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MATERNAL HEALTH
Issue Brief

The Positive Impact of Doula Care and State Regulation of Doulas and Doula Care

Introduction

Increasing access to safe and effective doula care could decrease the high maternal morbidity and mortality rate in the United States. Doula services are woefully underutilized, as only about six to 10 percent of births in the country involve a doula.[1] Lack of coverage for doula services from both private and public health insurance functionally limits access to doula care principally to those who can afford the services out-of-pocket.[2] The narrow ability to make a living as a doula suppresses the number of doulas available and the racial and ethnic diversity of doulas. Understanding how state regulation of doula certification, care, and coverage affects availability of and access to doula services can shed light on opportunities and challenges to using doulas to improve maternal health outcomes. For more details, see the accompanying 50-State Survey: State Laws Addressing Doula Scope of Practice.

Maternal Mortality and Morbidity in the United States is a Public Health Crisis

Indisputably, the U.S. is facing a maternal mortality crisis. **Maternal mortality** is defined as when an individual dies due to a pregnancy-related health condition or a pre-existing condition that is exacerbated through pregnancy, either during the pregnancy, at labor and delivery ("L&D") or following birth. Among high-income countries, the U.S. suffers one of the highest maternal mortality rates (MMR).[3]

Pregnancy-related deaths are deaths that occur within one year of pregnancy. Approximately one third (31 percent) occur during pregnancy, another third (36 percent) occur during labor or within the first week postpartum, and the remaining third (33 percent) occur one week to one year postpartum, underscoring the importance of access to health care beyond the period of pregnancy.[4]

The U.S. MMR is 32.9 per 100,000 live births and consistently rising each year.[5] For Black women,[6] the MMR is 69.9 deaths per 100,000 live births. Infants born to parents of color also face higher mortality rates than infants born to White parents.

Maternal *morbidity* rates in the U.S. are high, too. **Maternal morbidity** is defined by the World Health Organization "as any health condition attributed to and/or aggravated by pregnancy and childbirth that has negative outcomes" to the well-being of the birthing individual.[7] In the U.S., more than 50,000 women annually are affected by maternal morbidity.[8] The same disparities in health care inequity for people of color and low-income individuals exist with maternal morbidity.[9] Factors that increase maternal morbidity include: preexisting mental health conditions, lack of access to reproductive health care, previous trauma, stress during the prenatal period, and provider bias or discrimination. Maternal morbidity may occur during the prenatal, L&D, or postpartum period.

There are myriad reasons for the current maternal morbidity and mortality crisis. Frustratingly, about 84 percent of pregnancy-related deaths are considered preventable, according to data from state Maternal Mortality Review Committees.[10] Contributing factors to the MMR include "structural racism, poor maternal health, and socio-economic status."[11] Additionally, over 60 percent of pregnant people are fearful about childbirth, with Black pregnant people nearly twice as likely to express these concerns. This creates greater stress, which further contributes to higher risk of adverse pregnancy and birth outcomes.[12] Across the board, racial and ethnic minorities[13] and those of a lower socioeconomic status are more likely to experience maternal mortality and morbidity. Black MMRs are incredibly alarming. Even when other factors like age, income, and education are controlled,[14] Black patients face far lower health care quality and poorer health outcomes. This is due to health care provider biases and historic racism ingrained within our health care systems.

Poor maternal and infant health outcomes is a persistent problem in the U.S. There are many law and policy levers that may play a role in improving outcomes. Facilitating access to skilled, culturally competent doulas should be a focal policy for every state.

Doula Care May Reduce Maternal Mortality and Morbidity

What is a Doula?

DONA International, the largest doula certification organization in the U.S., defines **doula** as "a trained professional who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible."[15] While most states that regulate doula care have a unique statutory definition of doula, they are generally consistent with this definition.

Importantly, doulas provide care that is *non-medical*.[16] Doulas perform a variety of support tasks, including helping keep the birthing individual comfortable during L&D, providing emotional and spiritual support throughout the pregnancy and the postpartum period, suggesting breathing and posture techniques throughout labor, and advocating for the preferences of the birthing individual.[17] Much of this work directly addresses the factors that increase the risk of maternal morbidity and mortality. A doula and their client typically will meet ahead of birth to develop a relationship and discuss birth goals.[18] And the work of a doula does not end with birth; most doulas provide postpartum care, which may include telehealth visits or light housekeeping. This expansive practice is reflected in most state statutes, which include postpartum care within the doula scope of practice. Currently, most pregnant people who use doula services pay out-of-pocket, as most private and public insurers do not cover doula services.[19] Doula costs range, on average, from $500 to $3,500, depending on the services provided and the doula's level of experience.[20] These high costs are an insurmountable barrier for many pregnant individuals.

