Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid

By Taylor Platt and Neva Kaye

Introduction

The United States faces a steadily increasing rate of maternal mortality with significant racial, ethnic and socioeconomic disparities in birth outcomes. Doula services, which provide continuous physical, emotional, and informational support to women before, during, and shortly after childbirth, provide a way to address some of those inequities and generate potential savings over time to state Medicaid programs. This report highlights how four state programs support doula services to women covered by Medicaid.

Background

Women in the United States are more likely to experience poor birth outcomes than those from other countries and there are significant racial, ethnic and socio-economic disparities in US birth outcomes. The Centers for Disease Control and Prevention (CDC) reports that the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births.[1]

The United States is the only developed country in the world where the maternal mortality rate has been steadily increasing over the years.[2] In addition to the overall rise in maternal mortality, there are stark racial and age disparities.[3] In 2018, the maternal mortality rate for non-Latina White women was 14.7 deaths per 100,000 live births, compared to 37.1 deaths per 100,000 live births for non-Latina Black women, due to barriers to quality, culturally competent medical care and the effects of social determinants of health like housing, structural racism, and poverty.[4] Additionally, in 2016 the pregnancy-related mortality rate for American Indian/Alaskan Native non-Latina women was 30.4 deaths per 100,000 live births.[5]

Older women are also more at risk to die from pregnancy related causes. In 2018, the maternal mortality rate for women over 40 was 81.9 deaths per 100,000 live births while the rate for women between the ages of 25-39 was 16.6 deaths per 100,000 live births.[6] In 2014, more than 50,000 women experienced severe maternal morbidity (SMM), which are pregnancy complications that can be "near death misses" if not caught and addressed. In recent years, SMM rates have been steadily increasing.[7] With the

Four State Strategies

- Indiana uses Title V Maternal and Child Health (MCH) Services Block Grant funding to support Community Wellness Partners, which offers doula services to Medicaid-eligible women.
- Minnesota Medicaid covers doula services as one "extended service for pregnant women."
- The Nebraska Medicaid managed care organization WellCare covers doula services for pregnant youth in foster care.
- Oregon Medicaid covers doula services as a preventive service for pregnant women.

growing maternal mortality crisis, states are on the front lines in working to improve maternal health outcomes. States are beginning to turn to doulas as a strategy to help combat the rising maternal mortality rates and improve birth outcomes.

The COVID-19 pandemic and resulting job losses and economic downturn has generated an unprecedented decline in state revenues, and many are dipping into rainy day funds and have already proposed substantial cuts in Medicaid. The Coronavirus Aid, Relief, and Economic Security (CARES) Act requires states to meet a "maintenance of effort" – retaining both the number of eligible people enrolled in Medicaid and current benefit structure, which leaves little room for new expenditures. However, the pandemic also laid bare the inequities in health care delivery.

Doula services provide a way to address some of those inequities and bring savings in the longer term to Medicaid programs. This report presents a variety of options for supporting Medicaid-covered pregnant women's access to doulas. Based on document review and interviews with key stakeholders, the report presents evidence on the effectiveness of doula services and examines the experience of four states that are paying for doula services for pregnant women.

Doulas' Effectiveness and Return on Investment

Research confirms that pregnant women who receive doula care are more likely to experience healthy birth outcomes, including lower preterm birth and caesarean section rates,[8] higher five-minute Apgar scores for newborns (a test of five measures to evaluate an infant's health), and a more positive, self-reported birth experience.[9] One study found that women who gave birth with a doula present were:

- Four-times less likely to have a low-birth-weight baby;
- Two-times less likely to experience birth complications; and
- Significantly more likely to initiate breastfeeding.[10]

Because women who receive birth support from a doula experience healthier outcomes and lower rates of cesarean sections, it offers cost-saving opportunities for states.[11]

Based on the current evidence of effectiveness, paying for doula services could generate a potentially significant return on investment for Medicaid programs. In 2013, one model estimated that with the reduction in cesarean sections, a reimbursement rate for doulas of $200 would have the potential to save state Medicaid programs $2 million dollars annually.[12] In 2016, certified doulas were paid (through private insurance or out of pocket) between $27 to $35 per hour for prenatal and postpartum services and between $584 to $844 for attending births. As states begin to implement coverage of doula services in their Medicaid programs, it is important to note these services are new for Medicaid programs. The ability to report on the accuracy of return-on-investment projections will depend on implementation, utilization, and correct reimbursement rates. Additionally, the benefits of an improved birthing experience, reduced maternal mortality, and fewer cesarean births may not be reflected in short-term return on investment analysis.

