

Addressing Maternal Health Disparities: Doula Access in Medicaid

September 2022



Doulas provide person-centered care to pregnant and postpartum women through information, education, and physical, social, and emotional support. They are one solution to improving birth outcomes while addressing health disparities.

Background

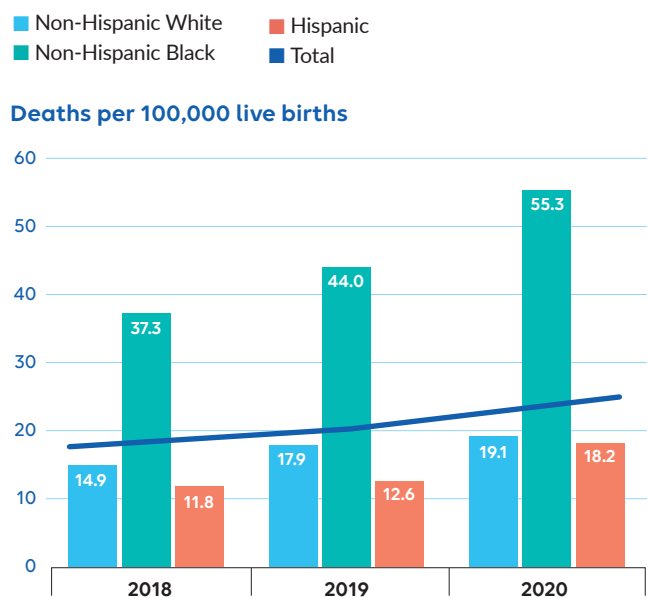
Maternal mortality rate. The overall maternal death rate in the U.S. rose from 17.4 deaths per 100,000 live births in 2018 to 23.8 deaths per 100,000 in 2020, with inequities continuing to increase among women identifying as Black.¹

- 37% total ↑ in mortality since 2018
- 28% ↑ among non-Hispanic White women
- 48% ↑ among non-Hispanic Black women
- 54% ↑ among Hispanic women

Severe health complications. In recent years the U.S. has seen a 200 percent increase in severe health complications (i.e., severe maternal morbidity) arising during pregnancy and labor and delivery.²

Medicaid reimbursement. In 2020, Medicaid paid for 42 percent of all births in the U.S. and paid for a greater share of deliveries by Hispanic, Black, and American Indian and Alaska Native women compared to private insurance.^{3,4} One in ten to 11 of Medicaid births were among members enrolled in one of Elevance Health’s affiliated Medicaid plans.

**Maternal Mortality Rate
2018–2020**



Doula Overview

Definition. A traditional doula is a trained non-clinical professional who provides continuous educational, physical, and emotional support to women and their birth partners “before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.”⁵

Value. Doulas help empower women to advocate for their healthcare preferences while also focusing on holistic approaches to a healthy pregnancy and birth like sleep, nutrition, breastfeeding, and mental health.⁶

Clinically supported. Doulas are supported by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine.

Community-based doula programs. These doula programs arose to provide care to underserved populations, including those enrolled in Medicaid. Doulas often are:

- Situated in the communities they serve, frequently sharing the same background, culture, and language with their clients.
- Able to navigate complex healthcare systems and social supports to provide clients with connections to community supports, positive experiences, reduced stress, and improved birth outcomes.
- Trained in “a cultural context on how race, institutional and interpersonal bias, and other social determinants play an integral role in birth disparities affecting communities of color.”⁷

Outcomes. Outcomes associated with doula support include increased maternal engagement, higher satisfaction with care, lower prevalence of poor five-minute Apgar scores, preterm births, and cesarean delivery rates, and lower birth costs.^{6,8,9}

Birth inequities. Doula care can mitigate birth inequities for at-risk women in rural communities and communities of color through prioritizing cultural concordance, providing psychosocial support and system navigation, and acknowledging the impacts of stress, racism, and trauma.¹⁰

State Models

Several state Medicaid programs reimburse for doula services for pregnant women enrolled in Medicaid. Below are three states in which Elevance Health examined the use of and outcomes from doula services offered by Elevance Health’s affiliated Medicaid plans.

California



- A pilot program began in Fresno, where the infant mortality rate is the same as some developing countries.
- Elevance Health’s affiliated plan contracts with community-based doulas as health education providers.
- Doulas provide at least six prenatal visits, at least three postpartum visits, and services during labor and birth.

Florida



- Elevance Health’s affiliated plan provides unlimited access to doulas in all counties where its plans are offered.
- Doulas are accessed via contracts with the National Doula Network (NDN), or members can request non-NDN doulas meeting the same qualifications.
- Doula network demographics match the populations served.
- Members have unlimited visits per pregnancy.

New York



- Medicaid enrolls doulas as a provider with the state; Elevance Health’s affiliated plan then contracts with Medicaid-enrolled doulas.
- Medicaid pays for up to four prenatal visits, up to four postpartum visits, and services during birth.
- Notably, doulas are offered in Buffalo-Niagara, which has the highest maternal and infant mortality rates in NY.

