Policy Brief

Getting Doulas Paid

Advancing Community-Based Doula Models In Medicaid Reimbursement Conversations

NARRATIVE SUMMARY

In recent years, there has been growing momentum around improving maternal health and addressing longstanding inequities in maternal health outcomes in the United States, including expanding access to doula care. Doulas provide non-clinical emotional, physical, and informational support before, during, and after labor and birth and have been consistently shown to improve birth outcomes and experiences of care. The community-based doula model responds to the disinvestment within Black, Brown, and Indigenous communities by providing culturally reflective support and access to information and referrals at little to no cost. Despite the essential role of community-based doulas in reducing the impacts of structural racism and addressing disparities in maternal health, this model of care continues to lack sustainable and equitable public funding. Legislation is urgently needed to support the growth of a robust community-based doula workforce and provide sustainable federal funding for this community-based work in perpetuity.

Introduction

Disparities in maternal health outcomes disproportionately affect Black, Brown, and Indigenous communities, and sustained; holistic progress is required to eliminate this gap. Communities with high levels of social exclusion often struggle with the effects of structural racism, such as economic instability, lack of community safety, low levels of social connectivity, and lack of culturally appropriate support for pregnancy, birth, and parenting.

Doulas—trained or community-based nonmedical birth companions—can disrupt families' experiences of harm, mistreatment, and adverse health impacts by acting as a supporting voice for birthing people within the medical system while enhancing birthing people's feelings of agency, security, and respect. Doulas are critical resources for birthing people during pregnancy, childbirth, and postpartum, providing direct emotional, physiological, and informational support and care. Numerous studies have indicated that birthing people with doula support experience greater satisfaction with their care and are less likely to experience birth complications, less likely to have low birth weight babies, and more likely to initiate breastfeeding [1-3].

The community-based doula model responds to the disinvestment within Black, Brown, and Indigenous communities by improving the health of birthing families of color and low-income families. Culturally reflective support within the community and a shared experience with a personal champion are crucial for investing in Black, Brown, and Indigenous communities and improving their outcomes and experiences. Where private, non-community-based doulas typically offer support only during pregnancy, labor, and early postpartum, community-based doulas provide additional support to birthing families by acting as a trusted resource and providing referrals and access to health information, social services, and culturally competent providers. Community-based doulas build bridges to connect birthing people from inadequately served communities with holistic and appropriate care to meet needs that the traditional medical system often fails to address.

Yet, due to inadequate compensation structures for this model of care, access to and availability of community-based doulas is lacking in communities that need them. With most private doulas being paid out of pocket and charging rates upwards of $2,000 per client, [4] hiring be cost-prohibitive for low-income families, who are disproportionately families of color and are often at the highest risk for adverse health outcomes. To counter the cost burden associated with having a private doula, community-based doulas services for lower-income communities are often offered to clients free of charge or on a sliding scale. These doulas typically operate within a community-rooted program, which can be funded by public grants, foundations, and private philanthropies. However, these programs often operate on an unstable and unsustainable business model due to uncertain long-term funding.

Without a pathway toward adequate and reliable compensation and strategic investments in workforce development, the community-based doula labor supply remains too low to meet the communities' demand.

Low pay should not be a core value of community-based doula work, nor should doulas have to balance several jobs to have a steady cash flow to support their livelihoods and families. As birth workers aligned with the reproductive justice and racial justice movement, community-based doulas provide support and linkages to services and systems not built to serve birthing families from disadvantaged communities. Dignified compensation is essential to sustain community-based doulas' provision of guidance and education to birthing families. Inadequate compensation only perpetuates the harmful systems that have fueled the maternal health crisis by increasing turnover and burnout in the doula profession.

