United States Commission on Civil Rights
Virtual Briefing on Racial Disparities in Maternal Health Outcomes
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"Of all the forms of inequality, injustice in health is the most shocking and inhuman."[1]
Rev. Dr. Martin Luther King, Jr.

I. Introduction and Background

Good afternoon, Chair Lhamon and distinguished members of the United States Commission on Civil Rights. I would like to thank the Commission for convening this briefing and the opportunity to provide testimony on the state of maternal health disparities in the United States and the role of the federal government in addressing them. My name is Nan Strauss, and I am the Managing Director of Policy, Advocacy, and Grantmaking at Every Mother Counts (EMC), a non-profit dedicated to making pregnancy and childbirth safe for every mother, everywhere. The organization educates the public about maternal health and engages thought leaders and partners, including community-based organizations and professional associations, to achieve quality, respectful, and equitable maternity care for all.

EMC seeks to strengthen systems and increase the availability of practices demonstrated to result in excellent maternal health outcomes and experiences of care for all members of the community. In the U.S. that requires focusing on Black, Native American, and other communities of color for whom race, ethnicity, socioeconomic status, gender and sexual identity, and other social factors result in disproportionately high rates of complications, death, and mistreatment. It is an honor to participate in this hearing, especially alongside the distinguished Black- and Indigenous-led organizations represented here – the groups spearheading this critical work.

The United States spends more on childbirth than any other country in the world, yet has the worst maternal health outcomes of any high-resource nation. Native American women and Black women are two and three times as likely to die from complications of pregnancy and childbirth compared with their white counterparts.[2] These disparities have not improved over the last six decades.

The devastating inequities in maternal health are rooted in structural and interpersonal racism in our health care system and a lack of accountability to the people and communities receiving care. As the former U.S. Surgeon General Vivek Murthy has stated, "To put it simply: health equity is a civil rights issue,"[3] and this is nowhere more evident than in the grave disparities in maternal health.

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[1] King, M.L. Jr. 1966. Untitled remarks. Presented at Natl. Conv. Med. Comm. Hum. Rights, 2nd, March 25, Chicago. Available at: https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032315-021926.
[2] Centers for Disease Control and Prevention. Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths. 2019. Available at: https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html.
[3] Murthy, V.A. 2015. *Build the great American community*. Remarks at Comm. and Change of Command for the 19th Surg. Gen. of the US, April 22, Ft. Myer, Va. Available at: https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032315-021926.

We have the opportunity to save lives and to improve the health of the hundreds of thousands of Black women, Indigenous women, and women of color who give birth every year in the U.S. Every Mother Counts calls for the establishment of a range of mechanisms to ensure that all women can access the high quality, respectful maternity care they need and deserve. Key strategies include:

- establishing accountability for equity in maternal health by requiring the collection and publication of hospital-level data on outcomes, complications, procedures, and experience of care that is disaggregated by race and ethnicity;
- developing standards for and measures of respectful, person-centered care practices;
- establishing a robust system to address patient reports of mistreatment and disrespectful care;
- integrating team-based approaches to care that incorporate high-value, evidence-based solutions that are currently underutilized, such as the midwifery model of care, community-based doula support, and community birth;
- extending Medicaid to cover people for a full year following childbirth;
- and making our first priority listening to the voices of the people giving birth, who are at the center of this issue.

II. Maternal Health Landscape in the United States

The United States is facing a maternal health crisis. Despite spending far more on maternity care than any other country, the U.S. maternal mortality rate is the highest of any high-resource nation.[4] In fact, the World Health Organization found that the U.S. was one of just two countries where maternal deaths are actually *increasing*.[5] The rate of U.S. maternal deaths has more than doubled in the past two decades, and for the first time, a woman is more likely to die from complications of childbirth than her mother was a generation ago. "Near misses," potentially life-threatening complications, are increasing at an even faster rate. Approximately 700 women die of complications related to pregnancy and childbirth every year in the U.S.,[6] and over half of these maternal deaths are preventable.[7] More than 50,000 women each year suffer life-threatening complications[8] – one every 10 minutes. Maternal health is considered a key indicator of a country's overall health system, and thus, the rapid rise of maternal mortality and morbidity clearly signals that the U.S. health system is broken and failing to meet the needs of women and families.

Prioritizing the transformation of the U.S. maternity care system and eliminating maternal health disparities are long overdue. With nearly 4 million births each year in the U.S., childbirth is the most

[4] Int'l Fed. of Health Plans. *2017 Comparative Price Report International Variation in Medical & Drug Prices*. 2019. Available at https://healthcostinstitute.org/images/pdfs/iFHP_Report_2017_191212.pdf; WHO et al. *Trends in Maternal Mortality: 2000 to 2017*. Geneva: World Health Organization, 2019. Available at: https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/.

[5] WHO et al. *Trends in Maternal Mortality: 2000 to 2017*.

[6] WHO et al. *Trends in Maternal Mortality: 2000 to 2017*; Hoyert, D.L. and Miniño, A.M. *Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018*. Hyattsville, MD: National Center for Health Statistics, National Vital Statistics Reports, 2020.

[7] Petersen, E.E., et al. *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017.* Morbidity and Mortality Weekly Report, 2019. 68(18): 423-429. Available at: https://doi.org/10.15585/mmwr.mm6818e1.

[8] Centers for Disease Control and Prevention. *Severe Maternal Morbidity in the United States*. 2017. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

common reason for hospitalization in the U.S., with childbearing women and newborns together accounting for nearly one of every four hospital discharges.[9] As a result, childbirth-related care is the largest category of hospital-based spending for Medicaid and most commercial health plans.[10]

We are here today, not just because the U.S. ranks 55th in the world in maternal mortality,[11] not just because of the nearly 4 million mothers and 4 million infants whose lives would be enhanced by maternity care that better meets their needs, and not just because the U.S. spends an estimated $111 billion each year on maternal, prenatal and newborn care.[12]

We are here because of the fundamental injustice that when a Black or Indigenous woman brings a new life into this world, she faces a greater risk of dying than a white woman. The burden of poor maternal health outcomes, of being mistreated, of being ignored while family members plead hospital staff for help, falls disproportionately on Black women, Indigenous women, other women of color and their families.

Disparities are reported in all regions of the country, and in areas with both high and low rates of maternal deaths. In New York City, Black women are a shocking 12 times more likely to experience a maternal death than white women.[13] This gap actually widened as the maternal mortality rate has decreased by 45 percent for white women, but barely changed for Black women.[14] Black women in New York City experience the highest rate of severe maternal morbidity, even after controlling for risk factors such as low education, pre-pregnancy obesity, and poverty. In fact, *Black women with at least a college degree experience a higher rate of severe maternal complications than women of other races and ethnicities who did not graduate from high school.*[15] A recent study of severe complications in New York City hospitals found that Black and Latina women are at higher risk of severe complications than white women giving birth in the same hospital, regardless of insurance type (Medicaid compared with commercial or private insurance).[16]

California, with the leadership of the California Maternal Quality Care Collaborative, has succeeded in reducing maternal mortality by 55 percent between 2006 and 2013, but that overall reduction did not result in a narrowing of the gap in outcomes for white and Black women.[17] Despite an overall decrease in maternal mortality for all racial and ethnic groups, the rate of maternal death is still three to four times higher for Black women than white women in California, indicating that to eliminate disparities, action must be targeted specifically towards improving care for Black childbearing people and communities.

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[9] Sun, R., Karaca, Z., and Wong, H.S. *Trends in Hospital Inpatient Stays by Age and Payer, 2000-2015*. H-CUP Statistical Brief, 235.2008. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb235-Inpatient-Stays-Age-Payer-Trends.jsp.
[10] Podulka, J., Stranges, E., and Steiner, C. *Hospitalizations Related to Childbirth, 2008*. *H-CUP Statistical Brief*, 110, 2011. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb110.jsp.
[11] WHO et al. Trends in Maternal Mortality: 2000 to 2017.
[12] Centers for Medicare and Medicaid Services. (2018, October). Strong start for mothers and newborns evaluation: YEAR 5 project synthesis volume 1: Cross-cutting findings. Available at: https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf
[13] NYC Dept. of Health & Mental Hygiene. *Pregnancy-Associated Mortality: New York City, 2006-2010.* New York, NY, 2015.
[14] NYC Dept. of Health & Mental Hygiene. 2015.
[15] NYC Dept. of Health & Mental Hygiene. *Severe Maternal Morbidity: New York City, 2008-2012*. New York, 2016.
[16] Howell, E.A. et al. *Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities*. Obstetrics & Gynecology, 2020. 135(2): 285–293. Available at: https://doi.org/10.1097/AOG.0000000000003667.
[17] Main, E.K., Markow, C., and Gould, J. *Addressing Maternal Mortality and Morbidity in California Through Public-Private Partnerships*. Health Affairs, 2018. 37(9): 1484–93. Available at: https://doi.org/10.1377/hlthaff.2018.0463.

