Introduction

The State of Missouri has below average outcomes for maternal and infant health; moreover, significant racial disparities exist. The Center for Health Economics and Policy (CHEP) hosted stakeholder convenings in August and November 2021 and interventions were discussed to address these poor health outcomes and disparities. One of the recommendations from convening attendees was to provide doula services to high-risk pregnant women and to provide a mechanism to fund these types of services. This approach is being considered by several states and some have already implemented programs to provide these services.

Doulas are trained professionals who provide continuous support to mothers and families before, during, and after childbirth. Doula care has been shown to be beneficial for improving the health outcomes of mothers and infants. Community-based doulas come from the under-resourced communities they serve and are trained at an organization that centers their community’s culture in their care model. Emerging research suggests that these community-based doulas can reduce racial disparities in birth outcomes.1

The challenge for authorizing Medicaid payment for doula care is that this form of care operates outside of traditional clinical provider organizations. State Medicaid programs require some type of accreditation in order to accurately define the scope of doula work, establish mutually understood guidelines for Medicaid payment eligibility, and ensure patient safety. A balance between the current structure of doula care, providers, and requirements of Medicaid programs is essential for any new policy seeking to increase access to doula care. The purpose of this brief is to explain the opportunities provided by doula care, summarize the current training and credentialing options of doula organizations in Missouri, and identify policy considerations.

Background

Doulas can fill a gap in the healthcare system for high-risk patients as advocates, providing physical, emotional, and informational support. Doulas meet with women and families before childbirth to understand what their pregnancy plans are, and they advocate for those intentions throughout the pregnancy and birth. Culturally congruent community-based doulas™ (CCCDs™), who share the cultural background of their clients, have for decades been working to reduce racial disparities in pregnancy and birth through a multifaceted approach that empowers women of color, mitigating discrimination, racism, loss of autonomy, and preventing other harms to communities that have been neglected by the medical system. Community-based doula organizations which support low-income families on Medicaid often help them navigate relevant social services and other resources available via community-based organizations (CBOs), effectively providing care management throughout the pregnancy and postpartum period.

Missouri’s rates of maternal mortality and other birth outcomes have been consistently worse than the US national averages. Infant mortality in Missouri is higher than the national average (6.4 deaths vs 5.8 deaths per 1,000 live births).4 Missouri ranks in the bottom half of states for pregnancy-related mortality (33 deaths vs a national average of 21 deaths per 100,000 live births). Further, Black women are four times more likely to die of a pregnancy-related cause than white women cause (88 deaths per 100,000 live births). Missouri ranks 33rd in the nation for low birthweight and 46th in the nation for the racial gap in birthweight.5 Black infant mortality is three times higher than White

*This term was coined and trademarked by Okunsola M. Amadou, CPM, of Jamaa Birth Village.
Evidence

**Doula Care and Birth Outcomes**

Missouri’s poor outcomes for mothers and infants, especially Black and rural individuals, show that innovation is needed in this space. A study by Kozhimannil and colleagues found that Black race and underinsured or uninsured status are the characteristics most strongly associated with desiring but not having a doula. Two Nevertheless, women of color are entering the doula profession in Missouri each year through organizations like the *Jamaa Birth Village* in St. Louis, *Mid-Missouri Black Doula Collective* in Columbia, *Uzazi Village* in Kansas City, and *Missouri Bootheel Regional Consortium* in the Bootheel region. These organizations are changing the scope of doula access in Missouri through their culturally congruent community-based doula care. As opposed to broad national training services, Missouri doula organizations train doulas with skills that are pertinent to the communities they serve. This increase in access to doulas in these communities is reshaping the social determinants of health in pregnancy care as they help navigate social services and make connections with CBOs (see quote box below).

Doulas’ continuous support during pregnancy and childbirth is shown to be effective and cost-efficient in randomized control trials using economic modeling. A 2017 report in the Cochrane Reviews highlights that when continuous labor support is part of the birthing process, there is a subsequent increase in spontaneous vaginal births, decrease in cesarean and instrumental vaginal births, decrease of time in labor, increase in mother satisfaction, and improved five-minute Apgar score for the newborn. This labor support is strongest when provided by an individual who is culturally congruent.

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**“Culturally Congruent Community-based Doulas provide care in a way that is nurturing, relevant and familiar for those receiving it. At its core, it is relational, not transactional. Black birthing persons need more than back rubs and hip squeezes to see them safely through the passage of pregnancy and birth; they need a trusted and relatable companion who can deliver care in a culturally appropriate context. Black families need doulas that see, hear, and understand them and that can help them navigate the murky waters of our current healthcare system.”**

– Hakima Payne, MSN RN CEO of Uzazi Village
neither employed by the hospital nor a family member/ friend without specialized training. Further, the American Journal of Obstetricians and Gynecologists provide an A-level recommendation with good quality evidence for the use of doulas during pregnancy. This report adds that doula support during labor is associated with a decrease in pain medication to the benefits mentioned in the previous study.

