Improving Our Maternity Care Now Through *Midwifery*

October 2021

Executive Summary

Our nation's maternity care system fails to provide many childbearing people* and newborns with equitable, accessible, respectful, safe, effective, and affordable care. More people die per capita from pregnancy and childbirth in this country than in any other high-income country in the world. Our maternity care system spectacularly fails communities struggling with the burden of structural inequities due to racism and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.

Both the maternal mortality rate and the much higher severe maternal morbidity rate (often reflecting a "near miss" of dying) have been increasing, and both reveal inequities by race and ethnicity. Relative to white non-Hispanic women, Black women are more than three times as likely – and Indigenous women are more than twice as likely – to experience pregnancy-related deaths. Moreover, Black, Indigenous, Hispanic, and Asian and Pacific Islander women disproportionately experience births with severe maternal morbidity relative to white non-Hispanic women.

This dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that there are specific care models that can make a concrete difference in improving maternity care quality and producing better outcomes, especially for birthing people of color. One of these models is **midwifery care.** This report outlines the evidence that supports midwifery's unique value across different communities, the safety and effectiveness of midwifery care in improving maternal and infant outcomes, the interest of birthing people in midwifery care, and the current availability of, and access to, midwifery services in the United States. We also provide recommendations for key decisionmakers in public and private sectors to help support and increase access to midwifery care.

Research shows that midwifery care provides equal or better care and outcomes compared to physician care on many key indicators, including higher rates of spontaneous vaginal birth, higher rates of breastfeeding, higher birthing person satisfaction with care, and lower overall costs. Community-based and -led midwifery services are especially powerful. Yet in the United States, midwives attend only about 10 percent of births; in nearly all other nations, midwives provide the majority of first-line maternity care to childbearing people and newborns, with far better outcomes.

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report gives preference to gender-neutral terms such as "people," "pregnant people," and "birthing persons." In references to studies, we use the typically gendered language of the authors.

Expanding the availability of midwifery care is a cost-effective solution to providing higher quality care and better birth outcomes. Barriers to this modality of care must be eliminated. These include: lack of support and funding for midwifery education, inconsistent Medicaid reimbursement for midwifery services, lack of state-level recognition of all nationally recognized midwifery credentials, and restrictive state practice laws that prohibit midwives from practicing to the full scope of their competencies and education.

Enabling more birthing people to receive care from midwives while diversifying the profession of midwifery should be a top priority for decisionmakers at the local, state, and federal levels. To achieve this, we recommend the following:

Federal policymakers should:

- Enact the bipartisan Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3352 and S. 1697 in the 117th Congress) to increase the supply of midwives with nationally recognized credentials (certified nurse-midwives, certified midwives, certified professional midwives), racially and ethnically diversify the midwifery workforce, and increase access to care in underserved areas.
- Mandate equitable payment for midwifery services by all federal health programs and make certified midwives and certified professional midwives eligible for federal loan repayment from the National Health Service Corps.
- Prohibit hospitals from denying admitting and clinical privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sexual orientation, gender identity, language, and disability disparities in critical indicators of maternal and infant health – including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State and territorial policymakers should:

- Ensure that their states license and regulate all nationally certified midwifery credentials.
- Amend restrictive midwifery and nurse practice acts to enable full-scope midwifery practice , in line with their full competencies and education as independent providers who collaborate with others according to the health needs of their clients.
- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for the services of licensed midwives holding nationally recognized midwifery credentials, mandate payment at 100 percent of physician payment levels for the same services.

Private sector decisionmakers, including purchasers and health plans, should:

- Incorporate clear expectations into service contracts about access to, and sustainable payment for, midwifery services offered by providers with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of maternity care provided by midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.

In all relevant deliberations, consistently engage early and proactively with community-based midwives bringing a birth justice framework. This involves their meaningful decision-making roles in shaping policy priorities and strategies, and diverse representation that reflects the demographic makeup of adversely affected communities.

