



The ROI of Community Care:

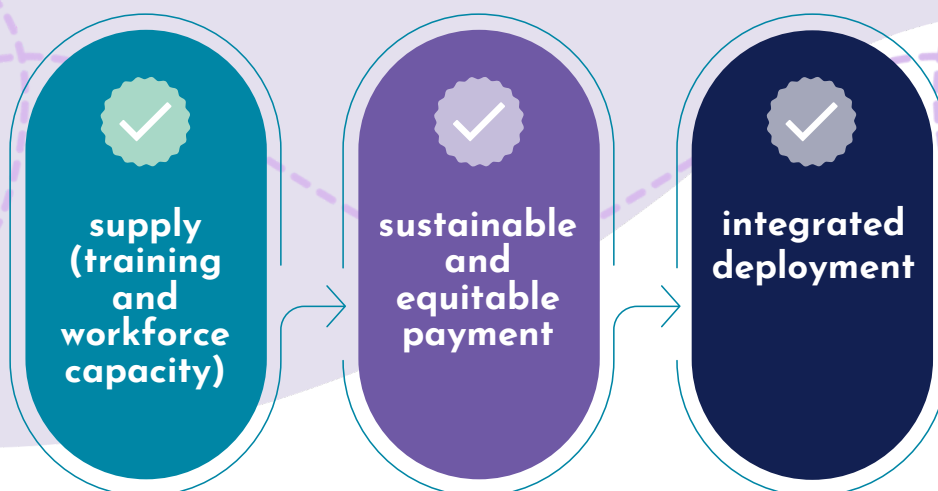
Why investing in doulas pays
dividends for payers
and local economies



Executive Summary

Across the U.S., maternal and newborn care faces a persistent gap: clinicians alone cannot fully meet the continuous, personalized support that birthing people and their families need. In recent years, rigorous evidence has mounted showing that doula support improves outcomes (fewer preterm births, reduced interventions, higher satisfaction), reduces postpartum depression, and narrows racial disparities in maternal health. Yet access remains fragmented, inconsistent, and underfunded.

To unlock the full potential of doula coverage at scale, three critical levers must be addressed:



This white paper makes the case to insurers (commercial and Medicaid), employers, and maternal health stakeholders that scaling doula services is not only a health imperative but also an economic opportunity, one that can generate jobs, contribute to local economies, and improve return on health investments.

This paper
organizes
around four
pillars:

1

**Workforce
& economic
impact:**

how training
doulas creates
jobs and can
contribute to
state GDP

2

**Demand vs.
coverage gap:**

evidence that
consumers want
doula care, but
many payers do
not reimburse it

3

**Inconsistent
payment
models:**

the current
patchwork of
reimbursement that
undermines
sustainability

4

**Training
demand
nationwide:**

evidence that
interest in doula
training is rising
and unmet

We conclude with policy and implementation recommendations, and show how **Pacify**, in partnership with **Doula Training International (DTI)**, offers a scalable, equitable pathway to meet demand while aligning with payer and state priorities.

1. Workforce & Economic Impact: Training Doulas Creates Jobs and Stimulates Growth

1.1 Doula work as workforce development and entrepreneurship

Doula work is inherently flexible, accessible to individuals without advanced clinical degrees, and well-suited for community-based models. **The University of Washington's CHWS rapid-response brief** describes how doulas often function as **small business owners or independent contractors**, building client networks and extending services into underserved communities (familymedicine.uw.edu).

This means that expanding doula training programs is not just training for healthcare support, it is **micro-enterprise development**.

For local economies in rural or low-resource regions, doula programs can serve as a vehicle for **job creation, especially among women of color**, those reentering the workforce, or residents in maternal care "deserts."



