Improving Our Maternity Care Now Through

Community Birth Settings

April 2022

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American College of Nurse-Midwives — With women, for a lifetime®

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Executive Summary

Our nation's maternity care system fails to provide many childbearing people* and newborns with equitable, accessible, respectful, safe, effective, and affordable care. More people die per capita from pregnancy and childbirth in the United States than in any other high-income country in the world. Our maternity care system spectacularly fails communities struggling with the burden of structural inequities due to racism and other forms of disadvantage, including Black, Indigenous, People of Color; rural communities; and people with low incomes.

Both the maternal mortality rate and the much higher severe maternal morbidity rate (often reflecting a "near miss" of dying) have been increasing. Both reveal inequities by race and ethnicity. Relative to white, non-Hispanic women, Black women are more than three times as likely – and Indigenous women are more than twice as likely – to experience pregnancy-related deaths. Moreover, Black, Indigenous, Hispanic, and Asian and Pacific Islander women disproportionately experience births with severe maternal morbidity relative to white, non-Hispanic women.

This dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that there are specific care models that can make a concrete difference in improving maternity care quality and producing better outcomes, including for birthing People of Color. One of these is the care provided in **community birth settings,** an increasingly used term for both birth centers and home birth care. Almost exclusively, such care is led by midwives. This report outlines the evidence that supports the unique value of community birth settings across different communities, the safety and effectiveness of care in these settings in improving maternal and infant outcomes, the interest of birthing people in use of birth centers and home birth care, and the current availability of, and access to, birth centers and home birth care in the United States. We also provide recommendations for key decisionmakers in public and private sectors to help support and increase access to care in community birth settings.

Research shows that community birth settings provide many benefits for birthing people and newborns relative to experiences of similar people in hospital settings. These

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report gives preference to gender-neutral terms such as "people," "pregnant people," and "birthing persons." In references to studies, we use the typically gendered language of the authors.

include lower rates of many interventions; more favorable assessments of experiences; better outcomes for such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding; and lower overall costs. Birth centers and home births are safe options for essentially healthy birthing families in the context of policies and practices that integrate community birth providers into the maternity care system. Care in these settings that is led by Black, Indigenous, People of Color is a crucial approach for meeting the needs of communities affected by structural racism and other forms of discrimination. While use of these settings has been steadily growing, and interest far exceeds access, just a fraction of births that might occur in these settings take place there at present. Access to, and use of, these beneficial settings by People of Color, who might disproportionately benefit from this attentive, individualized, relationship-based, and often culturally congruent model of care, is disproportionately lower than that of white people.

Expanding access to care in community birth settings is a cost-effective solution to providing higher quality care and better birth outcomes, and – with intentional focus – to advancing birth equity. Barriers to this care must be eliminated. These include: barriers to the growth of the midwifery workforce, which is most likely to practice in these settings; capital costs needed to establish and operate birth centers; inconsistent reimbursement or unsustainable levels of Medicaid and other reimbursement of midwifery and birth center services; needlessly restrictive birth center licensure; and failure to license and regulate birth centers in all states.

Enabling more birthing people to receive care in community birth settings and increasing access to community birth care provided by and for People of Color should be a top priority for decisionmakers at the local, state, and federal levels. To achieve this, we recommend the following:[†]

Expanding access to care in community birth settings is a cost-effective solution to providing higher quality care and better birth outcomes, and – with intentional focus – to advancing birth equity.

[†] The main body of this report provides fuller, more detailed versions of these recommendations.

Federal policymakers should:

- Ensure coverage of birth center services and of midwives practicing in birth centers by all federal providers and payers of maternity services.
- Ensure coverage of midwifery-led home birth services by all federal providers and payers of maternity services, with the exception of Bureau of Prisons and Department of Homeland Security detention centers.
- All midwives holding the three nationally recognized midwifery credentials should be eligible providers under federal health programs, and should receive payments at parity with physician-provided maternal-newborn health services.
- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3352 and S. 1697 in the 117th Congress) to increase access to midwives.
- Include in appropriations bills monies to increase the supply of midwives holding the three nationally recognized credentials by supporting programs or schools, preceptors, and students who will diversify the midwifery workforce and build capacity in underserved areas.
- The Department of Health and Human Services (HHS) should include Certified Midwives and Certified Professional Midwives as health professionals eligible for loan forgiveness under the National Health Service Corps program.
- HHS should issue updated guidance clarifying the ACA Section 2301 requirement of Medicaid coverage of birth center services to expand coverage and access for Medicaid enrollees.
- Enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 3337 and S. 1716 in the 117th Congress) to increase access to birth centers.
- Include in appropriations bills monies to support community-led solutions to maternal health inequities by supporting the capital needs of developing birth centers led by and serving birthing families in most adversely affected communities.
- Ensure sustainable payment of birth center services, of midwives practicing in birth centers, and of midwives providing home birth services by Medicaid, Medicaid managed care organizations, Child Health Insurance Programs (CHIP), and other federally supported programs.
- The Office of the National Coordinator should include birth centers as primary birth facilities when formulating the national strategy relating to electronic health information.
- The Veterans Affairs Community Care Network, TRICARE, and Military Treatment Facilities should include in-network birth centers and collaborating physician practices in any demonstrations of purchased care electronic health information interoperability.

- The Office of Personnel Management should encourage plans participating in the Federal Employee Health Benefits Program to increase the percentage of midwives, birth centers, and other maternity services purchased through value-based contracting.
- Reallocate available Coronavirus Aid, Relief, and Economic Security (CARES) Act provider relief fund monies to prepay electronic health records and Health Information Exchange expenses for qualified birth centers and their collaborators.
- Enact all provisions of the Black Maternal Health Momnibus Act of 2021 (H.R. 959 and S. 346 in the 117th Congress) to advance birth equity through a broad range of strategies.
- Congress should ensure that all Medicaid enrollees have coverage for one year postpartum by passing a permanent universal extension of the American Rescue Plan's state option to expand postpartum Medicaid coverage.
- Identify, track, and address health inequities, require collection and public reporting of key maternal-infant health indicators disaggregated by race and ethnicity and other dimensions across federal programs.
- Whenever feasible, include community birth settings, providers, and service users in data collection and reporting, performance measurement, payment reform, and quality improvement initiatives across federal programs.

State and territorial policymakers should:

- Enact birth center licensure without unnecessary legal restrictions limiting access in the nine states that do not currently regulate birth centers, and amend current state statutes to remove widespread and unnecessary restrictions.
- Enact certified midwife and certified professional midwife licensure in states and territories that currently fail to recognize holders of these credentials.
- Require Medicaid managed care organizations to contract with state-regulated birth centers and with midwives who practice in birth centers and provide home birth services.
- Whenever feasible, include community birth settings, providers, and service users in data collection and reporting, performance measurement, payment reform, and quality improvement initiatives.
- Develop and enact state "Momnibus" legislation modeled on legislation recently enacted in California and Colorado to advance birth equity.
- In consultation with relevant people from the most affected communities, create processes for equitable development investments that support community birth centers, modeled on similar work in Seattle.

Private sector decisionmakers, including purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to, and sustainable payment for, care in birth centers and home birth settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwifery-led care in community birth settings.
- Ensure that plan directories maintain up-to-date listings that identify all available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of maternity care that is integrated across providers and settings, with seamless consultation, shared care, transfer, and transport from community birth settings as needed.
- Whenever feasible, include community birth settings, providers, and service users in data collection and reporting, performance measurement, payment reform, and quality improvement initiatives.

Improving Maternity Care Through Community Birth Settings

The United States maternity care system fails to provide many childbearing people* and newborns with equitable, accessible, 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 nation.[1] The U.S. maternal care system is failing, and failing worst of all in communities struggling with the burden of structural inequities due to racism and other forms of disadvantage, including Black, Indigenous, People of Color; rural communities; and people with low incomes.[2]

Rates of maternal death and severe maternal morbidity in the United States have been worsening instead of improving. In 2019, the U.S. maternal mortality rate was 20.1 per 100,000 live births, a significant increase over the maternal mortality rate in 2018 (17.4 per 100,000 live births).[3] Between 1987 and 2017, pregnancy-related deaths in the United States more than doubled – from 7.2 to 17.3 deaths per 100,000 live births.[4] Between 2006 and 2015, severe maternal morbidity (SMM), often reflecting a "near miss" of dying, rose by 45 percent, from 101.3 to 146.6 per 10,000 hospitalizations for birth.[5] Following the 2015 shift to a new clinical coding system (ICD-10-CM/PCS), SMM continued to increase, overall and for People of Color, from 2016 to 2018.[6]

The crisis is especially severe in communities of color. Compared to white, non-Hispanic women, Black women were more than three times as likely – and Native women were more than twice as likely – to experience pregnancy-related deaths from 2014 through 2017. Moreover, Black, Hispanic, and Asian and Pacific Islander women disproportionately experience births with SMM relative to white, non-Hispanic women.[7] In 2015, relative to white, non-Hispanic women, the rate of SMM was 2.1 times higher for Black women, 1.3 times higher for Hispanic women, and 1.2 times higher for Asian and Pacific Islander women.[8] From 2012 through 2015, Indigenous women experienced 1.8 times the SMM rate of white women.[9]

Many factors drive maternal mortality and morbidity and the deep racial, ethnic, and geographic inequities in this area. These include gaps in health care coverage and access to care; unmet social needs, like transportation and time off from paid work for medical visits, and safe and secure housing; poor quality of care, including care warped with implicit and explicit bias; and for People of Color, the effects of contending

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report gives preference to gender-neutral terms such as "people," "pregnant people," and "birthing persons." In references to studies, we use the typically gendered language of the authors.

with systemic racism.[10] The terrible impacts of these inequities are unconscionable, especially considering that 60 percent of pregnancy-related deaths are preventable.[11]

In the long term, we must fundamentally re-imagine what a high-quality, equitable maternal care system looks like, and develop that system. We must continue to push for reforms, including delivery system and payment reform, performance measurement, consumer engagement, health professions education, and improving the workforce composition and distribution. We must better address the social needs of childbearing families. And right now, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm and immediately give birthing people the support they need to develop resilience and achieve their aspirations.

