

Medicaid Coverage of Doula Services in Minnesota:

Preliminary findings from the first year

Interim Report to the Minnesota Department of Human Services

July 2015

Authors

Katy B. Kozhimannil; PhD, MPA

Division of Health Policy and Management, University of Minnesota School of Public Health

Carrie A. Vogelsang

Division of Health Policy and Management, University of Minnesota School of Public Health

Rachel R Hardeman; PhD, MPH

Division of Health Care Policy & Research, Mayo Clinic College of Medicine; Research Program on Equity and Inclusion in Health Care

Acknowledgments

The authors gratefully acknowledge helpful input, guidance and collaboration from Debby L. Prudhomme and Mary R. Williams, Co-Founders of Everyday Miracles, as well as Rita O'Reilly and Amanda Huber at Hennepin County Medical Center. Both Everyday Miracles and Hennepin County Medical Center are partners in this research endeavor and have been involved in all aspects of this project. We are also grateful for research assistance from Shruthi Kamisetty.

The authors appreciate the time, energy, input, feedback, candor, and thoughtfulness of all of the respondents, to colleagues within the Minnesota Department of Human Services, the Minnesota Department of Health, managed care organizations, the Minnesota State Legislature, and doula programs and organizations; and also to members of the Twin Cities birth worker community who attended a community meeting we held in February 2015. We also appreciate the collaboration of the Cultural Wellness Center and Missionaries of Charity for assistance with recruitment and providing space for focus group discussions.

This research would not have been possible without the extraordinary work of the doulas trained through the Doula Access Project, those employed by Everyday Miracles, and those employed by Hennepin County Medical Center. We offer our deepest gratitude to the women and doulas who have shared their perspectives and experiences with us and allowed us a unique lens into the role doulas play in supporting diverse mothers during pregnancy and childbirth.

Funding Support

This project was supported by a Community Health Collaborative Grant from the University of Minnesota Clinical and Translational Sciences Institute. Research reported in this publication was supported by the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1TR000114. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. Funding also supported, in part, with a grant from the ACNM Foundation, Inc. and the Frances T. Thacher Midwifery Leadership Endowment.

Suggested Citation

Kozhimannil KB, Vogelsang CA, Hardeman RR. Medicaid Coverage of Doula Services in Minnesota: Preliminary findings from the first year. Interim Report to the Minnesota Department of Human Services. July 2015.

Executive Summary

In 2013, Minnesota passed legislation requiring Medicaid payment for doula services ([Minnesota Statutes, section 256B.0625, subd. 28b](#)). Minnesota is only the second state in the U.S. (after Oregon) to extend Medicaid coverage to include doula services. Other states have expressed interest and are watching our experiences here in Minnesota to guide their decisions. This document provides initial findings from a research project entitled “Improving maternal and child health by increasing doula support for diverse Minnesota women” - also known as the “Doula Access Project.” This interim report is being provided to the Minnesota Department of Human Services (DHS) with information on the early phases of implementation and as guidance for future implementation. We hope that it is useful both in Minnesota and in other states seeking to enact similar legislation.

Our prior research on doula care has examined both [Medicaid populations](#) and [pregnant women nationally](#). As part of our ongoing research project, we are learning about barriers to implementation. We conducted focus groups with pregnant Medicaid beneficiaries from diverse backgrounds to ask about their knowledge of doula care, their access to these services, and any barriers to access. We also recruited and trained 12 women from underserved communities to become doulas for pregnant Medicaid beneficiaries. We interviewed these new doulas about their work, and we also interviewed doula program administrators (the directors of both community-based and hospital-based doula programs) about their experiences as providers under the new legislation. Finally, we sent letters to each of the managed care organizations that serve Medicaid beneficiaries in Minnesota to solicit comments and feedback on implementation, from a payer perspective.

We systematically analyzed these data from pregnant women, doulas, doula program administrators, and Medicaid managed care organizations. The findings of our analysis have revealed a number of **challenges and barriers** to the implementation of the legislation, all of which may impede beneficiary access to services:

- Low reimbursement rates, defined in the Minnesota Medicaid Program’s State Plan Amendment, are a significant barrier to entry for doulas, an obstacle to sustainability and retention of doulas serving Medicaid beneficiaries, and a financial feasibility challenge for doula program administrators.
- Doulas have had difficulty becoming enrolled providers with managed care organizations.
- Medicaid programs must pay licensed providers in order to receive federal matching funds. Doulas are not licensed in Minnesota, so – to be reimbursed by Medicaid – doula services must be provided under the supervision of a licensed clinician and billed through that clinician’s National Provider Identification (NPI) number. Creating these structures has been challenging for doulas and maternity care clinicians, even in hospital-based programs that employ doulas.
- Lack of awareness of doula coverage among Medicaid beneficiaries, maternity care clinicians, and health care delivery systems.
- Lack of information among health plan customer service representatives to assist women who inquire about coverage or who receive information from their health plan about doula services.
- Doula training, certification, and registration are costly, and many low-income women and women from communities of color have limited financial access to the doula profession.
- Limited representativeness of communities of color among doula trainers and doulas.
- Topics that are crucial to doula care for Medicaid beneficiaries – including trauma, infant loss, poverty, intimate partner violence, structural racism, etc. – are not sufficiently covered in all doula certification courses.
- The purpose and utility of the [state doula registry](#) was questioned by doula organizations (cost was noted as a barrier) and managed care organizations (who would prefer to contract with doula organizations rather than individual doulas).

The following **preliminary recommendations** emerged from the analysis and consolidation of feedback and input from patients, providers, administrators, and payers. These recommendations reflect the views, opinions, and perspectives of the participants in this research and may inform future legislative or implementation efforts to overcome the barriers described above.

Recommendations: Legislative Changes

The impetus for Medicaid coverage for doula services came from a legislative effort, and respondents identified several additional potential legislative modifications or proposals that could be considered to fulfill the original intent of the legislation.

- Create a licensure process for doulas in Minnesota. The goal of doula licensure would be to allow for direct payment to doulas for their services and to render unnecessary the currently burdensome challenge of establishing supervisory relationships between doulas and maternity care clinicians. Such legislation should ensure that licensure does not criminalize practice by unlicensed providers.
- Modify the [Minnesota state doula registry](#) to allow for non-profit organizations to be listed. This would better meet the needs of Medicaid beneficiaries who could call several organizations (vs. several hundred potential doulas) to inquire about services, and of managed care organizations who would prefer to contract with organizations rather than individual doulas.
- Establish a fee waiver process for fees for doula certification and registration for low-income applicants, and also establish a separate fee for organizations to apply to appear on the registry.
- Allow payment for travel mileage as part of doula services reimbursement. Doulas – especially in rural areas – frequently travel substantial distances to meet with clients, and travel expenditures alone may outweigh earnings for prenatal visits for distant clients.
- Augment doula certification (or licensing) requirements to include education on trauma-informed care and on social and structural determinants of pregnancy and childbirth care.
- Enhance diversity and capacity by creating a grant program to support doula training to increase the available doula workforce to support pregnant Medicaid beneficiaries. Specifically, funds for doula training should be directed to communities of color, low-income communities, and rural areas to increase the diversity of the doula workforce and improve its capacity to meet the needs of Medicaid beneficiaries.

Recommendations: Improving Implementation

In addition to legislative changes, respondents suggested several steps that could be undertaken administratively by the Departments of Health and Human Services to improve implementation of current statute.

- DHS should review currently-available evidence and reassess the reimbursement rate for doula services in the State Plan Amendment.
- DHS should provide clear information about all of the documentation required for payment of claims for doula services.
- DHS and the Minnesota Department of Health (MDH) should establish a formal coordination structure to interface with one another on issues related to the registry/credentialing (MDH) and payment (DHS).
- This joint coordinating group should serve as a resource for doulas, maternity care clinicians, and managed care organizations so that shared information is clear and transparent.
- DHS should provide education to clinicians and hospitals about the role of a doula and the content of the statute that requires Medicaid payment for doula services.

