OFFICE OF THE UNDER SECRETARY OF WAR
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

FEB - 5 2026

Dear Mr. Chairman:

The Department's response to section 746(f)(2) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), "Extramedical Maternal Health Providers Demonstration Project," is enclosed. Section 746(f)(2) requires the Secretary of Defense to provide an annual report on an extramedical maternal health provider demonstration, which the Department has titled the Childbirth and Breastfeeding Support Demonstration (CBSD). This report updates the status of the CBSD in year 4.

The CBSD offers continuous labor support and antepartum/postpartum support services from certified labor doulas and breastfeeding support services from certified lactation consultants and counselors not otherwise TRICARE-authorized for most TRICARE-eligible beneficiaries receiving maternity services in private sector care. The CBSD began on January 1, 2022, and is set to expire on December 31, 2026, with overseas implementation beginning January 1, 2025.

Thank you for your continued strong support of the health and well-being of our Service members and their families. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF WAR
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

FEB - 5 2026

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The Department's response to section 746(f)(2) of, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), "Extramedical Maternal Health Providers Demonstration Project," is enclosed. Section 746(f)(2) requires the Secretary of Defense to provide an annual report on an extramedical maternal health provider demonstration, which the Department has titled the Childbirth and Breastfeeding Support Demonstration (CBSD). This report updates the status of the CBSD in year 4.

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Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

Report to the Committees on Armed Services of the Senate and the House of Representatives

Extramedical Maternal Health Providers Demonstration Project

February 2026

The estimated cost of this report or study for the Department of War (DoW) is approximately $7,950.00. This includes $0 in expenses and $7,950 in DoW labor.
Generated on 2025 Sep18 RefID: 8-1F26341

INTRODUCTION

This report updates Congress on the demonstration project mandated by section 746(f)(2) of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021 (Public Law 116–283), which required that the Secretary of Defense establish a 5-year demonstration project to evaluate the cost, quality of care, and impact on maternal and fetal outcomes of using extra medical (i.e., non-medical) maternal health providers under TRICARE to determine the appropriateness of making coverage of such providers permanent. The NDAA for FY 2021 required an initial report on implementation of the demonstration and annual reports due beginning one year after the start of the demonstration. All mandated reporting elements are addressed in this report.

BACKGROUND

The Defense Health Agency (DHA) implemented the congressionally-mandated extra-medical maternal health provider demonstration through a Federal Register notice (FRN) published on October 29, 2021 (86 Federal Register (FR) 60006). The demonstration project was titled the Childbirth and Breastfeeding Support Demonstration (CBSD). The CBSD added as authorized providers certified labor doulas (CLDs), who meet certain requirements, with up to six antepartum or postpartum visits covered, plus one episode of continuous labor support. An FRN published on April 11, 2024 (89 FR 25617), modified the antepartum and postpartum visit allowance to 6 hours of visits, to be billed in 15-minute increments. The services of certified lactation consultants/counselors (LCs), not otherwise TRICARE-authorized providers, such as registered nurses (RNs) (henceforth collectively referred to as "non-RN LCs"), who meet certain requirements are also covered for up to six total prenatal or postnatal breastfeeding counseling visits per birth event. The CBSD also added coverage of group breastfeeding counseling sessions (including prenatal breastfeeding classes) by a CBSD non-RN LC or another TRICARE-authorized provider, to be included in the six total visit allowance. The demonstration began in the United States (U.S.) on January 1, 2022, and expanded overseas on January 1, 2025. In September of 2023, DHA contracted with Booz Allen Hamilton to perform an independent evaluation of the CBSD. Relevant portions of the interim analysis were shared in the last report, which included a discussion of methodology. This report updates the interim analysis; however, the evaluation is ongoing, and all data reported should be considered preliminary.

Congress described annual reporting expectations in section 746 of the NDAA for FY 2021, which included utilization of demonstration services, qualitative results via survey responses, and the financial/logistical feasibility of creating a permanent benefit. This report addresses each requirement set forth by Congress. Limitations of this data were discussed in prior reports. Reports are expected each year on or by the anniversary of the demonstration commencement; this report updates the status of the CBSD in year 4. Each report must address, at a minimum, the following matters:

> (i) The number of covered beneficiaries who are enrolled in the demonstration project.

(ii) The number of enrolled covered beneficiaries who have participated in the demonstration project.

(iii) The results of the required survey under subsection (e).

(iv) The cost of the demonstration project.

(v) An assessment of the quality of care provided to participants in the demonstration project.

(vi) An assessment of the impact of the demonstration project on maternal and fetal outcomes.

(vii) An assessment of the effectiveness of the demonstration project.

(viii) Recommendations for adjustments to the demonstration project.

(ix) The estimated costs avoided as a result of improved maternal and fetal outcomes due to the demonstration project.

(x) Recommendations for extending the demonstration project or implementing permanent coverage under the TRICARE program of extramedical maternal health providers.

