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Original Scholarship

Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care

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Policy Points:

- Birth center services must be covered under Medicaid per federal mandate, but reimbursement and other policy barriers prevent birth centers from serving more Medicaid patients.
- Midwifery care provided through birth centers improves maternal and infant outcomes and lowers costs for Medicaid beneficiaries. Birth centers offer an array of birth options and have resources to care for patients with medical and psychosocial risks.
- Addressing the barriers identified in this study would promote birth centers' participation in Medicaid, leading to better outcomes for Medicaid-covered mothers and newborns and significant savings for the Medicaid program.

Context: Midwifery care, particularly when offered through birth centers, has shown promise in both improving pregnancy outcomes and containing costs. The national evaluation of Strong Start for Mothers and Newborns II, an initiative that tested enhanced prenatal care models for Medicaid beneficiaries, found that women receiving prenatal care at Strong Start birth centers experienced superior birth outcomes compared to matched and adjusted counterparts in typical Medicaid care. We use qualitative evaluation data to investigate birth

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centers' experiences participating in Medicaid, and identify policies that influence Medicaid beneficiaries' access to midwives and birth centers.

Methods: We analyzed data from more than 200 key informant interviews and 40 focus groups conducted during four case study rounds; a phone-based survey of Medicaid officials in Strong Start states; and an Internet-based survey of birth center sites. We identified themes related to access to midwives and birth centers, focusing on influential Medicaid policies.

Findings: Medicaid beneficiaries chose birth center care because they preferred midwife providers, wanted a more natural birth experience, or in some cases sought certain pain relief methods or birth procedures not available at hospitals. However, Medicaid enrollees currently have less access to birth centers than privately insured women. Many birth centers have difficulty contracting with managed care organizations and participating in Medicaid value-based delivery system reforms, and birth center reimbursement rates are sometimes too low to cover the actual cost of care. Some birth centers significantly limit Medicaid business because of low reimbursement rates and threats to facility sustainability.

Conclusions: Medicaid beneficiaries do not have the same access to maternity care providers and birth settings as their privately insured counterparts. Medicaid policy barriers prevent some birth centers from serving more Medicaid patients, or threaten the financial sustainability of centers. By addressing these barriers, more Medicaid beneficiaries could access care that is associated with positive birth outcomes for mothers and newborns, and the Medicaid program could reap significant savings.

Keywords: Medicaid, birth center, midwifery, prenatal care.

THE MIDWIFERY MODEL OF MATERNITY CARE, WHICH CAN BE practiced in any setting, is universally employed in freestanding birth centers, which as independent entities, fully control processes that allow fidelity to the model.[1] The midwifery model takes a holistic and wellness approach to pregnancy and birth, including an emphasis on individualized education.[2]

Care through the midwifery model shows promise for improving pregnancy outcomes and containing costs.[2-4] Compared to women receiving care led by obstetrician-gynecologists (OB/GYNs; hereafter referred to as obstetric care), women in midwifery-based prenatal care have higher levels of satisfaction; are less likely to have a preterm birth; are more likely to have their births attended by a provider they know; and

are less likely to have interventions such as epidurals, episiotomies, and instrumental births.[4]

Women who receive prenatal care in birth centers are less likely to have cesarean section deliveries.[5] Women who do not have medical risks requiring hospital delivery and who deliver at their birth center do not receive interventions such as medical labor induction or continuous electronic fetal monitoring (EFM)[6] and have access to nonpharmaceutical pain relief, such as laboring and birthing in water.[7] Birth center care is usually provided for women without pregnancy complications,[1,8] though many birth centers routinely serve women with psychosocial risks and some have collaborative relationships with physicians that allow them to serve women with medical risks as well.

