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A CALL TO ACTION

Healthy Moms, Healthy Babies America



**HEARTLAND
FORWARD**

MATERNAL & CHILD HEALTH
CENTER FOR POLICY & PRACTICE

INTRODUCTION

Maternal mortality in the United States has more than doubled over the past four decades, a reversal that no strong and prosperous nation should accept.

Over the same period, every comparable high-income nation has driven its maternal mortality rate downward, while the United States stands alone among industrialized countries moving in the opposite direction—compounded by an infant mortality rate that is roughly twice that of peer nations. Today, America’s moms face a greater risk of dying from pregnancy and childbirth than their mothers, and even grandmothers, did generations ago.

This is not a health care gap. It is a national emergency.

The consequences extend far beyond individual tragedy. Maternal health is directly tied to the economic infrastructure of the nation, and high maternal mortality and morbidity rates cost the U.S. economy \$165 billion—nearly 1% of GDP—in 2020 alone.¹ The health of mothers and babies impacts labor force participation, household stability and long-term human capital formation all of which contribute to national economic prosperity and global competitiveness. For the emotional and economic health of the nation, it is critical to invest in maternal care.

What makes this crisis especially troubling is that it is almost entirely preventable. According to the CDC, 87% of maternal deaths could be prevented

through established care models and proven practices to improve maternal outcomes.² Currently, the overwhelming majority of American mothers die from treatable complications because care comes too late, systems do not work together as they should and support often disappears shortly after mothers give birth. The problem is not a lack of solutions, but a failure to act with urgency and scale what already works across systems and communities. The time is now. The need has never been more urgent.

Heartland Forward’s Maternal and Child Health Center for Policy and Practice (MCH CPP) is designed to address this challenge. **We are advocating for a time-bound, five-year campaign to achieve one measurable goal: cut U.S. maternal mortality in half.**

To create sustainable, lasting change we are calling for a coordinated national response to take decisive action and align federal and state leaders, employers, philanthropies, providers and communities around evidence-based interventions already proven to save lives.

In the recommendations that follow, the Heartland Forward MCH CPP establishes guidelines and provides an actionable framework to cut U.S. maternal mortality in half—to be achieved through policy reform, workforce development initiatives and proven changes to care delivery.

PURPOSE AND SCOPE

The strategies below provide evidence for action, translating existing research and state policy guidance into an implementation framework to reduce U.S. maternal mortality by 50 percent within five years.

The Call to Action builds on the [National Governors Association’s maternal and infant health policy playbook](#) and [Heartland Forward’s economic analysis](#) of maternal health access, workforce capacity and

regional growth to identify the highest-impact levers for rapid, measurable improvement. This paper synthesizes national maternal mortality data, state policy adoption trends, economic modeling and evidence from clinical and care delivery literature. Policy recommendations were assessed based on strength of evidence, scalability within a five-year window and potential impact on preventable maternal mortality.

THE CASE FOR URGENT ACTION

The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births during the same period. This public health metric is widely used across global organizations to measure the risk of death associated with pregnancy and childbirth.

Maternal mortality data paint a stark picture. Since the 1980s, the U.S. maternal mortality rate has more than doubled, moving in the opposite direction of other high-income countries.³ In 2023, there were 18.6 maternal deaths for every 100,000 live births in the U.S. compared to the average maternal mortality ratio of 7.5 maternal deaths per 100,000 live births during the 1982-1996 period.⁴

Today, Maternal Mortality Review Committees estimate that 87 percent of maternal deaths that occur are preventable, and while this data indicate conditions nationwide, it is additionally important to note that maternal mortality varies widely between states.⁵ In Arkansas, for example, data indicates that 94 percent of maternal deaths are preventable.⁶ These preventable deaths point repeatedly to the same gaps in access, continuity and quality of care.

The economic consequences are equally alarming. The direct and indirect costs associated with maternal morbidity and mortality in one year alone equate to nearly one percent of U.S. GDP.⁷ Direct costs are the immediate and measurable costs associated with medical expenses, while indirect costs refer to the broader economic losses and ripple effects from maternal morbidity and mortality. Indirect costs include reduced work hours or reduced workforce participation rates and productivity losses from increased absenteeism, disability claims and extended leave.

