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NOTES

It Takes a Village: Pathways for Achieving Access to Doula Services for Medicaid Enrollees

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ABSTRACT

The United States is facing a maternal health crisis, and one that has a disparate impact on communities of color. Doula services can be an effective tool to reduce maternal health disparities. There are a number of pathways that have been and can continue to be leveraged to provide doula services to Medicaid enrollees. To ensure all Medicaid enrollees can permanently access doula services, a state must formally add doula services to a state's Medicaid benefits. In order to do so, a state must submit a state plan amendment to the Centers for Medicare and Medicaid Services. States have various tools at their disposal when pursuing a state plan amendment—including creating initial exploratory committees, following the traditional legislative processes to codify the requirement to add doula services, and/or enacting budget amendments to provide necessary funding. If a state cannot garner the political will required to submit a state plan amendment, Medicaid Managed Care Organizations (MCOs) can choose to include doula services in enhanced benefit packages. Given the recent proliferation of MCOs, this strategy can reach a large percentage of a state's Medicaid enrollees—however, the state has less control over the specifics of MCO benefit implementation, leading to potential variability and inequity. Lastly, a state can leverage federal and local grant programs. Grants do not guarantee statewide access to doula care, but this is a creative way to obtain funding for doula services when other options are not feasible. Ultimately, success with any strategy depends on dedicated advocates who are willing to dig into the specifics of state policy and politics, and who are committed to working with both policymakers and local doula communities.

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I. 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 seventeen maternal deaths for every 100,000 live births.[1] Analyzing this by race reveals a striking disparity——the maternal mortality rate for Black non-Hispanic 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; receiving doula services has been shown to have significant positive effects on maternal morbidity and mortality and to lower overall healthcare costs.

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 et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity in the United States*, 6 J. Racial & Ethnic Health Disparities 790, 790, 792 (2019).

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 United States, and over 65% of births by non-Hispanic Black women.[5] The federal government does not require states to cover doula services as a Medicaid benefit, though some states have begun to do so.[6]

This note will explore how grassroots advocates can leverage existing policy pathways at the state level to ensure Medicaid enrollees can access doula services. These policy levers include formally adding doula services to state Medicaid plans, advocating for Medicaid Managed Care plans to include doula services as an enhanced benefit, and leveraging available federal and state grant programs. Regardless of which technical approach advocates pursue, it is critical to work with doulas on the ground and to center doulas' voices in advocacy efforts.

II. Background

A. What Doulas Do

Birth doulas are non-clinical professionals that provide emotional, physical, and informational support throughout the reproductive process.[7] 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.[8] These families face the greatest risks, and doulas can serve as critical advocates for their patients' needs.[9] A study of socially disadvantaged mothers at risk for adverse birth outcomes found that mothers who received doula

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., Ctrs. for Disease Control, National Vital Statistics Report, Births: Final Data for 2018 6–7 (Nov. 27, 2019), https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

6. *See Doula Medicaid Project*, *Current State Doula Medicaid Efforts*, Nat'l Health L. Program (Apr. 2022), https://healthlaw.org/doulamedicaidproject/.

7. Nat'l Health L. Program, What is a Doula? (Apr. 16, 2020), https://healthlaw.org/wp-content/uploads/2020/04/WhatIsADoula_4.16.2020.pdf.

8. Kenneth J. Gruber et al., *Impact of Doulas on Healthy Birth Outcomes,* 22 J. Perinatal Educ. 49, 49–50 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/; Nan Strauss et al., *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, 25 J. Perinatal Educ. 145, 145–46 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6265610/pdf/sgrjpe_25_3_A3.pdf.