The United States has not kept pace with improvements in birth outcomes realized by other nations and, despite paying more for perinatal care than any other country,[9] now has maternal and infant health outcomes among the worst in the developed world.[10,11] Despite established benefits of midwifery care, particularly when offered through birth centers, even low-risk women in the United States usually receive highly medicalized obstetric care.[12,13] The number of freestanding birth centers in the United States grew 76% from 2010 to 2017 to a total of 345,[14] but of 3.8 million births in 2018, only 0.5% were in a freestanding birth center.[15]

Though midwives have worked with underserved and low-income women throughout modern history,[16] a current popular assumption is that women in midwifery care are predominantly healthy, white, middle or upper class, and pursuing "natural" birth,[17] and that these factors—not midwifery care itself—account for positive outcomes. These stereotypes are not supported by data. A review of 2014 birth certificate data for spontaneous vaginal births in hospitals showed that women with births attended by midwives vs. physicians were demographically similar on key variables such as age, race, education, marital status, and insurance type.[18] Though women who birth in community settings (e.g., home or freestanding birth center) are disproportionately white according to 2018 vital statistics data,[15] a study of a national sample of birth centers using 2007–2010 data reports 23% of birth center births were to nonwhite women.[6] That same study found that only 24% of birth center births were to Medicaid participants, far below the proportion of births covered by Medicaid.[6] National midwifery organizations have taken steps to diversify the workforce,[19,20] and midwifery programs

have increased enrollment of students of color.[21] Under-representation of women of color and Medicaid beneficiaries among birth center patients may be a result of lack of access to a range of birth settings rather than lack of interest. A survey of more than 2,500 women who gave birth in California hospitals in 2016 found that 45% of Black women and 41% of women covered by Medicaid expressed interest in a future birth center birth (compared to 40% of surveyed women overall, 41% of white women, and 37% of privately insured women).[22] A small number of birth centers have specifically sought to serve minority populations or lower-income women.[23,24] In one of the only prior studies that address birth center care for Black and Hispanic women enrolled in Medicaid, women in birth centers had fewer C-sections and more term births than did risk-matched women in obstetric prenatal care.[5]

Midwifery may have particular benefits for women with psychosocial risks for poor birth outcomes. While most obstetricians indicate that a typical appointment lasts 16 minutes or less,[25] the midwifery model of care emphasizes sufficient time to address holistic needs,[26] and a prenatal care visit in a birth center is typically 30 minutes or longer.[27] Standards for the midwives' model emphasize individualized approaches, including culturally sensitive care, patient and family engagement, shared decision making, and education and health promotion,[26] all attributes that women say they value in prenatal and birth care.[12] Personalized, longer visits may allow women to reveal needs such as food insecurity or depression that can then be addressed.[27] Forgoing a patient-centered approach and employing interventions when not medically necessary, such as continuous EFM or cesarean section, can reduce patient satisfaction and worsen outcomes.[28,29]

International research indicates that availability of midwifery care is essential to improving maternal and infant health,[30] but regulatory and reimbursement-related obstacles to midwifery and birth centers in the United States have persisted for decades.[31]

Though Medicaid coverage for midwifery and birth centers is a federal Medicaid mandate,[32] states vary in their interpretation of mandates and scope of practice and licensure requirements for midwives.[33] Both the American Association of Birth Centers (AABC) and the American College of Nurse Midwives have issued statements that insurance providers are not covering services in accordance with current regulations.[34,35] A 2020 consensus study report published by the National Academies of Sciences, Engineering, and Medicine concluded that a woman's access

to choice in birth settings is often limited by her ability to pay (including whether and what type of insurance coverage she has) and suggested that it is necessary to provide economic and geographic access to maternity care in all settings to improve maternal and infant outcomes in the United States.[36]

Background on the Strong Start Program

This study investigates the experiences of birth centers that participated in the Strong Start for Mothers and Newborns prenatal care initiative, funded by the Center for Medicare and Medicaid Innovation (CMMI) under authority of Section 1115A of the Social Security Act.[37] Strong Start intended to reduce rates of preterm birth, rates of low birthweight, and costs among women enrolled in Medicaid or the Children's Health Insurance Program (CHIP) (for simplicity, hereafter we reference only Medicaid). The initiative tested three outpatient models of enhanced prenatal care: birth centers, group prenatal care, and maternity care homes. Full descriptions of each Strong Start model can be found in the evaluation's project synthesis report.[27]

The Strong Start birth centers were all freestanding (i.e., not part of or attached to a hospital) and operated by either certified nurse midwives (CNMs) or, less commonly, certified professional midwives (CPMs). CNMs are trained in both nursing and midwifery; they can practice in all states and, although scope of practice varies by state, can care for patients in all settings including birth centers, hospitals, or homes. CPMs are trained in midwifery only and care for women in home or birth center settings; they can practice in most states but are not eligible for licensure in some.