While all doulas support positive birth outcomes, there is a particular term used for doulas focused on clients from marginalized populations. A **community-based doula** is a community member doula who "specialize[s] in providing culturally sensitive care, addressing discrimination, and meeting language gaps."[21] With racial, ethnic, language, and other concordance with their clients, these doulas may best relate to their clients and improve health equity for minoritized groups. Community-based doulas also can serve as a source of trust for people of color, who more often distrust medical professionals and establishments because of longstanding racist practices.[22] Some states include a definition of community-based doula within their code.[23]

As explained fully below, some states' regulatory provisions apply differently to doulas based on their certification status. A **state-certified doula** is a doula who receives certification through a state statutory or regulatory scheme.[24]

What is Culturally Competent Care?

Culturally competent care helps decrease maternal mortality and morbidity, including for people of color. **Cultural competency** is "the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients."[25] Key components of culturally competent care involve provider recognition of differences between themselves and the patient, language accessibility, effective cross-cultural communication, and understanding.[26] Essentially, culturally competent care reflects the unique needs and lived experiences of the patients within the community, ensuring that regardless of an individual's background, they receive high quality care. Without this type of care, patients are more likely to feel dissatisfied with care, receive poor quality services, or suffer from negative health consequences. Currently, racial and ethnic minority groups in the U.S. report that they are less satisfied with their care and participate less in making medical decisions collaboratively with their physicians. Because culturally competent care increases safety and satisfaction, while decreasing inefficiencies, care disparities, and costs, the practice is beneficial to patients and health care providers. Doulas, particularly community-based doulas, are often trained to provide culturally competent care and may help a client receive better care.

Why is Doula Care Important?

Increasing access to doula care increases health equity[27] and improves maternal health outcomes generally. Doula care is associated with better physical and mental health outcomes during pregnancy, L&D, and postpartum.[28] For example, an individual who is supported by a doula throughout the birthing process is less likely to undergo a cesarean section ("c-section"), uses less pain medication throughout L&D, and experiences shorter labor and improved breastfeeding.[29] One study found that the c-section rate for women giving birth with a doula was less than half the rate for those without a doula. For those who had induced labor, only 12.5 percent of the women with a doula had a c-section, whereas 58.8 percent of women without a doula delivered by a c-section. Given the high risks associated with c-sections, this impact is life-changing. Avoiding c-section procedures also saves costs, as a vaginal birth is $13,024 on average, whereas a c-section is $22,646 on average.[30]

Mental health issues postpartum are also of particular concern, with increased risks of depression and suicide.[31] Doulas can provide emotional support post-birth to help manage these feelings. For instance, birthing individuals with a doula report lower stress and anxiety throughout the birthing process.[32]

Doulas provide other meaningful benefits. Doula care "help[s] reduce the impacts of racism and racial bias in health care on pregnant people of color."[33] Culturally competent care from a doula increases the confidence and autonomy of the birthing individual.[34] Doulas also help match expectations to reality for birthing individuals. People who recently gave birth expected their L&D nurse to spend about half of their time providing support to the patient, but in actuality, 10 percent or less of the nurse's time is typically spent providing support. Doulas can fill this gap and provide the support birthing people are craving throughout the birth experience.[35]

From Certification to Reimbursement: State Regulation of Doulas

Increasingly, states are taking steps to regulate doula care, certification, and coverage. While there are still a notable number of states that fail to regulate any part of doula services (or fail to do so through formal statutes or regulations), the U.S. is trending toward state regulation of doulas. Particularly, policy is emerging over doula certification requirements, training, and eligibility; Medicaid coverage for doula services; and doula advisory committees.

The regulatory framework in many states is currently a work in progress. Tennessee is a prime example; the state's Doula Services Advisory Committee, started in 2023, is now working on numerous initiatives, including creating standards for doula services, developing core competencies, proposing reimbursement rates for Medicaid and incentive-based

programs, and providing the state legislature with a report within 18 months as to their recommendations.[36] Though not reflected on our accompanying chart, some states authorize doula reimbursement or certification programs through agency guidance documents. Our research did not include a review of state guidance documents.