Why States Cover Doula Services

Recognizing that doulas could help decrease maternal mortality and improve birth outcomes for women and infants covered by Medicaid, some states are considering paying for doula services. In addition to the states featured in this report, Washington State and New Jersey are currently implementing

statewide Medicaid coverage and New York Medicaid is piloting a program in two counties. In 2019, nine other state legislatures considered Medicaid reimbursement for doula services. Also, state Title V Maternal and Child Health (MCH) Services Block Grant programs, including Indiana's, have long invested in doula services for Medicaid-eligible pregnant women. Thirteen state Title V MCH Block Grant programs include doulas in their state action plans.[13]

The four states all prioritize and target doula services to improve birth outcomes for women covered by Medicaid, who are all low-income and at greater risk for poor birth outcomes. A study of statewide income levels demonstrated that unequal income distribution in states can be particularly harmful to the health of Black women.[14] Minnesota, Oregon, and Indiana were primarily seeking to address racial disparities in infant and maternal mortality. One of Nebraska's priorities was addressing the health and well-being of the foster care population. Because of this, the Medicaid managed care organization (MCO) WellCare decided to cover doula services for pregnant youth in foster care. Doulas interviewed for this report provided support services to pregnant women in a clinical setting as well as care coordination services to address social determinants of health, such as food insecurity and housing. States vary in how they define doulas and the services they provide.

All three states include the type of support doulas provide in their definition, and Nebraska and Minnesota specifically call out that a doula is a certified individual. For example, Minnesota's statute defines a doula as someone who has received a certification to perform doula services from one of eight organizations.[15] Additionally, a Medicaid statute further defines doula services as continuous emotional and physical support throughout labor and birth, and intermittently during the prenatal and postpartum periods. Oregon defines birth doulas as a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience and uses that definition for their contracts with coordinated care organizations (CCOs).[16]

State Strategies to Pay for Doula Services

The four states highlighted in this brief (IN, MN, NE, and OR) use three pathways to pay for doula services provided to a Medicaid-covered woman – Title V MCH Services Block Grant Program, Medicaid, and Medicaid MCOs. These pathways each offer different benefits and drawbacks

Indiana: Using a Title V MCH Block Grant

The Indiana State Department of Health (ISDH) Maternal and Child Health (MCH) Division led by the Governor's office, created the Indiana Safety PIN – Protecting Indiana's Newborns grant with Title V MCH Block Grant funds, to support the state's efforts to reduce the infant mortality rate. The Safety PIN grant program supports strategies to target the disparity in the Black infant mortality rate and improve birth outcomes for Black mothers, who face challenges in obtaining quality care and may have difficulty addressing social determinants of health like nutrition, transportation, and housing.[17] The Speak Life doula program was awarded a Safety PIN grant in 2017 to provide doula services to Medicaid-covered pregnant women. Grants such as this enable a state to help organizations and providers develop their capacity and test the utility of paying for doula services on a smaller scale. However, the coverage for doula services may be at risk when the grant ends or when other conditions, such as when the managing grantee organization or state priorities change.

The Speak Life program focused on training doulas from the target community where they serve and aimed to lower the infant and maternal mortality rates among African American and Latina mothers. The program provided at least two visits before the birth, with visits ramping up to once a month closer to the due date. During the visits, doulas provide information about physical and emotional health, resources on what to have in the home, smoking and tobacco cessation information, and childbirth education. Doulas also attend doctors' visits with the mother. In addition to attending and supporting the mother through childbirth, the Speak Life program offers services for up to one year postpartum. These services included assistance with follow-up appointments with the pediatrician and obstetrician, maternal depression screenings, home-visiting services, lactation services, education on safe sleep, and materials such as breast pumps, cribs, and diapers. The program was able to provide pregnant women with doula services from their communities, with cultural relevance and sensitivity. Currently, the Speak Life Doula program is undergoing changes due to a shift in the managing grantee organization.

Title V MCH Services Block Grant Program Basics

The Health Resources and Services Administration (HRSA) administers the Title V MCH Block Grant which is an important source of funding for promoting and improving the health and well-being of mothers, children, and their families. The program seeks to create federal and state partnerships that support both access to quality health care, especially for people with low incomes and/or limited availability of care, and access to comprehensive prenatal and postnatal care for women, among other goals. States have flexibility to use the funds in different ways to address the unique needs of their children and families.