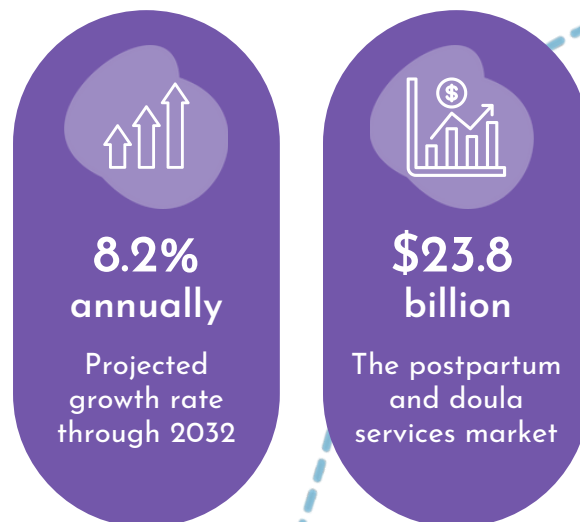
Lactation, behavioral health, and a doula... I can't be that for all patients, but those are critical tools almost every pregnant patient should have access to.

Dr. Jo'Ann Jackson, Chief Medical Officer
at Advantia for the Mid-Atlantic Region

1.2 Market growth forecasts

Market data reinforces the upward trajectory of doula services. The postpartum and doula services market is estimated at **\$23.8 billion**, with a projected growth rate of **8.2% annually through 2032** ([Business Insider](#)).

Such growth signals not just increasing household demand, but opportunities for new service providers and multiplier economic effects. With appropriate infrastructure (billing, referral networks, doula resource and network hubs), doula training pipelines can feed into a sustained growth sector in maternal health services.



1.3 Indirect savings and return on investment

Beyond direct job creation, doula care has been modeled in cost-effectiveness analyses to generate **net savings per birth**. Studies project savings of **\$929 to \$1,047 per birth**, primarily by reducing interventions (cesarean, preterm birth, NICU stays) and shortening labor durations ([PubMed Central](#)).

These avoided costs accrue to Medicaid, insurers, and health systems, strengthening the case that investment in doula workforce yields **downstream economic benefits** (less expensive complications, fewer readmissions). Such savings can counterbalance or exceed the cost of reimbursing doula services, especially at scale.



2. Demand for Doula Care vs. Coverage Gap

2.1 Demonstrated consumer demand

Surveys consistently show that many birthing people are interested in or would choose doula care if affordable. For example, the **ASPE Doula Issue Brief** notes high interest and acknowledges that **cost or lack of coverage is a key barrier** to uptake ([ASPE](#)).



A more recent growth narrative is captured by **Business Insider**, noting that new parents increasingly seek postpartum and doula care, and that the market is expanding rapidly ([Business Insider](#)).

Community-based research also affirms demand, especially among low-income and BIPOC birthing people, who often express that doulas fill advocacy, informational, and culturally responsive support roles that traditional clinician models cannot ([BioMed Central](#)).



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Reimagined

[Podcast Episode 1](#)

We integrate into the EMR, do all the follow-up, and provide ongoing reporting back to the OB.

Tina Keshani, CEO and Co-Founder,
Seven Starling



2.2 Low penetration of insurance coverage

Despite demand, reimbursement lags. As of 2025, many states have taken steps to integrate doula benefits into Medicaid, but **private insurer adoption remains limited** ([National Health Law Program](#)).

According to the National Health Law Program (NHeLP) Doula Medicaid Project, from 2019 onward more states have introduced Medicaid doula coverage, but significant variation in benefit design and reimbursement persists ([National Health Law Program](#)).



A state tracker shows that currently 20 states (plus DC) reimburse community-based doulas under Medicaid, and eight new states fully implemented Medicaid doula benefits in the recent cycle (Arizona, Colorado, Delaware, Illinois, Kansas, Massachusetts, Missouri, and New York), yet many states still lack any coverage or have only pilot programs ([Prenatal-to-3 Policy Impact Center](#)).



Rhode Island

Private insurance mandates are even rarer: Rhode Island is currently the only state that requires private plans to cover doula services ([Birthing Advocacy Doula Trainings](#)).



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In my population, most commercial payers don't cover doula services.