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I. Background

Birth outcomes and racial/ethnic disparities in Minnesota

Minnesota ranks at the top of the nation on many indicators of health and healthcare, but not everyone in the state enjoys good health and easy access to services. On average, Minnesotans rank among the healthiest in the US, but the state of Minnesota also has some of the nation's worst racial and ethnic disparities in health outcomes.¹ Preterm birth, infant mortality, maternal mortality, and breastfeeding rates are just a few of the disparate outcomes experienced by communities of color in Minnesota.²

Minnesota's infant mortality rate, for example shows that the most recent five-year recorded average (2006-2010) mortality rate for White infants was 4.4 per 1000 infants while the rate for African American and American Indian infants was more than twice as high at 9.8 and 9.1 respectively per 1,000 births.³ This translates to a startling statistic: African American and American Indian babies in Minnesota are twice as likely to die in the first year of life as white babies. Maternal mortality is also of grave concern. The United States is the only industrialized country to have an increasing maternal mortality rate.⁴ (CITE). The Healthy People 2010 goal of 3.3 maternal deaths per 100,000 was adjusted to a new target of 11.4 deaths per 100,000 in Healthy People 2020, which reflects the reality of the increase in rates that have occurred.^{5,6} Nationally African American women experience 42.8 pregnancy related deaths per 100,000 live births and are almost 4 times as likely to die a pregnancy related death than white women at 12.5 pregnancy related deaths per 100,000 live births.⁷

Disparities in birth outcomes also exist between rural and urban populations. A lack of local access to obstetric services is more than just an inconvenience for rural women. Extensive travel to obstetric services results in delayed initial prenatal care visits, missed return visits, and late identification of obstetric complications.⁸ The potential negative health outcomes for pregnant women and their newborns are significant and may include prematurity, perinatal mortality, and maternal morbidity and mortality.**Error! Bookmark not defined.** In Minnesota, rural women have limited access to local obstetric services owing to challenges such as workforce shortages, infrastructure constraints, and healthcare financing.⁹

Recently, Minnesota is taking important steps in explaining why these disparities exist and laying out plans for their elimination. Reports such as the Minnesota Department of Health (MDH) Rural Health Advisory Committee Report on Obstetric Services in Rural Minnesota (2013),⁹ Advancing Health Equity Report (2014)**Error! Bookmark not defined.** and the Infant Mortality Reduction Plan (2015),**Error! Bookmark not defined.** explain the role that structural factors – including historical disadvantages, systemic disenfranchisement, and racism - play in perpetuating these disparities. The reports also list multiple recommendations for how best to address and take action to reduce and ultimately eliminate these inequities. Policymakers and program administrators in the state of Minnesota have taken notice of disparities in childbirth-related outcomes and have actively pursued policy efforts to improve maternal and infant health, overall and among vulnerable subgroups.

Doula support and birth outcomes: the evidence

One type of care that has been shown to benefit women at the time of childbirth is continuous support during labor and childbirth.¹⁰ While such support can be provided by husbands, partners, sisters, mothers, friends, or medical staff (such as labor nurses), evidence shows that maternal support is most effective when it is provided by a professional (i.e., not a friend or family member) who is not employed by the hospital (i.e., not a nurse, midwife, or doctor).¹⁰

Doulas are trained professionals who provide continuous, one-on-one emotional, physical and informational support before, during and after delivery.¹¹ They are not medical professionals and do not provide medical services, but work alongside nurses, obstetricians, midwives and other health care

providers. Doula care in the United States has rarely been accessible for low-income women because of the costs, which are typically not covered by insurance.¹² This leaves many low-income women without an option for support from a doula even though their needs “may be more urgent than those of socially and economically advantaged women.”¹³ Given the strong evidence linking doula care with improved birth outcomes, including reduced number and types of interventions and cesarean rates, it is plausible that lack of access to evidence-based support may perpetuate recalcitrant disparities in maternal and child health outcomes.

Delivery-related complications are increasingly common, and those at highest risk are women of color and low-income women.^{14,15} Overall, evidence suggests that racial/ethnic minority women have higher rates of obstetric interventions and worse birth outcomes than their White counterparts.^{16,17} Low-income women who have insurance coverage through Medicaid programs have a higher risk of preterm birth (< 37 weeks gestation) and low birth weight (< 2500 g) than do privately insured women.^{18,19} The links between income, race/ethnicity, and adverse birth outcomes has been well documented in prior research,²⁰⁻²² but what is missing is documentation of effective ways of reducing this disparity have been lacking.²³ Evidence suggests that when low-income and women of color have access to doula care, they experience better outcomes than Medicaid recipients in general; that is, women with doula support have lower cesarean delivery rates and higher breastfeeding initiation rates.^{24,25} This means taxpayers who finance 42% of births in Minnesota through the Medicaid program may see better value for our state investment in childbirth care when we also cover the services of a doula.

Ample prior research addresses the positive clinical and psychosocial outcomes of doula care. However, members of our research team have pioneered the work that has brought the discussion of doula services into the realm of policy, payment, and health insurance coverage.²⁶⁻²⁸ Our 2013 study, published in the *American Journal of Public Health*, was a critical factor in the passage of the legislation allowing for Medicaid reimbursement of doula care in Minnesota.²⁶ Other studies have described the potential cost savings related to doula support,²⁶ the impact of doula care on breastfeeding²⁷ and quality of care,²⁸ in both low-income and other populations.

Increasing access to doula care for Minnesota mothers: Medicaid coverage

In passing legislation requiring Medicaid payment for doula services (Minnesota Statutes, section 256B.0625, subd. 28b, Covered Services: Doula Services)²⁹ Minnesota became the second state in the U.S. (after Oregon)³⁰ to extend Medicaid coverage to include doula services. Current explanation of the law on the Minnesota Department of Human Services website states this law became effective on July 1, 2014 and requires Minnesota Health Care Programs to cover doula services provided by certified doulas for fee-for-service (FFS) recipients. These services include emotional and physical support for pregnant women. Recipients enrolled in managed care must verify eligibility and confirm coverage of doula services with their managed care organization (MCO). Covered services are limited to childbirth education and support services, which include emotional and physical support before during and after delivery. The policy was recently amended in May 2015 to include seven sessions that include one for labor and delivery and the other six in the antepartum or postpartum periods based on the needs of the woman.³¹

In addition to expansion of Medicaid coverage to include doula services in Minnesota, other efforts are currently underway to increase access to doula services in Minnesota and across the country. In February 2014, the Minnesota Department of Health submitted an application to the U.S. Preventive Services Task Force requesting a review of evidence on doula care. This is significant because the Affordable Care Act requires that health insurance plans cover all services with an A or B rating from the Task Force, without out-of-pocket costs to patients.³² In addition, the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine released a consensus statement in

March 2014 which explicitly endorsed greater utilization of “one of the most effective tools to improve labor and delivery outcomes, the continuous presence of support personnel, such as a doula.”³³

II. Doula Access Project

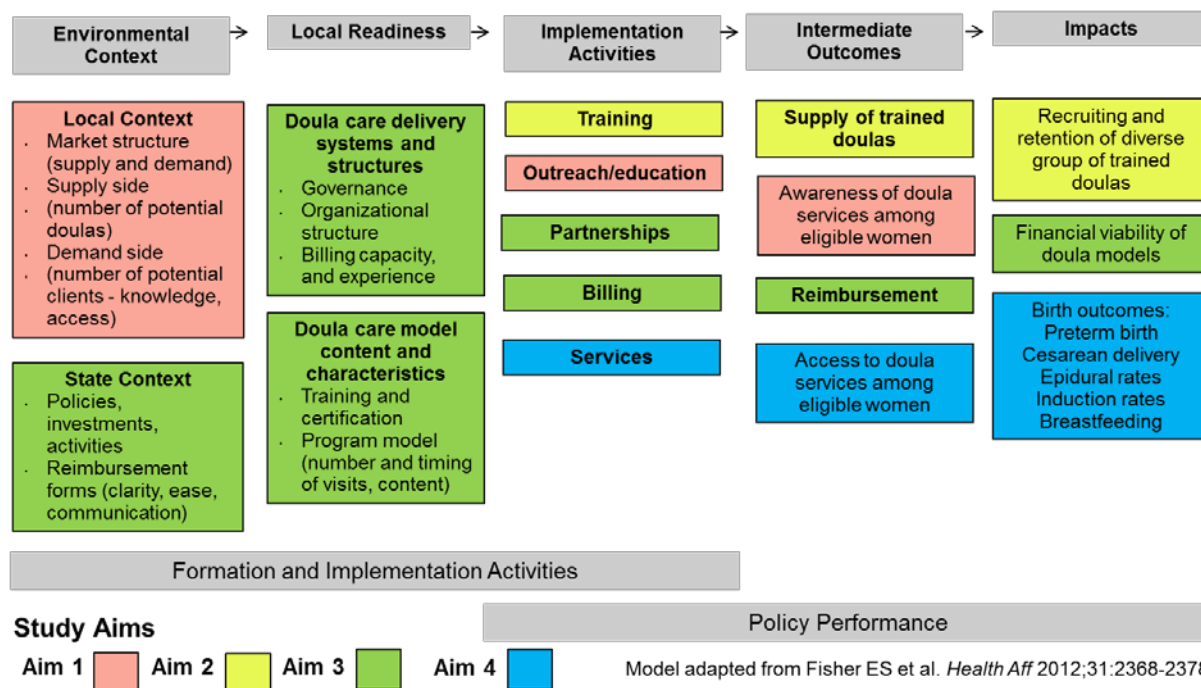
Description and specific aims

The goal of this research project – called the Doula Access Project - is to document the challenges, opportunities, and effectiveness of Minnesota’s policy extending Medicaid coverage to include doula care. Specifically, this project pursues the following aims:

- **Aim 1:** Assess demand for and barriers to doula care for diverse women through focus group discussions.
- **Aim 2:** Train 12 new culturally-competent doulas from under-represented communities (e.g., African-American, Somali, Hmong, Latina, American Indian) to increase the diversity of the doula workforce; administratively support these doulas in obtaining certification and registration.
- **Aim 3:** Document the challenges and opportunities presented by Medicaid reimbursement from the perspective of community- and hospital-based doula programs.
- **Aim 4:** Assess the effects of Medicaid reimbursement in the year following policy implementation, on the number of women served and outcomes for women with doula care, compared with the year prior to this policy.