Minnesota and Oregon Pay for Doula Services through Medicaid

Under federal law, state Medicaid programs must cover a set of mandatory benefits, but states can, within federal guidelines, also choose to offer optional benefits. Two state Medicaid agencies have chosen to cover doula services as an optional benefit. In order to implement the benefit each needed to establish policies that addressed four key topics:

1. Provider qualifications;
2. Determination of covered services and reimbursement rates;
3. Approaches to billing for Medicaid; and
4. Roles of contracted health plans.

Minnesota and Oregon both pay for doula services as a Medicaid service. Minnesota chose to cover doula services as an extended service for pregnant women[18] while Oregon chose to cover the services as a preventive service.[19] These choices presented different options for addressing different areas of implementing doula services. For example, under federal law, all Medicaid-covered services must be provided (and billed by) a physician or other licensed provider with few exceptions. However, preventive services provided by a traditional health

Medicaid Basics

The Medicaid program provides health coverage to millions of Americans and is funded jointly by states and the federal government. Low-income adults, children, pregnant women, elderly adults, and people with disabilities are all eligible for health coverage through the Medicaid program. States, which must operate their programs within federal guidelines, can use different federal authorities to pay for services. States set forth their policy choices in their state plans and obtain approval of changes to their policies by submitting a state plan amendment to the Centers for Medicare & Medicaid Services.

worker who meets state-established qualifications are one such exception.[20] These services may be provided at the recommendation of a physician or other licensed provider. Oregon's choice to cover doula services as a preventive service gave the state more billing policy flexibility than Minnesota. The following presents the specific coverage policies that each state established.

Provider Qualifications

Each state requires doulas to take different steps to qualify for Medicaid reimbursement (see Table 1). Doulas interested in becoming Medicaid providers in Minnesota must complete training approved by the Minnesota Department of Health (MDH) and complete the Doula Registry application. The MDH allows individual doulas as well as doula organizations in the state to enroll. Because doula services are covered as an extended service for pregnant women, doulas in Minnesota must work under the supervision of a Medicaid-enrolled provider. Similarly, doulas in Oregon must complete certification requirements outlined by the Oregon Health Authority (OHA). These requirements include at least 28 contact hours of in-person education, six hours of cultural competency training, and at least six contact hours related to doula care. Doulas are also required to complete an oral health training approved by OHA. Doulas then apply for a listing on OHA's traditional health worker (THW) Registry and enroll as a Medicaid provider in the state.

Despite the availability of doula services in Minnesota, access to care and provider challenges persist. Minnesota interviewees identified doulas' difficulty in developing an agreement with a supervising provider as the main barrier to doulas' delivery of services to Medicaid covered pregnant women. Two primary reasons cited for difficulty securing an agreement were a lack of provider familiarity with the services doulas can provide and provider concern that agreeing to supervise a doula would adversely affect their malpractice coverage.

Table 1: State Requirements for Doulas to Qualify for Medicaid Payment

Minnesota	1. Complete doula training through one of eight Minnesota Department of Health (MDH) approved organizations. 2. Obtain a listing on the MDH's Doula Registry by completing the Doula Registry application and submitting a $200 check to MDH. 3. Work under the supervision of a Medicaid-enrolled physician, nurse practitioner, or certified nurse midwife.
Oregon	1. Complete certification requirements, including more than 40 hours of approved training and attending at least three births and three postpartum visits. 2. Obtain a no-cost listing on the OHA's traditional health worker registry by completing an application and submitting documentation. 3. Enroll as a Medicaid provider, which requires first obtaining a National Provider Identifier.

Covered Services and Reimbursement Rates

Medicaid agencies in Minnesota and Oregon define who qualifies for services, which services doulas can provide, and how much will be paid for each service (see Table 2). In both states, all pregnant Medicaid participants are eligible to receive doula services. In some rare instances in Minnesota, pregnant women enrolled in the state's basic health plan are also eligible to receive doula care. Minnesota and Oregon

both cover doula services for prenatal care, labor and delivery, and postpartum care. Minnesota Department of Human Services (MNDHS) reimburses for individual sessions, while Oregon reimburses with a global payment. (A global payment is a single payment that covers a package of individual services needed to treat a health event, such as a pregnancy.) MNDHS will reimburse for additional visits if there is a prior authorization from a provider.

