Maternal Health
Learning & Innovation Center™

How Freestanding Birth Centers Can Help Solve the Maternal Health Crisis in the US

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Learning Goals

- Provide an understanding of policies that affect the opening, staffing, health care, payments, malpractice costs, and access to Freestanding Birth Center (FSBC) care.
- Educate policymakers and health professionals on the complex problems facing FSBCs.
- Describe the public health advantages of increasing FSBC access and use.
- Provide actions policymakers and national/state-level leaders can take to make FSBCs more accessible, thereby contributing to efforts to address the maternal health crisis.

Summary of Recommendations

1. Remove the Certificate of Need requirement in all states.
2. Make Medicaid coverage of FSBCs comparable to hospital payments.
3. Provide federal subsidies for malpractice insurance coverage for FSBCs.
4. Provide graduate medical education funds for the midwifery workforce serving FSBCs.

Introduction

The United States (US) ranks 64th in the world for maternal mortality (the annual number of female deaths per 100,000 live births from any cause related to pregnancy) - notwithstanding ranking first in health care spending - leaving the US outranked in maternal health outcomes by 30 low and middle-income countries and 34 high-income countries.[1] The US's maternal health crisis affects all people, yet disproportionately impacts black, indigenous, and other people of color (BIPOC). Black women in the US, from all socio-economic backgrounds, die from preventable pregnancy-related complications at three to four times the rate of non-Hispanic White women.[2] What's more, they have the highest infant mortality rate of any racial or ethnic group in the US. There are many factors that have contributed to this dismal maternal health picture – historic and systemic racism, the Medicaid coverage gap, underrepresentation of midwives and the midwifery model of care in the perinatal workforce, and recent trends in hospital obstetric unit closures in rural areas, to name a few.[3]

Within the US, approximately 12 percent of births are attended by midwives.[4] This percent is lower than many other high-income countries, a discrepancy that impacts the appropriate use of interventions, subsequent outcomes, and their associated costs. Freestanding Birth Centers (FSBCs) offer midwifery care, an exceptional model of birthing care associated with lower maternal and infant mortality, higher levels of maternal satisfaction, fewer interventions, less reported mistreatment, and a trend toward cost-savings.[5,6] Studies have shown that these outcomes apply across demographics such as race and income.[7]

State and federal legislators have an obligation to develop policies that support a comprehensive approach to addressing the many failures in our maternal health care system. Increasing access to FSBCs is an integral part of addressing the maternal health crisis while meeting the needs of individuals and families who would otherwise not have access to midwifery services. This brief will make specific policy recommendations for how to expand access to FSBCs – in rural areas (where maternity care is dangerously limited), for all birthing people, and especially for BIPOC who suffer disproportionately high rates of complications and maternal death. This brief will also examine the issues that are preventing FSBCs from being widely available for birthing people, including the policies that affect opening, staffing, health care payments, sustainability, and malpractice.

Background

FSBCs are defined as health care facilities for childbirth, where care is provided in the midwifery and wellness model.[8] An FSBC is a separate space from hospital-based acute obstetric/newborn care and provides essential autonomy to midwives as defined by the American Association of Birth Centers. The term FSBC cannot be applied to a hospital maternity floor that is called a birth center as FSBCs are distinguished by not being physically attached to a hospital.

Midwifery care in FSBCs includes longer prenatal visits and time for questions with midwives, as well as holistic health assessments. This model of care facilitates relationships between clients and their midwives and birth center staff which has been shown to reduce stress and improve outcomes.[9] When compared to hospital care, the birth center model of care is associated with significantly higher rates of spontaneous vaginal birth, breastfeeding, and satisfaction with care; it is also associated with lower rates of preterm birth, low birth weight, hemorrhages, postpartum depression, medical interventions, assisted vaginal births, and cesarean births.[10]

Further evidence of the advantages of birth center births is provided in an analysis of data from the Strong Start for Mothers and Newborns Initiative which compared women who received care in midwifery-led birth centers with matched and adjusted women receiving typical Medicaid care in the same counties. There were statistically significant advantages for birth center care across a range of outcomes (See Table 1).[7] Among the mothers who received care in the midwifery birth center model, disparities in preterm birth, low birth weight, cesarean birth, and breastfeeding initiation were significantly reduced among racial and ethnic groups.