III. The Inequitable Maternity Care System that Drives Disparities

Systemic and interpersonal racism, including differential access to high quality, respectful care, contribute to the poor outcomes that disproportionately affect Black and Native American women in the U.S. and result in the country's shocking inequities in maternal health outcomes. Women of color are needlessly dying after their concerns are ignored, their requests for help delayed, and their voices silenced. The devastating statistics are brought to life by the individual experiences of those who have died or nearly died from complications of pregnancy and childbirth. Recurring news accounts fill in the details that the numbers alone fail to convey. Stories like those of Erica Garner,[18] Amber Rose Isaac,[19] Sha-Asia Washington,[20] Tatia Oden French,[21] Yolanda "Shiphrah" Kadima,[22] and too many others bring to life the ways in which our health care system is failing mothers and families. We must remember those individuals who have died and the families that have lost mothers, sisters, and partners, and we must honor their stories in order to avoid preventable deaths in the future.

Memories of the human rights violations within the health system throughout the 19th and 20th centuries still affect the trust, decision-making, and attitudes of many women of color in their interactions with health care. Powerful examples of past human rights violations include the Tuskegee "study," in which diagnosis and treatment for syphilis was intentionally withheld from African American men and their families for decades; coercive and forced sterilization of Black, Latina, Native American, Asian, and other women in historically marginalized communities; and J. Marion Sims, the "father of modern gynecology," and his surgical experimentation on Black women slaves, performed without anesthesia. The historical basis of mistrust is reinforced by a system where women of color are still less likely to have control over making decisions about their own care and continue to experience interpersonal racism, disrespect, and mistreatment during maternity care.

A. Lack of Access to Care

Differential access to health care is driven by geographical, workforce, and financial factors. Barriers include difficulties finding health care providers and facilities within a reasonable distance, whose services are affordable or covered by health insurance, who provide care in the person's preferred language, and who offer care during hours that do not conflict with wage-earners' work schedules. All of these factors influence the health outcomes of people giving birth in the U.S. and contribute to racial disparities.

Maternity care deserts leave many communities in the U.S. with too few or no maternity care providers and facilities. In 2016, more than five million women lived in rural and urban counties with neither an obstetrician/gynecologist nor a nurse midwife, nor a hospital with a maternity unit.[23] The American

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[18] Lockhart, P.R. *Too many black women like Erica Garner are dying in America's maternal mortality crisis*. Vox, 2018. Available at: https://www.vox.com/identities/2018/1/10/16865750/black-women-maternal-mortality-erica-garner.
[19] Villarreal, A. *New York mother dies after raising alarm on hospital neglect*. The Guardian, 2020. Available at: https://www.theguardian.com/us-news/2020/may/02/amber-rose-isaac-new-york-childbirth-death.
[20] Dickson, E.J. *Death of Sha-Asia Washington, Pregnant 26-Year-Old Black Woman, Highlights Devastating Trend*. Rolling Stone, 2020. Available at: https://www.rollingstone.com/culture/culture-features/shaasia-washington-death-woodhull-hospital-black-maternal-mortality-rate-1026069/.
[21] Tatia Oden French Memorial Foundation. *Tatia's Story*. 2018. Available at: https://tatia.org/about-tatia/.
[22] Thomas, L. *Say Her Name – Yolanda Shiphrah Kadima*. Instagram, 2020. Available at: https://www.instagram.com/p/CDb7qkXnOB-/.
[23] March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the U.S.* 2018. Available at: https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf.

College of Obstetricians and Gynecologists (ACOG), which represents 90 percent of all board-certified obstetricians, estimates that half of all counties in the U.S. do not have a single obstetric care provider.[24]

Policies and practices rooted in institutional racism, such as redlining and health care segregation, have resulted in Black families and other families of color having less access to quality hospitals and health care.[25] Nearly one in four Black individuals lives in a provider shortage area, as compared to just over one in seven of their white counterparts.[26] Black women were found to be ten times as likely as white women to live in a county that had no in-hospital obstetric services and four times as likely to live in a county where hospital obstetric services had recently closed.[27]

A recent Health Resources and Services Administration (HRSA) report revealed that over the past ten years, more than 100 rural hospitals have closed their doors. This has placed 50 percent of rural women at least 30 miles away from the closest perinatal provider and 10 percent of rural women at least 100 miles from pregnancy-related health services. The vast majority of these hospital closures overwhelmingly affected Black, Hispanic, and low-income communities.[28]

Differential financial access to care and health care coverage also contribute to disparities in maternal health outcomes, because disparities in insurance coverage can lead to uneven access to care before pregnancy and delays or lack of access to prenatal care. Being uninsured prior to pregnancy results in inadequate preventive care, putting Black women at greater risk of unmanaged chronic health conditions, including diabetes, hypertension, and obesity, that can increase the incidence of pregnancy and childbirth complications.[29]

Black women are nearly twice as likely as white women to be uninsured and are less likely to have a primary care provider.[30] In states that have yet to expand Medicaid eligibility under the Affordable Care Act (ACA), many people are only able to obtain health care coverage after becoming pregnant. Without Medicaid expansion, many women, particularly women of color, are left in the "coverage gap," where they earn too much to qualify for Medicaid, but not enough to purchase private health insurance, even with tax subsidies.[31] Undocumented migrants often have no access to prenatal care and very limited access to care postpartum because they are ineligible for Medicaid in many states, and they may avoid

[24] Ollove, M. *A Shortage in the Nation's Maternal Health Care*. Pew, 2016. Available at: http://pew.org/2boYfvJ.
[25] National Institute for Children's Health Quality. *The Impact of Institutional Racism on Maternal and Child Health*. Available at: https://www.nichq.org/insight/impact-institutional-racism-maternal-and-child-health.
[26] Gaskin, D.J. et al. *Residential Segregation and the Availability of Primary Care Physicians*. Health Services Research, 2012. 47(6): 2353–76. Available at: https://doi.org/10.1111/j.1475-6773.2012.01417.x.
[27] Hung, P. et al. *Access to Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14*. Health Affairs, 2017. 36(9): 1663–71. Available at: https://doi.org/10.1377/hlthaff.2017.0338.
[28] Centers for Medicare and Medicaid Services. Improving Access to Maternal Health Care in Rural Communities. 2019. Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf.
[29] E.A. Howell et al., 2016.
[30] National Partnership for Women and Families. *Black Women Experience Pervasive Disparities in Access to Health Insurance*. Washington, DC: 2019. Available at: https://www.nationalpartnership.org/our-work/resources/health-care/black-womens-health-insurance-coverage.pdf.
[31] Kaiser Family Foundation. *Who Is Impacted by the Coverage Gap in States That Have Not Adopted the Medicaid Expansion?* The Kaiser Commission on Medicaid and the Uninsured, 2016. Available at: https://www.kff.org/slideshow/who-is-impacted-by-the-coverage-gap-in-states-that-have-not-adopted-the-medicaid-expansion/.

care due to fear of discrimination, language barriers, and the possibility of deportation.[32] Prenatal care includes risk assessment and treatment of maternal health measures and conditions, monitoring of the health of pregnant person and baby, and vital health information and education for the pregnant person. An inability to obtain timely prenatal care can result in worse outcomes for the childbearing person and their infant.

For the forty-two percent of all births in the U.S. paid for by Medicaid, coverage is still inadequate.[33] Over half of all maternal deaths occur after pregnancy and childbirth, with one in three pregnancy-related deaths occurring between one week and one year postpartum and 23.6 percent occurring between 43 days and one year postpartum.[34] However, pregnancy-related Medicaid ends just two months after childbirth,[35] leaving many without coverage of significant health needs that develop or persist throughout the first year following childbirth.[36] Research has found that 55 percent of women with coverage at delivery experience a coverage gap during the first six months following childbirth under these restrictions on Medicaid coverage.[37] Interruptions to insurance coverage can lead to a lack of continuous care, which can be critical throughout perinatal care, especially during the postpartum period.

Low reimbursement rates for providers also result in differential quality and accessibility of maternity care covered by Medicaid. Medicaid payments for maternity care average half of the amount spent by commercial insurance plans, and significantly below benchmarks established by Medicare, which can lead to financial challenges for hospitals and clinical practices, depending on their payer mix.[38] The high fixed costs of maternity care coupled with low reimbursement rates have made obstetric services financial "loss leaders" within hospitals across the country, especially those trying to provide care for the underserved.[39] The current payment model for maternity care in the U.S. has made it infeasible for practices to serve primarily Medicaid patients, leading to the closure of many hospitals with a large proportion of Medicaid patient populations.[40]

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[32] Korinek, K. and Smith, K.R. *Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status*. Social Science and Medicine, 2011. 72(10); ACOG. *Health Care for Unauthorized Immigrants*. Committee Opinion, 627, 2015. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/03/health-care-for-unauthorized-immigrants.

[33] Martin, J.A. et al. *Births: Final Data for 2018*. National Vital Statistics Reports, 2019. 68(13). Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

[34] Petersen, E.E., et al., 2019; Davis, N.L., Smoots, A.N. and Goodman, D.A. *Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2019.

[35] Daw, J.R. et al. *Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth*. Health Affairs, 2017. 36(4): 598–606. Available at: https://doi.org/10.1377/hlthaff.2016.1241.

