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The Role of Medicaid Policy in Reducing Racial Disparities in Maternal Mortality and Other Health Outcomes: A Literature Review Series

Issue 2: Freestanding Birth Centers

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Introduction to the Literature Review Series

Racial and ethnic disparities in maternal health outcomes in the United States continue to rise despite advancements in medical care. In 2022, the Biden-Harris administration released the White House Blueprint for Addressing the Maternal Health Crisis,[1] outlining specific actions that the federal government will take to improve maternal health and address disparities. Since publication of the blueprint, nearly all state Medicaid agencies have extended Medicaid postpartum coverage to 12 months through a provision in the American Rescue Plan Act, and the Center for Medicare and Medicaid Innovation has announced a new decade-long Transforming Maternal Health Model to support state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care.[2]

To offer insight into how Medicaid can leverage policies to advance maternal health equity, we conducted a systematic literature review focused on three Medicaid coverage policies: (a) prenatal and postpartum home visiting services, (b) freestanding birth centers, and (c) postpartum long-acting reversible contraception. These policies were selected because they are widely implemented by states and have been studied enough to glean formative findings. The aim of the literature review was to (a) examine the evidence on the effectiveness of these policies in reducing racial disparities in maternal mortality and other maternal health outcomes and (b) explore challenges and promising practices that can be applied to the Medicaid setting.

This brief summarizes findings from the literature review on freestanding birth centers. Literature review findings for Medicaid coverage of prenatal and postpartum home visiting and postpartum long-acting reversible contraception can be found here. Support for this work was provided by the AIR Equity Initiative. The authors thank Talia Fish, Naba Husain, and Karen Ghelman for their research support.

Literature Review Methodology

To examine the evidence on the effectiveness of the policies in reducing racial disparities in maternal health outcomes, we iteratively defined a list of search terms and inclusion/exclusion criteria for each of the three policies (e.g., inclusion of manuscripts published between 2017 and 2022[3] conducted in the United States) and searched a variety of databases and search engines to find applicable published manuscripts. To explore the literature on challenges and promising practices, we expanded our search to include gray literature, such as briefs and reports. We reviewed each article for relevancy to the goals of the literature review. We extracted data from each relevant article using a data extraction protocol and used the data to create a summary of findings. This issue brief summarizes our literature review findings for freestanding birth centers.

Use and Medicaid Coverage of Freestanding Birth Centers

Use and Ownership of Freestanding Birth Centers

An increasing number of people in the United States are making the decision to give birth in freestanding birth centers.[4] Though birth center births represent only about 1% of births in the United States, the number of births in birth centers has doubled over the past decade.[5] According to the American Association of Birth Centers (AABC), a birth center advocacy group and accrediting body, the number of freestanding birth centers in the United States has grown 97% since 2010, and as of 2023, more than 400 freestanding birth centers were operating across 37 states and Washington, DC.[6]

Freestanding birth centers are stand-alone health care facilities where midwives provide care to low-risk patients during pregnancy, childbirth, and postpartum.

Despite the growing popularity of freestanding birth centers, estimates suggest that only a handful (20) are owned or operated by people of color, and communities of color historically have had limited access to freestanding birth centers because of cost and location.[7,8,9] Studies show that about 7% of birth center births are to Black people, though there has been a recent uptick of birth center use by communities of color as a result of the COVID-19 pandemic.[10] Despite the increased use of birth centers by birthing people of color, significant disparities in use remain. Research indicates that Black and White birthing people report feeling safest giving birth in out-of-hospital settings at similar rates, leading researchers to conclude that racial disparities in out-of-hospital births cannot be explained by racial differences in preference.[11]

Birth center care has been shown to improve maternal and infant outcomes, increase satisfaction, and lower costs for Medicaid beneficiaries.