All Strong Start birth center providers followed the midwifery approach to care and AABC standards and offered services at no charge that would be considered enhanced in an OB/GYN clinic or private practice (e.g., doula care, breastfeeding education and support). Because prenatal visits generally lasted at least 30 minutes, midwives had enhanced capacity to build relationships and identify individual patient needs.

When severe medical risks arose, patients were usually transferred into physician-led full care. (Data on antepartum transfer rates for Strong Start birth center participants are not available, but in a 2013 national

study of birth centers, 13.7% of patients were referred to physician care for medical or obstetric complications that precluded birth center care during the prenatal period.[6]) Though women receiving care through Strong Start birth centers were at overall lower risk than their counterparts in group prenatal care and maternity care homes, they still had considerable economic, psychosocial, and medical needs (see Table 1). Strong Start birth centers could address many medical and psychosocial risk factors in-house. Under Strong Start, birth centers developed enhanced systems to refer patients to community resources (e.g., behavioral health, low-cost dental care), and some offered transportation and food vouchers. Some had services for women with specific medical risks, such as in-house nutritionist and diabetes specialty care, a substance use detoxification program, group classes for perinatal mood disorders, case management (including home visits and phone calls), and smoking cessation services.

More than half of the birth centers included in this study offered a choice of birthing at the center or a hospital, and given the choice, about half of patients birthed in each setting (a few centers also offered planned home birth). Birth center midwives usually attended planned hospital births. In the evaluation's survey of AABC's Strong Start sites, more than 80% of respondents who offered planned hospital births said those births were attended by birth center midwives.

The Strong Start evaluation's impact analysis found that women who received care in birth centers experienced significantly better birth outcomes (e.g., lower rates of preterm birth and low birthweight, and lower rates of cesarean section) at lower cost compared to Medicaid beneficiaries in non–Strong Start care who had similar risk profiles.[27] The evaluation concluded that Strong Start's birth center model, which was more holistic, individualized, time intensive, and education-focused than traditional medically focused prenatal care, made a significant difference in the pregnancy outcomes of Medicaid beneficiaries. This study takes advantage of the largest examination ever conducted of birth center care for Medicaid participants, using qualitative data from the Strong Start evaluation to investigate Medicaid beneficiaries' perspectives on birth center care and the experiences of birth centers participating in the Medicaid program.

Table 1. Characteristics of Women Receiving Prenatal Care at Strong Start Birth Centers

Characteristic	Proportion of Strong Start Participants With Characteristic (2014–2018)[a]			
	Birth Center (n = 8,806)	Group Prenatal Care (n = 10,503)	Maternity Care Home (n = 26,007)	All Models (n = 45,316)
Race/ethnicity				
Non-Hispanic white	53.2%	12.7%	22.5%	25.6%
Non-Hispanic Black	16.1%	45.0%	44.8%	39.8%
Hispanic	25.4%	37.1%	28.0%	29.7%
Other	5.4%	5.1%	4.7%	4.9%
Psychosocial risk factors				
Highest level of education was high school diploma/GED	57.5%	58.3%	57.9%	57.9%
Not employed or in school at intake	48.9%	51.0%	47.4%	48.5%
Reported difficulties attending prenatal care appointments	27.7%	38.7%	33.5%	33.8%
Exhibited symptoms of depression, anxiety, or both at intake	38.7%	49.6%	40.4%	42.1%
Food insecure at intake	19.1%	24.4%	19.2%	20.3%
Medical risk factors				
Obese at intake	25.0%	35.1%	40.4%	35.8%
Smoked cigarettes at intake	10.7%	10.1%	13.2%	12.1%
Prior preterm birth[b]	13.2%	21.3%	23.9%	21.1%
Short interpregnancy interval (<18 months) between Strong Start pregnancy and prior birth[b]	34.6%	24.3%	27.1%	28.1%
Prepregnancy diabetes	0.6%	6.8%	4.0%	3.7%
Prepregnancy hypertension	0.8%	8.3%	7.5%	6.1%