Table 1: Comparison of women who received care in a midwifery-led birth center group with matched and adjusted women receiving typical Medicaid care

Outcome	Birth Center Midwifery care	Matched comparison group (of Medicaid recipients)
Preterm birth	6.3%	8.5%
Low birth weight	5.9%	7.4%
Cesarean section rate	6.1%	32.1%
Primary (i.e., first-time) cesarean section rate	6.1%	22.3%
More vaginal births after c-section (VBACs)	24.2%	12.5%
Childbirth costs	$6,527	$8,286

Sources: National Partnership for Women & Families. Spotlight on Success: The Strong Start for Mothers and Newborns Initiative. Maternal Health Report. September 2020. Alliman J, Bauer K, Williams T. Freestanding Birth Centers: An Evidence-Based Option for Birth. J Perinat Educ. 2022 Jan 1;31(1):8-13.

In the National Birth Center Study II (2007-2010), researchers assessed data across 79 midwifery-led birth centers in 33 states from 2007-2010; there were no maternal deaths, the transfer rate was 16%, and the cesarean section rate was 6%.[11] The US has an overall cesarean section rate of nearly 32% and rising,[12] while

the World Health Organization recommends a cesarean rate of under 10-15%.[13] The US's high cesarean section rate is concerning due to its association with an increased risk of postpartum maternal death.[14] While this procedure can be lifesaving in an emergency, its overuse is putting American lives at risk.

In the National Birth Center Study II, out of 15,574 birth center births, there were 0.40 newborn deaths per 1,000 women. These data appear to support the neonatal safety of birth center births, however, a recent retrospective cohort study that assessed US national data for the years 2016-2019 found that while the neonatal death rate in FSBCs was low (0.346 per 1,000 women), it was higher than the neonatal death rate found among in-hospital births with physicians (.209 per 1,000) and higher than the rate among in-hospital births with midwives (0.095 per 1,000).[15] Notably, midwife-assisted hospital births in the study had the best outcomes. These data reinforce the need for clear information on the maternal and neonatal benefits and risks of birthing in all settings for women, clinicians, administrators, and policymakers as communities in the US work to improve maternal health.

Growing Demand for Freestanding Birth Centers

In the last decade or more, there has been a noticeable increase in the number of birthing people seeking birth centers. This change is driven in part by pregnant people, especially BIPOC, who prefer smaller health care practices where they can connect to providers with whom they have a shared life experience. Community birth (defined as either a planned home birth or a birth center birth) has begun to fill this need. The rate of community birth has steadily increased, by 59% from 2008 to 2012 and by 19.5% from 2019 to 2020.[16] In 2020, there were 21,884 birth center births in the US, representing 0.5% of all births.

The pandemic, along with the maternal health crisis, has brought increased attention to FSBCs as an important option for low-risk women. During the pandemic, birthing people were concerned about the risk of COVID-19 transmission; as a result, increasing numbers of individuals and families began to explore community settings as options for a safer birth environment.[17] However, there are not sufficient FSBCs to meet this growing demand, despite evidence supporting positive outcomes and high rates of satisfaction with FSBC births.

How to Increase Access to Freestanding Birth Centers

1. Remove the Certificate of Need (CON) Requirement

When we examine why FSBCs are not available in all communities, one of the first reasons some birth center owners report is the requirement to possess a CON. A CON is a state-level law that requires the approval of capital expenses for projects related to healthcare facilities. The CON governs the establishment, construction, renovation, and major medical equipment acquisitions of healthcare facilities (i.e., hospitals, nursing homes, home care agencies, and diagnostic and treatment centers). To satisfy the CON requirement, an FSBC would need to have the projected capital prior to the application process; however, unlike hospitals, FSBCs do not have significant capital, investors, or institutional resources as their primary purpose is not to generate revenue at a rate that would be attractive to potential financiers. FSBCs are small, community-based practices that serve low and middle-income birthing people and often operate on thin margins with lower levels of capital. These capital expenses are costly to the smaller structure of the FSBC. The CON process creates a barrier to highly qualified community birth providers if they cannot meet the high reserves needed for entry-level investment. Policymakers can assist stakeholders with opening FSBCs by introducing legislation that removes the CON requirement for FSBCs.