9. Asteir Bey et al., Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities 5 (Mar. 25, 2019), https://blackmamasmatter.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

services were "four times less likely to have a low birth weight (LBW) baby, two times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding."[10] In addition to reducing health disparities, continuous doula support has been shown to reduce healthcare costs by avoiding expensive healthcare emergencies.[11] One study demonstrated that doulas are cost-saving up to $884 per doula and cost-effective up to $1,360 per doula.[12] 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.[13]

B. Why Medicaid Matters

Nearly a quarter of people in the United States are covered by Medicaid—it is the nation's largest single provider of health coverage.[14] Anyone who meets a state's eligibility criteria has the right to payment for medically necessary healthcare services and can enroll in coverage.[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 few mandatory eligibility categories and a set of mandatory benefits.[16] Even with these requirements, 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

10. Gruber et al., *supra* note 8, at 54–55.

11. 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/.

12. Karen S. Greiner et al., *The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model*, 64 J. Midwifery Women's Health 410 (2019), https://pubmed.ncbi.nlm.nih.gov/31034756/.

13. *Medicaid Coverage of Doula Services in the United States,* Doula Series Footnotes, https://doulaseriesfootnotes.com/national-overview.html (last updated July 19, 2021).

14. Medicaid & CHIP Payment & Access Comm'n, MACStats: Medicaid and CHIP Data Book 3 (2019), https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf; *Eligibility,* Ctrs. for Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/eligibility/index.html (last visited Oct. 28, 2022).

15. *Medicaid 101*, Medicaid & CHIP Payment & Access Comm'n, https://www.macpac.gov/medicaid-101/ (last visited Oct. 28, 2022).

16. Kaiser Fam. Found., Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues 6 (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 (2017), https://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Clark-FinalPDF.pdf.

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.[19] For example, Medicaid covers non-emergency medical transportation; this is a non-clinical service not covered by traditional health plans, but the inclusion of transportation benefits on Medicaid allows low-income enrollees to access needed healthcare, thereby improving health outcomes and reducing total healthcare costs.[20] Medicaid legislation also includes flexibilities that allow for innovation around social determinants of health; for example, states can apply to use Medicaid funds for housing and food costs.[21] Policymakers are beginning to recognize that in order to address the widening health disparities in our country, it is necessary to look beyond just access to clinical healthcare services.[22]

III. Discussion

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 cost savings, adding doula services to Medicaid seems like an obvious policy priority. However, many states do not currently cover doula services on their Medicaid plans. In order to change this, advocates need to understand the nuances of a state's policy infrastructure—knowing the policymaking process, who has decision making authority, and the limitations of various approaches can inform the advocacy strategy and help decide where to focus lobbying efforts. There are multiple ways for states to enable Medicaid enrollees to access doula services: states can formally add doula benefits to Medicaid plans by submitting a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), Medicaid Managed Care Organizations (MCOs) can include doula

18. Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options,* Kaiser Fam. Found. 1 (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. *See* Med. Transp. Access Coal., The Value of Medicaid's Transportation Benefit (Aug. 2018), https://mtaccoalition.org/wp-content/uploads/2018/08/NEMT-ROI-Study-Results-One-Pager.pdf.

21. *See, e.g.*, Manatt, Phelps & Phillips LLP, *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/.

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

services in enhanced benefit packages, or a state can leverage federal and local grant programs to fund doula services.[23]

A. Adding Doula Benefits to Medicaid Plans

In order to formally add doula services to Medicaid plans, a state must submit a state plan amendment to CMS. As of June 2022, CMS has already granted approval to four states to provide doula benefits to Medicaid enrollees using federal funds: Oregon, Minnesota, New Jersey, and Virginia.[24] A handful of other states have followed suit and are in the process of implementing some type of doula benefit.[25] A state wanting to add doula benefits to its Medicaid program can and should look to lessons learned in these states.

1. How State Plan Amendments Work

A state outlines the specifics of how it will administer its Medicaid program in a document called a state plan. The state plan serves as the agreement between the state and the federal government about how its Medicaid program will operate; the state promises to abide by federal requirements, including covering all mandatory benefits and, in return, the federal government pledges to provide allotted federal match funding.[26] 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 matching funds 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

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23. Dee Mahan, Fams. USA, State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs 2 (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.

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 Oct. 28, 2022) (linking approved state plan amendments for doula services).