[36] ACOG. *Presidential Task Force on Redefining the Postpartum Visit*. ACOG Committee Opinion, 736, 2018. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care; Ranji, U., Gomez, I., and Salganicoff, A. *Expanding Postpartum Medicaid Coverage*. The Henry J. Kaiser Family Foundation, 2019. Available at: https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

[37] Daw, J.R. et al. *Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth*. Health Affairs, 2017. 36(4): 598–606. Available at: https://doi.org/10.1377/hlthaff.2016.1241.

[38] Truven Health Analytics. *The Cost of Having a Baby in the United States*. Ann Arbor: Truven, 2013. Available at: https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf.

[39] Shah, N.T. *Eroding Access and Quality of Childbirth Care in Rural US Counties*. JAMA, 2018. 319(12): 1203–4. Available at: https://doi.org/10.1001/jama.2018.1646.

[40] Itkowitz, C. *Closure of Two D.C. Maternity Wards Hurts Low-Income Women Most*. Washington Post, 2017. Available at: http://www.washingtonpost.com/local/closure-of-two-dc-maternity-wards-hurts-low-income-women-most/2017/10/28/753e4dee-ad06-11e7-9e58-e6288544af98_story.html; Hung, P. et al., 2017.

Brittney Henry's experience, recounted in an article in ProPublica, highlights how the limited period of postpartum health care coverage can put women at risk:

> *Brittney Henry, 28, was a Black mother who suffered a heart attack a few weeks after giving birth. At that time, she was still covered by her pregnancy-related Medicaid in Texas, which allowed her to obtain the care she needed, including a coronary stent and medication. When her Medicaid coverage ended two months after childbirth, Brittney and her husband struggled to fill the prescriptions for the medication she needed to manage her heart condition. Three months after her Medicaid lapsed, Brittney was attempting to get to the emergency room for help, when she collapsed on the sidewalk and died. Her husband, Raphael Martin, believes that if they hadn't had to struggle to afford the medication she needed, "She'd still be alive."*[41]

B. Differential Quality of Care

Structural, interpersonal, and institutional racism and bias all contribute to the large and persistent disparities in the quality of care received by childbearing people and infants.[42] Maternal health disparities cannot be explained away as an inevitable consequence of economic, educational, age, or other factors. In fact, disparities remain consistent when comparing outcomes for Black and white women across comparable levels education, income, and other socioeconomic factors and hold true across the country. Black women with a college degree are over five times as likely to experience a pregnancy-related death in comparison to their white counterparts.[43] Comparing maternal mortality in high-poverty, middle-poverty, and low-poverty groups, data shows that Black women experience a three times higher maternal mortality risk than white women in each income level.[44]

Likewise, disparities in mortality rates of Black and white women persist even when accounting for underlying health conditions. A comparison of women experiencing the same serious maternal health conditions (including preeclampsia, eclampsia, and obstetric hemorrhage) found that Black women were no more likely than white women to develop these conditions. Yet Black women were 2.5 to 4 times more likely than white women to die after developing the same type of condition.[45]

Black women have been found to be two to three times more likely to die from particular maternal complications, including preeclampsia, eclampsia, postpartum hemorrhage and others, compared with white women facing these same complications.[46] While research has found that hospitals with a higher proportion of Black patients had higher rates of severe maternal morbidity on average, the difference in

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[41] Martin, N. and Belluz, J. *The Extraordinary Danger of Being Pregnant and Uninsured in Texas*. ProPublica, 2019. Available at: https://www.propublica.org/article/the-extraordinary-danger-of-being-pregnant-and-uninsured-in-texas.

[42] Howell, E.A., 2018; McLemore, M.R. *To Prevent Women from Dying in Childbirth, First Stop Blaming Them*. Scientific American, 2019. Available at: https://doi.org/10.1038/scientificamerican0519-48; Sigurdson, K. et al. *Disparities in NICU Quality of Care: A Qualitative Study of Family and Clinician Accounts*. Journal of Perinatology, 2018. 38(5): 600.

[43] CDC, 2019.

[44] Singh, G.K. *Maternal Mortality in the United States, 1935-2007: Racial/Ethnic, Socioeconomic, and Geographic Disparities*. Health Resources and Services Administration, 2010. Available at: https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf.

[45] Tucker, M.J. et al. *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*. American Journal of Public Health, 2007. 97(2): 247-251. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1781382/.

[46] Tucker, M.J. et al. *The Black-White Disparity in Pregnancy-Related Mortality.*

place of birth does not fully account for the differences in outcomes.[47] Even when receiving care in the same hospital, Black and Latina women are more likely to experience severe maternal morbidity than white women, after accounting for patient sociodemographic and clinical characteristics.[48]

While some suffer as a result of receiving care that is "too little, too late," others face preventable complications that result from care that is "too much, too soon."[49] While most people giving birth in the U.S. are in good health with low-risk pregnancies, many people are often subjected to unnecessary and non-beneficial interventions, even though these interventions can be more costly, more appropriate for higher risk pregnancies or those with complications or associated with harmful side effects.[50] Women who are less likely to have the essential preventative and prenatal care needed to stay healthy are also more likely to have unnecessary medical interventions that may put them at greater health risks.[51]

For example, Black, Hispanic, and Native American women are more likely to give birth by cesarean section,[52] which increases the risk of postpartum complications for mothers and infants, complications in future pregnancies, and increased cost for both the family and the medical system.[53] The rate of cesarean sections in the U.S. is 31.9 percent of all births,[54] one of the highest rates among all high-resource countries.[55] Experts agree that this rate is too high because as with all major surgery, cesareans result in the risk of complications.[56] Cesareans can save lives when they are medically indicated, but in situations where evidence does not indicate their use, the surgery increases the potential for added health problems and costs without improving outcomes for women or infants. The maternal mortality rate for mothers who deliver by cesarean section is more than three times that of mothers who deliver vaginally, a difference of 13.3 deaths as opposed to 3.6 deaths per 100,000 live births.[57]

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[47] Howell, E.A. et al. *Black-White Differences in Severe Maternal Morbidity and Site of Care*. American Journal of Obstetrics & Gynecology, 2016. 214(1): 122.e1-122.e7. Available at: https://doi.org/10.1016/j.ajog.2015.08.019.

[48] Howell, E.A. et al. *Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities*. Obstetrics and Gynecology, 2020. 135(2): 285-293. Available at: https://journals.lww.com/greenjournal/Abstract/2020/02000/Race_and_Ethnicity,_Medical_Insurance,_and.7.aspx.

[49] Glantz, J.C. *Obstetric Variation, Intervention, and Outcomes: Doing More but Accomplishing Less*. Birth, 2012. 39(4): 286–90. Available at https://doi.org/10.1111/birt.12002; Miller, S. et al. *Beyond Too Little, Too Late & Too Much, Too Soon: A Pathway towards Evidence-Based, Respectful Maternity Care Worldwide*. Lancet, 2016. 388(10056): 2176–92. Available at: https://doi.org/10.1016/S0140-6736(16)31472-6.

[50] Avery, M.D. et al. *Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*. Washington, DC: National Partnership for Women and Families, 2018. Available at: https://www.nationalpartnership.org/our-work/health/reports/maternity-blueprint.html; Kennedy, H.P. et al. *Asking Different Questions: A Call to Action for Research to Improve the Quality of Care for Every Woman, Every Child*. Birth, 2018. 45(3): 222–31. Available at: https://doi.org/10.1111/birt.12361; Miller, S. et al., 2016.

[51] Black Mamas Matter Alliance. *Advancing the Human Right to Safe and Respectful Maternal Health Care.* 2018. Available at: http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf

[52] Roth, L.M. and Henley, M.M. *Unequal Motherhood: Racial-Ethnic and Socioeconomic Disparities in Cesarean Sections in the United States*. Social Problems, 2012. 59(2): 207–27. Available at: https://doi.org/10.1525/sp.2012.59.2.207.

[53] Black Mamas Matter Alliance, 2018.

[54] Hamilton, B.E. et al. *Births: Provisional Data for 2018*. Vital Statistics Rapid Release, 2019. 007: 25.

[55] Organisation for Economic Co-Operation and Development. *OECD Data*. 2019. Available at: https://stats.oecd.org.

[56] American College of Obstetricians and Gynecologists. *Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery, Reaffirmed 2019*. 2019. Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery; World Health Organization. *WHO Statement on Caesarean Section Rates*. 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=8F2C265B420604B6FD35FA593767F1CE?sequence=1%20And%20https://www.BMJ.c om/content/360/BMJ.k55.

[57] ACOG, 2019.

Currently, hospitals do not routinely track or report data on maternal health outcomes, severe maternal morbidity, experience of care, or procedure rates in the aggregate or disaggregated by race. The absence of detailed data on racial disparities in these process and outcome measures render it impossible to pinpoint the solutions needed to remedy them. Health care quality improvement efforts are one step towards addressing the disparities in maternal health outcomes, but in order for these efforts to be successful, patients, insurers, providers, and hospitals need to track and make available to the public a range of substantive quality measures on racial and ethnic disparities.[58]

C. Mistreatment, Discrimination, and Experience of Care

Too many people giving birth, especially Black and Native American women, experience a maternity care system where they are not listened to by their providers, not just resulting in negative birth experiences, but also putting their health and lives at risk. High-profile stories, like those of Dr. Shalon Irving, Kira Johnson, and Serena Williams, have brought increased attention to the consequences of childbearing people's concerns being ignored and their care delayed.