Preventing even half of these avoidable outcomes would generate an estimated \$79 billion in annual savings that could be reinvested in families, workforce participation and community well-being.⁸ Outside of maternal mortality, improving maternal health outcomes more generally is critical. For example, the medical cost of an extreme preterm birth can exceed

\$230,000 compared with approximately \$6,400 for a healthy full-term birth, illustrating the fiscal value of preventive, continuous care.⁹ Reducing maternal mortality and improving maternal health outcomes is not only a public health necessity but additionally a workforce and economic strategy with measurable fiscal returns.

Yet these losses are not inevitable. They are the predictable result of systemic weaknesses in how maternal care is structured and delivered. **Evidence consistently points to the same structural failures for high rates of maternal mortality in the United States: gaps in access during pregnancy, insufficient support during the postpartum period and systems that undervalue prevention, continuity and recovery.** Addressing these failures requires embracing structural change for both pregnancy and postpartum care and throughout the care system as a whole. The following three evidence-based pillars identify where intervention matters most to deliver measurable improvements in outcomes for mothers, infants and communities:

I. Improve prenatal care by expanding insurance coverage, telehealth and virtual care access; promoting team-based care models and embracing a whole-health approach to maternal care.

II. Strengthen postpartum care by starting home visits and virtual care checks within two weeks of birth, mandating mental health screenings and expanding paid leave.

III. Make maternal health good business by unbundling payments, expanding and increasing reimbursements, reforming medical liability laws, expanding maternal care education and innovating new payment systems for benefits and care.

Together, these pillars organize proven solutions into a clear and actionable framework for reducing preventable maternal deaths, strengthening families and supporting long-term economic growth.

State leaders across the country have already articulated core policy pathways to improve maternal health outcomes that closely align with this framework.¹⁰ The National Governors Association (NGA), for example, has identified expanding access to perinatal care, strengthening and diversifying the workforce, improving data collection and accountability, and addressing nonclinical barriers—such as transportation, child care and paid leave—as central state-level levers for change.¹¹ These priorities appropriately recognize that maternal health outcomes are shaped not only by clinical care, but also by cross-sector conditions that require coordination across agencies, health systems, employers and community-based organizations, underscoring the fact that durable progress cannot be achieved through fragmented or isolated interventions.

Building on this strong foundation, our strategy advances the work further by embedding structural mechanisms that make reform more sustainable over time. In addition to aligning with NGA's policy roadmap, our strategy incorporates payment reform, economic incentives that reward prevention and continuity of care, and a nationally coordinated five-year goal to cut maternal mortality in half. By linking policy priorities to financing structures, measurable benchmarks and cross-state accountability, this approach moves beyond programmatic improvement toward systemic transformation and sustainable, enduring change.

A FIVE-YEAR IMPLEMENTATION ROADMAP

This framework for action has identified a five-year timeframe to allow for a structured and phased implementation of priorities and changes to maternal care through near-, mid- and long-term priorities as outlined below:



Years 0-1

Prioritize extending coverage and reforming access to care. This will require states to implement coverage and eligibility changes that determine whether risk is detected early or missed entirely.



Years 1-3

Prioritize transforming care delivery and improving and stabilizing the fiscal frameworks for maternal care. This includes scaling the workforce and creating payment reforms that allow for team-based, continuous maternal care to become the default model.



Years 3-5

Prioritize national expansion of proven models and the transition to outcome-driven accountability.

By focusing on the three pillars of improving prenatal care, strengthening postpartum care and making maternal health good business while adhering to a five-year time frame, this action plan not only identifies actionable and integrated solutions but offers a time-bound roadmap to ensure immediate and effective improvements in maternal health outcomes.

PILLAR I: IMPROVE PRENATAL CARE

Improving access to prenatal care is the first and most consequential opportunity to reduce preventable maternal deaths. Inadequate prenatal care is associated with increased risk of preterm birth, stillbirth and infant mortality.¹² Early and continuous prenatal care is the single most effective intervention for identifying and managing the conditions that drive preventable maternal deaths. When risks can be identified early, conditions can be managed before they escalate, and care relationships can be established that carry through delivery and postpartum recovery.

