

Improving Our Maternity Care Now: *Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*

Executive Summary

The U.S. maternity care system fails to provide many childbearing people* and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income country.

Our health care system spectacularly fails communities struggling with the burden of structural inequities and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.

In the long term, we must transform the maternity care system through multiple avenues: delivery system and payment reform, performance measurement, consumer engagement, health professions education, and modifying the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models lead to demonstrably better care, experiences, and birth outcomes. We just have to take steps to make them readily and widely available. We have identified three reliably high-quality forms of maternal and newborn care, as well as one promising, emerging model.

Clear evidence shows **midwifery care**, **“community birth” settings** (birth center and home birth settings), and **doula support** (including the extended model of prenatal, childbirth, and postpartum support) provide excellent and appreciated woman- and family-centered experiences, leading to improved birth outcomes. In addition, **community-led and -based perinatal health worker groups** are a newer, hybrid model of care that explicitly centers meeting community needs and priorities – particularly in communities of color – by providing a wide range of services, including in many cases some combination of midwifery care, community birth settings, and doula support. This model has emerged

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this report uses both gendered terms such as “women” or “mothers” and gender-neutral terms such as “people,” “pregnant people,” and “birthing persons.”

The terrible impacts of these inequities are unfair and unconscionable, considering that 60 percent of pregnancy-related deaths are preventable.

as a very promising practice in maternal care that has not been extensively evaluated as a unit, even as specific elements of care clearly have strong evidence of success, as already described. Given the strong focus on community-led services and the prominent role Black, Indigenous, and other women leaders of color have played in its creation and growth, it is likely that this last model is highly effective in reducing intractable racial inequities that have plagued many communities.

These four models of care share characteristics that distinguish them from the typical maternal care currently available in the United States. They provide highly appropriate care, minimizing both overuse and underuse. Care team members tend to be highly mission-driven and committed to meet their clients where they are. They holistically help meet families' physical, emotional, and social needs, providing individualized, respectful, trusted, relationship-based care. They tend to incorporate the skills and understanding to expertly support physiologic childbearing for the growing proportion of people interested

in birthing in a less medicalized, more holistic way that avoids unneeded medical interventions. Their remarkable outcomes on key health indicators succeed for communities that are commonly left behind. Lastly, while demand for these services is great, too often women and families can't access and benefit from them.

This report describes each of these models, their current availability, and the evidence that supports their safety, effectiveness, and broader adoption to improve maternal and infant health. The report also provides recommendations for decisionmakers in the public and private sector to achieve this goal.

Models of Care Meriting Wide Adoption

Evidence shows that the first three models – midwifery care, community birth settings for medically low-risk pregnancies, and doula support – are highly effective and improve maternal and infant health. These results are especially notable given that usual maternity care continues to fail many birthing people and their families. We continue to have rates of preterm

birth, low birth weight, and cesarean births that are too high; rates of vaginal birth after cesarean and initiation and duration of breastfeeding that are too low; and extreme and unacceptable racial and ethnic inequities. Clearly, many more childbearing people and families could and should benefit from these higher-quality options.

The newer model comprises perinatal health worker groups headed by local community leaders. These multifunction groups are explicitly designed to meet the individual needs of childbearing people, families, and communities. They offer a wide range of services, often including one or more of the three evidence-based models described above. Frequently, they combine clinical and support services. They are particularly known for their expertise in offering respectful, trusted, culturally congruent care to communities of color. Such care acknowledges that women's cultural identity is central to the clinical encounter, upholds racial justice, fosters agency and practices cultural humility. In many cases, the groups also offer training programs that include national competencies such as comfort measures for doula support, as well as trauma-informed care to address the distinctive needs of marginalized communities and mitigate the harms of racism.

While evaluations of the perinatal health worker groups model are limited, available data show impressive results. And to the extent that these groups offer proven

services such as midwifery care, community birth, and doula support, they are based on clear evidence. Given the urgency to mitigate the country's maternal health crisis, support for these groups should be prioritized along with evaluations of their impact.

As we work to transform the maternity care system, midwifery care, community birth, doula support, and the services of community-led perinatal health groups must be central to quality, value, and equity.

RECOMMENDATIONS

The ongoing maternal health crisis, compounded by the current COVID pandemic, underscores the urgency of taking concrete action now to improve birth outcomes for women and their families.

Congress and federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act, a bipartisan bill designed to increase the supply of midwives with nationally recognized credentials.
- Enact the Birth Access Benefiting Improved Essential Facility Services (BABIES) Act, a bipartisan bill to fund sustainable Medicaid demonstrations of birth centers for enrollees with low-risk pregnancies in underserved areas.
- Enact the Kira Johnson Act, which would improve Black maternal health by providing funding for community-based perinatal health worker organizations, especially those led by Black women; address racism and bias in all maternal health settings; and support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act, which aims to grow the maternal health workforce, to provide guidance to states for promoting diverse maternity care teams and centering culturally congruent care in improving outcomes, and to study the barriers to entry for low-income and minority women into maternity care professions.
- Ensure that Medicaid, CHIP (Child Health Insurance Program), TRICARE (military health care program), Veterans Health Administration (VHA), Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service (as appropriate) cover:
 - ◆ Certified midwives (CMs) and certified professional midwives (CPMs)
 - ◆ Licensed birth centers and midwife birth center providers with nationally-recognized credentials
 - ◆ Home birth attended by midwives with nationally-recognized credentials
 - ◆ Doula support
- Create programs to support and evaluate community-based multi-functional programs, such as through the Center for Medicare and Medicaid Innovation.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health (including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding).

State decisionmakers should:

- Enact necessary licensure in remaining jurisdictions for CMs, CPMs, and birth centers.
- Ensure that midwives with nationally recognized credentials are paid at the same level as physicians for the same service.
- Ensure that state Medicaid and CHIP programs pay for
 - ◆ Services provided by CMs and CPMs
 - ◆ Facility fees of licensed birth centers and professional fees of midwives with nationally-recognized credentials practicing in licensed birth centers
 - ◆ Home births attended by midwives with nationally-recognized credentials
 - ◆ Doula support
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice “at the top of their license” according to their full competencies and education.
- Ensure that doula training is tailored to the specific needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Pursue partnerships with community-based perinatal health worker groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments.

Private sector decisionmakers should:

- Educate employees and beneficiaries about the benefits of high-value forms of maternal health care, including midwifery care, birth centers, and doula support.
- Ensure that plan directories maintain up-to-date listings for available birth centers and midwives.
- Ensure that plans contract with birth centers and midwives with nationally recognized credentials in their service area and reimburse care in all settings provided by midwives with nationally-recognized credentials.
- Include extended model doula support as a covered benefit in health plans.
- Make the services of community-based perinatal health worker groups available to beneficiaries and evaluate the return on investment, including implications for quality of care, health outcomes, and women’s experiences.

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Conclusion

Our nation's terrible birth outcomes and unconscionable racial and ethnic inequities are driven by many separate yet interrelated factors and will require a multifaceted strategy to solve permanently. Nevertheless, we already know what to do to make concrete progress and achieve healthier mothers and babies. We must not accept the status quo of inequitable and expensive care that perpetuates avoidable harm. Concrete progress is within reach if decisionmakers are willing to act.