Medicaid Coverage of Freestanding Birth Centers

The Medicaid Birth Center Reimbursement Act, passed into law as part of the Affordable Care Act, mandated Medicaid coverage of freestanding birth centers in states that license birth center facilities. Though coverage is required, Medicaid reimbursement for freestanding birth centers remains a significant issue, especially in managed care organizations (MCOs), which often do not include freestanding birth centers in their networks and are not required by state Medicaid agencies to include them.[12] Additionally, how midwives and birth centers are paid depends on state payment policies, and these policies partially determine whether birth centers can afford to accept Medicaid and also can limit accessibility for low-income populations.[6]

Evidence on the Effectiveness of Freestanding Birth Centers in Reducing Racial and Ethnic Disparities

Strong Start Evaluation

The most comprehensive study to date on the effect of freestanding birth centers on maternal health outcomes by race and ethnicity is the evaluation of the Strong Start for Mothers and Newborns program. The Strong Start initiative engaged nearly 46,000 women and children over a 4-year period. Compared to the typical Medicaid program, Strong Start enrolled participants who were disproportionately Black (40%) and Hispanic (30%). Of the nearly 46,000 Strong Start participants, 8,806 were enrolled in the birth center model (nearly 20%).[13] Birth centers that received Strong Start funding followed the midwifery model of care and utilized peer counselors to provide support, education, and referrals.[13]

Preterm birth, low birth weight, and C-section rates were lower among Strong Start birth center participants than among non-participants for all racial and ethnic groups, and on average Medicaid and CHIP costs for each parent–infant pair were $2,010 lower among participants.

The Strong Start evaluation is rich with findings showing that birth centers are able to improve maternal health outcomes. Its key takeaway is that **low-risk parents who received care in Strong Start–funded birth centers had better outcomes and reduced costs compared to Medicaid enrollees with similar characteristics who did not participate in the program,** regardless of where they gave birth.[13]

The evaluation also broke down findings by race and ethnicity, and it is the most comprehensive study of its kind to do so. Researchers discovered that several key evaluation findings stayed consistent when the data were examined by race and ethnicity. Specifically, they found that **among all racial and ethnic groups, unadjusted preterm birth, low-birth-weight,**

and C-section rates were lower for birth center participants than for women who participated in the other models evaluated by the Strong Start program (i.e., group prenatal care and maternity care home placement).[13]

The Strong Start evaluation did not go so far as to state that birth center births reduce racial disparities in maternal health outcomes. However, the researchers argue that since findings clearly show that the birth center model can significantly improve outcomes, it seems likely that expanding access to birth centers across all races and ethnicities, especially among Medicaid enrollees, could help more women experience healthier births.[13]

American Association of Birth Centers Study

Building on the Strong Start evaluation, Alliman et al. conducted a descriptive analysis of sociodemographic characteristics, care processes, and outcomes for mothers and infants receiving care at AABC sites using the Strong Start birth center model.[14] Specifically, this study included AABC Perinatal Data Registry data from all 6,424 Medicaid recipients enrolled with the 45 AABC Strong Start birth center sites in 19 states between 2013 and 2017.

The researchers analyzed findings on preterm birth, low birth weight, C-section, and breastfeeding rates by White non-Hispanic, Hispanic, and Black non-Hispanic demographics. Overall, the researchers found that although racial disparities in the studied outcomes were present within the sample, they were narrower than in national data. The study draws conclusions similar to those of the Strong Start evaluation: **Birth centers are able to improve outcomes within a racially and socioeconomically diverse population.** However, the study states that more research is needed to better understand the model's potential to reduce racial and ethnic disparities in birth outcomes.[14]

Barriers to Addressing Racial and Ethnic Disparities in Access to and Use of Freestanding Birth Centers

Medicaid Coverage and Reimbursement

Limited Medicaid coverage of freestanding birth centers, low reimbursement rates for midwives, and variation in state midwifery licensure and scope-of-practice laws present barriers to birth center care for Medicaid-covered parents.

Our research revealed that many barriers to obtaining birth center care, especially for communities of color, stem from limitations in Medicaid coverage and payment policy. Managed care has become the dominant model of care for Medicaid, but freestanding birth center providers experience barriers to contracting with MCOs, with the result that birth centers sometimes fail to be included in covered networks.[6] Because a lot of MCO health plan information is proprietary, understanding an MCO's network and provider operations can be difficult, including which maternal care services are covered under certain payment models. Furthermore, although states can use the state plan amendment process to offer coverage for enhanced prenatal care services, Medicaid policies rarely offer explicit coverage of these services, which were considered more viable and were more widely adopted in Medicaid fee-for-service models.[13]