Access to care, however, requires access to coverage, and in the United States, prenatal care remains uneven, fragmented and insufficiently responsive to the realities faced throughout pregnancy. As such, states that guarantee immediate and uninterrupted coverage during pregnancy ensure that expecting mothers access care early, and, as a result, see improved risk management and better outcomes.

Despite the well-established importance of early and continuous prenatal care, a recent CDC analysis found that a growing number of women are initiating care later in pregnancy or not receiving prenatal care at all.¹³ These delays are not evenly distributed. Disparities in timely and adequate prenatal access are particularly pronounced among women of color. Compared with white women, Black women are nearly four times more likely and Hispanic women nearly twice as likely to receive minimal prenatal care.¹⁴ Rates of first-trimester care are also lowest among Black, American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander women—64%, 59%, and 55%, respectively—highlighting persistent structural inequities in access at the earliest and most consequential stage of pregnancy.¹⁵

Failures in prenatal care are not limited to clinical practice alone. They reflect broader system gaps in insurance coverage, care delivery models and the scope of services offered during pregnancy. State and regional analyses show that improving provider availability and reducing logistical barriers to care are among the strongest predictors of improved maternal outcomes.

To improve prenatal care, states can focus on four key recommended actions:

1. Expand Insurance Coverage During Pregnancy

Access to prenatal care begins with insurance coverage. While private insurers cover many women throughout pregnancy and childbirth, Medicaid is a critical lifeline for two in five American mothers, as Medicaid finances more than 40 percent of births nationwide. As such, eligibility rules and coverage policies are critical determinants of successful and effective care as well as maternal outcomes. Among new mothers with Medicaid-covered prenatal care, 26.8 percent were uninsured before pregnancy, meaning that they experienced delayed entry into a critical window for identifying and managing risk.¹⁶

Gaps in coverage delay entry into care, disrupt continuity and increase the likelihood that manageable conditions progress into serious complications. These delays are particularly consequential given that many of the conditions associated with maternal mortality—including hypertension, diabetes and cardiovascular disease—are identifiable and treatable during pregnancy when care is timely and consistent.

Insurance churn and administrative delays remain major drivers of late entry into prenatal care. Presumptive eligibility—a policy which allows for immediate coverage for low-income pregnant women to access care while their full Medicaid application is processed—is a critical tool for ensuring coverage can be accessed early, improving outcomes and keeping medical costs lower in the long-term. Without presumptive eligibility policies, it can take up to 20 weeks for women to access Medicaid coverage, meaning they may not be able to see a doctor or access care until halfway through their pregnancy.¹⁷

Evidence from states that have adopted presumptive eligibility shows improved access to early prenatal care and more consistent engagement with the health system, resulting in better outcomes and lower costs over time. In Kansas, presumptive eligibility

policies were associated with a 1.92 percentage point increase in first-trimester prenatal care among women with high school education or less.¹⁸ Women enrolled under presumptive eligibility in Tennessee were 30 percent more likely to obtain prenatal care in the first trimester and 300 percent more likely to fill a prescription for prenatal vitamins in the first trimester, improving infant health long-term.¹⁹ Additionally, Tennessee's presumptive eligibility program extends through 12 months postpartum, ensuring consistent coverage during the postpartum window when women are at highest risk for poor outcomes.²⁰ Research from the University of Mississippi found that living in states with presumptive eligibility can reduce preterm births for women covered by Medicaid and improve costs associated with care.²¹

Ensuring that insurance coverage, including Medicaid, fully supports women throughout pregnancy is a foundational requirement for improving maternal outcomes. Without reliable coverage, even the most effective clinical interventions remain out of reach.

2. Promote Team-Based Models of Prenatal Care

Prenatal care in the United States has traditionally centered on obstetricians as the primary, and often sole, providers of care. While obstetricians play a critical role, this model does not reflect the full range of needs that shape maternal health during pregnancy.