25. *Doula Medicaid Project*, *supra* note 6.

26. *State Plan,* Medicaid & CHIP Payment & Access Comm'n, https://www.macpac.gov/subtopic/state-plan/ (last visited Oct. 28, 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 Oct. 28, 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 (2021).

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 formal 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.[32]

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.[33] This means that before an SPA is submitted, the scope of the benefit must be fully ironed out—including the number of prenatal and postpartum doula visits that will be covered per patient, how much doulas will be reimbursed, and the estimated enrollee utilization rate. 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 towards including doula services as a formal Medicaid benefit.

Once a state has worked with stakeholders to iron out the benefit logistics, the SPA can be submitted. State laws vary significantly regarding what must happen in order to submit an SPA; this information can typically be found in the state's code within the section focused on medical assistance programs, or within a section about designation of authority to state agencies more generally.[34] 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.[35] Other states require that the legislature be notified and given the opportunity to review any changes, but specific approval is not required.[36] 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.[37] In other states, approval is required by some other entity, whether that be a board, committee, council, etc.[38] 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

30. 42 C.F.R. § 430.16(a)(1) (2022).

31. 42 C.F.R. § 430.16(a)(2) (2022).

32. Dee Mahan, Fams. USA, State Plan Amendments and Approval Time Frames (Jan. 2019), https://familiesusa.org/wp-content/uploads/2019/01/MCD_Intro-Expansion_Fact-Sheet.pdf.

33. *Medicaid State Plan Amendments*, *supra* note 28.

34. *See, e.g.*, Mo. Rev. Stat. § 208.001 (2021).

35. Nat'l Health L. Program & Nat'l Assoc. of Cmty. Health Ctrs., Role of State Law in Limiting Medicaid Changes 2 (July 2006), https://healthlaw.org/wp-content/uploads/2018/09/role-of-state-in-limiting-medicaid-changes.pdf.

36. *Id.*

37. *Id.*

38. *Id.*

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.

2. Strategies to Pursue Prior to a State Plan Amendment

There are varying strategies advocates can pursue to encourage a state to start down the path of obtaining an SPA. The choice of how to pursue an SPA will largely depend on the state's politics and who has authority to make change. Grassroots coalitions are now driving the change in many states, aided by the fact that people across the country are gaining familiarity with doulas.[39] This awareness has spurred additional research that shows how effective doulas can be, both in bettering health outcomes and in decreasing healthcare costs.[40] Armed with this information, it is now easier for grassroots initiatives to make the case about doula benefits when asking policymakers to champion this cause within their state.

One unique challenge of grassroots advocacy campaigns for doula services is that even though doulas have a large historical significance, especially in communities of color, doulas do not have a long history of organizing and lobbying.[41] Doulas often work as solo practitioners or in small collectives, and most states do not have an already existing network of doulas that can be easily rallied to put political pressure on local politicians.[42] Some nationally recognized doula organizations do exist, but they do not have the same political capital as other medical professional associations.[43] Advocates can work to develop these networks, but doulas may be reluctant to be further entrenched in the medical establishment. These dynamics are delicate, and healthcare advocates from outside of 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 via an SPA, 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 currently has a doula benefit, but this began with the creation of an exploratory committee.[44] In 2011, Oregon passed House Bill 3311: "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

39. Nora Ellman, *Community-Based Doulas and Midwives*, Ctr. for Am. Progress (Apr. 14, 2020), https://www.americanprogress.org/article/community-based-doulas-midwives/.

40. Safon et al., *supra* note 4.

41. *The Historical Significance of Doulas and Midwives,* Smithsonian Nat'l Museum of Afr. Am. Hist. & Culture (Jan. 31, 2022), https://nmaahc.si.edu/explore/stories/historical-significance-doulas-and-midwives.

42. Ellman, *supra* note 39.

43. *See* Dona International, https://www.dona.org/ (last visited Oct. 28, 2022); Nat'l Black Doulas Ass'n, https://www.blackdoulas.org/ (last visited Oct. 28, 2022).