Fortunately, research shows that specific care models make a concrete difference in providing higher-quality care and improving birth outcomes. The type of care provided in birth centers and for planned home births is one example of better care that we must make widely available, especially for birthing people and families of color.‡

Community birth settings in the United States

While the vast majority of births in the United States occur in hospitals, demand is growing for care in birth centers and at home. People who plan to give birth in both of these settings experience a similar, distinctive model of prenatal-through-postpartum care. Together, maternal-newborn care in birth centers and at home birth is increasingly known as "community birth." These settings safely serve essentially healthy birthing people who wish to have a physiologic childbirth,** avoid the over-medicalization that is common in hospitals, retain more autonomy and self-determination, and receive more personalized, non-discriminatory, and culturally relevant care. Currently, many birthing people experience neglect and mistreatment around the time of birth, with especially high rates for People of Color having hospital births.[12]

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‡ To learn more about three other high-performing models of maternity care – midwifery care, doula support, and support and care from community-led perinatal health worker groups – see our foundational report *Improving Our Maternity Care Now* at www.nationalpartnership.org/improvingmaternitycare.

** With "physiologic birth," the care team supports the innate capabilities of the birthing person and fetus/newborn for labor, birth, breastfeeding, and attachment, and uses procedures, drugs, and other interventions judiciously, as needed, rather than commonly or routinely. See Sarah J. Buckley. *Hormonal Physiology of Childbearing* (Washington, DC: National Partnership for Women & Families, January 2015), www.nationalpartnership.org/physiology.

Birthing people who may plan to give birth in the hospital by choice – or alter plans and have a hospital birth when their situation evolves and they need a higher level of care – experience great benefits from the longer, more individualized, relationship-based prenatal and postpartum visits that are typical within the community birth model.[13]

Almost exclusively, birth centers and home birth care in the United States are led by midwives,[14] who provide exemplary care to childbearing people. In general, midwifery is a high-touch, low-tech approach to maternity care based on the core understanding that childbearing for most birthing people is a healthy process. A parallel report describes the midwifery workforce in the United States, the evidence supporting midwifery care, experiences and interests of birthing people in using midwifery care, and current access and use. It also provides recommendations for policymakers and other decisionmakers to increase access to midwifery care and resources for learning more.[15]

Historically, childbirth and other maternal and newborn care were situated in communities and provided by midwives. However, in the early 20th century, through intentional and highly racialized shifts, pregnancy and childbirth were reframed as medical – and often pathological – conditions, rather than as primarily healthy physiologic life processes. Birthing moved from being attended by midwives of all backgrounds and traditions at home, to hospitals dominated by white men who saw childbirth as a medical problem to be solved with an array of drugs, treatments, and interventions.[16] Through to the present, nearly all who give birth in hospitals receive such care, regardless of need or preferences.[17]

Medicine's denigration and elimination of Black, Indigenous, immigrant, and other community midwives is an example of the racism that pervades our society and health care system.[18] Both racism[19] and gender-based violence[20] toward birthing people have been well documented in obstetrics.

Just as in the broader society and health care system, racism is present in midwifery. Since the transition to obstetric and hospital dominance, midwifery in the United States has developed as a disproportionately white profession.[21] Efforts to combat racism in midwifery and diversify the profession are underway.[22] Culturally congruent community-based and -led models of midwifery and care in birth centers and at home are crucial.[23] Community birth can offer more opportunities for People of Color to receive the additional benefits of racially congruent care that acknowledge a person's cultural identity as central to the clinical encounter, uphold racial justice, foster agency, and practice cultural humility.[24] The work of Birth Center Equity, the National Black Midwives Alliance, and other birth justice organizations (see Resource Directory) brings an essential lens for conducting analysis, reclaiming suppressed traditions, and healing racial harm and trauma.[25]

HOW RACISM UNDERMINED MIDWIFERY

Today's lack of access to midwifery and to community birth settings in the United States is rooted in racism. At the turn of the 20th century, midwives attended the births of half the babies born in the country. Most Black midwives (known as "grannies" or "granny-midwives" in the South) received their training through apprenticeships. In many areas of the country, physicians working in hospitals largely displaced midwives, as women were told that hospital births were more "modern" and "advanced."[26]

National legislation played a large role in the decline of midwifery: The Sheppard-Towner Act of 1921 supported prenatal and children's health centers. The law established public health nurse supervision, training, and oversight of traditional midwives, which discouraged the practice of midwifery, particularly Black midwifery. Biased views held that the midwives were too uneducated and unclean and too involved with cultural practices to provide optimal maternity care. While midwifery practice and community standing declined among all midwives, Sheppard-Towner especially targeted Black midwives.[27]

The effects were severe. For example, in 1920, there were 5,000 Black midwives in Georgia alone, but by 2002, the state had just 15 practicing Black midwives; and in 2020, 7 percent of midwives certified by the American Midwifery Certification Board identify as Black or African American, in contrast to 16 percent of childbearing women.[28] By the 1930s and 1940s, primarily affluent native-born white male physicians with standardized curricula, formal credentials, authority to self-regulate, and hospital-based practice came to predominate as maternity care providers.[29]

Indigenous midwives have also faced a pattern of racialized barriers to practice. Over the course of a century and in the name of "safety," state and federal legislation has forced Indigenous midwives to assimilate into the predominant under-resourced and underperforming medical system. Indigenous midwives and their longstanding traditions, as well as the communities they serve, have been adversely affected. Many Indigenous people now live in communities designated as workforce shortage areas.[30]

The community birth model of care can achieve remarkable outcomes, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.

Community births are a small – but rapidly growing – portion of births in this country. In 2020, most people in the United States (98.0 percent) gave birth in hospitals, 1.3 percent gave birth at home (with at least 1.1 percent intentionally), and 0.6 percent in a birth center.[31] Rates of community birth vary from state to state, ranging from 0.4 percent in Louisiana to 7.2 percent in Alaska.[32] Rates of community birth tend to be higher in other high-income countries, with up to 20 percent giving birth at home in the Netherlands, and 10 to 11 percent using birth centers in New Zealand, the Netherlands, and England.[33]

Use of community birth settings in the United States has been increasing steeply. From 2004 to 2019, community births rose by 91 percent, with home births growing by 83 percent, and birth center births by 130 percent.[34] Overall interest in these settings is rising, and these increases are especially notable in the context of inconsistent insurance coverage of care in these settings and high levels of self-pay.[35] The loss of rural hospital maternity units may be an additional driver of growth of use of community birth, including both planned and unplanned home births.[36] More recently, there has been much anecdotal evidence that the COVID-19 pandemic has spurred an interest in these settings,[37] as birthing families have become concerned about reducing opportunities for exposure to the virus in acute facilities, and many hospitals have set hard limits on who can accompany birthing people during labor and birth. Lastly, with rising publicity about disrespectful and unsafe hospital treatment of Black birthing people in particular, interest in non-hospital care settings, which some view as safer and more respectful and responsive, appears to be growing in this community.[38]

Initial birth certificate data confirm these trends, with planned home births increasing by 23 percent nationally and birth center births by 13 percent nationally from 2019 to 2020. Overall, community births increased by 20 percent from 2019 to 2020, in contrast to the average annual increase from 2004 to 2019 of 0.05 percent. Across racial and ethnic groups, from 2019 to 2020, the increase for Black, non-Hispanic women was 30 percent, for Native American 26 percent, for Hispanic women 24 percent, for both Asian and white women 18 percent, and for Native Hawaiian

During labor and birth, birth centers provide care options not typically available in hospitals, which enables birthing persons to experience more freedom and autonomy.

or Pacific Islander women 13 percent.[39] A detailed analysis of this steep increase in use of community birth settings during the first year of the pandemic recognizes the contributions of midwives who greatly increased their services in these settings during a global pandemic while apparently maintaining standards of appropriate risk selection for such care.[40]

The community birth model of care can achieve remarkable outcomes, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding. Furthermore, surveys of childbearing people find that large proportions are interested in these forms of care. However, too often childbearing people and their families, especially those in communities of color, cannot access and benefit from care in these settings. Increasing access to this model of care is an urgent priority that will improve maternal care, experiences, and outcomes in the United States.

Birth center care differs in fundamental ways from care in hospitals. Birth centers are designed to provide homelike care, and many are in converted homes. Community birth centers led by Black, Indigenous, People of Color are intentionally located in neighborhoods that are accessible and feel safer to birthing People of Color. Compared to typical maternity office visits, prenatal and postpartum visits in birth centers are generally much longer. In addition to the standard clinical checks, significant time is invested in building relationships and trust, providing support and education, and answering questions.[41]

During labor and birth, birth centers provide care options not typically available in hospitals, which enables birthing persons to experience more freedom and autonomy – for example, in movement, positions, and ingestion of liquids and solid food, as desired. Birth centers welcome companions of choice, which may include a partner, family members, friends, and a doula. The fetus is monitored with a handheld device to allow for freedom of movement and to reduce the likelihood of cesareans and other high-risk interventions associated with continuous electronic fetal monitoring.[42] Birth centers use non-pharmacologic tools to help birthing people cope with the challenges of labor. The many possible comfort measures include use of tubs and showers, hot or cold compresses,

inflated exercise balls, and massage. Often, nitrous oxide is also available for pain relief. After birth, skin-to-skin contact and early breastfeeding initiation are highly encouraged and supported.[43]

Birthing people are typically discharged from birth centers to home several hours after birth, with midwife or nurse home visits common one and three days or so after birth. If needed, birth center midwives manage first-line complications and consult or transport to hospital settings as appropriate.[44]

Home birth care also contrasts notably with hospital care, and it shares attributes with birth center care. While home births are a small fraction of births in the country, they are growing in popularity. About 85 percent of home births are planned, and midwives attend most planned home births, although some physicians attend home births.[45] For most birthing people who plan to give birth at home, the values and preferences that guide that choice are similar to those that move people to choose birth centers. In fact, some birth centers offer home birth as an option for their prenatal care clients.