Certification

Historically, doulas could provide their services without securing certification.[37] Nevertheless, several national organizations established processes through which individuals may become certified as a doula; the requirements for certification vary. Some states require certification, which allows an individual to (1) receive the title of state-certified doula, and/or (2) register as an enrolled doula for Medicaid reimbursement. For example, Virginia grants the title of state-certified doula to any individual who receives certification from an organization approved by the State Board of Health.[38] In contrast, for New York, the purpose of doula certification is to get enrolled in the state doula directory for Medicaid reimbursement.[39]

The requirements for certification vary by state. However, some common requirements include paying fees, completing educational requirements and training programs, and receiving certification from a nationally recognized organization or state-approved organization.[40] These requirements are generally the same regardless of the certification purposes (title versus Medicaid reimbursement). Some states also require doulas to renew their certification. Typically, the certification renewal period is three years.[41]

At least six states provide for an amended certification process for “legacy” doulas, reciprocity for doulas registered in other states, or community-based doulas.[42] These amended processes allow a doula to receive state-recognized certification through a unique pathway. The latter exception is of particular interest, as it potentially can increase the availability of community-based doula services. For example, in Virginia, community-based doulas are allowed to use the title state-certified doula” as long as they received training, education, and certification from an approved entity, which is a pared down process.[43] In Washington, doulas who complete “ancestral pathway competencies … substantially equivalent to the required training” get certification, despite lacking other qualifications.[44]

Training and Eligibility Requirements

States impose training and eligibility requirements for doulas seeking certification. Training requirements typically include: completing training from a doula-certification organization, instruction in core competencies, observation of live births, serving as a doula during live birth (typically, at least three), and completion of first aid and CPR training.[45] Eligibility requirements often mandate that the applicant: is at least 18 years old, has a high school diploma or equivalent, signs a code of ethics, passes a background check or fingerprint clearance; provides reference or recommendation letters from people who attest to the training or experience of the doula or from previous clients, and, enroll in the Medicaid provider registry (where applicable).[46]

At least five states specify what content is required as part of the training curriculum for state certified or reimbursed doulas. Common training includes standards of practice and ethics, postpartum care and grief, communication skills, community resource referrals, and self-care. Some states also require doulas to receive training on scope of practice, the role of a doula on the birthing team, health literacy, newborn parenting education, emotional and psychosocial support, advocacy, and cultural doula practices.[47]

A number of states require state-certified doulas to participate in continuing education to keep their certification. The requirements vary by jurisdiction, as far as the hours of continuing education required and the topics covered. For example, Arizona requires 15 hours of general continued education,[48] whereas Washington state requires 10 hours of education, with at least five hours covering the birth doula practice and two hours addressing health equity.[49]

Medicaid Coverage and Reimbursement

Medicaid coverage of doula services is a key component to improving maternal health outcomes and equity, as 45 percent of all births are covered by Medicaid.[50] A state that intends to extend Medicaid coverage to doula services must

submit and get approval for a plan amendment from the Centers for Medicare and Medicaid Services (CMS)[51] and more states are doing so each year.[52] Pregnant Medicaid beneficiaries who received doula support during L&D exhibited lower c-section rates and higher rates of breastfeeding initiation.[53] Because birth complications, including c-sections, can be costly, doulas may help cut costs and ultimately save state Medicaid programs money.[54]

At least 20 states require some level of state Medicaid coverage of doula services (or are at least currently working to implement such coverage).[55] The level of coverage, reimbursement rates, and enrollment requirements vary greatly across the states. Even some states that lack comprehensive doula certification or regulation schemes may still reimburse doulas.[56] A number of states require, for reimbursement purposes, that the doula services are recommended by a physician or other healing arts licensed practitioner, before the state will cover the doula care.[57]

States that cover doula services through Medicaid must set reimbursement rates. Some of the first states to cover doula services have increased rates to upwards of $1,500 per pregnancy, in large part to increase doula registration and participation in the program.[58] While states that include doula services in Medicaid must set reimbursement rates, few do so in statute. Maryland and Minnesota are outliers. Maryland offers up to $494.96 in reimbursement, with $350 of that as a flat rate for services during L&D.[59] Minnesota codified a reimbursement rate, starting in 2024, of $100 per prenatal and postpartum visit and $1,400 for L&D.[60] The stark contrast between the reimbursement rates in Maryland and Minnesota highlights the diversity of potential income for Medicaid-enrolled doulas, depending on jurisdiction. Other states codify less-specific requirements on reimbursement rates. For example, Delaware requires a doula reimbursement rate “that supports a livable annual income for full-time practicing doulas.”[61]

