



Investing in our Moms: Three Ways State Medicaid Programs Can Improve Maternal Health

The United States is in the midst of a maternal health crisis. Women* are dying at rates the U.S. has not experienced since the 1960s.¹ Maternal mortality rates increased by nearly 38% year-over-year from 2020 to 2021, and nearly doubled from 2018 to 2021.² While the COVID-19 pandemic accelerated poor maternal health outcomes, maternal mortality has been trending in the wrong direction for over two decades.³

Black women have long experienced worse maternal health outcomes in the U.S.,⁴ and disparities in maternal mortality between Black and white women persist.⁵ Black women are almost three times as likely as white women to die during pregnancy or childbirth. For the first time in recent years, Hispanic women are now more likely than non-Hispanic white women to experience maternal mortality.⁶ American Indian and Alaska Native women are also more than twice as likely as white women to experience maternal mortality.⁷

* Families USA supports the interests and experiences of all individuals, including those who identify as transgender or nonbinary, and embraces inclusive language to describe the experience of all birthing people. We also recognize that many birthing people identify with the terms “woman,” “mother” and “maternal” and that embracing more inclusive language does not mean abandoning these terms. Some of the data and research cited in this report also assumes cisgender identity, and the data and research are described using gender labels that cannot be changed without misrepresenting the data.

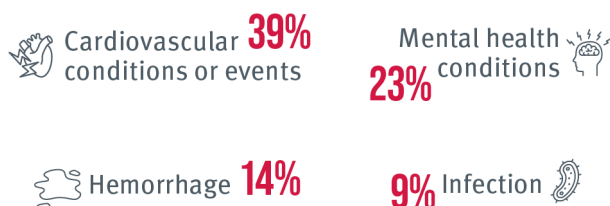
What can states do about the crisis?

Medicaid offers states the greatest opportunity to combat the maternal health crisis. Forty-two percent of all births are financed by Medicaid.⁸ Medicaid coverage for pregnant and postpartum women has been associated with a number of positive health outcomes, including increased access to prenatal and postpartum care. In recent years, Medicaid expansion has reduced postpartum hospitalizations.⁹ Many states are now turning to Medicaid to launch or expand maternal health initiatives. This report will outline some of the drivers of poor maternal health outcomes and discuss how adding and expanding doula care, midwifery services, and group prenatal care through Medicaid can help.¹⁰

What causes poor maternal health outcomes?

Poor maternal health outcomes are driven by a variety of causes. State maternal mortality review commissions have identified and linked a number of underlying medical conditions as causes of maternal deaths.¹² From 2017 to 2019, 39% of maternal deaths were caused by cardiovascular conditions or events (including cardiomyopathy and hypertensive disorders of pregnancy), 23% of maternal deaths were caused by mental health conditions (including suicide and overdose or poisoning related to substance use disorder), 14% were caused by hemorrhage, and 9% were caused by infection.¹³

MEDICAL CONDITIONS UNDERLYING MATERNAL DEATHS



What Are Maternal Mortality and Maternal Morbidity?

Centers for Disease Control and Prevention **maternal mortality** rates are measured by calculating the number of maternal deaths that occur across a population. Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy. **“Pregnancy-related deaths,”** which is a term used in some data sets and reports, including data reviewed by maternal mortality review commissions, includes deaths of women while pregnant or within one year of the end of pregnancy.

In contrast, **morbidity** refers to short- or long-term health consequences. **Severe maternal morbidity** refers to unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. **Maternal morbidity** refers to unexpected outcomes of *pregnancy and childbirth* that result in short- or long-term negative consequences to a woman’s health.¹¹ This report will use the term “maternal health outcomes” to refer to maternal mortality, maternal morbidity and severe maternal morbidity.

