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Birth Empowerment: Integrating Doula Services into Our Healthcare System

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BIRTH EMPOWERMENT: INTEGRATING DOULA SERVICES INTO OUR HEALTHCARE SYSTEM

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KHADIJA'S BIRTH STORY

"I wanted to get a doula because I felt disenfranchised as a person of color."[1] Khadija, a black woman in Brooklyn, New York City, endured a traumatic experience during the birth of her first child. Khadija recounted that the doctors were not transparent

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1. BUSTLE, *Natural Birth Seemed Impossible Romper's Doula Diaries*, YOUTUBE (Dec. 10, 2018), https://youtu.be/N2NJxt6m14E.

with her and that she had no choice or say in her birth plan. Kevin, her fiancé, observed that there were no other people of color throughout their first birth. Khadija's biggest fear for her second birth was another Cesarean section.

Enter Efe: a birth doula, assigned to Khadija through a New York City birth collective for low-income clients. Even before Khadija's birth, Efe was there to coach and provide education to her. Efe describes her role as a doula as aiding the family and protecting the client. That protection includes advocacy. "Whatever she wants me to help her advocate for herself. I'm there to empower her."[2] Efe recognizes the challenges that black women face in health care every day, especially in obstetric care. She acknowledges that providers easily dismiss black women's pain. "As a black doula helping black women . . . we're going to come out with a baby, and we're going to be healthy and we're going to happy—and we're not going to have the experience that you would have had had I not been here to help you."[3]

Khadija's birth story is a doula success story. Khadija delivered her son vaginally and was able to reclaim the joy of birth—the kind of joy that was robbed from her during the birth of her first child. Many women in the United States continue to be robbed of this joy each day. Doulas can help.

INTRODUCTION

This Note is first aimed at educating readers about modern childbirth experiences in the United States and the benefits of doula services to pregnant persons, infants, and families.[4] Second, this Note offers guidance to health insurance plan issuers

2. *Id.*

3. *Id.*

4. This Note uses gendered terms such as "women" and "mothers" to describe pregnant and childbirthing persons for simplicity. But people of all genders endure pregnancy and childbirth. Some doula organizations specialize in the provision of doula care services to LGBTQ+ families. *See, e.g.,* Madeline Thomas, *Many Doulas Work with Pregnant Women. This Group Focuses on Non-Binary, Queer and Gender Non-Conforming Families.*, THE LILY (July 2, 2020), https://www.thelily.com/many-doulas-work-with-pregnant-women-this-group-focuses-on-non-binary-queer-and-gender-non-conforming-families/ [https://perma.cc/6VN6-566W] (highlighting Rainbow Doula DC, a queer-specific doula collective in Washington D.C.).

regarding how coverage of doula services should be regulated and reimbursed. The goal of this Note is to be a point of reference for public and private insurers while they build their programs for coverage of doula services. Insurers may, for instance, consult this Note when instituting billing structures, setting doula reimbursement rates for services and travel, etc.

Existing literature focuses on education, research, and advocacy for coverage of doula services. Much of the literature seeks to educate the general public about doulas and doula services.[5] Available research regarding outcomes for clients that received doula services is based on a few states that have adopted state Medicaid coverage of doula services.[6] Some international studies on effectiveness of doula services exist.[7] There is little discussion regarding private coverage of doula services. At this time, many advocacy groups are targeting state and federal government officials to alter Medicaid laws to cover doula services.[8]

This Note consolidates and analyzes the existing literature to provide recommendations for adopting equitable health insurance coverage of doula services, both in the public and private sector. Part I provides an overview of maternal and infant mortality in the United States. Part II discusses the role of doulas and the impact of doula services in improving maternal and infant outcomes. Part III reviews current coverage of doula services, both in the public and private sector. Part IV critiques the current doula services regulatory scheme and highlights the need

5. *See*, *e.g.*, CLEVELAND CLINIC, *Doula: Pregnancy, Birth, Postpartum, Support & Services*, https://my.clevelandclinic.org/health/articles/23075-doula [https://perma.cc/FR57-6SFQ] (last visited May 23, 2022).

6. *See*, *e.g.*, Katy B. Kozhimannil et al., *Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery*, 43 J. BIRTH 20 (2016).

7. *See*, *e.g.*, Jenny McLeish & Maggie Redshaw, *"Being the Best Person that They Can Be and the Best Mum": A Qualitative Study of Community Volunteer Doula Support for Disadvantaged Mothers Before and After Birth in England*, 19 BMC PREGNANCY & CHILDBIRTH 21 (2019).

8. *See*, *e.g.*, Kelly Vyzral, *Medicaid Coverage of Doula Services Would Save the Lives of Mothers and Babies and Avoid Costly Complications*, CHILD'S DEF. FUND OHIO (2020), https://www.cdfohio.org/wp-content/uploads/sites/6/2020/11/Voice-November-2020.pdf [https://perma.cc/EM36-W3TV].

for equitable registration, adequate independence, and sustainable reimbursement for doulas. Public and private adoption of an equitable regulatory system for doulas ensures a sustainable profession for doulas.

I. AN OVERVIEW OF MATERNAL AND INFANT MORTALITY IN THE UNITED STATES

Childbirth is the primary reason for hospitalization in the United States.[9] New mothers and babies constitute 23% of all people discharged from hospitals.[10] Despite $111 billion in hospital spending on childbirth and related expenditures,[11] the Maternal Mortality Rate ("MMR") in the United States in 2019 was 20.1 deaths per 100,000 live births.[12] Over 60% of pregnancy-related deaths are preventable.[13] The United States MMR is much higher than other developed nations.[14] In New Zealand, Norway, and the

9. Katy B. Kozhimannil et al., *Trends in Hospital-Based Childbirth Care: The Role of Health Insurance*, 19 AM. J. MANAGED CARE 125 (2013).

10. Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* (2008), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/evidence-based-maternity-care.pdf [https://perma.cc/S55L-23C5].

11. Tara Wilson, *Medicaid Approaches to Addressing Maternal Mortality in the District of Columbia*, 20 GEO. J. GENDER & L. 215, 218 (2018).

12. CTRS. FOR DISEASE CONTROL & PREVENTION, *Maternal Mortality Rates in the United States, 2019* (Mar. 23, 2021), https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/maternal-mortality-2021.htm [https://perma.cc/UA93-XCE3].

13. CTRS. FOR DISEASE CONTROL & PREVENTION: MORBIDITY AND MORTALITY WEEKLY REPORT (MMWR), *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016* (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w [https://perma.cc/4AL9-WD9A].

14. Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald, Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Counties* (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality- maternity-care-us-compared-10-countries [https://perma.cc/3TYP-LCGS].

Netherlands, the MMR is less than 3.0 per 100,000.[15] Canada's MMR is more than twice as low as the United States' at 8.6 per 100,000.[16] The United States MMR has been described as "shockingly high"[17] and ever-increasing. From 1990 to 2013, the MMR has increased by 136%.[18] The still-high Infant Mortality Rates ("IMR") hit an all-time low in 2018 at 5.6 deaths per 1,000 live births.[19] Other developed nations' IMRs range from 2.0 in Japan to 4.5 in Canada with an average of 3.4 per 1,000.[20]

Maternal morbidity is an even greater problem.[21] Like the MMR, maternal morbidity in the United States has been steadily increasing.[22] Between 2014 and 2018, rates of both pregnancy and childbirth complications rose significantly.[23] The rate of pregnancy complications rose 16.4% from 168.4 to 196.0 per 1,000.[24] Women with pregnancy complications are twice as likely

15. *Id.*

16. *Id.*

17. Jennifer Hickey, *Nature is Smarter Than We Are: Midwifery and the Responsive State*, 40 COLUM. J. GENDER & L. 245 (2020).

18. WORLD HEALTH ORG., *Trends in Maternal Mortality: 1990 to 2013*, at 43 (2014), http://apps.who.int/iris/bitstream/handle/10665/112682/9789241507226_eng.pdf;jsessionid=8DD99DC17D07EBE1EBBC45F038786FDF?sequence=2 [https://perma.cc/9FUQ-A75Q].

19. Danielle M. Ely & Anne K. Driscoll, *Infant Mortality in the United States, 2018: Data from the Period Linked Birth / Infant Death File*, 69 NAT'L VITAL STAT. REP. 1 (2020), https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf [https://perma.cc/UX7L-L8AC].

20. Rabak Kamal, Julie Hudman, Daniel McDermott, *What Do We Know About Infant Mortality in the U.S. and Comparable Counties?* (Oct. 18, 2019), https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/ [https://perma.cc/53R3-ENLL].

21. Hickey, *supra* note 17, at 255.

22. *Id.* at 256.

23. BLUECROSS BLUESHIELD, *Trends in Pregnancy and Childbirth Complications in the U.S.* (June 17, 2020), https://www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us [https://perma.cc/93JG-WMDZ].