- *Dr. Shalon Irving was a CDC epidemiologist who researched health disparities. Nonetheless, Dr. Irving's postpartum complications and warning signs were overlooked by her providers, the concerns and questions from her and her family pushed aside, leading to her death from complications of high blood pressure in 2017.*[59]
- *Concerns about Kira Johnson's health after what was expected to be a routine cesarean section were ignored and treatment was delayed for hours by medical providers. Once Kira's internal bleeding was treated, it was too late to save her life,*[60] *despite the fact that death from obstetric hemorrhage is considered to be among the most preventable causes of maternal death.*
- *Serena Williams got the medical attention and care she needed after a postpartum pulmonary embolism, but only after repeatedly demanding the exact care she needed from her providers.*[61]

Everyday incidents of coercion, disrespect, and belittling occur with unacceptable frequency, and tangibly affect health outcomes, including whether the person survives.[62] In California, the most recent California Pregnancy-Associated Mortality Review found health care provider factors to be the highest contributor to maternal deaths.[63] Among these factors in preventable maternal deaths, delayed response to clinical warning signs was the most common, followed by ineffective care.

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[58] Howell, E.A. and Zeitlin, J. *Quality of Care and Disparities in Obstetrics*. Obstetrics and Gynecology Clinics of North America, 2017. 44(1). Available at: doi: 10.1016/j.ogc.2016.10.002.

[59] Martin, N. and Montagne, R. *U.S. Black Mothers Die In Childbirth At Three Times the Rate of White Mothers*. NPR, 2017. Available at: https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[60] Johnson, C. *Testimony of Charles Johnson IV*. Subcommittee on Health, Committee on Energy and Commerce, 2018. Available at: https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-Wstate-JohnsonC-20180927.pdf.

[61] Haskel, R. *Serena Williams on Motherhood, Marriage, and Making Her Comeback.* Vogue, 2018. Available at: https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018.

[62] Declercq, E.R. et al. *Listening to Mothers III: Pregnancy and Birth.* New York: Childbirth Connection, 2013.

[63] California Pregnancy-Associated Mortality Review. *Report from 2002 to 2007 Maternal Death Reviews*. Sacramento: California Department of Public Health, Maternal, Child and Adolescent Health Division, 2018. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/PAMR/CA-PAMR-Report-1.pdf

The nationwide Giving Voice to Mothers study, with responses from over 2,700 childbearing people across the U.S., demonstrates the disparities in experiences of maternity care reflecting widespread mistreatment and a lack of respectful care among people giving birth in U.S. hospitals.[64] One in four people giving birth in a U.S. hospital reported experiencing mistreatment or disrespectful care during childbirth,[65] and women of color were twice as likely to experience mistreatment as their white counterparts.[66] The most common forms of mistreatment and disrespectful care included being shouted at or scolded by a health care provider, being ignored or refused for a request for help by a provider, violations of physical privacy, and providers withholding treatment or forcing unwanted treatment.[67] Low-income women and women of color, especially Black women, also face a disproportionately higher risk of being arrested and given treatment without consent while pregnant.[68]

> *"The doctor … refused to test me for an amniotic fluid leak and instead tested me for an STD test I had already received during the pregnancy. I believe his assumption that I was leaking something due to an STD rather than a pregnancy complication was due to race and put my life and my newborn's life at risk - I went a week leaking fluid after I had gone in to get it checked out. I worry that the doctor is still discriminating against other mothers and they are receiving negligent care as well."*[69]

Place of birth also informs the risk of mistreatment. Giving birth in a hospital setting, or even a birth center within a hospital, was found to be correlated with a significantly greater likelihood of mistreatment than giving birth in a freestanding birth center or at home.[70] One in three women of color who gave birth in a hospital experienced mistreatment, as compared with just one woman of color in fifteen (6.6 percent) who gave birth in the community.[71]

> "*[I was] forced to be in a hospital because of having Medicaid, which led to many interventions and being bullied/talked down to until I agreed. This pregnancy we saved up for a midwife so I can have a home birth."*[72]

Despite clear legal and ethical standards enshrining the right of an individual to refuse medical treatment, reports of coercion and forced treatment during birth are not unusual. Unconsented interventions and constraints fall along a continuum including failing to provide information adequate to achieve informed consent, failing to ask for consent, performing interventions despite a person stating or indicating she does not consent, and using physical force to restrain or overpower a woman.[73]

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[64] Vedam, S. et al. *The Giving Voice to Mothers Study: Inequity and Mistreatment during Pregnancy and Childbirth in the United States*. Reproductive Health, 2019. 16(1): 77. Available at: https://doi.org/10.1186/s12978-019-0729-2; Birth Place Lab. *Giving Voice to Mothers of Color and Home Birth Mothers.* Unpublished Manuscript. University of British Columbia, 2019.
[65] Vedam, S. et al., 2019.
[66] Vedam, S. et al., 2019.
[67] Vedam, S. et al., 2019.
[68] Paltrow, L.M. and Flavin, J. *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*. Journal of Health Politics, Policy and Law, 2013. 38(2): 299–343. Available at: https://doi.org/10.1215/03616878-1966324.
[69] Vedam, S. et al., 2019. (quote by a Black woman in California).
[70] Vedam, S. et al., 2019.
[71] Vedam, S. et al., 2019.
[72] Birth Place Lab, 2019 (quote by a Native American woman in New York).
[73] Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRAction Project, Harvard School of Public Health. 2010 Sep 20. Amnesty International. Deadly Delivery: The Maternal Health Care Crisis In the USA. Amnesty International Publications. 2010.

> *"I was refused food and water for 26 hours. I wasn't allowed to move out of bed to walk around. I felt like I lost my autonomy over my own body. I had given up. These professionals broke my spirit."*[74]

The Giving Voice to Mothers study documents a disturbing disregard for childbearing people's right to bodily autonomy and a lack true informed consent for medical procedures. More than 20 percent of participants reported not feeling comfortable exercising their right to decline care, feeling like they did not have the opportunity to make decisions about the care they received, or that their personal preferences were not respected. Black and Indigenous women were most likely to report such interactions with providers.[75] White women were found to be significantly more likely than Black or Latina women to be asked about involvement in decision-making, to be informed of a variety of care options, and to be given the opportunity to decide their preferred course of care among possible options.[76] Despite being most likely to report wanting to lead decisions around their pregnancy and birth, Black women reported the lowest scores in autonomy of decision-making and had the least access to models of care that support decision-making.[77] Among Black and Native American women, research has found a high unmet demand for doula support and a desire for culturally concordant care providers.[78]

Global coalitions and national advocates have recognized the universal rights of childbearing people and the right to respectful maternity care as explicitly tied to social, economic, and cultural rights.[79] The U.S. maternity care system currently has no pathway to incorporate feedback from or provide redress to individual patients who experience violations of their rights, discriminatory care, or mistreatment, which results in the continuation of harmful patterns and practices.

IV. Addressing the Maternal Health Crisis: Strategies to Reduce Disparities in U.S. Maternal Health

In 2018, unprecedented bipartisan support for improving maternal health led to two important bills being signed into law: The Preventing Maternal Deaths Act (H.R. 1318), which provides federal grants to states to investigate maternal deaths by establishing and maintaining Maternal Mortality Review Committees; and The Improving Access to Maternity Care Act (H.R. 315), which directs the government to identify areas with shortages of maternity care providers in order to target maternity care resources to fill those gaps.

While these bills reflect progress, further action must be taken to target the elimination of disparities, deaths, and complications. Over the past ten years, health care clinician organizations have driven considerable efforts to improve maternal health by implementing key innovations, such as maternal mortality review committees, safety bundles, and perinatal quality collaboratives. These efforts have

[74] Birth Place Lab, 2019 (quote by a Latina woman in North Carolina).
[75] Vedam, S. et al., 2019.
[76] Vedam, S. et al., 2019.
[77] Birth Place Lab, 2019.
[78] Vedam, S. et al., 2019.
[79] White Ribbon Alliance. *Respectful Maternity Care: The Universal Rights of Childbearing Women*. 2011. Available at: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf; National Association to Advance Black Birth. *Black Birthing Bill of Rights*. 2020. Available at: https://thenaabb.org/black-birthing-bill-of-rights/.

reduced maternal deaths from certain complications, such as hemorrhage, yet maternal mortality and severe morbidity have continued to rise overall. Clinical quality improvement initiatives are a requisite part of the solution, but these efforts alone are not sufficient to drive the transformative changes needed to move the U.S. maternity care system towards health equity.

For example, California, a leader in clinical quality improvement initiatives to improve maternal health, is the only state in which the rate of maternal deaths has decreased over the past decade.[80] However, the state has not experienced significant change in the racial disparities in maternal mortality and morbidity rates. The failure to reduce disparities has been attributed to the limited scope of existing quality improvement projects and their inability to address social determinants of health, pre-existing comorbidities, and mistrust in the health system.[81] California's progress must be recognized and repeated, but their approach must also be seen as just one of many steps that will be required to achieve maternal health equity.