Dr. Jo'Ann Jackson, Chief Medical Officer at Advantia for the Mid-Atlantic Region



Key takeaway: the supply side (willing and trained doulas) is constrained by lack of reliable payer demand, dampening market uptake. Insurers and Medicaid plans that adopt doula benefits early can gain a competitive and value-based advantage.

3. Inconsistent Payment & Reimbursement Models

3.1 Variation in Medicaid reimbursement across states

One of the biggest barriers to scaling doula services is **the patchwork of reimbursement levels, eligibility rules, and billing processes**. The **NASHP State Medicaid Approaches to Doula Service Benefits** tracker highlights substantial heterogeneity in how states design doula benefits, some with robust perinatal visit reimbursements, others with minimal support ([NASHP](#)).



California

For example, California's doula benefit (effective January 2023) includes:

- ✓ Initial prenatal visit (90 minutes): \$197.98
- ✓ Up to eight perinatal visits: \$162.11 each
- ✓ Labor support: \$685.07
- ✓ Cesarean support: \$795.73
- ✓ Postpartum extended visits: \$486.36 each (plus additional postpartum visits under certain conditions) ([NASHP](#))



Other states reimburse far lower, or bundle services, or require a physician referral before doula services can be billed ([NASHP](#)).

11

The **MACPAC case study on doulas in Medicaid** further underlines that as of 2023 only **11 state Medicaid programs plus DC had fully implemented doula reimbursement**, with several more in planning phases ([MACPAC](#)).



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Early-adopter states are now trying to right-size doula rates, but until we look at pregnancy reimbursement across the continuum, we won't fix the parts.

Jodi Neuhauser, Founder & Chief Executive Officer, In Women's Health



3.2 Issues of undervaluation, delays, and sustainability

Even in states with reimbursement, many doulas report that the **effective hourly rate is low**, especially considering on-call time, travel, and postpartum home visits. Several reports note that flat rates sometimes result in **less than \$10/hour equivalent** once all labor is accounted for, undermining sustainability. (See UW “This Work That We’re Doing...” & NHeLP commentary (familymedicine.uw.edu)).

Payment delays, credentialing hurdles, and complex billing requirements further discourage doulas from participating in Medicaid and managed care provider networks ([National Health Law Program](#)).

Some states have acknowledged the need to increase reimbursement rates to retain workforce; newer state doula benefits trend toward higher reimbursement ceilings than earlier entrants ([National Health Law Program](#)).



3.3 Structural inequities and potential bias

The inconsistency in payment not only undermines scaling, but also risks reinforcing inequities: doulas in low-income communities or rural areas may find compensation unfeasible to sustain, thus concentrating coverage in more affluent areas. Without fair reimbursement, community-based and BIPOC doulas are at a disadvantage, risking perpetuation of inequities in maternal care access.

4. Training Demand and Supply Constraints Across the U.S.

4.1 Rising interest and unmet capacity

Business Insider reports that as demand for postpartum and doula services grows, more people are pursuing certification and training programs ([Business Insider](#)).

The **UW Doula Workforce Rapid Response Brief** notes that doula training programs regularly operate near capacity and often waitlist prospective trainees ([familymedicine.uw.edu](#)).

The **NASHP / PN-3 Policy Roadmap** reports that states are scaling Medicaid doula benefits, triggering new demand for credentialed doulas where supply is insufficient ([Prenatal-to-3 Policy Impact Center](#)).

Reports from national doula training networks (e.g. Badoula Trainings) cite rising enrollment and expansion of state-level adoption of doula training infrastructure ([Birthing Advocacy Doula Trainings](#)).

These signals confirm that demand for training is not latent; it's actively growing, often faster than existing training institutions can accommodate.



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Wraparound services that complement what providers do help us meet needs together as a collective.

Dr. Jo'Ann Jackson, Chief Medical Officer
at Advantia for the Mid-Atlantic Region



4.2 Bottlenecks in scaling training

Despite demand, barriers exist:

REGIONAL DISPARITIES:

Some states have few training programs or none in rural areas, limiting access for prospective doulas.