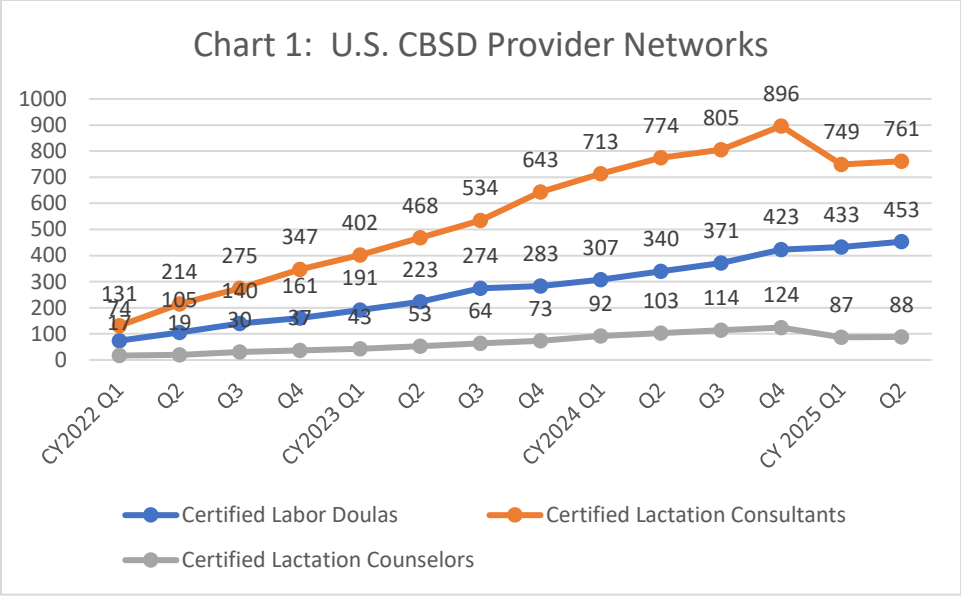
(xi) An identification of legislative or administrative action necessary to make the demonstration project permanent.

DISCUSSION

Calendar Year 2025 has been a transition year for the CBSD. On January 1, 2025, the TRICARE program transitioned to its next phase of managed care contracts, referred to as the T5 contracts, for care delivered in the U.S. This transition shifted five States from the TRICARE East region to the TRICARE West region and changed the managed care support contractor (MCSC) for the West region from HealthNet Federal Services to TriWest. In addition to the T5 transition, the CBSD completed its changeover from Phase 1 to Phase 2 for childbirth support services. Phase 2 requires CLDs to become participating providers, use new codes, and bill antepartum and postpartum visits per 15 minutes rather than as untimed visits. CLDs also now receive a higher reimbursement rate and have additional options to qualify for the CBSD. As participating providers, CLDs must file claims and accept TRICARE payment as reimbursement in full, which means that TRICARE beneficiaries no longer have to pay out-of-pocket for doula services and do not have to file claims for reimbursement. Finally, on January 1, 2025, the CBSD expanded to include beneficiaries enrolled to the TRICARE Overseas Program (TOP) contractor.

This report was prepared in September of 2025 (with data pulled earlier to allow for sufficient time for analysis), thus DHA is still evaluating the impact of these changes.

Beneficiary use of CBSD services has continued to increase. Last year we reported that 10,579 beneficiaries had accessed CBSD services in the U.S. (January to July 2024). As of July 2025, that number has nearly doubled to 18,382. However, where previously we have reported that U.S. MCSC-reported provider networks had continually increased, this year, following the T5 transition, the networks saw decreases for lactation providers. DHA will continue to monitor claims to determine what, if any, impact these decreases have had on use of services.



In addition to the changes in the U.S., this year the CBSD began reimbursing for services in overseas locations. As of the end of June 2025, the TOP contractor has qualified 45 CLDs in 14 countries or territories, 40 certified lactation consultants in 16 countries or territories, and 6 certified lactation counselors in 5 countries or territories.

Mandatory Reporting Elements:

(i) The number of covered beneficiaries enrolled in the demonstration.

1. U.S.

For CBSD participation within the U.S., DHA considers a beneficiary enrolled in the demonstration when a claim is received for services under the CBSD. That is, enrollment is automatic.

2. Overseas

For CBSD participation by beneficiaries enrolled to the TOP contractor, the DHA required beneficiary registration prior to receiving services. As of September 10, 2025, 157 beneficiaries registered to receive childbirth support services and 142 registered to receive breastfeeding support services. An enrollment process was required overseas but not in the U.S. due to differences in how the program operates overseas compared to the U.S. The lack of an enrollment process in the U.S. was facilitated by known, uniform provider requirements such that both beneficiaries and providers could be assured that requirements were met prior to the receipt of services. However, overseas the DHA has approved changes to provider requirements consistent with care delivery in other countries, which means beneficiaries do not have the same ability to independently verify the qualifications of a provider without interacting with the TOP contractor. An enrollment requirement therefore was added.

(ii) The number of enrolled covered beneficiaries who have participated in the demonstration.

1. U.S.

For CBSD services received in the U.S., the number of enrolled beneficiaries is equivalent to the number of beneficiaries who participated in the demonstration. Table 1 shows the number of unique beneficiaries for each service based on claims data; a small number of beneficiaries used both services.

Table 1. Number of Beneficiaries Receiving CBSD Services in the U.S., January 2022 – August 2025

Beneficiary Category	Breastfeeding Support	Childbirth Support	Total Unique Beneficiaries*
Active Duty Service Member (ADSM)	2,512	475	2,881*
Active Duty Family Member (ADFM)	9,719	2,420	11,555*
Retirees and Retiree Dependents	3,629	424	3,979*
Other	90	9	95*
Totals**	15,864*	3,292*	18,382*

*The unique beneficiary total includes a small number of beneficiaries who used both breastfeeding and childbirth support services under their beneficiary category.
**There were a small number of beneficiaries who received services as both an ADSM and ADFM (for example, if an ADSM was married to an ADSM and received some services before separating/retiring and receiving services as an ADFM).
***Beneficiaries who enrolled in the CBSD through the TOP contractor but who returned to the U.S. to receive maternity care would be included in this table, which was created based on the location in the claims data, while also being counted in the overseas numbers below.

2. Overseas

The number of TOP enrolled beneficiaries who had received (and had a claim filed for) CBSD services as of September 10, 2025, was 35 for childbirth support services and 55 for breastfeeding support services, based on information provided by the TOP contractor.