However, a rising number of maternal deaths are only part of the picture when it comes to poor maternal health outcomes in the U.S. Maternal morbidity¹⁴ and severe maternal morbidity¹⁵ are also on the rise. And like maternal mortality, maternal morbidity and severe maternal morbidity disproportionately impact women of color.¹⁶ Women in rural areas are also disproportionately impacted by maternal mortality and morbidity.¹⁷ According to the American College of Obstetricians and Gynecologists, “[s]evere maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death.”¹⁸ Remarkably, the Centers for Disease Control and Prevention has found that more than 80% of maternal deaths are preventable.¹⁹ These poor maternal health outcomes demonstrate how poorly our health system functions for women.

Maternal deaths and morbidity are also the result of a number of influencing factors, in addition to underlying medical causes.²⁰ The impact of social drivers of health on maternal health outcomes is well documented. Significant social drivers in this space include geographic barriers to accessing care, racism (both inside and outside the health care delivery system), language and literacy barriers, domestic violence, food access and nutrition, and access to pollution-free communities and green space.²¹

Women of different races and ethnicities experience different maternal health outcomes. For example, the top two leading causes of maternal deaths among white and Hispanic women are mental health conditions and hemorrhage, while the leading causes of maternal deaths among Black women are cardiac and coronary conditions and cardiomyopathy. The two leading causes of maternal death among Asian women are hemorrhage and cardiac and coronary conditions.²² To be clear, these differences are not caused by race, but are often the result of bias in health care and racism more broadly.²³

*The Centers for Disease Control and Prevention has found that **more than 80%** of maternal deaths are preventable.*

SOCIAL DRIVERS OF HEALTH CAUSING MOMS TO DIE AND BE SICK



Geographic barriers to accessing care



Racism



Language and literacy barriers



Domestic violence



Food access and nutrition



Access to pollution-free communities and green space

RACISM AND MATERNAL MORTALITY AND MORBIDITY

One way racism shows up is in the quality of care provided. Significant issues exist in maternal health care, such as care providers not respecting patients, ignoring their complaints, discounting their pain, etc. One of the most well-known examples of this is the care experienced by tennis champion Serena Williams.

Following the delivery of her child, Williams complained of shortness of breath and knew from her own experience with blood clots that she may be suffering a pulmonary

embolism. When she requested the care she knew she needed, her requests were ignored and alternative tests were ordered by the medical staff. Only later did doctors begin to listen to Williams and deliver the appropriate life-saving care.²⁴ Many maternal health experts have pointed to this example as a common way Black women experience racism in health care.²⁵ For some of these women the result can end in a preventable death due to “missed or delayed opportunities for care” like those initially experienced by Williams.²⁶



Why are poor maternal health outcomes increasing?

Prior to the 1990s, maternal mortality had been steadily declining in the U.S. Then in 1999, the trend reversed course and has been rising ever since.²⁷ The increase in poor maternal health outcomes coincides with the rise in other negative health outcomes. For example, life expectancy in the U.S. has been decreasing for nearly a decade.²⁸ However, changes more specific to maternal health care delivery are significant drivers of recent trends in maternal health outcomes.

Cesarean section rates have increased by about 60% since 1996.²⁹ The proportion of women needing blood transfusions because of hemorrhage during childbirth has also increased — growing fourfold from 1993 to 2014. Given that women are more likely to hemorrhage after a C-section, many poor maternal health outcomes are inextricably linked to the increase in C-sections performed.³⁰ Women who have C-sections are also more likely to experience infection.³¹

Rates of maternal depression have also been increasing in recent years, particularly post-pandemic.³² Ensuring women have access to care and treatment prior to pregnancy has been more challenging in recent decades as state family planning budgets have been restricted and clinics have been shut down.³³ Access to care has also been challenged by the growth of maternity care deserts,³⁴ as hospitals close and consolidate across the country, and rural communities lose doctors.³⁵

What are the most promising opportunities for states to leverage Medicaid to address this crisis?

The remainder of this report will examine three of the most impactful maternal health policy interventions available to states within Medicaid:

1. Establishing or expanding coverage toward a universal doula benefit.
2. Covering all midwives.
3. Scaling up group prenatal care.