> **Dignified compensation is essential to sustain community-based doulas' provision of guidance and education to birthing families.**

A critical component of increasing access to community-based doula care is fair compensation for doulas so that doulas can receive a living wage while providing care to clients who would benefit most greatly. Adequate Medicaid insurance reimbursement is a key strategy for ensuring that these services are available to low-income, pregnant Medicaid recipients who would benefit most from doula services paid for by their insurance while also equitably paying doulas for their time. Approximately 40% of all births nationwide are covered by Medicaid, offering valuable coverage for pregnant people and women in general [5]. This coverage is especially critical in communities of color where an even larger percentage of births are funded by Medicaid. Evidence demonstrates that coverage of doula services by state Medicaid programs can be cost-effective because the presence of doulas reduces the risk of preterm birth and cesarean delivery [6].

Community-based doulas require sufficient government funding to scale and sustain their work. This is an essential step in enabling them to effectively carry out their work in the community, which has often been unpaid labor. Despite the momentum around improving maternal health and the inequities therein, policymakers have been slow to implement publicly funded, sustainable solutions. Legislation is urgently needed to support the growth of a strong community-based doula workforce and provide sustainable government funding at the federal, state, and local levels for this community-based work in perpetuity. Despite state leadership in leveraging Medicaid to advance support for doula care, there is little understanding among policymakers of the difference between the models of doula care—private doula models versus community-based doulas, in particular—and the importance of the community-based doula model in reducing the impact of structural racism and the maternal health crisis.

Why are community-based models well-positioned to advance birth equity?

Community-based doulas offer culturally pertinent support to under-resourced and marginalized families during pregnancy, childbirth, and postpartum in communities facing systemic and structural inequities. This model expands on traditional doula care by providing comprehensive services through a holistic and multifaceted approach, building ongoing relationships with community members, and sharing lived experience, culture, and language with the communities they serve. Using community strength to scaffold program delivery, community-based doula models reject the deficit-based approach commonly used in clinical settings to support under-resourced communities [7].

There are two key distinctions between community-based doula models and traditional private doula care:

First, community-based doula models are intentionally designed to meet the community's specific needs by employing doulas who share similar social, cultural, religious, racial, and economic backgrounds with their communities. Community-based doulas, and the organizations that support them, focus on centering the specific needs and preferences of clients by matching them with doulas who meet those criteria, which is critically important in the vulnerable space of birth work when it comes to reducing income and racial disparities in maternal and newborn health outcomes. Community-based doulas often have expertise and connection with the local community. They are frequently integrated with other community health organizations and services, providing supportive and accessible referrals to connect families to healthcare and other social supports, resulting in holistic and continuous care.

Second, community-based doula models provide a unique career structure for working doulas. Community-based doula organizations offer mentorship, career development, and administrative support that can make it more accessible for community members to work as doulas, in contrast to the entrepreneurial model of private doulas. The workforce development model supports community-based doulas by providing tuition-free training in both birth support and professional skills (core competencies) that will improve the effectiveness of the community-based doulas in performing important doula work with individual clients and building an understanding of community trust. This community-centric model generates job creation in the community by formalizing and making visible a path toward becoming a doula and birth work professional.

Additionally, community-based organizations can establish a network of referral relationships that benefit pregnant people and doulas. These relationships can be challenging for individual doulas to maintain independently. Within a community-based doula organization, doulas may be paid for their time working outside of direct client visits, including for time spent on the phone, text, and email communication with their clients; travel to/from the site of care (most doula visits are conducted at clients' homes); documentation of client interactions and time spent making referrals; continuing education training; and organizational meetings or employment requirements the doula may otherwise not have as an independent practitioner. The organizational success of community-based doula programs is critical to addressing the unacceptable racial disparities in maternal health outcomes in the United States. Community-based doulas are more financially accessible and frequently provide care free of charge to their clients. Organizations or doula groups have the potential to offer increased stability for community-based doulas by offering administrative support, backup doula care coordination (for emergencies, sickness, or long births), and paying living wages and possible benefits. These forms of structural support can also help doulas avoid burnout and stay in the doula profession.

