



**Written Testimony  
of  
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**Before the U.S. House of Representatives  
House Appropriations Committee Subcommittee on Labor, Health and Human Services,  
Education, and Related Agencies  
“Addressing the Maternal Health Crisis”  
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Chair DeLauro, Ranking Member Cole, and members of the Subcommittee, thank you for the opportunity to testify today on this topic of extreme importance. This Subcommittee is made up of some of the foremost champions for women and families so I look forward to today’s discussion. My name is Dr. Carol Sakala and I lead maternal health and maternity care policy for the National Partnership for Women & Families’ Health Justice Program.

The National Partnership’s Health Justice Program frames our work with the understanding that health and economic equity are inextricably linked, and that we can’t achieve gender equity without achieving racial equity. When we talk about maternal health and the maternal health crisis facing our nation, this means ensuring that we center the needs and priorities of birthing people and families of color in all of our work. While I am honored to be here today, I encourage you to continue to listen to those most impacted as you make policy decisions.

**Overview**

The U.S. maternity care system is failing our communities, with disastrous outcomes for Black, Indigenous, and other people of color (BIPOC). Today, my testimony will focus on the key drivers of this maternal health crisis – and the racial, ethnic, and geographic inequities –

including: gaps in health coverage; lack of access to care; unmet social needs, like lack of transportation and lack of paid sick days at work, as well as lack of safe and secure housing; poor quality of care, including implicit bias and explicit bigotry in health care; and structural and institutional racism in health care as well as our economy and society as a whole.<sup>1</sup>

Fortunately, research shows that specific care models lead to demonstrably better care, experiences, and birth outcomes. I will briefly identify and discuss three reliably high-quality, evidence-based forms of maternal and newborn care, as well as one promising, emerging model. These forms of care share attributes that distinguish them from typical maternal care currently provided in the United States. Overall, we can leverage and expand these models now to provide optimal care and support. Specifically:

- The outcomes they achieve are remarkable, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.
- They tend to provide individualized, relationship-based care and support that are respectful, dignifying, trustworthy and trusted, and often culturally congruent.
- They offer holistic services that build on the individual's and family's strengths to support better health, more confidence, and increased resilience.

This Subcommittee has already, and should continue to seek out ways to foster innovation and quality improvement in maternal health in order to address these persistent gaps.

### **The Maternal Health Crisis and the Disproportionate Harm to Black, Indigenous and Other Communities of Color**

The United States fails to provide many birthing people and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of

pregnancy and childbirth in this country than in any other high-income country.<sup>ii</sup> Severe maternal morbidity, a term that captures a “near miss of dying,” is also alarmingly on the rise.<sup>iii</sup> The crisis is far greater in communities struggling with the burden of structural inequities and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.<sup>iv</sup>

In this country, access to maternity care depends on many factors, including availability of health insurance. The Congressional Budget Office (CBO), for example, estimates that about 45 percent of women covered by Medicaid on the basis of pregnancy, become uninsured after the end of the 60-day postpartum coverage period.<sup>v</sup> Moreover, for many communities across the country, particularly rural and low-income communities, having health insurance does not ensure access to care. The many obstacles to care for those with insurance include cost, lack of transportation, family caregiving responsibilities, lack of paid sick leave from work, and cultural and linguistic barriers.<sup>vi</sup> One of the most challenging barriers to accessing care is provider availability – either in your insurance network or at all. More than one-third of counties in the United States, in both rural and urban locations, are “maternity care deserts,” with neither a hospital maternity unit nor any obstetrician-gynecologist or certified nurse-midwife.<sup>vii</sup>

Even when people have access to maternity care, it may not be the high-quality, culturally congruent care they need to promote healthy pregnancies, births, and babies. Disrespectful maternal care can include withholding or distorting information, coercion, and unfounded threats of harm to the baby to gain consent for unwanted and often unnecessary procedures. In some cases, there may even be physical or sexual abuse in the form of hitting, unnecessary restraints, and rough vaginal examinations.<sup>viii</sup> Oftentimes, providers don’t listen to pregnant people about their birth preferences and concerns, and Black women are the least likely

to be listened to.<sup>ix</sup> The all-too-common lack of regard for birthing people and their input increases the risk of death and complications for themselves and their babies. This mistreatment overall is experienced more frequently by women of color, by those birthing in hospitals, and among those who experience social, economic, and health inequities in the United States. This can cause additional harm to birthing people already shouldering experiences of ongoing systemic racism, toxic stress, and trauma – from failing to mitigate the impact of Black women’s lack of trust in the health care system, to disregarding Native women’s traditional ways of caring for pregnant people.<sup>x</sup>

Every birthing person should have equitable access to high-quality maternity care that is culturally congruent, comprehensive, personalized, and evidence-based (when applicable evidence is available). They should be respected and supported with high-quality information to make informed decisions about their care and birth experience, and their choices should be honored. Unfortunately, this is not what usually happens.