The project began in July 2014 and will be completed at the end of December 2015. Work on the 4 aims described above is ongoing. This interim report provides preliminary findings from Aims 1-3. It is our hope that these early findings will inform ongoing implementation efforts.

Schematic Overview Of The MN DHS Doula Reimbursement System Logic Model



Conceptual Model

To guide the development of this proposal, we created a logic model as a conceptual framework for the specific aims. Based on prior work in the context of health care policy and reform,³⁴ we

structured this model to guide policy makers and payers (including Medicaid) in understanding the implementation of the state's recent policy change, improving the design and effectiveness of doula reimbursement via Medicaid, and providing insights for doula programs on approaches that are most likely to be successful in different contexts. The logic model first highlights the intended impacts of the policy, both for increasing the availability and supply of doulas as well as improving birth outcomes. The model then distinguishes state and local contexts; the readiness of the doula organizations and their payer partners to implement reimbursement, as well as the structures of the organizations themselves; the specific implementation activities that doula organizations and the state Medicaid program pursue; and the intermediate outcomes of those activities. All of the preceding steps will influence the achievement of intended impacts, and the figure above shows how study aims correspond to facets of the model using different sources of information: women (Aim 1), doulas (Aim 2), program administrators (Aim 3), and administrative data (Aim 4).

Theoretical framework: A Good Birth

In addition to the conceptual framework described above, we grounded our analysis in a theoretical framework derived from Dr. Anne Lyster's landmark study - A Good Birth.³⁵ In 2013, Dr. Lyster, published her book of the same title, A Good Birth, describing her extensive research interviewing a diverse sample of more than a hundred women to determine what constitutes a good birth.³⁵ Lyster identified 5 themes associated with a good birth: agency, personal security, connectedness, respect, and knowledge.³⁵ Lyster "shows how considering these core elements of a good birth can help women, loved ones, and health care providers develop strategies to meet the physical and emotional needs of mothers and mothers-to-be, going well beyond standard birth plans and conversations." (p 17)³⁵

This insight derived from the 5 themes produced a framework to explore the beliefs pregnant women have about the potential and actual benefits of having a doula as well as the barriers to accessing doula services. We expanded upon the Good Birth theory to not only better understand what matters most to women during labor and delivery but also during pregnancy, which includes their emotional, educational and physical needs and the specific support a doula provides to meet those needs. This was an important component to understanding the demand for doula support services and better understand how the support of a doula is meeting the specific needs of women and gaining better insight into how they might be improving birth outcomes.

Partnership

Our study team includes both University- and community-based partners and represents the fields of doula care/labor support, nursing, lactation counseling, healthcare administration, obstetrics, midwifery, and public policy. Each member of this collaborative effort brings an essential skill set and perspective to achieve the project aims. In addition to the University-based researchers, our team includes both community- and hospital-based doula programs.

Community-based doula program: Everyday Miracles is a Minnesota-based non-profit organization that aims to reduce health disparities by providing perinatal education and doula services to low-income women. Everyday Miracles employs an ethnically diverse group of doulas (including Somali, Latina, Hmong and African-American doulas) and attempts to match doulas to clients based on language and race/ethnicity. Established in 2003, Everyday Miracles doulas have supported more than 3300 births, with very positive outcomes, including a low-birth weight rate below 5% and a breastfeeding initiation rate over 95%.

Hospital-based doula program: Hennepin County Medical Center (HCMC) runs a hospital-based doula program that offers labor support to any woman delivering at HCMC at no out-of-pocket cost to the patient. HCMC serves a disproportionately low-income, high-risk population of women delivering

newborns at their hospital. The HCMC Doula program has been serving women since 1999. Since its inception it has grown to employ 9 on-call doulas from diverse cultural backgrounds. Languages spoken include English, Somali, and Spanish. In addition to providing doula services at no cost to all women through the HCMC Doula Program, HCMC also welcomes women to have a doula present at childbirth with whom the patient has already established a relationship. In the past, the Nurse Midwives have made referrals to Everyday Miracles for women eligible for their services and who show interest in having prenatal engagement with a doula.

Project activities and timeline

- **Doula Recruitment (August - October)** Recruitment to fill 12 funded spots for DONA certification training. Recruitment was conducted through email distribution to university and community contacts and partners to pass on. It was specified that we were looking to diversify the doula work force by considering candidates from underrepresented communities who also had a financial need.
- **Doula Training (October 27-30th 2014)** Out of 58 applications 12 candidates were selected for DONA (Doulas of North America) training, which is one of the most respected Doula certification programs in the country. Training was held for 4 days with a DONA trainer and a guest trainer who discussed various cultural practices associated with birth. There were 3 African American, 3 American Indian, 2 Hispanic, 1 Karen, 1 Ghanaian, 1 Somali and 1 Yemeni final candidates selected to be trained. To become certified the doulas then had to complete three doula-assisted births with feedback from healthcare providers and the mothers giving birth. The doulas then became contracted employees with community partner Everyday Miracles.
- **Doula Survey (November-Present)** - Survey was distributed to gather background information from the doulas at Everyday Miracles and HCMC to 1) better understand the women who do doula work and 2) learn more about the work they do to support women and babies.
- **Focus Groups (November and December 2014)** - Conducted at 3 locations - Cultural Wellness Center, Everyday Miracles and Missionaries of Charity. 4 focus groups were held with a total of 13 low-income, racially/ethnically diverse pregnant women to discuss 1) the desire for doula support and 2) barriers to accessing doula services. The focus groups each lasted about 90 minutes and each participant was given a \$25 gift card in appreciation for their time and sharing their knowledge.
- **Doula Interviews (January and February 2015)** Semi-structured interviews with 8 of the 12 newly trained doulas to discuss 1) how doula care may improve outcomes for women in their communities, and 2) the viability of a career as a doula and the role of Medicaid reimbursement in facilitating this. These interviews lasted between 30-90 minutes.
- **Administrator Interviews (February and March 2015)** Semi-structured interviews with administrators at HCMC, Everyday Miracles, Cultural Wellness Center, and the Ilythia Project to discuss 1) state context, 2) doula care delivery systems, 3) doula care model content, and 4) billing and reimbursement processes. These interviews lasted between 30-60 minutes.
- **Community Meeting (February 9th, 2015)** Community meeting was held with partners and supporters in the doula, birth, university, and legislative/government communities to discuss what activities had taken place, initial findings and next steps.
- **CEO Letters to Managed Care Organizations (April 2015)** Letters were written and sent by primary investigator Dr. Katy B. Kozhimannil to the CEOs of Medica, Health Partners, Blue Cross/Blue Shield of Minnesota, Ucare and Hallelund Habicht-LPAC Alliance to solicit input on the legislation from a payer perspective. Responses were analyzed for key themes.
- **Administrative Data Collection and Analysis (July 1, 2013-June 30, 2015)** De-identified information is being collected on births attended by doulas in the Everyday Miracles and HCMC doula programs from clients who give birth to a singleton baby between July 1, 2013 and June 30, 2015. This time

period was selected to encompass one year prior to and one year following the anticipated July 1, 2014 start for Medicaid reimbursement of doula care. Everyday Miracles data are collected in a childbirth report that is filed within one month of delivery, and HCMC data are collected in a doula log and merged with electronic health data in order to gather information on birth outcomes. A standardized form was developed for collaborative research on this project. This form includes information on key variables, including the following childbirth outcomes and procedures: preterm birth, cesarean delivery, labor induction, medical pain management, and breastfeeding. This data collection and analysis will be a key part of Aim 4 of the project.

III. Preliminary Findings on Implementation from Multiple Perspectives

A. Perspectives from Pregnant Women: Focus Groups

In November and December of 2014, semi-structured focus group discussions were conducted using a prepared questionnaire. In addition to learning more about how a doula might affect their pregnancy and childbirth, these discussions with low-income, racially/ethnically diverse pregnant women focused on 1) the role of a doula and participants' knowledge about a doula, 2) the current law, including why they would want or not want a doula, 3) barriers to accessing a doula, and 4) recommendations the women had to overcome those barriers. We also hoped women would be able to reflect on any experiences they had with a doula, and if they had never had a doula the questions would encourage discussion about how they would feel about an experience with a doula and their desire for having a doula after having been given the definition of a doula. This allowed us to better understand the demand for doula services once women became aware of the role of a doula and the law giving them access to a doula.