24. *Id.*

to have childbirth complications.[25] Childbirth complications also rose 14.2% from 14.8 to 16.9 per 1,000.[26] The number of women experiencing both pregnancy and childbirth complications rose 31.5% from 5.0 to 6.6 per 1,000.[27] While most pregnancies are classified as low-risk,[28] more women are entering pregnancy with underlying conditions.[29]

The CDC defines severe maternal morbidity as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[30] The rates of severe maternal morbidity have increased almost 200% from 1993 to 2014.[31] While it is unknown why maternal morbidity is increasing, the health consequences to women and increased health care costs are clear.[32]

Maternal morbidity, maternal mortality,[33] and infant mortality[34] rates are even more dismal for racial and ethnic minorities. Black women in the United States have especially poorer pregnancy and childbirth outcomes. Racism—not merely race or class—contributes to stark disparities in outcomes.[35] In

25. *Id.*

26. *Id.*

27. *Id.*

28. *Low-Risk Pregnancies*, UCSF DEP'T OF OBSTETRICS, GYNECOLOGY & REPRODUCTIVE SERV., https://obgyn.ucsf.edu/maternal-fetal-medicine/low-risk-pregnancies [https://perma.cc/QT8G-4SKS] (last visited Jan. 15, 2022).

29. BLUECROSS BLUESHIELD, *supra* note 23.

30. CTRS. FOR DISEASE CONTROL & PREVENTION, *Severe Maternal Morbidity in the United States* (Feb. 2, 2021), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html [https://perma.cc/VM8H-TQY5].

31. *Id.*

32. *Id.*

33. Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 388 (2018).

34. CTRS. FOR DISEASE CONTROL & PREVENTION, *Infant Mortality* (June 22, 2022), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm [https://perma.cc/A9EW-FCLE].

35. Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243, 255 (2021).

other words, Black women are subject to structural racism and implicit bias in the healthcare system, which translates to poorer outcomes.[36] Black women are three times more likely to die during pregnancy than white women.[37] Another 2016 study revealed that Black, college-educated women who gave birth in New York City hospitals were more likely to experience severe complications than white women who did not complete high school.[38]

As a response, some women are abandoning the traditional hospital route altogether.[39] From 2004 to 2017, the rate of home births increased by 77%, and the number of births at freestanding birth centers more than doubled.[40] In the past, childbirth occurred at home with female family and friends nearby.[41] Childbirth was a social experience.[42] The move from home to hospital began in the twentieth century, and by 1950, 88% of women were giving birth in hospitals.[43] Today, 98.5% of women give birth in hospitals, 0.99% give birth at home, and 0.52% give birth in freestanding birth centers.[44]

Hospital births, however, do not mean better births for moms and babies. Hospital deliveries have created an adversarial relationship between mothers and health care providers.[45] Mothers and providers may disagree about the appropriate course

36. CTRS. FOR DISEASE CONTROL & PREVENTION, *Working Together to Reduce Black Maternal Mortality* (Apr. 6, 2022), https://www.cdc.gov/healthequity/features/maternal-mortality/index.html [https://perma.cc/R2F6-DAFU].

37. *Id.*

38. N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, SEVERE MATERNAL MORBIDITY IN NEW YORK CITY, 2008-2012, at 15 (2016).

39. *See* Marian MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 279 (2019).

40. *Id.*

41. Ivey E. Best, *This Is My [D]oula – [S]he's [A]lso A [L]awyer*, 50 CUMB. L. REV. 175, 176; *see also* William F. McCool & Sara A. Simeone, *Birth in the United States: An Overview of Trends Past and Present*, 37 NURSING CLINICS OF N. AM. 735, 744 (2002).

42. Best, *supra* note 41, at 176.

43. *Id.* at 177.

44. MacDorman & Declercq, *supra* note 39, at 280.

45. Best, *supra* note 41, at 178.

of treatment during labor and delivery.[46] Cesarean surgery is a common conflict.[47] Cesarean surgery is the most common surgical procedure in the United States.[48] 31.7% of all babies born in the United States in 2019 were born by Cesarean.[49] This figure exceeds the World Health Organization's recommendation that 10-15% of births in high-resource countries, such as the United States, be Cesarean deliveries.[50] Some European countries have lower Cesarean rates, between 25-30%.[51] Finland, Iceland, and Norway have had low Cesarean rates, hovering around 15%.[52]

Cesareans are also costly on the healthcare system. The average cost of a vaginal birth is $13,024 whereas the average cost of a Cesarean birth is $22,646.[53] Actual costs of birth, both vaginal and Cesarean, vary greatly depending on the state the patient is in.[54] Louisiana maintains the largest price gap between vaginal and Cesarean births: $22,401.[55] Maryland is one of the most expensive states to give birth in: $37,220 for a vaginal delivery and $58,415 for a Cesarean delivery.[56]

46. Elizabeth Kukura, *Birth Conflicts: Leveraging State Power to Coerce Health Care Decision-Making*, 47 U. BALT. L. REV. 247, 248–49 (2018).

47. *Id.* at 249.

48. Sharon Sung & Heba Mahdy, *Cesarean Section*, https://www.ncbi.nlm.nih.gov/books/NBK546707/ [https://perma.cc/XG6Q-RBNK] (last updated Sept. 18, 2022).

49. Joyce A. Martin et al., *Births: Final Data for 2019*, 70 NAT'L VITAL STAT. REPS. 1, 1–2 (2021).

50. WORLD HEALTH ORG., WHO STATEMENT ON CAESAREAN SECTION RATES, at 2 (2015).

51. Ana Pilar Betrán et al., *The Increasing Trend in Caesarean Section Rates: Global, Regional & National Estimates: 1990-2014,* 11 PLOS ONE 1, 4 (2016).

52. *Id.* at 9.

53. Andrew Hurst, *The Cost of a C-Section Is More Than $9,000 Greater on Average Than a Vaginal Delivery*, VALUEPENGUIN, https://www.valuepenguin.com/cost-of-vaginal-births-vs-c-sections [https://perma.cc/7LTN-4UJM] (last updated May 3, 2021).

54. *Id.*

55. *Id.*

56. *Id.*

A pattern of "almost random decision making" exists when providers are deciding to employ Cesarean surgery.[57] Some hospitals sustain a Cesarean rate as high as 60%.[58] In the United States, 11.6% of Cesareans are estimated to be not medically necessary.[59] A 2013 study reported that 13% of respondents experienced pressure from a provider to have a Cesarean, whether a first-time or repeat procedure.[60] Carla Keirns, a physician herself, recounted the pressure she felt intermittently to have a Cesarean birth during the last month of her pregnancy and throughout labor.[61] Certain women are more likely to succumb to provider pressure due to vulnerability, including uninsured women, Medicaid recipients without preexisting relationships with providers, young women, immigrant women, women who have limited or no English skills, and women without resources to hire a doula for emotional support.[62]

57. Steven Clark et al., *Variation in the Rates of Operative Delivery in the United States*, 196 AM. J. OBSTETRICS & GYNECOLOGY 526, 526 (2007).

58. Adrianna Rodriguez, *Unnecessary C-sections are a Problem in the US. Will Publicizing Hospital Rates Change That?,* USA TODAY, https://www.usatoday.com/story/news/health/2020/12/21/the-joint-commission-report-cesarean-section-birth-rates/3943700001/ [https://perma.cc/L7XQ-933T] (last updated Dec. 21, 2020, 2:26 PM).

59. Whitney P. Witt et al., *Determinants of Cesarean Delivery in the U.S.: A Lifecourse Approach*, 19 J. MATERNAL AND CHILD HEALTH 84, 84 (2015).

60. Eugene R. Declercq et al., *Listening to Mothers III – Pregnancy and Birth*, CHILDBIRTH CONNECTION, at 6 (2013), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-major-findings.pdf [https://perma.cc/UL9Y-CZJH].

61. Carla C. Keirns, *I Didn't Realize the Pressure to Have a C-section Until I Was About to Deliver*, WASH. POST (Jan. 5, 2015), https://www.washingtonpost.com/national/health-science/pregnant-doctor-finds-intense-pressure-to-have-a-caesarean-delivery/2015/01/05/949ed918-7bd3-11e4-84d4-7c896b90abdc_story.html [https://perma.cc/23WJ-NDQK].

62. *See* WORLD HEALTH ORG., *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2015), http://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1 [https://perma.cc/9MLV-34C9].

In the face of rising maternal morbidity and mortality rates, infant mortality rates, and less-than-stellar care for women of racial and ethnic minorities, many women are seeking alternatives. Some alternatives include home birth, delivery at one of 384 freestanding birth centers,[63] midwifery, and doula services. Doula services, especially, show promise for better, more empowered births.

II. DOULAS AND IMPROVED MATERNAL AND INFANT OUTCOMES

A. The Role of Doulas

The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, both preeminent professional associations for obstetric care, report that doula services are "one of the most effective tools to improve labor and delivery outcomes."[64] Doula services are frequently described as an "underused resource"[65] or "underutilized."[66] As of 2015, only 6% of birthing care involved doula services.[67]

Doulas offer physical, emotional, and educational support throughout pregnancy, childbirth, and the postpartum period.[68]

63. AM. ASS'N BIRTH CTRS., *A Historical Timeline: Highlights of 4 Decades of Developing the Birth Center Concept in the U.S.*, https://www.birthcenters.org/page/history [https://perma.cc/6UK6-9UQG] (last visited Oct. 23, 2022).

64. Aaron B. Caughey et al., *Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery*, 210 AM. J. OBSTETRICS & GYNECOLOGY 179, 189 [hereinafter Obstetric Care Consensus].