3. Service Delivery (U.S. and Overseas)

For all beneficiaries enrolled in the demonstration to date, 45,215 breastfeeding support services were reimbursed. Table 2 provides a specific breakdown of the types of breastfeeding support services utilized by year.

Table 2: Total Breastfeeding Support Services Provided Under the CBSD January 2022-August 2025, by CPT Code

CPT Code	Services Description	2022	2023	2024	2025	Total
99401	Individual, 15 minutes	192	134	75	36	437
99402	Individual, 30 minutes	328	606	453	97	1,484
99403	Individual, 45 minutes	94	329	616	184	1,223
99404	Individual, 60 minutes	1,862	4,498	7,157	2,385	15,902
99411	Group, 30 minutes	4	3	0	0	7
99412	Group, 60 minutes	1,972	8,521	12,147	3,522	26,162
Total		4,452	14,091	20,448	6,224	45,215

Claims data shows that 13,251 childbirth support services have been reimbursed since the start of the CBSD (see Table 3).

Table 3: Total Childbirth Support Services Provided Under the CBSD through August 2025, by Service

Service Description	2022	2023	2024	2025	Total
Antepartum or Postpartum Visit Total	1,413	3,321	4,502	1,311	10,547
Continuous Labor Support Total	303	805	1,193	403	2,704
Total	1,716	4,126	5,695	1,714	13,251

(iii) The results of the required survey under subsection (e).

The Maternity Survey information in the below subparagraphs was requested by Congress.[1] Each item includes data starting in 2021, unless otherwise stated, and both private sector care and direct care responses. Data from 2025 is preliminary and will be updated in the next report. Some numbers from prior reports have been updated based on changes to how we defined the population subgroups. For example, for the first question below we initially included ADSMs and all ADFMs, but this year refined our definitions to include only ADSMs and ADFMs who reported they were the spouse of an ADSM. This removed some responses from individuals who may be other dependents of an ADSM—such as a child of an ADSM. These

[1] As discussed in prior reports, the Maternity Survey is sent to all beneficiaries who give birth within the Military Health System (MHS) for whom an email address is available. For beneficiaries who deliver in private sector care, the DHA obtains the email addresses from the MCSCs; because not all beneficiaries had an email address on file, DHA was only able to send the survey to about 65 percent of beneficiaries who gave birth in private sector care. For direct care, DHA was only able to obtain email addresses for about 5,000 active duty service member beneficiaries annually, or what is likely only about 15 percent of the population who gives birth in Military medical treatment facilities. The response rates to date are low, 11 to 12 percent for 2024 and 2025, but those rates are largely consistent with other MHS surveys.

refinements were minor and intended to ensure data specifically answered each question asked by Congress. Each table lists the total number of respondents eligible to answer a particular question, in grey at the top of the table, with the number who were asked but chose not to answer or selected "prefer not to answer" (if available) in a footnote below the table. Tables 4 to 19 detail mandatory survey reporting elements. Limitations of survey data have been detailed in prior reports.

1. How many members of the Armed Forces or spouses of such members give birth while their spouse or birthing partner is unable to be present due to deployment, training, or other mission requirements.

Table 4: ADSM and ADFM Respondents Who Gave Birth Without a Spouse or Partner Due to Deployment, Training, or Other Mission Requirements, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM and ADFM)	2,354	3,602	3,397	3,223	943	13,519
Number of ADSM and ADFM Respondents Who Gave Birth Without Spouse or Partner	92	129	91	92	26	430

* Four ADSM respondents and 14 ADFM respondents did not answer if their spouse/partner was able to be present during their childbirth or selected "Prefer not to answer."

2. How many single members of the Armed Forces give birth alone. DHA defined "gave birth alone" as respondents who reported that only medical personnel were available during delivery.

Table 5: Single ADSM Respondents Who Gave Birth Alone, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSMs)	888	1,359	1,036	1,016	243	4,542
Number of Respondents (single ADSMs)	101	173	116	131	19	540
Number of Single ADSMs who Gave Birth Alone	10	11	11	8	2	42

* 47 ADSM respondents did not provide a relationship status or selected "Prefer not to answer."
* 14 ADSM respondents did not answer who was present in the room during their childbirth or selected "Prefer not to answer."

3. How many members of the Armed Forces or spouses of such members use doula, lactation consultant, or lactation counselor support.

Table 6: ADSM and ADFM Respondents Who Used a Doula or Lactation Consultant/Counselor Support

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSMs and ADFMs)	2,354	3,602	3,397	3,223	943	13,519
Number of ADSM/ADFM Used a Doula	214	439	456	379	124	1,612
Number of ADSM/ADFM Used a Lactation Consultant or Counselor	1,540	2,348	2,289	2,277	622	9,076

* Three ADSM respondents and 17 ADFM respondents did not answer this question.