Team-based prenatal care integrates obstetric providers with midwives, nurses, doulas and behavioral health professionals, creating a more comprehensive and responsive care environment. These models improve continuity, expand capacity and allow each provider to contribute their expertise at the appropriate point in care, giving women a greater number of touch points with the providers they need to maintain a healthy pregnancy—both physically and mentally. In countries with well-integrated systems, community-based midwifery is both safe and cost-effective, with outcomes comparable to or better than hospital-based care for low-risk births. Community-based midwives are associated with lower rates of interventions such as cesarean delivery, episiotomy, and induction, and with higher levels of maternal satisfaction.²²

Evidence shows that team-based approaches improve patient health outcomes, support earlier identification of risk and reduce strain on an already limited obstetric workforce. They are particularly important in underserved and rural communities, where access to obstetricians alone is often insufficient to meet demand. For example, women who received doula care had 52.9 percent lower odds of cesarean delivery and 57.5 percent lower odds of postpartum depression and anxiety.²³ Doula care was associated with three to four fewer preterm births per 100 deliveries, improved attendance at postpartum visits and 20 percent higher rates of exclusive breastfeeding.²⁴ Women who initiated doula services during their first trimester also experienced the greatest reductions in cesarean delivery—underscoring the importance of early relationship-building.²⁵

Beyond clinical outcomes, these models generate measurable system savings. Medicaid reimbursements for doula support—at an average of \$986 per birth—have been shown to reduce overall Medicaid spending, and increasing midwife-led care from 8.9 percent to 20 percent over the next decade could generate an estimated \$4 billion in cost savings.²⁶

These models are particularly critical in underserved and rural communities where many counties have lost their hospital-based obstetric services.²⁷

By shifting from siloed OB-GYN care to a broader suite of maternal health providers, prenatal services become more accessible and aligned with women's needs throughout pregnancy and postpartum.

3. Adopt a Whole-Health Approach to Prenatal Care

Maternal health outcomes are shaped by more than pregnancy-related conditions alone. Physical health, mental health and social factors all influence risk during pregnancy, yet prenatal care often focuses narrowly on obstetric indicators while overlooking other critical drivers of morbidity and mortality. Cardiovascular disease is the leading cause of maternal death, yet prenatal care often focuses narrowly on pregnancy-specific conditions.²⁸

The elevated rates of obesity and cardiometabolic

disease among racial and ethnic minority women, and the strong link between these comorbidities and adverse maternal outcomes, highlights the need to focus on whole health before and during pregnancy.²⁹

A whole-health approach to prenatal care incorporates screening, prevention and treatment for mental health conditions, nutritional needs, metabolic disorders and chronic disease alongside routine obstetric care. Mental health conditions are among the leading underlying causes of pregnancy-related death, ranking first for Hispanic and white women, yet screening and treatment remain inconsistently integrated into standard prenatal protocols.³⁰ Addressing these conditions earlier in the care continuum reflects the role that unmanaged physical and behavioral health needs play in complications during pregnancy and the postpartum period.

Whole-health prenatal care also acknowledges the role of social determinants—such as food insecurity, housing instability and transportation barriers—in shaping health outcomes. When these factors are identified and addressed during pregnancy, care becomes more effective and holistic.

Treating prenatal care as whole-health care aligns clinical practice with the realities reflected in maternal mortality data and strengthens prevention at the earliest possible stage.

4. Expand Access to Virtual Prenatal Support

Even when prenatal care is available, a focus on in-person care alone can limit access for many patients. Work schedules, transportation challenges and provider shortages often make it difficult for pregnant women to attend frequent in-person visits, particularly in rural communities and among working families.

Virtual prenatal support expands access by allowing care to be delivered more flexibly. Telehealth services can support mental health care, education, follow-up consultations and routine check-ins, complementing in-person visits rather than replacing them.

A growing body of evidence has evaluated whether telehealth-supported prenatal care can maintain clinical quality and patient experience. One report found that replacing or supplementing care with

telehealth produced similar—and sometimes better—outcomes and patient satisfaction.³¹ Another report demonstrated that in-person prenatal care supplemented with telehealth for women with low-risk pregnancies was associated with similar clinical and obstetric outcomes.³²

Findings from large cohort analyses during the pandemic period further indicate that telehealth did not increase adverse outcomes for mothers or their infants³³

When integrated into prenatal care, virtual services increase continuity, reduce missed visits and make care more responsive to women's lives. They are especially valuable for extending support between scheduled appointments and maintaining engagement throughout pregnancy.