Birthing in the familiar surroundings of one's own home can provide the maximum freedom and autonomy to have a physiologic birth.

Midwives who attend home births bring needed tools and supplies to provide care similar to that provided in birth centers. Some childbearing people obtain inflatable birth pools for use at home.

The National Academies of Sciences, Engineering, and Medicine's *Birth Settings in America* report provides additional details about practices and precautions in both birth center and home birth settings.[46]

Best available evidence finds equal or better outcomes with community birth, at lower cost

Birth Settings in America concludes that the patterns of use of interventions and health outcomes of community birth settings reflect both the self-selection of women who want this type of care and contributions of the "wellness-oriented, individualized, relationship-centered approach of midwifery care."[47]

Evidence about care in both community birth settings. Some studies have evaluated both community birth settings together. A systematic review[††] summarized results of nine outcomes in 26 studies of low-risk women planning birth in these settings in high-income countries.[48] Pooling results

[††] A systematic review is a method of assessing the weight of the best available evidence about possible benefits and harms of interventions or exposures. An investigation by the Institute of Medicine found that this rigorous methodology is the best way of "knowing what works in health care." Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation* (Washington, DC: The National Academies Press, 2008), https://doi.org/10.17226/12038

of comparable studies provides overall estimates of patterns of care and outcomes and also enables reporting on rare but critical outcomes.

Relative to women with planned hospital births, similar *women with planned birth center births:*

- Were more likely to have a vaginal birth
- Were less likely to have a cesarean birth and an assisted vaginal birth with forceps or vacuum
- Had similar rates of intact perineum (neither tear nor episiotomy), severe perineal tearing, and severe postpartum bleeding (hemorrhage)

Relative to women with planned hospital births, similar *women with planned home births were:*

- More likely to have a vaginal birth and an intact perineum (neither tear nor episiotomy)
- Less likely to have a cesarean birth, an assisted vaginal birth with forceps or vacuum, severe perineal tearing, and severe postpartum bleeding (hemorrhage)

Relative to babies with planned hospital births, similar *babies with planned birth center births:*

- Had similar rates of stillbirth, early newborn death, and admission to neonatal intensive care units (NICUs)

Relative to babies with planned hospital births, similar *babies with planned home births:*

- Had similar rates of stillbirth and early newborn death
- Were less likely to be admitted to NICUs

Results consistent with this systematic review were recently reported in a study of more than 11,000 planned community births in Washington State within professional guidelines for eligibility and transfer,‡‡ representing the care of 139 midwives.[49] Key findings include:

- Low rates of interventions (e.g., cesarean birth: 4.7 percent, epidural analgesia: 9.0 percent, episiotomy: 0.9 percent, NICU admission: 2.2 percent)
- High rates of physiologic birth (85.3 percent) and exclusive breastfeeding at six weeks (93.0 percent)
- Rates of birth in intended place (86 percent) and of hospital transfer during labor or within six hours after birth (16.2 percent), suggesting appropriate use of higher levels of care as needed
- No difference in rates of maternal and newborn adverse outcomes between birth center and home birth groups
- Perinatal mortality rate comparable to nations with strong midwifery integration across birth settings and meeting home birth benchmark set by American College of Obstetricians and Gynecologists

‡‡ Among the 7 percent of births outside of guidelines, the most common reason for the informed choice of community birth was the difficulty of receiving desired care in hospitals; for example, planned vaginal birth after cesarean or planned vaginal twin birth.

- Conclusion that "where community midwives are more integrated into the health system, hospitals, birth centers, and home can all be safe settings for birth in the United States."

Integration of care across settings and providers includes such elements as regulation of community birth care providers, home birth providers carrying emergency equipment and supplies, and ability to make seamless transfers when higher levels of care are needed.[50]

Evidence about birth center care. An integrative review summarized quantitative and qualitative studies of maternal outcomes in birth centers. It compares birth center outcomes to outcomes in hospitals and to national averages. This study complements the birth center studies included in the systematic review of community birth summarized above. A majority of studies in this earlier maternal-specific review were from the United States, and it similarly reports that maternal health outcomes in birth centers were better than, or not different from, those in hospitals.[51] The review found that, compared to women with hospital births, similar women with birth center births averaged:

- Higher rates of spontaneous vaginal birth
- Higher rates of intact perineum (without a tear or episiotomy)
- Lower rates of cesarean birth
- Lower rates of episiotomy
- Similar rates of serious perineal tears

The main reasons for transfers from birth centers to hospitals were non-emergency conditions, such as lack of progress in labor. Serious maternal outcomes were extremely rare, and the reviewed studies reported no incidents of maternal death.[52]

The same authors also carried out a systematic review of newborn outcomes in birth centers.[53] As with their maternal outcomes review, the newborn review complements results summarized in the previous section in reporting on earlier studies and on more from the United States than any other nation. This review similarly found that no studies reported higher rates of newborn death in birth center versus hospital births. *Birth Settings in America* found that birth center care is associated with higher rates of breastfeeding initiation and of exclusive breastfeeding six to eight weeks after birth than hospital care.[54]

A study comparing results of planned birth center births by women with obese versus non-obese body mass indices (BMIs) further suggests distinctive benefits of this individualized model of care and the potential population impact if this care were widely scaled.[55] Participants were having their first births and were matched for other key attributes. In standard maternity care, birthing people with obese BMIs are widely considered to be at elevated risk and have high rates of cesarean birth and complications.[56] Those with birth center care, by contrast, experienced no added risk relative to women with normal BMIs in rates of prenatal and postpartum complications, prolonged pregnancy, prolonged labor, newborn

outcomes, and postpartum or newborn hospital transfer rates. While the women with obesity had a higher cesarean rate than those with normal BMIs (11.1 percent versus 5.8 percent), this rate was far lower than the nation's overall rate of low-risk cesarean birth in first-birth women at the time of the study (26.9 percent) and the even higher rates for women with obesity. These results reflect the person-centered approach and judicious use of interventions of midwives practicing in community birth settings.

Evidence about home births. A systematic review comparing planned home and hospital birth found that, compared to women with hospital births, women with home birth were less likely to experience:

- Epidural analgesia
- Medication to speed labor
- Episiotomy
- Vaginal birth with vacuum or forceps
- Cesarean birth
- Serious perineal tears
- Infection

In home births, hemorrhage rates were either less likely than in hospital or similar, and there were no reported maternal deaths.[57]

This review has important implications for the United States as a stratified analysis found that women were less likely to experience benefits of home birth in jurisdictions in which home birth settings and providers are less integrated into the health care system. Less integrated settings were defined as those in which home birth practitioners lacked one or more of the following conditions: are recognized by statute in their jurisdiction, have received formal training, can provide or arrange for care in hospitals, have access to high-functioning emergency transport system, and carry emergency supplies and equipment. With less integration, home and hospital did not differ for some outcomes that could be included in the stratified analysis: medication to speed labor, vaginal birth with vacuum or forceps, cesarean birth, serious perineal tears, and infection.[58]

A systematic review of studies in countries where home birth midwives are well integrated into the health system found that neither perinatal nor neonatal mortality differed across home and hospital settings.

The same author team carried out a parallel systematic review to compare perinatal and newborn death for similarly low-risk women with planned home versus hospital births. In well-integrated settings, they found no differences for mortality, as well as for NICU admissions, Apgar scores, and need for resuscitation.[59]

The quality of studies from less integrated settings was worse, and fewer participants were available, making conclusions less precise. While authors did not find home-hospital differences, there was a trend toward favoring hospital in results for settings with poorer integration.[60]

The U.S. maternal care system currently fails to reliably integrate home birth settings and providers. In U.S. studies of home versus hospital birth, *Birth Settings in America* identified a small, increased absolute risk of newborn death.[61] In reviewing the international literature, researchers found that home and hospital are equally safe for newborns in integrated systems with seamless transfer, ongoing risk assessment and selection for eligibility, and well-qualified providers. By contrast, in the United States, care is less safe due to "lack of integration and coordination and unreliable collaboration across maternity care providers and settings."[62] To facilitate such integration, a multidisciplinary team has developed "Best Practice Guidelines: Transfer from Planned Home Birth to Hospital" and accompanying model transfer forms.[63]

Cost of care in community birth settings. In addition to a record of safety – and in many instances, better health outcomes – community birth is also a good value. A review of the costs of birthing at home and in birth centers found that resource use was generally lower in community birth settings due to fewer interventions, shorter lengths of stay, or both.[64] A recent estimate of the costs of maternal and newborn care for a U.S. home birth was $4,650. The authors contrast this to estimates of $8,309 for a birth center birth and $13,562 for a vaginal birth in hospital. They project a cost savings of $321 million annually with a shift of 1 percent of births from hospital to home, and an annual savings of $189 million with a shift of 1 percent of births from hospital to birth center.[65]

The United States might attain a cost savings of $321M annually with a shift of 1 percent of births from hospital to home, and an annual savings of $189M with a shift of 1 percent of births from hospital to birth center.