Participant-level data collected through the Strong Start evaluation, 2014–2018.[27]
[a]*N* value indicates number of participants with participant-level data. Denominators for specific data elements vary because of missing data.
[b]Denominator is women with a previous birth.

Methods

Between 2013 and 2017, 27 awardees operated Strong Start programs at more than 200 sites in 32 states, the District of Columbia, and Puerto

Rico. Awardees included health systems, state agencies, medical practices, and national organizations such as AABC, which operated all but one of 47 sites implementing the birth center model. Strong Start ultimately served 45,999 women.[27]

The national Strong Start evaluation was conducted from 2013 to 2018 by an independent contractor selected by CMMI through a competitive process. The evaluation team collected data with approval from the Institutional Review Board of the Urban Institute, via mixed methods that included surveys, chart reviews, an impacts analysis, and qualitative case studies. In-depth information about the evaluation's methods and data collection instruments are available in the final evaluation report.[27]

The analysis in this paper considers four years of qualitative data collected from birth centers by uniformly trained researchers using multiple methods to collect data on the same topic. Data collection methods and sources are summarized in Table 2. Researchers conducted yearly semistructured interviews with birth center key informants using standardized questions related to prenatal care practice and Strong Start program implementation. Key informants were selected for interviews based on involvement in the Strong Start program and provision of participant care. We additionally interviewed 20 Medicaid officials about maternity care policies in states where the Strong Start program was implemented. Researchers conducted focus groups with Strong Start participants to assess their Strong Start and overall maternity care experiences and fielded an Internet survey with the birth centers participating in AABC's Strong Start award; the survey focused on birthing options and Medicaid participation.

Researchers cleaned the data, organized it by theme, and coded it using NVivo and a flexible framework designed to address the evaluation's primary research questions, which explored how Strong Start prenatal care differed from typical Medicaid maternity practice; the characteristics of Strong Start participants; the impact of Strong Start on outcomes; and the features of Strong Start that helped explain variations in outcomes and impacts.[36] After three rounds of testing to obtain a high (93%) intercoder reliability rating, we queried the NVivo database to identify themes related to birth centers' experiences participating in Medicaid and policies influencing beneficiaries' access to birth center and midwifery care. We used a grounded theory approach to analyze the

Table 2. Strong Start Birth Center Data Collection

Type (and Mode) of Data Collection	Study Population	Topics Covered	Data Collection Period
Key informant interviews (in-person and by phone)	187 interviews with 248 birth center key informants, including Strong Start awardee and site-level program managers; prenatal care providers (e.g., midwives, RNs); Strong Start enhanced service providers (e.g., peer counselors)	Pre-Strong Start model of care; program implementation and key features of the intervention; perspectives on Strong Start–related outcomes; successes, challenges, and lessons learned	First round: Mar. 2014–Nov. 2014 Second round: Mar. 2015–Jun. 2015 Third round: Nov. 2015–Jun. 2016 Fourth round: Oct. 2016–May 2017 Fifth round: May 2018
Focus groups (in-person)	29 focus groups with 215 pregnant and postpartum Medicaid and CHIP beneficiaries enrolled in Strong Start's birth center model	Selecting a maternity care provider; experiences with Strong Start (e.g., services received, relationships with program staff, satisfaction) and comparisons to previous maternity care experiences	First round: Mar. 2014–Nov. 2014 Second round: Nov. 2015–Jun. 2016
Survey of Medicaid officials (by phone)	Senior officials representing Medicaid programs (e.g., Medicaid directors, chief medical officers, policy analysts) in 20 states with Strong Start programs	Policies related to Medicaid coverage for pregnant women, including eligibility and enrollment; payment models; benefits; and quality improvement initiatives	Aug.–Dec. 2016
Survey of AABC's Strong Start sites (Internet-based)	38 birth center staff representing AABC Strong Start sites	Labor and delivery options; sustaining the Strong Start intervention; Medicaid participation	Dec. 2016