While there is less established history of community-based doula care to support women in rural areas, it is becoming more common, including in Missouri. The original community-based model was, as described above, aimed at reducing racial disparities and has grown to include navigation of social supports. There are many areas in Missouri which have fewer minority women but many women who need help navigating social supports in an integrated manner to support a better pregnancy and birth experience. As cited above, these rural women also experience disparities in outcomes, some of which are due to geographic lack of access to primary and specialty care which doulas cannot remedy. But to the extent that outcomes can be improved by comprehensive support, education, and navigation of appropriate supports, doula care represents an excellent opportunity. The Doula Foundation in Springfield exemplifies this model, and their data show very promising results in deploying the community-based doula model. In fact, their doulas are also trained as perinatal community health workers. A recent report cites a 96% full-term birth rate, a 92% breastfeeding initiation rate, and a 95% satisfaction rate with the birth experience.

**Doula Credentialing**

Most or all of the doulas who were involved in many of the studies that have shown improved pregnancy outcomes underwent some form of training, and our survey of doula training requirements finds many common elements that likely contribute to success. The evidence shows that doulas are effective, but the variation in training requirements suggests that a review of the components of the various training and accreditation services is useful in identifying the core elements of training that we may expect to contribute to improved outcomes.

There are several national and international doula accreditation entities, but for the purposes of building flexible policies, it is more important to identify the training components than to specify particular names. Indeed, many CCCB doulas believe that the standards of a national or international body will almost certainly fail to capture some of the defining aspects of their work, i.e. how to ensure cultural congruence and community knowledge. While the current patchwork of doula training organizations may add complexity when considering reimbursement policy, it is important to recognize that this situation allows doulas to retain flexibility to operate as needed in their communities, which is a strength. To preserve this flexibility, Missouri policymakers may want to specify the components of training but not the specific accrediting agency. Such decisions could facilitate innovation and community-level support.

Doula certification services and classes have several common factors. Most accredited doulas read and heard lectures on topics such as the role of doulas in birth, breastfeeding, post-partum depression, birth after cesarean, cultural competency, and more; were evaluated by a medical birth professional and sometimes a client; took an exam and successfully completed experiential learning; had a client write a recommendation letter; and must recertify every 2-5 years with proof of continuing education (Table 1). Cultural competency is a newer requirement added by many long-standing organizations, as historically doula services have been accessible mainly to white, affluent mothers who can afford to pay out-of-pocket. In contrast, several doula organizations in Missouri treat cultural competency as a foundational skill for a doula, integrating aspects of cultural awareness and community knowledge throughout the training experience. In seeking to emphasize doula care as a way to address racial disparities in maternal health, it follows that cultural competency should be considered an essential skill for doulas.

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"**Culturally Congruent Community-Based Doulas** change the entire trajectory of care and support in comparison to traditional doulas in the medical care system. Traditional doulas are typically in the here and now, providing comfort measures for this moment, addressing current issues that may arise with remedies that address only that moment. **CCCDs enter care from a holistic perspective addressing root issues related to systemic and historical SDOH, which have ripple effects from mother to baby and the family, dismantling “survival mode” and helping establish true pathways to flourish and thrive. CCCDs connected to CBOs have the opportunity to help dismantle generational and historic barriers, further unraveling complex issues to support the mother and family improving their overall well-being as a unit. **CCCDs improve family health, not just mother-baby health.**"

– Okunsola M. Amadou, CPM
CEO of Jamaa Birth Village
<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
<th>Level 1: Private-Pay</th>
<th>Level 2: Community-based</th>
<th>Level 3: Culturally congruent, community-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum topics</td>
<td>A doula’s role, breastfeeding, postpartum depression, birth after cesarean, basic cultural competency</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Training required</td>
<td>Hours of training which must occur before certification (24-64 hours)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certification</td>
<td>Evaluation by a medical birth professional, including a passing score on a certification exam and successful completion of experiential learning</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Continuing education and recertification</td>
<td>Recertify every 2-5 years with proof of continuing education</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Culture of caring</td>
<td>The doula training organization has a culture of caring for every client that their doulas work with</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prioritize self-determination and client autonomy</td>
<td>The doula training organization prioritizes client’s wishes for the birthing process. They have strategies to increase their clients’ autonomy during the pregnancy and birthing process.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community services</td>
<td>Competencies in social determinants of health, including navigation of social services, trauma-informed care, and strategies specific to the community served.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bereavement and loss training</td>
<td>Skills in supporting individuals through the loss of a birth</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Social justice focus</td>
<td>The doula training organization recruits and trains doulas in practical social justice, aiding their clients to aiding clients in avoiding the harms that can occur when giving birth in an institutional setting.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Community participation in development</td>
<td>The doula training organization is a non-profit developed by and deeply connected to the community that it serves. The organization is in frequent contact with the community to uplift their needs.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diversified work force</td>
<td>The doula training organization trains and empowers doulas who come from the racial and ethnic communities that the organization serves.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designed to reduce health inequity and racialized harms</td>
<td>The doula training organization has an actionable mission to reduce health inequity and racialized harms in the community served. The organization’s leadership and staff reflect this mission.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rooted in anti-racism with an understanding of historical racism and its role in health outcomes</td>
<td>The doula training organization has an anti-racist mission statement. They understand and actively resist the harms that racism has done to their community. They understand how the social determinants of health intersect with race and ethnicity and have strategies to help their clients overcome those determinants.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand cultural dynamics of communities served</td>
<td>The doula training organization takes advice and input from the community served. They share the same culture with the community they serve, which means that their clients do not need to “code switch,” or change how they speak or behave, when working with a doula from the organization.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2. Itemization of common activities and supports to be eligible for MO HealthNet reimbursement

