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Coverage for doula services: how state Medicaid programs can address concerns about maternity care costs and quality

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One of the key issues facing US health insurers, managed care organizations, state policymakers, and clinicians who care for low-income populations is Medicaid spending. Each year, Medicaid programs pay \$13 billion to hospitals for maternal and newborn care for just under 2 million births.(1) The high costs of childbirth are sometimes compounded by the expenses related to adverse birth outcomes such as cesarean delivery, preterm births and morbidity. Preterm births for instance, cost the U.S. health care system more than \$26 billion annually, and infants born preterm are likely to incur medical costs that are ten times higher than full-term infants during their first year.(2) Costs also increase when complications arise that lead to a cesarean delivery, which in 2010 cost state Medicaid programs \$13,590, per birth on average, compared with \$9,131 for a vaginal delivery.(3) Concerns for costs and the well-being of women and infants has led policymakers to search for innovative solutions that meet the “triple aim” of providing better care, improving population health, and reducing healthcare costs.(4)

One specific approach has been expanding pregnant women’s access to care from a doula, a trained maternal support professional who offers care in the emotional, informational, and psycho-social aspects of pregnancy, childbirth and the postpartum period. Policy efforts to expand access to doula services gained traction following the March 2014 consensus statement by the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine,(5) which explicitly endorsed greater use of “one of the most effective tools to improve labor and delivery outcomes, the continuous presence of support personnel, such as a doula.” This consensus statement describes the substantial evidence base underpinning this recommendation, including a review of randomized controlled trials of doula support during labor, which show stronger effects for women who are low income, socially disadvantaged, or who experience cultural or language barriers to accessing care.(6) Furthermore, support from a doula during labor and delivery is associated with lower cesarean rates and fewer obstetric interventions, fewer complications, less pain medication, shorter labor hours, and higher infant APGAR scores.(6–10) Access to doula support also shows potential for reducing racial-ethnic and socioeconomic disparities in breastfeeding initiation.(11)

Two states (Oregon and Minnesota) allow Medicaid reimbursement for doula services. In 2012, Oregon’s Medicaid program began coverage of birth doulas through the same “non-

traditional health workers” reimbursement category used for community health workers.(12) However, uptake has been minimal because reimbursement rates are currently set well below the costs for doulas to provide services. This is a payment challenge that is certainly not unique to doulas but without private health insurance coverage to balance a payer-mix portfolio, doula work has limited financial viability. Minnesota passed legislation in May 2013 establishing Medicaid reimbursement for doulas starting after federal approval of their Medicaid waiver, which occurred on September 25, 2014.(13)

In Minnesota, there have been substantial implementation challenges which include: defining standards; verifying certification; establishing payment codes; setting reimbursement rates for these codes under fee-for-service Medicaid; communicating with women, doulas, medical providers, healthcare delivery systems and managed care organizations; establishing contractual agreements between doulas and clinicians for payment purposes; and ensuring that doulas are registered as enrolled providers with the state and with managed care organizations to provide the services protected in statute.(14) In spite of these obstacles, on September 10, 2015, the first check was sent by a Medicaid Managed Care organization to pay for doula services (50 weeks after the effective date of the legislation). Yet many challenges remain. Further efforts on the part of implementing agencies as well as doulas and medical providers, Medicaid beneficiaries, managed care organizations, and state regulators will likely be required to ensure full implementation to the intent of the statutory language.

One area of innovation in healthcare financing that may complement ongoing legislative efforts on doula coverage is the adoption of bundled payments for discrete care episodes. Most Medicaid managed care programs currently reimburse maternity care clinicians for a bundle of outpatient services that include prenatal and postpartum care. One strategy to create incentives for managed care services to include access to doulas during the prenatal period would be to administratively or legislatively require that the billing entity have a contracted agreement with a minimum number of certified doulas per total pregnant beneficiaries. For example, successful perinatal care episode payment models, such as Geisinger’s ProvenCare Perinatal® (15) or the Arkansas Health Care Payment Improvement Initiative (16) could potentially improve outcomes and reduce costs further by including doula care as a covered service within the bundle.