These policies are particularly impactful because they combat significant drivers of poor maternal health outcomes, namely a lack of centering patient interests and respect, growing maternity care deserts, complications from c-sections, and postpartum depression and other mental health conditions.

1. Expanding access to doula services

One of the most impactful maternal health policy interventions within Medicaid is establishing or expanding to a universal doula benefit, where every pregnant woman on Medicaid who wants a doula can have a doula throughout the perinatal period. While no state currently operates a doula benefit with this capacity, many states have adopted doula coverage and improved benefits in recent years.

What are doulas?

Doulas serve as patient advocates and act in the best interest of the birthing mother during the perinatal period. One common definition is:

*a non-clinical support worker who provides continuous emotional, informational, and physical support for individuals before, during, and after labor. This includes explanations and guidance on medical procedures, lactation support, physical comfort measures during labor, education on coping skills and infant care, and encouragement of bodily autonomy and personal advocacy in the medical institution.*³⁶

Doulas are trained professionals, and many are uniquely positioned to work within their communities to ensure that culturally congruent care is provided to the perinatal patient. Community doulas “are often members of the communities they serve, and share cultures and languages with their clients.”³⁷ Doulas advocate for birthing women and empower them to address racist and unsupportive maternal health care practices. Importantly, doulas help to address social inequities by directing birthing women to resources in their communities.³⁸ Some doulas provide full-spectrum doula services that cover the entire perinatal period, while other doulas may focus on labor and delivery or postpartum care.

Doulas improve maternal health outcomes in multiple ways

Data shows that the support of a doula leads to lower rates of C-sections and preterm births. Reducing the number of C-sections reduces other complications and surgical interventions, which are directly connected to maternal mortality and morbidity.³⁹ Further, women who have a high risk of adverse birth outcomes and receive doula care are “two times less likely to experience a birth complication, four times less likely to have a low birthweight baby, more likely to breastfeed, and more likely to be satisfied with their care.”⁴⁰ Full-spectrum doulas and postpartum doulas are also in a position to improve maternal mental health, by ensuring that their clients are connected to services throughout the perinatal period. A review of Medicaid claims from California, Florida and the Northeast found that doula care reduced the likelihood of a mother experiencing postpartum depression or anxiety by almost 60%.⁴¹

Expanding doula care requires states to address workforce issues and training and certification requirements

While some states have been relatively quick to adopt new doula benefits in Medicaid, new programs have been fraught with extremely low and delayed reimbursements, administrative burdens, and insufficient administrative support and recognition for community-based doula models of care.⁴² These roadblocks prevent doulas from providing care and serving their communities. When expanding doula supports in Medicaid, it is critical that the training and certification models are affordable and meet the needs of communities across the state, and that the payment model is sustainable and fair. Increasing access to doulas is a necessary step toward addressing the maternal health crisis.

Medicaid requires states to set minimum qualification requirements for individuals providing Medicaid services. However, historically, most states have not licensed doulas, so many states will need to establish new regulatory frameworks prior to adopting a Medicaid benefit. Many doulas obtain training and certifications from private organizations. According to the National Health Law Program (NHeLP), more than 100 independent organizations offer some form of doula training and certification. Some doulas have decades of experience and the same competencies as certified doulas even

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though they have not participated in any organized training or certification programs. All of these factors need to be considered as states determine doula qualification requirements for Medicaid.⁴³

Best practices include: (1) not restricting training to a select set of expensive certification programs, (2) requiring evidence of core competencies (for example, allowing doulas to document evidence of coursework and community-based trainings rather than requiring certificates), and (3) providing legacy or experience pathways to qualification that allow doulas to document experience, such as the number of births attended or the number of hours of service provided, in place of trainings or certifications.⁴⁴

Medicaid reimbursement policy is key for states to expand access to doulas

States have a number of options when structuring reimbursement for doula benefits. First, some states cover doulas as an optional preventive service in their state plans while others cover doulas as an optional service for pregnant women. This distinction is key because preventive services do not need to be supervised by a physician or licensed health care provider.⁴⁵ Medicaid agencies also have options in determining who can receive doula benefits. Given the impact of doula services on improving maternal health outcomes and eliminating disparities, states should work toward a universal doula benefit, where everyone who wants a doula can access one throughout the perinatal period.