Abbreviations: AABC, American Association of Birth Centers; CHIP, Children's Health Insurance Program
Source: Strong Start Case Study Data Collection, 2014–2018.[27]

queries and memos summarizing findings from the surveys and annual case studies.[39]

Results

Beneficiary Perspectives on Strong Start Birth Centers

Strong Start focus group participants often reported choosing a birth center because they were attracted to the midwifery model of care, specifically its emphasis on personalized patient-provider relationships and patient involvement in care decisions. Many relayed negative experiences with hospital birth or obstetric care. A participant who had experienced both typical obstetric and birth center care contrasted the two models' approaches to decision making when reflecting on her choice of a birth center for her Strong Start–enrolled pregnancy: "At the birth center … instead of telling you how to do things, or what you should do, [the midwives] empower you to make your own decisions. They educate you and let you do what you feel is best. In [obstetric care], that is far from the case." In addition, many Strong Start participants wanted a natural birth experience with minimal medical intervention. Some were specifically seeking pain relief methods not available in their local hospital, such as water birth and nitrous oxide.

Other reasons that Strong Start participants chose birth center care included convenience, a reputation for high-quality care, and recommendations from family and friends. Nearly all women receiving prenatal care at the Strong Start birth centers praised their care, with more than 96% saying they were either "very satisfied" or "extremely satisfied."[40]

Birth Center Experiences Participating in State Medicaid Programs

Participating birth center sites reported that in their overall patient population, at least a third of patients were enrolled in Medicaid. A few centers, including some affiliated with federally qualified or rural health centers, reported that more than three-quarters of patients had Medicaid coverage. Still, birth centers experienced a host of challenges related to

serving Medicaid participants (summarized in Table 3 and addressed in detail in the following paragraphs).

Reimbursement Rates. Insufficient reimbursement was a recurrent theme among key informants. This issue is not unique to birth centers as Medicaid providers, but because centers are usually small businesses and serve a limited patient panel, absorbing unmet costs or passing them on to other patients is not a viable strategy. About half of the birth centers included in this study struggled to serve Medicaid beneficiaries because reimbursement was inadequate to cover the baseline costs of care. In the evaluation's 2016 survey of Medicaid programs, officials in eight states reported that midwives were paid less than physicians for the same services, while only two states reported equal rates between the two types of providers. In states with differentials, midwives were reportedly paid between 70% and 92% of physician rates, though several states reported only that midwives were paid "less." The survey also revealed Medicaid payment differentials for uncomplicated vaginal deliveries at birth centers versus hospitals. Of the six states that responded to this question, five reported that birth centers were paid less than hospitals, though only two shared specific information; in one state, birth centers were reportedly paid 70% of hospital rates and in the other they were paid just 15% of hospital rates. Many key informants noted that Medicaid usually offered a global payment for all prenatal services, but birth center costs for prenatal visits could be higher than those in obstetric care because birth center midwives offer more frequent and longer visits, as well as more education and other support to high-need patients, compared to practitioners providing obstetric care.

For women who received prenatal care at a birth center but delivered elsewhere, Medicaid reimbursement could be especially fraught. Three Strong Start centers reported that when a patient began labor at the center but ultimately needed a hospital transfer, the birth center received no reimbursement for labor care. And four centers indicated that their state Medicaid programs did not reimburse for immediate newborn care provided at birth centers. Centers that did receive reimbursement for these services reported a wide payment range. For professional and facility fees for labor care in the event of a transfer, reported reimbursement ranged from $257 to $2,845, with an average payment of $1,107; and for newborn care, reported reimbursement ranged from $32 to $764, with an average payment of $231 (written communication, 2019).