A broader approach is needed in order to transform the U.S. maternity care system to reduce disparities and improve maternal health outcomes for everyone. Shifts will be required at every level: from a focus on rescue and emergency response to an emphasis on prevention; from a narrow clinical perspective to a comprehensive approach that meets people's needs holistically; and from measuring the drastic disparities in maternal health outcomes to focusing on implementing equitable solutions by working to scale and integrate models of care that work. The high-value, evidence-based models that could help move the maternity care system towards equity exist but are underutilized and inaccessible for those who would benefit most greatly due to legislative and regulatory barriers. Moreover, transparent mechanisms must be introduced to hold health systems and government accountable for their duty to put an end to the preventable deaths of Black and Indigenous women and other women of color.

A. Solutions: Accountability and Equity in Maternity Care

Every Mother Counts urges the U.S. Commission on Civil Rights to recommend key policy changes to hold the health system accountable for ensuring high quality, respectful care for everyone giving birth in the U.S. A systemic shift towards the universal provision of such care requires transparent mechanisms to identify detailed information regarding the extent of disparate treatment and incidents of disrespectful care, systemic and interpersonal bias, and mistreatment. That information must then be used to inform and guide quality improvement efforts and provide the opportunity for individuals to have disrespectful care, discrimination, and mistreatment addressed and remedied.

Individual studies have thoroughly documented that Black women and other women of color experience worse outcomes and more mistreatment but pinpointing and implementing solutions to save lives and improve outcomes requires the routine collection of foundational data on the race and ethnicity of pregnant and childbearing women, rates of severe maternal complications and medical procedures performed (such as cesareans and episiotomies), and the experience of care at the hospital level. Only by measuring quality of care and experience and separating the data by race and ethnicity can we obtain granular, specific information on disparities in order to develop interventions to eliminate those disparities. Additionally, this data must be publicly reported online so that it is widely available to the public and can inform patient choice about the facility where they are seeking care.

[80] MacDorman, M.F., Declercq, E., Cabral, H. and Morton, C. *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues Short Title: U.S. Maternal Mortality Trends*. Obstetrics and Gynecology, 2016. 128(3): 447–55. Available at: https://doi.org/10.1097/AOG.0000000000001556.
[81] Main, E.K. et al., 2018.

When incidents of discriminatory treatment, disrespectful care, violations of the right to informed consent, or other forms of mistreatment occur, individuals and families often have no opportunity to seek redress. Hospitals and health systems must create mechanisms to ensure they are accountable for providing care that is non-discriminatory, that protects patients' rights to informed consent and bodily autonomy are protected, and where all patients are treated with dignity and respect. A Respectful Maternity Care Compliance program should be developed to create respectful maternity care compliance offices in hospitals, health systems, and other maternity care delivery settings to institutionalize reporting on and accountability for incidences of bias, racism, discrimination and mistreatment. Respectful care compliance programs could establish roles such as maternity care ambassadors and compliance offices. Funding is necessary to support and incentivize ongoing education, accountability, and transparency at the institutional level.

Accountability also needs to be reinforced within practices at the health care provider level. The American College of Obstetricians and Gynecologists acknowledges that racial bias contributes to the disparities in maternal health outcomes.[82] Addressing systemic and interpersonal bias must be built into health professional education as a critical step to increase the practice of respectful maternity care. Implicit bias and culturally appropriate care curricula must be further developed to include basic education around autonomy, respect, racism, and human rights, as well as implicit bias and trauma-informed care. Providers will also need continuing education around consent and patient bodily autonomy to provide patient-centered care. Such trainings and education reform can be integrated into health professional curricula, as well as quality improvement efforts.[83]

Within health systems, it is important to encourage collaborative care teams that are interdisciplinary, integrating physicians, midwives, nurses, doulas, and the childbearing people and their support people to ensure a team-based approach to care. A collaborative care approach builds interprofessional accountability within health care institutions and teams in order to provide the safest, most respectful care to childbearing people. In fact, a study found that greater integration of midwives was associated with higher quality maternity care and better maternal health outcomes across the U.S.[84] This can be encouraged by enhancing team-based communication strategies within the medical system and also by supporting the growth and diversification of the perinatal workforce, including midwives and doulas.[85] A more diverse perinatal workforce is better able to provide culturally congruent care to those most affected by maternal health disparities.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in any program or activity receiving federal financial assistance, and the federal government is responsible for ensuring compliance with Title VI. Most hospitals, clinics and health care services fall within the scope of Title VI, based on federal funding through Medicaid or the Health Resources and

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[82] ACOG. *Racial and Ethnic Disparities in Obstetrics and Gynecology*. Committee Opinion, 649, 2015. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in-obstetrics-and-gynecology.

[83] Howell, E.A. et al. *reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle.* Journal of Obstetric, Gynecological, and Neonatal Nursing, 2018. 47(3): p275-289. Available at: https://www.jognn.org/article/S0884-2175(18)30064-9/fulltext#sec5.

[84] Vedam, S. et al. *Mapping integration of midwives across the United States: Impact on Access, Equity, and Outcomes.* PLOS One, 2018. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523.

[85] Ellmann, N. *Community-Based Doulas and Midwives*. Center for American Progress, 2020. Available at: https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/.

Services Agency. The Office for Civil Rights of the U.S. Department of Health and Human Services, which enforces federal laws which prohibit discrimination by health care providers receiving funds from the Department, should clarify its mandate to encompass enforcement of civil rights violations based on disparate impact. The Civil Rights Division of the Department of Justice should also add enforcement of Title VI in the area of health to its on-going work on discrimination in housing, employment and education.

B. Solutions: High-Value, Person-Centered Models of Care and Support

Every Mother Counts urges the U.S. Commission on Civil Rights to recommend expanding and extending access to high-value, evidence-based solutions that are currently underutilized in order to create an equitable, comprehensive, and proactive maternity care system. Strategies with proven track records include midwife-led clinical care, perinatal support provided by doulas, and access to community birth in freestanding birth centers, all of which have demonstrated potential to improve health equity and all need to be scaled up to improve access.

Increasing the number of midwives and doulas while also retaining and making judicious use of needed physician services is essential to achieving a high-value system that can meet the needs of the population in a way that is cost-effective. The midwifery model of care and doula support meet the Triple Aim for health care improvement by leading to excellent health outcomes and reducing disparities, enhancing the experience of care and engagement in decision-making, and achieving cost savings through reduced non-beneficial spending and avoidance of complications.[86] Despite their benefits, these evidence-based solutions continue to be out of reach for many communities, particularly those with the greatest need for the practices and approaches they employ. The extension of Medicaid coverage and restructuring of licensure processes for these types of care are essential to their accessibility, especially for those most at risk of adverse outcomes.

These models of care can be made more accessible by increasing insurance coverage for these models, supporting the education and training of a sufficient and diverse workforce to provide needed services, and supporting their integration into the maternity care system.

i. The Midwifery Model of Care

For women of color facing the worst maternal and infant outcomes, the midwifery mode of care has the potential to diminish the gap in health outcomes by improving the health of those with the greatest needs. The midwifery model emphasizes relationship-based care and fosters trust, respect and emotional support, an approach that can be especially beneficial for women of color who worry that they will experience racism and mistreatment when seeking health care.

The midwifery model of care treats pregnancy and birth as healthy, normal life events and supports the physiological processes of labor, childbirth, and breastfeeding. Midwifery prioritizes person-centered and comprehensive care, evidence-based practices, shared decision-making, and respectful treatment. By using medical procedures only when their benefits outweigh their harms, midwifery care can reduce avoidable complications and chronic conditions. While the midwifery model of care has demonstrated excellent health outcomes and positive experiences of care in all populations, it holds particular promise in meeting the needs of underserved and at-risk communities and in contributing to the elimination of health disparities, by filling some of the gaps in the traditional medical model.

[86] Agency for Healthcare Research and Quality. *National Quality Strategy*. 2017. Available at: http://www.ahrq.gov/workingforquality/about.htm#aims.

As a profession, midwifery has long prioritized meeting the needs of underserved and vulnerable populations and has achieved excellent outcomes.[87] U.S. midwives have worked in a range of communities with high infant and maternal mortality, including Indian reservations, remote rural areas, and under-resourced urban areas.[88] Midwives often care for clients who, although they may not have medical complications, have social risk factors that make them more likely to have poor health outcomes. Midwives are disproportionately likely to work in Health Provider Shortage Areas and to serve clients covered by Medicaid.[89] Midwives are more than twice as likely as doctors to care for clients of color.[90] Midwives serve a higher proportion of women who are less educated, low-income, immigrant, and from communities of color, characteristics that put them at increased risk of poor outcomes. Yet as a group, people cared for by midwives report lower than average rates of poor outcomes such as low birthweight and infant mortality.[91]

Tenets of the midwifery model that have particular relevance to those in communities of color and other marginalized populations include establishing a trusting relationship; respecting families' culture, values, dignity, and privacy; emphasizing shared decision-making to prevent coercion, conflict, or confusion; and reducing unnecessary interventions to avoid potential harms.[92]

Considerable evidence demonstrates that the midwifery model of care achieves excellent outcomes for childbearing people and infants and shows no area where their care is worse than other models. Research has found that the midwifery model results in fewer medical interventions such as cesareans, episiotomies, and epidurals, fewer serious lacerations, a higher likelihood of breastfeeding, and greater patient satisfaction.[93]

The Centers for Medicare and Medicaid Services' Strong Start Study found that midwife-led care significantly improved outcomes for Medicaid-enrolled clients in terms of population health, experience of care, and value of care. In the study model, participants received comprehensive, relationship-based prenatal, intrapartum, and postpartum care led by midwives practicing within a continuum of interprofessional care, with the option of laboring and delivering in either hospitals or non-hospital birth centers.