Mechanisms through which doula support influences a “Good Birth” and healthy pregnancy

Doulas may fulfill some of the support needs that low-income, racially/ethnically diverse women need in order to have a healthy pregnancy and a “Good Birth,” consistent with Lyerly’s theoretical concept.³⁵ They expressed that doulas provide them with education about what is happening to their body and advice about healthy living. Many respondents reported having concerns about information they receive from healthcare providers, and feeling unsure or uninformed about changes to their body that may be normal during pregnancy. The women expressed that a doula is a person that they can trust. Doulas will be there for women who otherwise might not have that support, whether they have people in their life or are completely alone.

“I know I can be a difficult person and sometimes I might even get like, so frustrated and stressed out I burst into tears, I don’t know, it just doesn’t make sense and I’m like, “Am I going to die having this baby?” Like, I can be really dramatic and she’s [the Doula] just like, very cool, calm and collected and like balances me out. It’s like, I really don’t really have anybody to talk to about my pregnancy, or sometimes people just don’t want to hear it.”

This support includes doulas attending prenatal visits with their clients, being available by phone, visiting their homes before and after delivery, and being at the hospital for their labor and delivery.

“I’m scared and nervous with my first child, but having the support of a doula there who will comfort you and [help you] avoid c-sections and have a natural birth.”

Barriers to accessing a doula

Some women discussed how they were unaware of what a doula was, until attending our focus groups. Others reported not knowing what a doula was in previous pregnancies but learning more about doulas with subsequent pregnancies. They expressed the notion that many women were likely unaware of doulas, and that clinics or other places where pregnant women may receive such information (e.g., health plan, Women Infants and Children (WIC) program, Healthy Start, prenatal education classes) are either unaware of doulas or do not actively promote doulas as an option for pregnant women to consider.

"I think [the barriers] would probably be either misinformation or not having access because I don't think doulas are promoted enough. And I think it should be more than just [advertised at] a clinic, because pregnant women go everywhere."

None of the pregnant women in the study were aware of Minnesota's law allowing reimbursement for doulas who provide services for pregnant Medicaid beneficiaries. Most were quite surprised and expressed the need for this policy to be advertised and communicated more effectively. The women also expressed the importance of doulas and doula organizations forming partnerships with healthcare organizations for outreach and referrals so the word can spread about doula services and the law that covers the Medicaid population.

Many women shared that they thought financially they would not be able to afford a doula and that most women they know are unlikely to consider a doula due to the high cost. Others discussed the salience of language, culture and religion as part of doula support and ensuring that there are doulas who represent their backgrounds, cultures and beliefs. One participant who had a doula with a previous birth shared her experience:

"...she's [the doula] Native American and African American, which was important to me because every doula that I had heard about at that time, there was no one of color."

Summary of Preliminary Findings

- Pregnant women are not aware of the law that requires Medicaid coverage for doula services.
- Pregnant women do not consistently receive information about doulas before or during pregnancy.
- Pregnant women expressed a desire for doulas to be connected more closely to healthcare providers, health insurance plans, and social/personal networks so the word spreads about doulas being an option for pregnant women to consider.
- Doulas support women in unique ways that positively impact women's perceptions about a healthy pregnancy and good birth in addition to improving birth outcomes.
- The ability for doulas to communicate with pregnant women about their concerns can potentially reduce the frequency of unnecessary visits to the doctor/midwife, to the emergency room, or to the hospital.
- Pregnant women value the opportunity to have access to a doula that shares their cultural background.

B. Perspectives from Doulas: Doula Training

The second aim of the project was to train 12 doulas from under-represented communities to increase the diversity of the doula workforce and to administratively support these doulas in obtaining DONA (Doulas of North America) certification and registration. Recruitment was done through various channels in the birth and academic communities through the networks of the project partners. There was a high demand for access to the training with a total of 58 applications received for the 12 available spots. On the application the women had to describe why they wanted to be a doula, any past experience working with pregnant women and birth, the communities they would like to work with and the financial need that prevents them covering the cost of training. A diverse applicant pool allowed for selection of 3 African American, 3 American Indian, 2 Latin American, 2 African, 1 Karen, 1 Yemeni doulas to be trained. The training was conducted October 27th-October 30th 2014. We conducted a formal evaluation process, collecting written feedback from doulas about their training experience. We also conducted a debriefing interview with the lead trainer for the doula training about her experience conducting the training for this project.

Doulas were grateful to receive the DONA training and were able to apply what they learned in their interactions with clients and healthcare providers. Many felt that more could have been shared in the training to address the specific needs of women in the communities they serve. They expressed concerns with the general DONA curriculum and feeling as though it wasn't inclusive of the issues women in marginalized communities face while pregnant. The interview with the lead trainer supported these concerns. She explained that doula trainings are often impacted by the lived experiences of the women participating in the training. Given that this group of women was more diverse than the typical cohort of doula trainees (white, upper-middle class), it was not surprising that the socio-cultural experiences representing their reality were brought to the forefront. Some issues that are not common in the general population may be more common among vulnerable subgroups. For example, one doula mentioned a need to address infant mortality in the context of doula training, noting a need for:

“Resources about stillbirth and infant deaths...realizing that this is an important issue for communities of color and training in general needs to be more relevant to the communities they serve.”

Summary of Preliminary Findings

- All women trained through this project would not have been able to afford training if they had not been selected to attend, demonstrating that cost was a barrier to accessing doula training for women from populations that are underrepresented and low-income.
- Training revealed additional challenges to addressing the needs of Medicaid populations and communities of color; these included having doula clients with diverse backgrounds, language barriers, low social support, low health literacy, lack of economic resources, etc.
- Newly-trained doulas highlighted the need for more culturally-relevant doula training, representative of the cultural values of diverse communities and the struggles faced by pregnant women from underserved populations.
- Newly-trained doulas noted the limited representativeness of communities of color among doula trainers and doulas as an important challenge to overcome.
- They also determined that it was important that doula training programs incorporate trauma-informed care topics and information on social determinants of health in a childbirth context, so that doulas would be aware of these challenges that women face and the techniques that can be used to help these women.

C. Perspectives from Doulas: Interviews

Semi-structured interviews were conducted in January and February 2015 with eight of the 12 doulas that were trained through the Doula Access Project. The objectives for the interviews focused on each of their perspectives on how doulas may improve birth outcomes for women in their communities and also the viability of a career as a doula as well as the role of Medicaid reimbursement in facilitating this. We wanted to better understand their motivation for becoming a doula and how it would be possible for them to continue in this career and also still serve women in their communities.

Improving birth outcomes

The newly-trained doulas were just becoming accustomed to techniques they learned in training when we conducted the interviews. There was also an emerging awareness for some about the impact they were having on the women they were supporting. Many of the doulas discussed how they helped meet the psychosocial support needs for pregnant women, especially clients who might have experienced trauma in their lives:

“She [the client] was very sensitive and didn’t like to be touched. She had a hard time relating to the nurses. I think she was happy to have someone there that was her peer that she could talk to...I think she was respected by the providers but I don’t think she realized it. She had a lot of anger and I helped relieve the stress, and the nurses thanked me for being there and being a good advocate for her.”

They also spoke about their influence on breastfeeding and how they helped women initiate breastfeeding.

“I find a lot of moms I’m working with now were going to go with formula and then I explain why they might consider to switch to breastfeeding. I tell them about the breastfeeding baby connection.”

Others did not describe specific techniques, but rather told us that women would say after they gave birth that “I couldn’t have done it without you,” noting that “just being there” for the women was important.

“I think just knowing that someone is there for you, and especially after baby comes and everyone rushes to baby, and you are just there for the mom.”

Barriers to doula work

All of the doulas were able to list multiple barriers to effective functioning as a doula, in general and specifically in working with diverse communities. These barriers included the following:

- Challenges of working with women who face both individual and community -level barriers and discrimination when seeking and receiving high quality maternity care
- Lack of childbirth education and informational materials in languages other than English
- Out of pocket costs related to travel, transportation, parking and gas
- Expense of doula training
- Financial viability of a career as a doula for low-income women

Working with the unique needs of the Medicaid population increased the emotional strain on the newly-trained doulas, who themselves come from underserved communities. This also made it

difficult for some of the doulas to establish professional boundaries. The challenges of serving underserved communities were described by doulas in vivid language:

“...a couple of my referrals hit close to home. [One client was] a 15 year old girl who is due soon, and I have a 15 year old daughter. How do I stay professional and not get personal and be like a mom?”

“I was surprised because I thought I was meeting her at a childbirth class and then realized when I got there that it was a shelter.”