Spotlight on Success

THE STRONG START FOR MOTHERS AND NEWBORNS INITIATIVE: BIRTH CENTERS OFFER MAJOR BENEFITS TO MEDICAID BENEFICIARIES

The Strong Start for Mothers and Newborns Initiative was a federal five-year, multi-site project to test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or the Children's Health Insurance Program (CHIP) who were at risk for having a preterm birth. One of the first Center for Medicare and Medicaid Innovation initiatives, it launched in 2012 to test three models of enhanced prenatal care among Medicaid beneficiaries: birth centers, group prenatal care, and maternity care homes.[66] Midwifery-led care across 47 birth centers generated stellar results, whereas results of the other two care models were underwhelming.[67]

An independent evaluation compared women and infants in the midwifery-led birth center group with matched and adjusted women receiving typical Medicaid care in the same counties. The differences in outcomes between these two groups were compelling:

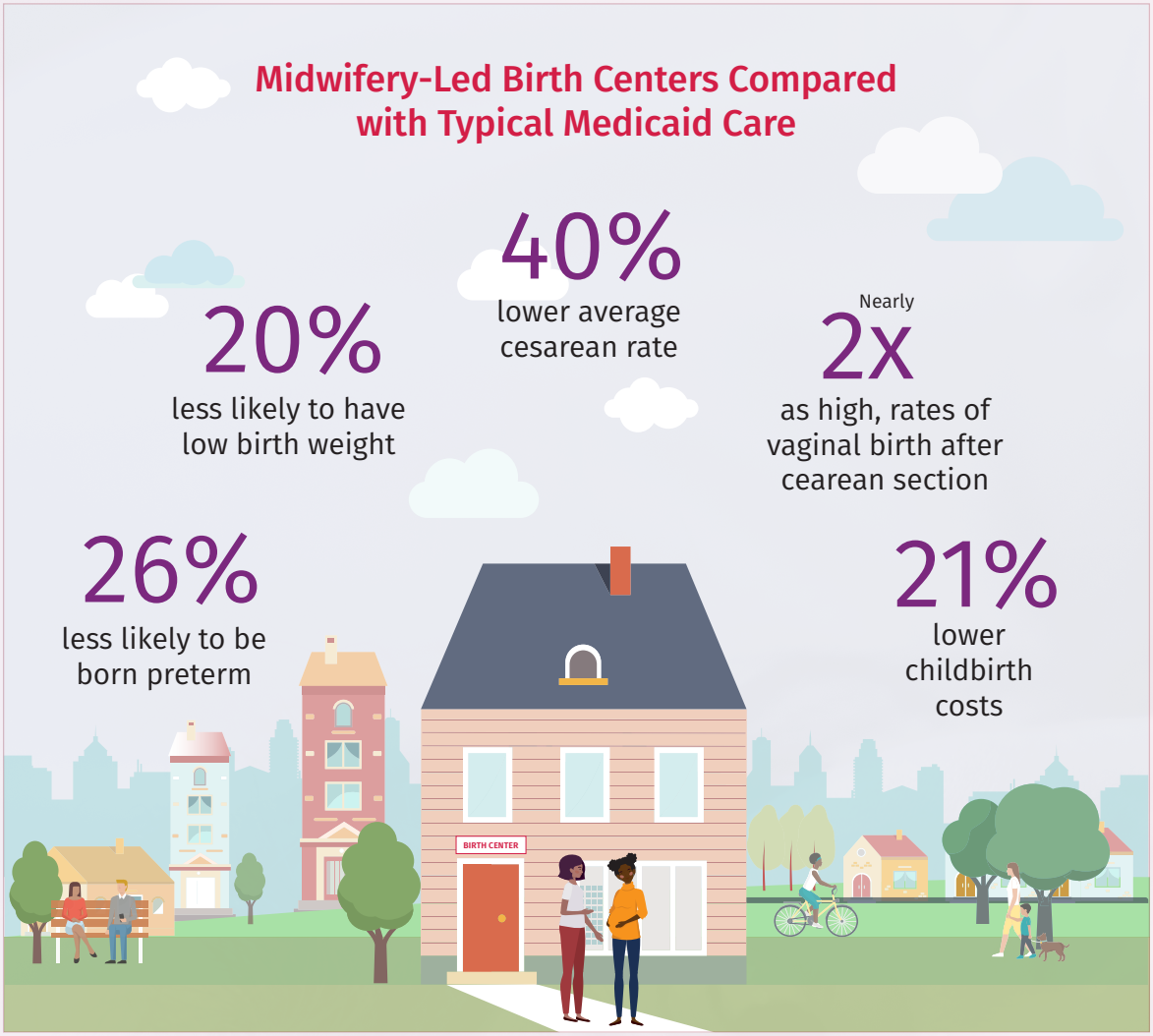
- Birth center infants were 26 percent **less likely to be born preterm** (6.3 percent versus 8.5 percent).
- Birth center infants were 20 percent **less likely to have a low birth weight** (5.9 percent versus 7.4 percent).
- The average cesarean rate in birth centers was **40 percent lower** (17.5 percent versus 29.0 percent).
- **Rates of vaginal birth after a cesarean** at birth centers were **nearly twice as high** (94 percent more likely: 24.2 percent versus 12.5 percent).
- **Childbirth costs** at birth centers were **21 percent lower** ($6,527 versus $8,286).
- At birth centers, **total childbirth and post-birth costs** up to one year after birth were **16 percent lower** ($10,562 versus $12,572).

All of these are statistically significant advantages favoring birth center care. They include the many participants who received birth center prenatal care and gave birth in hospitals, either by choice or because protocols dictated a higher level of care.[68]

In addition, Strong Start results were exceptional in reducing racial inequities. There were no differences by race among birth center participants for rates of cesarean birth

Continued on the next page.

Spotlight on Success



and breastfeeding, or for the experience of care. Notably, participants reported being able to understand communications with the care team, feeling heard, having time for questions, being involved in decision-making, and being treated with respect.[69]

The midwifery-led birth centers succeeded in providing benefits to families, the health system, and taxpayers by improving a series of fundamental health outcomes relative to usual approaches to maternity care. Given that Medicaid covered 42 percent of the nation's births in 2020, including 66 percent of American Indian or Alaska Native, 64 percent of Black, and 58 percent of Hispanic births,[70] advancing this model for Medicaid enrollees at lower medical risk could significantly mitigate our nation's inequitable maternal and infant health crisis.

Birthing people report better experiences with community birth

An integrative review of maternal outcomes in birth centers found that, compared to women birthing in hospitals, those birthing in birth centers reported greater satisfaction and desire to use this care model again, and were more likely to feel that prenatal care elevated their self-esteem. Specifically, they were more satisfied with the personalization of their care, their care environment, the quality of their relationship with their maternity care provider, their confidence, their ability to cope with life challenges, and their ability to have a physiologic childbirth.[71]

With regard to home birth, while we found no systematic reviews comparing satisfaction with hospital birth, a review of 11 studies of women's experience of birthing at home identified three interrelated themes about benefits of not birthing in a hospital setting. First, giving birth at home contrasted with their perceptions or prior experience of hospital birth, which included too many interventions, too many disruptions, common use of pain medications, disrespectful care, and unfamiliar personnel. Second, they felt that they would have more control, be more able to make decisions, and be empowered in general. Lastly, the home was valued as being a peaceful, restful, and comfortable setting.[72]

With investments in providers of color, both forms of community birth can also offer additional benefits to birthing People of Color because they enhance their opportunity to receive racially and culturally congruent care[73] and avoid the institutional racism documented in hospital care.[74]

Access to community birth is limited and inequitable; interest vastly exceeds use

The many barriers to midwifery care currently limit access to midwifery-led community birth, particularly for birthing People of Color. Barriers to midwifery care include:[75]

- Failure of all jurisdictions to license midwives holding two of the three nationally recognized midwifery credentials: certified midwives (CMs) and certified professional midwives (CPMs)
- Failure of Medicaid and private insurance to pay for the services of CMs and CPMs in all jurisdictions where they are licensed
- Unnecessarily restrictive practice acts in many jurisdictions for certified nurse-midwives, CMs, and CPMs, who are autonomous care providers
- Failure to consistently provide pay parity with physicians for the same service in fee schedules, despite the fact that the midwifery model of care prioritizes relationship- and trust-building and visits that are longer than the current average when midwives can control schedules, as well as prolonged presence and support around the time of birth

Lack of legal recognition and insurance coverage for community birth providers creates insurmountable financial barriers for many people who would otherwise choose to give birth in these settings.