Commonly, when states reimburse doula services through public insurance, the laws or regulations set limits on the number, length, and even types of visits.[62] The District of Columbia is a prime example. D.C. limits coverage of doula services to 12 visits total between the perinatal and postpartum periods, including L&D.[63] Any consultation is also included as one of these visits.[64] Postpartum visits are limited to six hours or less per visit.[65] Other states are less specific. For example, Massachusetts simply authorizes “up to 8 hours of perinatal visits per member … and one labor and delivery support per perinatal period.”[66] A birthing individual could still receive doula services after hitting the covered limit of visits, but only if they pay out-of-pocket.

Doula Advisory Committees, Maternal Mortality Review Committees, and Health Equity

Many states have implemented doula advisory boards or committees tasked with advising the state government on doula policies.[67] Often these committees are key in initiating and shaping jurisdictional certification and reimbursement requirements and processes. Many states require the committee to appoint at least one member who is a doula.[68] Tennessee takes this a step further by requiring two community-based doulas with experience providing services to Medicaid recipients in areas “with high rates of maternal and infant mortality” to serve on the Doula Services Advisory Committee and advise the State Department of Health.[69]

Many of these entities are also looking to address health equity, culturally congruent care, and the Black MMR. For example, New Jersey established a Maternal Care Quality Collaborative to “work with the Governor's office to coordinate all efforts and strategies to reduce maternal mortality, mobility, and racial and ethnic disparities," with at least one member who is an expert in doula services.[70] In Colorado, the maternity advisory committee must be "composed predominantly of Black, Indigenous, and other people of color with maternity care experience as recipients."[71] Additionally, some states mandate that their Maternal Mortality Review Committee include a doula as a member.[72] For example, Massachusetts requires that two doulas be included on the state Maternal Mortality and Morbidity Review Committee.[73]

Expanding Doula Care Access and Coverage Through Policy

After reviewing the current legal and policy landscape of doula care, one can identify ample opportunities and hurdles to increasing access and awareness. The main policy efforts to focus on are: (1) Improving Coverage of Doula Services

Through Greater Affordability & Accessibility; (2) Inclusion of Cultural Competency Training; and (3) Increasing Awareness of Doula Care.

Improve Coverage of Doula Services Through Greater Affordability and Accessibility

Increase Reimbursement Rates for Doula Services Covered Under Medicaid

One effective measure to increase access is to set higher Medicaid reimbursement rates for doula services.[74] Reimbursement rates are currently set too low to incentivize or make it feasible for doulas to participate and enroll as Medicaid providers. Costs associated with meeting Medicaid certification requirements, coupled with low reimbursement rates, create a barrier to entry and to financial viability for doula practice.[75] The low number of enrolled doulas severely limits the potential positive impact of these policies, particularly for marginalized communities.[76]

States are not compensating doulas within the Medicaid program at market rate, indicating a need to put greater value on these services, especially for community-based doulas. Commonly, the state reimbursement rates are so low they inhibit a doula from making a living wage.[77] Early implementers, like Oregon and Maine, experienced the hindrance of low reimbursement rates on creating meaningful impact through Medicaid reimbursement for doula services. Thus, both states submitted amended plans to CMS and now will give up to $1,500 in reimbursement to a doula per pregnancy.[78] For comparison, Oregon started reimbursement rates at $75 for attending L&D.[79] After Oregon increased the reimbursement rate, the state experienced an increase in the number of doulas joining the state registry.[80] This supports the conclusion that a fair wage will attract more doulas for Medicaid beneficiaries, who comprise over 40 percent of birthing individuals.

Remove Hurdles to Enrollment in Medicaid Reimbursement Programs

Enrolling in Medicaid as a doula provider or certified doula can take a lot of time, energy, and expense. Doulas often work as solo practitioners without administrative support to process billing and meet insurance requirements.[81] Even if a doula wanted to provide Medicaid covered services, the administrative burden of getting paid might create a barrier.[82] States that are working to implement greater doula coverage should eliminate needless barriers and possibly implement support services for doulas seeking to enroll.