The participants with prenatal and postpartum care in a birth center (regardless of whether their labor and childbirth care took place in a hospital or birth center) were significantly less likely to experience preterm birth, low birthweight, and cesarean birth, and more likely to experience vaginal birth after

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[87] Raisler J, Kennedy H. Midwifery care of poor and vulnerable women, 1925–2003. Journal of Midwifery & Women's Health. 2005 Mar 4;50(2):113-21.
[88] Raisler, J. and Kennedy, H., 2005.
[89] Paine LL, Lang JM, Strobino DM, et al. Characteristics of nurse-midwife patients and visits, 1991. Am J Public Health 1999;89:906–9.
[90] Declercq ER, Williams DR, Koontz AM, et al. Serving women in need: Nurse-midwifery practice in the United States. J Midwifery Women's Health 2001;46:11–16.
[91] Declercq ER. Midwifery care and medical complications: The role of risk screening. Birth 1995;22:68–73Clarke SC, Martin JA, Taffel SM. Trends and characteristics of births attended by midwives. Statistical bulletin (Metropolitan Life Insurance Company: 1984). 1997;78(1):9-18. Scupholme A, DeJoseph J, Strobino DM, Paine LL. Nurse-midwifery care to vulnerable populations. Phase I. Demographic characteristics of the national CNM sample. J Nurse Midwifery 1992;31:341–8.
[92] Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM.
[93] Newhouse, R.P. et al. *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*. Nursing Economics, 2011. 29(5): 230–50; Sutcliffe, K. et al. *Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews*. Journal of Advanced Nursing, 2012. 68(11): 2376–86. Available at: https://doi.org/10.1111/j.1365-2648.2012.05998.x.

cesarean (VBAC). Infants in the birth center group were born at higher average gestational ages and birthweights. When looking at the impact for different groups by race and ethnicity, Black women who received midwife-led care were five to six percent less likely to have a preterm birth than counterparts receiving other types of care.[94]

Other research shows that people who receive midwifery care also report increased agency and autonomy in decision making, compared with those cared for primarily by a physician, and research has documented that midwife-led care is more likely to result in a positive childbirth experience and a greater sense of satisfaction, control, and confidence than traditional models of care.[95]

People cared for by midwives are less likely to report disrespectful or coercive care compared with those cared for in a traditional medical model and are more likely to report effective communication and engagement in decision-making.[96] Factors associated with these positive experiences of care include the midwifery model's emphasis on client engagement in decision-making and a "relationship-based" model of care that fosters trust, respect, and emotional support.[97] Communities of color in particular benefit from the midwifery model's prioritization of establishing trusting relationships and respect for culture, values, dignity, and privacy throughout the pregnancy and childbirth process.

Expanding midwifery care has the potential to significantly reduce Medicaid and private insurance spending on maternity care and can enhance the value of care that hospitals provide. Midwifery care lowers costs by avoiding the overuse of interventions, which also eliminates avoidable short- and long-term complications and chronic conditions for women and newborns that sometimes result from unnecessary medical procedures.[98] Additional cost savings are achieved by increased breastfeeding and by a reduction in the number of people who decide to use epidural pain relief.[99] In the Strong Start study, birth center mothers and infants were found to incur lower costs through the first year following childbirth.[100]

Midwifery care is a proven model of effective maternity care that has been underutilized in the U.S. health care system. Achieving the Triple Aim of health care improvement, the midwifery model of care can address inequities in poor maternal health outcomes, especially when its accessibility is expanded for those who are most affected by disparities, such as Black women and women enrolled in Medicaid.

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[94] Hill, I. et al. *Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis Volume 1: Cross-Cutting Findings*. Center for Medicare and Medicaid Innovation, 2018.
[95] Sutcliffe, K. et al., 2012.
[96] Vedam, S. et al. *The Mothers on Respect (MOR) Index: Measuring Quality, Safety, and Human Rights in Childbirth*. SSM - Population Health, 2017. 3: 201–10. Available at: https://doi.org/10.1016/j.ssmph.2017.01.005; Kozhimannil, K.B. et al. *Midwifery Care and Patient-Provider Communication in Maternity Decisions in the United State*s. Maternal and Child Health Journal, 2015. 19(7): 1608–15. Available at: https://doi.org/10.1007/s10995-015-1671-8.
[97] ACNM, MANA, and NACPM. *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*. The Journal of Perinatal Education, 2013. 22(1): 14–18. Available at: https://doi.org/10.1891/1058-1243.22.1.14.
[98] Sandall, J. et al. *Midwife-led Continuity Models versus Other Models of Care for Childbearing Women*. Cochrane Database of Systematic Reviews, 2016. Available at: https://doi.org/10.1002/14651858.CD004667.pub5.
[99] Anim-Somuah, M., Smyth, R.M., and Jones, L. *Epidural versus Non-Epidural or No Analgesia in Labour*. The Cochrane Database of Systematic Reviews, 2011. 12: CD000331. Available at: https://doi.org/10.1002/14651858.CD000331.pub3; Bartick, M. and Reinhold, A. *The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis*. Pediatrics, 2010. 125(5): e1048-1056. Available at: https://doi.org/10.1542/peds.2009-1616.
[100] Hill, I. et al., 2018.

ii. Community-Based Doula Support

Doula care is a proven method of improving birth outcomes, and community-based models are especially effective in supporting better health outcomes, more positive birth experiences, and cost-effective care in communities of color. Despite the robust evidence base of the effectiveness of doula care, perinatal support from doulas is still inaccessible for those who need it most.

Doulas are trained to provide non-clinical emotional, physical, and informational support before, during, and after labor and birth. Doulas work with pregnant people to help them experience care that is individualized, safe, healthy, and equitable. Research suggests that maternal health benefits derived from doula support are greatest among people from low-income and socially disadvantaged communities, as well as those facing language or cultural barriers.[101]

Consistent, high-quality research shows that continuous labor support by a doula reduces cesareans by an average of 39 percent, lowers negative experiences of childbirth by 35 percent, and shortens the length of labor.[102] In the "Safe Prevention of the Primary Cesarean Delivery," the ACOG and the Society for Maternal-Fetal Medicine (SMFM), the pre-eminent professional associations for obstetric care, report that continuous labor support by a doula is "one of the most effective tools to improve labor and delivery outcomes."[103] Other studies have found that community-based doula support that begins during pregnancy and continues through childbirth and the postpartum period is associated with lower rates of preterm and low birthweight births and postpartum depression, while increasing breastfeeding initiation and duration.[104] The Centers for Disease Control and Prevention (CDC) and HRSA have identified community-based support as a promising approach to meeting the needs of vulnerable and high-risk mothers and families.[105]

Community-based doula programs have achieved positive results across the United States by improving outcomes and care practices, elevating the voices of pregnant people in marginalized communities, and taking a comprehensive approach to maternal health by linking clients with a variety of support services. Community-based programs offer culturally congruent doula support to people in underserved communities, generally at no or low charge to the client. Community-based doula programs engage and educate trusted members of the communities served to become birth doulas and home visitors who can provide childbirth education, breastfeeding support, and support navigating the health care system, as well as continuous support during labor and birth.[106]

The demand for doula care is high, and yet the current payment models make it unaffordable for the communities who need it most. In the *Listening to Mothers III Survey*, Childbirth Connection found that

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[101] Vonderheid S. C., Kishi R., Norr K. F., and Klima C. *Group prenatal care and doula care for pregnant women*. In Handler A., Kennelly J., & Peacock N. (Eds.), Reducing racial/ethnic disparities in reproductive and perinatal outcomes: The evidence from population-based interventions, 369–399, 2011.

[102] Bohren, M. et al. *Continuous support for women during childbirth*. The Cochrane database of systematic reviews, 7, 2017.

[103] American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. *Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery*. Obstetrics and Gynecology, 2014. 123(3): p. 693-711.

[104] Health Connect One. *The Perinatal Revolution*. Chicago, IL: 2014; Kozhimannil, K.B., et al. *Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery*. Birth, 2016. 43(1): p. 20-27; Thomas, M.P., et al. *Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population*. 2017. 21(1): p. 59-64; Trotter, C., et al. *The Effect of Social Support during Labour on Postpartum Depression*. 1992. 22(3): p. 134-139.

[105] Health Connect One, 2014.

