Voices for Vermont's Children

January 25, 2024

Respectfully submitted to the Senate Health & Welfare Committee,

Thank you for the opportunity to submit testimony on S.109, Medicaid reimbursement for doula services. Voices for Vermont's Children began research and advocacy on this policy in 2017 with the introduction of the first iteration of this bill, when the only states who had adopted it were Oregon and Minnesota. Already, the implementation in those two states suggested some improvements: certifying organizations should not be listed in the legislation itself, and rates need to be high enough that doulas, including experienced doulas, will participate.

It's no surprise that these are also some of the key questions I've heard this committee ask. I want to speak to these questions by sharing some takeaways from the research and outreach we have done over the past seven years - during which time the number of states who have adopted this policy has significantly increased. Vermont is now very well situated to benefit from all the lessons learned.

Below I've addressed the following areas:

- Qualifications and competencies
- Family and stakeholder expertise
- Doula independence
- Recommendations by other bodies
- Additional key research
- Vermont statistics
- Summary

<u>Qualifications and competencies</u>:

First, it's important to know that to support a family in this way, in Vermont and everywhere, a doula simply needs to be chosen by a birthing person to be a trusted companion as they navigate this part of their life. As has been noted already, it is a completely non-clinical, non-medical activity of support and companionship. Generally, doulas choose to be formally trained in some way, and some choose to be certified. Families can and do ask about these things, and make their choices according to what's important to them. During the early part of Covid, when traffic in health care settings was tightly controlled, one hospital in our broader

region instituted a requirement that doulas be certified, but that has now been lifted. In general, it is understood that the birthing person is the one best able to judge who they would like in the room with them, and will hire a doula based on their own criteria and comfort, just as they invite in friends and family according to their own wishes.

With Medicaid in the picture, it is also understood that there will need to be some way to administer and control a program that reimburses for this type of support. Nonetheless, I want to suggest as a principle something very important to doula care: that *the doula can unconditionally offer support for the self-determined needs and choices of the birthing person, and that this principle be protected and maintained for families covered by Medicaid just as it is for families who pay privately.* The principle of the agency of the birthing person is actually foundational to why doulas have the impact they do in the first place, which I will elaborate on later. We should strive to preserve that central goal if we want to see the biggest impact.

There are more than a hundred organizations in the United States that certify doulas. Some are national, some are very small, some have a specific emphasis on reproductive justice, community-based doulas, or full-spectrum doula support. Many offer very good training and could adequately prepare a doula to work with the Medicaid population; some would not. Some of the biggest and most well-known organizations have not historically been focused on the additional skill sets that are important when thinking about Medicaid, because they grew out of a context where doulas were usually supporting people with relative privilege. The simplified–but valid–critique has been that supporting people with some privilege doesn't necessarily equip a doula with a more nuanced, social-justice informed lens on the various oppressions many new parents might be in the midst of. Still, a more likely pitfall of naming specific organizations is also that quality trainings that *do* speak to these realities could easily be left out, and that experienced doulas who are very skilled and qualified but who are not certified (either never were or have not maintained) would also be left out. There is no overarching entity or body that accredits or evaluates any of these certifying organizations and therefore, it is the competencies supported by these trainings, and the relationship of trust that a family develops with a doula, that usually matters most to the birthing person.

In this same vein, naming organizations or even attempting to list competencies in the legislation itself leaves states in the position of having to revisit legislation to evolve these pieces, which is why recommendations as states have moved forward have shifted to leaving these pieces in administrative and rule-making processes. That is where we'd recommend they be held in Vermont.

Recognizing that what actually makes a doula qualified, especially to support families insured by Medicaid, is more easily assured by evaluating competencies, states that have adopted this policy more recently have established models that include multiple pathways to eligibility. Certification can and should remain one of these pathways, with appropriate attention to the particular certification, measured against the state's goals, and augmented with other qualifications when necessary. Other pathways can include a set of core competencies, completion of particular state-verified trainings, and/or demonstration of significant experience

and ongoing practice as a doula. Because this has always been an unregulated profession, there are already doulas in every state who are very experienced and deeply embedded in their communities, and as appropriate, should have a pathway to make use of that expertise with this added potential for sustainability. Both the community and the doula will benefit from the opportunity that Medicaid could provide to make this work more viable.

For expert discussion of regulatory questions and particularly the experiences of other states that have led to this evolution, I'd encourage you to consult with Amy Chen, senior attorney at the National Health Law Program and director of the Doula Medicaid Project. She is available to testify, and has consulted with us several times over the years. The Doula Medicaid Project has curated a comprehensive library of resources and research addressing all of these pieces.

Family and stakeholder expertise:

It is also with the consultation of the Doula Medicaid Project that the establishment of a Doula Advisory Board has been recommended to us, and in turn I will recommend to you that this component be considered for this bill, so that the expertise of the field of doulas in Vermont as well as other stakeholders, can be utilized in the development and implementation of the details of this policy. I would also recommend that family voice be included in this body.

Doula independence:

One thing I know from connecting with doulas and other providers across the state over the years is that there is a lot of enthusiasm for this idea, and there is also a concern for the principles of the work that need to be preserved. This is a field of work that has existed outside of systems (which is key to the efficacy of it, as I have alluded to already). It is important that policymakers hear from families as well as doulas about why this matters and why it works, so we can consider how best to preserve the particular unique relationship between family and doula even while attaching it to a new programmatic infrastructure.