4. The race, ethnicity, age, sex, relationship status, Armed Force, military occupation, and rank, as applicable, of each individual surveyed.

    a. Race and Ethnicity

Table 7: Respondent Race and Ethnicity Data, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents	2,727	4,033	3,881	4,058	1,208	15,907
American Indian or Alaska Native	12	19	11	14	1	57
Asian	104	129	168	173	52	626
Black or African American	198	357	322	326	83	1,286
Hispanic/ Latino	356	604	524	565	151	2,200
Native Hawaiian Or Other Pacific Islander	19	16	15	15	3	68
White	1,890	2,696	2,657	2,334	715	10,292
2 or More Races	118	183	153	145	50	649

* 729 respondents did not answer this question.

    b. Age

Table 8: Respondent Age Data, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents	2,727	4,033	3,881	4,058	1,208	15,907
Under 18	0	0	0	1	0	1
18-24 years old	172	419	379	350	111	1,431
25-34 years old	1,637	2,479	2,434	2,224	686	9,460
35-44 years old	892	1,101	1,029	1,003	264	4,289
45-54 years old	10	14	14	6	0	44

* 682 respondents did not answer this question or selected “Prefer not to answer.”

c. Relationship Status

Table 9: Respondent Relationship Status, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents	2,727	4,033	3,881	4,058	1,208	15,907
Married or domestic partner	2,572	3,799	3,724	3,427	1,034	14,556
Single, never married	57	127	85	102	17	388
Divorced	48	51	34	36	8	177
Separated	28	27	21	14	6	96
Widowed	8	7	1	11	1	28

* 662 respondents did not answer this question or selected "Prefer not to answer."

d. Armed Force: From 2021 to 2023, only ADSMs and retirees were asked for their branch of service. In 2024 and 2025, DHA added a question to the survey asking spouses of ADSMs and spouses of retirees for their spouse's branch of service. Some respondents may be counted in more than one table starting in 2024 if they are both a member of the military (ADSM or retiree) and the spouse of a member of the military (ADSM or retiree). For example, a Navy ADSM married to an Air Force retiree would be listed both in the ADSM table (as Navy) and the retiree spouse table (as Air Force). Some respondents, such as children of ADSMs, were not asked this question and are not listed in the tables below.

(1) Armed Force (ADSM)

Table 10: ADSM Respondent's Branch of the Armed Forces, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM)	888	1,359	1,036	1,016	243	4,542
Air Force	276	401	317	305	89	1,388
Army	268	365	242	243	62	1,180
Coast Guard	41	76	62	43	8	230
Marine Corps	59	98	52	46	4	259
National Guard	70	117	113	97	22	419
Navy	127	231	183	227	46	814
Reserves	27	50	48	40	10	175
Space Force	8	10	9	7	2	36

* 41 ADSM respondents did not answer this question.

(2) Armed Force (Spouse of ADSM)

Table 11: Spouse of ADSM Respondent's Spouse's Branch of the Armed Forces, 2024-2025

	2024	2025	Total
Number of Respondents (Spouse of ADSM)	2,628	802	3,340
Air Force	663	237	900
Army	739	218	957
Coast Guard	115	35	150
Marine Corps	263	79	342
National Guard	208	56	264
Navy	523	142	665
Reserves	85	29	114
Space Force	24	5	29

* Nine spouse of ADSM respondents did not answer this question.

(3) Armed Force (Retiree)

Table 12: Retiree Respondent's Branch of the Armed Forces, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (Retirees)	76	76	107	87	16	362
Air Force	17	18	20	26	3	84
Army	35	32	55	33	7	162
Coast Guard	4	2	0	0	1	7
Marine Corps	8	9	8	8	0	33
National Guard	1	2	2	4	3	12
Navy	7	13	20	14	2	56
Reserves	3	0	1	1	0	5
Space Force	0	0	1	0	0	1

* Two retiree respondents did not answer this question.

(4) Armed Force (Retiree spouse)

Table 13: Spouse of Retiree Respondent's Spouse's Branch of the Armed Forces, 2024-2025

	2024	2025	Total
Number of Respondents (Retiree Spouse)	279	93	372
Air Force	46	16	62
Army	136	35	171
Coast Guard	6	4	10
Marine Corps	39	10	49
National Guard	12	4	16
Navy	37	21	58
Reserves	1	1	2
Space Force	2	1	3

* One retiree spouse respondent did not answer this question or selected "Prefer not to answer."

e. Military Occupation

Table 14: Military Occupation of ADSM Respondents, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM)	888	1,359	1,036	1,016	243	4,542
Administrative	174	244	196	191	38	843
Combat specialty	27	52	33	42	4	158
Construction	4	4	5	11	0	24
Engineering, science, or technical	72	108	91	95	22	388
Executive, administrative, or managerial officer	49	64	54	38	17	222
Healthcare	182	271	211	215	63	942
Human resource development	28	58	35	35	4	160
Machine operator or repair	16	24	27	23	10	100
Media or public affairs	13	17	7	12	3	52
Protective service/law enforcement	26	40	42	32	5	145
Support service	83	135	77	88	17	400
Transportation or material-handling	45	55	50	32	10	192
Vehicle and mechanical machinery	17	20	15	16	2	70
Other	150	266	188	181	47	832

* 14 ADSM respondents did not respond to this question.

f. Rank

(1) Current Rank (ADSM)

Table 15: Rank of ADSM Respondents, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM)	888	1,359	1,036	1,016	243	4,542
E1 to E3	13	44	29	42	5	133
E4 to E6	432	671	522	504	132	2,261
E7 to E9	105	132	106	79	20	442
Warrant Officer	12	12	4	11	1	40
O1 to O3	132	272	204	220	43	871
O4 to O6	190	224	169	156	41	780
O7 to O10	1	1	0	0	0	2

* 13 ADSM respondents did not answer this question.

(2) Rank at Retirement (Retiree)

Table 16: Rank at Retirement of Retiree Respondents, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (Retirees)	76	76	107	87	16	362
E1 to E3	8	13	8	10	0	39
E4 to E6	46	44	62	47	11	210
E7 to E9	8	10	12	8	1	39
Warrant Officer	0	0	1	0	0	1
O1 to O3	12	7	20	14	3	56
O4 to O6	2	1	2	5	1	11
O7 to O10	0	0	0	0	0	0

* Six retiree respondents did not answer this question.