> **The organizational success of community-based doula programs is critical to addressing the unacceptable racial disparities in maternal health outcomes in the United States.**

Current doula Medicaid reimbursement rates

Current doula reimbursement plans under state Medicaid programs are structured as a per-birth and per-visit compensation model with a cap on the maximum level of services reimbursed (see Annex 1). Current reimbursement rates among states implementing Medicaid coverage for doula care are exceedingly low. For example, Oregon's initial reimbursement rate of $75 in 2014, which increased to $350 per birth in 2017, was the nation's lowest doula reimbursement rate under Medicaid. Oregon's program has been largely unsuccessful since implementation due to low uptake —as of June 2020, only 90 doulas were enrolled as providers in Oregon Medicaid [9]. From 2018 to 2021, only 39 per 10,000 births covered under Medicaid utilized a doula [8]. However, in June of 2022, Oregon state health authorities announced a plan to increase its Medicaid doula fee-for-service rate from $350 to $1500 to reimburse and value services at a more appropriate rate [9]. Furthermore, doulas in Minnesota had similarly low reimbursement rates. In response, advocates in the state demanded an increase in the rate and the removal of barriers to program uptake, such as a $200 certification fee. Changes to the reimbursement rate and certification requirement were implemented in 2019 and 2021, respectively [10].

The various reimbursement rates established or proposed by the states listed in Annex 1 are modeled after private doula models of care, which typically consist of 4 to 8 prenatal/postpartum visits in addition to labor and delivery support. These visit structures and guidelines differ from how community-based doulas engage with clients, which often includes more frequent or high-touch visits across the perinatal period and additional care coordination and referrals. **Therefore, the current rates state Medicaid programs are paying do not reflect or adequately reimburse the work of community-based doulas, who are best suited to provide care for Medicaid-enrolled birthing people.**

While community-based doulas provide a broad range of services beyond the typical private doula model, there is little data on how community-based doula spend their time. The limited available data is largely anecdotal or based on imprecise estimates, making it challenging to advocate for appropriate, evidence-based reimbursement rates.

To gain a more in-depth understanding of community-based doulas' scope of services and the time they spend on the varied activities that fall under the category of "doula care," but outside the scope of direct client care, SisterWeb, a California-based community-based doula organization, conducted a time-use analysis in which data from SisterWeb's case management system and time diary data from eight SisterWeb doulas were collected and analyzed [15].

The SisterWeb Time-Use Study

SisterWeb is a network of culturally congruent community-based doulas from and for Black communities through the Kindred Birth Companions program, Pacific Islander communities through the M.A.N.A. Pasefika program, and Latina/o/x communities through the Semilla Sagrada program. SisterWeb provides no-cost doula care to their clients, who are often experiencing the health, social, and economic effects of longstanding structural inequities. In February 2021, SisterWeb and the University of California Berkeley tracked how SisterWeb's doulas spent their time on the wide range of activities that fall under the umbrella of providing community-based doula care. The doulas logged their hours and activities each day throughout the month, and this data showed that of 108.8 working hours each month on average, about half (51.7%; 56.3 hours) were spent in direct client care and support, such as prenatal, labor/delivery, and postpartum visits; additional communication to provide clients information about the birth process, comfort measures, coping skills, and common procedures; and referrals to resources and care coordination.

SisterWeb doulas, who work in cohorts of 2-3 doulas, also spent time with their colleagues (cohort, doula mentor, and program coordinator) in client care-focused meetings to review doula care plans for their clients (13.6% of doulas' working hours each month; 14.8 hours); administrative, organizational, and planning work needed for community-based doula organization operations (18.9% of working hours per month; 20.5 hours); and skills-based training and professional career development (5.6% of working hours per month; 6.1 hours).