65. Cara B. Safon et al., *Doula Care Saves Lives, Improves Equity, And Empowers Mothers. State Medicaid Programs Should Pay For It,* HEALTHAFFAIRS (May 26, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210525.295915/full/ [https://perma.cc/N7AB-7HYN].

66. Obstetric Care Consensus, *supra* note 64, at 189.

67. Safon et al., *supra* note 65.

68. AM. PREGNANCY ASS'N, *Having a Doula – What are the Benefits?*, https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/having-a-doula/ [https://perma.cc/H549-GLQ7] (last visited Oct. 23, 2022); *see also* NAT'L P'SHIP FOR WOMEN AND FAMILIES & CHILDBIRTH CONNECTION, OVERDUE: MEDICAID AND PRIVATE INSURANCE COVERAGE OF DOULA CARE TO STRENGTHEN MATERNAL AND INFANT HEALTH, at 1 (Jan. 2016),

Most doulas are women, but anyone can be a doula.[69] In some states, doulas are not required to complete training to practice as a non-certified or lay doula.[70] Certified doulas typically receive a certificate upon completion of a doula training program.[71]

Doulas and nurse-midwives both work in pregnancy and childbirth, but their roles are different. Doulas do not receive clinical training through a professional program, such as nursing or medicine.[72] Certified nurse-midwives are clinically trained through an accredited advanced nursing program and must pass the American Midwifery Certification Board exam.[73] Nurse-midwives can perform gynecological exams, administer pain medications and labor-inducing drugs, monitor the fetus using electronic equipment, order an epidural, perform an episiotomy, perform vaginal deliveries, and other tasks associated with

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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 [https://perma.cc/K2Z2-SPCB].

69. CHILDBIRTH PRO'S. INT'L., *Questions About Becoming a Doula*, https://thechildbirthprofession.com/top-10-questions-about-becoming-a-doula/ [https://perma.cc/C43K-ZN2R] (last visited Oct. 27, 2022); *see also* INT'L DOULA INST., *8 Misconceptions About Becoming a Doula* (July 19, 2016), https://internationaldoulainstitute.com/2016/07/8-misconceptions-about-becoming-a-doula/ [https://perma.cc/CGA5-2CA2].

70. INT'L DOULA INST., *Is Certification Important for Doulas?* (Jan. 12, 2021), https://internationaldoulainstitute.com/2021/01/is-certification-important-for-doulas/ [https://perma.cc/HQ7F-Z7AZ].

71. CLEVELAND CLINIC, *Doula: Pregnancy, Birth, Postpartum, Support & Services*, https://my.clevelandclinic.org/health/articles/23075-doula [https://perma.cc/3AV5-2UCD] (last updated May 23, 2022).

72. Tara Haelle, *What Is a Doula? And Do You Need One?*, N.Y. TIMES (Apr. 15, 2020), https://www.nytimes.com/2020/04/15/parenting/pregnancy/doula.html [https://perma.cc/CE8X-NQWS].

73. *See* AM. COLL. NURSE-MIDWIVES, *Pathways to Midwifery Education*, https://portal.midwife.org/education/education-pathway?reload=timezone [https://perma.cc/9ZS4-B3HU] (last visited Oct. 23, 2022).

pregnancy and childbirth.[74] Doulas cannot perform any of these medical tasks or procedures.[75] Doulas offer comfort measures, resources or referrals to social services, and education on childbirth and breastfeeding.[76] Doula services, in conjunction with a traditional hospital experience, add a layer of emotional support that may not be available from a hospital or its providers alone.[77]

Doulas may also be viewed as advocates for their clients.[78] The amount of advocacy that doulas should provide on behalf of their clients, however, is debated within the doula community.[79] Some scholars believe that doulas and non-doula providers (hereinafter "providers") are increasingly coming into conflict.[80] Providers are concerned that doulas give untrained medical opinions or act as intermediates in a way that negatively impacts the provider-patient relationship.[81] Doulas may feel that providers are simply uncooperative and may unfairly assume that a doula's presence in the room alone influences a client's decision to refuse medical intervention.[82]

74. *Doula vs. Midwife: What's the Difference?*, HEALTHLINE (Mar. 4, 2019), https://www.healthline.com/health/pregnancy/doula-vs-midwife [https://perma.cc/7PCK-2VDA].

75. Haelle, *supra* note 72.

76. NAT'L P'SHIP FOR WOMEN AND FAMILIES & CHILDBIRTH CONNECTION, *supra* note 68, at 3.

77. Ambria D. Mahomes, *You Should Have Said Something: Exploring the Ways that History, Implicit Bias, and Stereotypes Inform the Current Trends of Black Women Dying in Childbirth*, 55 U.S.F. L. REV. 17, 29 (2020); *see also* Kenneth J. Gruber, Susan H. Cupito, & Christina F. Dobson, *Impact of Doulas on Healthy Birth Outcomes,* 22 J. PERINATAL EDUC. 49, 49 (2013).

78. DONA INT'L, *Benefits of a Doula*, https://www.dona.org/what-is-a-doula/benefits-of-a-doula/ [https://perma.cc/QN7R-BERE] (last visited Oct. 23, 2022).

79. Hickey, *supra* note 17, at 295.

80. *Id.*

81. Suein Hwang, *As 'Doulas' Enter Delivery Rooms, Conflicts Arise*, WALL ST. J. (Jan. 19, 2004), https://www.wsj.com/articles/SB107446888698004731 [https://perma.cc/N92D-YQA4].

82. *Id.*; *see also* Pamela Paul, *And the Doula Makes Four*, N.Y. TIMES (Mar. 2, 2008), https://www.nytimes.com/2008/03/02/fashion/02doula.html [https://perma.cc/VK3W-DJNF].

Doulas of North America (DONA) International, the largest doula certification organization in the United States, describes the doula's role between providers and their clients as "support, information, and mediation or negotiation."[83] Doulas are meant to encourage communication between clients and providers, rather than speaking for their clients.[84] Doulas can assist clients to "articulate their questions, preferences and values" to health care providers.[85] The complex relationship between doulas and providers can be eased through education and understanding. One Ohio doula explained that many providers do not understand their role and mission, or even why a client would seek out doula services to begin with.[86] Conflicts may be more easily remedied when both providers and doulas recognize that their interests lie in the best interest of the joint client.

Between doulas and their clients, low-income families may benefit greatly from doula services due to the overwhelming nature of pregnancy and childbirth.[87] Community-based doula services are most beneficial: a person who is already considered part of the community has a higher likelihood of being trusted and understanding the context of the community in terms of challenges, available services, and other intricacies.[88] Like Khadija's experience of having a Black woman as her doula, other clients have noted the value of having a doula who shares a

83. DONA INT'L, *Standards of Practice: Birth Doula* (Aug. 20, 2020), https://www.dona.org/wp-content/uploads/2017/08/COESOP-2020-FINAL-Birth.pdf [https://perma.cc/DKZ9-5PBW].

84. *Id.*

85. NAT'L P'SHIP FOR WOMEN AND FAMILIES & CHILDBIRTH CONNECTION, *supra* note 68.

86. Discussed during the Ohio Department of Medicaid Doula Services virtual stakeholder meeting on June 23, 2021.

87. Vyzral, *supra* note 8.

88. *Id.*; *see also* Asteir Bey et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (Mar. 25, 2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf [https://perma.cc/UK2V-NL7N].

cultural background.[89] Culturally contextual and competent care improves health equity for racial and ethnic minority clients.[90]

In other extreme cases, lawyer-doulas may be sought out.[91] A lawyer-doula is a professionally-trained advocate, with extensive knowledge of both childbirth and the law.[92] A lawyer-doula may assert a client's rights throughout pregnancy, as well as during labor and delivery. A lawyer-doula may aid a client in a variety of matters, such as ensuring access to quality medical care, preventing abuse from health care providers, and intercepting unwanted medical procedures.[93]

Despite the interest in doula services, many women and families are prevented from accessing services for a variety of reasons.[94] First and foremost, cost restricts access. Arranging doula services is simply cost prohibitive for many.[95] Because Medicaid and private health insurers generally do not cover doula services, families must obtain doula services on their own. As a result, private doula services, costing up to $1,500-2,000, will be available only to affluent families.[96] Second, there is a general lack of access to maternity care providers,[97] especially for those in rural

89. Katy B. Kozhimannil et al., *Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year*, at 8 (2015), https://static1.squarespace.com/static/577d7562ff7c5018d6ea200a/t/5840c791cd0f683f8477920a/1480640403710/FullReport.pdf [https://perma.cc/26Q5-9YB4].

90. Safon et al., *supra* note 65.

91. Cristen Pascucci, *When Your Lawyer Is Your Doula,* BIRTH MONOPOLY (Oct. 23, 2018), https://birthmonopoly.com/when-your-lawyer-is-your-doula/ [https://perma.cc/5NNH-JG4N].

92. *Id.*

93. *Id.*

94. Safon et al., *supra* note 65.

95. Alexa Mikhail, *Doulas and Midwives are Crucial in Addressing Postpartum Depression for Black People. Many Can't Afford One.*, THE 19TH NEWS (Apr. 17, 2021), https://19thnews.org/2021/04/doulas-and-midwives-are-crucial-in-addressing-postpartum-depression-for-black-people-many-cant-afford-one/ [https://perma.cc/RV4Z-JASD].

