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S1.09 Doula Coverage for Medicaid

Blue Cross VT is agnostic on S. 109, this is a policy decision between DVHA and the Legislature. We think a lot about health equity. In the second whitest state in the nation, all too often people look at the demographics and think that because the number of People of Color is so small, we don't have problems with racism and unconscious bias that the much larger states and cities have, when in fact it is the very opposite.

Yesterday the GMCB heard a report out of Act 167's community outreach; an executive of a hospital was taking part in a discussion about health equity they said: "We don't have any diversity in VT, so it's not a problem here."

I think a key task in a very homogeneous state is challenging what lies beneath our assumptions, and our stereotypes, and look those unconscious biases in the eye. It's uncomfortable, but it's critical, especially given the population differential, and people for whom English is not their first language—especially in health care, where people are trusting us with their deepest vulnerabilities, in life and death situations.

I want to throw out some maternal health data that I think is pretty shocking.

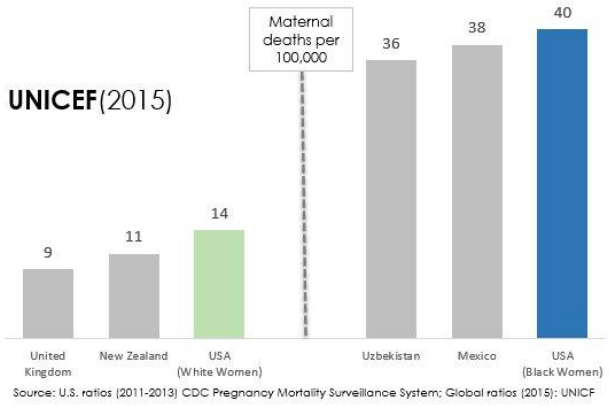
1.) 1 in 5 women report mistreatment from medical staff during pregnancy according to the Centers for Disease Control and Prevention.
   - The women reported signs of mistreatment, such as being verbally abused, having their requests for help go unanswered, having their physical privacy infringed upon and receiving threats to withhold treatment.
   - Data: About 2,400 women were surveyed. Of the 20% of women who said they were mistreated, 30% were Black, 29% were Hispanic, 27% were multiracial, 19% were white, 18% were American Indian/Native Hawaiian/Pacific Islander and 15% were Asian.
   - Forty-five percent of respondents said they were hesitant to approach their provider with questions or concerns during maternity care.
     - They cited reasons such as thinking or being told by friends or family that what they were concerned about was normal, not wanting to be seen as difficult or making a big deal of something or feeling embarrassed, or thinking their provider seemed to be in a hurry.

Imagine if those people had a trusted person in their corner during their pregnancy, labor and delivery.

2.) The U.S. maternal death rate rose sharply during the COVID-19 pandemic.

- An NPR story found that "In 2021, about 1,200 women died from maternal-related causes, a 40% spike from the previous year and one of the worst rates of maternal mortality in the country's history."

1.) Black birthing people in the U.S. are more likely to die in childbirth than birthing people in the developing countries of Mexico and Uzbekistan (UNICEF and World Health Organization data, 2015).



- Black birthing people are three times more likely to die from childbirth complications than White birthing people, and face a 70% higher risk of severe maternal morbidity (SMM), or life-threatening events, than any other racial groups—often related to conditions that require close attention throughout their pregnancy.
    - In 2020, the maternal mortality rate for non-Hispanic Black people was 55.3 deaths per 100,000 live births, nearly 3 times (2.9) the rate for non-Hispanic White people.
    - These rates increased precipitously with maternal age.
        - Rates in 2020 were 13.8 deaths per 100,000 live births for women under age 25, 22.8 for those aged 25–39, and 107.9 for those aged 40 and over (Figure 2 and Table).

What is shocking about these statistics is that according to the CDC, over 60% of these deaths are preventable.

A key point about this is that these disparities span education levels, socioeconomic status, age and geography—it points to deeper-seated issues like underlying chronic conditions, racial inequities and bias within the health care system that must be addressed systemically and across a woman's life span—not just while she is pregnant.

This are really depressing statistics. So, what can we do about it?

Meaningful actions must combat the cultural, operational and structural barriers that have created inequities that exist today, while also addressing disparities in maternal health. Maternal care must be culturally conscious and competent.

Doula care seems simple and low tech, and you may wonder what it has to do with these statistics. Research has shown that the presence of a doula in pregnancy, labor, delivery or postpartum is a simple but effective key to begin to close the gap in Maternal Health Equity.

Doulas have been shown to significantly improve outcomes like reducing cesarean births and preterm deliveries.