In order to attract a sufficient number of doulas to enroll as Medicaid providers, states will need to ensure that reimbursement is sustainable for doulas and incentivizes quality care throughout the perinatal period. One way to do this is through global payments. Global payments are flat-rate fees issued on a per patient basis that cover a set of interventions or period of time. Global payments for doulas that cover the entire perinatal period or phases within the perinatal period could be structured to incentivize high-value, high-quality care for pregnant women. Global payments may also allow states and managed care organizations to share cost savings generated by doulas, as pregnant women will be less likely to need C-sections or other surgical interventions that are more expensive than vaginal births without complications. Either way, states will need to ensure payments support the interests of mothers and doulas. Some mothers may only want a birth doula. And some doulas are only trained as either birth doulas, postpartum doulas or abortion doulas and want to remain within a limited scope of practice. In some instances, fee-for-service payment structures may be needed in order to ensure the full array of doula services are available and a sufficient number of doulas enroll. California⁴⁶ and Oregon⁴⁷ both have payment models that are more likely to be sustainable for doulas and provide doulas the freedom to tailor and structure their services in ways that best meet their clients' needs. Virginia and Michigan have also recently enacted Medicaid doula benefits with promising reimbursement structures.⁴⁸

Finally, states may also opt to only provide doula services as a "value-added service" within managed care.⁴⁹ This option may be particularly suitable where all Medicaid members are enrolled in managed care plans. The advantage of this option is that it does not require a state

plan amendment or waiver application from the state. Rather, managed care organizations maintain an arrangement with the state Medicaid agency and agree to provide services to their members under a capitation model and other arrangements.⁵⁰ States that are currently utilizing this policy lever include Florida, Missouri, Nebraska and Texas.⁵¹

States can also utilize Title V funding to support community-based organizations and to compensate doulas for costs associated with training and credentialing to provide Medicaid services

States should also consider using their federal Title V Maternal and Child Health Services Block Grant funds to provide support for community-based organizations providing doula services.⁵² The Title V block grant program aims to “support the health and well-being of all mothers, children, and families” by providing funding to improve access to quality maternal and child health services for low-income individuals, including providing perinatal care.⁵³ Funds could be used to pay for training and certifications for doulas enrolling in Medicaid. These funds could also be used to help community-based organizations improve billing and data systems to better meet the billing and data requirements for Medicaid managed care organizations and state Medicaid agencies. Indiana currently utilizes Title V block grant funds to provide doula services to Medicaid-eligible women. Title V doula funds in Indiana support training for doulas, as well as provide two-generational postpartum services, such as pediatrician visit follow-ups, maternal depression screenings, lactation services and infant care education.⁵⁴

Doulas and mothers must be part of the policymaking process

As states are considering the options to expand access to doula services, they must engage doulas and mothers in the policymaking process. Some poorly structured doula benefits have failed to enroll a sufficient number of providers. Doula care is too important and too impactful for a Medicaid benefit to be poorly crafted in a way that is unsustainable for doulas. In order to overcome some of the challenges of structuring a doula benefit, California engaged a facilitator to assist in a months-long process that brought Medicaid officials and doulas together to better understand doula services and the parameters of Medicaid. The experience of doulas and state Medicaid officials working together has been chronicled extensively by experts at NHeLP.⁵⁵ Feedback from doulas shows that this approach has been successful.⁵⁶ More information about this effort can be found at <https://healthlaw.org/doulamedicaidproject/>. States should study the approach taken in California and take a similar approach when seeking to establish a new doula benefit or improve an existing one.