- Current supply of midwives that is far below women's interest in and access to this type of care
- Lack of access to sufficient supply of clinical practice sites and preceptors for midwifery students, and lack of a reliable source of funding parallel to Medicare payment for medical residencies

CPMs are specifically educated to practice in community birth settings, yet are not legally regulated in 15 states and U.S. territories. And while the number of birth centers has been growing in the United States, 10 states and the U.S. territories do not have birth center licensure. Thus, these care options still do not exist in many communities.[76]

Payment of CPM services by Medicaid and private insurance is uneven, as is payment of other midwives when practicing in community settings.[77] While the Affordable Care Act clarified that services of licensed birth centers and of licensed providers practicing in those birth centers are covered Medicaid services, and regulatory guidance has subsequently provided additional details, implementation has been uneven.[78]

Lastly, a barrier to midwifery specific to Indigenous peoples is that midwives who are recognized by their Native communities often face challenges to legal recognition and reimbursement.[79]

This lack of legal recognition and insurance coverage for community birth providers creates insurmountable financial barriers for many people who would otherwise choose to give birth in these settings. In 2020, only 3.0 percent of hospital births were paid out of pocket, but about seven in 10 (69.6 percent) planned home births and one in three (34.1 percent) birth center births were self-pay.[80]

Another reason for this mismatch between supply and demand is that Medicaid pays for 42 percent of all births in this country, including, in 2020, 66 percent of Native American and Alaska Native births, 64 percent of Black births, 58 percent of Hispanic births and 57 percent of Native Hawaiian and other Pacific Islander births.[81] Medicaid payments are so low that operating a birth center with a large proportion of Medicaid clients is not financially sustainable.[82] To extend the exceptional benefits of birth center care

to the many eligible childbearing people who currently lack access will require new payment models.[83]

As a result of financial barriers, those with greatest interest and who might disproportionately benefit from this model of care are least able to choose it. Birthing People of Color are disproportionately disadvantaged by existing payment systems, in addition to other barriers to care, which sharply limit their access to high-quality birth center and home birth care. Our country's history of racially unjust wealth distribution means People of Color often lack access to the capital needed to start birth centers in their communities. In a national survey of birth centers, 83 percent of participating centers reported operating within a for-profit model. Major sources of startup capital included personal funds (58 percent); a bank line of credit or mortgage (42 percent); and loans, gifts or investment by family and friends (27 percent).[84] Birth Center Equity estimates that less than 5 percent of community birth centers are led by People of Color.[85] The need for birth centers in communities of color far outstrips availability.

Although about one-half of birthing people are white, non-Hispanic women, the great majority of people having birth center and home births are white. Hispanic birthing people and non-Hispanic Black, Asian, Native American, and Pacific Islander birthing people are vastly underrepresented among birth center births and, to an even greater extent, among home birth (Table 1).

Table 1. Birthing Population and Use of Community Birth Settings, by Race and Ethnicity, United States, 2020[86]

Race and Ethnicity	Birthing Population	Birth Center Births	Intended Home Births
White Non-Hispanic	51%	76%	84%
Hispanic	24%	12%	7%
Black Non-Hispanic	15%	7%	5%
Asian Non-Hispanic	6%	2%	1%
Native American Non-Hispanic	1%	0.4%	0.4%
Pacific Islander Non-Hispanic	0.3%	0.1%	0.1%

There is also a very large mismatch between actual use and the level of interest in community birthing options overall, and especially by race and ethnicity. Overall, just 1 percent of the birthing population gives birth at home and fewer than 1 percent at a birth center, with broad inequities by race and ethnicity (Table 1). By contrast, interest in these settings far exceeds access and actual use. For example, in 2016 in California, use of these settings closely paralleled national rates. However, *Listening to Mothers in California* survey participants who gave birth in hospitals that year reported much higher interest in birthing in these settings should they give birth in the future. A full 40 percent expressed interest in birth center births, and 21 percent expressed interest in home births. Disproportionately high interest in both community birth settings among Black women, and strong interest among women with Medicaid coverage are notable (Table 2).

In contrast to the current paltry access of People of Color to care in birth centers and at home, community-based, culturally congruent care in these settings has the potential to be exceedingly well matched to the needs and preferences of many birthing People of Color (see Spotlight on Success: Roots Community Birth Center).

Table 2. Interest in Birth Center and Home Birth Should Respondent Again Give Birth, by Race and Ethnicity and Type of Payer, California, 2017[87]

	Birth Center		Home Birth	
	Would definitely want	Would consider	Would definitely want	Would consider
Overall	11%	29%	6%	15%
Black	14%	34%	8%	21%
White	12%	29%	7%	17%
Latina	10%	30%	7%	14%
Asian and Pacific Islander	7%	25%	3%	8%
Medicaid Coverage	11%	30%	8%	18%
Private Insurance	10%	27%	5%	12%

Spotlight on Success

ROOTS COMMUNITY BIRTH CENTER: COMMUNITY-LED CARE AS AN ESSENTIAL WAY TO ADVANCE BIRTH JUSTICE

The Roots Community Birth Center demonstrates the exceptional value of community-based and -led forms of the birth center model for communities disadvantaged by structural racism, intergenerational underinvestment, and other forms of discrimination. Roots enables childbearing families in the predominantly Black neighborhood of North Minneapolis, Minn., to experience midwifery-led care that is accessible, respectful, trusted, and relationship-based.[88]

Most of the diverse clients at Roots also receive culturally congruent care. According to the midwives, student midwives, and doulas serving Roots clients, culturally congruent care recognizes that the cultural identity of birthing people is a core part of the clinical encounter, incorporates a commitment to racial justice, and is grounded in the birthing person's agency and birth worker's cultural humility.[89] Incorporating a critical race lens into this relationship-based model has the potential to mitigate pernicious effects of racism on Roots clients.[90]

The Roots care model prioritizes education, informed choice, prevention, and personalization. Compared to typical prenatal care, prenatal visits at Roots begin earlier in the pregnancy, occur more frequently, and last longer. Labor and birth practices support the innate capabilities of the birthing person and fetus/newborn for labor, birth, and adaptation after birth. Roots clients experience at least six home and clinic postpartum visits, far more than typical postpartum care.[91]

The neighborhood served by Roots experiences disproportionately adverse maternal and newborn outcomes. However, Roots' 2020 outcomes were exceptional despite happening in the middle of the COVID-19 pandemic and at the epicenter of the racist trauma unleashed by George Floyd's murder. They include:

- 0 percent low birth weight rate
- 9 percent cesarean birth rate (compared to 32 percent nationally)
- 0 percent episiotomy rate
- 99 percent breastfeeding rate at six months (compared to 58 percent nationally)
- 17 percent hospital transfer rate, with 97 percent of these for such non-emergency issues as prolonged labor and desire for pain medications[92]

Continued on the next page.

Spotlight on Success

For comparison with the Roots experience of no clients with low birth weight or episiotomy, the national low birth weight rate in 2019 was 8 percent, rising to 14 percent among Black women,[93] and hospitals reported an average episiotomy rate of 5 percent to the Leapfrog Group in 2020.[94] Investigators compared experiences of Roots clients to a general sample of birth center clients from across the country, and found that both clients of color and white clients at Roots had higher scores on validated tools measuring autonomy and respect than the general sample.[95]

In addition to powerful holistic health benefits, Roots contributes to community development by employing and training community members and others from racially and ethnically diverse backgrounds. All employees must have a deep understanding of structural racism and culturally centered care, and a commitment to equity and anti-oppression. Continuing education further builds these skills and knowledge.[96] Staff midwives are highly motivated to provide racially concordant and physically and emotionally safe care, and to bring racial justice to their work.[97]

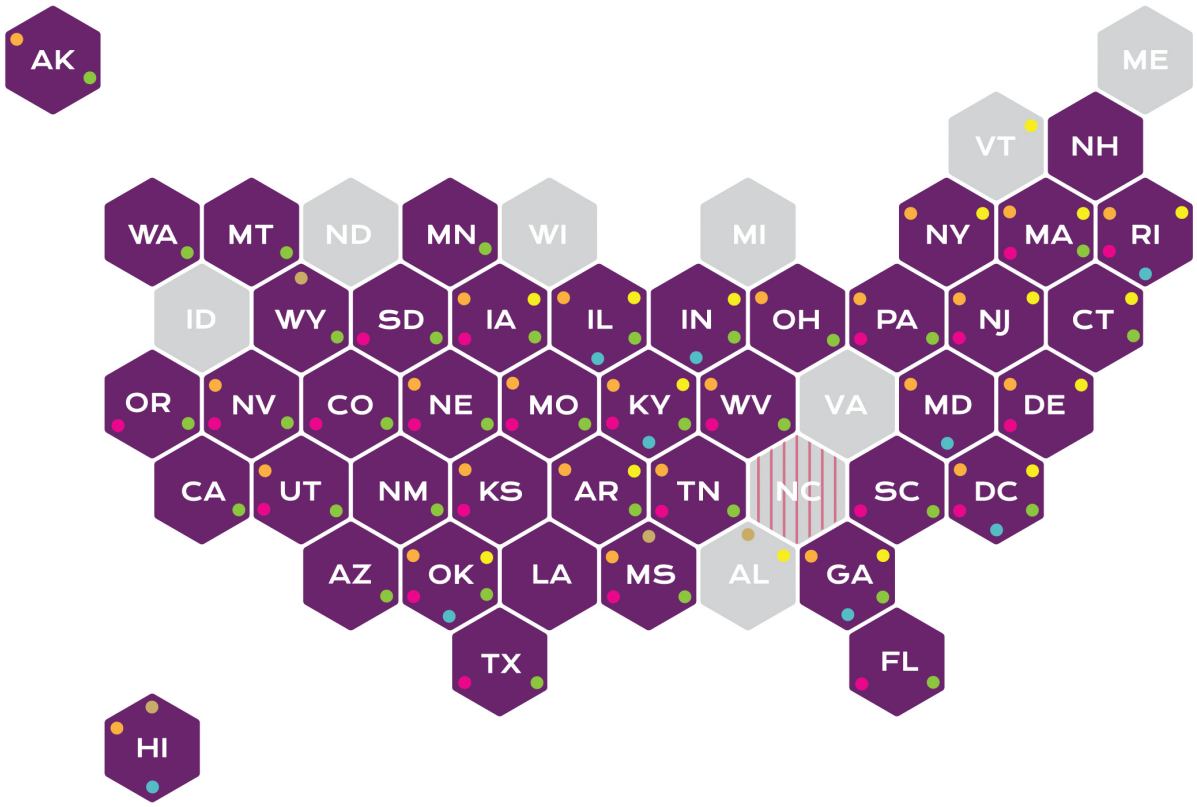
Unfortunately, current payment systems do not adequately pay for this highly effective, labor-intensive model of care. Payments by Medicaid, the predominant payer of Roots clients, are especially low.[98]

Policymakers can take many steps to increase access to community birth settings, both overall and for those experiencing structural precarity. State statutes and regulations can address such avoidable barriers to birth center care as failure to license birth centers, failure of Medicaid to reimburse for birth center services, certificate-of-need requirements, failure to recognize all three national midwifery licenses, requirement for a physician clinical director, and requirement for written agreements with a physician or hospital (Figure 1).

