



Re: *Doula Services: Medicaid Reimbursement, Certification, and Fiscal Notes*

EXECUTIVE SUMMARY

Among the 15 member states of the CSG South region, Virginia is currently the only state with enacted legislation explicitly directing Medicaid reimbursement for doula services. No other Southern state has enacted a statewide Medicaid doula reimbursement benefit or a state doula certification framework in statute as of December 2025.

Recent national tracking, including the [National Health Law Program’s Doula Medicaid Project: February 2024 State Roundup](#), provides additional context for Southern states. **That analysis confirms that within the CSG South region, most doula-related activity occurs through Medicaid managed care options, pilot programs, or certification frameworks, rather than through statewide Medicaid fee-for-service benefits enacted in statute.**

Specifically, [Florida](#) allows doula services as an optional benefit within Medicaid managed care plans; [Oklahoma](#) has reported Medicaid coverage implemented administratively without a clearly identified statutory mandate; and [Louisiana](#) has enacted doula certification and private insurance coverage requirements without establishing Medicaid reimbursement. [Georgia](#) and [Alabama](#) are identified as having pilot programs or adjacent initiatives rather than statewide Medicaid benefits. Virginia, researched more deeply below, remains the sole Southern state with comprehensive statutory direction for Medicaid reimbursement of doula services.

States that have expanded access to doula care have generally done so through two policy mechanisms:

- Medicaid reimbursement for doula services, typically implemented through a Medicaid State Plan Amendment (SPA) or waiver authority, sometimes directed by statute; and
- Certification, credentialing, or registry frameworks, most often to establish minimum qualifications for Medicaid participation rather than professional licensure.

As a result, most enacted doula reimbursement policies nationally are concentrated outside the Southern region. States vary in whether these policies are enacted directly in statute or implemented through administrative action. Fiscal documentation also varies by state.

FINDINGS AND ANALYSIS

Medicaid Reimbursement for Doula Services: Enacted or Implemented

State	Policy Mechanism	Legislative Reference	Fiscal Documentation
Minnesota	<p>Medicaid reimbursement; state “certified doula” registry</p> <p>Minnesota established a Certified Doula Registry under Minnesota Statute §§ 148.995–148.996, requiring DHS (Human Services) to cover doula services under Medicaid for eligible, certified providers, though implementation details</p>	<p>Minn. Stat. §§ 148.995–148.996</p>	DHS budget materials



	and specific reimbursement rates are found within. The state aims to recognize doula care who meet criteria from approved organizations, integrating them into the state system to expand maternal care, with DHS budget materials detailing funding for this mandate.		
New Jersey	<p>Medicaid doula benefit</p> <p>New Jersey's Senate Bill 1784 (2019) mandated Medicaid coverage for doula care, aiming to improve maternal health, especially for minorities, and while the bill itself didn't detail precise dollar impacts, it allocated \$1 million in the state budget for pilot support, acknowledging doula care's cost-effectiveness by reducing C-sections and interventions, with implementation requiring federal approval and leading to state-level funding and evolving reimbursement rates to encourage provider participation, as explained in official documents and analyses from groups like the National Health Law Program.</p>	<p>Senate Bill 1784 (2019)</p>	<p>Fiscal impact discussed in bill</p>
Maryland	<p>Medicaid doula pilot program</p> <p>Maryland's Senate Bill 163 (2021) and Senate Bill 166 (2022) established a Medicaid doula pilot program, evolving into permanent coverage for healthier pregnancies, requiring provider enrollment, NPIs, & contracts with MCOs, aiming to reduce maternal disparities by offering comprehensive doula support (antenatal, labor, postpartum) via State Plan Amendments and implementing requirements like training & billing, detailed in formal notes available via Maryland Health/Legislative sites.</p> <p><i>Senate Bill 163 (2021):</i> Initiated the groundwork for studying and implementing doula coverage within Maryland Medicaid.</p> <p><i>Senate Bill 166 (2022):</i> Carried forward these efforts, leading to the formal establishment and</p>	<p>Senate Bill 163 (2021); Carried Forward Senate Bill 166 (2022)</p>	<p>Senate Bill 163 Formal Fiscal & Policy Note</p>