44. H.B. 3311, 76th Leg. Assemb., Reg. Sess. (Or. 2011).

outcomes."[45] Oregon's bill further required the Oregon Health Authority to report to the state legislature on its findings.[46] Connecticut is now 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.[47] The state health department put together a working group that included doulas and other professionals interested in doula benefits.[48] This type of legislation brings policymakers' attention to the topic and provides an opportunity to demonstrate the benefits of doula services, explore potential coverage strategies, and get people comfortable with the idea before moving forward with a permanent Medicaid benefit.

A similar strategy involves advocating for initial legislation that sets up a process for doula certification and registration, but that does not initially create a mandatory benefit. In order to be reimbursed, most states require that doulas abide by some level of state regulation.[49] Setting up this process before formally adding doula benefits to Medicaid can allow a smoother transition to statewide coverage of doula services. 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 for doula services.[50] 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.[51] The Board was charged with creating criteria for registration, reviewing applications, and approving registrations of doulas.[52] 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.

3. Pursuing Policy Changes via the Legislative Process

Policies that include doula services as Medicaid benefits are typically pursued via standalone legislation in the form of individual bills brought to the floor by state representatives.[53] In most states, lawmakers have multiple opportunities throughout the year to introduce a bill. Proposing a bill requires deciding whether to introduce sparse legislation that gives authority to a specified group to

45. *Id.*
46. *Id.*
47. 2021 Conn. Pub. Acts No. 21-35 (Reg. Sess.).
48. *Id.*
49. *See Doula Medicaid Project, supra* note 6.
50. H.B. 190, Reg. Sess. (La. 2021).
51. *Id.*
52. *Id.*
53. *See Doula Medicaid Project*, *supra* note 6.

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.[54] The state health department then issued follow-up newsletters detailing how doulas were to be certified and reimbursed.[55] Rhode Island took the opposite approach, detailing the scope of practice and the reimbursement rate directly in the legislation.[56] Including details in legislation more clearly sets out program goals and expectations, but it leaves the Medicaid agency with less authority, and it is more difficult to amend. It may make sense to include significant details in legislation when doula groups are involved in crafting the legislation from the start, as was the case in Rhode Island.[57] 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 and future rulemaking. Doula voices can then be integrated in the subsequent regulatory process.

4. Pursuing Policy Changes via the State Budget Process

Rather than passing standalone authorizing legislation directing the state to take action, advocates can lobby for the state budget bill to include healthcare funds that can be used towards doula services or other doula programming.[58] Advocates are often wary of the seemingly impenetrable budget process, but learning 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.[59] In Missouri, the 2022 state budget includes funds for a doula training program.[60] Even though this particular bill does not fund an actual doula benefit, building the doula workforce within communities can be a critical first step towards an eventual Medicaid benefit.

Even when pursuing doula services through more typical legislative advocacy, engaging in budget advocacy is still important because budgets include funding, and funding is critical for success. Because Medicaid is jointly funded

54. S.B. 1784, P.L. 2019, c. 85, Reg. Sess. (N.J. 2019).

55. *Doula Care*, N.J. Dep't of Hum. Servs., https://www.state.nj.us/humanservices/dmahs/info/doula.html (last visited Oct. 28, 2022).

56. S. 484A, Gen. Assemb., Jan. Sess. (R.I. 2021).

57. *Id.*

58. *State Budget Advocacy Issue Brief,* Mental Health Am., https://www.mhanational.org/issues/state-budget-advocacy-issue-brief (last visited Oct. 28, 2022).

59. H.B. 1800 (Va. 2021); A.B. 128 (Cal. 2021).

60. H.B. 3010, 101st Gen. Assemb., 2nd Reg. Sess. (Mo. 2022).

by states and the federal government, advocates must ensure that state funds are appropriated for doula services once a bill creating a benefit is passed. In 2019, the Indiana state legislature passed a bill allowing doulas to be reimbursed under Medicaid.[61] 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.[62]

5. The Mechanics of a Doula Benefit

Regardless of how a state arrives at the point of SPA submission, advocates and legislators need to determine the scope of the benefit and how it will be administered. It is particularly important that policymakers work directly with doulas when developing these benefit parameters, as the long-term success of a benefit depends largely on ensuring doulas are willing to work within the Medicaid system.