96. Safon et al., *supra* note 65.

97. Leia Dingott, *Pushing for Change: The State of Arizona Should Allow Women Greater Access to Midwifery Care*, 49 ARIZ. ST. L.J. 433, 439 (2017).

areas, where fewer doula services are available.[98] Finally, there is a general lack of awareness about doula services.[99] While many organizations try to help educate families about their options for pregnancy, childbirth, and postpartum services, the message does not always reach the intended audience.[100] But this is changing for the better. Doulas and the benefits of doula services are being discussed more than ever before.[101]

B. Benefits of Doula Services

Doulas offer better maternal and infant outcomes.[102] Doula services are not associated with measurable harms to patients.[103] In Minnesota, a 2013 study of 1,079 births showed that the utilization of doula services resulted in the Cesarean delivery rate dropping nearly 40%.[104] A more recent study showed that Medicaid beneficiaries with doula services were 56% less likely to give birth by Cesarean.[105] Birth by Cesarean does not translate to better outcomes.[106] Instead, Cesarean deliveries are related to

98. Safon et al., *supra* note 65.

99. *Id.*

100. Dingott, *supra* note 97, at 439.

101. *See, e.g.,* Lauren Milligan, *The Rise of the Doula: A Lifeline for New Mothers, But Do You Need One?*, BAZAAR (Mar. 22, 2021), https://www.harpersbazaar.com/uk/beauty/mind-body/a35884015/what-is-a-doula/ [https://perma.cc/83QB-PFA2] (detailing one doula's experience where others now know what she does for a living when she tells them).

102. Lynae Carlson, The Effects of Doula Care on Birth Outcomes and Patient Satisfaction in the United States (2021) (The Eleanor Mann School of Nursing Undergraduate Honors Theses, University of Arkansas).

103. Obstetric Care Consensus, *supra* note 64, at 13.

104. Katy B. Kozhimannil et al., *Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries*, AM. J. PUB. HEALTH e113, e114-16 (2013).

105. Mattie Quinn, *To Reduce Fatal Pregnancies, Some States Look to Doulas*, GOVERNING (Dec. 18, 2018), https://www.governing.com/archive/gov-doula-medicaid-new-york-2019-pregnant.html [https://perma.cc/W5EN-7UEH].

106. Megan Thielking, *Sky-High C-section Rates in the US Don't Translate to Better Birth Outcomes*, STAT (Dec. 1, 2015), https://www.statnews.com/2015/12/01/cesarean-section-childbirth/ [https://perma.cc/PR6F-7C3E].

complications. Cesarean deliveries increase the risk of severe maternal complications by 80% when compared to vaginal delivery.[107]

In 2015, the World Health Organization (WHO) opined that when the Cesarean rate is less than 10%, the number of maternal and new born deaths decrease.[108] When the Cesarean rate is above 10%, there is no evidence that mortality rates improve.[109] Another study, released later that year in the Journal of the American Medical Association, reviewed global Cesarean rates to test WHO's claim.[110] The study concluded that a Cesarean rate of 19% among the WHO member states was associated with lower maternal and infant mortality rates.[111] WHO's recommended Cesarean rate of 10-15% may be too low,[112] but the United States' Cesarean rate of 31.7% still exceeds all recommended figures.[113] Increased use of doula services may assist in lowering our Cesarean rate over time.

Those with doula support also had a 22% lower rate of preterm births when compared to those without doula support.[114] Expanded access to doula services would prevent 3,288 preterm

107. Dennis Thompson, *Study: C-Section Does Carry Added Risks*, GROW BY WEBMD (Apr. 1, 2019), https://www.webmd.com/baby/news/20190401/study-c-section-does-carry-added-risks#1 [https://perma.cc/U3TN-HWZF].

108. WORLD HEALTH ORG., *Caesarean Sections Should Only Be Performed When Medically Necessary Says WHO* (Apr. 9, 2015), https://www.who.int/reproductivehealth/topics/maternal_perinatal/cs-statement/en/ [https://perma.cc/E5Y2-PJUJ].

109. *Id.*

110. George Molina et al., *Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality*, 314 J. AM. MED. ASS'N 2263 (2015).

111. *Id.*

112. *Id.*; WORLD HEALTH ORG., *Caesarean Sections Should Only Be Performed When Medically Necessary Says WHO*, *supra* note 108.

113. Martin et al., *supra* note 49.

114. Vyzral, *supra* note 8; Chloe Bakst et al., *Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid*, at 6 (2020), https://www.medicaidinnovation.org/_images/content/2020-IMI-Community_Based_Maternal_Support_Services-Report.pdf [https://perma.cc/29NB-4WMQ].

births per year.[115] In addition, immediately after birth, babies whose mothers received doula services are less likely to have low five-minute Apgar scores.[116]

Doula services are also associated with reduced reliance on pain medication.[117] Doulas may help those in labor find more comfortable positions and offer non-invasive pain relief techniques,[118] as well as reduced anxiety and stress.[119] Continuous labor support by personnel other than the traditional maternal healthcare team is associated with an increased likelihood of spontaneous vaginal delivery and decreased use of pain medication.[120] Research shows that those with doula support do not request as much pain medication, have fewer forceps and vacuum-extractor delivers, have fewer Cesareans, and generally have less need for major labor interventions.[121]

Doula services also offer intangible outcomes, such as higher maternal engagement in care and higher maternal satisfaction.[122] Those with doula support have reported an increased satisfaction with the childbirth experience when compared with those only receiving traditional care from a maternal healthcare team.[123]

Finally, doula services promise cost-savings for states. Medicaid is the largest single payor of maternity care in the United States, covering 43% of births.[124] While Medicaid coverage

115. Vyzral, *supra* note 8.

116. Safon et al., *supra* note 65.

117. Ramin Ravangard et al., *Comparison of the Effects of Using Psychological Methods and Accompanying a Doula in Deliveries on Nulliparious Women's Anxiety and Pain: A Case Study in Iran*, 36 THE HEALTH CARE MANAGER 372, 374 (2017).

118. Sakala & Corry, *supra* note 10, at 54.

119. Jenny McLeish & Maggie Redshaw, *Being the Best Person That They Can Be and the Best Mum: A Qualitative Study of Community Volunteer Doula Support for Disadvantaged Mothers Before and After Birth in England*, 19 BMC PREGNANCY AND CHILDBIRTH 1 (Jan. 10, 2019), https://pubmed.ncbi.nlm.nih.gov/30630445/ [https://perma.cc/3HZ4-WUDP].

120. Sakala & Corry, *supra* note 10, at 54.

121. *Id.*

122. Safon et al., *supra* note 65.

123. Sakala & Corry, *supra* note 10, at 53–54.

124. Bakst et al., *supra* note 114, at 2.

of doula services would increase costs to state budgets, the increase would be offset by reduced reimbursement to hospitals and providers for obstetric complications and Cesarean deliveries.[125] Most state Medicaid programs could save more than $2 million gross by avoiding Cesarean deliveries.[126] In a study from the University of Minnesota that reviewed 67,000 Medicaid-funded births across 12 states, the estimated cost savings from access to doula services among Medicaid beneficiaries is $58.4 million.[127]

Doula services promise better outcomes for mothers and babies: both quantifiable and intangible. Integration of these underutilized services into maternal care is one solution to the maternal and infant mortality crisis in the United States. While many states have legislation pending to expand coverage of doula services,[128] women and families are left without support in the interim.

III. CURRENT DOULA SERVICES COVERAGE

Few private health insurers cover doula services, and many of those private insurers that do cover doula services rely on retroactive reimbursement.[129] This means that clients are on the hook for costs of doula services until insurers issue reimbursement—if they ever do. One pilot program from Blue Cross and Blue Shield of Rhode Island paid for postpartum-only doula services, but it was discontinued due to lack of funding.[130] Some employers, including CVS Health and Microsoft, have

125. Wilson, *supra* note 11, at 235.

126. Amy Chen, *Routes to Success for Medicaid Coverage of Doula Care,* at 1, NAT'L HEALTH L. PROGRAM, https://healthlaw.org/wp-content/uploads/2018/12/NHeLP-PTBi-Doula-Care-Report.pdf [https://perma.cc/EPY9-6P5V].

127. Vyzral, *supra* note 8.

128. *See* NAT'L HEALTH L. PROGRAM, *Doula Medicaid Project,* https://healthlaw.org/doulamedicaidproject/ [https://perma.cc/9ZY6-DUWF] (last visited Nov. 22, 2022) (tracking proposed and implemented state Medicaid coverage of doula services).

129. Chen, *supra* note 126, at 11.

130. *Id.*

stepped up to cover doula services in their own health plans.[131] The health insurer Cigna recommends that clients who cannot afford doula services search for a doula who will either donate their time or set their fees on a sliding scale, based on what the client can afford.[132] But relying solely on a doula's free or reduced rate of services is not a sustainable solution, nor is it compatible with a robust and well-structured doula profession.

