionately higher among non-Hispanic Black women.[4] One approach to address these concerning trends includes offering doula support to women during pregnancy, delivery, and the postpartum period.

Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.

Doulas are trained, non-clinical professionals who provide emotional, physical, and educational support to women before, during, and after childbirth.[5] Doulas focus on supporting the pregnant woman's well-being and comfort throughout the pregnancy and birthing process and can help women develop birth plans, offer relaxation and lactation techniques, provide continuous encouragement during labor, and support individuals during the postpartum period. Doulas also facilitate communication between pregnant women and their medical team, advocating for individuals' preferences and concerns.[6]

While adverse birth outcomes affect individuals across all levels of education and income, doula services are particularly difficult to afford for people with low incomes, as these services have not traditionally been covered through health insurance, including Medicaid. Yet, doulas serve as an effective strategy to address disparities in maternal health, especially among women who are at higher risk for maternal mortality and morbidity.

Previous research on doulas shows many benefits associated with doula care, including decreased rates of cesarean delivery (C-section), increased likeliness to initiate breastfeeding, and decreased rates of postpartum anxiety (PPA) or postpartum depression (PPD).[7-9] Evidence suggests these benefits are even greater among under-served and marginalized populations with access to community-based doulas who undergo additional training in cultural humility.[10,11] Furthermore, community-based doula programs may also prioritize cultural concordance as these doulas often share the same background, culture, and/or language as the clients they serve.[12] Finally, community-based doulas offer additional support through screening for health-related social needs (HRSN) and providing referrals to relevant programs and resources.

This brief will describe state doula activity in Medicaid, present the results of a multi-state doula evaluation and lessons learned from Medicaid health plans, and discuss considerations for implementing a doula benefit.

State Doula Activity in Medicaid

Several states have enacted legislation or are in the process of implementing state-wide coverage for doula care through Medicaid.

As of February 2024, 13 states, including Washington, D.C., reimburse for doula services. At least 30 other states are in various stages of considering, planning for, or implementing access to doula services. These states are either in the process of implementing a Medicaid doula benefit or they have taken related actions such as executing a pilot program or creating a doula registry.[13] (Figure 1)

Figure 1

State Doula Efforts, as of February 2024

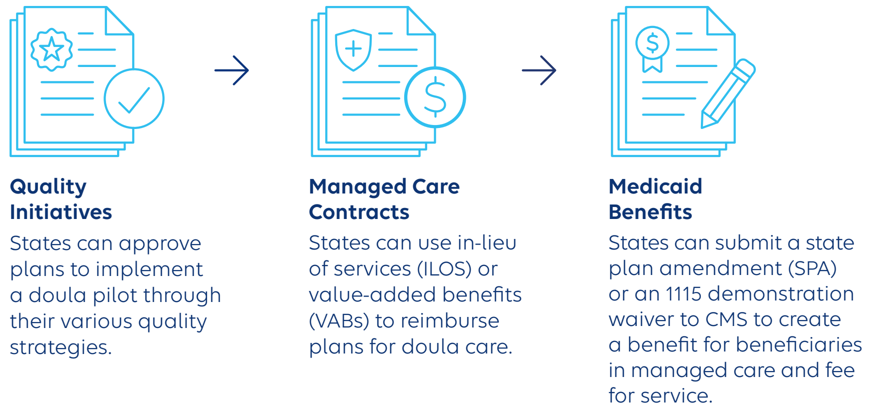
Actively providing doula coverage
Taken related or adjacent action
In process of implementation
No action taken or status unknown

Source. National Health Law Program. (n.d.) Doula Medicaid Project. Retrieved February 6, 2024, from https://healthlaw.org/doulamedicaidproject/. Visit this website for the most up-to-date information on state doula efforts.

State Medicaid programs have several policy mechanisms to cover doula services. The mechanism of choice will determine the scale of the doula program and the number of beneficiaries who could potentially access doula services. Figure 2 lists these mechanisms from smallest to largest scale.