First, policymakers must decide which benefit category doulas fall into—typically, either maternal care or preventive care. The benefit category can have large implications for doulas and how they practice.[63] Including doula services as part of the maternal care benefit requires that doulas work under the supervision of a Medicaid provider, since Medicaid regulations require that this type of care be furnished under the direction of a licensed practitioner.[64] Minnesota was one of the first states to include a doula benefit on Medicaid; it chose to offer doula services as a maternal health benefit, but this supervision requirement hindered the benefit rollout.[65] Providers were hesitant to agree to supervise doulas due to a lack of familiarity with the services they provided as well as a concern for their malpractice insurance, and doulas were concerned with what this could mean for their independence and ability to provide care as they saw fit.[66] In 2022, the Minnesota state legislature passed an amendment that allows doulas to operate more independently, which will hopefully ameliorate some of these issues.[67]

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61. S.B. 416, 121st Gen. Assemb., Reg. Sess. (Ind. 2019).

62. Jill Sheridan, *Funding for Doulas Cut Out of Budget*, IND. PUB. RADIO (Apr. 26, 2019), https://indianapublicradio.org/news/2019/04/funding-for-doulas-cut-out-of-budget/.

63. Medicaid has very little patient cost-sharing, and pregnant women are exempt from most remaining Medicaid cost-sharing requirements, so the benefit category is less relevant to enrollees (as compared to most other insurance plans where preventive services are much more affordable than other care). *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 Oct. 28, 2022).

64. 42 C.F.R. § 440.210 (2022) (incorporated by § 440.210(a)(1)).

65. *See* 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.

66. *Id.*

67. H.F. 4706, 92 Sess. (Minn. 2022), https://www.revisor.mn.gov/bills/text.php?number=HF4706&type=bill&version=1&session=ls92&session_year=2022&session_number=0.

Doula services can also be included as a preventive care benefit, which enables more flexibility. 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 the services are recommended by a licensed Medicaid provider.[68] This was intended to allow for a more robust set of preventive services benefits and broader access to non-traditional care.[69] However, some states initially interpreted the "recommended by" language very narrowly, essentially replicating a supervision requirement and undermining the purpose of the regulation. CMS has since approved New Jersey's and Virginia's SPAs, both of which include doula services as a preventive care benefit without requiring a specific written recommendation or prescription, indicating federal support for interpreting the recommendation requirement broadly.[70] 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.

To create a doula benefit, states may also need to set up pathways for doula certification and registration, depending on how the state wants to go about regulating doula services. Advocates need to balance the administrative needs of the state with the burdens that registration and certification requirements place on doulas, as the willingness of doulas to engage with Medicaid depends in part on how difficult it is to meet state requirements. Many states have proposed the requirement that doulas must undergo specified training, usually from a list of standard doula training programs. However, many of these national doula training and certification organizations are not well tailored to the needs of Medicaid populations and underserved communities.[71] Some doulas instead recommend that states set out a list of core competencies that doulas must meet, as was initially proposed in Massachusetts.[72] A core competency requirement ensures doulas have adequate knowledge but allows for more flexibility and more community-based training. Further, many doulas have been practicing for years and do not necessarily need to participate in a comprehensive training process. One potential solution is to include a legacy pathway for such doulas, where an established

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68. 42 C.F.R. § 440.130(c) (2022); NAT'L P'SHIP FOR WOMEN & FAMS., OVERDUE: MEDICAID AND PRIVATE INSURANCE COVERAGE OF DOULA CARE TO STRENGTHEN MATERNAL AND INFANT HEALTH (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.

69. *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).