	authorization of the pilot program, with later legislation making coverage permanent.		
California	<p>Medi-Cal doula benefit</p> <p>California's Medi-Cal doula benefit, established via Senate Bill 65 (2021) and the state's Budget Act, covers non-medical birth support for low-income families, aiming to improve maternal health outcomes, especially for Black and Indigenous birthing people, with reimbursement rates negotiated in the budget process (up from initial offers to around \$1154/birth). The benefit provides prenatal, labor/delivery, and postpartum support, with implementation led by the Department of Health Care Services (DHCS) and a required report by July 2025 detailing usage.</p> <p>Budget analyses from groups like the LAO and CPEHN tracked funding and policy details, showing initial debate on rates but ultimate approval of significant funding for this preventive care service.</p> <p><i>Senate Bill 65 (2021) ("M omnibus"):</i> Originally included detailed doula care, but its implementation language was moved to the budget, though the bill still pushed for comprehensive, full-spectrum support (prenatal, labor, postpartum, miscarriage, abortion).</p> <p><i>Budget Act (2021-2022):</i> Funded the Medi-Cal doula benefit as a preventive service, with initial proposals from the Governor initially lower (\$450) but later increased significantly through negotiations</p>	<p>Senate Bill 65 (2021) + Budget Act</p>	Budget analyses
Rhode Island	<p>Doula service coverage</p> <p>In 2021, Rhode Island passed legislation (House Bill 5929), making doula services reimbursable by</p>	<p>H5929 / S0484 (2021)</p>	Legislative fiscal notes weren't included; however, the Medicaid SPA document (RI-21-



	<p>private insurance and adding them as a benefit under Medicaid.</p> <p><i>Medicaid Coverage:</i> Implemented via a State Plan Amendment (SPA) with a retroactive start of January 1, 2021, providing a maximum of \$1,500 per client.</p> <p><i>Reimbursement Structure (Medicaid):</i> A set fee system: up to 6 prenatal/postpartum visits at \$100 each, plus \$900 for labor and delivery support.</p> <p><i>Permanent Program:</i> Funding for the Medicaid doula program was made permanent in 2022.</p>		<p>0013) details the Medicaid plan, which received approval in February 2021</p>
Nevada	<p>Medicaid doula coverage</p> <p>Nevada's AB 256 (2021) mandated Medicaid coverage for doula services, requiring the state to seek federal approval for reimbursement, which led to a State Plan Amendment (SPA) approval in 2022, making doula care a benefit starting April 1, 2022, with increased reimbursement rates (e.g., from \$450 to \$1,650) implemented later to address care deserts. The bill aimed to reduce disparities, and its fiscal note projected savings for the state, largely due to federal matching funds.</p>	<p>Assembly Bill 256 (2021)</p>	<p>Bill identifies fiscal note</p>
Massachusetts	<p>MassHealth doula coverage</p> <p>Massachusetts's 2022 Maternal Health Law mandated MassHealth doula coverage, expanding access to prenatal, labor, birth, and postpartum support, with limits like \$1,500 per pregnancy and specific training/certification for doulas, aiming to improve maternal outcomes, though full implementation involved fiscal planning and advisory boards to integrate it sustainably within the MassHealth system for better racial equity in maternal care. The 2024 MassHealth actions represent the implementation phase of the 2022 law.</p>	<p>2022 Maternal Health Law</p>	<p>MassHealth fiscal planning</p>