A review of SisterWeb's case management software data, in which the doulas track all interactions with clients, revealed that for the standard course of care (7 prenatal and postpartum visits in total, and labor and birth support), SisterWeb doulas spent an average of 22 hours directly caring for each client. However, these time logs also suggest that [1] SisterWeb doulas spent significant time working on behalf of clients outside of planned visits. On average, doulas spent an additional 10 hours communicating with and supporting each client during pregnancy and the postpartum period outside of prenatal/postpartum visits and labor/delivery support for a total of 32 hours of support [1] per client. For every hour that doulas spent with clients in prenatal and postpartum visits, on average, they also spent:

- 22 additional minutes gathering research and resources for clients (for example, to answer clients' questions or identify referrals), distributing supplies to clients, and coordinating care with outside health providers.
- 47 additional minutes communicating with clients and directly supporting them (usually by text, phone, and video call); and
- 60 additional minutes in client care-focused meetings with their SisterWeb doula cohort and doula supervisor to ensure clients' continuity of care within SisterWeb.

The combination of doula time use data and case management data from the study provides a comprehensive description of community doulas' time use on both direct client care activities and the necessary tasks for the additional work required for a successful community-based doula organization with highly trained doulas. As interest in state funding and Medicaid reimbursement for doula services increases, it is important to understand the work of community-based doulas. The SisterWeb time-use study collected comprehensive data on the scope of work activities that community-based doulas engage in and how they allocate their working hours across these activities. Investments in community-led, data-driven strategies are crucial to recognize the contributions of community-based doulas and compensate them appropriately through government funding.

[1] Based on average lengths per prenatal and postpartum visits and birth support, calculated using February 2021 time tracking data. With doulas currently more regularly allowed in hospitals at the present stage of the COVID-19 pandemic than in February 2021, doulas' average time spent with clients for labor and birth support is likely longer now. The average number of hours spent in labor/birth support was 8.3, with a range of 0 to 34. Not all doulas provided labor/birth support in February 2021.
[2] Based on the average length per additional client interaction (28.5 minutes), the average number of interactions per client per month (3.5), and an average total length of doula care of 6 months.

Consideration for equitable coverage of community-based doula programs

Current and proposed state legislation for Medicaid coverage of doula support has primarily failed to tailor reimbursement rates and processes to address the unique components of community-based doula models. A comprehensive review of approved or proposed state legislation and Medicaid health care plans related to coverage of doula care services found that 12 states, plus Washington, D.C., are either actively reimbursing doula services on Medicaid plans or are in the process of implementing such benefits [11]. Much of this legislative progress has been made within the past two years as states utilize new findings and lessons gleaned from select doula pilot projects and first-mover states such as Minnesota and Oregon to implement doula Medicaid benefits. Of the 12 states actively reimbursing or implementing reimbursement for doula care under Medicaid, only one state, Minnesota, makes specific reference to community-based doulas in the legislative text [12]. In Michigan, where the doula benefit began in January 2023, community-based doulas are explicitly listed as beneficiaries of the Medicaid doula benefit. [13] The Illinois Sustainability Subcommittee Medicaid Recommendations (January 2021) also indirectly mentions community-based doula compensation, stating that reimbursement through Medicaid may be administratively simpler if doulas work with or receive reimbursement through community-based organizations [14]. Though reimbursement rates for doula services, in general, are detailed in some legislative proposals, rates and reimbursement specifically for community-based models of doula care are notably absent.

Considering the non-clinical role of doulas and the non-traditional working hours, Medicaid reimbursement can be complex, as clinical models and pathways for payment established for clinical providers do not suit the type of reimbursement needed for doula work. Most current and planned Medicaid pilots for doula coverage use the per-birth reimbursement model or place a cap on how much can be charged per client, sometimes referred to as bundled or capitated payments. When this was suggested as a model to reimburse doula care, several doulas willing to participate declined, as seen in the Oregon doula Medicaid reimbursement model, where between 2016 and 2020, only 0.01% of births were attended by doulas covered by Medicaid [15]. While this payment model aligns with the standard Medicaid practice for physicians and midwives, the rates are too low and do not provide enough income to compensate for community-based doulas' administrative time and high-contact approach. As the SisterWeb time use study reveals, community-based doulas often perform tasks outside direct client care. **Current reimbursement models do not adequately cover the full range of work involved in community-based doula care. To promote doula care as a beneficial form of support and maternal health intervention for birthing families of color, it is necessary to provide appropriate compensation for all activities performed by community-based doulas.**