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2. Expanding access to Medicaid coverage of midwifery care

Midwives improve maternal health outcomes

Midwifery is a medical specialty that predates modern gynecology and, for low-risk pregnancies, is associated with improved maternal health outcomes and reduced risk of medical intervention during birth, unnecessary C-section, preterm birth, infant mortality and a variety of negative birthing experiences.⁵⁷ Midwives are trained and educated health care professionals specializing in pregnancy, childbirth, postpartum health and newborn care as well as gynecological health, reproductive health and family planning services.⁵⁸

Some of the best maternal and infant health outcomes under midwife care occur in birth centers, which greatly reduce the amount of interventions used during labor resulting in lower costs and sometimes safer births.⁵⁹

Midwife training, certification and licensure vary across states, creating obstacles to widespread adoption

Midwives gain professional competency through a variety of degree and certification programs, training opportunities and other experiences. Different types of midwives include certified nurse-midwives (CNMs), certified midwives (CMs) and certified professional midwives (CPMs), licensed midwives, and community midwives. Midwives practice in a variety of settings depending on the scope of practice determined by the state where they work. These settings include hospitals,

WHAT IS THE ROLE OF BIRTH CENTERS?

Despite the Affordable Care Act requirement that Medicaid cover birth centers, as of 2020, only two-thirds of states offered Medicaid coverage for free-standing birth centers.⁶⁰ Licensure and certification of birth centers remains a significant barrier to Medicaid coverage as the process to license a birth center can be lengthy, costly and convoluted.⁶¹ While proper regulation and certification is an important part of ensuring the safety of pregnant women overly stringent and costly licensure processes contribute to the scarcity of maternal health care providers.⁶²

Similarly, Medicaid reimbursement policy for birth centers limits accessibility. One study noted pregnant women covered by Medicaid had limited access to midwives and birth centers because Medicaid reimbursement for birth centers was too low. The study stated, “[a]bout 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.”⁶³ While birth centers show significant promise to improve maternal health outcomes, particularly when combined with midwifery services, birth center policy is outside of the scope of this report.

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homes, medical offices and birth centers. While states may license and credential midwives under a variety of titles, CNMs, CMs and CPMs are all nationally recognized credentials with education programs recognized by the U.S. Department of Education.⁶⁴ Some states have “grandmother” clauses or other provisions to license or credential midwives based on experience or other demonstrated competencies. For example, Hawaii has historically exempted traditional Hawaiian healers from state licensing requirements. Maine also allows the “practice of midwifery” by a “traditional birth attendant ... [who] has cultural or religious traditions that have historically included the attendance of traditional birth attendants at births and that birth attendant serves only the women and families in that distinct cultural or religious group.” And Minnesota licenses midwives without requiring a nursing degree or nationally recognized certification.⁶⁵

Despite significant shortages of OB-GYNs and other birth workers, poorly crafted policies also limit access to midwives

Despite the overwhelming evidence that midwives and birth centers support positive maternal and infant health outcomes and have the opportunity to fill the maternal health provider shortage, midwifery services are still unavailable to many pregnant women. According to a 2022 March of Dimes report, there are 1,119 maternity care deserts. The report defines maternity care desert as a county where there are no hospitals or birth centers providing obstetrics care and no OB-GYNs or nurse-midwives.⁶⁶ On top of this, there are 323 low-access counties that have less than 60 obstetric providers per 10,000 births and only one hospital offering obstetric services.⁶⁷ Low reimbursement rates, inconsistent Medicaid coverage, barriers to obtaining licensure and certification, and the historical push away from traditional midwifery toward hospital-based maternal care all contribute to the inaccessibility of this safe and affordable alternative to physician-based obstetric care.⁶⁸ Unlike Hawaii, Maine and Minnesota, many states have excluded traditional cultures of midwifery, such as Black and Indigenous midwifery, from licensure and reimbursement models.⁶⁹ On top of this, prospective midwives of color are the most impacted by educational and financial barriers, resulting in a predominantly white midwifery workforce and the perpetuation of racial disparities in maternal health access and outcomes.⁷⁰