“She [the client] had a really hard life – [her] mom was sober 5 years from meth and she had been living in 6 different foster homes. Her mom didn’t have custody of her 6 kids... Father of baby wasn’t involved since his mom said he needed to have a DNA test before going further.”

Other doulas shared about the challenges of following up with some clients whose phones were disconnected or had moved suddenly without leaving any contact information.

“I have referrals that are incommunicado. I go to their house and call, and then she changes her mind and asked to reschedule.”

“[The client] missed her prenatal with me and [I] couldn’t get a hold of her. Called the clinic and counselor, and [found out that] she is incarcerated. She’s supposed to be released at Christmas time, and I told them to have her call me...haven’t heard from her...and she’s due in March.”

The unmet social needs of many of the clients the doulas were working with present significant challenges in providing doula care. However, the doulas also recognized how much women need doulas and the overall significance of their work in their communities. They are passionate and highly fulfilled by the opportunity to help empower pregnant women and to have the ability to make a positive impact in their communities.

“Our communities are starting to crumble....A lot of neighborhoods where these women are coming from are experiencing the same thing. Being able to be within the community and help each other both in celebration and loss allows everyone to stay connected.”

Many doulas also expressed the challenge of funding the cost of traveling to visit clients at their homes, driving to clients’ doctor appointments, and driving to the hospital and paying for parking at the time of childbirth. While not all doulas attend prenatal visits with their clients, many do, and all make plans with their clients to be present at the time of childbirth, so transportation costs are substantial for many doulas. Some are also feeling limited in the number of visits they can do before and after birth if they are not reimbursed adequately for that number of visits and time spent with the women.

“I was there for the births - parking fees and driving to clients and Everyday Miracles, and then add to 6 visits required – if you are really doing it hourly then I am getting less than \$10 hour.”

When asked if they see a career as a doula working with Medicaid beneficiaries being financially viable many doulas said they would be pressured to have to take on private pay clients for two important reasons: 1) the length of time that had elapsed since the effective date of Medicaid reimbursement legislation without payment being numerated, and 2) the reimbursement rate (total of

\$411 for 6 prenatal visits and childbirth support) was below minimum necessary. Doulas almost universally noted that taking on private pay clients will become a financial necessity – given current reimbursement rates for Medicaid - if they want to make this their career, but it will most likely require them to seek clients outside of the communities that they are committed to serving. Some of the financial limitations described include:

“Right now no, [a career as a doula is not financially viable]. I will definitely have to do private pay. I’ve been thinking about this a lot and I will have to have 3-4 births per month through Everyday Miracles in order to make it financially viable without private clients. That’s me taking the bus and going to the food shelf and paying rent and electricity. I’m used to being poor.”

“I calculated the hourly wage of my first birth and when you include the prenatal visits and the birth, it comes out to less than minimum wage—that’s insane! That’s the challenge. I want to do more [doula work] but I need it to make sense financially. I love it but I can’t do it out of volunteerism. I thought about private clients but my concern is, will I be serving my community?”

“I want to work with the communities I’m comfortable with and are comfortable with me.”

“I’m hoping that whatever they are doing with the legislature [doula legislation] that they do it quick because I would like to do more of doula work....It would be nice to get a rich person every once in awhile, but I wouldn’t be as fulfilled. I want to work with women who really need a doula.”

Doulas also spoke about the challenges of balancing other jobs if they are not paid sufficiently to make doula work a full time career. There are not many flexible jobs that would allow for a doula to take time off at the last minute for births, and it is difficult to sacrifice a consistent schedule with another job that will help pay the bills for a job that is not paying them enough right now to support their families.

“I’m not taking on as much as I would normally just so I can do this. I’m trying to find a way... trying to find something [a part time job] where I can do work and still have my own time to be available for mamas.”

“...it’s just hard to have to leave your job, or if you can’t be at home with your kids or leave at a moment’s notice. You have to really enjoy it [doula work] and really want to make it work.”

“...I have other jobs. Thursdays are my doula days that I try to do most of visits. I don’t know – it’s all hanging in the balance. At the moment I have arrangements for [child] care, but if I quit this other job that supports me and my family then I don’t know – I’m in limbo right now going forward.”

Interaction between doulas and clients

All doulas acknowledged the connection with their clients and saw the importance of the regular ongoing communication with the women they supported. They wanted to be available to their clients whenever the women needed to talk with them and they focused on building trust with the women.

“I know the studies show that even if you don’t know them [the client] the outcomes are still better, but [I think] it’s even better when you do know them. I go to childbirth classes and then I can refer to those [classes] when I’m talking with them [the clients]. And they can call me whenever they want.”

"I feel like I've played a role in their [the client's] satisfaction. In the birth process, you need someone you can trust."

Many doulas expressed the importance of supporting underserved women with the same racial or ethnic background as themselves, and they valued being able to connect to clients in a deeper way because they have a better understanding of their needs. They value their ability to care for birthing women within their communities and feel that it allows them to provide culturally relevant and trauma-informed care for women who may not otherwise have access to this kind of support.

"Cultural stuff, smudging the room, etc. [is important]. Being the buffer [around the mom] and be comfortable with dealing with that and taking care of the mom, etc. "

"Ideally it would be nice to have a large group of doulas representative of all tribes so that we could be there for these women spiritually and in the way that they want."

However, racial/ethnic concordance between doulas and clients was not happening universally for a variety of reasons. First, given the small number of doulas representing racially/ethnically diverse communities in Minnesota there are workforce limitations. If a doula with a particular racial/ethnic background or language was not available for the expected due date, a client was left without the type of maternal support she desired. Second, geography plays an important role. Given the current reimbursement rate, and the fact that the newly-trained doulas were themselves low-income, the doulas have to be cognizant of where a woman lives and will deliver her baby. If she lives too far away, the doulas really have to consider the feasibility of taking on that client, even if she shares her cultural background or language. Finally, administrators tasked with coordinating client referrals were not consistently matching clients and doulas based on understanding their racial and/or ethnic backgrounds. One doula pointed out:

"[The] referral process is hard. I've been referred two Native women and then I found out there were some other ones. I think the referral process is confusing—are they asking client background? Do they know my background?—It would make for better match."

"I talk to the women before I accept or decline. If it's too far, then I can't even try talking to them since I don't want to fall in love with them and then they are so far away."

Another who works with refugee women talked about some of her experiences working within her community:

"Life is totally different here than in our country. Some [pregnant women] almost have a depression when they are pregnant. Some mamas are thinking about having the baby and are worried. Some don't have any help – who is going to help them, go with them, and make the food for them. I do everything for them. I bring the food for them to the hospital. And also when I go back and pick them up and take them home...I talk about their health and how important is breastfeeding."

Informing and educating women about their options was a shared experience with other doulas. Doulas explained that their work *"can bring some kind of power and some kind of choice back [to the woman]."*

Interaction between doulas and healthcare providers

Many of the newly-trained doulas spoke about attending prenatal visits with women in addition to being at the hospital for labor and delivery. They felt that they were able to be a liaison between the women and their health care providers. They reported that many healthcare providers appreciated their work as doulas.

“I meet them [the client] at their doctor’s appointment, and I then have an idea of what’s going on with birth and how they feel about the provider and how the provider treats them. I get lots of time to talk with the women. Some providers recognize me now and they say “It’s good to have a doula there” to remind them what the doctor says.”

As they began taking on clients, some of the doulas expressed that they had clients who may be challenging for them and for healthcare providers to work with. Many doulas expressed that it was difficult to witness how healthcare providers treat some of the women and that they felt they were in a position to help improve that interaction.

“I help them to ask questions of their doctors or I will ask provider questions in [a] non-threatening way.”

“She had a lot of anger, and I helped relieve the stress – and the nurses thanked me for being there and being a good advocate for her.”

The ability of the doula to positively impact the healthcare provider-patient relationship is also supported in findings from our focus group discussion with pregnant women where the pregnant women shared anecdotes of the provider spending more time with them when the doula was present at a prenatal visit or perceiving their provider as more warm and less judgmental when the doula was present.

Summary of Preliminary Findings

- Barriers to doula work are substantial and include the following: transportation, child care, other jobs, emotional strain, financial limitations, lack of knowledge by healthcare providers, paying for hospital parking.
- Matching doulas with clients can be a challenge in managing concordance with racial/ethnic background and language due to doula availability, distance, or lack of information about either doula or client racial/ethnic background.
- Doulas recognize the challenges their clients face in receiving culturally-appropriate care or trauma-informed care from healthcare providers; doulas perceive themselves as helping to create a safe environment, and also meet the needs of women and/or advocate for them.
- Doulas feel they are making a positive impact on improving the birth experience for women and improving birth outcomes during pregnancy and labor and delivery.
- Doulas feel they are a good liaison at the hospital between healthcare providers and their clients, and they have received positive feedback from healthcare providers.