Cost is another primary hurdle to enrollment. To register with a doula training and certification program, costs range from $800 to $1,200.[83] This does not include the cost of registration with the state. Almost every state that mandates certification imposes a registration fee, ranging from $100 to $300.[84] More states should follow New York's lead; if certification is required, do not require a registration fee.[85] The same is true for renewal fee requirements. States should also fund and subsidize the costs of training and certification to increase the doula workforce. One way to do so is through funding from grant programs or need-based financial aid for enrollment fees, certification costs, or training expenses.[86] Some states are already implementing these initiatives. Colorado set up a doula scholarship funding program for doula trainees who lack the financial ability to complete needed training and certification.[87] Ohio waives the certification and renewal fees for doula certification applicants with a family income below 200 percent of the federal poverty line.[88] Creative options exist to incentivize and support doula certification and registration.

Require All Insurers/Payers to Cover Doula Services

An effective—yet quite difficult to achieve—method of increasing access to doula services is to require that all health insurance policies that cover pregnancy and childbirth also cover doula services. Only two states currently require all insurers to provide doula coverage: Rhode Island and Louisiana.[89] The Rhode Island law became effective on July 1, 2022;[90] the Louisiana law went into effect on January 1, 2024.[91] In Louisiana, the legislature cited the "well-established benefits of maternity support services provided by doulas," including lower rates of c-sections, obstetric intervention, complications during L&D and postpartum, pain medication use, and labor hours as part of the legislative findings that support this policy.[92] As states continue to tailor their doula coverage and certification programs, it would be impactful to add this universal coverage requirement for all insurers, rather than limiting coverage to Medicaid recipients. In part, this is because for Black women, education and income levels do not change the high MMR.[93]

Greater Access for Doulas to Enter Hospitals

One opportunity to encourage greater doula presence during labor is to require hospitals and birthing centers to allow doulas access as staff during L&D, if requested by the birthing individual. Currently, some hospitals qualify doulas as a general visitor, not a member of the birthing team.[94] With limitations on the number of visitors in the L&D room, especially post COVID, doulas may face access limitations during this critical phase of the pregnancy. Legislatures can enact statutes that require health facilities to allow the birthing individual to have a doula by their side during L&D, to make it easier for doulas to provide care.[95]

Invest in Hybrid/Virtual Doula Care

To provide easier access to doula care, states can invest in or more broadly allow virtual/hybrid doula care.[96] By allowing doula services over a telehealth model, access will improve, especially for those in rural areas where in-person services are typically less available. Florida is working in two counties to implement such policies. Duval and Orange County are required to establish a telehealth pilot program for minority maternity care to improve maternal health outcomes.[97] Conversely, other states, like Maryland and Oklahoma, prohibit telehealth doula services during the L&D.[98] These states should remove telehealth prohibitions, as virtual doula care can help provide greater access, particularly to needed postpartum support.

Expand Statutory Postpartum Period

Expanding the postpartum period to a full year, rather than just 60 or 180 days, is crucial to address the full spectrum of postpartum struggles and provide holistic care to birthing individuals. The specified postpartum period varies greatly by state, with the shortest period as six weeks post-delivery in Arizona[99] and the longest in states like Illinois and Minnesota as a full year post delivery.[100] All states should adopt the latter period. This change can directly mitigate the high MMR, specifically the higher rate for racial and ethnic minorities.[101]

Create More Legacy Pathways and Adopt Alternative Certification Models

As discussed above, some states enact alternative pathways to certification. If more states put in place pathways for community-based doulas, legacy doulas, and multi-state doulas, there likely will be a greater supply of certified doulas. This can also be done by decreasing restrictions on the specific certification organizations that can provide state-certification.[102]

Remove Restrictions on Coverage of Visits

States can improve access to doulas by removing limitations on the length of each visit and the total number of reimbursable visits allowed from a doula under the state Medicaid program. For example, a state like Maryland, which currently limits Medicaid coverage of doula services to eight prenatal or postpartum visits and one L&D service,[103] could increase the maximum number of prenatal and postpartum visits, to better support the needs of a birthing person throughout the entire pregnancy. What Maryland does well--not placing time limits on the doula visits.[104] Oklahoma is also innovating in the visit space by requiring all Medicaid reimbursed visits to be at least 60 minutes.[105] Other states should follow the lead of Maryland and Oklahoma by removing time restrictions on doula visits to allow for greater potential for doulas to meet the needs of the birthing individual.