5. If individuals surveyed were members of the Armed Forces or the spouses of such members, or both.

Table 17: Number of Respondents Who Are ADSMs, Spouse of ADSMs, or Both, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM and spouse of ADSM)	2,354	3,602	3,397	3,223	943	13,519
ADSM only	524	768	572	595	141	2,600
Spouse of ADSM only	1,466	2,243	2,361	2,207	700	8,977
ADSM and spouse of ADSM	364	591	464	421	102	1,942

6. The length of advanced notice received by individuals surveyed that the member of the Armed Forces would be unable to be present during the birth, if applicable.

Table 18: Amount of Advanced Notice Received by ADSM and ADFM Respondents Whose Spouse/Partner Would Not Be Present Due to Mission Requirements, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents (ADSM and ADFM Respondents for whom their spouse/partner would be unable to be present due to mission requirements)	105	138	98	100	28	469
Less than 24 hours	25	29	25	30	4	113
Less than 30 days	12	27	26	19	4	88
Between 31 and 90 days	30	26	12	21	8	97
More than 90 days	35	46	30	22	9	142

* 7 ADSM and 19 ADFM respondents for whom their spouse/partner would be unable to be present due to mission requirements did not respond or selected "Prefer not to answer."

7. Any resources or support that the individuals surveyed found useful during the pregnancy and birth process, including doula, lactation consultant, or lactation counselor support.

Table 19: Resources Identified by Respondents as Useful During Pregnancy and Birthing Process, 2021-2025

	2021	2022	2023	2024	2025	Total
Number of Respondents	2,727	4,033	3,881	4,058	1,208	15,907
Family (including spouse/partner) and/or friends	2,189	3,255	3,189	3,215	981	12,829
Nursing Staff	1,377	2,089	2,207	2,150	659	8,482
Primary care provider/pediatrician	1,397	2,027	2,029	2,037	615	8,105
Lactation consultant/counselor	1,103	1,544	1,559	1,677	470	6,353
Support from my command or my partner's command	316	532	487	525	161	2,021
Doula	250	463	467	422	138	1,740
Peer Support Group	287	424	366	327	95	1,499
Base or Military Treatment Facility (MTF) provided support	114	158	146	172	44	634

* Beneficiaries are able to select more than one option in response to this question.
** 189 beneficiaries did not respond or selected "Prefer not to answer."

(iv) The cost of the demonstration project.

Table 20: Total Amount Paid for CBSD Services by Calendar Year, through August 1, 2025

	2022	2023	2024	2025	Total
Breastfeeding Support Services	$236,160	$626,570	$932,813	$293,507	$2,089,050
Childbirth Support Services	$264,102	$725,684	$1,292,253	$614,339	$2,896,378
Total	$500,262	$1,352,254	$2,225,066	$907,846	$4,985,428

*Amounts reported in prior reports may have changed if new claims were received or if existing claims were reprocessed for that time period. These dollar amounts are from claims available on 8/1/2025.

(v) An assessment of the quality of care provided to participants in the demonstration project.

The DHA uses the Maternity Survey to assess the quality of CLDs under the CBSD. On the survey, beneficiaries are able to indicate how their doula was funded. Of 1,375 doula users since 2022, 303 reported their doula was funded in full or in part by TRICARE. DHA reviewed responses to several survey questions for indications of differences in care provided by doulas funded by TRICARE compared to doulas funded another way. These included questions that directly asked about services by doulas (e.g., the respondent's rating of the doula on a scale of one to 10) as well as general health questions that may serve as an indirect indicator of the quality of care (e.g., the respondent's rating of their birth experience). For four metrics, there were no statistically significant differences in survey responses between respondents who used a

doula funded by TRICARE and respondents whose doula was funded another way. However, the analysis found statistically significant differences for three questions. Respondents who used doulas funded by TRICARE were more likely to rate their mental health in the post-delivery period as "very good" or "excellent" and were less likely to rate their doula's birthing support as "very useful" or "extremely useful" or rate their doula as "very useful" or "extremely useful" during the postpartum period (all statistically significant). These results suggest that for certain metrics, there may be differences in the quality of care provided by doulas who are funded by TRICARE and doulas who are funded another way, a finding the DHA will continue to evaluate. Details are provided in Table 21.

Table 21. Comparison of Survey Responses from Respondents who Used a Doula Funded by TRICARE to Respondents who Used a Doula Funded Another Way

	Doula Users (n = 1,375)	Non-TRICARE Funded Doula Users (n = 1,072)	TRICARE-Funded Doula Users (n = 303)
Respondents rating their doula's birthing support as "Very Useful" or "Extremely Useful"*	1,116 (84.8%)	877 (85.9%)	239 (81.0%)
Respondents rating their doula during the postpartum period as "Very Useful" or "Extremely Useful"*	855 (66.0%)	681 (67.6%)	174 (60.6%)
Respondents rating the quality of childbirth support received from their doula as a "9" or "10"	912 (67.7%)	719 (68.6%)	193 (64.3%)
Respondents rating their birth experience as "Very Good" or "Excellent"	950 (69.5%)	729 (68.5%)	221 (73.4%)
Respondents rating their physical health as "Very Good" or "Excellent" in the post-delivery period	619 (45.1%)	475 (44.4%)	144 (47.7%)
Respondents rating their mental health as "Very Good" or "Excellent" in the post-delivery period*	457 (33.5%)	340 (32.0%)	117 (38.7%)
Respondents rating their confidence in caring for infant as "Confident" or "Very Confident"	1,270 (92.5%)	987 (92.2%)	283 (93.4%)

*Shaded rows indicate chi-squared test was significant at the $p<0.05$ level (comparing TRICARE-funded doula user and non-TRICARE-funded doula user responses).