<table>
<thead>
<tr>
<th>Activity or Support Provided</th>
<th>Description</th>
<th>Level 1: Private-Pay</th>
<th>Level 2: Community-based</th>
<th>Level 3: Culturally Congruent, Community-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-medical supportive care</td>
<td>Attends the birth and supports the mother through the process as a non-medical member of the clinical care team.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Extended number of client visits (in addition to the birth)</td>
<td>Doula meets with the client during the pregnancy, post-partum, and interconception periods, as needed, to address special client needs.</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Full spectrum doula care</td>
<td>Full-spectrum doulas cover birth services, adoption, surrogacy, and loss of birth</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td>Works as a case manager for the mother and family during the pregnancy, birth, and post-partum.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Social support resources</td>
<td>The doula provides social support resources, such as connections crisis housing, food access, car seats, and baby clothing. The doula is well-connected to the resources and programs accessible in the mother and family's geographic area.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Models from Other States

Five states currently reimburse for doula services in their Medicaid programs: Maryland, Florida, New Jersey, Minnesota, and Oregon. In Maryland, doulas are reimbursed for up to 8 prenatal or post-partum visits as well as labor and delivery. Doulas must be registered with one of 9 organizations and have liability insurance.

Florida’s Agency for Health Care Administration (AHCA) expanded Managed Care benefits to include doula services, meaning that individuals need to be enrolled within Managed Care to receive the benefit. The implementation of these benefits varies by Managed Care organization, and the AHCA has not released guidance on implementation. Reimbursement is also negotiated within each Managed Care plan. Some plans have limited the doula benefit to high-risk pregnancies. The AHCA has a work group focused on monitoring doula benefit implementation efforts. Importantly, the provision of culturally competent care has been identified as an obstacle in Florida as there has been difficulty meeting the needs of Spanish speakers in the state.

In New Jersey, doulas are individually certified, so they may choose to reimburse individually, as part of an agency, or with a healthcare organization (such as a FQHC). There are current efforts to create a registry where doulas must be registered to receive Medicaid reimbursement.

Rhode Island is in the process of implementing doula reimbursement by Medicaid, and doulas have been active in that process. Rhode Island is the first state to require both Medicaid and private insurance to cover doula services. Doulas in Rhode Island must meet a list of requirements, including training that meets a list of core competencies as well as liability insurance. Importantly, being community-based and culturally competent are core components of the doula certification process. Moreover, if a live birth does not occur, Rhode Island law states that doulas can use the remainder of the 3 prenatal visits as post-partum visits for bereavement support.

In Minnesota, doulas are limited to the scope of a qualified health professional, must train through a state-approved organization, and must pay for a listing on a registry of doulas. Under the Minnesota system, doula services are connected to an NPI, which adds a clinical lens to doula care. Minnesota’s policy limits the scope of practice for doulas and adds cost barriers to being paid by Medicaid. Moreover, rather than choosing what skills the accreditation should reflect, Minnesota Medicaid chooses specific accrediting organizations whose credentials become necessary for employment as a doula. This limits innovation among doulas because Minnesota has chosen the organizations that will receive funding rather than the accreditation curricula that are required, meaning that doulas training at new or smaller organizations will not be reimbursed by Medicaid.
In Oregon, doulas must work under a provider’s National Provider Identifier (NPI), although they can register for their own NPI to bill Oregon’s Medicaid program directly. They must also be certified and registered in the Oregon Traditional Health Worker system. Doulas in Oregon have expressed frustration at the billing and reimbursement processes, including the amount of payment. In January 2022, the law was changed to remove the requirement for a referral from another licensed provider and to remove other administrative barriers.