Medicaid policies can improve access to midwives

Given that Medicaid covers over 40% of all births nationwide, Medicaid policy can have a significant impact on the availability of midwifery care.⁷¹ Medicaid requires coverage of midwifery and birth center services. However, poorly crafted Medicaid policy can also limit the availability of midwives in states. Access to midwifery services within Medicaid depends on licensure and certification requirements, scope of practice requirements, and sustainable reimbursement. Advocates should consider all of these factors in their efforts to improve access to midwives in Medicaid.

Providing multiple pathways to licensure or certification, and broadening the scope of practice for midwives can be a safe and effective way to expand the availability of midwives

When evaluating state approaches to integrating midwifery into maternal health care, states that take a comprehensive approach stand out from the rest.⁷² A study examining state integration of midwifery services and the correlation between integration and access, equity and outcomes found that states that licensed all types of midwives, as opposed to strictly CNMs, and integrated midwifery into health care regardless of birth setting had the best outcomes for both mothers and babies.⁷³ Federal law requires states to determine qualification requirements for providers enrolled in Medicaid.

While CNMs are regulated and licensed in all 50 states, licensure, training, workforce and regulatory language for other midwives vary between states, creating unnecessary confusion and disjointedness.⁷⁴ Thirty-seven states currently license and regulate CNMs and other types of midwives. Many of these states license and regulate CPMs or CMs,⁷⁵ although requirements can vary greatly. For example, Oregon requires midwives who are not CNMs to hold a CPM credential while New York requires midwives who are not CNMs to be CMs.⁷⁶ New Jersey is one of the few states that officially recognizes and licenses CNMs, CPMs and CMs.⁷⁷ Because the state recognizes multiple midwife certifications, midwives have multiple pathways to licensure in New Jersey, making the profession more widely accessible.

Along with ensuring there are multiple pathways to licensure, states wishing to develop or improve midwifery integration should ensure midwives have a scope of practice that is as broad as their competencies. States have varying scope of practice requirements for midwives, with some states allowing CNMs to practice independently while others require collaborative or supervisory agreements between nurse-midwives and partnering physicians.⁷⁸ Midwives without a CNM credential experience even more variability in scope of practice requirements across states. For example, Georgia prohibits any midwifery practice for providers without a CNM credential while Maryland allows more midwives to practice in a variety of settings and provide critical services, like administering approved medications.⁷⁹ Notably, CNMs in Washington are able to independently practice, and other licensed midwives in Washington have a comprehensive scope of practice encompassing lab work, pregnancy and birth counseling, labor and delivery, and limited prescriptive authority among other critical services.⁸⁰

Advocates looking to support access to maternal health care should consider whether their state laws are in line with the competencies of midwives. Laws should reflect the abilities, skills and credentials of midwives by protecting and expanding the scopes of practice for all licensed midwives and ensuring midwives can practice midwifery in a variety of environments, including hospitals, free-standing birth centers and homes. This may mean changing state licensing and scope of practice laws in addition to Medicaid policies.

Sustainable Medicaid funding improves access to midwives

State Medicaid reimbursement policy is another policy lever states have to influence access to midwives. While each state is required to reimburse CNMs through Medicaid, reimbursement rates vary by state.⁸¹ Low reimbursement rates are often a barrier to midwifery practice as midwives can be reimbursed for a small fraction of what a physician would be reimbursed for the same services.⁸² For example, nurse-midwives, nurse practitioners and nurse anesthetists are all considered advanced practice registered nurses, but according to the U.S. Bureau of Labor Statistics, not only do nurse-midwives make the least on average out of the three professions, but also their median income is \$82,780 less than that of nurse anesthetists.⁸³ States like Colorado, Delaware and Maryland have worked to address low reimbursement rates by increasing reimbursement to 100% of the physician rate, but many states continue to reimburse midwives substantially less than physicians for the same services.⁸⁴ While 37 states license midwives without CNM credentials, only 19 states provide Medicaid reimbursement to midwives without CNM credentials, resulting in little opportunity for many midwives to receive any Medicaid reimbursement at all.⁸⁵

