The ACNM asks Congress to Cosponsor the

Midwives for Maximizing Optimal Maternity Services (MOMS) Act

Problem Statement: What action should Congress take to address the high rates of maternal and infant mortality in the U.S.?

Background: The U.S. is experiencing a crisis in maternal health care. Maternal mortality rates in the U.S. are higher than any other developed nation[1] and are not improving.[2] Each year, more than 700 women die due to pregnancy complications, and for every maternal death, another 70 experience a life threatening condition.[3] Preterm birth rates among all women have increased since 2015, despite years of decline between 2007 and 2014.[4] Preterm birth is one of the leading causes of infant mortality in the U.S.[5]

There are a myriad of factors which contribute to high U.S. maternal morbidity and mortality rates. First, the high rates are associated with racial disparities in maternal health, especially among underrepresented minority women. Black women of all ages are three times more likely to die from pregnancy-related complications and 27% more likely to experience severe pregnancy complications when compared to white women.[6, 7] Native American women are more than twice as likely to die from pregnancy-related causes.[8] A 2017 study in New York City found that Hispanic women experienced 1.8 times the rate of several maternal morbidity when compared to non-Hispanic white women.[9] Rates of preterm birth among Hispanic, American Indian/Alaska Native, and Black women are also much higher when compared to white women. In fact, the preterm birth rate among Black women is 50% higher than that of all other women combined.[10] Women of color also experience postpartum depression at 2 to 3 more times than their white peers, which when left untreated, can have multigenerational long-term negative impacts on her and her child's physical, emotional, and developmental health.[11]

Racial disparities in maternal health may be caused by implicit bias in the delivery of healthcare, a lack of access to health insurance, and social determinants of health such as racism, lack of housing and education, and food scarcity.[12, 13] The impact of racism should not be understated, as a college-educated Black woman is more likely to die from a pregnancy-related complication than a white woman without a high school degree.[7]

Second, many women lack access to maternity care. Maternal mortality is higher in rural areas of the U.S., and postpartum hemorrhage rates are higher in rural hospitals.[14] Of U.S. counties, 35% have no maternity care services and an additional 11% have limited access.[2] There are also 10 metropolitan areas at risk for an obstetrician-gynecologist (OB-GYN) shortage.[15] Despite the population growth of U.S. female adults, there is a stagnant number of OB-GYN residency programs.[15] The American College of Obstetricians and Gynecologists (ACOG) predicts an OB-GYN shortage of 18% by 2030.[16] This shortage is exacerbated by high rates of burnout among OB-GYNs,[15] an increased emphasis on work-life balance among the OB-GYN workforce,[17] and a dramatic shift from a male to female profession. Women balance their lives differently than men, working part time more often, and retiring from obstetric practice earlier.[18]

Third, the rising morbidity and mortality rates are congruent with the increase in use of obstetric procedures, including labor induction and cesarean birth.[19] The U.S. has one of the highest cesarean rates among developed countries (31.7%),[4] with a dramatic increase since 1996 (20.7%).[20] ACOG argues that this high cesarean rate is the result of an overuse of the procedure, and that maternal and infant health could be improved with less cesarean births.[21] A 2014 study found a dramatic variation in the U.S. cesarean birth rate exists by hospital and region, ranging from 8% to 36% among low-risk women, even when accounting for patient and hospital factors.[22] Overuse of the procedure also contributes to unnecessary costs. The cost of performing a CS is 68% higher compared to a vaginal birth.[23] Nearly half of U.S. births are funded through state Medicaid programs.[24]

The Landscape: Poor birth outcomes, overuse of obstetric procedures, and high costs of care require urgent action by Congress to improve quality and lower costs associated with maternal health care. Up to 50% of maternal deaths could be prevented based on quality-of-care improvements at the patient, system, and provider levels.[25] A scaling up and diversifying of midwifery-led care can lead to a significant improvement in birth outcomes.[26] Studies have found that women cared for by midwives have excellent birth outcomes, including lower episiotomy, cesarean birth, and preterm birth rates.[27, 28] A 2018 U.S. mapping study found that states with higher density of midwives, and a higher proportion of midwife-attended births, had higher rates of optimal birth outcomes such as vaginal births, lower rates of cesarean and preterm births and neonatal deaths.[27] Racially concordant midwife-patient dyads have led to increased trust in the midwife provider and improved birth outcomes.[13, 29]

Growth of the midwifery workforce can also lead to significant cost savings. Midwifery-led care is associated with fewer unnecessary interventions and procedures.[28, 30] A 2019 study at the University of Massachusetts found that the average cost of childbirth for low-risk women under the care of a midwife was $2,262 less, due to lower rates of preterm birth and episiotomy, when compared to care by obstetricians.[30] A 2019 policy brief by the University of Minnesota School of Public Health, using previously published estimates based on improved clinical outcomes and less procedures, found that if midwives were attending 20% of births by 2027, cost savings to private insurance and state Medicaid funds would reach $4 billion.[31]

While the prevalence of midwife-attended births varies by state, it is much lower when compared to other developed nations such as Australia and the UK, where more than 70% of low-risk births are attended by midwives.[27, 32] Although midwives educated and qualified based on international standards can provide 87% of services needed by mothers and their newborns, they only attend approximately 9% of U.S. births.[4] Midwives are educated in fewer years (2-3 years compared to 8 years) and at a lower cost when compared to obstetricians. While the methodology used to determine graduate medical education (GME) payments to any specific

hospital is complex, on average, GME funding from taxpayers for OB-GYN residents is approximately $400,000 per resident.[18]

OB-GYNs and midwives are essential components in a collaborative maternity care team, an approach supported by ACOG.[33, 34] Midwives are experts in caring for low-risk women and supporting physiologic birth and OB-GYNs are highly skilled at caring for pregnant and laboring women who develop complications outside the scope of midwifery care.[32, 34, 35] Midwives are currently underutilized in the U.S. health system due to restrictive supervisory and collaborative practice requirements,[14] restrictions in prescriptive privileging and hospital credentialing, and a shortage of preceptors and clinical sites to train midwifery students.[27] The majority of midwifery preceptors are not compensated for their time.[36]

Recommendation: Cosponsor the Midwives for Maximizing Optimal Maternity Services (MOMS) Act

Legislation developed by Rep. Roybal-Allard (D-CA) will address maternity care provider shortage with a goal of improving maternal and child health outcomes, especially among underrepresented minority women, and scale up and diversify the midwifery workforce. This bill will establish two new funding streams for accredited midwifery education programs under HRSA's Title VII Health Professions Training Program and Title VIII Nursing Workforce Development Programs. Funds would be directed toward students who plan to practice in a maternity care provider shortage area and/or are from underrepresented minority groups, preceptors who train midwifery students, and the establishment or expansion of midwifery education programs.

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