D. Perspectives from Doula Program Administrators: Interviews

In March and April 2015, approximately 6 months after the September 25, 2014 approval by the federal Centers for Medicare and Medicaid Services (CMS) of the State Plan Amendment (and the effective date of the doula services clause of the 2013 Minnesota statute), we conducted semi-structured interviews with administrators of 4 different doula programs. The interviewees included one hospital-based program (HCMC), one volunteer, soon-to-be clinic-based program serving HIV positive mothers (Ilythia Project), one independent non-profit organization (Everyday Miracles), and one doula project that is embedded in a larger community organization (Cultural Wellness Center). The interviews focused on 1) state context, 2) doula care delivery systems, 3) doula care model content, and 4) billing and reimbursement processes. Key findings are presented below.

State context

All administrators expressed some level of confusion or uncertainty in their responses when asked about the current policy regarding the Medicaid reimbursement for doulas in Minnesota. There was consensus in awareness of the law, but each administrator stated that it was currently not being implemented. Some contacted DHS by phone or website multiple times, but expressed dissatisfaction with their understanding. Administrators from one organization heard that DHS had sent information about the legislation changes and met with managed care organizations before the July 1, 2014 implementation date. At the time of the interview the same administrators mentioned that UCare and Medica (two Medicaid managed care organizations - MCOs) were the only companies posting doula services on their website, and they had also heard that HealthPartners (another Medicaid MCO) was sharing information with their beneficiaries about the availability of doula services. There is general confusion about the billing process and how it works among all administrators. Some administrators say they are aware of the specific covered services, but others say they aren't sure what they can bill for. Some found out they need to be under a supervising clinician's National Provider Identification (NPI) number, but are unsure about the requirements or establishing the infrastructure for doing this. According to one organization, DHS also has stated that in order to bill, doulas need to send supporting documentation, but they are not aware of the specific documentation required. All administrators are also getting information from various sources outside of DHS, including managed care organizations, doulas, clients, social media, and professional networks, which contributes to the confusion of understanding the exact requirements for billing for fee-for-service and managed care births.

Doula care delivery systems and structures

The organizations we interviewed vary widely in their organizational structures. HCMC owns and operates their doula program, and their doulas are hired employees. Everyday Miracles retains all of their doulas as contracted employees. Everyday Miracles and HCMC both have in-house billing structures and have the capacity to bill for reimbursement. The doula program at HCMC relies on the hospital's finance department to set up billing for reimbursement through Medicaid. This infrastructure was not set up at the time of the interview, but Metropolitan Health Plan had paid HCMC in the past. Everyday Miracles has a system they use for reimbursements from managed care organizations for non-doula services and the billing for Medical Assistance (Medicaid fee-for-service) will take place through DHS's website.

The other two organizations we spoke with have small, volunteer-based doula programs with little formal infrastructure and no current billing process. One – the Ilythia Project – planned to formally merge with a clinic-based program in order to gain needed infrastructure for billing.

Doula care model content and characteristics

At all of the organizations we contacted, doulas are free to work independently on their own with private pay clients, but they also have the opportunity to be volunteers, employees or contracted employees through organizations who offer doula services to women. The interviews with administrators from four different organizations reveal the diversity within the doula community in terms of the client populations they serve and their organizational structures for doing so. Each of the organizations works with underserved, low-income, racially/ethnically diverse populations, but not exclusively. HCMC is the one program that varies distinctly from the other three programs since it is hospital-based and currently limited to only providing doula services at the time of labor and delivery, after clients are admitted to the hospital for childbirth. All of their 13 trained and certified trained doulas are on-call and employed by the hospital. The community-based programs have anywhere from one to 75 trained doulas, including both certified and non-certified doulas. One of the programs consists only of doula volunteers who work exclusively with HIV positive women. Each of the community-based organizations provides services before, during and after delivery to women, and they also offer or connect women to other resources such as Women, Infants and Children Program (WIC), breastfeeding pumps, yoga, chiropractor, massage therapist, car seats, clothing, food, etc. Doula programs recruit clients and doulas from word of mouth, online through their websites and also through referrals through clinics within health systems, and community partners, including specific clinics that communicate and work directly with the community-based programs.

Billing and reimbursement processes

None of the administrators we interviewed had yet received payment for doula services under the new legislation; however some doula organizations had the capacity for billing, and reported past success with billing and being reimbursed for other childbirth-related services. Two of the organizations are not involved in billing and reimbursement at all for the services they provide, but two other organizations, HCMC and Everyday Miracles, were able to share the processes they use for billing for covered services such as prenatal education, breast pump distribution, and car seat education and distribution.

The doula program at HCMC is a hospital-based program. Hospital finance staff meet with women both before and after childbirth, and guide them on their insurance options if they are not already enrolled in a plan. The hospital's coders assign codes to each of the services provided, based on clinical notes from patient visits. The services are bundled together for their department - prenatal, delivery and postpartum care. The finance department then submits the required billing claims to health plans for payment. The payment is made after all services are rendered. Currently, the doula program is not participating in any part of the billing or reimbursement process, but all of the HCMC doulas are listed on the doula registry in hopes of billing in the future. Within HCMC, there is particular concern with billing for doula services under a clinician's National Provider Identification (NPI) number, and the hospital's legal department has been involved in some of the discussions, but no resolutions have been made. However, if HCMC's doula program were reimbursed by Medicaid, the rates would not cover the existing program costs, and the concern is that the dollar value is too low for the effort required to complete the reimbursement process, especially the since HCMC's doula program would be collecting money only from the delivery portion of the payment (not the prenatal visits) under the current structure of their program.

Everyday Miracles is a non-profit organization that employs doulas who provide a range of support services to Medicaid beneficiaries. They hold a contract with a Medicaid MCO to provide services such as breastfeeding education, car seat education and supplies such as breast pumps and car seats. At the time of the interview, Everyday Miracles was negotiating an updated contract, specifically to include doula services. They have reached out to all Medicaid MCOs to inquire about contracting.

Summary of Preliminary Findings

- There is confusion about NPI number/supervision requirements for payment for doula services for Medicaid beneficiaries, even for doula programs that are integrated within healthcare delivery systems.
- Doula organizations need clear and specific guidance from DHS regarding the required contract language with supervising providers and the required documentation for billing. They expressed that they are willing to follow regulations but do not understand what is required.
- There has been limited communication between doula organizations and MCOs regarding contracting. Doula organizations are not sure who to contact and whether there is a process that should be followed.
- There has been a lack of clarity in communication between DHS and the doula community about how the law is being implemented and what actions need to be taken (and by whom) to move the process forward.
- There are challenges with MDH registry in terms of the cost of registration, and whether doula organizations can be listed in order for them to be paid on behalf of doulas that are employed or contracted with them.
- The current reimbursement amount is not sufficient cover the cost of the services being rendered by a doula, and this is complicated further when a doula program has overhead/administrative costs associated doula employment/contracts.
- Doulas have yet to be reimbursed for the services they have provided to women in the Medicaid population even though they have been providing these services since the law became effective September 25, 2014.
- Both hospital-based and community-based non-profit doula organizations have the billing capacity to work with DHS and managed care organizations in order to submit billing forms and receive reimbursements, but they need more guidance to be able to successfully do so.

E. Perspectives from Managed Care Organizations

On April 13, 2015, we sent letters to the CEOs (copying the legislative or government affairs representatives) of all of the Minnesota Managed Care organizations that participate in Medicaid, and these included Medica, UCare, BlueCross BlueShield of Minnesota, HealthPartners, and Hallelund Habicht-LPAC Alliance. We contacted the Managed Care Organizations with a specific request for information regarding the implementation status of the legislation.

We received written responses from Medica, UCare, and HealthPartners. These written responses are included in an appendix document. We received an email response from Hallelund Habicht-LPAC Alliance and scheduled a subsequent telephone conversation with Chuck McKinzie, Medical Director for PrimeWest. We did not receive a response from BlueCross Blue Shield of Minnesota. Below is a compilation of key insights that emerged from the experiences of the payors who responded to our request.

Access and awareness

There is no common way that members are currently accessing doula services. Some payors report advising members to inquire with their maternity care providers or their hospital or birth center. One payor reports including information on this benefit in their documentation and notes that members can discuss questions about accessing this benefit with Member Services. Another payor reports more active outreach efforts, informing enrolled providers via a provider notice, informing members not only in the Evidence of Coverage document but also in their member newsletter, and providing call center staff with specific information regarding the availability of a doula benefit.

Current status: benefits received

As of April 2015, none of the organizations had yet paid for doula services rendered to Medicaid members. UCare reported that several claims for the doula services code had been submitted, but that none had yet been paid, owing in part to the submitted claim lacking the appropriate modifier and supervising provider NPI number. Medica notes that their system is set up to pay claims that meet the qualifications, but that no such claims have yet been received.