<p>Oregon</p>	<p>Medicaid reimbursement via the Traditional Health Worker (THW) model</p> <p>Oregon's Medicaid (Oregon Health Plan - OHP) reimburses THWs like CHWs, Doulas, Peer Specialists, etc., through specific rules in Oregon Revised Statutes (ORS) & Oregon Administrative Rules (OARs), implemented by OHA's THW Commission, requiring certification & billing by Managed Care Organizations (MCOs) for covered services, focusing on culturally responsive care to improve health equity for diverse populations.</p>	<p>ORS; OHA rules</p>	<p>Administrative implementation</p>
<p>Virginia</p>	<p>Medicaid reimbursement for postpartum doula care</p> <p>The Governor has approved Virginia's House Bill 1614 from the 2025 session, and it is now law (Chapter 690, effective July 1, 2025). House Bill 1614 expands Virginia's Medicaid coverage for doula services, increasing the total covered visits to ten (up to four prenatal and six postpartum within 12 months) and allowing additional visits if medically necessary. The covered services include emotional and physical support, assistance with infant care, education, and connecting families to community resources. The Department of Medical Assistance Services (DMAS) is required to report annually on the program's implementation and outcomes starting December 31, 2026. A fiscal impact statement noted increased expenditures resulting from the expansion of covered visits.</p>	<p>House Bill 1614 (2025)</p>	<p>Fiscal Impact Statement issued</p>

Doula Certification or Credentialing Policies

States generally do not license doulas as a regulated health profession. Instead, certification or training standards are used to support participation in Medicaid.

State	Certification / Credentialing Approach	Authority
Minnesota	Statutory “certified doula” registry	State statute



SOUTH

ALABAMA • ARKANSAS • FLORIDA • GEORGIA • KENTUCKY • LOUISIANA • MISSISSIPPI • MISSOURI
 NORTH CAROLINA • OKLAHOMA • SOUTH CAROLINA • TENNESSEE • TEXAS • VIRGINIA • WEST VIRGINIA

	<p>Minnesota has a statutory certified doula registry, established by Minnesota Statutes, sections 148.995 to 148.997, managed by the MN Dept. of Health (MDH) to list doulas certified by approved organizations, requiring background checks, fees, and annual certification from a designated body for inclusion, ensuring quality care and allowing for Medicaid/MinnesotaCare reimbursement.</p>	
Washington	<p>Voluntary state certification as health profession</p> <p>Washington's House Bill 1881 from the 2022 legislative session was signed into law by the Governor on March 30, 2022 (certification process took effect on October 1, 2023), and created a new, voluntary state certification process for birth doulas as a health profession. The bill designates the Department of Health (DOH) as the disciplining authority under the Uniform Disciplinary Act (UDA) for certified birth doulas. It outlines the requirements for certification, such as completing required competencies and not having engaged in unprofessional conduct. The legislation followed a 2020 requirement that the Washington State Health Care Authority (HCA) reimburse for maternity support services provided by doulas, with the new certification intended to facilitate this reimbursement.</p>	<p>House Bill 1881 (2022)</p>
Oregon	<p>Traditional Health Worker certification</p> <p>Oregon's Traditional Health Worker (THW) certification is governed by the Oregon Health Authority (OHA) under specific Oregon Administrative Rules, primarily focusing on roles like Community Health Workers, Doulas, and Peer Support Specialists, requiring training, experience, and background checks for official registration, with key rules detailed in OAR Chapter 410, particularly around legacy applications (OAR 410-180-0325) and approved training providers.</p>	<p>Administrative rule</p>
California	<p>Doula training or experience pathways for Medi-Cal</p> <p>To become a Medi-Cal doula in California, a person must meet the California Department of Health Care Services (DHCS) requirements (18+, CPR, HIPAA training) <i>and</i> choose between a Training Pathway (16+ hours training, 3+ births) or an Experience Pathway (5+ years active doula work), then enroll via the Provider Application and Validation for Enrollment (PAVE) portal to join the official directory and provide</p>	<p>DHCS policy</p>