Increased access to community birth settings for People of Color would help to promote birth equity and address their disproportionately low current use of birth centers and home birth despite strong interest in these settings. Birth Center Equity supports access to birth centers across the country that are led by Black, Indigenous, People of Color. At present, the organization has grown a network of more than 30 operating or developing birth centers across the nation and has identified other people-of-color-led birth centers that are operating or under development (Figure 2).

Lastly, insurance reimbursement for home birth is uneven. At present, many state Medicaid programs do not pay for home birth services (Figure 3), and in some cases payment does not extend to holders of all midwifery credentials licensed in the state.

FIGURE 1. BIRTH CENTERS: REGULATION AND LEGAL BARRIERS



REGULATION

- RECOGNIZED BY STATE STATUTE
- NOT RECOGNIZED BY STATE STATUTE
- NOT RECOGNIZED BY STATE STATUTE; MEDICAID REIMBURSES ACCREDITED BIRTH CENTERS

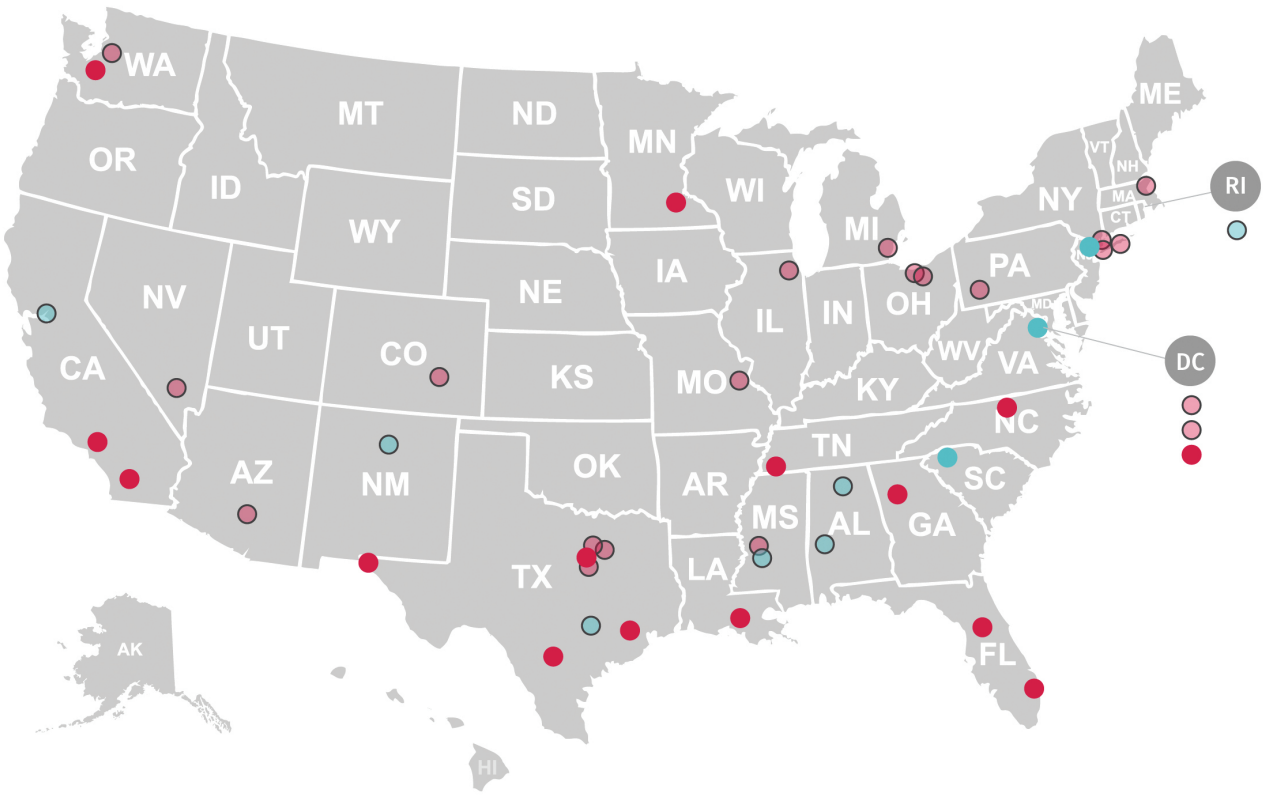
BARRIERS

- MEDICAID DOES NOT REIMBURSE
- CERTIFICATE OF NEED REQUIRED
- DOES NOT RECOGNIZE ALL 3 NATIONAL MIDWIFERY LICENSES
- PHYSICIAN CLINICAL DIRECTOR REQUIRED
- WRITTEN AGREEMENT WITH PHYSICIAN REQUIRED
- WRITTEN AGREEMENT WITH HOSPITAL REQUIRED

Notes:
1. Medicaid reimburses birth centers in states with birth center licensure and no●.
2. Louisiana has enacted a licensing statute, and the regulation process to clarify details – which may include barriers – is under way. Until finalized, Medicaid in Louisiana will continue to reimburse accredited birth centers.
3. Reasons for not recognizing three midwifery licenses include state does not license all three and/or birth center statute or regulation does not recognize all three.

Sources:
1. American Association of Birth Centers. "Birth Center Regulations," last updated November 29, 2019, https://www.birthcenters.org/page/bc_regulations
2. The Commonwealth Fund. "State Policies to Improve Maternal Health Outcomes: State by State Comparison," November, 2020, https://www.commonwealthfund.org/sites/default/files/2020-11/State_Policies_Maternal_Health_Outcomes_Comparison_TABLE_11-19-2020.pdf
3. Kate Bauer and Jill Alliman, email message to author, July 30, 2021.
4. U.S. Centers for Medicare & Medicaid Services. "CMCS Informational Bulletin, Recent Developments in Medicaid and CHIP Policy," March 25, 2011, https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CMCS-Info-Bulletin-March-2011-Final.pdf
5. "Joint Informational Bulletin. Strong Start for Mothers and Newborns Initiative (Strong Start)," November 9, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf

FIGURE 2. BIRTH CENTER EQUITY (BCE) AND OTHER BIRTH CENTERS LED BY BLACK, INDIGENOUS, PEOPLE OF COLOR



ALABAMA
- Alabama Women's Wellness Center, Huntsville
- Birth Sanctuary, Gainesville

ARIZONA
- Parteras de Maiz, Phoenix

CALIFORNIA
- Kindred Space/Birthing People Foundation, Los Angeles
- Oakland Partera, Oakland
- San Diego Community Birth Center, San Diego

COLORADO
- A Mother's Choice, Colorado Springs

DISTRICT OF COLUMBIA
- Birth and Milk Co., Washington
- Birth Supporters United, Washington
- Community of Hope: Family Health and Birth Center, Washington

FLORIDA
- The Birth Place, Winter Garden
- Magnolia Birth House, North Miami Beach

GEORGIA
- Atlanta Birth Center, Atlanta

Continued from last page: Figure 2. Birth Center Equity (BCE) and Other Birth Centers Led by Black, Indigenous, People of Color.

● BCE ESTABLISHED ● BCE UNDER DEVELOPMENT ● OTHER ESTABLISHED ● OTHER UNDER DEVELOPMENT

ILLINOIS
- South Side Birth Center, Chicago

LOUISIANA
- Baby Catcher Birth Center, Lafayette

MASSACHUSETTS
- Neighborhood Birth Center, Boston

MICHIGAN
- Birth Detroit, Detroit

MINNESOTA
- Roots Community Birth Center, Minneapolis

MISSISSIPPI
- Hathor's Birthing House, Jackson
- Sisters in Birth, Jackson

MISSOURI
- Jamaa Birth Village, Ferguson

NEW JERSEY
- Birth Center of New Jersey, Union

NEW MEXICO
- Changing Woman Initiative, Albuquerque

NEW YORK
- Haven Midwifery Birthing Center, Brooklyn
- Long Island Birth Center, Suffolk County
- The Birthing Place, Bronx