Inclusion of Cultural Competency Training and Services

To address Black MMR and the lack of doula access to those from lower socioeconomic backgrounds, including cultural competency training as a mandatory part of all state certification policies is imperative. Many states require some sort of cultural competence training,[106] but these policies are not widespread or specific enough. Washington state provides a strong model for how to implement this suggestion, by explicitly requiring any doula seeking certification to complete cultural congruency and ancestral practice training and education.[107]

Increase Awareness About Doula Care

Increase Doula Participation as Members of State Maternal Mortality Review Committees

As discussed above, numerous states have established some form of a doula advisory committee or board that addresses the substance and implementation of doula care regulations, often requiring that a doula be appointed to that

committee. However, only a handful of states require a doula to serve as part of their Maternal Mortality Review Committee.[108] Increasing doula representation on these committees is a useful policy tool to improve awareness and understanding of how doula services and perspectives can address the MMR.

Maternal Mortality Review Committees are tasked with investigating pregnancy-associated deaths, reporting on outcomes, and providing recommendations to the state on how to address these outcomes.[109] Forty-nine states (all but Idaho) and the District of Columbia established formal Maternal Mortality Review Committees. Fourteen of these committees also evaluate maternal morbidity as part of their work and ten states, along with D.C., explicitly consider racial equity in their review. Since states already have these committees in place, mandating that a doula member be appointed is a low-cost, low-administrative burden option that can greatly increase awareness of a doula's role, both in care and in health equity. And it signifies the importance of doulas in preventing maternal morbidity and mortality, sending a strong message of support. Further, community-based doulas can provide needed insight on how to best address the high MMR for historically underrepresented communities.

Educate the Public and Professionals About the Role of Doulas
Increasing awareness about the role and availability of doulas, both amongst the public and physicians, can increase doula usage. Community outreach, particularly in communities with higher MMRs, may help facilitate greater reliance on doula services. "[E]ducat[ing] medical professionals on the role and benefits of doula care, and ways doulas can be included in care teams" can ensure these professionals more frequently recommend doula services and include doulas during L&D.[110] Another way to increase awareness is by requiring certain organizations to promote doula services and access information. For example, Oregon requires coordinated care organizations to provide information on how to access doula services on their websites and in print.[111]

Conclusion

Increasing doula access and affordability is an exciting and effective way to reduce the high maternal mortality and morbidity rates in the U.S. While at least 25 states currently implement some sort of doula certification or coverage policy, making doula care truly available to all should be a policy priority. Contact the Network to learn more about the laws and opportunities in your state.

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[24] E.g., ARIZ. REV. STAT. § 36-766; CONN. GEN. STAT. § 20-86bb; VA. CODE § 32.1-77.1; WASH. REV. CODE § 18.47.040; WASH. ADMIN. CODE § 246-835-005.

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[26] *How to Improve Cultural Competence in Health Care*, TULANE UNIV. (Mar. 1, 2021), https://publichealth.tulane.edu/blog/cultural-competence-in-health-care/.

[27] Tomás Guarnizo & Maggie Clark, *Doula Services in Medicaid: Pathways and Payment Rates (Part 3 in a series)*, GEO. UNIV., CTR. FOR CHILD. & FAMILIES (Oct. 6, 2022), https://ccf.georgetown.edu/2022/10/06/doula-services-in-medicaid-pathways-and-payment-rates/.

[28] Sobczak, *supra* note 12.

[29] CLEVELAND CLINIC, *supra* note 169.

[30] Singer-Miller, *supra* note 144, at 506.

[31] 2022 REPORT, *supra* note 133.

[32] Salamon, *supra* note 18.

[33] *Doula Medicaid Project*, NAT'L HEALTH L. PROGRAM, https://healthlaw.org/doulamedicaidproject/ (last visited March 12, 2024).

[34] Sobczak, *supra* note 1212.

[35] Landor, *supra* note 144, at 101. *See generally* Kenneth J. Gruber et al., *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[36] *Doula Services Advisory Committee*, TENN. DEP'T OF HEALTH, https://www.tn.gov/health/health-program-areas/fhw/rwh/doula-services.html (last visited March 11, 2024).

[37] Salamon, *supra* note 18.

[38] 12 VA. ADMIN. CODE § 5-403-40.

[39] N.Y. PUB. HEALTH § 2594-c.

[40] E.g., ARIZ. ADMIN. CODE § 9-16-902; D.C. CODE § 3-1205.04; MD. CODE, HEALTH-GEN. § 15-141.4; MINN. STAT. § 148.996; N.Y. PUB. HEALTH § 2594-c; OHIO REV. CODE § 4723.89; OKLA. ADMIN. CODE § 317:30-5-1216; 12 VA. ADMIN. CODE § 5-403-20; WASH. REV. CODE § 18.47.020; WASH. ADMIN. CODE § 246-835-030.