DHA relies primarily on claims data for the assessment of the quality of lactation services received under the demonstration. There are currently no indicators that services from CBSD non-RN LCs were of lower quality than the same services received from RN LCs.

Supplementing the claims data is survey data. For the first 2 years of the demonstration, the survey did not differentiate between lactation providers based on how they were reimbursed.

In 2024, a question was added to the survey that asked how the lactation provider was funded. The analysis looked at responses to seven questions. Of those seven, four showed a statistically significant difference in favor of lactation support funded by TRICARE (see Table 22). With one-year worth of survey data, the analysis suggests that quality of care provided by lactation providers funded by TRICARE may be of higher quality than that provided by lactation providers funded another way. Unlike claims data, the survey data does not differentiate between services provided by RN LCs and non-RN LCs as DHA deemed it likely most beneficiaries would not be aware of or be able to recall the details of their provider's qualifications.

Table 22. Comparison of Survey Responses from Respondents who Used Lactation Support Funded by TRICARE to Respondents who Used Lactation Support Funded Another Way, 2024

	2024 Lactation Support Users (n = 2,544)	Non-TRICARE Lactation Support Users (n = 1,511)	TRICARE Lactation Support Users (n = 1,010)
Respondents who "Strongly Agreed" or "Agreed" that their lactation consultant or counselor provided useful breastfeeding support*	2,050 (84.8%)	1,223 (81.7%)	827 (89.9%)
Respondents who stated that their lactation consultant or counselor "Very Frequently" or "Frequently" resolved breastfeeding issues*	1,458 (71.4%)	793 (66.1%)	665 (78.8%)
Respondents who rated the quality of lactation support they received as a "9" or "10"*	1,194 (49.6%)	644 (43.1%)	550 (60.1%)
Respondents rating birth experience as "Very Good" or "Excellent"	1,742 (69.6%)	1,027 (68.3%)	715 (71.5%)
Respondents rating physical health as "Very Good" or "Excellent" in the Post-Delivery Period*	1,114 (44.3%)	631 (41.9%)	483 (47.9%)
Respondents rating mental health as "Very Good" or "Excellent" in the post-delivery period	852 (33.9%)	511 (34.0%)	341 (33.8%)
Respondents rating confidence in breastfeeding their infant as "Confident" or "Very Confident"	1,772 (82.5%)	1,061 (83.1%)	711 (81.5%)

*Chi-squared test was significant at the $p<0.05$ level (comparing TRICARE lactation support and non-TRICARE lactation support user responses).

(vi) An assessment of the impact of the demonstration project on maternal and fetal outcomes.

DHA hypothesized that use of a TRICARE-authorized doula would be associated with improved maternal and infant outcomes compared to the absence of a doula. For lactation support, DHA hypothesized that use of a non-RN TRICARE-authorized lactation counselor or consultant would be associated with the same or improved maternal and infant outcomes when compared to services from providers who provided covered lactation counseling services before the CBSD (e.g., RNs). As with the prior report, the evaluation of outcome measures analyzed both private sector claims and survey data; data from electronic health records, MTFs, and other health insurance was not available.

Impact of doulas on outcomes

To assess the impact of TRICARE-authorized doulas using claims data, the evaluation created a logistic regression model and used propensity score matching (PSM) to create control and experimental cohorts. This methodology was discussed in detail in the last report and updated this year with several adjustments to the evaluation approach, including: stricter inclusion criteria; more granular matching; introduction of new covariates such as certified nurse midwife use, updated Maternal Comorbidity Index, and addition of severe maternal morbidity (SMM) as an outcome. Statistical significance was defined as p less than 0.05 and the evaluation team determined the sample size had sufficient statistical power. Results are reported as odds ratios (OR).

The results of the regression analysis identified that use of a TRICARE-authorized doula for continuous labor support was associated with 32 percent lower odds of c-section, 37 percent lower odds of pre-term birth, 16 percent higher odds of prolonged labor, and 44 percent higher odds of a postpartum depression (PPD) diagnosis. There were no statistically significant differences in the odds of infant low birth weight, maternal re-hospitalization, or SMM. Except for PPD diagnoses (previously not statistically significant) and low birthweight (previously a significant reduction in proportion of low-birth-weight infants for doula users), these results are largely consistent with the prior year's evaluation, although this report's results include an additional year of data and refinements to the PSM and regression model. Results are presented below in table 23.

Table 23: Results of Regression Model for Doula Outcomes

Health Outcome	OR (Treatment Effect)
C-section*	0.68 (0.58–0.80)
Preterm Birth*	0.63 (0.46–0.87)
Prolonged Labor*	1.16 (1.00–1.34)
Infant Low Birthweight	0.96 (0.65–1.41)
Maternal Rehospitalization Within 60 Days of Birth	0.86 (0.51–1.43)
PPD Diagnosis*	1.44 (1.08–1.92)
SMM	1.11 (0.65–1.90)

*Indicates a statistically significant difference at the p<0.05 between the treatment and comparison group (highlighted).

Additionally, the evaluation analyzed specific survey questions to further assess how TRICARE-authorized doulas might impact outcomes. Compared to respondents who indicated

they did not use a doula, respondents who indicated they used a doula funded by TRICARE were more likely to rate their birth experience as "Very Good" or "Excellent," more likely to report their post-delivery physical health as "Very Good" or "Excellent," more likely to report their post-delivery mental health as "Very Good" or "Excellent," and more likely to report exclusive breastfeeding. Each of these responses was statistically significant using chi-squared testing with significance defined as p less than 0.05; all other responses had no statistically significant differences. These results are presented below in table 24. These results analyze respondents who used a doula funded by TRICARE compared to respondents who reported no doula use, whereas Section E evaluated respondents who used a doula funded by TRICARE compared to respondents who used a doula funded another way.