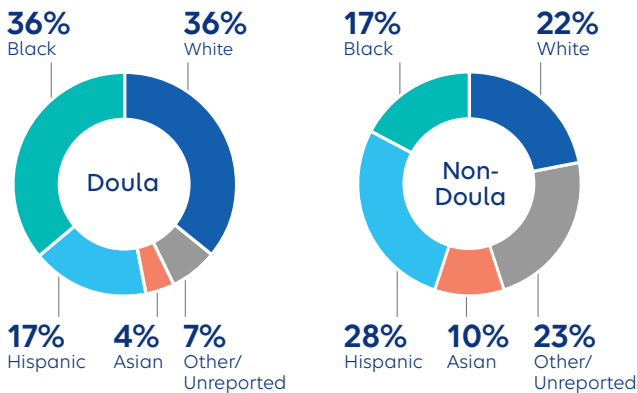
Results

Differences in the use of services and outcomes were observed when Elevance Health compared women who received doula services in the three state models (California, Florida, New York) to women who did not receive doula care.¹¹

Demographics

Race/Ethnicity

- Higher percentage of Black (36 percent vs. 17 percent) and White (36 percent vs. 22 percent) women using doula care.
- Lower prevalence of Hispanic (17 percent vs. 28 percent) and Asian (4 percent vs. 10 percent) women using doula care.
- Differences in race/ethnicity of women using vs. not using doula services are likely due, at least in part, to the demographics of the counties in which doula services were offered.



Age

- Mean maternal age of women using a doula is just slightly older than women not using a doula (28.2 years vs. 27.7 years).

Diagnosis Prevalence

- Higher prevalence of pregnancy complications in mothers using doulas vs. those not using doulas is expected given that the programs target women at higher risk for poor maternal or birth outcomes.

	Doula	Non-Doula
Any pregnancy complication*	23.0%	18.7%
Pre-eclampsia*	9.0%	6.0%
Anemia*	5.5%	2.5%

*Significant at alpha level < 0.05

Access/Utilization

- Women receiving doula care were more likely to have at least one prenatal visit and less likely to have a hospital admission during pregnancy as compared to women not using doula services.
- Women using doulas had significantly greater odds of receiving a postnatal visit.

	Doula	Non-Doula
At least one prenatal visit*	99.1%	93.8%
Hospital admissions during pregnancy*	13.3%	21.3%
ER visits during pregnancy [†]	42.1%	38.2%
ER visits 30 days postpartum [†]	2.8%	6.5%

*Significant at alpha level < 0.05

[†]Numbers were trending down but not statistically significant

Postnatal Visit*



Term/Post-Term Birth*



*Significant at alpha level < 0.05

Outcomes

- Women using doulas had significantly greater odds of having a term or post-term birth (as opposed to a preterm birth).
- Women receiving doula services had superior outcomes, including being less likely to have babies of low birth weight or requiring a NICU admission.

	Doula	Non-Doula
Low birth weight*	8.1%	12.3%
NICU admission*	5.9%	11.4%

*Significant at alpha level < 0.05

- Women using a doula had significantly lower odds of cesarean delivery compared to women not using a doula, adjusting for race, socioeconomic status, hospital type (teaching hospital or non-teaching hospital), obesity, and maternal comorbidity index (MCI).

Prevalence of Cesarean Delivery*



*Significant at alpha level < 0.05

- Women using a doula had significantly lower odds of postpartum depression or postpartum anxiety, adjusting for race, socioeconomic status, hospital type (teaching hospital or non-teaching hospital), obesity, prenatal depression or anxiety, and MCI.

Costs

Figures cited below are the total allowed medical costs for prenatal care and labor/delivery (not including postpartum care).

- Women using a doula had \$1,675* lower prenatal and birth costs than women not using a doula.
- Prenatal and birth costs were \$1,181* lower after controlling for deliveries attended only by OB/GYNs.

*Significant at alpha level < 0.05

Policy Options

State Plan Amendment (SPA). Non-licensed practitioners, such as doulas, can provide and be reimbursed for doula services as long as those services are recommended by a physician or other licensed practitioners, through a preventive services SPA.¹²

1115 Demonstration Waivers. States use this type of waiver – typically five years in duration—to test different benefit designs or new models for delivering care, including paying for doula services, and typically have a significant amount of flexibility in designing these new models.¹³

Managed Care Organization (MCO) Contracts. States can use their MCO contracts to promote the uptake of doulas in their Medicaid programs such as by requiring doula services for beneficiaries or piloting doula initiatives in specific regions served.

Quality Initiatives. Federal Medicaid rules require states to implement a managed care quality strategy with a plan to address health disparities which could include a specific focus on maternal health outcomes and using doulas as a strategy.¹⁴

Considerations

Workforce strategy. Support a trained and certified doula workforce going beyond traditional doula training to include equity, cultural humility, trauma-informed approaches, home visiting skills, and knowledge of social services, for example.

Scope of services. Offer a wider array of services, including miscarriage, loss, and still birth services, that allows for a sufficient frequency of prenatal visits while also prioritizing the postpartum period.