Other relevant policy considerations for enhancing the effectiveness and improving implementation of policies designed to increase access to doula care for Medicaid beneficiaries could address both geographic and cultural barriers to care. Currently, most doulas are white upper-middle class women, and most doulas practice in metropolitan areas. (17) To increase the diversity of the doula workforce to reflect the population of Medicaid beneficiaries giving birth and to expand the workforce to rural areas, states may want to consider grant programs to subsidize doula training for women from culturally diverse backgrounds and from rural communities. Doula training, certification, and registration are costly, generally ranging from \$800–\$1200, and many low-income women and women from communities of color have limited financial access to the training required to become a doula. Additionally, establishing a fee waiver process for fees for doula certification and registration for low-income applicants is an important policy consideration and would likely

contribute to diversifying the doula workforce. Finally, there is a need for a focus on ensuring access to doula care for women in rural areas who have more limited access to both healthcare services and other supportive resources.(18) For example, allowing doulas to claim reimbursement for travel mileage may facilitate access for women in rural and remote areas. Without these policy considerations, rural doulas, who frequently travel substantial distances to meet with clients, may find that travel expenditures alone may outweigh earnings for prenatal visits for distant clients.

There are steps that state Medicaid programs and other payers can take, in collaboration with professional associations and health care delivery systems, to both increase uptake of doula support among low-income pregnant women and to better document the effects. First, maternity care clinicians (midwives, obstetricians, family physicians, and others) could receive education and information about the role of doulas and how to work with them in the prenatal period. This may facilitate increased knowledge among both pregnant women and their providers regarding the potential role of a doula in their pregnancy and childbirth while simultaneously solidifying the doula's role as part of the care team. Second, efforts to coordinate payment and credentialing are vital to the uptake of doula support among Medicaid beneficiaries. A formal coordination structure that handles issues related to the doula registry/credentialing (this might be housed in a state Department of Health) and payment/Medicaid (state level Department of Human Services) is an important next step in creating the infrastructure necessary to embed doulas into the system. This joint coordinating group might also serve as a resource for doulas, maternity care clinicians, and managed care organizations so that shared information is clear and transparent. Along the same lines, this coordinating group may also be tasked with providing clear guidance for doulas as to how they become enrolled providers and how they bill for their services. Finally, consideration must be given regarding how to best inform managed care organizations regarding what types of services and supports doulas provide, what services are covered under the law, and how to efficiently contract with them.

Having doula support for patients during the prenatal period may hold particular resonance for high risk obstetricians, maternal-fetal medicine specialists, or hospitals, clinics, health systems, and payers that serve women at higher risk for preterm birth. African-American women, women with substance abuse diagnoses, adolescents who give birth, and women who suffer from disproportionate levels of psychosocial and emotional stress (e.g. those with current or historical trauma, violence, homelessness, abuse, etc.) are a few of the examples of women who may benefit most from doula support. The involvement of a doula in the prenatal period and birth for a women considered at high risk for adverse birth outcomes may have a profound impact on birth outcomes and may strongly influence the pervasive inequities at the center of maternal and child health.

The link between income, sociodemographic factors, and adverse birth outcomes is well documented, (19, 20) but effective means of reducing known risks, including doula care, have not been widely implemented or made widely accessible. There is an urgent need to address non-medical, social determinants of health in order to stem rising perinatal care costs in a time of increasing fiscal pressures on health care systems and state Medicaid budgets. Oregon and Minnesota should be lauded for their pioneering efforts to expand

access to doula care, an evidence-based intervention. However, more can be done to improve implementation effectiveness. Other states should follow the leadership of Oregon and Minnesota and endeavor to learn from the experiences of their predecessors. The triple aim is within reach, and – in maternity care – it’s an increasingly urgent priority for women, families, clinicians, and policymakers.

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