Table 24: Comparison of Survey Responses from Respondents who Used a Doula Funded by TRICARE to Respondents who Did Not Use a Doula

	Total (All Private Care Respondents) (n = 11,146)	Non-Doula Users (n = 9,570)	TRICARE Doula Users (n = 303)
Respondents Rating Birth Experience as "Very Good" or "Excellent"	7,091 (65.3%)	6,137 (64.6%)	221 (73.4%)*
Respondents Rating Physical Health as "Very Good" or "Excellent" in the Post-Delivery Period	4,599 (42.1%)	3,976 (41.7%)	144 (47.7%)*
Respondents Rating Mental Health as "Very Good" or "Excellent" in the Post-Delivery Period	3,494 (32.1%)	3,033 (31.8%)	117 (38.7%)*
Respondents Rating Confidence in Caring for Infant as "Confident" or "Very Confident"	10,111 (93.1%)	8,837 (93.2%)	283 (93.4%)
Respondents reporting formula-only feeding of infants	1,899 (17.8%)	1,783 (19.2%)	21 (7.0%)
Respondents reporting exclusive breastfeeding (including feeding expressed breast milk)	6,448 (60.6%)	5,430 (58.5%)	231 (76.7%)*
Respondents reporting combination feeding (formula and breast milk)	2,298 (21.6%)	2,070 (22.3%)	49 (16.3%)

*Chi-squared test was significant at the p<0.05 level (comparing TRICARE-authorized doula user and non-doula user responses).

Claims data and survey analyses together indicate that while TRICARE-authorized doulas may contribute to certain improved outcomes, there was no impact on other key outcomes and increased odds of certain negative outcomes.

Impact of non-RN lactation counselors and consultants on outcomes

Last year, our evaluation of lactation support claims grouped services by both non-RN certified lactation consultants and certified lactation counselors into one group, and analyzed that group compared to RN-LCs. As the end of the demonstration approaches, it is important that DHA be able to make distinct decisions on the two new provider classes. We therefore separated claims by non-RN consultants from lactation counselors and evaluated each provider type against RN-LCs. As a result of this change, there was insufficient claims data and too low of a PSM match rate to assess outcomes using hypothesis testing as we did last year.

Instead, the evaluation compared the proportion of each outcome for each group to the other groups without controlling for population statistics. This provides a direct comparison to existing TRICARE lactation support services, as this demonstration is not designed to determine the benefits of lactation support or breastfeeding,[2] but rather to assess the impact of authorizing new provider categories. Further, it allows us to evaluate our two new provider classes separately. For this reason, beneficiaries who used multiple provider types for lactation support were excluded from the analysis. Pre-identified outcomes of interest were engorgement, mastitis, suppressed lactation, hypogalactia (insufficient milk supply), infant ear infections, infant respiratory issues, infant gastrointestinal (GI) issues, and infant feeding difficulties. Data for maternal outcomes (Table 25) was limited due to low counts of each condition in claims data, but there was no evidence that outcome prevalence differed substantially between provider types. Infant outcomes (Table 26) claims data was more robust, but also did not indicate substantial differences between provider types.

Table 25: Prevalence of Maternal Outcomes Among RN Lactation Consultant, Non-RN Lactation Consultant, and Lactation Counselor Groups

	RN Lactation Consultant		CBSD Non-RN Lactation Consultant		CBSD Lactation Counselor	
Totals	912		3,363		505	
Outcomes	RN Lactation Consultant	Percent (%)	CBSD Non-RN Lactation Consultant	Percent (%)	CBSD Lactation Counselor	Percent (%)
Engorgement	0	0.0%	0	0.0%	0	0.0%
Suppressed Lactation	4	0.4%	14	0.4%	1	0.2%
Hypogalactia	11	1.2%	29	0.9%	2	0.4%
Mastitis	45	4.9%	128	4.1%	30	5.9%

[2] The DHA promotes all safe feeding practices and the ability of a mother to seek support for the feeding practice that is best for her and her child. Lactation-related outcome measures were chosen to compare provider quality.

Table 26: Prevalence of Infant Outcomes Among RN Lactation Consultant, Non-RN Lactation Consultant, and Lactation Counselor Groups

	RN Lactation Consultant		CBSD Non-RN Lactation Consultant		CBSD Lactation Counselor	
Totals	854		3,078		453	
Outcomes	RN Lactation Consultant	Percent (%)	CBSD Non-RN Lactation Consultant	Percent (%)	CBSD Lactation Counselor	Percent (%)
Infant Ear Infections	52	6.1%	202	6.6%	27	6.0%
Infant Respiratory Issues	43	5.0%	170	5.5%	29	6.4%
Infant GI Issues	118	13.8%	429	13.9%	43	9.5%
Infant Feeding Difficulties	102	11.9%	391	12.7%	42	9.3%

Survey data also provided information on the impact of lactation support on birth experience, mental health, physical health, confidence in caring for their newborn, and feeding practices. As discussed in Section E, results only include information for births occurring in 2024 and do not compare RN and non-RN lactation consultant and counselor outcomes. Overall, compared to respondents who indicated they did not use any lactation support services, beneficiaries who indicated they used a TRICARE-covered lactation support provider were more likely to rate their birth experience as "Very Good" or "Excellent," more likely to report their post-delivery physical health as "Very Good" or "Excellent," less likely to report their post-delivery mental health as "Very Good" or "Excellent," more likely to report exclusive breastfeeding, and less likely to report exclusive formula use. Each of these responses was statistically significant using chi-squared testing with significance defined as p less than 0.05; all other responses had no statistically significant differences. These results are presented below in table 27. These results analyze respondents who used lactation support funded by TRICARE compared to respondents who reported no lactation support use, whereas Section E evaluated respondents who used a lactation support provider funded by TRICARE to respondents who used lactation support funded another way.