Both states reported that the initial reimbursement rates set for doulas was too low to attract interested doulas to serve enrollees. Because of low reimbursement rates, doulas reported needing to work other jobs to support themselves and being unable to provide doula services as a full-time job. This led both states to pursue increasing reimbursement rates. After 2019 state legislation paved the way to increase the reimbursement rate, Minnesota currently has a State Plan Amendment pending approval to increase rates to $47 per prenatal and postpartum session and $488 for labor and delivery. In Oregon, the initial reimbursement was $75 and was ultimately increased to $350. Oregon reported experiencing an increase in doulas joining the THW registry after this rate increase.

Table 2: Covered Services, Reimbursement, and Billing Requirements

	Covered Services and Reimbursement Rates	Billing Procedures
Minnesota	MNDHS reimburses doulas for individual services • Covers up to seven sessions (prenatal and postpartum), one of which must be labor and delivery. • Doulas receive $47 per prenatal or postpartum visit and $488 for labor and delivery.	• All services must be billed by the supervising physician. • Billing for labor and delivery session is billed separately from non-labor sessions.
Oregon	OHA reimburses doulas in two ways: • A $350 global payment for a package consisting of at least two prenatal visits and two postnatal visits plus support on the day of delivery; or • If the doula does not provide the entire package: $50/visit for up to four maternity visits and $150 for support on the day of delivery.	• Medicaid-enrolled doulas can either bill OHA directly or through an organization or clinic that bills on their behalf. • Services must be provided at the request of a licensed obstetrical provider. • Doulas must bill for the global payment except in extenuating circumstances.

Medicaid Billing

Both states have also established requirements for services to qualify for Medicaid payment (see Table 2). Minnesota doula services must be billed by the supervising provider. Also, doulas must bill for labor and delivery separately from other sessions. The previously discussed difficulties of identifying a supervising provider continue to pose a barrier for doulas seeking Medicaid reimbursement. Minnesota Medicaid has proposed establishing a licensing process for doulas, which would enable the agency to allow doulas to bill Medicaid directly. However, doulas in the state are concerned that the cost of obtaining a license would be a barrier for lower-income people seeking to become doulas.

In Oregon, doulas enrolled in Medicaid can either bill the state Medicaid agency directly or through an organization that bills on their behalf. In order to bill Medicaid, doula services must be provided at the request of a licensed obstetrical provider. (This contrasts to Minnesota's requirement that the services be supervised and billed for by a licensed provider). While doulas can bill Medicaid directly, navigating the complicated billing process has been a reported challenge for doulas in the state. In response to this, OHA assisted in creating doula "hubs" to help self-employed doulas navigate the complexities of Medicaid billing. The doula hubs allow groups of doulas registered as traditional health workers (THW) to bill together instead of as individuals. The doula hubs have proven successful in helping doulas navigate the billing process and have worked with OHA to improve delivery of services.

Medicaid Managed Care Organizations (MCOs) Basics: MCOs are health care delivery systems organized to manage cost, utilization, and quality. MCOs deliver Medicaid health benefits and additional services under contracted arrangements with state Medicaid agencies. MCOs may cover value-added services for their members in addition to those covered by the Medicaid program.

Role of Contracted Health Plans

The Medicaid agencies in Minnesota and Oregon deliver a comprehensive benefit package, including doula services, to pregnant women through contracted managed care organizations (MCOs) in Minnesota and coordinated care organizations (CCOs) in Oregon. As a result, Medicaid agencies need to convey their expectations regarding coverage of doulas to the organizations with which they contract through a Medicaid managed care contract (see Table 3). Oregon has taken additional steps when working with the CCOs to provide education on doula services and how CCOs can support doulas and Medicaid members. The THW commission engages with the workforce through the doula hubs and continuous improvement efforts, and the CCOs have liaisons between doulas and their Medicaid members to ensure easy access and delivery to services. OHA also requires CCOs to submit the number of doulas members were able to access to monitor success and also help with quality improvement when needed.

Table 3: What's Included in MCO/CCO Contracts

Minnesota	The contract between the Medicaid agency and the MCOs states that, "Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered." (See Section 6.1.33.2 of the contract)
Oregon	CCOs, under their contract with the Medicaid agency, must support use of doulas (THWs), including paying for doula services, communicating to members and providers about the scope of practice and benefits of THWs, and increase member utilization of THWs. (See page 268 of the contract.)