Improving Maternity Care Through Midwifery

The U.S. maternity care system fails to provide many childbearing people[†] and newborns with equitable, accessible, respectful, safe, effective, and affordable care.[1] More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income nation.[2] Our maternity care system spectacularly fails communities struggling with the burden of structural inequities due to racism and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.[3]

Rates of maternal death and severe maternal morbidity in the United States have been worsening instead of improving. In 2019, the U.S. maternal mortality rate was 20.1 per 100,000 live births, a significant increase over the maternal mortality rate in 2018 (17.4 per 100,000 live births).[4] Between 1987 and 2017, pregnancy-related deaths in the United States more than doubled – from 7.2 to 17.3 deaths per 100,000 live births.[5] Between 2006 and 2015, severe maternal morbidity (SMM), often reflecting a "near miss" of dying, rose by 45 percent, from 101.3 to 146.6 per 10,000 hospitalizations for birth.[6] Following the 2015 shift to a new clinical coding system (ICD-10-CM/PCS), SMM continued to show a trend of increase, overall and for people of color, from 2016 to 2018.[7]

In communities of color, the crisis is far greater. Compared to white non-Hispanic women, Black women are more than three times as likely – and Native women are more than twice as likely – to experience pregnancy-related deaths. Moreover, Black, Hispanic, and Asian and Pacific Islander women disproportionately experience births with SMM relative to white non-Hispanic women.[8] In 2015, relative to white non-Hispanic women, the rate of SMM was 2.1 times higher for Black women, 1.3 times higher for Hispanic women, and 1.2 times higher for Asian and Pacific Islander women.[9] From 2012 through 2015, Indigenous women experienced 1.8 times the SMM rate of white women.[10]

Many factors drive maternal mortality and morbidity and the deep racial, ethnic, and geographic inequities in this area. These include gaps in health coverage and access to care; poor quality care, including implicit biases and explicit discrimination; unmet social needs, like transportation and time off from paid work for medical visits and safe and secure housing; and for people of color, the effects of contending with systemic racism.[11] The terrible impacts of these inequities are unconscionable, especially considering that 60 percent of pregnancy-related deaths are preventable.[12]

[†] We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report gives preference to gender-neutral terms such as "people," "pregnant people," and "birthing persons." In references to studies, we use the typically gendered language of the authors.

In the long term, we must transform the maternity care system through levers such as delivery system and payment reform, performance measurement, consumer engagement, health professions education, and the improvement of the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that there are specific care models that make a concrete difference in providing higher quality care and improving birth outcomes. Midwifery care is one example of better care that we must make widely available, especially for birthing people and families of color.[§]

Midwifery in the United States.

Midwifery provides high-quality and high-value care to childbearing people. In general, midwifery is a high-touch, low-tech approach to maternity care. The midwifery model is based on the core understanding that childbearing for most birthing people is a healthy process that requires protecting, supporting, and promoting innate physiologic processes and monitoring to identify when higher levels of care are needed. It centers the childbearing person and family. The midwifery model of care emphasizes a trusted relationship, health-promoting practices, providing information that birthing people need to make their own care decisions, and personalized care tailored to individual needs and preferences.

In nearly all nations, midwives provide first-line maternity care to childbearing people and newborns. However, in the United States, the vast majority of births are attended by obstetricians, while midwives attend only about 10 percent of births.[13] In the early 20th century, pregnancy and childbirth in the United States were reframed as medical – even pathological – conditions, rather than what in most cases was a healthy physiologic life process. Birthing shifted from happening at home, attended by midwives of all backgrounds and traditions, to occurring in hospitals dominated by white men who saw childbirth as a medical problem to be solved with an array of drugs, treatments, and interventions. Medicine's denigration and elimination of Black, Indigenous, immigrant, and other community midwives is another example of racism pervading our society and health care system.[14] Both racism[15] and gender-based violence toward birthing people[16] have been well documented in obstetrics.

In contrast to the medical focus on childbirth pathology, physiologic childbirth approaches birthing from a more holistic frame that avoids unneeded medical interventions. This type of care, which is a hallmark of much midwifery care, actively supports the innate capabilities of birthing people and their fetus or newborn for labor, birth, breastfeeding, and attachment. Medical interventions are used judiciously, as needed, and not as routine practices.[17] Although any type of maternity care provider can theoretically offer the midwifery model of care and can foster physiologic birth, midwives do so most consistently.[18]

[§] To learn more about three other models of high-quality maternity care – doula support, "community birth" (birth centers and planned home births), and community-led perinatal health worker groups – see our foundational report, *Improving Our Maternity Care Now,* at www.nationalpartnership.org/improvingmaternitycare.