Public coverage of doula services, while still limited, is more robust than private coverage. Before the passing of the Affordable Care Act (ACA), the vast majority of health insurance policies sold on the individual market did not cover pregnancy-related costs.[133] The ACA brought affordable coverage to millions of women that were previously uninsured or underinsured.[134] The ACA attempted to expand Medicaid coverage to all adults with incomes up to 138% of the Federal Poverty Level.[135] Medicaid expansion stood to have the greatest impact on women.[136] But in 2012, the U.S. Supreme Court limited the role of the ACA on states' Medicaid expansion.[137] The Court struck down the ACA provision requiring compulsory Medicaid expansion; states were

131. Ashley Nguyen, *Some Big Companies are Starting to Cover the Cost of Doulas. Will Others Follow?*, THE LILY (May 21, 2021), https://www.thelily.com/some-big-companies-are-starting-to-cover-the-cost-of-doulas-will-others-follow/ [https://perma.cc/3APA-62P2].

132. CIGNA, *Doulas and Support During Childbirth,* https://www.cigna.com/individuals-families/health-wellness/hw/medical-topics/doulas-and-support-during-childbirth-tn9822 [https://perma.cc/C5YN-7DA4] (last visited Nov. 22, 2022).

133. Sara R. Collins et al., *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010,* at 1, THE COMMONWEALTH FUND (July 30, 2010), https://www.commonwealthfund.org/publications/issue-briefs/2010/jul/realizing-health-reforms-potential-women-and-affordable-care-act [https://perma.cc/K7DP-DPQS].

134. *Id.* at 2.

135. Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care,* 94 NEB. L. REV. 799, 825 (2016).

136. *Id.*

137. *Id.; see also* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

left with discretion to either maintain or expand their Medicaid programs.[138]

To date, 39 states (including Washington D.C.) have expanded their Medicaid programs.[139] Certain women will continue to lack insurance coverage, despite the ACA's Medicaid reforms.[140] This includes women living in non-expanded states who are not eligible for Medicaid and are too poor to qualify for subsidized insurance, known as the "Medicaid gap," legal immigrants (who must wait five years before they are eligible for Medicaid), and undocumented immigrants (who continue to be excluded from Medicaid coverage entirely).[141]

At this time, Oregon, Minnesota, Indiana, and New Jersey mandate Medicaid coverage for doula services.[142] New York[143] and Washington D.C.[144] have introduced pilot programs for Medicaid coverage based on the demonstrated effectiveness of doula support in improving maternal outcomes.

Oregon and Minnesota Medicaid doula services coverage will be analyzed below, along with Ohio, a state that does not offer Medicaid doula services coverage. Private insurers can model doula services coverage on the existing Medicaid programs. The

138. KAISER FAM. FOUND., *Status of State Medicaid Expansion Decisions: Interactive Map* (Sep. 20, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/529K-ER5C].

139. *Id.*

140. Kukura, *Giving Birth Under the ACA*, *supra* note 135, at 826.

141. *Id.*

142. 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-closed [https://perma.cc/2LTY-TFHE]; DOULA SERIES FOOTNOTES, *Medicaid Coverage of Doula Services in the United States: Frequently Asked Questions* (July 19, 2021), https://doulaseriesfootnotes.com/national-overview.html [https://perma.cc/W3G4-U2PZ].

143. *See* NYS DOULA MANUAL POL'Y GUIDELINES (Mar. 1, 2019), https://www.health.ny.gov/health_care/medicaid/redesign/doula_pilot/docs/provider_manual.pdf [https://perma.cc/CN6H-XCH6].

144. D.C. CODE § 3-1206.72 (2021).

most important features of any doula services coverage program are routes to registration, doula independence, and method of reimbursement.

A. Oregon[145]

In 2012, Oregon became the first state to authorize Medicaid coverage of doula services.[146] Doulas must become certified and registered as traditional health workers.[147] The certification program requires (a) at least twenty-eight hours of in-person education, (b) at least six hours of cultural competency training, (c) at least six contact hours related to doula care in inter-professional collaboration, HIPAA compliance, or trauma-informed care, (d) oral health training, and (e) CPR certification.[148] Once a doula is certified, they complete a no-cost application to be registered as a traditional health worker.[149] After certification and registration, the doula may function independently, specifically as an independent contractor.

Oregon doulas are offered flexibility in choosing methods of reimbursement once doulas obtain a National Provider

145. Oregon had an MMR of 12.8 in 2018 and an IMR of 4.85 in 2019. *See* ADVISORY BD., *The States With the Highest (and Lowest) Maternal Mortality, Mapped* (Nov. 9, 2018), https://www.advisory.com/en/daily-briefing/2018/11/09/maternal-mortality [https://perma.cc/R5JG-LQND]; CTRS. FOR DISEASE CONTROL & PREVENTION, *Infant Mortality Rates by State – 2019*, (Mar. 12, 2021), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm [https://perma.cc/HRF5-JZGQ].

146. Katy B. Kozhimannil & Rachel R. Hardeman, *Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality*, 43 BIRTH 97 (2016), https://edenmidwifery.com/womens-health-resources-springfield-oregon/coverage-for-doula-services.pdf [https://perma.cc/4PLW-RYCF].

147. OR. HEALTH AUTH., *Oregon Medicaid Reimbursement for Doula Services,* (Sept. 12, 2018), https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20reimbursement%20for%20doula%20services.pdf [https://perma.cc/WF6E-XERH].

148. OR. HEALTH AUTH., *OHA Approved Form for Birth Doula State Registry Certification*, https://www.oregon.gov/oha/OEI/Documents/Doula-Checklist-State-Registry-Certification.pdf (last visited Jan. 16, 2022) [https://perma.cc/S9N3-J8A6].

149. Platt & Kaye, *supra* note 142.

Identifier.[150] Oregon is the only state that allows for doulas to bill Medicaid directly for services rendered.[151] This method, however, requires that doula services be provided *at the request of* a licensed obstetrical provider.[152] Doulas may also bill through an organization, clinic, or under another health care provider on behalf of the doula.[153] The Oregon Health Authority has assisted in creating doula "hubs" to help self-employed doulas navigate the billing process.[154] The "hubs" allow groups of doulas to bill together, rather than as individuals.[155] This billing structure has also led to improvement in the delivery of doula services.[156]

Minimal Medicaid reimbursement rates at the start of the program were problematic.[157] Without adequate reimbursement, doula work is not financially viable.[158] Initially, Oregon Medicaid reimbursed $75 for labor and delivery doula services—no matter how long labor and delivery took.[159] Reimbursement was later increased to $350 for services rendered through a 2-1-2 method: two prenatal maternity support visits, support on the day of delivery, and two postpartum visits.[160] When doula services are rendered a la carte (rather than through a 2-1-2 package), up to four maternity support visits (two prenatal and two postpartum) are reimbursed at $50 per visit and one day of delivery services is reimbursed at $150.[161]

150. OR. HEALTH AUTH., *Oregon Medicaid Reimbursement for Doula Services*, supra note 147.

151. Platt & Kaye, *supra* note 142.

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. Kozhimannil & Hardeman, *supra* note 146.

158. *Id.*

159. Platt & Kaye, *supra* note 142.

160. Ashley Nguyen, *Oregon Covers Doula Work, but Progress is Moving at a 'Glacial Pace,'* THE LILY (Mar. 1, 2021), https://www.washingtonpost.com/graphics/2021/the-lily/doulas-in-oregon-costs-payment/ [https://perma.cc/L7W4-ERX7].

161. *Id.*

After the increase in reimbursement rates, Oregon reported an increase in doulas joining the traditional health workers registry.[162] But in practice, the Medicaid reimbursement system has been described by doulas as "frustrating and fragmented."[163] It took nearly two years for individual doulas to obtain payment for past services rendered once the program went into effect.[164] The use of "hubs" helped to streamline doula work for one person to handle the administrative tasks while other doulas support Medicaid clients.[165] Despite the challenges, one Oregon doula remarked, "We just have to keep pushing forward to make sure that every mother can receive a doula from her community."[166] As of February 2023, there are 199 certified doulas registered in Oregon.[167]

B. Minnesota[168]

Minnesota became the second state to require Medicaid payment for doula services in 2013.[169] Since 2014, doulas have supported more than 850 Medicaid-sponsored births.[170] Doulas must be certified through a verified doula training program that has been approved by the Minnesota Department of Health.[171] After certification, doulas must register with the Minnesota Doula

162. Platt & Kaye, *supra* note 142.

163. Nguyen, *supra* note 160.

164. *Id.*

165. *Id.*

166. *Id.*

167. OREGON HEALTH AUTH., *Traditional Health Worker Registry*, https://traditionalhealthworkerregistry.oregon.gov/Search [https://perma.cc/82VJ-AJEL] (last visited Feb. 16, 2023).

168. Minnesota had an MMR of 11.8 in 2018 and an IMR of 4.47 in 2019. *See*, respectively, ADVISORY BD., *supra* note 145; CTRS. FOR DISEASE CONTROL & PREVENTION, *Infant Mortality Rates by State – 2019*, *supra* note 145.

169. Kozhimannil et al., *Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year*, *supra* note 89, at 2.

170. Ashely Nguyen, *Behind the Growing Movement to Include Doulas under Medicaid*, THE LILY (Mar. 1, 2021), https://www.washingtonpost.com/graphics/2021/the-lily/covering-doulas-medicaid/ [https://perma.cc/4EAJ-CZHK].

171. Platt & Kaye, *supra* note 142.

Registry,[172] which requires a one-time application fee of $200.[173] There are no additional requirements to become a certified doula in Minnesota.