70. CTRS. FOR MEDICARE & MEDICAID SERVS., NJ-20-0011, NEW JERSEY STATE PLAN AMENDMENT (Feb. 19, 2021), https://www.medicaid.gov/Medicaid/spa/downloads/NJ-20-0011.pdf; CTRS. FOR MEDICARE & MEDICAID SERVS., VA-21-0013, VIRGINIA STATE PLAN AMENDMENT (Oct. 29, 2021), https://www.medicaid.gov/medicaid/spa/downloads/VA-21-0013.pdf.

71. Marieke S. Van Eijk et al., *Addressing Systemic Racism in Birth Doula Services to Reduce Health Inequities in the United States*, 6 HEALTH EQUITY 98, 103 (2022).

72. *See, e.g.*, H. 2372, 192nd Gen. Ct. (Mass. 2021).

community doula can demonstrate expertise through alternate mechanisms. Balancing the state's desire to regulate providers with the needs of doulas can be tricky and takes time and thought, 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. Doulas should be paid a living wage. 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 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.[73] 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 bundled payment that includes between 6-8 appointments, split between prenatal and postpartum visits, as well as attendance at labor and delivery.[74]

Even once payment details are agreed upon, it can be logistically difficult to reimburse doulas through existing the health insurance system. Because doulas are non-clinical providers, 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.[75] 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.[76] Alternatively, a state can require that an already registered 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.

All of these elements—benefit category, doula certification requirements, and payment rates—must be ironed out and agreed upon before a state can actually begin providing doula services to Medicaid enrollees. This process can take a long time, especially when states are intentional about including all stakeholders in the decision making, but this investment in stakeholder engagement has tremendous long-term benefit for both doulas and enrollees.

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73. BEY ET AL., *supra* note 9, at 19.

74. *Doula Medicaid Project*, *supra* note 6.

75. AMY CHEN, ROUTES TO SUCCESS FOR MEDICAID COVERAGE OF DOULA CARE 11–13 (2018), https://healthlaw.org/wp-content/uploads/2018/12/NHeLP-PTBi-Doula-Care-Report.pdf.

76. *See, e.g.*, MD. DEP'T OF HEALTH, MEDICAID DOULA SERVICES PROGRAM MANUAL 6 (2022), https://health.maryland.gov/mmcp/Documents/Medicaid%20MCH%20Initiatives/Doulas/Doula%20Program%20Manual%206.8.22.pdf.

B. 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 access doula care if Medicaid Managed Care Organizations (MCOs) choose to offer these services as part of an enhanced or expanded benefits package.[77]

1. What is a Medicaid Managed Care Organization

Managed care organizations were created to optimize healthcare delivery, with the goal of reducing cost while also improving health outcomes.[78] In many states, the state Medicaid agency contracts with MCOs to administer Medicaid benefits.[79] The state pays the MCO a flat monthly rate per enrollee, so the MCO is incentivized to reduce cost while meeting and maintaining specific quality measures.[80] Now nearly all Medicaid beneficiaries are enrolled in some type of managed care plan, so leveraging these MCOs can be an effective way to reach most eligible people without going through a formal administrative process.[81]

2. Doula Services as an Enhanced Benefit

MCOs have flexibility to offer expanded or enhanced benefits—benefits beyond just the mandatory Medicaid services. Advocates and state health departments can encourage MCOs to include doula services in this expanded package as a health equity measure. Additionally, MCOs may want to include these services of their own volition as a cost-effectiveness tool or to create a competitive edge in the MCO pool, considering enrollees usually have a choice between multiple managed care plan providers.

Many of the decisions regarding benefit design and implementation, as described above, must still be made when an MCO decides to include doula services as an enhanced benefit. One potential downside is that because the state government has little control over MCO benefit administration, it can lead to inconsistency between benefits on different MCOs and confusion for enrollees. Even if the state health department monitors implementation efforts, it generally does 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 members.[82] Because each MCO can determine its own scope of benefits, access to services depends on which MCO an enrollee chooses,

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77. *See, e.g.*, Fla. Agency for Health Care Admin., Statewide Medicaid Managed Care Update 13 (July 10, 2018), https://ahca.myflorida.com/medicaid/mcac/docs/2018-07-10_Meeting/SMMC_Update_7-2018.pdf.