Nebraska: A Medicaid MCO pays for doula services as a managed care value-added service.

Nebraska requires its contracted MCOs to provide value-added services to Medicaid members, but allows each MCO to choose which value-added services it will offer. Value-added services in Nebraska must be medically appropriate and cost effective. These services may include health care services that

are currently non-covered services by the Medicaid State Plan or which are in excess of the amount, duration, and scope in the Medicaid State Plan.[21] One MCO, WellCare of Nebraska, chose to cover doula services as a value-added service.[22] WellCare of Nebraska pays for doula services provided to members who are pregnant females up to 21 years old, engaged with the foster care system, and live in a group home, maternity home, and have minimal parent support.[23] WellCare requires doulas to be certified through a national organization and will pay for up to four prenatal and postpartum visits as well as attendance at labor and delivery. Doulas can bill the MCO directly for services. The plan outlines specific diagnosis and procedure codes which doulas may bill. Including doula services as a value-added service under Medicaid managed care enabled Nebraska to cover the service without need of a State Plan Amendment and at no additional cost to the Medicaid agency. However, few foster care youth chose to use the service. In the contract between WellCare and the Nebraska Medicaid agency, there is an annual review of the value-added services and both entities decide, based on utilization, cost and outcome metrics, whether the service should be continued or replaced.[24] As of June 2020, WellCare and the Medicaid agency had decided to end doula coverage for youth in foster care due to little use of the benefit. Representatives noted that most social services workers who work with youth in the foster care system were unaware of the service's availability and believed that contributed to its low utilization.

Lessons Learned and Conclusion

The experience of these four states yields lessons for other states that might be considering paying for doula services provided to pregnant women covered by Medicaid.

Doulas play a key role in addressing the social determinants of health (SDOH) needs of their clients. Doulas interviewed for this brief reported connecting Medicaid-covered pregnant women to community resources. "Maybe a mom might be in a situation where she's facing physical violence or emotional violence, or she may have just moved to the area and didn't have access to many resources," one doula explained. Others reported providing cribs. Some also helped facilitate pregnant women's interactions with the medical system, helping women identify concerns they might want to discuss with their obstetricians. Oregon included this type of support in doulas' scope of practice.

Some interviewees reported encouraging results. One doula reported, "We never lost a mom [in over 200 births] and our breastfeeding initiation rates shot up [compared to previous rates]. We had, I think, an 85 percent initiation rate and 69 percent duration over the past three to four months." State officials in Oregon were hopeful that their program would reduce cesarean and pre-term birth rates. One Minnesota official, however, reported that he had used 2015-2018 data to compare outcomes of those who received doula services to those who did not. This analysis found little difference in maternal mortality and length of hospital stay post-delivery. However, the analysis found benefits in other areas. The analysis did find that, "The rate of vaginal births versus cesareans was five percentage points higher in the group who received doula services…The percentage of women who received maternal depression screenings through a well-child visit was almost twice as high for those who received doula services." However, the official felt these differences could be due to other factors, such as selection bias (i.e., women who use doula services might be more receptive to other preventive services, such as maternal depression screening).

Medicaid billing for doulas can be challenging, but Medicaid policies can help overcome those challenges. Doulas found both enrolling as a Medicaid provider and billing Medicaid to be challenging. Oregon was able to minimize this administrative burden by covering doula services as a preventive

service and designating doulas as THWs. This enabled doulas to enroll as Medicaid providers without becoming licensed and to bill Medicaid directly instead of through a supervising provider. Although this was helpful, Oregon found that doulas, especially self-employed doulas, still found billing to be challenging. Doulas also found it challenging to develop payment arrangements with and bill CCOs, which deliver almost all Medicaid covered services in Oregon. In response, OHA enabled the creation of doula hubs that bill on behalf of doulas. These agencies remove much of the administrative burden of billing Medicaid and CCOs from the doula and have now spread throughout most of Oregon.

States' choice of federal Medicaid authority affects the policy options available for implementation of services. One of the major policy issues reported by Minnesota stems from the federal authority under which the service is covered. As previously discussed, doulas in Minnesota, who are all certified but not licensed, cannot bill the Medicaid agency directly. They must work under the supervision of a licensed provider who is enrolled in Medicaid and bills the program for the services provided by the doula. This policy stems from the federal Medicaid rules that require almost all Medicaid services to be provided by a physician or licensed provider. This requirement has been a major barrier to doulas' participation in Medicaid as doulas have found it very difficult to develop these supervisory relationships with providers. The only two potential solutions to this challenge are for a state to license doulas or for a state to cover doula services as a preventive service, which only requires that services be provided at the direction of a licensed provider.