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Funding and investment in midwifery care and birth center services go beyond increasing reimbursement through traditional fee-for-service Medicaid. States should work to incorporate midwifery services into value-based models. Beneficiaries within managed care organizations often face barriers to accessing out-of-hospital birthing options. To help remedy this, managed care organizations should expand networks to include midwives.⁸⁶ Furthermore, through efforts such as tuition forgiveness programs and scholarships for midwifery school, states can invest in midwife education and lower the barrier of entry into the profession. Many states have already begun instituting loan repayment programs, including West Virginia through the Recruitment and Retention Community Project which provides up to \$20,000 per year for four years in loan repayment to nurse practitioners and midwives.⁸⁷

Ultimately, there are a variety of policy levers available to states to close the maternal health gap and end the maternal health crisis, and expanding access to midwives through Medicaid policy is one of the most promising options.

3. Expanding Medicaid coverage of group prenatal care

Group prenatal care is another impactful maternal health care delivery model that has demonstrated improved maternal health outcomes. Rather than providing prenatal care during individual visits, providers serve a group of pregnant women at each visit. Group prenatal care allows providers to spend more time with patients, collectively, by combining elements of individual exams, patient education, patient self-assessment and peer support. The model typically begins at the start of the second trimester, with visits lasting from 90 minutes to two hours. The groups typically consist of about eight to 10 women of similar gestational age, their support partners, an obstetric care provider and a co-facilitator.⁸⁸ The visits occur every two to four weeks for a total of up to 10 visits. All women attending group prenatal care are examined by their provider, often in a private-screened environment in the group prenatal care room. In addition to an exam by a provider, women take their own weight and blood pressure, and track the results. The care session includes a facilitated discussion based on a group prenatal care curriculum, but women participating are given agency over which topics are discussed and where the discussion goes.⁸⁹ Topics may include labor and delivery, self-care, stress management, and breastfeeding.⁹⁰ By combining individual visits into group care, providers are able to spend more time with patients. The group setting also creates an opportunity for empowering group discussion where patients provide support to their peers, enhancing the value of the visit for many expecting mothers.

The most widely studied model is CenteringPregnancy.⁹¹ Many other group prenatal care models are variations of CenteringPregnancy, such as Expect With Me and Pregnancy and Parenting Partners.⁹² EMBRACE is a group prenatal care model developed by the University of California San Francisco for Black pregnant women.⁹³

Group prenatal care improves patient satisfaction, reduces stress and can eliminate unnecessary C-sections

Group prenatal care improves maternal health outcomes in multiple ways. First, women who participate in group prenatal care report increased satisfaction with their care.⁹⁴ One study found that group prenatal care met patients' expressed needs related to care.⁹⁵ For example, women felt respected, as the visits were not rushed, and providers and staff were not dismissive of questions or concerns. The same study also found group prenatal care combatted stress and feelings of isolation, as women were able to share stories about similar experiences with each other and prepare for birth together.⁹⁶

The ability of group prenatal care to reduce stress during the prenatal period also manifests itself in other important outcome measures. Many studies have shown that women in group prenatal care had longer gestations.⁹⁷ Longer gestational periods can be an indication of less stress during the prenatal period, as stress increases the likelihood of preterm birth.⁹⁸ In one study, CenteringPregnancy was shown to reduce the risk of preterm birth by 33%, and the effect was strengthened for African American women.⁹⁹ Given the disparities in the likelihood for Black

women to deliver preterm, the potential for group prenatal care to mitigate stress and eliminate racial disparities in some maternal health outcomes is substantial.