Community-rooted doula work has always existed informally. However, to integrate doula care into government insurance systems, it is necessary to recognize it as a skilled, multifaceted profession that deserves fair compensation. The SisterWeb time-use study demonstrates the varied tasks that community-based doulas perform outside of standard doula care, which helps address the maternal health crisis. Yet, current reimbursement models propose capitated payments that will not adequately cover the costs associated with this effective high-touch model of care. Doula compensation through Medicaid reimbursement should reflect the workload and scope of services provided by community-based doulas, ensuring the success of community-based doula organizations and the well-being of the doulas themselves.

RECOMMENDATIONS

1. **Engage with community-based doula leadership.**
Policymakers and multi-level stakeholders should meaningfully engage with and be accountable to the expertise of community-based doulas to ensure that their invaluable knowledge and experience are adequately centered in legislation, program development and the full scope of work and support provided by community-based doulas is reflected in any proposed compensation.

2. **Provide fair, equitable, and sustainable compensation.**
Community-based doula programs should have the opportunity to provide fair, equitable, and sustainable compensation to their doulas and employ them with regular pay, health benefits, and paid leave to ensure that community-based doulas receive adequate compensation for their services; it is important to review and update the compensation rates regularly. This should be done by and held accountable to a group such as the "Doula Care Commission" to ensure the rates remain adequate and appropriate for the services provided. [16].

3. **Include compensation for all labor in reimbursement rates.**
Reimbursement rates should consider the administrative time and other client interactions outside of prenatal, delivery, and postpartum visits included in community-based doula services. These are also key to addressing social determinants of health and improving outcomes.

RECOMMENDATIONS

4 **Fund data collection and impact studies.**

To effectively inform and update the rates of reimbursement, local or region-specific community-based doula programs should receive adequate and ongoing funding to regularly collect data on how doulas spend their time and conduct a study on the impact of high-touch models of doula care.

5 **Compensation structures should focus on client-centered needs.**

Policymakers should consider time-use data from community-based doula programs, cost of living, and community feedback to decide on a per-birth rate or fee that pays a fair wage. This will enable doulas to provide care for their clients throughout the prenatal, birth, and postpartum period via a community-based doula model. Each client's requirements should mainly determine the number of services delivered.

6 **Ensure administrative ease and accessibility.**

Reimbursement processes must be accessible to community-based doulas and designed without cumbersome obstacles to accreditation and/or participation.

7 **Prioritize funding for community-based doula organizations and collectives.**

The administrative and operating expenses necessary for doula organizations to operate sustainably must be included in the proposed payment structures. Without adequate appropriation of funding, it is not realistic that organizations will be able to provide the thriving professional home doulas need and deserve.

8 **Allow doulas to explore per-visit vs. per-birth reimbursement models on a state-by-state basis.**

As cost-of-living expenses vary dramatically by geographic region, state advisory boards with a doula (and community-based doula organization) representation should be centered in determining these rates.

ABOUT THE PARTNERING ORGANIZATIONS

HealthConnect One

HealthConnect One is a nationally recognized nonprofit training and technical assistance agency that uses innovative, community-based approaches to support direct-service providers in promoting the health of mothers, infants, and birthing families. Together with community-based organizations and advocates, HealthConnect One trains community health workers connects community-based initiatives and mobilizes diverse stakeholders to build policies and programs that improve birth equity.

SisterWeb San Francisco Community Doula Network

SisterWeb is a network of culturally congruent community doulas and birth workers from and for Black, Pacific Islander, and Latina/o/x communities, works to dismantle racist healthcare systems, strengthen community resilience, and advance economic justice for birthing families and doulas in San Francisco. In 2018, the San Francisco Department of Public Health launched a new partnership with SisterWeb to establish a citywide doula program creating access to culturally relevant doula services for families in San Francisco most at risk of maternal mortality and premature birth.