As in other countries, U.S. midwives holding nationally recognized credentials provide expert care for birthing people.

The midwifery model of care is less pathology-focused and procedure-intensive than medical approaches to care of birthing people. For example, midwives regularly use non-pharmacologic tools to help manage pain, such as tubs and showers, hot and cold compresses, exercise balls, and massage. Hospital-based midwives also have access to epidural analgesia and other technologies. Dependent on hospital protocols and culture of practice, as well as the needs and preferences of people with hospital births, the overall style of practice of hospital-based midwives can involve more interventions than midwives practicing in birth centers and at home.[19]

Just as in the broader society and health care system, racism is present in midwifery. Since the transition to obstetric and hospital dominance, midwifery has been a disproportionately white profession.[20] Efforts to combat racism in midwifery and diversify the profession are underway.[21] Culturally congruent community-based and -led models of midwifery care are especially powerful.[22] The work of groups such as the National Black Midwives Alliance and other birth justice organizations brings an essential lens for conducting analysis, reclaiming suppressed traditions, and healing racial harm and trauma.[23]

As in other countries, U.S. midwives holding nationally recognized credentials provide expert care for birthing people. They are educated to identify when a birthing person needs higher levels of more specialized care than midwives can provide. Midwives may consult, share care, transfer care, or transport birthing people and newborns to specialty care when higher risks and complications emerge.[24] Most births in the United States occur in hospitals, and most midwives attend births in hospitals. However, nearly all maternity care providers in birth center and home birth settings are midwives.[25]

The United States has three nationally recognized midwifery credentials with education programs recognized by the U.S. Department of Education: certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs). The latter two credentials were recognized more recently, in the 1990s. All three credentials are accredited by the National Commission for Certifying Agencies, the accrediting body of the Institute for Credentialing Excellence.

Both CNMs and CMs have completed graduate-level midwifery training accredited by the Accreditation Commission for Midwifery Education (ACME). Both sit for the same national certification exam administered by the American Midwifery Certification Board (AMCB). CNMs are required to hold a nursing degree in addition to their midwifery training, while CMs are

not. They both provide care in all three birth settings (hospitals, birth centers, and homes). While CNMs are licensed to practice and are Medicaid and Medicare providers in all jurisdictions, CMs are currently recognized in only nine states and can be paid by Medicaid in four.[26]

The CPM credential requires knowledge and experience in community birth – that is, care in birth centers or homes.[27] Midwives qualify to become CPMs through graduating from a school accredited by the Midwifery Education Accreditation Council (MEAC) or by completing the Portfolio Evaluation Process (PEP). Regardless of route of education, all CPMs are required to achieve the same clinical and academic competencies and sit for the national certification exam administered by the North American Registry of Midwives (NARM). The CPM credential is competency-based; demonstrating achievement of the competencies is required, while a degree is not. Nonetheless, about half of all CPMs practicing in the United States hold a bachelor's degree or higher.[28] Five of the MEAC-accredited schools confer a diploma, and five confer associate, bachelor's, or master's degrees.[29] Currently, 34 states and the District of Columbia have a path to CPM licensure, with ongoing efforts for legal recognition in the remaining states and U.S. territories. Medicaid covers CPM services in 16 jurisdictions.[30]

Midwives with Nationally Recognized Credentials: CNMs, CMs and CPMs[31]

Credential	Degree	Setting	Legal recognition	Medicaid coverage
Certified nurse-midwife (CNM)	RN + master's degree	Hospital, birth center, home	All states, DC, U.S. territories*	Yes, by federal statute
Certified midwife (CM)	Bachelor's + master's degree	Hospital, birth center, home	9 states: DE, HI, ME, MD, NJ, NY, OK, RI, VA	4 states: ME, MD, NY, RI
Certified professional midwife (CPM)	High school diploma or equivalent; may earn certificate, associate's, bachelor's, or master's degree	Birth center, home	34 states + DC (all except CT, GA, IA, IL, KS, MA, MO, MS, ND, NE, NC, NY, NV, OH, PA, WV, and U.S. territories)	15 states + DC: AK, AZ, CA, DC, FL, ID, MN (birth centers only), NH, NM, OR, SC, TX (birth centers only), VA, VT, WA, and WI