Table 27: Comparison of Survey Responses from Respondents who Used Lactation Support Funded by TRICARE to Respondents who Did Not Use Lactation Support

	Total (2024 Private Care Respondents) (n = 3,822)	Non-Lactation Support Users (n = 1,077)	TRICARE Lactation Support Users (n = 1,010)
Respondents Rating Birth Experience as "Very Good" or "Excellent"*	2,426 (67.6%)	664 (62.8%)	715 (71.5%)
Respondents Rating Physical Health as "Very Good" or "Excellent" in the Post-Delivery Period*	1,605 (44.4%)	483 (45.0%)	483 (47.9%)
Respondents Rating Mental Health as "Very Good" or "Excellent" in the Post-Delivery Period*	1,262 (35.0%)	404 (37.7%)	341 (33.8%)
Respondents Rating Their Confidence in Breastfeeding their Infant as "Very Confident" or "Confident"	2,455 (82.6%)	657 (82.6%)	711 (81.5%)
Exclusively Breastfeeding*	2,204 (61.9%)	610 (58.6%)	637 (63.5%)
Combination of Breastfeeding & Formula	797 (22.4%)	195 (18.7%)	240 (23.9%)
Exclusively Using Formula*	560 (15.7%)	236 (22.7%)	126 (12.6%)

*Chi-squared test was significant at the $p<0.05$ level (comparing TRICARE Lactation Support and Non-Lactation Support User responses).

The claims data shows no substantial differences between outcomes across RN LCs, non-RN lactation consultants, and lactation counselors. These results are similar to the prior report, which also found no substantial differences between RN LCs and non-RN LCs in outcome measures reported in claims data. Survey data indicates that respondents who used lactation support funded by TRICARE experienced a better perception of some birth outcomes and higher rates of exclusive breastfeeding compared to beneficiaries who did not use lactation support but were also less likely to report positive mental health post-delivery. Future evaluations will examine the impact of group lactation counseling and include additional data for more robust results.

For both childbirth support and lactation support, this impact assessment has several significant limitations that restrict its generalizability. First, data sources may contain inaccuracies, incomplete data, or be subject to bias. For example, claims data does not indicate if beneficiaries used doula or lactation counseling service when paid out of pocket and data is dependent on consistent and accurate claims processing. Likewise, survey data is subject to response bias and recall bias. Second, many outcomes are impossible to collect or quantify accurately in claims or survey data (e.g., breastfeeding initiation, smoking status, postpartum depression screening scores). Additionally, it was infeasible to make this assessment a true experimental design by incorporating random assignment or collecting pre-demonstration observations. Finally, limited access to providers in many states and regions means that not every beneficiary who may wish to use services provided under this demonstration will be able to access these services, particularly for doula services.

(vii) An assessment of the effectiveness of the demonstration project.

The CBSD is largely effective for the purposes of assessing the hypotheses under study. There are sufficient claims data and survey responses for the evaluation contractor to assess maternal and fetal outcomes and cost, though that analysis is ongoing.

(viii) Recommendations for adjustments to the demonstration project.

There are no recommendations for additional adjustments to the demonstration project. As we approach the final year of data collection, stability in the benefit will be important for ensuring we can complete the evaluation with limited confounding variables.

(ix) The estimated costs avoided as a result of improved maternal and fetal outcomes due to the demonstration project.

The analysis in Section F found that the presence of a doula funded by TRICARE was likely to impact several outcome measures; of those, the most likely to impact TRICARE maternity care costs was a reduction in c-section rates. To calculate the estimated cost-savings per birth, the evaluation team calculated the probabilities of c-section versus vaginal deliveries associated with both the TRICARE-authorized doula group and the comparison group based on doula presence at delivery as indicated in the claims data. This represents the average marginal effect on doula presence at birth on the likelihood of a c-section. Then, the evaluation team calculated the difference in costs for maternity episodes resulting in c-sections and for those resulting in vaginal births based on actual claims data for all 2024 births. This estimate found an estimated cost-savings of $217.00 for each birth where a doula was present based on a reduced likelihood of c-sections. These cost savings are those associated with the cost of delivery and do not include the cost for doula services.

Because there is no difference in outcomes for non-RN LCs compared to RN LCs, there are no estimated costs avoided as a result of improved maternal and fetal outcomes due to the demonstration project.

(x) Recommendations for extending the demonstration project or implementing permanent coverage under the TRICARE program of extramedical maternal health providers.

DHA is still evaluating whether to recommend extension of some or all of the demonstration beyond December 31, 2026.

(xi) An identification of legislative or administrative action necessary to make the demonstration project permanent.

DHA has no recommendations regarding legislative or administrative action needed to make the CBSD permanent under the Basic (i.e., medical) benefit at this time.

CONCLUSION

The preliminary claims analysis indicates that TRICARE reimbursement of CLDs may be associated with lower odds of a caesarean section, lower odds of a pre-term birth, increased odds of prolonged labor, and increased odds of a PPD diagnosis. The preliminary claims and survey analysis suggest that breastfeeding counseling performed by non-RN LCs funded by TRICARE is of the same quality as counseling performed by TRICARE RN LCs. The results in this report should be considered preliminary and subject to change. DHA intends to use the final year of the evaluation to continue to gather data and refine the analyses. A decision regarding permanent coverage has not been made for any of the services under study. The next year will be more stable than the last for the CBSD, which will result in better data and allow for greater confidence in the results. DHA is grateful to all of the beneficiaries and providers who have participated in the CBSD to date.