Although doulas receive a National Provider Identifier to bill for services,[174] Minnesota doulas are not afforded the same flexibility as in Oregon in provider oversight and billing. In Minnesota, doulas must practice under the supervision of an enrolled Medicaid provider,[175] specifically a physician, nurse practitioner, or certified nurse midwife.[176] Individual doulas may work as a part of a collective or organization, but the Minnesota List of Registered Doulas lists all doulas individually.[177] This makes it difficult for both Medicaid and potential clients to identify individual doulas who work as a part of the collective.[178] Minnesota has acknowledged that billing as an independent doula is the "least likely scenario."[179] Only one doula successfully billed independently by corresponding directly with her clients' managed care organizations. But in the end, "the amount of time she spent on paperwork led her to give up [on billing independently]."[180]

Reimbursement of doula services is rendered using a 3-1-3 method: three prenatal visits, one labor and delivery service, and three postpartum visits.[181] Minnesota Medicaid originally limited reimbursement rates of prenatal and postpartum visits to $25.71

172. *Id.*

173. Bakst et al., *supra* note 114, at 7.

174. *Id.*

175. *Id.*

176. Platt & Kaye, *supra* note 142.

177. MINN. DEP'T OF HEALTH, *List of Registered Doulas*, https://www.health.state.mn.us/facilities/providers/doula/registry.html [https://perma.cc/DPB5-DDJB] (last visited Jan. 16, 2022).

178. Bakst et al., *supra* note 114, at 7.

179. DOULA SERIES FOOTNOTES, *Frequently Asked Questions – Minnesota*, https://doulaseriesfootnotes.com/minnesota-FAQs.html [https://perma.cc/M3SU-7ENK] (last visited Jan. 16, 2022).

180. *Id.*

181. METHODS TO SECURE DOULA REIMBURSEMENT APPROVAL FROM CMS, WASH. STATE HEALTH CARE AUTH., at 8 (2020).

per visit, and one labor and delivery service to $257.10[182] Like Oregon, in the face of low reimbursement rates, participation in the Doula Registry was low.[183] In 2019, Medicaid reimbursement rates were increased to $47 per prenatal or postpartum visit and $488 for labor and delivery.[184] As of January 2023, there are over 150 doulas registered in Minnesota.[185]

C. Ohio[186]

Ohio ranks 21 out of 50 states in terms of highest MMR.[187] In 2019, the Black infant mortality rate was nearly three times higher than white infants.[188] This disparity has increased by 26% over the past decade.[189] Cuyahoga County, which contains the Cleveland metropolitan area, has one of the highest infant mortality rates in the United States.[190]

The demand for doula services in Ohio has only increased in recent years.[191] Doula services in Ohio generally cost between $800

182. Bakst et al., *supra* note 114, at 8.

183. *See id.*

184. DOULA SERIES FOOTNOTES, *Medicaid Coverage of Doula Services in the United States: Frequently Asked Questions*, *supra* note 142; Platt & Kaye, *supra* note 142.

185. MINN. DEP'T OF HEALTH, *List of Registered Doulas*, *supra* note 177.

186. Ohio had an MMR of 19.2 in 2018 and an IMR of 6.89 in 2019, which are significantly higher rates than the doula-sponsoring states of Oregon and Minnesota. *See*, respectively, ADVISORY BD., *supra* note 145; CTRS. FOR DISEASE CONTROL AND PREVENTION, *Infant Mortality Rates by State – 2019*, *supra* note 145.

187. Josh Rultenberg, *Bill to Cover Doula Expenses A "ROOTT Issue" for One Company*, SPECTRUM NEWS 1 (Mar. 12, 2021, 10:50 AM), ttps://spectrumnews1.com/oh/columbus/news/2021/03/11/bill-to-cover-doula-expenses-a--root-issue--for-one-company [https://perma.cc/JF9Q-X66Z].

188. HEALTH POLICY FACT SHEET: TAKING ACTION: ELIMINATING RACIAL DISPARITIES IN INFANT MORTALITY, HEALTH POL'Y INST. OF OHIO, at 1 (2021).

189. *Id.* at 2.

190. *Infant Mortality*, FIRST YEAR CLEVELAND: THE ISSUE, https://www.firstyearcleveland.org/the-issue [https://perma.cc/FP6E-A74S] (last visited Oct. 27, 2022).

191. Debbie Holmes, *Doulas Growing In Demand To Save Black Moms And Babies*, WOSU (May 6, 2021, 6:33AM),

to $1,500,[192] but costs vary depending on geographic location. Private doula care in central Ohio starts around $500, with an average cost of $800-1,000.[193] Birthing Beautiful Communities (BBC) is an African American-founded and community-based doula organization.[194] BBC serves the Cleveland and Akron areas through Labor Support, Life Goal Planning, Childbirth and Parenting, and Support Groups services.[195] Since its founding in 2014, BBC has educated and supported over 500 pregnant women and families.[196] Of the women who completed the Sisters Offering Support (SOS) Circle program, one of the many peer-on-peer support groups that is offered in conjunction with doula services,[197] 92% had full-term pregnancies in 2019, and an overall infant survival rate of 99.8%.[198]

Another local, Black-led reproductive justice organization is Restoring Our Own Through Transformation, or ROOTT.[199] This Columbus-based doula organization is boasting a 0% Black

https://news.wosu.org/2021-05-06/doulas-growing-in-demand-to-save-black-moms-and-babies [https://perma.cc/T5T2-8FGT].

192. Camri Nelson, *House Bill 142 Looks Good to Get Doula Services Covered by Medicaid*, SPECTRUM NEWS 1 (June 16, 2022), https://spectrumnews1.com/oh/columbus/politics/2022/06/15/new-house-bill-looks-to-get-doula-services-covered-by-medicaid- [https://perma.cc/5GW9-4CLP].

193. MOUNT CARMEL FOUND., *Doulas Make a Difference*, https://www.mountcarmelhealth.com/mount-carmel-foundation/our-impact/doulas-make-a-difference [https://perma.cc/M74F-4M4E] (last visited Nov. 7, 2022).

194. BIRTHING BEAUTIFUL CMTY'S, *About Us: Our Story*, https://www.birthingbeautiful.org/about/ [https://perma.cc/VV4F-RA4G] (last visited Nov. 7, 2022).

195. BIRTHING BEAUTIFUL CMTY'S, *Let's Have A Baby: Our Services*, https://www.birthingbeautiful.org/services/ [https://perma.cc/N9VA-P5LT] (last visited Nov. 7, 2022).

196. Vyzral, *supra* note 8.

197. Jen Jones Donatelli, *Local Black Babies Are 4x As Likely to Die Before Age One. This Clevelander is Saying, "No More."*, FRESHWATER (July 10, 2019), https://www.freshwatercleveland.com/features/bbc071019.aspx [https://perma.cc/ZMH5-ZEBC].

198. Vyzral, *supra* note 8.

199. ROOTT, *What We Do*, https://www.roottrj.org/what-we-do-3 [https://perma.cc/6WQX-MTLM] (last visited Jan. 17, 2022).

maternal and infant mortality rate.[200] Both the Ohio legislative and executive branches have taken notice of these organizations' successes and have undertaken efforts to expand access to doula services.

Many bills have been introduced to the Ohio General Assembly for Medicaid coverage of doula services: S.B. 328[201] and H.B. 611 in 2020,[202] and H.B. 142 in 2021.[203] The doula services coverage program described in H.B. 142 is expected to cost $14 million per year, with the federal government reimbursing the state up to 63%.[204] Doula services reimbursement would be capped at $2,500 per pregnancy.[205] After a near-unanimous vote in the Ohio House in June 2022, H.B. 142 has moved to the Ohio Senate for consideration.[206]

The Ohio Department of Medicaid (ODM) does not directly reimburse for doula services but has offered grants through the Ohio Equity Institute.[207] 562 clients across three counties have received over $1 million in grant funds in 2020.[208] ODM has recently proposed instituting direct Medicaid reimbursement based on the Oregon and Minnesota programs.[209] Ohio doulas would be required to obtain certification from an approved doula training organization.[210] Doulas would be supervised by a physician or an Advanced Practice Registered Nurse, including a

200. Rultenberg, *supra* note 187, at 3.

201. S.B. 328, 133rd Gen. Assemb., Reg. Sess. (Ohio 2020).

202. H.B. 611, 133rd Gen. Assemb., Reg. Sess. (Ohio 2020).

203. H.B. 142, 134th Gen. Assemb., Reg. Sess. (Ohio 2021).

204. Rultenberg, *supra* note 187, at 3.

205. *Id.*

206. Andy Chow, *Ohio House Approves Bill Allowing Doula Services to be Covered by Medicaid*, WKSU (June 6, 2022), https://www.wksu.org/health-science/2022-06-06/ohio-house-approves-bill-allowing-doula-services-to-be-covered-by-medicaid [https://perma.cc/BYB6-LFVL].

207. OHIO DEP'T MEDICAID, *Doula Services*, (June 23, 2021), https://medicaid.ohio.gov/static/Families%2C+Individuals/Programs/MISP/Doula-Services-June23-15Jun21.pdf.