[106] Asteir Bey et al. *Advancing Birth Justice: Community-based Doula Models as a Standard of Care for Ending Racial Disparities*. 2019. Available at: https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

underserved women were disproportionately likely to want access to doula care, yet financial and other barriers prevented them from accessing these non-clinical support services. The study also found that Black women were nearly twice as likely as white women to want doula care during their pregnancy.[107]

The added support of doula care is beneficial to people of color, who are most affected by health inequities resulting from structural racism and implicit bias. Because community-based doulas share the same background, culture, and language with their clients, they are able to serve as a key resource for addressing discrimination and disparities. By facilitating positive communication between pregnant people and their care providers, doulas allow questions, preferences, and values to be addressed, while averting difficulties related to language or cultural barriers. Doulas provide non-clinical emotional, physical, and informational support before, during, and after labor and birth that ultimately incorporates cultural sensitivity and awareness into quality maternity care, resulting in improved childbirth experiences for people of color.

Doula care is also cost-effective. Medicaid coverage of doula support has been found to reduce spending by as much as $1,450 per birth, when focusing solely on the cost savings that are easiest to track and realized in the short term, such as a reduction in cesarean rates and lower rates of preterm birth.[108] Unnecessarily high cesarean rates and neonatal intensive care unit stays for premature newborns are substantial drivers of cost in our maternity care system, both of which have been found to be reduced by community-based doula care.[109]

These short-term, easily estimated cost savings reflect only a small portion of the spending that would be avoided in subsequent months and years. Additional savings would be expected by preventing or reducing the severity of complications and avoiding rehospitalizations and chronic conditions requiring long-term treatment, care, and cost. Savings could also be achieved by avoiding repeat cesareans, as currently 87 percent of births following a cesarean result in a repeat cesarean.[110] Eliminating spending on non-beneficial procedures, avoidable complications, and preventable chronic conditions would each contribute to significant savings that would cover the cost of doula care and contribute to health benefits that will continue well into the future.

iii. Integration of Community Birth Options

Birth setting also affects birth outcomes, in addition to individual health factors, social determinants of health, and structural inequities and biases in the health system, and society at large.[111] Creating a system that allows for an informed choice of birth setting for mothers can improve birth experiences and encourage birth in birth settings that are associated with lower rates of intervention and respectful care. In the U.S., the majority of births currently happen in hospitals, with only about 0.99 percent of births happening at home, and 0.52 percent of births happening in freestanding birth centers. In 2017, 43.4 percent of hospital births were covered by Medicaid compared with 17.9 percent of births in birth centers, and 8.6 percent of births at home.[112]

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[107] Declercq, E.R. et al., 2013).
[108] Greiner, K.S., et al. *A Two-Delivery Model Utilizing Doula Care: A Cost-Effectiveness Analysis*. Obstetrics & Gynecology, 2018. 131: p. 36S-37S
[109] Bohren, M. et al., 2017; Health Connect One, 2014; Thomas, M.P. et al., 2017.
[110] Martin, J.A. et al., 2017.
[111] Committee on Assessing Health Outcomes by Birth Settings. (2020). *Birth Settings in America: Outcomes, Quality, Access, and Choice.* National Academies Press. Available at: https://doi.org/10.17226/25636.
[112] MacDorman, M.F. and Declercq, E. *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*. Birth, 2019. 46(2): 279–88. Available at: https://doi.org/10.1111/birt.12411.

Studies find that women with low-risk pregnancies who give birth at home or in birth centers consistently show lower rates of intervention and intervention-related maternal morbidity, compared with those giving birth in a hospital.[113] The Strong Start for Mothers and Newborns study found that free-standing birth centers serving mothers enrolled in Medicaid and CHIP have better outcomes and lower rates of preterm birth, low birthweight, and cesarean section, and higher rates of VBAC than hospital settings.[114]

Research also shows that the mistreatment, discrimination, and lack of clinical attention reported by Black and Native American women occur at higher rates in hospital settings, indicating that other birth settings may provide an opportunity to address racial disparities in maternal health outcomes and birth experience. In the Giving Voice to Mothers survey, one-third of women of color who had given birth in a hospital setting reported being mistreated by staff, compared with only one in 15 of those giving birth at home or in a birth center.[115] For many women, however, a community birth is not an available option. In the Listening to Mothers California study, Black women were most likely to report interest in a birth center birth, but were significantly less likely to obtain care at a birth center than white women.[116]

Decisions regarding birth setting are constrained by various barriers, including economic and insurance coverage factors, mistrust of the health system, fear of disrespect and mistreatment, and geographic accessibility for rural and underserved urban areas.[117] While pregnant people might be interested in non-hospital birth, the fragmentation of the health care system can make it unaffordable or make transfers from community settings to higher levels of care prohibitively difficult.

Under the ACA, Medicaid programs are required to cover the costs of services at and facility fees for freestanding birth centers as long as the providers and facilities are recognized by state law.[118] The implementation of this provision, however, has been inconsistent and inadequate.[119] As of 2017, only 32 states and the District of Columbia reported covering births at birth centers and 11 states reported not covering services or fees from birth centers.[120] Medicaid managed care organizations (MCOs) in 38 states and the District of Columbia can impose additional barriers, including: restrictive policies regarding in-network providers, offering prohibitively low reimbursement rates for birth centers and midwives, imposing requirements that make it difficult for certain providers to receive payment, and enforcing requirements for birth centers and midwives that exceed state regulations.[121]

Freestanding birth centers are high-value, patient-centered birth settings that can be utilized to mitigate the harm associated with medical models that have historically disrespected pregnant people of color.

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[113] Committee on Assessing Health Outcomes by Birth Settings, 2020.
[114] Hill, I. et al., 2018.
[115] Hill, I. et al., 2018.
[116] Carol Sakala et al. *Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report*. Washington, DC: National Partnership for Women and Families, 2018.
[117] Committee on Assessing Health Outcomes by Birth Settings, 2020.
[118] Centers for Medicare and Medicaid Services. *Recent Developments in Medicaid and CHIP Policy*. 2011. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CMCS-Info-Bulletin-March-2011-Final.pdf.
[119] Bauer, K., Bushman, J.S. and Lawlor, M. *Letter to CMS on Birth Center Regulation*. American College of Nurse-Midwives. Available at: https://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005105/AABC-ACNM-NACPM-LettertoCMSonBirthCenterRegulation.pdf.
[120] Kaiser Family Foundation. *Medicaid Benefits: Freestanding Birth Center Services*. State Health Facts, 2019. Available at: https://www.kff.org/other/state-indicator/medicaid-benefits-freestanding-birth-center-services/.
[121] Committee on Assessing Health Outcomes by Birth Settings, 2020.

Birth centers offer a holistic approach to health and wellbeing, often with low rates of intervention, that can be effective with ongoing risk assessment and strong relationships for transfer with higher levels of care. Informed choice on birth setting can be improved greatly by ensuring that every birth setting is safe, accessible, and encourages integration and collaboration between different birth settings.

C. Solutions: Extending Medicaid Coverage through the Postpartum Year

Every Mother Counts urges the U.S. Commission on Civil Rights to recommend the extension of Medicaid coverage to cover a full year following childbirth. Medicaid has played a key role in expanding access to life-saving care for mothers and pregnant people who need it most. In 22 states, at least half of all births were financed by Medicaid, according to most recent data reported from 2013 to 2019.[122]

Interruption of health care coverage during the postpartum period creates a barrier to accessing continuous health care that puts women's health at risk and can allow complications to become life-threatening or deadly as was the case for Brittney Henry. Under the ACA, 36 states and the District of Columbia have expanded Medicaid, increasing access to essential care for low-income women.[123] Medicaid expansion has played a key role in improving maternal health in U.S. by increasing access to preventive health care before pregnancy. Access to care prior to pregnancy reduces the likelihood that people will enter pregnancy with unmanaged chronic conditions, which reduces the risk of adverse health outcomes for women and infants before, during, and following pregnancy. The Georgetown University Health Policy Institute recently found that states that opted to participate in Medicaid expansion were associated with lower rates of maternal mortality.[124]

One in three pregnancy-related deaths occur between one week and one year after childbirth, and almost one in four occur between 43 days and one year postpartum.[125] In 2019, the American Medical Association and ACOG jointly endorsed the extension of Medicaid coverage to one year postpartum.[126] While no states have yet extended comprehensive Medicaid coverage to a full year postpartum, a number of states have taken steps towards that goal. Four states have submitted Section 1115 waiver requests to the Centers for Medicare and Medicaid Services and are awaiting the federal approval needed to obtain matching funds for postpartum Medicaid coverage beyond the standard 60-day cutoff.[127]

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[122] Kaiser Family Foundation. *Births Financed by Medicaid*. State Health Facts, 2019. Available at: https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/.

[123] Kaiser Family Foundation. *Status of State Action on the Medicaid Expansion Decision*. State Health Facts, 2020. Available at: https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[124] Georgetown Health Policy Institute. *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies.* Washington, D.C.: 2020. Available at: https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf

[125] Davis, N.L. et al. *Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2019; Centers for Disease Control and Prevention. *Pregnancy-Related Deaths*. Vital Signs, 2019. Available at: https://www.cdc.gov/vitalsigns/maternal-deaths/index.html.

[126] Anderson, T. *ACOG Statement on AMA Support for 12 Months of Postpartum Coverage under Medicaid*. American College of Obstetricians and Gynecologists, 2019. Available at: https://www.acog.org/About-ACOG/News-Room/Statements/2019/AMA-Support-for-12-Months-Postpartum-Medicaid-Coverage?IsMobileSet=false.