Table 3. Summary of Birth Center Challenges Serving Medicaid Beneficiaries

Challenge	Examples
Inadequate reimbursement for services	• Midwives were paid less than physicians for the same services • Large payment differentials between birth centers and hospitals for same type of delivery • Global payments do not reflect more frequent or more time-involved prenatal care visits • No payment for labor care when patient transfers to hospital, or for newborn care
Inability to contract with MCOs	• MCOs refuse to include birth centers in network • Birth centers have limited or no negotiating power
Coverage limitations	• No coverage for services such as home births, lactation consultants, childbirth education • Limits on coverage for other services such as prenatal visits
Limited ability to participate in delivery system reforms	• Payment structures not set up to accommodate nonhospital birth settings or nonphysician providers
State and local licensure laws	• Requirements such as Certificate of Need, mandated relationships with physicians, transport/transfer agreements with local hospitals or EMS, and structural facility elements that are stricter than necessary make it difficult for birth centers to obtain licenses

Abbreviations: EMS, emergency medical services; MCO, managed care organization.
Source: Strong Start Evaluation Data, 2014–2018.[27]

Even though outreach to Medicaid beneficiaries would have increased Strong Start program enrollment and patient volume, birth centers often avoided such outreach because of insufficient reimbursement. One key informant reported that, even without a concerted outreach effort, the Strong Start program had increased her center's Medicaid population, which she described as "good and bad at the same time, because of the lack of funds …; business-wise, we have to pay our bills."

At least three birth centers either encouraged or required Medicaid-covered patients to give birth at the hospital because reimbursement was not sufficient to cover costs for birth center births. For instance, a midwife at a birth center that restricted Medicaid enrollees to planned hospital birth noted that Medicaid reimbursed the center about $400 for a birth, which did not even cover the cost of the labor nurse.

Other Strong Start birth centers addressed inadequate reimbursement by capping Medicaid enrollment. In the survey of AABC's Strong Start sites, 7 of 34 respondents reported that inadequate Medicaid reimbursement had prompted the birth center to restrict the volume of Medicaid patients, or in the case of one center, stop accepting Medicaid-insured women entirely. Slow claims processing and billing errors also threatened centers' financial stability.

Relationships With Medicaid Managed Care Organizations. In a Medicaid managed care model, state Medicaid agencies enter agreements with managed care organizations (MCOs) to deliver covered health benefits to Medicaid enrollees for a set per member per month (capitation) payment. Though freestanding birth center services are a mandatory covered benefit in Medicaid, some birth centers were not able to contract with Medicaid MCOs. MCOs refused to include at least five of the Strong Start birth centers in their networks, reportedly reasoning that similar services were already available at hospitals and physician-based practices. At these and other sites, center administrators reported little or no negotiating power with the health plans—at one center, an MCO reportedly refused to update a 2005 contract with the center because the population benefiting from the coverage was too small. MCOs are now the dominant service and payment model in most state Medicaid programs, so when birth centers are not included in MCO networks, Medicaid beneficiaries, who generally cannot afford out-of-pocket costs, cannot access birth center care. Key informants believed that some MCOs were uninterested in contracting with birth centers because they are often small

practices with lower volume than other maternity care providers and because they are not operated by physicians. A key informant explained, "It feels like MCOs want to deal with people they are used to dealing with, which is bigger hospitals and health networks."

Several Strong Start birth centers were in a state where the Medicaid program was transitioning to a statewide managed care delivery system during the program's demonstration period. Key informants from the birth centers identified multiple challenges related to the transition from fee-for-service to Medicaid managed care, including the time required to negotiate contracts with each individual MCO, to submit prior authorization requests and claims if a contract was established, and to track reimbursements. These challenges were acute for birth centers, which usually have lean administrative resources and no staff person dedicated to billing and reimbursement. Birth center key informants in other states echoed concerns about administrative burden and expressed frustration that birth centers had to "jump through so many hoops" to participate in networks with low reimbursement relative to other payers.