To expand vital prenatal services will require action from federal and state leaders as well as insurers and employers: federal leaders should create policy to align funding and data requirements to support continuous maternal coverage and integrated prenatal care while protecting patient privacy; states should adopt presumptive eligibility, expand and sustain pregnancy coverage and reimburse team-based prenatal care models; payers should finance integrated physical, behavioral and virtual prenatal services; and employers should structure maternal health benefits to enable early and continuous engagement in care.

PILLAR II: STRENGTHEN POSTPARTUM CARE

It is a persistent myth that most maternal deaths happen during pregnancy or in the delivery room. The reality is more sobering: roughly 65% of maternal deaths occur after childbirth—often weeks or months later—when medical contact drops off and support systems are weakest.

The postpartum period represents the highest-risk phase of pregnancy, yet it remains the most fragmented and under-resourced segment of maternal care in the United States. Improving maternal mortality requires improving postpartum care.

In recent years, the profile of risk during this phase has also shifted. While hemorrhage, cardiac conditions and infection once dominated postpartum mortality, suicide and drug overdose have become the leading causes of death in the year following delivery. One in five women experiences anxiety, perinatal or postpartum depression or birth-related post-traumatic stress disorder. Yet three-quarters of women with postpartum mental health conditions go untreated a full year after giving birth.³⁴

Despite this elevated risk, postpartum care is still structured around a single follow-up visit typically six weeks after birth, which fails to reflect the timing and nature of maternal complications. Complications such as hypertension, infection, cardiomyopathy, hemorrhage and perinatal mood disorders frequently emerge well after new mothers have been discharged, often without timely detection or intervention. Strengthening postpartum care requires redesigning it as a continuous system of support rather than an isolated clinical event as outlined by the recommendations below.

1. Extend Insurance Coverage Through the Full Postpartum Year

Continuous access to care during the postpartum period is essential to preventing avoidable maternal deaths. Yet some insurance structures often terminate coverage within weeks of delivery, with standard

Medicaid coverage historically ending 60 days after delivery, severing access precisely when medical and mental health risks remain highest.

Extending coverage through the full postpartum year, including Medicaid coverage, aligns insurance policy with clinical reality. It ensures continuity of care for managing chronic conditions, addressing mental health needs and responding to complications that arise well after childbirth. Without sustained coverage, postpartum care becomes fragmented and reactive, limiting the effectiveness of even the best-designed clinical interventions.

States that have extended postpartum coverage have improved access to care and reduced coverage inconsistencies during this highest-risk period. Medicaid coverage for 12 months postpartum is now supported by federal policy, but implementation remains uneven across states, leaving significant gaps in protection for postpartum women.

2. Increase Access to Postpartum Home Visiting

Postpartum home visiting provides early, high-touch support during the weeks immediately following childbirth, when maternal risk is greatest and traditional care engagement is lowest. Delivered by trained nurses, midwives or qualified providers, home visits allow for timely assessment of physical recovery, mental health, breastfeeding, home environment and other factors that influence maternal outcomes.

Home visiting is particularly important because it can reach families who are least likely to attend clinic-based postpartum visits. Transportation barriers, work demands, childcare responsibilities and recovery challenges all contribute to missed care. By meeting mothers where they are, home visiting closes gaps that clinic-centered models consistently fail to address.

Evidence shows that early postpartum home visits improve health outcomes, reduce emergency department utilization and strengthen connections to

follow-up care and community supports. When offered broadly, rather than limited to narrowly defined high-risk populations, these programs increase participation and healthier outcomes while simplifying access.