Current status: enrolled providers

At the time they responded to our inquiry, there were no doulas currently listed as enrolled providers with any of the health plans we contacted. Several reasons are given for this, and all point to the need for supervising provider's NPI. One organization noted that doulas would not be listed as a unique provider type owing to the supervising requirement. Another organization stated that creating a supervising relationship with an eligible Medicaid provider had been a "barrier" for doulas and that no eligible doulas had yet approached the organization to contract with them. Finally, one organization – at the time of their response – was close to completing a contract with a non-profit doula organization, which would provide doula services for their Medicaid members.

Implementation challenges

Respondents noted several key challenges that have occurred during implementation regarding network development, billing, and consumer outreach. The most frequently mentioned challenge was the requirement that doulas bill through a supervising provider and use that provider's NPI number for billing purposes. This was mentioned as a "significant barrier" by all respondents and echoes the concerns raised by doula program administrators. It is noted that "few, if any, physicians or nurse practitioners have agreed to act as a supervising provider due to quality concerns and liability." Another organization noted that "most doulas have operated independently, rather than under the auspices of a

specific provider or provider group; the women they support receive care from a wide variety of providers and deliver at a variety of hospitals” making the requisite supervisory relationship a challenge. Another challenge identified by one organization is determining whether doulas meet qualifications at the time of service delivery and the potential concern of the risk of financial burden on members, should a claim be denied.

Recommendations for Minnesota

The managed care organizations that responded offered several recommendations and suggestions for improving implementation of the doula benefit in under the current State Plan Amendment.

- HealthPartners suggests the state develop a system to require licensure so that doulas are paid directly, rather than through a supervising provider.
- On a similar note, Medica recommends the establishment of a unique provider type for doulas, which would be used by all health plans and notes the Administrative Uniformity Committee could facilitate this.
- UCare suggests that doulas consider restructuring their services to comply with supervision requirement by aligning their care with that provided by a supervising provider or another health care delivery setting.
- Medica suggests outreach to clinics to understand their perspectives on doula care and offers the idea of piloting doula care within clinics where the health plan has an established relationship.
- UCare further recommends that DHS and/or MCOs provide education to the doula community about the fee schedule and the process and advantages of contracting with health plans, in spite of reimbursement rates that are below market value.
- Another educational need identified by Medica was the need for education to members about the benefits and values of doula care.

Recommendations for other states

As other states consider the inclusion of doula services into a State Plan, our respondents also offered insight and suggestions based on their experiences. Overwhelmingly, managed care organizations emphasize the complexity of the relationships between members, clinics, medical providers, doulas, health plans, and regulators. HealthPartners suggests that states solicit stakeholder input on benefit design and on identification of possible barriers in order to enhance the potential benefits of doula care among Medicaid members.

IV. Summary of Preliminary Recommendations

The following **preliminary recommendations** emerged from this interim analysis and consolidation of feedback and input from patients, providers, administrators, and payers. These recommendations reflect the views, opinions, and perspectives of the participants in this research and may inform future legislative or implementation efforts to overcome the barriers described above. We anticipate further development and expansion of preliminary recommendations upon completion of the research project. At this juncture, the following recommendations emerged.

Recommendations: Legislative Changes

The impetus for Medicaid coverage for doula services came from a legislative effort, and respondents identified several additional potential legislative modifications or proposals that could be considered to fulfill the original intent of the legislation.

- Create a licensure process for doulas in Minnesota. The goal of doula licensure would be to allow for direct payment to doulas for their services and to render unnecessary the currently burdensome challenge of establishing supervisory relationships between doulas and maternity care clinicians. Such legislation should ensure that licensure does not criminalize practice by unlicensed providers.
- Modify the [Minnesota state doula registry](#) to allow for non-profit organizations to be listed. This would better meet the needs of Medicaid beneficiaries who could call several organizations (vs. several hundred potential doulas) to inquire about services, and of managed care organizations who would prefer to contract with organizations rather than individual doulas.
- Establish a fee waiver process for fees for doula certification and registration for low-income applicants, and also establish a separate fee for organizations to apply to appear on the registry.
- Allow payment for travel mileage as part of doula services reimbursement. Doulas – especially in rural areas – frequently travel substantial distances to meet with clients, and travel expenditures alone may outweigh earnings for prenatal visits for distant clients.
- Augment doula certification (or licensing) requirements to include education on trauma-informed care and on social and structural determinants of pregnancy and childbirth care.
- Enhance diversity and capacity by creating a grant program to support doula training to increase the available doula workforce to support pregnant Medicaid beneficiaries. Specifically, funds for doula training should be directed to communities of color, low-income communities, and rural areas to increase the diversity of the doula workforce and improve its capacity to meet the needs of Medicaid beneficiaries.

Recommendations: Improving Implementation

In addition to legislative changes, respondents suggested several steps that could be undertaken administratively by the Departments of Health and Human Services to improve implementation of current statute.

- DHS should review currently-available evidence and reassess the reimbursement rate for doula services in the State Plan Amendment.
- DHS should provide clear information about all of the documentation required for payment of claims for doula services.
- DHS and the Minnesota Department of Health (MDH) should establish a formal coordination structure to interface with one another on issues related to the registry/credentialing (MDH) and payment (DHS).

- This joint coordinating group should serve as a resource for doulas, maternity care clinicians, and managed care organizations so that shared information is clear and transparent.
- DHS should provide education to clinicians and hospitals about the role of a doula and the content of the statute that requires Medicaid payment for doula services.

Conclusion

Given that disparities in birth outcomes persist in Minnesota and across the U.S., it is important to examine new strategies to advance health equity and improve birth outcomes both in our own state and nationally. This report provides a first look at the implementation of Minnesota's legislation allowing for Medicaid coverage of doula services. We gathered data from multiple perspectives (pregnant women, doulas, doula program administrators and MCOs) within the healthcare system regarding the challenges and barriers to implementing this legislation, and the preliminary findings and recommendations reported here can contribute to ongoing implementation of the current legislation. We anticipate that sharing this information will facilitate discussions around overcoming challenges of implementation, including licensing, payment rates, contracting, and other features in order to successfully enact the intent of the legislation in Minnesota. In the longer term, we hope that these initial findings will contribute to national dialogue about increasing access to evidence-based, culturally appropriate, and affordable support for women giving birth.

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Appendices: Minnesota managed care organization responses to request for information

HealthPartners
Government Programs
8170 33rd Avenue South, M.S. 21103C
Bloomington, MN 55425

healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309



May 14, 2015

Katy B. Kozhimannil, Ph.D., M.P.A.
Division of Health Policy and Management
School of Public Health
University of Minnesota
Mayo Mail Code 729
420 Delaware Street S.E.
Minneapolis, MN 55455

Dear Dr. Kozhimannil,

On behalf of HealthPartners, thank you for your request for information regarding the doula services benefit for Medicaid members. We appreciate the opportunity to provide our perspective on the implementation process of this benefit and to address the barriers to care that our members may be experiencing due to the benefit design selected for implementation. Our response to your requested information is below.

In your letter you mention that the information gathered from this request for information would be presented to the Minnesota Department of Human Services (DHS) to provide guidance on how to improve implementation. As this service is a Medicaid benefit, the state legislation and DHS set forth the requirements for the benefit. We appreciate that you are working closely with DHS to learn more about this benefit.

HealthPartners responses are as follow:

Describe how individuals are currently accessing doula services and any efforts your organization has taken to increase awareness of this new benefit.

Certified doulas with a supervising professional can bill for services provided to our Medicaid members. These services include up to 6 visits, including labor and delivery. Members select their own doulas and can consult with their provider to connect with doulas. Additionally, some birthing centers have doulas on staff, or that work frequently at the birthing center, and members may access these doulas as well. We include this benefit in our Evidence of Coverage and members can discuss any questions about the benefit with Member Services which is available by phone, via email, and via electronic "chat." Marketing for the Medicaid products has regulatory limitations and restrictions and we do not promote this particular benefit beyond the standard description of benefits.

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Government Programs
8170 33rd Avenue South, M.S. 21103C
Bloomington, MN 55425



healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309

Provide information on the number of individuals who have received doula services in the past year

To date, we do not have any specific claims for doula services for our Medicaid members. Members may be accessing doulas through a birthing center or other practice. However, these doula services may be included in the global Labor and Delivery claim being billed and not an individual claim. In this situation, we would not know the utilization of doula services.

Provide information on the number of doulas who are currently listed as enrolled providers with your health plan

To date, we do not have any doulas contracted as providers for our Medicaid population. In order to be an eligible Medicaid provider, DHS requires doulas to bill under a supervising provider's NPI (National Provider Identification) number. This has been a barrier for doulas and no eligible doulas have approached HealthPartners to contract.