States that have a CON have far fewer FSBCs. Hospital regulation under the CON has attempted to hinder competition between hospitals and FSBCs, putting FSBCs at a disadvantage as they do not have the infrastructure nor the resources to compete with hospitals. The CON process does not account for this discrepancy. Each state sets policies and regulations that determine the exact requirements that a state's CON mandates, such as the amount of investment needed before an FSBC can open (e.g., a full year of operating

costs), a stipulation that midwives cannot operate a facility until this financial burden can be met, or requiring the permission of a competing hospital to operate.

Often, FSBCs face two main administrative barriers to opening: one, the competitive relationship with hospitals, and two, the documentation burden stemming from the CON requirement. For many FSBCs these challenges are insurmountable. An FSBC often does not have the resources of a hospital and is burdened with the process of the CON application given they only supply one medical function in the community. In some municipalities, the application process can take several months to years to be reviewed. Therefore, CON laws may interfere with the needs of birthing people who prefer to give birth outside of hospitals, as they make FSBCs less available in regions where the CON is required.

A national policy that supports FSBC access could remove the state CON process thereby allowing more facilities to open. In January 2023, two midwives in the state of Iowa began the legal process to request the removal of Iowa's CON requirement. The two midwives reported that the laws regarding the CON are prohibitive to opening an FSBC and requested that the process be removed.[18] An alternative to the CON that is employed by some states is creating regulations that are specific to FSBCs, a model that seems to level the playing field between FSBCs and hospitals. Such alternatives include a national standard that would replace the CON requirements in individual states. Texas is one state that has FSBC-specific regulations and has 92 FSBCs as of 2022.

2. Make Medicaid coverage at FSBCs comparable to hospital payments and mandate fair treatment by private insurers

The financial sustainability of birth centers is strongly correlated to the reimbursement received via health insurance – without reimbursement that covers the operating and workforce costs, birth centers will not be a viable option for childbearing people in the US. The reimbursement rates postured as "industry standard" for birth centers are a significant barrier. In the US, Medicaid provides insurance coverage for nearly half of all birthing people; the Medicaid reimbursement rate is set by each state and is the same for Certified Nurse Midwives (CNMs) as for physicians in half of the states and at 75%-98% the rate in 20 states; this is compounded by the fact that the facility fees that can be collected by FSBCs have been significantly less than what hospitals collect, in many instances, for identical levels of acuity.

Medicaid payment rates for maternity care services are lower than commercial insurance payment rates.[19] Furthermore, Medicaid coverage of maternity services from non-physician providers such as midwives, and for out-of-hospital births such as in FSBCs, varies by state and is dependent on licensure and credentialing regulations.[20] The economics of low volume at FSBCs combined with high personnel costs, malpractice insurance, and other operating and facility costs have driven birth centers to concentrate on self-pay clients for services, often excluding Medicaid beneficiaries who benefit most from their services.

This model is not sustainable nor equitable when we consider BIPOC families who are most impacted by the current maternal health crisis and desire midwifery care in FSBCs. To alleviate this burden, federal policymakers could develop funding strategies aimed at equitable coverage of midwifery-led care costs at FSBCs. Currently, FSBCs are individually leading this charge with policymakers, state-by-state. However, a quicker and more efficient process could happen if federal policymakers take the lead. A federal policy that protects and expands access to FSBCs would ensure compensation for the FSBC model at the same rate as hospitals, thereby providing families with a birthing option that leads to improved health outcomes and higher patient satisfaction rates while ensuring the future viability of the FSBC model.

Setting equal pay for equal services ensures FSBCs are fairly and equally accessible by leveling the playing field for maternity care. This model improves outcomes and contains costs through the significant savings garnered from safely avoided cesarean births and other interventions.