The [Family Connects](#) model, launched in North Carolina and now operating in communities across 20 states, has been particularly effective.³⁵ The program pairs parents with a specially trained nurse for a personalized home visit within the first two weeks after birth—offered at no cost to all families, regardless of income or circumstances. During the visit, nurses assess maternal and infant health, answer questions and connect families to additional support as needed, including referrals for food insecurity, formula assistance and postpartum mental health care.³⁶ Preliminary analysis from researchers at Tulane University found that Louisiana families who received the visits were more likely to stay on track with recommended pediatric and postpartum appointments. In addition, mothers and infants had fewer hospitalizations, and total health care costs declined among Medicaid-covered families.³⁷ In North Carolina, one study indicates that children randomly assigned to Family Connects had significantly less total emergency medical care (by 37%) through age 24 months, and that every \$1 invested in program costs resulted in \$3.17 in downstream medical savings.³⁸

States can look to the Family Connects program or [Michigan's Maternal Infant Health](#) program as strong state-run models for individualized and in-home postpartum support. Michigan's program—which conducts over 100,000 home visits each year—is open to all Medicaid families and provides home visiting services during pregnancy and throughout the first year after birth.³⁹

3. Expand Ongoing Virtual Postpartum Support

Postpartum recovery unfolds over months, not a single appointment. Ongoing support is essential for identifying complications that emerge later in the postpartum year and for sustaining engagement with care. Virtual maternal health services—including lactation counseling, nursing follow-ups and mental health care—extend the reach of postpartum care beyond traditional settings.

Virtual support is especially valuable for working mothers, rural families and communities with limited provider availability. It allows care teams to monitor symptoms, respond to concerns in real time and intervene before complications escalate. When integrated into postpartum care, virtual services increase continuity, reduce missed follow-up and make care more responsive to women's lives.

Importantly, virtual care complements rather than replaces in-person services. Together, they create a more flexible and accessible postpartum care model, ensuring a greater number of touchpoints and opportunities to identify and address risks before they escalate.

In Arkansas, nurses from the Arkansas Center for Women and Infants Health [Proactive Postpartum Call Center](#) contact mothers in the days following delivery to screen for physical complications, mental health concerns and other basic needs. It is the first proactive postpartum call initiative in the United States. In its near first full year of operation, 67 percent of mothers answered the call and 24 percent reported an urgent maternal warning sign and were referred for follow-up care that might otherwise have been delayed or missed.⁴⁰ States with similar rural demographics can look to this model for increased virtual care to strengthen maternal health outreach and improve early identification of postpartum complications in their own communities.

4. Expand Paid Family and Medical Leave

Paid time off after birth is a critical component of postpartum care, contributing to better physical and mental health outcomes for mothers and infants alike.⁴¹

However, one in four new moms in the United States returns to work only two weeks after giving birth, and the average maternity leave for American mothers lasts approximately seven weeks.⁴² Paid family and medical leave support postpartum recovery by allowing mothers the time needed to heal, engage with care and build family connection. It also strengthens workforce participation by improving job retention over time and limiting turnover by reducing postpartum depression and mental health struggles. As a result, paid leave functions as a health intervention, a fiscal support for families and an economic benefit all while ensuring better physical

and mental health outcomes for new mothers.

Three in four Americans report it is important for Congress to create a national paid family and medical leave program, but in the absence of federal action, states have stepped in to help fill the gap⁴³

In Arkansas, Governor Sarah Huckabee Sanders increased paid maternity leave benefits to twelve weeks for state employees and public school teachers to both improve retention and support families.⁴⁴ Thirteen other states as well as Washington, D.C. have active family leave programs that can serve as models for policymakers.

PILLAR III: MAKE MATERNAL HEALTH GOOD BUSINESS

Maternal mortality will not decline at scale until health care coverage, workforce policy and legal environments are aligned with outcome-based care. Payment models that reward prevention, continuity and team-based services create the conditions for sustainable improvement.

Maternal health outcomes directly influence labor force participation, productivity and long-term human capital development.⁴⁵ The loss of mothers during peak working years and the long-term impacts of adverse birth outcomes generate substantial economic costs for employers, states and the national economy.

Making maternal health “good business” does not mean prioritizing profit over care. It means aligning incentives so doing that which improves health outcomes is also financially viable for providers, employers and payers. Without this alignment, even well-designed clinical reforms will struggle to scale or endure. To reform this system, four key recommendations are outlined below.