Even if a freestanding birth center obtains a network contract with a Medicaid health plan, it faces many financing and reimbursement challenges. For example, many of the enhanced care services that are central to the midwifery model are not reimbursed or are reimbursed at too low a rate to cover the actual cost of care. Further, payment rates for midwives are typically lower than for physicians.[6] These reimbursement challenges are exacerbated by common Medicaid program issues, such as delayed payments to providers and delays in Medicaid eligibility determinations.[13] Another key financial challenge for freestanding birth centers is the way that transfers from birth centers to hospitals are reimbursed. Specifically, the facility fee for a birth is paid based on the facility in which the baby emerges, even if the majority of labor services were performed elsewhere. Given that transfers to hospitals may be necessary for 20% to 30% of birth center patients, such transfers represent a significant financial burden for birth centers.[15]

Other Barriers and Considerations

Our review of the literature uncovered additional factors that may affect the extent to which birth centers impact racial and ethnic disparities in outcomes. These include the following:

- **Scope-of-practice and licensure regulations.** State laws can make freestanding birth center operations challenging. For example, some state scope-of-practice and licensure requirements make it difficult for all or certain types of midwives (such as direct entry or certified professional midwives) to practice, limiting the availability of midwives and the proliferation and sustainability of birth centers.
- **Diversity of birth center providers and ownership.** Racially concordant care has been shown to improve health outcomes and increase satisfaction for people of color.[16,17] Research also shows that racial diversity within the health care workforce leads to improved quality of care for people of color and could potentially reduce disparities in maternal health.[18,19] Yet, the midwifery workforce continues to be racially homogenous. Despite recent efforts by midwifery organizations to diversify midwifery programs by increasing enrollment of students of color, nearly 86% of midwives are White, and Black midwives make up only 7% of the total.[20,21] Furthermore, only 5% of the approximately 400 birth centers in the United States are owned or led by midwives of color.
- **Wraparound services and referrals to address health-related social needs.** Medicaid enrollees of color often confront barriers to care and have unmet social needs that require integrated, coordinated support and services. Even if not Medicaid eligible, people of color face life-long systemic racism and racial discrimination that can lead to unaddressed health challenges and can limit access to basic resources, impacting their health and well-being. To fully address patients' psychosocial needs and lack of access to care, birth centers must establish processes to screen for health-related social needs and create collaborative and consistent referral relationships with other community-based services and resources.[13] By integrating staff such as perinatal community health workers, peer counselors, and community-based doulas into their operations to help coordinate care and address the comprehensive needs of patients, birth centers can help to offset the resource and time limitations they often face.[22]

- **Culturally compassionate and trauma-informed care.** A growing body of research demonstrates the high prevalence of trauma experienced by racial and ethnic minorities.[23] Racial trauma can originate from adverse childhood experiences, racism, racial discrimination, and race-related stressors.[24] These causes of trauma can have lasting negative effects on physical and mental health and well-being. Culturally compassionate and trauma-informed care has been shown to improve outcomes, improve patient engagement, and increase satisfaction for patients with trauma.[25]

Policy and Program Considerations

Our research underscores the potential for freestanding birth centers to improve disparities in maternal health outcomes. As federal and state Medicaid programs consider investing in birth center models and adopting policies to increase access to and use of birth centers, they need to place a special emphasis on racial and ethnic equity. In particular, federal and state Medicaid policymakers should consider using the following strategies:

- Investing in a **diverse midwifery workforce** and promoting **ownership of freestanding birth centers by midwives of color**
- Promoting the integration of **culturally compassionate and trauma-informed care practices** into midwifery training programs and birth center care models
- Requiring Medicaid payers to include **separate categories for midwives and freestanding birth centers** in their health care provider directories to help consumers locate them more easily
- Supporting **new models and methods of reimbursement** for midwifery-led care in birth centers, including models that reimburse midwives for care provided to patients even in cases of hospital transfer
- Ensuring **payment parity** by reimbursing midwives at the same rate as physicians
- Reimbursing birth centers for the provision of **health-related social needs screening and referrals**
- Allowing midwives to **practice to their full scope** and **recognizing all three midwifery licenses**
- Directing **more funds toward research** that examines birth center strategies to address racial and ethnic disparities in maternal health outcomes
- Requiring state Medicaid agencies and birth center models to report and **disaggregate service and outcome data** by race and ethnicity to identify inequalities and uncover strategies for improvement

Endnotes

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