Figure 2

State Policy Options



Medicaid managed care plans also have invested in doula programs to increase access. Elevance Health's affiliated Medicaid plans, for instance, have supported the provision of doula care through a multi-pronged strategy:

In states where doula services are a covered Medicaid benefit, this strategy includes establishing doula networks and partnering with doulas regarding billing, certification, and member outreach.

In states that do not have a doula benefit, Elevance Health's affiliated Medicaid plans have participated in pilot programs, provided grants for training and development, leveraged their partnerships with doula organizations and other community-based organizations to expand members' access to doulas, and contributed data for research efforts to support coverage and reimbursement of doula services.

Positive Outcomes with Doula Care

This evaluation expands upon results initially reported by Elevance Health in 2022.[14] The expanded results include outcomes from nine Elevance Health-affiliated Medicaid managed care plans between 2014 and 2023.

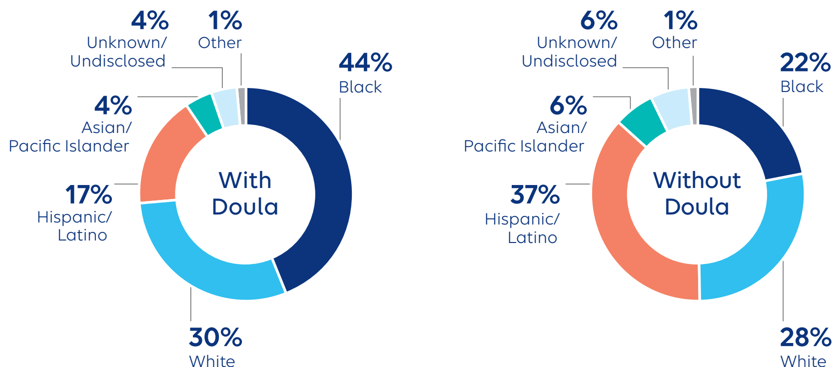
It compares outcomes from women enrolled in Medicaid managed care who received doula services (n=869) with those who did not receive doula services (n=1,094,005). Chi-square tests and t-tests determined statistical significance with all comparisons unadjusted.

Demographics

The women who used doula services differed by several characteristics, which often revolved around their risk for adverse health outcomes. For example, women who used doula care were more likely Black ($p<0.001$) and less likely Hispanic/Latino ($p<0.001$). (Figure 3) This higher proportion of Black women is expected as the women who received doula services often received outreach about doula programs because of clinical or sociodemographic characteristics that placed them at higher risk for adverse outcomes.

Figure 3

Race and Ethnicity of Women with and without Doula Care



Access and Location

Women with doula care resided in counties with fewer OB-GYNs/certified midwives compared to women without a doula (195.1/1,000 residents vs. 282.0/1,000 residents). Results, therefore, suggest that even though women with a doula had lower access to perinatal providers, they still had more favorable outcomes through the inclusion of an additional support person (i.e., a doula) during their prenatal experience.

Finally, despite residing in counties with fewer perinatal providers, over 90 percent of women with a doula resided in urban or suburban areas. Conversely, there was a higher percentage of women without a doula

who resided in rural areas. The lower percentage of women with a doula in rural areas could be a condition of how the doula programs included in the analysis focused on specific areas or populations and the availability of doulas in rural areas. (Table 1)

Table 1

Location of Women with and without Doula Care

Location	With Doula	Without Doula
Urban*	66.2%	52.5%
Suburban*	25.7%	34.2%
Rural*	1.0%	7.8%
Unknown*	7.1%	5.5%

Note. * = $p<0.001$

Maternal Health

Women who received doula services, compared to women who did not, overall experienced lower prevalence of C-sections and a higher prevalence of vaginal birth after a C-section (VBAC) and postpartum visits. Also, women who received doula care starting in their first trimester experienced a lower prevalence of PPA/PPD. (Figure 4)

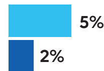
Figure 4

Outcomes for Women with and without Doula Care

With Doula
Without Doula

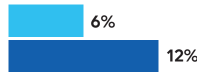
Prevalence of C-section**

Prevalence of Vaginal Birth after C-section**



Prevalence with a Postpartum Visit**

Prevalence of Postpartum Anxiety and/or Postpartum Depression*†



Note.
* = $p<0.05$
** = $p<0.001$
† = Results based on women who initiated doula care in their first trimester

Any pregnancy complication is defined as having at least one of the following diagnoses: gestational diabetes, gestational hypertension, placental abruption, pre-eclampsia, thrombocytopenia, placenta previa, placenta accreta spectrum, short cervix, depression, anxiety, or anemia.