Across studies, research has found that the impacts are strongest when the doula isn't an employee of the health care setting or a member of the birthing person's social circle. It is the very fact of doulas being situated outside of this system that has been the reason they have been in demand all along by those who can afford it. I want to reiterate that the experience that people who can pay privately for a doula support have–which is that their doula works for them alone and can therefore support them unconditionally–should be likewise accessible to a family who is covered by Medicaid.

The continuous and personal support that doulas provide is part of what makes doulas so impactful and unique. We know that health care providers have shifts, and are caring for multiple people at once. Doulas have established a relationship through extended contact beforehand and will maintain contact after birth. They are also often the only one on call for one family for multiple weeks in a row. Once they join a family in labor, they are there for the duration. This is why doulas can only support a limited number of families per month/year, and

this unique type of schedule should also be considered as a factor in rate-setting. Vermont will find that we will need to nurture a growing workforce of new doulas, so policy should also consider the cultural congruence, skillset, and incentives we're establishing to grow the best possible workforce for Vermont's families.

Recommendations by other bodies:

While the positive impact of doulas has already been well established in other testimony, I also want to share that in 2017, the American College of Obstetricians and Gynecologists released a Committee Opinion, Approaches to Limit Intervention During Labor and Birth, (and reaffirmed this consensus statement again in 2021), affirming that "evidence suggests that, in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor." The goal of limiting intervention facilitates the further goal of promoting lower-risk births that end up being safer as well as less expensive.

As early as 2012, federal Centers for Medicaid and Medicare Services (CMS) was exploring doula care as a recommended innovative service to improve birth outcomes. In 2023 CMS hosted its first Health Equity conference, including a presentation on Medicaid reimbursement for doula services which reiterates the recommendations I've presented here regarding competencies and doula advisory. Aside from it clearly being a popular policy among states, it is also included as a recommendation in the White House Blueprint for Addressing the Maternal Health Crisis, and Vermont's Building Bright Futures has included expanding Medicaid coverage for doula services in their own policy recommendations this year.

Continuous support during labor and birth is named as a key component of safe, respectful birth care worldwide and across all circumstances and settings by:

- MotherBaby Childbirth Initiative
- mother-Friendly Childbirth Initiative
- Rights of Childbearing Women
- World Health Organization

Additional key research:

The impact statistics that have circulated for years suggest some easily measurable outcomes, including a 30% reduced risk of labor induction, a 28% reduced risk of cesarean section, and a 14% reduced risk of a newborn admission to the NICU.[1] The most recent scoping review includes discussion of the impact on birth trauma, breastfeeding, and racial disparities across multiple areas.[2] Conceptual models attempting to explain why outcomes are so good rest

[1] Bohren MA, Hofmeyr G, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6

[2] Sobczak A, Taylor L, Solomon S, Ho J, Kemper S, Phillips B, Jacobson K, Castellano C, Ring A, Castellano B, Jacobs RJ. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review.

fundamentally on experiences of safety and trust, which is why I am emphasizing the importance of the integrity of the doula/client relationship.

Vermont Statistics:

Medicaid does cover a significant portion of the births in Vermont, and now, with expansion of coverage to a full postpartum year, doulas would be an impactful use of that expanded postpartum coverage period.

As has been mentioned in other testimony, Medicaid paid for just over 2,000 births in 2021, representing 37.6% of all births in the state.[3] Medicaid reaches many young families. For all age groups under 30, the rate of Medicaid births is above the state overall rate and for births to people under 20 the rate is nearly 90% and 20-24 is 66%.[4]

Cesarean-section is the most commonly performed operation in the world. Vermont's rate relative to other states is lower, at 20.1% for primary cesareans. The World Health Organization has recommended rates never be higher than 15% and additional studies have shown no health and safety benefits found with rates above 19%, so there is room for improvement.

There are indications that NICU admissions are higher for Medicaid births in Vermont, and Vermont Medicaid insurance reaches more BIPOC birthing people in general.

Summary:

Reasons to implement this policy in order of priority should be:

1. Well-being of families, in both measurable and immeasurable ways
2. Benefits and savings to broader systems in the short and long term
3. Value and cost savings to the Medicaid program

Fortunately, this policy does check all of these boxes in significant ways.

Priority considerations are:

Cureus. 2023 May 24;15(5):e39451. doi: 10.7759/cureus.39451. PMID: 37378162; PMCID: PMC10292163.

[3] Births covered by Medicaid, https://datacenter.aecf.org/data/tables/10157-births-covered-by-medicaid?loc=47&loct=2#detailed/2/any/false/2048,574,1729,37,871,870/any/19594,19595

[4] Births covered by Medicaid by maternal age. https://datacenter.aecf.org/data/tables/10158-births-covered-by-medicaid-by-maternal-age?loc=47&loct=2#detailed/2/any/false/2048,574,1729,37,871,870,573/838,7,4122,6263,6264,6265,6272,122/19597,19596

- Incentivize the growth of a workforce of community-based doulas. Adequate rates and understanding important competencies are critical.
- Protect the autonomy and independence of the doulas role. The doula works for the birthing person and must be free of any other conflicts of interest, and the birthing person must be able to perceive unconditional support from the doula.
- No place of birth should restrict or place conditions on which type of doula can support within that venue.
- We should look to other states and to families and doulas for expertise in the process of developing and implementing this policy.

The foundational mechanism of doula support is the preservation and protection of a birthing person's agency and knowledge of their own self and their own needs. In any and all iterations of this policy that should be centered because to the extent that doulas seek to work with that, that is why doulas work.

Thank you for considering this important policy.

Respectfully,
Sarah Teel
Research Director
Voices for Vermont's Children
steel@voicesforvtkids.org