	reimbursable care throughout pregnancy, birth, postpartum, and even abortion/miscarriage support.	
New Jersey	<p>Approved doula training programs for Medicaid</p> <p>To become a Medicaid-approved doula in New Jersey, a person must complete an approved training program, like Community Doulas of South Jersey (CDOSJ), meet state competency/experience requirements, and register with NJ FamilyCare, with CDOSJ offering training that meets these requirements, including community-based models emphasizing cultural competency for diverse communities. Key providers include CDOSJ and programs associated with CHSNJ (AMAR), which focus on culturally relevant support. Training covers over 24 hours of skills and client support for eligibility.</p> <p><i>Community-based models:</i> Medicaid-approved doula training blends national standards (like DONA, CAPP) with unique state requirements, often through local programs such as the Perinatal Health Equity Initiative (PHEI), which offers scholarships and hospital partnerships for culturally competent care, focusing on underserved communities, and supporting the whole credentialing process to become a New Jersey Medicaid provider.</p>	Administrative rule
Maryland	<p>Approved certification for pilot participation</p> <p>Maryland offers a Medicaid doula benefit, which requires state certification for pilot participation. Approved doulas are reimbursed for services such as pregnancy & postpartum support, leveraging established training programs like DONA International and CAPP, under a CMS-approved plan. This makes doulas accessible via Medicaid.</p>	Statute

Fiscal Notes and Fiscal Impact Statements

States vary considerably in how they document the fiscal implications of policies related to Medicaid reimbursement for doula services. The differences are mainly driven by legislative drafting practices, Medicaid financing structures, and whether implementation is directed by statute or delegated to the Medicaid agency.

Some states prepare formal fiscal notes or fiscal impact statements that accompany doula-related legislation as it moves through the legislative process. In these states, legislators had access to a standalone fiscal document during consideration of doula legislation, often because the bill explicitly created a new benefit, pilot, or provider type in statute.

- **Maryland**



- Maryland’s Senate Bill 163 (2021), which established a Medicaid doula pilot program, was accompanied by a [Fiscal and Policy Note](#) prepared by the Department of Legislative Services.
- The fiscal note identified expected general fund and federal fund expenditures, administrative costs, and assumptions about utilization during the pilot period.
- Because the policy was established explicitly in statute and structured as a pilot, Maryland’s legislative process required a detailed fiscal analysis before enactment.
- **Virginia**
 - Virginia’s House Bill 1614 (2025), directing Medicaid reimbursement for postpartum doula services, included a [Fiscal Impact Statement](#) prepared by the Department of Planning and Budget.
 - The statement estimated costs based on the number of covered visits, projected utilization, and the federal Medicaid matching rate.
 - Virginia’s approach reflects its standard practice of attaching fiscal impact statements to legislation that directs Medicaid benefit changes.
- **Nevada**
 - Nevada’s AB 256 (2021), which authorized Medicaid coverage of doula services, explicitly indicated that a [fiscal note was required](#).
 - While the bill text flags fiscal impact, detailed cost estimates are typically found in legislative fiscal notes or budget work sessions rather than embedded in statute.
 - Nevada’s fiscal documentation reflects anticipated state and federal Medicaid expenditures tied to benefit implementation.

In other states, fiscal effects are discussed through bill analyses, committee reports, or Medicaid budget materials, rather than through a single, formal fiscal note. For example, states such as New Jersey, California, and Rhode Island discussed fiscal impacts in legislative analyses or budget documents tied to Medicaid expansions, rather than issuing a separate fiscal note solely focused on doula services.

Where doula benefits are implemented administratively—for example, through a Medicaid State Plan Amendment or agency rulemaking—fiscal impacts are often reflected in: annual or biennial Medicaid budgets, agency fiscal projections submitted to CMS, or internal actuarial or rate-setting documents. The absence of a bill-specific fiscal note does not indicate a lack of cost analysis; instead, the analysis occurs within the Medicaid budgeting and federal approval process. In these cases, the legislature may authorize or encourage coverage; however, detailed cost projections are developed by the Medicaid agency as part of its ongoing program administration.