These results are especially promising given that women in the study who received doula care were more likely to have any pregnancy complication compared to women who did not receive doula services (35% vs. 27%; $p<0.001$) which is likely associated with how the doula programs focused outreach efforts to women with higher pregnancy risks. Interestingly, there were no differences in postpartum emergency department (ED) visits, inpatient admissions, or SMM despite the women with doula care having more clinical risk factors.

Managed Care Perspective and State Considerations

Among states where Elevance Health has an affiliated Medicaid health plan, several have implemented a Medicaid doula benefit or pilot, while others rely on managed care plans to improve access to doulas through grants, quality initiatives, in-lieu of services (ILOS), or value-added benefits (VABs).

Below are lessons learned from Elevance Health's affiliated Medicaid managed care plans across multiple states that may help inform Medicaid programs in implementing a successful doula benefit.

1 State legislation directing Medicaid agencies to create a doula benefit does not necessarily mean funding for the benefit.

States will need to include the benefit in their state budget to fund the state match for the Medicaid benefit.

Considerations. In some states, there has been a significant time lag between legislation and a budget item to fund the new benefit and therefore this consideration should be built into a new benefit's overall project timeline.

2 Foster a sustainable relationship with well-known local organizations to build trust between managed care plans, state Medicaid programs, and doulas.

There should be open communication and transparency among all stakeholders early in the process of developing a doula program to understand the future Medicaid doula workforce's qualifications, training needs, and reimbursement needs.

Considerations. Early in the benefit design process, states may need to establish a list of diverse stakeholders as potential partners. They should build in a substantial amount of time for external outreach and communication and offer multiple opportunities for engagement to interested organizations and doulas. A transparent approach will help build trust between all organizations involved.

3 Building a doula provider network takes a lot of effort, time, and persistence.

Managed care plans should begin building relationships with doulas from the beginning of program development, recruit from doulas who already have the required state Medicaid training/certification, and help other doulas attain the required state Medicaid training/certification.

Considerations. States will need to contemplate similar planning as they build a brand-new provider network within their Medicaid programs.

4 Implementing a doula benefit does not guarantee an active network.

There are no requirements for doulas to be licensed or credentialed to practice in the U.S., and though many doulas do seek certification from private organizations, there are over 100 organizations that offer some form of doula training and certification.[15] However, doulas are required to meet minimum requirements set by state Medicaid programs to enroll as a Medicaid provider.

Considerations. States need to carefully review the available doula workforce and align their doula provider credentials with the existing doula network in their states and work with these organizations to define Medicaid provider certification requirements. Otherwise, states may have a benefit without a workforce that meets the provider criteria—therefore limiting access for beneficiaries. Other considerations include whether states will require doulas to practice under the supervision of a clinician and if doulas will be required to meet additional requirements such as completing HIPAA training or having adequate liability insurance.

5 Reduce barriers for doulas to become Medicaid providers and serve health plan members.

To be a Medicaid provider, doulas must be trained/certified, have a National Provider Identification (NPI) number, and be educated on the proper process for claims filings to receive reimbursement. With cash payments and out-of-pocket payments being administratively easier for doulas, managed care plans should have a dedicated person to address these challenges and help doulas navigate the Medicaid provider system.

Considerations. As doulas are not traditional medical professionals, states and/or Medicaid managed care plans will need to make additional efforts to provide extensive managed care training for doulas as new Medicaid providers, specifically as it relates to submitting medical claims for reimbursement. In addition to training on billing practices, if states want to pursue a community-based program, they could consider training on "how race, institutional and interpersonal bias, and other social determinants play an integral role in birth disparities affecting communities of color."[16]

6

Reimbursement for doulas should consider the volume of people they can effectively serve and be at a rate that encourages doulas to participate in Medicaid.