[127] National Academy for State Health Policy. *Each State's Efforts to Extend Medicaid Coverage to Postpartum Women*. 2020. Available at: https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/.

V. Recommendations

Every Mother Counts recommends the following federal legislative and administrative strategies to reduce disparities and ensure equitable, quality care for mothers:

- *Utilize existing civil rights offices to investigate and remedy disparities in maternal health outcomes.*
    - ⊄ Congress should increase funding for the Office of Civil Rights in the Department of Health and Human Services. The DHHS Office of Civil Rights should undertake investigations to assess where laws, policies, and practices constitute obstacles to equal access to respectful, quality maternity care.
    - ⊄ Congress should create a Health Section in the Civil Rights Division of the Department of Justice to address issues of discrimination in health care, including maternity care.

- *Enact policies that establish accountability for quality, equitable, and respectful maternity care* through legal guarantees and reporting mechanisms.
    - ⊄ The Kira Johnson Act (H.R. 6144) would create the Respectful Maternity Care Compliance program to establish respectful maternity care compliance offices in hospitals, health systems, and other maternity care delivery settings to institutionalize reporting on incidences of bias, racism, discrimination and mistreatment.

- *Enhance hospital level data collection and publication needed to end disparities* by requiring hospitals and health systems to:
    - ⊄ routinely collect data on patient race and ethnicity,
    - ⊄ collect and publish data on severe maternal complications, experience of maternity care, and maternity care procedure rates and disaggregate this data by race and ethnicity, and
    - ⊄ develop and implement systemwide and facility level solutions to address disparities informed by this disaggregated data.

- *Establish a federal Interagency Coordinating Committee on Maternal Health Accountability and Equity* led by the Secretary of Health and Human Services to provide coordinated oversight of and guidance for policy and program development efforts across the federal and state governments with respect to eliminating maternal health disparities.
    - ⊄ The Interagency Coordinating Committee should seek the input of and consult with appropriate stakeholders, including community-based organizations representing the most affected communities, State Health Departments, public health research and interest groups, foundations, childbearing women from affected communities and their advocates, and maternity care professional associations and organizations, reflecting racially, ethnically, demographically, and geographically diverse communities.
    - ⊄ The Committee should develop and implement strategy for increasing accountability and equity in the maternity care system to ensure the elimination of maternal health disparities, the integration of high-value, respectful maternity care practices, and accountability mechanisms to address discrimination, disrespectful care, and mistreatment.
    - ⊄ The Committee should report to the US Congress on an annual basis on progress made.

- *Extend Medicaid coverage to one year postpartum*.
    - ⊄ The Helping MOMS Act (H.R. 4996, *bipartisan*) would extend Medicaid and CHIP coverage for women from 60 days to one year postpartum. In addition, this bill directs Medicaid to evaluate doula care under state Medicaid programs, identifying barriers related to implementation and opportunities for improvement. The Helping MOMS Act has already passed in the House of Representatives, and now awaits a vote in the Senate.
    - ⊄ The MOMMA's Act (S. 916 / H.R.1897) and the MOMMIES Act (S. 1343 / H.R. 2602), among other important pieces of legislation, offer similar pathways to extend Medicaid and CHIP coverage for postpartum care from 60 days to one year.

- *Ensure appropriate and equitable quality of care, funds, and resources for Native Americans, including through the Indian Health Service.*
    - ⊄ Congress should remedy persistent budget shortfalls affecting care provided through the Indian Health Service. In order to ensure that public funding levels do not discriminate on the basis of race or Indigenous status, funding levels for Indian Health Services must be at an equal or higher level per capita than that of Medicaid and other Federal health programs.
    - ⊄ Congress must ensure adequate and high-quality health care services for Native American women that are culturally competent, including prenatal care, labor and delivery services, and perinatal support services.
    - ⊄ IHS must increase access to resources community-based health care facilities, including indigenous midwives, doulas, and birth centers.
    - ⊄ The Department of Health and Human Services, IHS, and the Health Resources and Services Administration (HRSA) must prioritize policy for American Indian, Alaska Native, and Native Hawaiian women to reduce long-standing and well-known barriers to access culturally competent maternal health services.

- *Strengthen, expand, and diversify the midwifery workforce*.
    - ⊄ The Midwives for MOMS Act of 2019 (H.R. 3849, *bipartisan*) would do this by establishing two new streams of funding for midwifery education, focusing on students from racial and ethnic minority groups or disadvantaged communities.
    - ⊄ Congress should authorize and fund a review of Medicaid provider payments for maternity care, including increasing reimbursement rates to equitable levels for different types of providers and facilities providing similar services, particularly addressing the disparity in reimbursement between midwives and physicians.

- *Expand access to freestanding birth centers*.
    - ⊄ The BABIES Act (H.R. 5189, *bipartisan*) would establish a Medicaid demonstration program to develop and advance innovative payment models for freestanding birth center services to expand access for women with low-risk pregnancies.

- *Include doula support and community-based perinatal support as Medicaid covered services.*
    - ⊄ The Centers for Medicare and Medicaid Services should take active steps to facilitate state coverage of doula care and perinatal support services by providing guidance to

state Medicaid agencies, including on payment pathways, reimbursement mechanisms, billing codes, and workforce development.
    - ⊄ The MOMMIES Act (S.1343 / H.R. 2402) would increase Medicaid coverage of doula care by directing the Medicaid and CHIP Payment and Access Commission to report on the coverage of doula care under state Medicaid programs and create strategies to improve access.
    - ⊄ The Helping MOMS Act (H.R. 4996, *bipartisan*) and the TRICARE for Doula Support Act (S. 3826) would also expand access to doula care.

- *Pass the Black Maternal Health Momnibus to fill gaps in existing legislation and improve maternal health outcomes for Black childbearing people*.
    - ⊄ The Black Maternal Health Momnibus (S. 3424 / H.R. 6142) is a package of nine bills that would build on existing legislation to address racial disparities in maternal health outcomes, by investing in the social determinants of health, funding community-based organizations, study the impact on childbearing veterans, diversify the perinatal workforce, improve data collection processes and quality measures, invest in maternal mental health care, improve support for incarcerated women, invest in telehealth solutions, and promote innovative payment models for maternity care.

- *Training in culturally appropriate care and implicit bias should be incorporated into the basic training curriculum of all health care professionals, as well as in their continuing education and licensure requirements.*
    - ⊄ The Maternal Health Quality Improvement Act (H.R. 4995, *bipartisan*), the Maternal Care Access and Reducing Emergencies Act (S. 1600 / H.R. 2902), the MOMMA's Act (S. 916 / H.R.1897), the Maternal Outcomes Matter (S. 2586 / H.R. 4215, *bipartisan*), and the Black Maternal Health Momnibus (S. 3424 / H.R. 6142) all would support the implementation of implicit bias training.

- *Expand access to coordinated, comprehensive care* through maternity care home models.
    - The MOMMIES Act (S.1343 / H.R. 2402) also includes a component to establish and evaluate a Maternity Care Home Demonstration Project to provide comprehensive care services including dental care and mental health counseling, care coordination, lactation support, health education, and community-based doula support.

VI. Conclusion

As Amnesty International found more than a decade ago, poor maternal health outcomes and extreme racial disparities in the U.S. constitute a violation of human rights that must be addressed with urgency.[128] We are here today because most maternal deaths and maternal health disparities are preventable, if we make the commitment to realize that goal. As Mahmoud Fathalla, a former president of the International Federation of Obstetricians and Gynecologists, once said, “Women are not dying of

[128] Amnesty International. *Deadly Delivery: The Maternal Health Care Crisis in the USA*. London: Amnesty International Publications, 2010.

diseases we can't treat… They are dying because societies have yet to make the decision that their lives are worth saving."[129]

Today's hearing is an opportunity to collectively affirm that the lives of Black and Indigenous women and women of color are worth saving. Never before has there been such widespread recognition of the devastating impact of racial disparities in U.S. maternal health. The evidence-based solutions that could move the system towards maternal health equity already exist but are underutilized and inaccessible to those who would most benefit from them.

Building a maternity care system rooted in equity, transparency, and accountability will require collecting and publishing hospital-level data on race and ethnicity, severe maternal complications, experience of care, mistreatment, and procedure rates - critical steps towards eliminating disparities and improving the health of Black and Native American women and other women of color. Additional solutions include strengthening, diversifying, and deploying workforces using proven, high-value, models, such as midwives and doulas, and ensuring their integration into the system through interdisciplinary care teams. Finally, we must prioritize respectful, person-centered, rights-based approaches and ensure a comprehensive approach to maternal health and well-being, if we are truly committed to achieving a system based on health equity.

Our country's deep, persistent maternal health disparities are not inevitable. They are not the consequence of biology. They are the results of the decisions we make as a society – decisions about whose lives matter, whose lives we value, and whose lives we choose to save.

Our action is overdue. It is time to do everything in our power to ensure that not one more Black woman, Native American woman, or woman of color suffers a preventable death while giving birth.

[129] Fathalla, M F. "Imagine a world where no woman is denied her right to health- Seven propositions." *Facts, views & vision in ObGyn* vol. 3,4 (2011): 247-51.