COST & FUNDING GAPS:

Trainees often must pay tuition out-of-pocket; states and Medicaid agencies rarely subsidize training directly.

CERTIFICATION FRAGMENTATION:

There is no single national credential; multiple doula certification organizations, varied curricula, and inconsistent standards create confusion and difficulty in scaling.

TRANSITION TO EMPLOYMENT:

Even when training is available, connecting newly certified doulas to paid positions (through Medicaid, insurers, health systems) is challenging without coordinated referral networks or payer partnerships.

5. Pathways Forward: Scaling Doula Coverage Sustainably

4.1 Rising interest and unmet capacity



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Product innovation and policy alignment have to move together, otherwise every model stalls on reimbursement.

Jodi Neuhauser, Founder & Chief
Executive Officer, In Women's Health



Below are recommended strategies and roles for stakeholders, with Pacify + Doula Trainings International (DTI) as an enabling infrastructure solution.

5.1 Principles for design and implementation



Equitable and livable reimbursement:

States and payers should establish doula reimbursement rates sufficient to cover full scope of work, including on-call, travel, and postpartum home visits, not just labor presence.



Flexibility and inclusivity in credentialing:

Recognize diverse training backgrounds; allow multiple pathways to participate (e.g. community-based, apprenticeship, hybrid) while maintaining quality standards.



Streamlined enrollment and billing:

Simplify provider onboarding, credentialing, and claims submission (e.g. via doula hubs or shared administrative platforms).



Performance measurement and evaluation:

Embed data collection for outcomes (preterm birth, cesarean, postpartum depression, satisfaction) and financial return.



Workforce pipelines tied to employment:

Training should connect directly to reimbursed opportunities, not just classroom completion. Use hub models or matching platforms.



Public-private partnerships:

Encourage insurers, employers, and Medicaid agencies to co-invest in doula training subsidies, mentorship, and retention incentives.

5.2 Role of Pacify + DTI

Pacify, in partnership with **Doula Training International** (DTI), is uniquely positioned to operationalize scalable doula training and deployment across states:



Digital-first training footprint:

Pacify + DTI can deliver hybrid curricula (online theory + in-person practicums), reducing geographic barriers to certification.



Referral & matching infrastructure:

As doulas are certified, Pacify's systems can integrate with health systems, payers, and state Medicaid agencies to match clients, route claims, and monitor performance.



Administrative support and billing hubs:

Pacify can offer administrative back-end services (billing, credentialing support, claims management) to reduce the burden on doulas.



Quality assurance and continuing education:

Ongoing training, mentorship, and quality tracking help maintain standards and improve maternal outcomes.



Scaling with equity:

Pacify can prioritize recruitment and support for doulas in underserved, rural, and BIPOC communities, aligning with equity goals of payers and states.



By combining training capacity, deployment infrastructure, and payer integration, Pacify offers a turnkey, scalable model to expand doula coverage nationwide without reinventing local logistics.

Conclusion

Scaling doula services nationally is more than a maternal health initiative, it is a strategic investment in workforce development, health equity, and value-based care. The evidence is clear: well-supported doula care improves maternal and newborn outcomes, reduces costly interventions, and enhances patient satisfaction. But to realize this at scale, we must address supply constraints, payment inconsistency, and gaps between training and deployment.



For insurers, Medicaid agencies, employers, and health systems, the opportunity is compelling: early investment in scalable doula networks can generate positive returns, financially, clinically, and socially. Pacify and DTI offer a proven, scalable infrastructure to bridge from demand to delivery, ensuring doulas are fairly paid, equitably distributed, and connected to the clients and systems that need them most.

We invite partners in payers, policy, and care delivery to collaborate with Pacify to build the architecture for universal doula access, for healthier mothers, healthier babies, and stronger communities.



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[Podcast Episode 5](#)

Women's health has never been more front-and-center, and these conversations are moving the system.

Dr. Jocelyn Fitzgerald, urogynecologist and Assistant Professor at the University of Pittsburgh



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