### **Promising and Evidence-Based Models of Care for Achieving Equitable Maternal Health Outcomes**

In the National Partnership’s “Improving Our Maternity Care Now” report, we highlighted four care models that are essential to achieving better and more equitable maternal health outcomes: midwifery care, community birth, doula support, and community-led perinatal health worker groups.

First, in nearly all other nations, midwives provide first-line maternity care to childbearing people and newborns. However, in the United States, midwives attend only about 10 percent of births.<sup>xi</sup> Midwifery emphasizes building a relationship of trust over time, promoting health, providing information that birthing people need to make their own informed

care decisions, and tailoring care to individual needs and preferences. The second model is community birth settings. While the vast majority of births in the United States occur in hospitals, demand is rapidly growing for alternatives outside of hospitals and within communities – both in birth centers and at home. This likely reflects growing appreciation for the distinctive care available in these settings, fear of giving birth in a hospital during a pandemic, as well as loss of hospital maternity units in rural areas and some urban communities.<sup>xii</sup> The third care model is doula support. Doulas are trusted non-clinical advocates who provide information about childbirth, foster communication between pregnant people and members of the care team, offer both practical and emotional support, and help give the birthing person confidence and a sense of control.<sup>xiii</sup> Community-based approaches to doula support have also been developed to help meet the particular needs of birthing people and families from communities of color and other marginalized groups. This model tends to provide culturally congruent, trauma-informed support that extends from pregnancy through birth and into the postpartum period. A strong evidence base supports these three models.

The fourth and final model is community-led perinatal health worker (CPHW) groups. CPHW organizations generally offer a wide range of support services, which may include doulas, lactation support, mental health support, and health care and social services navigation. Many also provide clinical services, such as midwifery and birth center care. Frequently, they create programs to address unmet community needs, such as long-term parenting support for young families. Many offer birth worker training tailored to their communities. Furthermore, their explicit focus on dignity and respect and on mitigating and dismantling racism and discrimination enables them to understand their clients' intersectional identities (such as race, ethnicity, gender, sexual orientation) and alleviate the toxic stress and trauma they may

experience, both in engaging with the health care system and in their daily lives.<sup>xiv</sup> Many of these groups offer proven midwifery, birth center and doula services, which may in combination have powerful synergistic effects. However, the impact of these multi-functional, community-tailored groups has rarely been evaluated. A notable exception, Commonsense Childbirth in Central Florida, achieves impressive disparity-reducing preterm birth, low birth weight and cesarean rates. This model has the potential to play a major role in mitigating our maternal health crisis, especially among those most affected, and should be expanded, in tandem with evaluation efforts.

While these models have the potential to reduce avoidable harm now, we must also continue the longer-term work of transforming the maternity care system to reliably provide high-quality care and achieve exemplary outcomes for all through levers such as, delivery system and payment reform, performance measurement, and workforce development.

### **Impactful Recommendations to Improve our Maternity Care Now**

The success and value of these care models offer insight into critical opportunities that are within this Subcommittee's jurisdiction to achieve better and more equitable access to high-quality, evidence-based maternity care. In all of the following recommendations, we encourage the Subcommittee to seek out ways to require and expand data collection and reporting that is disaggregated by race, ethnicity, and other demographic information. Addressing maternal health inequities starts with better data – because you can't see it if you don't count it.

One opportunity for improvement is via increased funding for Perinatal Quality Collaboratives, or PQCs. PQCs are groups of maternity care providers and other diverse stakeholders working together to accelerate the adoption of best practices, such as eliminating elective births before 39 weeks, increasing breastfeeding rates, safely reducing cesarean birth and

much more. They also facilitate essential data collection and provide technical assistance to providers and institutions, all of which help address maternal mortality and improve health outcomes for pregnant people and babies. This Subcommittee has supported the Center for Disease Control's Perinatal Quality Collaborative funding in prior fiscal years' report language. The National Partnership encourages you to consider directly funding PQCs, which are so often limited in the scope of good work they can do by underfunding. We also recommend report language that encourages PQCs to involve all birth settings and maternity care providers in their state for bidirectional learning and quality improvement, and building relationships for safer more integrated care systems. For example, current participants could help community-based providers and settings collect and apply standardized data, and community-based providers could help hospitals and physicians achieve the Department of Health and Human Services (HHS) Maternal Health Action Plan goal of reducing the low-risk cesarean rate by 25 percent.