Discuss any challenges that have occurred during implementation regarding network development, billing, consumer outreach, or other areas of interest

Many doulas are finding the state requirement of a supervising provider and supervising provider's NPI number a significant barrier to contracting with health plans. Few, if any, physicians or nurse practitioners have agreed to act as a supervising provider due to quality concerns and liability. As the supervising provider does not need to be present for the services provided by the doula, including labor and delivery, we understand that some providers' legal advisers have advised providers not to agree to this arrangement because of these liability concerns.

Our understanding is that DHS has chosen to enroll doulas as a Medicaid provider who may not meet the eligibility criteria at the time of enrollment and then later determine if the doula meets the qualifications at the time of billing. HealthPartners does not contract with non-qualified providers for any service. Also, HealthPartners is concerned about the risk of financial burden on members if a claim did not pay and the cost would then potentially be placed on the member.

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Government Programs
8170 33rd Avenue South, M.S. 21103C
Bloomington, MN 55425

healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309



Given doula services are now part of the State Plan, discuss any recommendations to address the above listed concerns that could be taken by the MCOs, the State and the doula community

HealthPartners suggests that the state develop a system to require licensure and certification to ensure quality services and support access.

Share any insights you think other states should consider when evaluating the inclusion of doula services into a State Plan

States may want to solicit stakeholder input into benefit design and identification of potential implementation barriers. Checking in with stakeholders and the provider community can be helpful to proactively identify challenges and support quality access and a smooth transition.

As part of the HealthPartners Children's Health Initiative, we support services for our pregnant mothers and youngest members. We hope that this inquiry leads to the improved access to quality doula services for the community.

If you have any questions, I can be reached at 952.967.5119 or jennifer.j.clelland@healthpartners.com.

With best regards,

Jennifer J. Clelland
Senior Director, Government Programs

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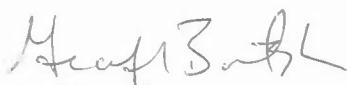
May 13, 2015

Katy B. Kozhimannil, PhD., M.P.A.
University of Minnesota
Division of Health Policy and Management
School of Public Health
Mayo Mail Code 729
420 Delaware Street S.E.
Minneapolis, MN 55455

Dear Dr. Kozhimannil:

Attached is Medica's response to your April 13, 2015, request for information regarding Medicaid payment for doula services in Minnesota. Please contact me with any additional questions.

Sincerely,



Geoff Bartsh
VP & GM, Medica, State Public Programs
952-992-2461
geoffrey.bartsh@medica.com

GB/rg

Medica is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans*, Medica Health Plans of Wisconsin, Medica Insurance Company*, Medica Self-Insured*, and Medica Health Management, LLC.

May 13, 2015

Re: Medica Health Plan Response to The University of Minnesota RFI - Medicaid payment for doula services in Minnesota

1. Describe how individuals are currently access doula services and any efforts your organization has taken to increase awareness of this new benefit

Medica sent out a provider notice in the January 2015 issue of the *Connections* newsletter to notify all network providers that certified doula services are to be covered as additional support for pregnant women. This change, effective with September 25, 2014 dates of service, applies to Minnesota Health Care Programs (MHCP) enrollees in Medica Choice CareSM, Medica MinnesotaCare and Medica AccessAbility Solution[®].

In addition, a member notice was completed with the 2015 Evidence of Coverage document and Addendums that were sent to members notifying them of the change.

Future promotional efforts include:

- An article in our biennial member newsletter *It's Your Health*. We hope to feature a doula's perspective in this article, and reemphasize the value a doula can provide to members. This will be released in Spring 2016.
- We also have a Consumer Advisory Council for our Medicaid members and stakeholders, held twice each year. Doula services will be a topic at our May 2015 Council meeting and we will invite discussion from stakeholders on the use of the doula benefit.

Additionally, internal communications about the use of doula services were developed and shared with Medica call center provider service staff. The communications are included below.

A doula is a professional labor coach, usually a woman who has gone through pregnancy, labor, and delivery. The purpose is for the coach to be available and helpful to a woman throughout the labor and delivery experience providing information and emotional support.

- Effective with DOS 9/25/14, certified doula services are covered as additional support for pregnant women.
- Members seeking doula services should contact their Medica participating physician, nurse practitioner, or certified nurse midwife overseeing their prenatal care.
- Coverage allows up to six sessions, one of which must be for labor and delivery. Covered services are limited to childbirth education and support services, which include emotional and physical support provided at the following times:
 - Before childbirth (antepartum)
 - Labor and delivery
 - Postpartum

- Note: Doulas that are registered with the Minnesota Department of Health (MDH) and are certified by one of the following organizations are eligible to provide and bill for services under a supervising professional's NPI:
 - Association of Labor Assistants and Childbirth Educators (ALACE)
 - Birthworks
 - Childbirth and Postpartum Professional Association (CAPPa)
 - Childbirth International
 - Commonsense Childbirth Inc.
 - Doulas of North America (DONA)
 - International Center for Traditional Childbearing (ICTC)
 - International Childbirth Education Association (ICEA)

2. Provide information on the number of individuals who have received doula services in the past year

Claims reports that were run as of April 2015 indicate that we have not had any claims billed for Doula Services.

3. Provide information on the number of doulas who are currently listed as enrolled providers with your health plan

Currently, Doula's are required to bill under the supervision of Contracted Physicians, Nurse Practitioners or Certified Nurse Midwives using the supervising professional's NPI. Because they are to bill under supervision steps have not been taken to create a unique provider type for them.

4. Discuss any challenges that have occurred during implementation regarding network development, billing, consumer outreach, or other areas of interest.

Because the claims require the supervising professional's NPI, many contracted providers are not willing to give this information out.

5. Given doula services are now part of the State Plan, discuss any recommendations to address the above listed concerns that could be taken by the MCOs, the State and the doula community

The issue of doula services has repeatedly come up in the Government Programs Committee at the Minnesota Council of Health Plans. Very few clinics have partnered with Doulas. Our system is set up to pay the claims if they come in with all the qualifications met, but we haven't received any claims as of April 2015.

To increase the use of Doula Services, we would recommend the following:

- Establishing a unique provider type for doulas, used by all health plans. This would need to be facilitated by the Administrative Uniformity Committee

- Initiate conversations with clinics to understand their perspectives on the use of doulas
- Piloting doula usage at a few clinics where we already have a close working relationship
- Developing additional education to members about the benefits and values of Doulas

6. Share any insights you think other states should consider when evaluating the inclusion of doula services into a State Plan

If coverage will be mandated in a state's Medicaid program, they must understand all the linkages that must occur between doulas, providers, payers and consumers to have a successful implementation

**UCare Responses to University of Minnesota School of Public Health
Request for Information – Doula Benefit**

1. Describe how individuals are currently accessing doula services and any efforts your organization has taken to increase awareness of this new benefit.

Our Customer Services staff are advising members to follow up with their Ob/Gyn provider and/or hospital they plan to deliver at to see if they have doulas available. If they do not, we are encouraging the member to sign up for a childbirth preparation class.

2. Provide information on the number of individuals who have received doula services in the past year.

At this time we do not have any contracts in place. We ran an internal claims report to see how many claims were billed with S9445 and there are roughly 2,300+ claims. Some or all of these claims would be rebilled with the S9445-U4 modifier and the supervising provider's NPI, but at this time we do not have a specific number.

3. Provide information on the number of doulas who are currently listed as enrolled providers with your health plan.

Everyday Miracles will be our one and only agency. We are very close to completing the contract with Everyday Miracles and their effective date will be Sept. 25, 2014. Milk Moms and Musical Beginning have shown interest, however they are not able to meet the supervision requirements at this time. We do anticipate that some doula's will be part of Ob/Gyn groups or care systems, and as long as they are certified/registered, they can bill under the supervising provider's NPI.

4. Discuss any challenges that have occurred during implementation regarding network development, billing, consumer outreach, or other areas of interest.

The biggest challenge in implementing the benefit has been finding doulas who meet the DHS criteria for supervision by an enrolled doctor, certified nurse midwife, or nurse practitioner. Most doulas have operated independently, rather than under the auspices of a specific provider or provider group. The women they support receive care from a wide variety of providers and deliver at a variety of hospitals.

5. Given doula services are now part of the State Plan, discuss any recommendations to address the above listed concerns that could be taken by the MCOs, the State and the doula community.

For the doula benefit to become widely available, as long as the supervision requirement remains in effect, the doulas would need to re-structure their services to comply with these requirements.

One additional thought relates to the DHS fee schedule for doula services. Doulas typically charge private clients approximately twice the DHS rate for their services. Since insurance coverage is new for doulas, DHS/MCOs may need to provide some education to the doula

community on the advantages of contracting with the health plans, despite the reduced reimbursement rate.

- 6. Share any insights you think other states should consider when evaluating the inclusion of doula services into a State Plan.**

See response to #5.