3. Provide the midwifery workforce at FSBCs with graduate medical education funds to ensure staffing.

Federal funding is critical to ensuring an adequate midwifery workforce for FSBCs. One challenge is a lack of trained midwives - CNMs, Certified Professional Midwives (CPMs), and Certified Midwives (CMs) - who provide care in FSBCs. There are two separate certifying bodies in the US for midwives. As of December 31, 2021, there were a total of 13,409 American Midwifery Certification Board-certified midwives in the US, of which 13,287 (99.1%) were CNMs and 122 (0.9%) were CMs. In May 2021, there were approximately 2,600 active, credentialed CPMs (who may complete programs accredited by the Midwifery Education Accreditation Council.)[21] The number of midwives in the US is not enough to meet the needs of staffing at FSBCs. The National Center for Health Workforce Analysis estimates that an additional 2,690 midwives will be needed to meet the demands of the birthing population nationwide by 2030.[22]

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Most owners of FSBCs report that there are not enough midwives to staff their facilities. Currently, Graduate Medical Education (GME) financing of medical residents (including residents of obstetrics and gynecology) is funded from several sources including Medicare/Medicaid, Veterans Health Administration, and Health Resources and Services Administration, estimated at $15 billion per year. These funds are not currently available to midwives to support their medical education. Community midwifery is a specialty that requires training to provide midwives with the skill set that distinguishes midwifery care in FSBCs from midwifery care in hospitals.

GME financing could fill a gap by increasing the number of skilled midwives available to attend community births in FSBCs. If FSBCs were able to tap into financial resources like GME, they could achieve a workforce of a sufficient size to adequately staff their facilities. Currently, FSBC owners are tasked with providing this specialty training which cuts into the resources they utilize to fund the operating costs of their FSBC. The financial cost for specialized teams at FSBCs must be supported by the federal government. Furthermore, if hospitals receive subsidies that support the medical training of their practitioners for hospitals, the same case should be made for FSBCs to have equitable access to medical training resources.[23]

4. Ensure that birth centers' malpractice coverage is equally subsidized by the government

Malpractice premiums in most industries have increased substantially. "The average premium cost has increased rapidly, with over 7% of all premiums rising 10% or more in 2021."[24] This is significant given malpractice costs will rise annually for FSBCs. FSBC owners would benefit from a federal subsidy for malpractice similar to what hospitals receive to help with the exorbitant and often prohibitive cost of coverage. These malpractice premiums affect FSBCs ability to meet the cost of their daily operations. Rates for FSBCs vary based on their geographic region, length of years in operation, provider experience, services provided, and clinical policies set by the facility.

Policies related to clinical components (e.g., the time of rupture of the membranes prior to labor, vaginal delivery after cesarean, or the number of previous births) can impact the cost of malpractice policy. The insurance industry and the underwriters compile risk and assign a value for the coverage. Once this value is assigned it will increase annually regardless of outcomes. These assessments are often linked to the cost of maternity care regardless of outcomes by a given facility. Depending on the clinical guidelines it can impact the cost of the malpractice policy.

There have been calls for the Federal Tort Claims Act to be applied to FSBCs which meet the requirements to be considered Federally Qualified Health Centers (FQHC), allowing them to receive Section 330 grant funding. (Section 330 of the Public Health Service Act created and authorized the health center program and permits the Health Resources and Services Administration to make grants to health centers.) If FSBCs were to qualify for Section 330 funding, malpractice insurance would be more affordable. Moreover, this solution would allow FSBC owners autonomy over the cost of coverage and would allow them to operate without the detrimental financial burden of malpractice.

Call to Action

FSBCs led by community stakeholders are an essential tool that birthing people desire, and provide a proven model of care that leads to improved health outcomes. We must explore ways to further quantify the quality of care offered at FSBCs and work toward leveling the playing field between FSBCs and hospitals so that FSBCs are a viable and sustainable alternative to hospital births. The viability of opening and sustaining FSBCs rests on policymakers' capacity to address regulation, payments, and staffing. With a few critical changes in policy, the US could finally turn the tide of maternal and neonatal outcomes for families.

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