Medicaid Coverage Limitations. Several birth centers identified challenges related to Medicaid coverage limits. Fourteen of the 20 states included in the Medicaid officials survey did not cover nonclinical services such as lactation consultants or doulas. Two of the Strong Start centers with a home birth option reported Medicaid did not cover home births. In the Medicaid officials survey, three of 20 states reported limits on the number of prenatal visits covered for "normal" pregnancies, which could particularly impact birth centers, as many had a standard that exceeded the cap. For example, birth center key informants in Florida said the state's limit of 10-visit coverage was not sufficient for birth center care, as they offered a standard of at least 14 visits.

Limited Ability to Participate in Medicaid Delivery System Reforms. Key informants agreed that high-quality, low-cost provider facilities such as birth centers could help Medicaid achieve its goals for a value-based health care delivery system, but current payment and incentive structures are not set up to accommodate nonhospital birth settings or births with nonphysician primary attendants. For instance, births are covered as inpatient services, but birth centers are classified as outpatient settings, so standard value-based reimbursement methodologies cannot be applied to birth center births. Many Medicaid programs do not have a mechanism for midwives to be primary accountable providers, so only

physicians can be directly reimbursed. One key informant familiar with many state Medicaid programs explained, "Reforms related to risk and gain sharing could work well for birth centers, but at the implementation level, things fall apart."

Challenges Related to State and Local Licensure Laws. State and local licensure laws can limit birth center access and coverage. During the Strong Start program, some birth centers reported their states were considering additional regulations for birth centers and midwives, such as in South Carolina, where informants described a regulation that would require birth centers to always have a physician available at the birth center. Though a full examination of licensure laws and their effects was beyond the scope of this study, survey data collected by AABC in 2014 highlighted the influence of such laws on birth centers. AABC members reported requirements that made it more difficult for birth centers to qualify for licenses, including Certificate of Need requirements (reported by 20% of members), medical director requirements (58%), written consultant agreements (66%), hospital transfer agreements (54%), and structural facility elements that are stricter than necessary for safe center operations, such as those that might be applied to a surgical center (50%).[41]

Additionally, Medicaid requires facility-based licensing or credentialing, but associated fees can be unaffordable, especially for independently operated birth centers. Some MCOs require both credentialing by AABC and state licensing. One birth center reported that it could no longer afford the former, resulting in health plans refusing to pay for Medicaid beneficiaries.

Discussion

Despite high rates of spending on maternity care, the United States experiences some of the worst maternal and infant outcomes among developed countries, including high rates of preterm birth and low birthweight.[10,11] These priority outcomes have significant consequences for both the families that experience them and for health care spending. The Strong Start demonstration indicates both can be addressed by the midwifery and birth center models of care. Specifically, under Strong Start, Medicaid beneficiaries cared for by midwives in birth centers fared better in terms of these outcomes than a risk-matched comparison group

that received care from typical Medicaid providers, and the better outcomes were achieved at a lower overall cost. Ensuring beneficiary access to a range of maternity providers and care settings promotes patient choice and individualized care, and ensuring access to birth center care in particular promotes access to more effective care. Many Strong Start participants sought birth centers to access the midwifery model of care or an alternative to obstetric care and hospital birth, but even those who chose birth centers because of convenience or necessity (e.g., a dearth of other local Medicaid providers) had positive impressions of their care. Strong Start birth centers offered patients an array of birth options and had resources to serve patients with medical and psychosocial risks.

Despite beneficiary interest and birth centers' proven abilities to serve Medicaid patients effectively, many barriers stand in the way of Medicaid beneficiaries having broad access to birth center care. As long as these barriers are in place, women with Medicaid coverage do not have the same access to birth centers as privately insured women. Managed care has become the dominant service delivery and payment model for Medicaid, but birth centers often have difficulty contracting with MCOs. Medicaid value-based delivery system reforms have been engineered for hospital birth settings and physician-based maternity practices and often do not consider other providers or settings. Birth centers and their staff are frequently paid less by Medicaid than other maternity care providers and facilities for the same services, with reimbursement rates sometimes too low to cover actual costs. These conditions have prompted some Strong Start birth centers to minimize losses by capping Medicaid patient enrollment, restricting Medicaid patients' birth options to hospital delivery, or ceasing participation in the Medicaid program altogether. State scope-of-practice laws and licensing policies can compound these challenges and limit the supply of birth centers available to all pregnant women, regardless of Medicaid status.