NORTH CAROLINA
- Sankofa Birth and Women's Care, Durham

OHIO
- Birthing Beautiful Communities, Cleveland
- Birth of a Nation, Cleveland

PENNSYLVANIA
- Allegheny Reproductive, Pittsburgh

RHODE ISLAND
- Our Journ3i, Providence

SOUTH CAROLINA
- Genesis Birth and Wellness, Greenville

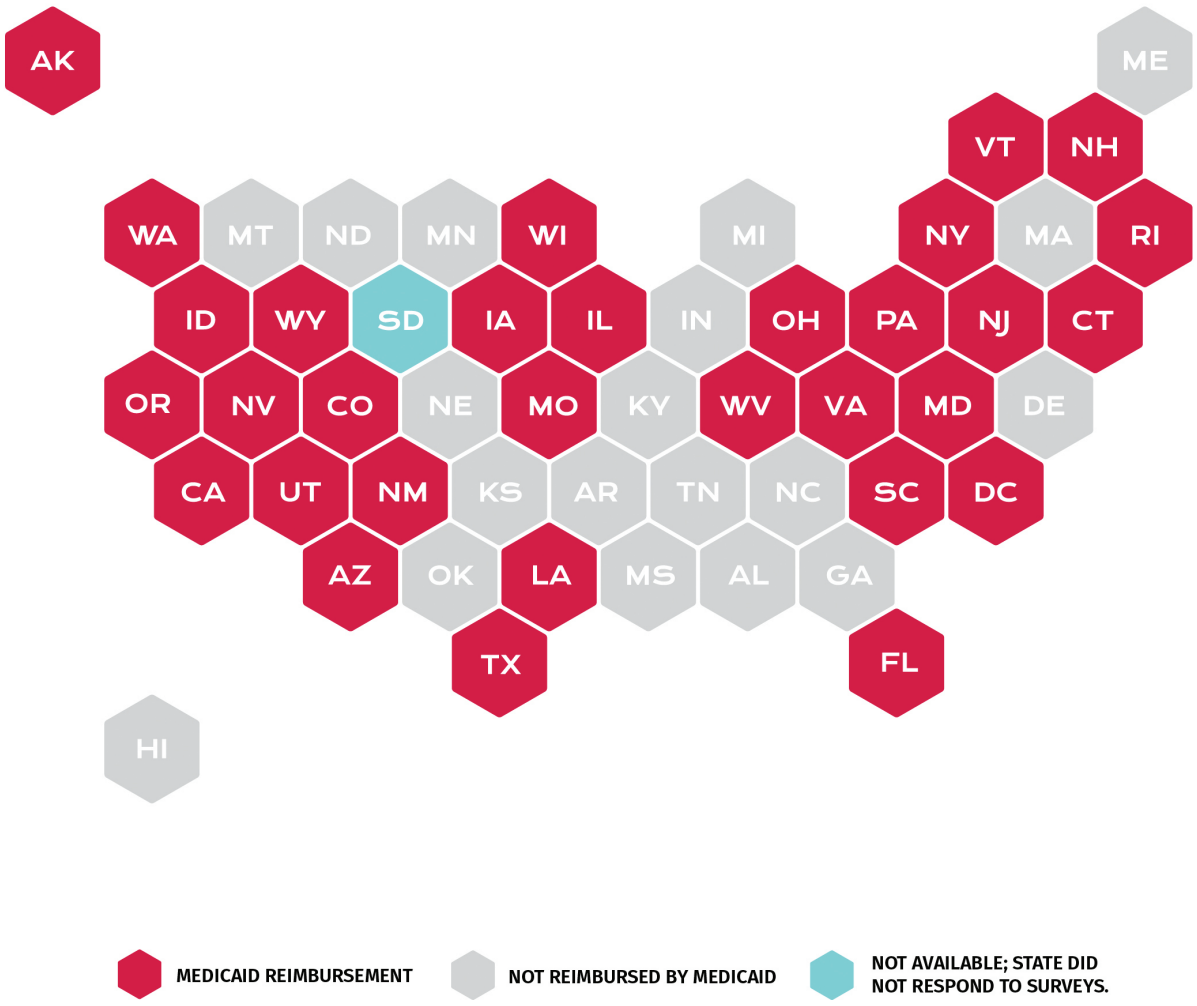
TENNESSEE
- Choices: Memphis Center for Reproductive Health, Memphis

TEXAS
- Abide, Dallas
- Delivering Unto You, Austin
- Lovers Lane Birth Center, Richardson
- Luna Tierra Birth Center, El Paso
- My Sister's Keeper, Hurst
- The Birthing Place, Houston
- San Antonio Nurse Midwife, San Antonio
- Serenity Midwifery and Birth Center, Forreston

VIRGINIA
- Birth Care, Alexandria

WASHINGTON
- Community Birth Center, Lacey
- Rainier Valley Midwives, Seattle

FIGURE 3. HOME BIRTH: MEDICAID REIMBURSEMENT



Note:
Medicaid reimbursement indicates that at least one type of clinician is reimbursed for home birth services. This may not apply to all midwives recognized by the state.

Sources:
1. Kaiser Family Foundation, "Medicaid Coverage of Pregnancy-Related Benefits: Findings from a 2021 State Survey," 2022. Data provided by Usha Ranji, March 10, 2022. Responses reflect policy as of July 1, 2021.
2. Results for Arkansas, Georgia, Kentucky, Minnesota, Nebraska, New Hampshire, New Mexico, and Ohio are based on responses to the prior KFF survey. "Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey," April 27, 2017, https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/
3. Mary Lawlor, National Association of Certified Professional Midwives, email message to author, August 19, 2021.

RECOMMENDATIONS TO INCREASE ACCESS TO COMMUNITY BIRTH SETTINGS

The benefits of community birth for essentially healthy pregnant people are clear. Compared to usual hospital care, community birth better aligns with optimal care. It limits unneeded medical interventions such as induced labor, continuous electronic fetal monitoring, and cesarean birth (curbing overuse), and more frequently provides beneficial care that is not reliably available in hospitals, such as encouraging birthing people to eat and drink, to be upright and mobile during labor, and to use their birthing position of choice, according to interest (curbing underuse). In addition, compared to the routinized care provided in hospitals, community birth is more likely to offer respectful, individualized, and person-centered care.[99] For many pregnant people, community birth options offer better care, more positive experiences, improved health outcomes, and potential cost benefits. Given this track record and the increasing use of, and unmet need for, this model of care, decision-makers should act to make it widely available to lower-risk pregnant people who desire it. Above all, it is urgent to scale up access to this high-value model of care as an essential way to advance birth justice and mitigate the nation's maternal health crisis.

The recommendations below focus on access to care in community birth settings. As midwives are the primary maternity care providers practicing in these settings, increased access to midwifery care is essential for broader access to community birth settings. Selected recommendations for increasing access to midwifery are included below. Please see the companion midwifery report for a full set of midwifery-related recommendations.[100]

Federal policymakers should:

- Ensure coverage by Medicaid, Medicare, the Child Health Insurance Program (CHIP), the Federal Employee Health Benefits (FEHB) Program, TRICARE, the Veterans Health Administration (VHA), the Indian Health Service (IHS), the Commissioned Corps of the U.S. Public Health Service (USPHS), Bureau of Prisons, and in Department of Homeland Security detention centers for care in licensed, accredited, or otherwise recognized birth centers and for midwife providers in birth centers who hold nationally recognized credentials and are recognized in their jurisdiction. Ensure that this coverage also applies to external maternity care purchased/referred by the IHS and VHA.

- Ensure coverage by Medicaid, Medicare, CHIP, FEHB Program, TRICARE, VHA, IHS, and the USPHS Commissioned Corps for home births attended by midwives with nationally recognized credentials who are recognized in their jurisdiction, including certified midwives (CMs) and certified professional midwives (CPMs).
- Ensure that all midwives holding nationally recognized credentials – including CMs and CPMs – are eligible providers under federal health programs.[†] Federal payments for midwifery services should be at parity with physician-provided maternal-newborn health services.
- Encourage Congress to enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3352 and S. 1697 in the 117th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (certified nurse-midwives [CNMs], CMs, and certified professional midwives) by supporting midwifery programs or schools, preceptors, and students. It would give funding preference to programs supporting students who would diversify the profession and who intend to practice in underserved areas.
- Encourage Congress to include in appropriations bills monies to increase the supply of midwives by supporting CNM, CM, and CPM students, preceptors, and programs or schools, giving preference to a pipeline for diversifying the profession and building capacity in underserved areas.
- Encourage the Department of Health and Human Services (HHS) to include CMs and CPMs as health professionals eligible to apply for loan forgiveness under the National Health Service Corps Loan Repayment Program.
- Encourage HHS to issue updated guidance clarifying the ACA Section 2301 requirement of Medicaid coverage of birth center services to expand coverage and access for Medicaid enrollees, including improved network adequacy for managed care organizations.

[†] The Women's Preventive Services Initiative is an example of federal recognition of this spectrum of credentials on a more limited basis. https://www.womenspreventivehealth.org/recommendations/breastfeeding-services-and-supplies/

- Encourage Congress to enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 3337 and S. 1716 in the 117th Congress). This bipartisan bill would fund demonstrations of birth center models for improved maternity care access and quality for Medicaid beneficiaries with low-risk pregnancies in underserved areas and would develop sustainable approaches to payment for high-value birth center care.
- Encourage Congress to include in appropriations bills monies to support community-led solutions to maternal health inequities by supporting the capital needs of developing birth centers led by and serving birthing families in most adversely affected communities.
- Ensure sustainable payment by Medicaid agencies, Medicaid managed care organizations, CHIP, and other federally supported programs for care in licensed birth centers, for services provided by midwife birth center providers with nationally recognized credentials who are recognized in their jurisdiction, and for home birth with midwives with nationally recognized credentials who are recognized in their jurisdiction.
- Encourage the Office of the National Coordinator to include birth centers as primary birth facilities when formulating the national strategy to reduce provider burden and improve: equity in urban and rural communities, perinatal vendor usability, interoperability of electronic health information, and longitudinal personal health records of pregnant persons and their newborns.
- Encourage the Veterans Affairs Community Care Network (VA CCN), TRICARE, and Military Treatment Facilities to include in-network birth centers and collaborating physician practices in any demonstrations of purchased care interoperability of electronic health information.
- Encourage the Office of Personnel Management to support plans participating in the Federal Employee Health Benefits Program that increase the percentage of maternity services purchased through value-based contracting, including with midwives and birth centers. The Office of Management and Budget should calculate cost savings based on increased utilization of value-based care.