208. *Id.*

209. *Id.*

210. *Id.* at 14.

nurse midwife.[211] The supervising provider would bill on behalf of the doula.[212] Services provided would be limited to emotional support, physical support, and childbirth education.[213] Services rendered would follow a 2-1-2 or 3-1-3 method, much like Oregon or Minnesota, with 2-3 prenatal support visits, 1 labor and delivery service, and 2-3 postpartum support visits.[214] Reimbursement rates would be comparable to other state Medicaid programs and services.[215]

ODM held a virtual stakeholder meeting on June 23, 2021, regarding Medicaid coverage of doula services. ODM assured the attendants that this was the first of many meetings regarding doulas, and that more information would be available at a later time. ODM held its next meeting on December 15, 2021, discussing policy changes effective January 1, 2022.[216] On May 6, 2022, ODM held another stakeholder to review the Comprehensive Maternal Care Draft Rule.[217] ODM's presentation references Doulas Services as "Phase 4" of the Maternal Infant Support Program.[218] But ODM has yet to provide detailed information as to the adminsitration of the doula program or when Medicaid coverage is expected to begin.[219]

211. *Id.* at 11.

212. *Id.*

213. *Id.* at 15.

214. *Id.* at 9.

215. *Id.*

216. OHIO DEP'T MEDICAID, *MISP-Related Policy Changes Effective 1/1/22* (Dec. 15, 2022), https://medicaid.ohio.gov/static/Families%2C+Individuals/Programs/MISP/MISP+Policy+Changes+Stakeholder+Presentation+15Dec21-Final.pdf.

217. OHIO DEP'T MEDICAID, *Maternal and Infant Support*, https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/maternal-and-infant-support/maternal-and-infant-support [https://perma.cc/BX62-2V6P] (last visited Feb. 16, 2023).

218. OHIO DEP'T MEDICAID, *Comprehensive Maternal Care Program Draft Review* (May 6, 2022), https://medicaid.ohio.gov/static/Families%2C+Individuals/Programs/MISP/CMC+Program+Stakeholder+Review+06May22.pdf [https://perma.cc/SKL3-KEY2].

219. *Id.*

IV. INTEGRATING DOULA SERVICES INTO OUR HEALTHCARE SYSTEM

The need for health plan issuer-provided doula services has only grown in recent years. Doulas help facilitate equitable and empowered pregnancies and births. Public and private insurers are incentivized to cover doula services because of improved health outcomes for both mothers and babies, as well as demonstrated long-term cost savings. The following recommendations are aimed at *equitably* integrating doula services into our healthcare system. Legislators and insurers have discretion when determining how doula services may be covered. But insurers should not implement a standard, "one size fits all" program. Instead, insurers must actively consider the program's effect on doulas who are low-income, or racial and ethnic minorities. Doulas from these populations—who serve women in their same populations—can have the greatest impact to improve maternal and infant outcomes. Instituting a doula services coverage program with administrative hurdles will negatively impact this group from gaining access to the doula profession. Instituting such a program would be futile; the insurer will never fully realize the benefits and cost savings of doulas. The path forward requires diligence and consideration of the doula profession and the clientele whom doulas will serve.

Legislation, both at the federal and state level, is the best tool to ensure that public insurers are required to cover doula services. At the federal level, amending the ACA would be the most effective approach. The ACA states that all individual and employer insurance plans, including those purchased on the marketplace, must cover maternity and newborn care.[220] The ACA should be amended to more clearly define covered benefits pertaining to pregnancy and childbirth.

Currently, the ACA mandates that all plans offered in the marketplace cover ten essential health benefits.[221] Services related to "pregnancy, maternity, and newborn care (both before and

220. *Affordance Care Act: Coverage for New Mothers*, WEBMD (Sept. 4, 2020), https://www.webmd.com/health-insurance/pregnancy-childbirth-coverage [https://perma.cc/Q7FJ-S99U].

221. *What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ [https://perma.cc/KXU4-DW25/] (last visited Mar. 20, 2022).

after birth)" are covered as essential services.[222] "Birth control coverage" and "breastfeeding coverage" are classified as "additional benefits" that must be included in all plans.[223] Doula services would clearly fit within this category of "additional benefits" that are aimed at women's reproductive health. Because doulas are also associated with higher rates of breastfeeding at six weeks postpartum,[224] including doula services coverage supports the worldwide breastfeeding initiative,[225] which the ACA's breastfeeding coverage is meant to encourage. The ACA should, therefore, be amended for clear inclusion of doula services as "additional benefits." Private insurers would be subject to any ACA amendments,[226] making this the best choice for doula services coverage.

222. *Id.*

223. *Id.*

224. Laurie A. Nommsen-Rivers et al., *Doula Care, Early Breastfeeding Outcomes, and Breastfeeding Status at 6 Weeks Postpartum Among Low-Income Primiparae*, 38 J. OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 157 (2009).

225. Beginning in the 1990's, the World Health Organization launched the "Breast is Best" campaign to encourage exclusively-breastfed infants for the first six months of life. Soon after its inception, many organizations have also adopted the "breast is best" view, such as the American Academy of Pediatrics, UNICEF, and more. While the campaign has focused on benefits of exclusive breastfeeding, fear mongering and scare tactics have also been used to induce breastfeeding, as seen in the National Breastfeeding Awareness Campaign—cosponsored by the U.S. Department of Health and Human Services and the Ad Council in the early 2000's. *See* Jennifer Gerson, THE 19TH*, *When 'Breast is Best' Becomes Too Much* (Aug. 5, 2021, 7:00 A.M), https://19thnews.org/2021/08/when-breast-is-best-becomes-too-much/ [https://perma.cc/C7Z3-7FJQ/]; WORLD HEALTH ORG., *Breastfeeding – Recommendations*, https://www.who.int/health-topics/breastfeeding#tab=tab_2 [https://perma.cc/4CSJ-WS4G] (last visited Mar. 20, 2022); Joan B. Wolf, *Is Breast Really Best? Risk and Total Motherhood in the National Breastfeeding Awareness Campaign*, 32 J. HEALTH POL., POL'Y, AND L. 595 (2007).

226. NAT'L P'SHIP FOR WOMEN AND FAMILIES & CHILDBIRTH CONNECTION, *supra* note 68, at 12.

At the state level, Medicaid expansion is key.[227] Missouri is the latest state to opt for Medicaid expansion in late 2021.[228] Section 1115 waivers are one avenue for states to expand Medicaid coverage, but still retain flexibility over how their programs are operated.[229] If a state expands its Medicaid program, the state will receive additional funding from the federal government. If a state does not expand their Medicaid program, that state can still enact legislation for coverage of doula services through Medicaid. But without the additional funding and federal contributions, a non-expanded Medicaid state will face barriers to implement equitable coverage of doula services.

Private insurers encounter fewer barriers to cover doula services on their own accord. Some private insurers currently retroactively reimburse for doula services, but the doula must usually be registered with a National Provider Identification ("NPI") number.[230] Obtaining an NPI is an added administrative hurdle that restricts the number of doulas who may be covered. As it stands, many states do not require doulas to be licensed or registered. Private insurers must balance their need for adequate credentialing and limiting liability while acknowledging that community-based doulas who serve their local populations will achieve desired outcomes.

Once an insurer decides to cover doula services, the insurer must design the program. Three courses of action are crucial for equitable integration of doula services coverage: (1) doula registration processes must balance the need for high-quality care

227. Jamila Taylor & Anna Bernstein, *The Medicaid Coverage Gap and Maternal and Reproductive Health Equity*, THE CENTURY FOUND. (Aug. 10, 2021), https://tcf.org/content/commentary/medicaid-coverage-gap-maternal-reproductive-health-equity/ [https://perma.cc/B4EK-45T7].

228. KAISER FAM. FOUND., *supra* note 138.

229. Madeline Guth, Elizabeth Hinton, MaryBeth Musumeci & Robin Rudowitz, *The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election*, KAISER FAM. FOUND. (Oct. 30, 2020), https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/ [https://perma.cc/3VT6-YS2M].

230. Andrea Abenoza-Filardi, *How to Get Your Insurance Company to Pay For Your Doula* (Oct. 18, 2016), https://www.holisticallyloved.com/blog/2014/9/14/insurance-paying-for-a-doula [https://perma.cc/5M3C-RBC8].

and accessibility to the profession; (2) doulas must be afforded adequate independence to fulfill their role as the client's advocate adjacent to the traditional healthcare system; and (3) sustainable reimbursement for doula services must come directly from payors—rather than from supervisory providers—to preserve the administrative divide between the doula and the health care provider.

A. Doula Registration

Doula registration processes must balance the need for high-quality care and accessibility to the profession. As a practical matter, states will need to institute a registration scheme to establish minimum competency of doulas for both public and private coverage. Doulas will most easily fit into the body that oversees registered Community Health Workers. "Community Health Worker" is an umbrella term that encompasses several categories of health and health-related providers.[231] Many states that offer Medicaid reimbursement already have systems in place to oversee the registration of Community Health Workers.[232] Adding doulas to this regime, rather than creating a doula-specific registration scheme, will ease some of the administrative burdens on implementing doula services coverage.

Registration processes must be equitable for those seeking entry into the profession. States should be mindful of the barriers to practice for doulas who are low income or from racial or ethnic minorities. Doula registration requires training from a certified program and registration—all of which are costly.[233] Total fees generally range from $800-1,200.[234] States should seek to include local and low-cost doula certification programs during the selection of approved programs. States may also provide grants to low-income doula trainees to cover program tuition.