1. Invest in the Maternal Health Workforce and Full Scope of Practice

Access to maternal care depends on the availability of a trained workforce. Yet many communities face persistent shortages of maternity care providers, driven in part by underinvestment in training, restrictive scope-of-practice policies and reimbursement structures that discourage participation.

Strengthening and sustaining the maternal health workforce requires robust education and training pathways for doctors, midwives, doulas, nurses, and

community health workers—particularly programs that prepare providers for rural settings, like West Virginia University’s Rural Maternal Child Health Fellowship Program.⁴⁶ It also means removing unnecessary restrictions that prevent these professionals from practicing to the full scope of their training, especially when those limits do little to improve safety but significantly constrain access to care. During the COVID-19 pandemic, states including Maine, New Jersey, New York, Pennsylvania, Tennessee and Texas issued emergency orders that expanded access to midwifery care. These actions eased certain continuing education requirements, reduced barriers for out-of-state providers and relaxed some oversight rules to increase care capacity.⁴⁷ States should not wait for a crisis to adopt this kind of flexibility; policies that allow qualified providers to meet patient needs should be standard practice, not temporary exceptions.

Midwives are trained health professionals who provide care to women during pregnancy, childbirth and the postpartum period and who also provide care to newborns. In countries with the strongest maternal health outcomes, midwives are the standard maternity care providers. In these places, low-risk pregnancies are typically managed by midwives, with OB-GYNs involved for more complicated or high-risk cases. A 2021 study concluded that a well-integrated midwifery workforce could provide 80 percent of essential maternal care around the world and potentially avert 41 percent of maternal deaths, 39 percent of neonatal deaths and 26 percent of stillbirths.⁴⁸ In 2022, certified nurse-midwives and certified midwives attended just 10.9 percent of total US births.⁴⁹ Expanding midwifery-led care for low-risk pregnancies represents an evidence-based strategy to improve maternal health outcomes.

A diversified and well-supported maternal health workforce improves access, strengthens continuity and enhances the responsiveness of care—factors that are closely linked to improved maternal outcomes and reduced disparities.

2. Reform Maternity Care Payments to Reflect the Full Maternal Journey

Most maternity care today uses bundled payment models, where a single fee covers all pregnancy-related care including prenatal visits, labor, delivery and one postpartum visit. The original goal of these models was to incentivize better outcomes through value-based care. However, this system has significant flaws when applied to maternal health without a direct connection to transparency and quality health outcomes. Further, bundled rates also typically exclude mental health screenings and substance use disorder treatment, leaving critical gaps in care that often lead to severe outcomes.

Due to these factors, the American Medical Association (AMA) retired bundled maternity codes in September of 2025, stating that they no longer met the standard of care.⁵⁰ States like Iowa and Arkansas have already moved away from bundled Medicaid payments, switching to fee-for-service models with performance incentives that better align payment with actual care delivered.⁵¹

Payment reform like unbundling also supports broader participation in maternal care by ensuring that providers who play essential roles—such as midwives, doulas and behavioral health professionals—are compensated in ways that sustain access and quality.

3. Develop Innovative Benefit and Payment Models to Expand Access

Employer-sponsored maternal health benefits play an important role in this landscape. Employers have a direct stake in maternal health through workforce participation, productivity and retention. When benefits are intentionally designed to support prenatal care, postpartum recovery and ongoing health needs, they contribute not only to improved outcomes for families but also to a more stable and resilient workforce.

To strengthen these efforts, innovative benefit

models—such as pooled wage insurance systems—can help close persistent gaps by spreading risk, distributing costs and expanding access to evidence-based services. By reducing the financial volatility associated with leave and maternal health needs, these models make comprehensive support more feasible, particularly for small and mid-sized employers.

More broadly, approaches that align public coverage, private benefits and community-based services offer a practical pathway for scaling maternal health support beyond traditional insurance structures and into the ecosystems where care and support are needed most. In parallel, federal and state leaders can reinforce these efforts by supporting small and local businesses in offering enhanced benefits or paid leave through targeted incentives including tax credits and state social insurance paid leave funds.