We also encourage the Subcommittee to work within its jurisdiction to advance maternal health through two new initiatives at the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS). First, modeled after the impressive completed CMMI Strong Start evaluation of birth centers, CMMI could make a similar contribution by evaluating the community-led, -based, and -tailored perinatal health worker model of care and support described above. Second, as Medicaid covers 42 percent of the nation's births, CMMI could make a major contribution to maternal and infant health nationally by carefully designing and encouraging uptake of a maternity care episode alternative payment model with input from birthing people in the development, testing, implementation and evaluation phase. A strong policy signal for more accountable maternity care would help drive needed delivery system reform and quality improvement.

We commend this Subcommittee for its FY20 request to CMMI for a report on how CMMI could develop a proposal for CMS to increase access to birth centers and midwifery care in all state Medicaid programs and to incentivize this model of care for low-risk women. The Affordable Care Act authorizes the Secretary of HHS to expand care models that have been found through CMMI evaluation to improve care and reduce costs. The Strong Start birth center evaluation meets these criteria. Relative to Medicaid beneficiaries with typical care, Strong Start birth center participants had lower rates of preterm birth, low birthweight, and cesarean birth, among other benefits, and at reduced cost. This care is especially valuable, as conventional maternity care has faced challenges in reducing these consequential outcomes and maternity care costs. We also look forward to this CMMI report and hope this Subcommittee will continue to identify opportunities to encourage uptake of these effective care models..

Relatedly, workforce development of growing the cadre and racial diversity of midwives with the three credentials recognized by the U.S. Department of Education is essential to ensuring broader access to quality care for birthing people. We thank the Subcommittee for targeting resources under the Scholarships for Disadvantaged Students funding stream specifically for these Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives. We ask that you continue to invest in growing and diversifying the maternity care workforce, particularly since more than 90 percent of certified nurse-midwives are white, and both birthing people and midwives of color identify midwives of color as uniquely positioned to provide high-quality care for BIPOC communities.<sup>xv</sup>

An important driver of quality improvement in health care is the development and utilization of quality measures. Funding for the Agency for Healthcare Research and Quality (AHRQ) above current levels could help fill crucial gaps in maternal health measures. We



encourage a set-aside for building a more robust maternal health measures pipeline, especially Patient-Reported Measures. Measures of the patient experience of receiving maternal and newborn care are urgently needed to serve as powerful guardrails against the widely-reported disrespectful and coercive patient-provider encounters, and as tools for helping to reduce these harmful experiences. Similarly, a composite measure of maternal health outcomes in the postpartum period would enable standardized measurement, provide clinical opportunities to address identified problems, and allow tracking and improvement over time. These measures, which should be designed to capture and reduce inequities and measure care across the continuum of maternity care providers and settings, would elevate birthing people's voices in standardized ways that would enhance accountability and quality improvement. If publicly reported, they would also enhance choice.

The Alliance for Innovation on Maternal Health (AIM) Maternity Care Safety Bundles are a set of targeted and evidence-based best practices that, when implemented, improve patient outcomes and reduce maternal mortality and severe maternal morbidity. We support increased funding for AIM safety bundles.

To further fund strategies that reduce maternal mortality and address critical gaps in maternity care service delivery, this Subcommittee has supported State Maternal Health Innovation Grants. We commend the Subcommittee for recognizing the need for these demonstration projects to be representative of the demographic and geographic composition of communities most affected by maternal mortality.

As a final point, the National Partnership for Women & Families advocates for evidence-based models to improve maternity care, but we want to acknowledge that when it comes to understanding the efficacy of scientific evidence, care models, and other interventions for

BIPOC people and other groups affected by inequities, there are enormous gaps and significant biases in the evidence base. We encourage the Subcommittee to seed money at Federal health research agencies to address these long-standing evidence gaps, to be more transparent about the limitations of the evidence base, and to underscore that agencies and researchers should equitably partner with impacted communities to help guide all steps of relevant research initiatives.

## **Conclusion**

I want to praise the Congressional champions we have here today – Chair DeLauro for being a long-time advocate for the needs of women and families and for seeing paid family and medical leave and paid sick days as the maternal health issues they are; Representatives Roybal-Allard and Herrera Beutler for being maternal health leaders and co-chairs of the Maternity Care Caucus; and Representatives Clark, Frankel, Lee, Watson Coleman, and Lawrence for being point and cosponsors of so many priority maternal health bills.

We are at a critical point and Congress must act on maternal health, including by extending Medicaid coverage to 12 months postpartum permanently and for residents of every state, and by passing the Black Maternal Health Momnibus, the BABIES Act, and the Midwives for MOMS Act, among other fantastic bills. Thankfully, this Subcommittee plays an essential role by investing in federal programs that help states and localities target inequities and fund community-based programs. Congress can continue to help scale these successful, high-value solutions in order to improve the health of mothers and infants – especially in communities suffering from deep inequities.

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