78. *Managed Care*, Ctrs. for Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/managed-care/index.html (last visited Oct. 28, 2022).

79. *Id.*

80. *Id.*

81. *Managed Care*, Medicaid & CHIP Payment & Access Comm'n, https://www.macpac.gov/topics/managed-care/ (last visited Oct. 28, 2022).

82. *See Doula Medicaid Project*, *supra* note 6 (Florida entry of chart).

which can lead to inequality of access among 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.[83] Even despite these limitations, leveraging MCOs can be an effective way to provide doula care in states where it may be difficult to gather the political capital needed to pass doula legislation.

To date, Florida is the only state to have implemented doula benefits using this method; the state's Agency for Healthcare Administration (AHCA) included doula services in its optional expanded benefits for Medicaid Managed Care, meaning the state encouraged MCOs to include this benefit in their plans.[84] Most MCOs in the state 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.[85] 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.[86] There is no standard fee schedule, so reimbursement is negotiated with each plan, which can be very time consuming and inequitable.[87]

Though only Florida has taken this approach, it will likely become more common—especially in other states that lack the political will to implement a permanent benefit. This option leverages the private market and consumer choice, so it may be easier to convince conservative leaders to champion this pathway. However, advocates must keep in mind that 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 the states can ensure the benefits are robust, even without being able to directly control MCOs. One option is for state health departments to issue guidance; even though guidance is not binding, suggested best practices for MCOs can 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.[88] For this to work, doulas must be in the provider network, and, in some circumstances, forcing an MCO to adopt a minimum fee schedule requires federal approval.[89] And 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

83. *Id.*

84. Fla. Agency for Health Care Admin., *supra* note 77; *see also Doula Medicaid Project*, *supra* note 6 (Florida entry of chart).

85. *Doula Medicaid Project*, *supra* note 6.

86. *Id.*

87. *Id.*

88. 42 C.F.R. § 438.6(c) (2022).

89. *Id.*

mechanism is to implement sanctions against the MCO, which ultimately hurts the intended beneficiaries.[90] As MCOs become a larger presence in the Medicaid space, the government should consider creating more nuanced enforcement mechanisms that enable states to leverage this pathway while still ensuring equitable and robust access to doula care.

C. Grant Programs

Grant programs, both at the federal and state levels, can be excellent ways to get doula services to people more quickly. This is because implementing a grant does not require legislative action, nor does it require coordination with MCOs. Because they are typically narrow in scope, grant programs allow for creative benefit design and direct reimbursement to doulas—which can lead to targeted and effective programs. Grants can also serve as opportunities to pilot community doula programs and build 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 for adding a permanent benefit in the future. Additionally, in some cases 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, leveraging grants can be a good strategy to get administrative details ironed out before transitioning to a statewide Medicaid benefit. This was the case in Maryland, where the governor introduced a four-year state funded doula pilot grant, which the Department of Health is now using as the starting point for an SPA.[91]

However, grants are not permanent, and they do not guarantee doula services for all Medicaid enrollees—they are typically time limited programs directed at a very specific population. Applying for grants also requires a significant amount of work. Accordingly, grant programs should be used strategically to fill in the gaps where other options are not plausible.

1. Federal Grant Programs

At least one existing federal grant program has already been leveraged to provide doula services—the Title V Maternal and Child Health Services Block Grant program, which makes grants available to states to address current and emerging maternal and child health challenges.[92] In 2017, a $2.1 million Title V grant was awarded to an Indiana organization that provides access to doulas to

90. 42 C.F.R. § 438.700 (2022).

91. Press Release, Off. of Governor Larry Hogan, Governor Hogan Announces Launch of $72 Million Maternal and Child Health Care Initiative, (July 6, 2021), https://governor.maryland.gov/2021/07/06/governor-hogan-announces-launch-of-72-million-maternal-and-child-health-care-initiative/; *see* S.B. 166, 2022 Leg., 444th Sess. (Md. 2022).