[41] E.g., ARIZ. REV. STAT. § 36-766.01; MINN. STAT. § 148.996; OR. ADMIN. R. 950-060-0060.

[42] E.g., ARIZ. REV. STAT. § 36-766.03; CONN. GEN. STAT. § 20-86bb; 130 Mass. Code. Regs. 463.404; OR. ADMIN. R. 950-060-0040; TEX. GOV'T CODE § 531.653; VA. CODE § 32.1-77.1; 12 VA. ADMIN. CODE § 5-403-30; WASH. ADMIN. CODE § 246-835-022; WASH. ADMIN. CODE § 246-835-040.

[43] VA. CODE § 32.1-77.1; 12 VA. ADMIN. CODE § 5-403-30.

[44] WASH. ADMIN. CODE § 246-835-022; WASH. ADMIN. CODE § 246-835-040.

[45] ARIZ. REV. STAT. § 36-766.03; CONN. GEN. STAT. § 20-86bb; D.C. CODE § 3-1201.01; 130 MASS. CODE. REGS. 463.404; NEV. REV. STAT. § 422.27177; OR. ADMIN. R. 950-060-0150; OR. ADMIN. R. 950-060-0060; 12 VA. ADMIN. CODE § 5-403-30; 12 VA. ADMIN. CODE § 5-403-20; WASH. ADMIN. CODE § 246-835-015.

[46] ARIZ. ADMIN. CODE § 9-16-902; ARIZ. ADMIN. CODE § 9-16-902; CONN. GEN. STAT. § 20-86bb; D.C. MUN. REGS. tit. 29, § 11202; 130 MASS. CODE. REGS. 463.404; N.Y. PUB. HEALTH § 2594-c; OKLA. ADMIN. CODE § 317:30-5-1216; OR. ADMIN. R. 950-060-0060

[47] *See, e.g.*, ARIZ. ADMIN. CODE § 9-16-901; OR. ADMIN. R. 950-060-0150.; 12 VA. ADMIN. CODE § 5-403-50; WASH. ADMIN. CODE §§ 246-835-020, 246-835-030, 246-835-025.

[48] ARIZ. REV. STAT. § 36-766.01.

[49] WASH. ADMIN. CODE § 246-835-060.

[50] Safon, *supra* note 3.

[51] Sarah Hart, *It Takes a Village: Pathways for Achieving Access to Doula Services for Medicaid Enrollees,* 30 GEO. J. POVERTY L. & POL'Y 97, 102 (2022).

[52] Ganny Belloni, *Maternal Health Woes Prompting States to Turn to Doula Care*, BLOOMBERG L. (Dec. 16, 2022, 5:35 AM), https://news.bloomberglaw.com/health-law-and-business/maternal-health-woes-prompting-states-to-turn-to-doula-care.

[53] Kathleen Knocke et al., *Doula Care and Maternal Health: An Evidence Review*, ASSISTANT SEC. FOR PLANNING & EVAL. (Dec. 13, 2022), https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.

[54] Guarnizo & Clark, *supra* note 217; Singer-Miller, *supra* note 144, at 516.

[55] CAL. WELF. & INST. CODE § 14105.201; CAL. WELF. & INST. CODE § 14105.202; COLO. REV. STAT. § 25.5-4-506; DEL. CODE ANN. tit. 31, § 530; D.C. CODE § 3-1206.72; D.C. MUN. REGS. tit. 29, § 11201; 305 ILL. COMP. STAT. 5/5-18.10; 305 ILL. COMP. STAT. 5/5-18.5; IND. CODE § 12-15-5-7; LA. STAT. § 22:1059.1; LA. STAT. § 22:1059.2; MD. CODE, HEALTH-GEN. § 15-141.4; MD. CODE REGS. 10.09.39.06; 130 MASS. CODE. REGS. 463.401, 463.403, 463.406-407; MINN. STAT. § 256B.625; NEV. REV. STAT. § 422.27177; N.H. REV. STAT. § 126-A:99; N.J. STAT. § 30:4D-6; N.Y. PUB. HEALTH § 2594-c; OHIO REV. CODE § 5164.071; OKLA. ADMIN. CODE § 317:30-5-1215; OR. ADMIN. R. 410-130-0015; OR. ADMIN. R. 410-141-3590; 27 R.I. GEN. LAWS §§ 27-18-75, 27-18-79, 27-18-87, 27-18-92; TEX. HUM. RES. CODE § 32.024; UTAH CODE § 49-20-422.

