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The Current Medicaid Reimbursement Model is Hurting Access to Maternal Care. Here's How We Fix It.

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The United States is facing a severe maternal mortality crisis, with outcomes lagging far behind other developed nations and stark racial disparities persisting. Black and Hispanic birthing people, in particular, report higher rates of mistreatment in traditional hospital settings. Freestanding birth centers (FBCs), which offer midwifery-led care for low-risk pregnancies, are a proven, high-value alternative that provides safer outcomes, higher patient satisfaction, and lower costs.

Despite this, FBCs are critically underutilized, especially by the populations who could benefit the most. A primary barrier is inadequate and inconsistent Medicaid reimbursement. A nine-state analysis of Medicaid policy found extreme, irrational variations in facility fee reimbursement. Legislators and state Medicaid officials must consider their available policy actions in order to improve maternal health outcomes, reduce costs, and advance health equity.

How Birth Centers Improve Maternal Health

Compared to other high-income countries, the U.S. has the highest rate of maternal mortality, and the problem is worsening, with disparities widening. Black and Hispanic birthing people experience significantly higher rates of severe maternal morbidity and mortality.

Beyond clinical outcomes, patient experience is a critical indicator of quality. Nearly 30% of Black and Hispanic birthing people report mistreatment during perinatal care (i.e. violations of physical privacy, ignoring requests for help, or verbal abuse), and almost 40% report discrimination based on race or ethnicity, age or weight. This erodes trust and underscores the urgent need for alternative models of care that are safe, respectful, and culturally supportive.

Freestanding birth centers (FBCs) are a high-value, evidence-based solution. As midwifery-led alternatives to hospitals, they are designed for individuals with healthy, uncomplicated pregnancies, centering the experience of the birthing person and family.

Decades of research show that for low-risk individuals, birth center care is associated with:

- **Improved Health Outcomes:** Significant reductions in interventions, lower cesarean rates, and fewer emergency department visits.
- **Superior Patient Experience:** FBC users report higher-quality experiences and greater satisfaction, a crucial factor in addressing the mistreatment reported by women of color.

- **Lower Costs:** Birth center births cost significantly less than hospital births, driven primarily by reduced interventions and shorter facility stays.

Despite these proven benefits and high patient interest (one survey found that 64% of mothers who gave birth in a hospital would be interested in a birth center for a future birth), FBCs remain a tiny fraction of the U.S. birth landscape, accounting for less than 1% of all births.

Medicaid and Birth Centers

A primary barrier to birth centers' growth and access is a flawed financial model. Medicaid, the single largest payer for births in the U.S., fails to adequately reimburse for birth center services. Medicaid finances 41% of all U.S. births, but only 24% of births in birth centers, mainly because low facility reimbursement rates make it financially unsustainable for many centers to serve Medicaid patients.

Many FBCs cannot afford to accept Medicaid patients because the reimbursement rates do not cover the baseline costs of care. A recent policy analysis comparing nine similar states based on demographics and policy environment (Connecticut, Delaware, Illinois, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, and Rhode Island) revealed a broken and unsupportive policy environment.

Reimbursement Rates Vary by State

Of the states in the analysis with publicly available data, the Medicaid facility fee reimbursement rates varied dramatically.

- **Massachusetts:** $6,012
- **Illinois:** $2,544
- **Connecticut:** $2,500
- **Maryland:** $2,500
- **Pennsylvania:** $1,328
- **New Jersey:** $1,300

The rates in New Jersey and Pennsylvania are *four-and-a-half times lower* than the rate in Massachusetts. These low rates are also the oldest (New Jersey's was set in 2018, Pennsylvania's in 2013), failing to keep pace with inflation and the rising costs of providing care.

The analysis also found that states impose severe reimbursement cuts if a patient is transferred from a birth center to a hospital during labor (e.g., for pain relief or medical complications). This "fee-for-service" model, which pays based on "where the baby emerges, not where resources were expended," is counterproductive. It financially punishes birth centers for making appropriate and safe clinical decisions. Measures like this should be considered standard protocol in a well-integrated health system. This policy may disincentivize centers from admitting patients they deem a "risk" of transfer and, in turn, harm the collaborative care system that is safest for mothers and babies.

Policy Levers for Improving Access

States have a powerful policy lever to immediately improve maternal health, reduce disparities, and lower costs.

1. Immediately Increase and Regularly Update Facility Fee Reimbursement. States with low rates must increase their Medicaid reimbursement for birth center facility fees to a level that covers the true cost of care. Rates should be brought in line with higher-paying states (e.g., $2,500-$6,000) to ensure sustainability. Furthermore, states should follow the lead of others (like Alaska, which sets its rate at 75% of the average hospital fee) by establishing a regular, transparent process for rate review and updates.

2. Eliminate Punitive Reimbursement Reductions for Hospital Transfers. Reimbursement models must be changed to reflect the resources expended and time spent caring for a patient, regardless of the birth's final location. Eliminating the "transfer penalty" is a critical step to ensure clinical decisions are based on safety, not financial constraints, and to foster a collaborative relationship between birth centers and hospitals.

3. Transition to Value-Based Payment Models. The long-term solution is to move away from fee-for-service entirely. States should develop and implement VBP models, such as perinatal "Episode of Care" programs, which New Jersey is currently piloting. A value-based payment model would provide a comprehensive payment for all perinatal care (prenatal, labor, delivery, postpartum) and reward all providers (midwives, birth centers, physicians, hospitals) for collaborating to achieve positive health outcomes and a positive patient experience.

Freestanding birth centers are not a niche preference; they are a critical, evidence-based component of a high-functioning maternal healthcare system. The primary barriers to their expansion and accessibility are financial and policy-driven. By reforming Medicaid reimbursement to reflect the high value of birth center care, policymakers can directly address sustainability, improve access for low-income families and women of color, and take a significant step toward resolving the U.S. maternal health crisis.