Taken together, these strategies recognize maternal health not as a peripheral benefit but as a foundational workforce and economic priority. By aligning policy design with employer incentives and community infrastructure, policymakers can advance a model that strengthens families, supports businesses and promotes long-term economic stability.

4. Reform Medical Liability to Protect Access to Maternal Care

Over the past two decades, hundreds of U.S. hospitals—disproportionately in rural communities—have closed maternity wards. Liability costs and unpredictability contribute to these decisions by increasing financial risk and reinforcing workforce shortages. When local services disappear, families must travel farther for prenatal visits and delivery, disrupting continuity of care and increasing the risk of complications. In states with already elevated maternal morbidity rates, additional travel burdens can widen existing disparities.

High-liability environments may also encourage defensive medicine. Cesarean delivery rates in the United States exceed 30 percent—well above levels associated with optimal outcomes—and while multiple factors influence this trend, fear of litigation has been identified as one contributing pressure.⁵² Evidence from state and institutional reforms

suggests that liability policy design matters. In the early 2000s, the University of Michigan Health System replaced a traditional “deny and defend” strategy with an open disclosure and offer model. Following implementation, the system reported fewer malpractice claims, faster resolution times and significant reductions in both total liability costs and average cost per claim. By emphasizing transparency, early communication and system learning, the model aligned patient safety with financial sustainability.⁵³

At the state level, Texas voters approved a 2003 constitutional amendment capping non-economic

damages in medical malpractice cases at \$250,000. In the years that followed, malpractice premiums stabilized and physician supply—particularly in high-risk specialties—grew.⁵⁴ Similar frameworks in states such as California and Colorado have been associated with more predictable insurance markets. Together, these experiences suggest that thoughtfully designed liability frameworks can help stabilize care delivery environments, strengthen workforce capacity and support more reliable access to maternity services, particularly in communities that need them most.

GOVERNANCE AND ACCOUNTABILITY FOR NATIONAL SCALE

Improving prenatal care, strengthening postpartum care and making maternal health good business are the three categories of change necessary to improve our country’s maternal mortality rate and promote maternal well-being at scale. The mechanisms to drive this change will require coordinated action across five reinforcing levers:

- ① **Federal and executive leadership** can set maternal health as a national priority, remove administrative barriers and align incentives and data systems.
- ② **State and local policy** is where reform scales first, shaping coverage, payment and workforce rules that determine access on the ground.
- ③ **Philanthropy and funders** can move quickly, funding innovation and building the capacity needed for durable change.
- ④ **Private employers** play a critical role by shaping benefits, paid leave and workforce stability, reinforcing maternal health as both a health and economic imperative.
- ⑤ **Awareness and storytelling** sustain accountability, maintain public will and ensure progress endures beyond any single administration.

Federal Acceleration

Declaring a national maternal health emergency would signal urgency — and unlock action. The evidence is clear; what’s holding progress back are regulatory and operational barriers, not proof.

A coordinated federal response can fast-track implementation, clear red tape, and rapidly scale proven interventions nationwide to meet this initiative’s five-year goal to cut maternal mortality in half. A nationally coordinated strategy must also protect and strengthen maternal mortality data systems. As leading health policy experts have warned, weakening national data infrastructure risks obscuring preventable deaths and undermining accountability at precisely the moment urgent action is required.⁵⁵

CONCLUSION

America's maternal mortality crisis is not the result of medical uncertainty or a lack of evidence. Eighty-four percent of maternal deaths in the United States are preventable, yet poor maternal health continues to cost the nation \$165 billion annually—nearly one percent of GDP. The solutions outlined in this paper are not experimental. They are proven, measurable and ready to scale. What has been missing is a coordinated national commitment to act with the speed and seriousness this emergency demands.

Cutting maternal mortality in half within five years is an ambitious goal, but it is achievable. The path forward requires aligning policy, payment and

workforce reform with a clear national benchmark and shared accountability across federal and state leaders, employers, providers and communities. Investing in maternal health is the most strategic investment we can make—because healthy moms and babies are the bedrock of thriving families, stronger communities and America's future prosperity.

By acting decisively now, the United States can reverse course and ensure that motherhood is not a risk factor for death but a foundation for thriving families, resilient communities and enduring national strength.

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