*The U.S. territories are American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

Midwifery care provides equal or better outcomes compared to usual care

Several systematic reviews** have compared the care and outcomes of midwives and physicians. Compared to physician care, midwifery care resulted in:

- Increased use of intermittent auscultation (instead of continuous electronic fetal monitoring)
- Less use of epidural or spinal analgesia
- Less use of pain medication overall
- Fewer episiotomies
- Increased spontaneous vaginal birth (with neither forceps nor vacuum)
- More vaginal births after a cesarean
- Greater initiation of breastfeeding
- Better psychological experience (e.g., sense of control or confidence, satisfaction)
- Lower costs

Physicians and midwives produced similar results with regard to:

- Use of IV fluids in labor
- Maternal hemorrhage (excess bleeding)
- Signs of fetal distress in labor
- Condition of newborn just after birth
- Admission to a neonatal intensive care unit (NICU)
- Fetal loss or newborn death

For some indicators, systematic reviews varied in their conclusions. Compared to physicians, midwives had similar or better results for:

- Hospitalization in pregnancy
- Preterm birth
- Low birth weight
- Labor induction
- Use of medicine to speed labor
- Cesarean birth[32]

Other researchers have found that states that have more fully integrated midwifery care tend to have better maternal and infant health outcomes. More integrated states (measured by indicators such as regulation of the profession, Medicaid payment for their services, and the degree to which regulations support autonomous practice) were more likely to report higher rates of physiologic childbearing, lower rates of cesarean and other obstetric interventions, lower risk of adverse newborn outcomes (preterm birth, low birth weight, and infant mortality), and increased breastfeeding both at birth and at six months postpartum.[33]

Similarly, the availability of midwifery care at the hospital level has been associated with less use of labor induction, medication to speed labor, and cesarean birth, and greater likelihood of vaginal birth, including vaginal birth after a cesarean, than hospitals with physician-only maternity services.[34]

** A systematic review is a method of assessing the weight of the best available evidence about possible benefits and harms of interventions or exposures. An investigation by the Institute of Medicine found that this rigorous methodology is the best way of "knowing what works in health care." Institute of Medicine. Knowing What Works in Health Care: A Roadmap for the Nation. (Washington, DC: The National Academies Press, 2008), https://doi.org/10.17226/12038

Midwives who provide racially centered or congruent care can offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.

Higher percentages of midwife-attended births at hospitals have been associated with lower rates of cesarean birth and episiotomy.[35]

In light of the intractable maternal health crisis plaguing the country, investing more resources in training and supporting high-quality, high-value midwifery care is a powerful strategy for rapidly expanding access to effective maternity care services. Compared to the time and money it takes to train an obstetrician or family physician, midwives can be educated to serve pregnant people and their families more quickly and at a lower cost.[36] Thus, midwifery is an expedient pathway to a more diverse cadre of maternity care providers that more closely mirrors the racial and ethnic composition of childbearing people.

People have positive experiences with midwifery care and interest in using it is high

In recent years, concerns about disrespectful maternity care have come to the fore, and many childbearing people – including those with tragic outcomes – have reported being ignored, having their concerns dismissed, not having choices in care, and otherwise being mistreated.[37] Two systematic reviews found that people who received midwifery care were more likely to report feeling more control, confidence, and satisfaction than people who received physician-led care.[38]

In addition, midwives who provide racially centered or congruent care can offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.[39] Increasing the diversity of the midwifery profession would enable more birthing people of color to obtain high-quality care that helps mitigate the racism embedded in maternity and other types of health care.[40]

Birthing people's interest in midwifery care far exceeds their current access and use. For example, in the population-based *Listening to Mothers in California* survey, six times as many participants with 2016 births indicated an interest in midwifery care should they give birth in the future, compared to people who actually received midwifery care. A total of 54 percent expressed some degree of interest, with 17 percent stating they would definitely want midwifery care, and 37 percent stating they would consider this type of care provider. Interest was especially high among Black women (66 percent), and interest among women with Medi-Cal (California's Medicaid program) was similar to that of women with private insurance.[41]

Spotlight on Success

MERCY BIRTHING CENTER

The Mercy Birthing Center illustrates the potential of a flourishing midwifery-led unit within a hospital. The center is a separate unit operated by CNMs within Mercy Hospital St. Louis. It was established in response to women's growing interests in receiving support for physiologic childbearing.[42]