92. *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 reviewed July 2022).

communities with high infant mortality rates.[93] Title V grants are federal-state partnerships, requiring three dollars of state or local matching funds for every four dollars of federal spending.[94] Though states need to reapply for Title V grants every year, applying for Title V grants and other similar grant opportunities can be a great way for grassroots organizations to get funding to expand the reach of doula services without needing to work through the traditional political process.[95]

2. State Grant Programs

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 enacting Medicaid benefits and applying for federal grants). For example, in Ohio the Department of Medicaid chose to provide grants to cover doula services through its Maternal Infant Support Program, which did not include federal funding.[96] State grantmaking processes vary dramatically, so understanding if this could be a useful tool requires digging into the budget and grant processes of an individual state. It is also worth noting how long a grant will be in effect—some state grant programs may have longer horizons, but they are not unlimited. This information is not readily available, and sometimes obtaining a grant requires knowing the right people. But, grants could be worthwhile to investigate in states where other options are untenable.

Overall, the biggest drawback to implementing benefits via a grant program is the lack of permanence. Even still, grants can be 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, and grants can lay the groundwork for further investments in this area.

IV. Conclusion

Given the demonstrated benefits of doula care, from reducing health disparities to reducing healthcare costs, ensuring that Medicaid enrollees can access doula services should be a key policy priority. There are a number of pathways that have been and can continue to be leveraged in order to do this, with varying degrees of ease and likelihood of success. Advocates should look to their states'

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93. Ben Middelkamp, *Speak Life: Pregnancy Outreach Program Launches in Cass County,* Pharos Trib. (Mar. 9, 2018), https://www.pharostribune.com/news/local_news/article_a4fba591-e44a-5f7b-b2c1-d31a8adf583b.html.

94. *Title V Maternal and Child Health (MCH) Block Grant, supra* note 92.

95. U.S. Dep't of Health & Hum. Servs, HHS-0906-2020-F-7259, 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 (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/.

96. Ohio Dep't of Medicaid, Presentation at the Maternal & Infant Support Stakeholder Meeting: Doula Services, (June 23, 2021), https://medicaid.ohio.gov/static/Families%2C+Individuals/Programs/MISP/Doula-Services-June23-15Jun21.pdf.

political landscapes to determine the most feasible routes to providing doula benefits and should work with doulas on the ground during the planning, implementing, and evaluating processes.

Adding permanent doula benefits to state Medicaid plans is ultimately the most powerful pathway to doula accessibility; it is the only option that guarantees the long-term provision of services. However, the process of creating a benefit and then submitting a state plan amendment is labor intensive and requires significant political will. States that have not yet begun this process generally have less progressive politics, and so it may be difficult to get the necessary decision makers on board. Nevertheless, the maternal health crisis facing this country is stark, and doula movements are gaining momentum even in more conservative states. Advocates in states that have not yet begun the SPA process should focus on forming coalitions of doulas and laying the groundwork for an eventual benefit, even if this just means introducing bills to familiarize leaders with the concept of the benefits of doula services. Advocates do not need to start from scratch—they can look to existing resources and modify existing materials from other jurisdictions, tailoring them to the distinct needs of their state.

In states with a high need for maternal health investment but less political will to make structural change, leveraging increasingly prevalent Medicaid Managed Care Organizations can be effective. Encouraging MCOs to include doula services as an enhanced benefit is a good intermediate solution. It does not require significant governmental involvement, so it can happen fairly independently from the political process, but it still serves to get many eligible people needed care. However, it does not provide as much stability for enrollees as an SPA because there are not standardized policies and procedures and there is no long-term guarantee of services.

Grant opportunities that provide funding for doula services are more limited in scope and impact, so they should be pursued when necessary but not relied upon as a long-term solution. Grant programs do present the ability to pilot doula benefits and demonstrate effectiveness, which may set the stage for longer-term investment.

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.