In general, there are costs involved in becoming a certified or accredited doula. When states add significant registration costs to gain entry to a reimbursement system, such actions are often criticized as potentially limiting the program’s ability to recruit doulas from socially disadvantaged backgrounds; Florida cites this as a key issue for the implementation of its program.

Rhode Island, New Jersey, and Florida take different approaches that each allow the implementation of doula services into the Medicaid program to retain flexibility to be targeted to communities. None of these state programs list organizations that doulas must be certified with to qualify for reimbursement. Rhode Island and New Jersey list core competencies and requirements that must be met, and Florida allows Managed Care plans to determine how doulas may become Medicaid providers. Overall, states that maintained strong partnerships with community-based doula organizations have reimbursement policies that most strongly support the role that CCCDs play in reducing harmful birth outcomes for high-risk pregnancies by retaining flexibility for community-based doulas to operate outside of clinical settings.

### Policy Recommendations

To better understand Missouri’s sub-standard pregnancy outcomes, as well as disparities in these outcomes, the State can use its Managed Care Organization (MCO) contract authority to increase reporting of various key measures, including reporting by race/ethnicity and urban/rural status. But in order for MCOs, which provide coverage for almost all of Missouri’s pregnant women, to have the tools to actually improve outcomes and address disparities, policies must be modified to allow increased flexibility to adopt innovative solutions, such as greater reliance on doula support among others. Given that doula support was a strongly recommended intervention at our Center convenings, and that it is reported to decrease the rate of cesarean sections, increase birth weights, decrease complication rates, and increase breastfeeding rates, it is important that policy changes be considered to allow for reimbursement of these services.

If policies are implemented to include payment for doula services, it is important for the State to assess their effectiveness, primarily by measuring cesarean section rates, birth weights, complication rates, and breastfeeding rates. In addition, maternal mortality, post-partum depression, race, urban/rural differences, and maternal satisfaction are important factors to understand in order to fully capture the effectiveness of this policy. Importantly, other states that are altering doula policy are tracking these metrics. New York, for instance, is tracking reach, effectiveness, doula and member satisfaction, breastfeeding rates, and attendance at post-partum visits via follow up surveys within the state’s pilot program for doula care. In addition, quality data could be collected through the MCOs via member satisfaction surveys, which can be used by the MCO to refer women to highly-rated doulas. MCOs may consider using a reimbursement framework that is scaled to the amount of support provided, with additional payment available for support of women identified as high-risk early in pregnancy.

Policymakers considering doula credentialing policy can refer to Table 1 to understand the common definitions, skills, and trainings that are relevant for Missouri and to Table 2 to understand the types of supports doulas provide. We recommend an approach that acknowledges the differences among the three main types of doula training and support. Further, an approach that is built on required competencies rather than listing a group of approved organizations will likely be the most flexible over time, as well as placing community-led doula organizations in a role that recognizes them as partners. The state’s Medicaid agency and the MCOs could develop a relationship with the newly-formed Missouri Community Doula Council, which could assume the task of verifying which agencies provide the required training components for each level. This would avoid unnecessary burdens on individual doulas, who could simply submit their training certificates to the payers to be approved for reimbursement. Finally, when considering reimbursement rates, it is important to understand the value – both clinical and financial – that doula services can provide to the Medicaid program and design reimbursement accordingly.
Conclusion

Stakeholders from Missouri organizations have suggested that providing pregnant women access to doula care may help improve maternal and infant health outcomes. There is evidence that doulas are effective in developing relationships with pregnant women in order to improve satisfaction and pregnancy outcomes.\textsuperscript{12,16} Several academic studies show doula care to be cost-effective in improving birth outcomes.\textsuperscript{11,15-17,19} Although doula care traditionally occurs outside the medical provider establishment, it could potentially reach more women in need of these services if coverage for doula services were available through Medicaid. Many women with both high-risk and low-risk pregnancies desire doula care in order to improve their birth experiences.

It is not surprising that improved birth experiences are cost-effective, as healthier mothers and babies require less healthcare utilization. This creates a significant opportunity for states looking to improve outcomes and design payments that reflect the value provided by community-based doulas. The most innovative policy ideas will specifically incentivize reductions in disparities; this would provide a justification for reimbursing CCCDs in particular.

Some states are offering coverage for doula services; their approaches to providing coverage and reimbursement are varied and are not always well-received in the doula community. If Missouri Medicaid considers covering doula care for pregnant women, the policies developed will need to be carefully crafted to avoid unnecessarily limitations to the scope of doulas or unnecessary cost hurdles that may turn away individuals from vulnerable communities.\textsuperscript{2} Also, Black, rural, and low-income mothers are at the highest risk of poor pregnancy outcomes,\textsuperscript{2,3} and doula care definitions and policies should be explicitly designed utilizing the knowledge of community-based organizations and experts already involved in this work.

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