Paying for services through state Title V MCH Block Grant programs enables community capacity building and provides program flexibilities and coverage of critical supports not covered by Medicaid. The Indiana Title V MCH Block Grant program fostered the growth of doula capacity. The Title V MCH Block Grant program recruited and trained people who were members of the communities they would serve and had a background that would enable them to interact with the health system, such as previous training as a community health worker or massage therapist. One interviewee stated that as community members, the newly trained doulas were able to discuss issues with pregnant women that they might be reluctant to discuss with medical staff, such as domestic violence or food insecurity. Most also knew about local resources that could help meet clients' needs. Although the reach of this program was not statewide, the experience of this program informed the development of state legislation extending Medicaid coverage to doula services. This legislation passed in 2019, but has not yet been implemented.

Payment rates matter. Both Minnesota and Oregon state Medicaid officials reported that the initial payment rates established by Medicaid were insufficient. One state official observed that the state's rates were so low that doulas could not afford to practice full-time because they needed to work at another job. This limited Medicaid-covered pregnant women's access to doula services. Both states have since raised their payment rates. Oregon did so in 2017 and Minnesota's raises will be implemented later in 2020. Oregon reported that more doulas began billing Medicaid after the 2017 policy changes, which included the payment increase.

MCOs and other managed care entities need clear guidance on coverage expectations. In Minnesota, Oregon, and Nebraska almost all Medicaid beneficiaries are enrolled in either MCOs (Minnesota and Nebraska) or CCOs (Oregon). Although MCOs and CCOs differ in important ways, both types of contractors accept responsibility for delivering a comprehensive package of services to enrolled Medicaid enrollees. As previously discussed, all three states codified doula coverage in these contractors' contracts. One Oregon official summed up the purpose of these changes as necessary to

ensure that, "…out of Oregon Medicaid dollars, everyone who wants to have access to a doula can access one."

Including doulas in policy development helps ensure that the resulting policies facilitate the ability of doulas to serve Medicaid-covered pregnant women. Three of the states included doulas in policy development. In Minnesota and Oregon, doulas were instrumental in developing the legislation that defined the benefit. According to one Oregon official, "They [doulas] did a lot of work on the legislation. The intent was for them to identify what the bill needed to contain and also be involved in rule-making." Oregon continues to work closely with the Oregon Doulas' Association providing funding for a statewide needs assessment as well as the development of guidelines and protocols defining how hospitals can work with birth doulas. Minnesota also continues to discuss policy options with doulas. In Indiana, a doula who worked with low-income women developed the program and wrote the grant. In Nebraska, the MCO conducted community focus groups to help staff decide what services to propose as value-added services, but did not work directly with doulas or the agency that administers the foster care system. MCO staff cited this as one reason few doula services were actually being provided, thereby underscoring the need for active engagement of doulas in policy development.

An ongoing relationship with doulas and their advocates enables states to quickly address emerging issues. The OHA described its relationship with the state's doula association as one that sought to foster continuous improvement in access to doula services. It also created the THW Commission to advise the agency on policies related to all THWs, including doulas. This state reported that these avenues of communication were helping them to quickly identify and respond to emerging issues. These included preparing a letter to help ensure that, even during the COVID-19 pandemic, pregnant woman would be able to continue to lean on their doulas for support, even if that support must now be via telehealth.

Conclusion

Lower-income women, especially those who are not White, continue to be at significant risk for poor birth outcomes, including death. Doulas not only provide emotional support but also help Medicaid-covered pregnant women navigate the health care system and secure resources to meet their health-related, non-medical needs, such as housing. These activities may be particularly important during fiscal crisis, epidemics, and other external events that can strain health care systems, safety nets, and families themselves. As policymakers are forced to make tough budget decisions, understanding the value and benefits of various strategies to improve birth outcomes will be increasingly important. Direct Medicaid coverage of doula services is one option for providing doula services to women enrolled in Medicaid. But there are other options, such as those chosen by Indiana and Nebraska. And, any state or organization that chooses to help Medicaid-covered pregnant women access doula services can benefit from a better understanding of the policy choices and lessons learned by the four states featured in this brief.

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