Group prenatal care can also have a substantial impact in reducing C-section rates. A 2017 study found that women who received group prenatal care were four times less likely than women who only received individual care to require cesarean delivery.¹⁰⁰ While many women need C-sections for delivery, the rate of unnecessary C-sections in the U.S. is high.¹⁰¹ Reducing unnecessary C-sections may also help alleviate racial and ethnic disparities in maternal health outcomes.¹⁰²

Like doula and midwifery care, Medicaid offers substantial policy levers to scale up group prenatal care

Twenty-four states are known to cover some form of group prenatal care for certain people in Medicaid.¹⁰³ While California, Texas and Utah cover group prenatal care, they limit the number of group prenatal visits or hours.¹⁰⁴ In some states, like Mississippi, group prenatal services are prioritized for women with high-risk pregnancies.¹⁰⁵ In 2023, Maryland adopted new reimbursement policy to cover group prenatal care.¹⁰⁶ Availability of group prenatal care within states can vary, and most women covered by Medicaid do not have access.¹⁰⁷

Like expanding access to doula and midwifery services, states have similar options when it comes to structuring group prenatal care benefits in Medicaid. Many states may be able to adopt Medicaid reimbursement for group prenatal care through internal administrative guidance and policy changes that would permit billing for group prenatal care with existing CPT codes.¹⁰⁸ However, to ensure the long-term availability of the benefit, advocates should consider seeking legislative or rule-making changes that would embed this benefit into law. Montana covers group prenatal care through a Medicaid state plan amendment, which also affords some additional protections to the benefit.¹⁰⁹

Most states that cover group prenatal care either provide enhanced reimbursement through managed care arrangements or include group prenatal care as an option in alternative payment models for maternity care.¹¹⁰ Supporting group prenatal care through existing managed care contracts offers states and advocates a streamlined option to cover group prenatal care with minimal policy or regulatory changes. Even if coverage is limited to people served by managed care organizations, advocates should ensure state policy allows mothers to have access to group prenatal care through a provider of their choice, either a midwife or a doctor.

Advocates should also work with local federally qualified health centers (FQHCs) to ensure FQHCs have funding to support and expand group prenatal care. FQHCs have a variety of options to establish funding streams through Medicaid to support group prenatal care. For example, Delaware already has a state plan amendment that allows for costs of certain programs delivered in FQHCs to be captured in future cost reports to increase FQHC payment rates.¹¹¹ Ohio provides enhanced reimbursement for group prenatal care delivered by FQHCs. Similar policies could be used to expand group prenatal care in other states.¹¹²

Finally, establishing and scaling group prenatal care in some states may require additional seed funding, beyond reimbursement. New and upfront cost to adopting group prenatal care could include purchasing and implementing a group prenatal care curriculum, securing space, and adjusting systems and work flows to accommodate group prenatal care. To address these costs, states and advocates may want to pursue providing capacity grants for providers to start new group prenatal care programs in Medicaid.¹¹³

Conclusion

States have multiple policy levers when it comes to addressing the maternal health crisis. Some of the most impactful policy interventions include adopting and expanding doula care, eliminating red tape that inhibits midwifery services, and scaling group prenatal care. All of these policy interventions are best deployed through state Medicaid programs, which already cover more than 40% of all births nationwide. These powerful interventions will allow states to improve maternal health outcomes and work toward eliminating disparities.

Endnotes

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This publication was written by:
Ben Anderson, Director, Maternal and Child Health Initiatives, Families USA
Lisa Shapiro, Senior Advisor for Strategy and Children's Policy, Families USA
Alica Camaliche, Policy Analyst, Families USA
Mackenzie Marshall, Federal Relations Associate, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Chantez Bailey, Director of Communications
Justin Charles, Digital Media Associate
Nichole Edralin, Associate Director, Design and Publications
Staci Lofton, Senior Director, Health Equity
Jude McCartin, Chief of Staff



1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org [facebook / FamiliesUSA](https://www.facebook.com/FamiliesUSA) [twitter / @FamiliesUSA](https://twitter.com/FamiliesUSA)