Another way to expand access to the profession is to minimize administrative fees. For example, Oregon does not require a fee

231. NAT'L ACAD. FOR STATE HEALTH POL'Y, *State Community Health Worker Models* (Dec. 10, 2021), https://nashp.org/state-community-health-worker-models/ [https://perma.cc/3LHR-WMBL].

232. *Id.*

233. Kozhimannil & Hardeman, *supra* note 146, at 98.

234. *Id.*

to become registered as a traditional health worker.[235] Minnesota, on the other hand, requires a $200 fee to be a part of the Doula Registry.[236] In addition, a fee waiver process can be instituted for qualifying low-income doulas.[237]

B. Doula Independence

Doulas must be afforded adequate independence to fulfill their role as the client's advocate adjacent to the traditional health care system. While the term "advocate" may connotate opposition, the role of a doula is *support*. That support is meant to enhance any traditional care received by a client, rather than stifle or overtake any provider-client relationship. Doulas should be free from direct supervision by health care providers to serve this role most effectively.

For doulas to maintain adequate independence, state-run doula boards can review doula conduct and services to control the quality of doula care. Such a structure would be similar to how physician care and conduct is reviewed. This proposed quality control mechanism would differ from that of Community Health Workers, who are directly supervised by other health care providers. As the doula profession grows, establishing a state-run board will become more practicable.

In granting independence to doulas, administrative structures in billing insurers and receiving reimbursement must be reasonable. In Oregon, the complex process to bill as an independent provider initially prevented doulas from doing so.[238] Once Oregon created a "hub" system for doulas to bill as a group, yet still maintain their independence, the administrative burdens were lessened.[239] Minnesota's billing structure effectively foreclosed doulas from billing independently.[240]

Choosing how to organize a doula practice is a personal decision. Doulas may choose to operate as sole practitioners, to create their own organization with other doulas, to join a local

235. Platt & Kaye, *supra* note 142.

236. Bakst et al., *supra* note 114, at 7.

237. Kozhimannil & Hardeman, *supra* note 146, at 98.

238. Platt & Kaye, *supra* note 142.

239. *Id.*

240. DOULA SERIES FOOTNOTES, *Frequently Asked Questions – Minnesota*, *supra* note 179.

doula collective, or to affiliate themselves with a health care organization. Doulas should not be prevented from organizing their practice as they would like because of an insurer's administrative requirements, meaning that insurers should not be able to discriminate against doulas if they choose to work as a sole practitioner or within a local doula collective. Doulas should be allowed flexibility in deciding how they want to bill insurers and should not be unnecessarily hindered by administrative burdens.

C. Sustainable Reimbursement for Doula Services

Sustainable reimbursement for doula services must come directly from payors—rather than from supervisory providers—to preserve the administrative divide between the doula and the health care provider. First, reimbursement rates must be sustainable for doulas to continue in the profession and support the care provided. When reimbursement rates are too low, the ability to practice and offer services as a doula is also low. This was exhibited by Oregon and Minnesota's initially low reimbursement rates.[241] Doulas had to work other jobs because they could not afford to practice full-time.[242] One cost-effectiveness study of ten midwestern states found that the cost equivalency point—the point at which the costs of doula services were offset by the savings gained by rendering the services—ranged from $929 to $1,047.[243] This figure can be used as a starting point in determining reimbursement rates while considering that a doula's cost of living will vary by geographic location.

Medicaid considers a variety of factors when it decides service reimbursement rates, such as individual state policies[244] and how

241. Platt & Kaye, *supra* note 142.

242. *Id.*

243. Cate Sturtevant & Molly Firth, *The Doula Option: An Opportunity to Improve Birth Outcomes in Washington State,* UNIV. WASH. CTR. FOR HEALTH INNOVATION & POL'Y SCI., at 5 (Mar. 2019), https://depts.washington.edu/uwchips/docs/brief-doula-option.pdf [https://perma.cc/48WE-984E].

244. CTRS. FOR MEDICARE & MEDICAID SERV., *Comparing Reimbursement Rates*, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/understand-the-reimbursement-process [https://perma.cc/3KSM-ZVUW] (last visited Oct. 17, 2022).

much is paid for comparable services.[245] The Centers for Medicare & Medicaid Services calculates reimbursement rates on a sliding scale, consisting of federally-established minimum and maximum limits.[246] At the lowest end is a national minimum.[247] There is also a cost-basis rate, which is based on a particular facility's previous annual cost report.[248] For instance, doulas working in a collective may have higher overhead costs, which may be considered when calculating reimbursement rates. Next is an enhanced rate, which is a negotiated rate that is higher than the national minimum or a standard rate.[249] The national maximum is the upper payment limit.[250] Medicaid should incentivize doulas to begin and continue their practice. This can be achieved by reimbursing doulas at an enhanced rate,[251] or through a cost-basis rate if the doula is part of a collective. Medicaid should also reimburse long-practicing doulas at an enhanced rate or near the upper payment limit to incentivize doulas to remain in the profession.[252]

245. OHIO DEP'T MEDICAID, *Doula Services*, *supra* note 207, at 13.

246. CTRS. FOR MEDICARE & MEDICAID SERV., *Comparing Reimbursement Rates*, *supra* note 244.

247. *Id.*

248. *Id.*

249. *Id.*

250. *Id.*

251. Opting to reimburse doulas at an enhanced rate is likely to be a legislative decision. For instance, in 2013 and 2014, Congress chose to reimburse qualifying primary care physicians under Medicaid at an enhanced rate due to the influx of new Medicaid-eligible patients established through the ACA. *See* AM. COLL. OF PHYSICIANS, *Enhanced Medicaid Reimbursement Rates for Primary Care Services*, at 1, https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/v1-enhanced-medicaid-reimbursement-rates.pdf [https://perma.cc/4LLZ-9CWK] (last visited July 29, 2022) (unpublished work).

252. A 2019 study concluded that increasing Medicaid reimbursement rates expanded access to care across the board. Specifically, each $10 increase in Medicaid reimbursement per visit generated a 0.3 percentage point increase in the probability that a Medicaid recipient reported a doctor visit in the past two weeks. *See* NAT'L BUREAU ECON. RSCH., *Increased Medicaid Reimbursement Rates Expand Access to Care* (Oct. 2019), https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care [https://perma.cc/8MV6-9TEW] (citing Diane Alexander & Molly Schnell, *The Impacts of Physician Payments on Patient Access,*

Second, costs associated with travel should be included in reimbursement. There are disparities in maternal outcomes between rural and urban populations. One study found that, after controlling for sociodemographic factors and clinical conditions, rural residents have a 9% greater probability of severe maternal morbidity and mortality than urban residents.[253] There are a myriad of reasons why rural residents may have poorer outcomes. Rural communities encounter more barriers to social determinants of health, along with structural and systemic issues to health care.[254] Systemic barriers include a lack of insurance coverage, hospital closures, loss of obstetric services, and workforce shortages.[255] Pregnant women in rural areas need reliable access to doula care to respond to reductions in rural obstetric services.[256] Rural doulas, who frequently travel substantial distances to meet with clients, may find that their travel expenditures alone outweigh their earnings for prenatal or postpartum visits for distant clients.[257] Reimbursing rural doulas for travel will aid in improving rural maternal and infant outcomes while promoting rural doulas to continue their practices.

In all, if a private payor or state Medicaid program seeks to expand coverage of doula services, modeling its program after Oregon's doula services coverage program is a good place to start. Some notable features of Oregon's program are reduced fees in registration and a doula's independence as a provider, both in oversight and in billing. Supplementing Oregon's program with

Use, and Health (NAT'L BUREAU ECON RSCH. Working Paper No. 26095) (last revised Aug. 2020)). The Ohio Department of Medicaid also suggested utilizing bonus or incentive payments, including a retroactive bonus based on the provider's performance the year prior. It is unclear whether doulas would directly benefit from such a program. *See* OHIO DEP'T MEDICAID, *Comprehensive Maternal Care Program Draft Review*, *supra* note 218.

253. NAT'L ADVISORY COMM. ON RURAL HEALTH AND HUM. SERV., *Maternal and Obstetric Care Challenges in Rural America*, at 4 (Aug. 25, 2020), https://www.ruralhealthinfo.org/assets/3749-15835/maternal-health-nacrhhs-082620.pdf [https://perma.cc/9M6N-V6AL].

254. *Id.* at 4.

255. *Id.*

256. Kozhimannil & Hardeman, *supra* note 146, at 98.

257. *Id.*

the above recommendations will ensure that doulas have equitable access to registration, are afforded adequate independence, and can continue their profession through sustainable reimbursement rates.

CONCLUSION

Doulas show great promise for mothers, babies, and families across the United States. Doula services are linked to improved medical outcomes and more empowered births. Many states have legislation pending regarding the inclusion of doula services in public health plans, like Medicaid.[258] Although pending legislation is a sign of recognition for the importance of doula services, the passing of equitable legislation will ensure that doulas can sustainably provide care to our most vulnerable families. Access to doula services must be expanded to all, but states and private payors must keep in mind those who will stand to benefit the most: low-income, underrepresented families.

258. NAT'L HEALTH L. PROGRAM, *Doula Medicaid Project*, *supra* note 128.