Federal and state Medicaid officials could consider several policy changes to improve beneficiary access to midwives and birth centers. These include increased reimbursement (including both professional and facility fees) or some form of cost-based reimbursement such as for federally qualified health centers, as well as paying for care provided to newborns and women who labor at the birth center but ultimately transfer to a hospital. The Affordable Care Act required parity in payment for midwives and physicians under the Medicare fee schedule. Though this

provision, effective in January 2011, does not extend to Medicaid, it is notable because Medicare serves as an important standard-setter for health insurance reimbursement rates. In addition, Medicaid programs could enforce MCO compliance with current federal guidance that requires at least one birth center in their provider network. This guidance came into effect in July 2017 near the end of the Strong Start evaluation, but early reports from birth centers indicated that some MCOs were not complying with it. More broadly, the programs could establish payment or delivery mechanisms to encourage enhanced prenatal care delivery. The Strong Start evaluation found that while Medicaid policies generally support financial access to prenatal care, they rarely offer explicit coverage of or incentives for enhancements. A bill introduced in the US Congress in November 2019, the Birth Access Benefiting Improved Essential Facility Services (BABIES) Act, would create a four-year demonstration program to use a prospective payment system for reimbursing birth centers.[43] By addressing challenges related to insufficient payment rates, the BABIES Act intends to increase birth centers' capacity to serve Medicaid beneficiaries. If enacted, the legislation could expand access to the birth center model of care under state Medicaid programs.

Strengths and Limitations

This study's strengths include its use of data from national-level research that spanned several years and encompassed both quantitative and qualitative components, allowing our team to confirm findings across methods. The Strong Start evaluation's qualitative team collected data from several different sources (interviews with program staff and providers, focus groups with beneficiaries, and surveys of Medicaid officials and birth center sites) on the same topic, further ensuring the validity of our findings. The evaluation also represents one of the largest comprehensive studies of birth center care to date, and the only such study of its size to focus exclusively on Medicaid beneficiaries who receive care in birth centers. Given the key role that Medicaid plays in the provision of maternity care in the United States, covering approximately 42% of all births, this study's findings have significant public policy implications for our nation's health system.

Study limitations include the fact that Strong Start birth centers (our study focus) may not be representative of all US birth centers.

However, our data reflect the experiences of dozens of birth centers operating in diverse policy environments across 22 states. As part of this study we compared characteristics of the Strong Start birth centers with a sample of 151 US birth centers surveyed by AABC in 2016;[42] we found that the centers included in our study are reasonably representative of birth centers in the United States overall in terms of geographic location, payer mix, provider types, services offered, and annual birth volume. Data also include multiple interviews with AABC, whose staff are familiar with the experiences of hundreds of birth centers.

The research team had limited information about Medicaid payment structures for prenatal care. Not all states participated in the Medicaid survey; even for the 20 participating states, officials were often not able to fully describe mechanisms by which MCOs pay prenatal care providers. MCO representatives were not key informants in this study, so their perspectives are not included in our findings. Finally, because service-specific Medicaid payment data are not publicly available, we also had insufficient information to make precise comparisons between payments for birth center- and hospital-based births.

Conclusion

Many of the barriers to midwifery and birth center care identified by the Strong Start evaluation are not new; regulatory and reimbursement-related obstacles for these providers have been documented since interest in midwifery care increased in the 1980s and 1990s.[31] However, the evaluation also found that midwifery care provided through birth centers resulted in better outcomes and lower costs. This presents an especially compelling case for scaling up this model of care, particularly in light of the fact that the typical (hospital- and physician-based) maternity care system has struggled to improve outcomes for mothers and newborns despite significant spending. Investments that increase access to midwifery and birth center care are critical given the current performance of the US maternity care system. If progress is made in addressing the barriers to the model of care identified in this study, both women and their infants enrolled in Medicaid would experience better birth outcomes, and the Medicaid program could reap significant savings.

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