- Increase community capacity during a pandemic by reallocating available Coronavirus Aid, Relief, and Economic Security (CARES) Act provider relief fund monies to prepay five years of electronic health records and for Health Information Exchange (HIE) installation, training, and operational expenses for qualified birth centers and their collaborators during transformation to value-based models of maternity care delivery and payment.
- Encourage Congress to enact all provisions of the Black Maternal Health Momnibus Act of 2021, either by including its investments in a future reconciliation package, or by passing the full package of bills (H.R. 959 and S. 346 in the 117th Congress). This comprehensive set of bills includes provisions to make critical investments in social drivers of maternal health outcomes; provide funding to community-based organizations working to improve maternal health outcomes for Black and Indigenous women in communities impacted by racial health disparities; grow and diversify the perinatal workforce, including Black and Indigenous birthworkers; to increase access to culturally congruent care and support; address maternal mental health; and much more.
- Encourage Congress to ensure that all Medicaid enrollees have coverage for one year postpartum by passing a permanent universal extension of the American Rescue Plan's state option to expand postpartum Medicaid coverage.
- Require the collection and public reporting of data across federal programs to identify, track, and address health inequities, such as disaggregation by race and ethnicity, socioeconomic status, sexual orientation, gender identity, language, and disability status in critical indicators of maternal and infant health. These indicators include, but are not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding. Collaborate with Indigenous people to address the undercounting of their births, including by improving the categories indicating Indigenous identity.
- Extend data collection and reporting across federal programs, performance measurement, payment reform, and quality improvement (e.g., work of perinatal quality collaboratives) to community birth settings and providers and birthing people in those settings whenever feasible.

State and territorial policymakers should:

- Enact birth center licensure without unnecessary legal restrictions that limit access in the nine states that do not currently regulate birth centers: Alabama, Idaho, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, and Wisconsin, and in the U.S. territories. Amend current state statutes to remove widespread and unnecessary restrictions.
- Enact CM and CPM licensure in the states and territories that currently fail to recognize these autonomous providers of maternal and newborn care with nationally recognized credentials.
- Require Medicaid managed care organizations to contract with state-regulated birth centers and with midwives who practice in birth centers and provide home birth services.
- Extend data collection and reporting, performance measurement, payment reform, and quality improvement (e.g., work of perinatal quality collaboratives) to community birth settings and providers and birthing people in those settings whenever feasible.
- Develop and enact in other states legislation modeled on the recently enacted Colorado Birth Equity Package and California Momnibus Act, which advances birth equity and strengthens the maternity care infrastructure.
- Create, in consultation with relevant people from most affected communities, a process for equitable development investments that support community birth centers, which the city of Seattle has done.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to, and sustainable payment for, community birth (birth center and home) settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwifery-led care in community birth settings.
- Ensure that plan directories maintain up-to-date listings identifying all available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of maternity care that is integrated across providers and settings, with seamless consultation, shared care, transfer, and transport from community birth settings as needed. Encourage adoption of guidelines and other policies that foster integration and safety.
- Extend data collection and reporting, performance measurement, payment reform, and quality improvement (e.g., work of perinatal quality collaboratives) to community birth settings and providers and birthing people in those settings whenever feasible.

Resource Directory

Community Birth Settings: Birth Centers and Home Birth

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- *Smooth Transitions*
  Foundation for Health Care Quality, 2022, https://www.qualityhealth.org/smoothtransitions/
- *Transfer Tools for Midwives, EMs, and Hospital Providers*
  HiveCE: Online Continuing Education for Midwives … and More! https://www.h ivece.com/courses/transfer-tools

Community Birth Organizations

- *American Association of Birth Centers*
  https://www.birthcenters.org/
- *Birth Center Equity*
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- *National Association of Birth Centers of Color*
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Reproductive and Birth Justice

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- *21-Point Black Midwives Care© Model*
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- *The Birth Equity Agenda: A Blueprint for Reproductive Health and Wellbeing*
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- *Birth Justice Bill of Rights*
  Southern Birth Justice Network, https://southernbirthjustice.org/birth-justice
- *A Black Mama's Guide to Living and Thriving*
  Mamatoto Village, 2020, https://www.mamatotovillage.org/uploads/9/7/4/8/97484346/black_mamas_guide.pdf
- *Black Women Birthing Justice*
  https://www.blackwomenbirthingjustice.org/what-is-birth-justice
- *Building a Movement to Birth a More Just and Loving World*
  Haile Eshe Cole, Paula X. Rojas, and Jennie Joseph. National Perinatal Task Force, March 2018, https://perinataltaskforce.com/wp-content/uploads/2021/06/Groundswell_Report_final_online.pdf
- *Reproductive Justice*
  SisterSong Women of Color Reproductive Justice Collective, https://www.sistersong.net/reproductive-justice

Physiologic Childbearing and Preferences of Birthing People

- *Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*
  Melissa D. Avery, Amy D. Bell, Debra Bingham, Maureen P. Corry, Suzanne F. Delbanco, Susan Leavitt Gullo, Catherine H. Ivory, et al. National Partnership for Women & Families, June 2018, https://www.nationalpartnership.org/our-work/resources/health-care/maternity/blueprint-for-advancing-high-value-maternity-care.pdf
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- *What Matters to Women: A Systematic Scoping Review to Identify the Processes and Outcomes of Antenatal Care Provision That Are Important to Healthy Pregnant Women*
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- *What Matters to Women During Childbirth: A Systematic Qualitative Review*
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- *What Matters to Women in the Postnatal Period: A Meta-Synthesis of Qualitative Studies*
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Advancing Practice and Research

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- *Community-Informed Models of Perinatal and Reproductive Health Services Provision: A Justice-Centered Paradigm Toward Equity Among Black Birthing Communities.*
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- *Social and Structural Determinants of Health Inequities in Maternal Health*
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About the Partnering Organizations

The National Partnership for Women & Families

For more than 50 years, the National Partnership for Women & Families has worked to advance every major policy impacting the lives of women and families. The National Partnership works for a just and equitable society in which all women and families can live with dignity, respect, and security; every person has the opportunity to achieve their potential; and no person is held back by discrimination or bias. The National Partnership's robust maternal health programming focuses on transforming the maternity care system to be equitable and high-performing, and effectively and respectfully meeting the current needs of childbearing families, especially those experiencing the ongoing effects of centuries of racist and inequitable social policies and conditions.

American Association of Birth Centers

The American Association of Birth Centers (AABC) is a multidisciplinary membership organization comprised of birth centers, individuals, and organizations that support the birth center model. A global leader in the midwifery-led birth center model, AABC sets national standards and provides support, resources, and advocacy for developing, promoting, and sustaining birth centers. AABC is dedicated to developing quality holistic services for childbearing families that promote self-reliance and confidence in birth and parenting in the wellness model of care.

American College of Nurse-Midwives

The American College of Nurse-Midwives (ACNM) is the professional association that represents advanced practice midwives (Certified Nurse-Midwives and Certified Midwives) in the United States. ACNM's members are primary health care clinicians who provide evidence-based midwifery care for women and gender-nonconforming people throughout the lifespan, with an emphasis on pregnancy, childbirth, gynecologic, and reproductive health care. ACNM works to promote equity, diversity, and inclusion throughout the midwifery profession and across the care continuum to ensure better health care outcomes for the people midwives serve. The ACNM and its members stand for increasing access to advanced practice midwives and midwifery-led care models and support policy solutions that ensure guaranteed health coverage and access to a full range of sexual and reproductive health services.

Continued on the next page.

About the Partnering Organizations, continued

Birth Center Equity

Birth Center Equity ensures birth center leaders of color have access to funding and investment for startup and sustainability, creates leadership pipelines for needed skills and tools, and grows infrastructure to support all birth centers. We leverage the collective strength and visibility of our network to generate funding and investment with a focus on targeting investments to support developing community birth centers who are ready to open their doors, and innovating sustainable community birth models and reduce costs through economies of scale. BCE has grown a network of more than 30 established and developing community birth center leaders in 20 states and DC, including 19 developing birth centers poised to open within the next four years.

National Association of Certified Professional Midwives

The National Association of Certified Professional Midwives (NACPM) represents Certified Professional Midwives (CPMs) in the U.S. As holders of one of three nationally recognized midwife credentials, CPMs are primary perinatal care providers. They provide unique and critical access to normal physiologic birth, which profoundly benefits birthing people and their newborns. As community-based midwives, CPMs have a vital role to play in providing services in communities most affected by inequities in birth outcomes, where the need is most urgent, the outcomes the poorest, and services currently most limited. Founded in 2001, NACPM directs its influence toward improving outcomes for childbearing people and their infants, developing, strengthening, and diversifying the profession, and informing public policy with the values inherent in CPM care.

National Black Midwives Alliance

The National Black Midwives Alliance (NBMA) is the only professional alliance of Black midwives in the United States. Its goal is to have a representative voice at the national level that clearly outlines the various needs of Black midwives. The alliance represents all pathways to midwifery, including traditional, licensed, student, and retired Black midwives representing a range of practice experience from hospital and clinic, to home and birth center settings. NBMA's objectives include increasing the number of Black midwives and access to Black midwives so as to have more providers who can impact perinatal health disparities, raising public awareness about the existence and contributions of Black midwives, and eliminating barriers to the profession while supporting educational pathways for Black student midwives.

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- Carol Sakala, Director for Maternal Health
- Sinsi Hernández-Cancio, Vice President for Health Justice
- Rachel Wei, Former Health Justice Graduate Intern

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- Sarah Coombs, Director for Health System Transformation
- Ndome Essoka, Former Health Justice Legal Intern
- Stephanie Green, Health Justice Policy Associate
- Llenda Jackson-Leslie, Senior Communications Specialist
- Blosmeli León-Depass, Former Health Policy Counsel
- Nikita Mhatre, Former Health Justice Policy Associate
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