Reimbursement models. Reimburse at a rate that offers a sustainable, living wage for doulas to limit barriers to providing services and consider how long services can be rendered after a birth.

Partnerships. Partner with doula organizations to support infrastructure, capacity, workforce diversity, and training through educating doulas on Medicaid provider and billing policies, supporting organizations in measurement and evaluation of doula care, and collectively expanding the workforce in rural and urban areas to equitably enhance the availability of doula services.

Conclusion

This brief demonstrates that women utilizing doulas in Medicaid have fewer inpatient hospital admissions during pregnancy, are more likely to attend their postnatal visit, experience lower odds of cesarean delivery, have lower odds of postpartum depression or anxiety, and have lower overall costs when compared to women who do not utilize doulas. As doulas offer a personalized and effective approach for improving delivery of culturally competent maternal health care and mitigating birth inequities, state Medicaid programs should continue to consider reimbursing for doula services as part of their overall maternal health strategies.

Methods

- The retrospective cohort study used encounter and enrollment data before, during, and after pregnancy for members enrolled in Elevance Health’s affiliated Medicaid plans in California, Florida, and New York, in 2014-2020, depending on when the doula program began in each state.
- The study population included 330 women between the ages of 12 and 51 who had at least one pregnancy during the time period and at least one day of medical eligibility during the time frame.
- A 1:1 propensity score matching approach was utilized on state, age, socioeconomic status quartile, and delivery hospital type (teaching or non-teaching).
- Descriptive analyses by proportions and means were stratified by state/pilot program to account for geographic and state policy differences.
- Multivariate logistic regression models were fit with maternal health as the dependent outcome and doula care as the primary exposure.
- Though the study was able to control for deliveries with OB/GYNs as the sole clinical provider present, deliveries attended by midwives could include those where the midwife was the sole clinical provider or those where they delivered alongside an OB/GYN.

Definitions

Pregnancy complications. Gestational diabetes, gestational hypertension, pre-eclampsia, placental abruption, thrombocytopenia, placenta previa, placenta accrete spectrum, short cervix, depression, anxiety, or anemia

Preterm. Babies born alive before 37 weeks of pregnancy

Term. Babies born alive between 37 and 42 weeks of pregnancy

Post-term. Babies born alive after 42 weeks of pregnancy

Low birth weight (LBW). Babies with a weight at birth of < 2500 grams (5.5 pounds)

Maternal comorbidity index (MCI). Predicts occurrence of maternal end-organ injury or death during delivery to 30 days postpartum

Endnotes

- ¹The Centers for Disease Control and Prevention. (2022, February 22). Maternal Mortality Rates in the United States, 2020. <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>.
- ²The Centers for Disease Control and Prevention. (2021, February). Severe Maternal Morbidity after Delivery Discharge among U.S. Women, 2010-2014. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/smm-after-delivery-discharge-among-us-women/index.htm>.
- ³Kaiser Family Foundation. (2022, December 17). Births Financed by Medicaid. <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/>.
- ⁴Medicaid and CHIP Payment and Access Commission. (n.d.). Medicaid’s Role in Maternal Health. <https://www.macpac.gov/publication/chapter-5-medicoids-role-in-maternal-health/>.
- ⁵Dona International (n.d.). What is a Doula? <https://www.dona.org/what-is-a-doula/>.
- ⁶Gruber, K.J., Cupito, S.H., & Dobson, C.F. (2013) Impact of Doulas on Healthy Birth Outcomes. *The Journal of Perinatal Education* 22 (1), 49–58. https://www.academia.edu/en/53382342/Impact_of_Doulas_on_Healthy_Birth_Outcomes.
- ⁷Bey, A., Brill, A., Porchia-Albert C., Gradilla, M., & Strauss, N. (2019, March 25). Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>.
- ⁸Strauss, N., Sakala, C., & Corry, M. (2014). Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. *The Journal of Perinatal Education* 25 (3), 145–149. <http://dx.doi.org/10.1891/1058-1243.25.3.145>.
- ⁹Kozhimannil, K.T., Hardeman, R.R., Attanasio, L.B., Blauer-Peterson, C., & O’Brien, M. (April 2013). Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries, *American Journal of Public Health* 103 (4) e113-e120. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617571/pdf/AJPH.2012.301201.pdf>.
- ¹⁰Bey, A., Brill, A., Porchia-Albert C., Gradilla, M., & Strauss, N. (2019, March 25). Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>.
- ¹¹Falconi, A.M., Bromfield, S.G., Tang, T., Malloy, D., Blanco, D., & Disciglio, S. et al. (2022, August 1). Doula Care Across the Maternity Care Continuum and Impact on Maternal Health: Evaluation of Doula Programs Across Three States Using Propensity Score Matching. *The Lancet* 50 (101531).
- ¹²42 CFR § 440.130
- ¹³42 CFR Subpart G
- ¹⁴42 CFR 438.340 (b)(6)

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Elevance Health Public Policy Institute

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