Blue Cross VT is a health plan that supports a comparatively tiny population, with our member size equal to that of many mid-size cities. Cost containment is critically important to us, so let's look at the numbers:

- The cost of a normal birth can range from $9300 ($9,340) in Morrisville to just under $29,000 ($28,962) in Burlington.

- A cesarian birth can cost about $20k ($20,277) at Copley or about $35,000 ($35,090) at UVM Medical Center.

- The cost for a premature birth can cost about $61,442, and that just scratches the surface for the costs for the infant's NICU stay.

The cost differential between a normal healthy birth at term and a birth with complications are significant.

Doulas also can reduce anxiety and depression (which can directly affect labor progress and improve vaginal birth rates) as well as reduce disparities by advocating, educating and supporting people of color to be engaged in their own health care, and to be heard and respected by their providers. When a birthing person has a trusted person in their corner to help advocate for them, it makes an enormous difference in health outcomes.

Postpartum:

Doulas have also been shown to increase breastfeeding rates (which has significant implications for a baby's lifelong wellness) and lower rates of postpartum depression. There is an incredible retrospective cohort study[1] using Medicaid medical claims from California, Florida, and a northeastern state that compares maternal health outcomes between women who did and did not receive doula care between 2014 and 2020.

[1] Falconi, et.al. "Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching." eClinicalMedicine 2022; 50: 101531 Published online 1 July 2022. https://doi.org/10.1016/j.eclinm.2022.101531.

- included 298 pairs of women matched on age, race/ethnicity, state, socioeconomic status, and hospital type (teaching or non-teaching).

The study found that women who received doula care had 52.9% lower odds of cesarean delivery and 57.5% lower odds of postpartum depression/postpartum anxiety. Doulas who provided care with a clinical team that included a midwife most consistently showed a reduction in odds of cesarean delivery, regardless of the trimester when doula care was received. Women who received doula care during labor and birth, but not necessarily during pregnancy, showed a 64.7% reduction in odds of postpartum depression and anxiety. The study found that the use of doulas is an effective strategy for improving maternal health, especially among socioeconomically vulnerable and marginalized minority populations.

Blue Cross VT is a health plan, and a tiny one at that, and so we rely heavily on data to show that benefits outweigh the increased cost we are asking our members to shoulder. Unfortunately, in a state with demographics like ours, we don't have great data to pull from, so I along with members of our Better Beginnings program (maternal health), our Diversity Equity Inclusion Council and our Health Equity team approached our Innovation Lab with a proposal to create a Blue Cross VT Health Equity Doula Pilot.

Population served by the pilot:

- 20 spots for Black, Asian, Pacific Islander, Hispanic people or refugees
- 10 spots for White people with high "Resource Utilization Band" score (4 or 5), or those who meet one of these criteria:
    - Previous low birth weight
    - Previous cesarean
    - Previous traumatic birth
    - Maternal health or social risk factors
    - Social Determinants of Health

Current status of the Blue Cross VT Health Equity Doula Pilot:

- White birthing people with high risk birth: 10 members have enrolled
- Black, Asian, Pacific Islander, Hispanic, or "Refugee" population 9 members have enrolled.
- We have 4 members in the pilot that have given birth. The rest are in various stages of their pregnancy journey post-partum.
- We will use the findings from the pilot to determine whether we it makes sense to offer a doula benefit to our entire member population.

Quotes from the exit interviews from the people from the pilot who have given birth to date:

- "I couldn't imagine doing it again without her. She was a massively important component to that day."

- "I can't say enough good things about having a doula. This is my time to advocate! Our system is not set up for families especially for the birthing person to feel like they have enough time or financial resources to have a healthy post-partum healing journey. To even just have the time to focus on healing and bonding with the baby. I really think that having a post-partum doula is critical for all of that."

- “It was empowering as well as helpful to have my doula. I felt relieved from stress around the process which led to a healthier experience.”

- "She helped fill in gaps of general knowledge and information, and what to expect during delivery. She was a great advocate/support going through the labor and delivery process. Having a couple post-partum visits was great in her being there to answer questions about the baby."

Some concerns are geographic equity for our members—Central VT, Chittenden, Addison, Grand Isle, Upper Valley that have more doulas available, versus the doula deserts in Rutland, Bennington, Windham, and Northeast Kingdom. Certification is also a challenge, given the diversity of certification programs.

Blue Cross VT supported the Vermont Department of Health late in 2023 to apply for a HRSA STAMPP grant (Health Resources and Services Administration (HRSA) /Screening, Treatment, & Access for Mothers & Perinatal Partners (STAMPP) grant) to expand maternal health equity programs in Vermont, including the possibility of a train the trainers program. We are looking forward to hearing whether those funds are granted. VDH would be a great resource to invite into your committee to hear about their efforts around maternal health equity.