[56] E.g., TEX. HUM. RES. CODE § 32.024.

[57] E.G., OKLA. ADMIN. CODE § 317:30-5-1217.

[58] Belloni, *supra* note 512.

[59] MD. CODE REGS. 10.09.39.06.

[60] MINN. STAT. § 256B.758.

[61] DEL. CODE ANN. tit. 31, § 530.

[62] E.g., MD. CODE REGS. 10.09.39.04; OKLA. ADMIN. CODE § 317:30-5-1217.

[63] D.C. CODE § 3-1201.03.

[64] D.C. CODE § 3-1201.04.

[65] D.C. CODE § 3-1203.05.

[66] 130 MASS. CODE. REGS. 463.409.

[67] E.g., ARIZ. REV. STAT. § 36-766.02; COLO. REV. STAT. § 25.5-4-506; CONN. GEN. STAT. § 20-86bb; D.C. CODE §§ 7-743.09, 7-671-03; 20 ILL. COMP. STAT. 5145/10; IND. CODE § 12-8-6.5-14; N.J. STAT. § 26:18-3; OHIO REV. CODE § 4723.90; TENN. CODE § 63-15-103; TENN. CODE § 63-15-104.

[68] E.g., ARIZ. REV. STAT. § 36-766.02; IND. CODE § 12-8-6.5-14; LA. STAT. § 22:1059.1; OHIO REV. CODE § 4723.90; TENN. CODE § 63-15-104.

[69] TENN. CODE § 63-15-104.

[70] N.J. STAT. § 26:18-3.

[71] COLO. REV. STAT. § 25.5-4-506.

[72] E.g., D.C. CODE §§ 7-743.09, 7-671-03; MASS. GEN. LAWS ch. 111, § 24O; OR. REV. STAT. § 432.600.

[73] MASS. GEN. LAWS ch. 111, § 24O.

[74] Guarnizo & Clark, *supra* note 27.

[75] Roux, *supra* note 1.

[76] Belloni, *supra* note 512.

[77] Landor, *supra* note 4, at 104.

[78] Belloni, *supra* 512.

[79] Guarnizo & Clark, *supra* note 27.

[80] Safon, *supra* note 3.

[81] Guarnizo & Clark, *supra* note 27.

[82] Knocke, *supra* note 533.

[83] Singer-Miller, *supra* note 144, at 530.

[84] E.g., ARIZ. ADMIN. CODE § 9-16-909; CONN. GEN. STAT. § 14.

[85] N.Y. PUB. HEALTH § 2594-b.

[86] Guarnizo & Clark, *supra* note 217.

[87] COLO. REV. STAT. § 25.5-4-506.

[88] OHIO REV. CODE § 4723.89.

[89] 27 R.I. GEN. LAWS §§ 27-18-75, 27-18-79, 27-18-87, 27-18-92; LA. STAT. § 22:1059.2.

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[91] Josie Abugov, *'Game Changer': New Law Covers Doula Services for Private Insurance*, LA. ILLUMINATOR (Aug. 1, 2023 6:00 AM), https://lailluminator.com/2023/08/01/game-changer-new-law-covers-doula-services-for-private-insurance/.

[92] LA. STAT. § 22:1059.2.

[93] Knocke, *supra* note 533. *See generally* Landor, *supra* note 144.

[94] Deise De Los Santos, *I'm an Ob-Gyn. Here's Why I Had a Doula Help With My Delivery*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (July 2023), https://www.acog.org/womens-health/experts-and-stories/the-latest/im-an-ob-gyn-heres-why-i-had-a-doula-help-with-my-delivery.

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[96] Waymouth, *supra* note 1.

[97] FL. STAT. § 383.2163.

[98] MD. CODE REGS. 10.09.39.05; OKLA. ADMIN. CODE § 317:30-5-1217.

[99] ARIZ. ADMIN. CODE § 9-16-901.

[100] 305 ILL. COMP. STAT. 5/5-18.5; MINN. STAT. § 256B.795.

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[104] MD. CODE REGS. 10.09.39.04.

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[106] E.g., ARIZ. REV. STAT. § 36-766.02; D.C. CODE § 3-1201.01; OR. ADMIN. R. 950-060-0150; 12 VA. ADMIN. CODE § 5-403-10; WASH. ADMIN. CODE § 246-835-015.

[107] WASH. ADMIN. CODE § 246-835-015.

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[111] OR. REV. STAT. § 414.668.