ABOUT THE PARTNERING ORGANIZATIONS

Accompany Doula Care

Accompany Doula Care is an independent, sustainably-funded Doula Agency that provides culturally and linguistically tailored services to individuals and healthcare systems seeking safe and positive birthing experiences in Massachusetts. Accompany Doula Care is a group of doulas whose passion for eradicating healthcare inequities is rooted in achieving Berwick's Triple Aim. This healthcare framework hopes to improve health system performance by improving health outcomes of the patient population, reducing the per capita cost of health care, and improving the patient experience and satisfaction.

BirthMatters

BirthMatters is the only community-based doula program in South Carolina. BirthMatters provides support in Spartanburg and in outlying rural communities. The BirthMatters team attends 50 births per year with three community-based doulas on staff, with 65 families currently enrolled (October 2021). Ninety-Two percent of participants served by BirthMatters are Black, while all participants are on or eligible for Medicaid.

Ancient Song

Ancient Song is a national birth justice organization working to eliminate maternal and infant mortality and morbidity among Black and Latinx people. Ancient Song provides doula training and services, offers community education, and advocates for policy change to support reproductive and birth justice.

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ANNEX 1

Table 1: Current State Reimbursement Rate Benefits Under Medicaid as of 2/22/2023

Medicaid Reimbursement Rate for Doula Services		
State	**# of Visits (prenatal & postpartum)**	**Reimbursement Rate(s)**
Actively Reimbursing		
Oregon	4	$1,500 maximum total payment
Minnesota	6	$770 maximum total payment ($488 for delivery + $47/visit)
New Jersey	8	$1,165 maximum ($500 for delivery + $16.61/15-minute unit visits) + $100 incentive for postpartum follow-up
Florida	Plan-specific	Reimbursement negotiated with each managed care extended benefit plan
Virginia	8	$859 maximum total payment ($350 for delivery + $89.92 initial visit + $59.92 subsequent visits + $100 in incentives for postpartum)
Maryland	8	$930 maximum total payment ($16.62/15-minute unit prenatal + $350 for delivery + $19.62/15-minute postpartum)
DC	12	$1,950.71 maximum total payment ($686.23 delivery + $97.04/prenatal visit + $12.13/15-minute unit visits + $100 in incentives for postpartum)
California	8	$1,154 maximum total payment (Initial visit at $126.31 + $60.48 per follow-up visit, $544.28 for vaginal delivery)
Michigan	6	$1,150 maximum total payment ($700 for labor/delivery + $75/visit)
Nevada	4	$350 maximum total payment ($150 for labor/delivery + $50/visits)
Rhode Island	6	$1,500 maximum total payment ($900 for labor/delivery + $100/visit)
Legislation Passed & In Process of Implementation[1]		
Massachusetts	T.B.D.	$1,500 maximum reimbursement proposed **still under review**
Pilot Programs and Proposed/Recommended Rates		
New York	8	$600 maximum total payment ($360 for delivery + $30/visit)
Washington	4	$650 maximum total payment ($450 for delivery + $50/visit)
Vermont	4 hrs. + 2 hrs.	$850 maximum total payment ($650 for delivery + $25/hour for prenatal and postpartum visits + up to $50 for admin expenses)
DoD Tricare Health	6	2022 pilot program: $966 total maximum payment ($690 for delivery + $46/visit)
Georgia	4	2022 pilot program: $700 maximum total payment ($50/visit + $500 for delivery)
Wisconsin	-	2019 pilot program: $1,040 payment per birth
Iowa	8	2022 pilot program: $1,200 for three prenatal visits, delivery, and 5 postpartum visits

[1] Illinois, Connecticut, Indiana, Missouri, and Ohio have proposed legislation to implement Medicaid reimbursement for doula services, although have not provided reimbursement rates.

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