Doulas have many administrative requirements they must meet in addition to serving people such as being on call for labor and delivery, coordinating multiple in-person visits, and needing to travel to members' homes. Homes could be in rural areas, requiring longer drive times, or in areas that have high rates of crime. Doulas also have a limit of how many members they can serve at once so that they have adequate availability to be present during the birth.

Considerations. Doula reimbursement should reflect the full scope of their services and number of members they can feasibly serve. While ensuring the program is fiscally sustainable is important, too low reimbursement may lead to low uptake of doulas participating in the program.[17]

7

Discuss with partners the scope of service, such as number of visits allowed during pregnancy, labor and delivery, and postpartum.

The timing of covering these services is important too, such as allowing services early in pregnancy and ensuring adequate duration of services into the postpartum period. Additional scope of service policy considerations include reimbursing for doula services regardless of the pregnancy outcome (such as when women miscarry or have a stillborn birth) or if there is a desire for doulas to help with identified HRSN.

Considerations. As states determine the scope of services that they will reimburse under doula care, they should consult with doula organizations and other advocates to agree upon the ideal coverage of services.

8

Consider if a community-based focus is the best option for the program.

Community-based doulas specialize in providing care to underserved and marginalized populations and often are situated in the communities they serve. Community-based doulas may share the same background, culture, and language with their clients and can help people navigate the healthcare system while also helping to address HRSN.

Considerations. States should determine if focusing on community-based doulas could further their mission to improve maternal and infant outcomes for their Medicaid beneficiaries.

9

Be mindful of rural access, including closures.

Access to obstetric care in rural areas continues to worsen due to hospital or labor and delivery unit closures. Doulas can help families living in rural areas navigate the healthcare system, which is especially helpful for women who are giving birth in a non-local hospital.

Considerations. Reimbursement for travel time could potentially improve access to doula services in rural areas.

10 **Measurement and evaluation will be important to informing this work.**

Prior to implementation, doula programs should consider what data and information would be important to determine if a program is delivering desired outcomes.

Considerations. States should develop an evaluation plan with desired outcomes to determine if the doula benefit is meeting program goals, if there are opportunities for improvement, and to continue adding to the literature on doula care in Medicaid.

As with building any new program or partnering with a workforce unfamiliar with Medicaid, the timeline from program inception to implementation may be lengthy. However, as the evidence suggests improved health outcomes for women who receive doula services, these investments will contribute to improving maternal health among Medicaid beneficiaries.

Conclusion

The U.S. maternal morbidity and mortality rates have worsened in recent years across all demographics, with the largest disparities persisting among Black women. Doulas serve as a valuable strategy to address these disparities.

This evaluation provides evidence that doula programs are effectively outreaching to women enrolled in Medicaid managed care plans who could benefit from doula services, including a higher proportion of Black women and women residing in counties with fewer OB-GYNs and certified midwives. These results also demonstrate that even though the cohort of women who engaged with a doula had more pregnancy complications, they experienced better overall outcomes including lower prevalence of C-section rates and higher prevalence of VBACs.

Additionally, results show that women with doula care had a higher prevalence of a postpartum visit, which is critical for identifying postpartum complications, and when women initiated prenatal doula care in the first trimester, they had lower prevalence of PPA/PPD. Given that Medicaid beneficiaries tend to have limited resources, it is encouraging to see improved outcomes for members receiving doula services.

As more states consider incorporating doula services into their maternal health strategies, they can choose from multiple pathways, including a range of quality initiatives, the option to use ILOS or VABs to reimburse plans for doulas, or adding doula services as a full Medicaid benefit. States should keep in mind factors that can influence the accessibility and impact of doula services, such as the importance of provider education and training, drawing on the experience of health plans in these endeavors. Finally, future research should continue to assess maternal and infant outcomes related to doula care in Medicaid to strengthen the evidence base for these services.

Medicaid members receiving doula services can experience positive maternal outcomes, even when at higher risk for pregnancy complications.

Endnotes

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