COMMENTARY

# Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality

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Controlling Medicaid costs is a key issue facing United States health insurers, managed care organizations, state policymakers, and clinicians who care for low-income populations. 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 United States 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 health care costs (4).

Expanding pregnant women's access to care from a doula is one specific approach that has been demonstrated to improve birth outcomes and reduce medical costs (5–7). A doula is a trained maternal support professional who offers care in the emotional, informational, and psychosocial aspects of pregnancy, childbirth, and the postpartum period. In March 2014, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal Fetal Medicine issued a consensus statement (8) that 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 (9). The growing body of evidence indicates that support from a doula during labor and delivery is associated with lower cesarean rates, lower preterm birth rates, fewer obstetric interventions, fewer complications, less pain medication, shorter labor hours, and higher infant APGAR scores (5–10). Notably, the association between doula support and positive birth outcomes is larger, and in some cases statistically stronger, among women who are low income, socially disadvantaged, or who experience cultural or language barriers to accessing care (9–11). For example, access to doula support may reduce racial-ethnic and socioeconomic disparities in breastfeeding initiation (12).

Policy efforts to expand access to doula support gained traction following the March 2014 ACOG statement. Attention has focused on the two states (Oregon and Minnesota) that currently allow Medicaid reimbursement for doula services. In 2012, Oregon's Medicaid program began coverage of birth doulas through the same "nontraditional health workers" reimbursement category used for community health workers (13). However, uptake has been minimal because reimbursement rates are currently set well below the costs for doulas to provide services. Without adequate reimbursement, doula work is not financially viable.

A second state, Minnesota, passed legislation in May 2013 establishing Medicaid reimbursement for doulas

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starting after federal approval of their Medicaid waiver, which occurred on September 25, 2014 (14). 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 practitioners, health care delivery systems, and managed care organizations; establishing contractual agreements between doulas and clinicians for payment purposes; and ensuring that doulas are registered as enrolled practitioners with the state and with managed care organizations to provide the services protected in statute (15).

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. Furthermore, efforts on the part of implementing agencies as well as doulas and medical practitioners, Medicaid beneficiaries, managed care organizations, and state regulators will likely be required to ensure full implementation to the intent of the statutory language.

The adoption of bundled payments for discrete care episodes is one innovation in health care financing that may support greater access to doula services. 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 a requirement (administrative or legislative) 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 (16) or the Arkansas Health Care Payment Improvement Initiative (17) could potentially improve outcomes and reduce costs furthermore by including doula care as a covered service within the bundle.

Increasing access to doula care for Medicaid beneficiaries could reduce both geographic and cultural barriers to care. However, to fully accomplish this, it is essential to 1) increase the diversity of the doula workforce to reflect the population of Medicaid beneficiaries giving birth, and 2) to expand the doula workforce to rural areas. Currently, most doulas are white upper-middle class women, and most doulas practice in metropolitan areas (18). To build a more diverse doula workforce, states could implement 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 to $1,200, and many low-income women and women from communities of color have limited financial access to the training required to become a doula. In addition, establishing fee waivers for doula certification and registration costs for low-income applicants would reduce financial barriers to entry into the profession. Finally, pregnant women in rural areas need reliable access to doula care, as these women have more limited access to both health care services and other supportive resources (19). 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 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 could increase knowledge among both pregnant women and their practitioners about the potential role of a doula in their pregnancy and childbirth whereas 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 doula coordinating group could be established with joint participation by state departments of health and human services to: 1) facilitate doula registration and credentialing; 2) assist with reimbursement processes and interaction with Medicaid program administration; 3) provide clear guidance for doulas on how to become enrolled practitioners and how to bill for their services; 4) inform managed care organizations and health care delivery systems about the types of services and supports doulas provide, what services are covered under the law, and how to efficiently contract with doulas; and 5) serve as a resource for women, doulas, clinicians, and other stakeholders to ensure that shared information is clear and transparent.

Ensuring doula support for women during the prenatal period may hold particular resonance for high-risk obstetricians, maternal-fetal medicine specialists, hospitals, clinics, health systems, and payers that serve women at higher risk for preterm birth. African-American women, teenage mothers, women with substance abuse problems, and women who suffer from disproportionate levels of psychosocial and emotional stress (e.g., those with current or historical trauma, violence, homelessness, abuse, etc.) may benefit most from doula sup-

port. The involvement of a doula in the prenatal period and birth for a woman considered at high risk for adverse birth outcomes may have a profound influence on birth outcomes and potentially reduce the pervasive inequities at the center of maternal and child health.

The link between income, socio-demographic factors, and adverse birth outcomes is well documented (20,21), 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 nonmedical, social determinants of health 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" of providing better care, improving population health, and reducing health care costs is within reach. In maternity care, this is an increasingly urgent priority for women, families, clinicians, and policymakers. Both clinical evidence and fiscal prudence point Medicaid programs in the direction of doula care.

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