The homelike center includes four birthing suites with tubs and showers, a central living room and kitchen, an area for classes, and rooms for prenatal and postpartum and newborn visits.[43] The center offers comfort measures as well as nitrous oxide ("laughing gas") to help women cope with labor. The midwives use handheld devices for monitoring the fetal heart status ("intermittent auscultation"). In contrast to many typical hospital settings, laboring women are free to eat, drink, and move about, according to their interest, and to give birth in their position of choice. If they need higher levels of care (for example, an epidural or continuous electronic fetal monitoring) or develop a complication or concern, their midwife can accompany them upstairs to the standard labor unit and continue to care for them there. Care by obstetricians and maternal-fetal medicine specialists is available if needed.[44]

The center's care and outcomes contrast sharply with standard hospital birthing care:

- Their **cesarean rate is 70 percent lower** than that national average (less than one out of 10 births, compared to one in three).
- Their **rate of vaginal births after a cesarean (VBAC) among women planning to have one is up to 40 percent higher** (84 percent compared to usual rates of 60 to 80 percent, depending on the study).[45]
- Their **episiotomy rate is only 0.4 percent,** compared to 6.9 percent among hospitals reporting in 2018 – more than 17 times higher.[46]
- Their **epidural rate was 6.4 percent,** versus 75 percent nationally in 2019.[47]
- Their **labor induction rate (8.7 percent) was 68 percent lower than national rates** reported on 2019 birth certificates.[ǂ, 48]

In addition to these excellent clinical outcomes, 100 percent of their clients reported they would recommend this care to friends.

ǂ It is important to note that birth certificates are known to greatly undercount inductions. For example, women in California who gave birth in 2016 reported a rate of 40 percent.

Access to midwifery care is limited

Despite the clear value of midwifery care, especially as a pathway to help solve the nation's maternal health crisis and obtain better outcomes for birthing people and infants, there are significant limitations to its availability. One indicator of limited access is the gap between the number of people who say they are interested in midwifery care – the majority – and the number who actually use it, which is roughly one in 10. Another indicator of lack of access is that in 2017, 55 percent of U.S. counties did not have a single practicing certified nurse-midwife or certified midwife. Moreover, roughly one in three U.S. counties that year were considered maternity care deserts, meaning that the county had neither an obstetrician-gynecologist, nor a nurse-midwife, nor a hospital maternity unit.[49]

The American College of Obstetricians and Gynecologists recommends increasing the number of midwives as an essential strategy to solve this access crisis.[50] The availability of midwifery care is influenced by the supply and distribution of midwives and birthing facilities. CMs are only licensed in nine states, and CPMs still are not licensed in 16 states and U.S. territories. A model legislation process undertaken by leading midwifery organizations points the way to robust, woman-centered midwifery legislation.[51]

Another factor that limits the supply of midwives is the lack of consistent, systemic support for midwifery education and educators, including preceptors, parallel to Medicare's support for medical residencies. As a result, the burden on midwifery educators (as well as student tuitions) and on preceptors is great. This is also a limiting factor in the availability of midwives to share their distinctive knowledge and first-line approaches to maternal-newborn care with medical students and trainees, and nursing and other students.[52] The Further Consolidated Appropriations Act of 2020 included $2.5 million for this purpose, and a bill introduced in the current Congress would greatly expand support for CNM, CM, and CPM accredited education. Both initiatives are grounded in an equity framing to help with the crucial goals of diversifying the midwifery profession and improving the geographic distribution of midwives.

Another barrier to increased access to midwifery care is the time intensiveness

Despite the clear value of midwifery care, especially as a pathway to help solve the nation's maternal health crisis and obtain better outcomes for birthing people and infants, there are significant limitations to its availability.

of this relationship-based model of person-centered care. Midwifery care often involves longer office visits and significantly more time waiting for labor to progress naturally, rather than accelerating it with medications and procedures, so providing adequate payment can be a challenge. Across states, Medicaid payment for CNMs/CMs ranges from 70 percent to 100 percent of physician payment for the equivalent service.[53] However, Medicaid payment levels vary widely and the average payment for CNMs/CMs is just 65 percent of the CNM Medicare fee schedule rate.[54]

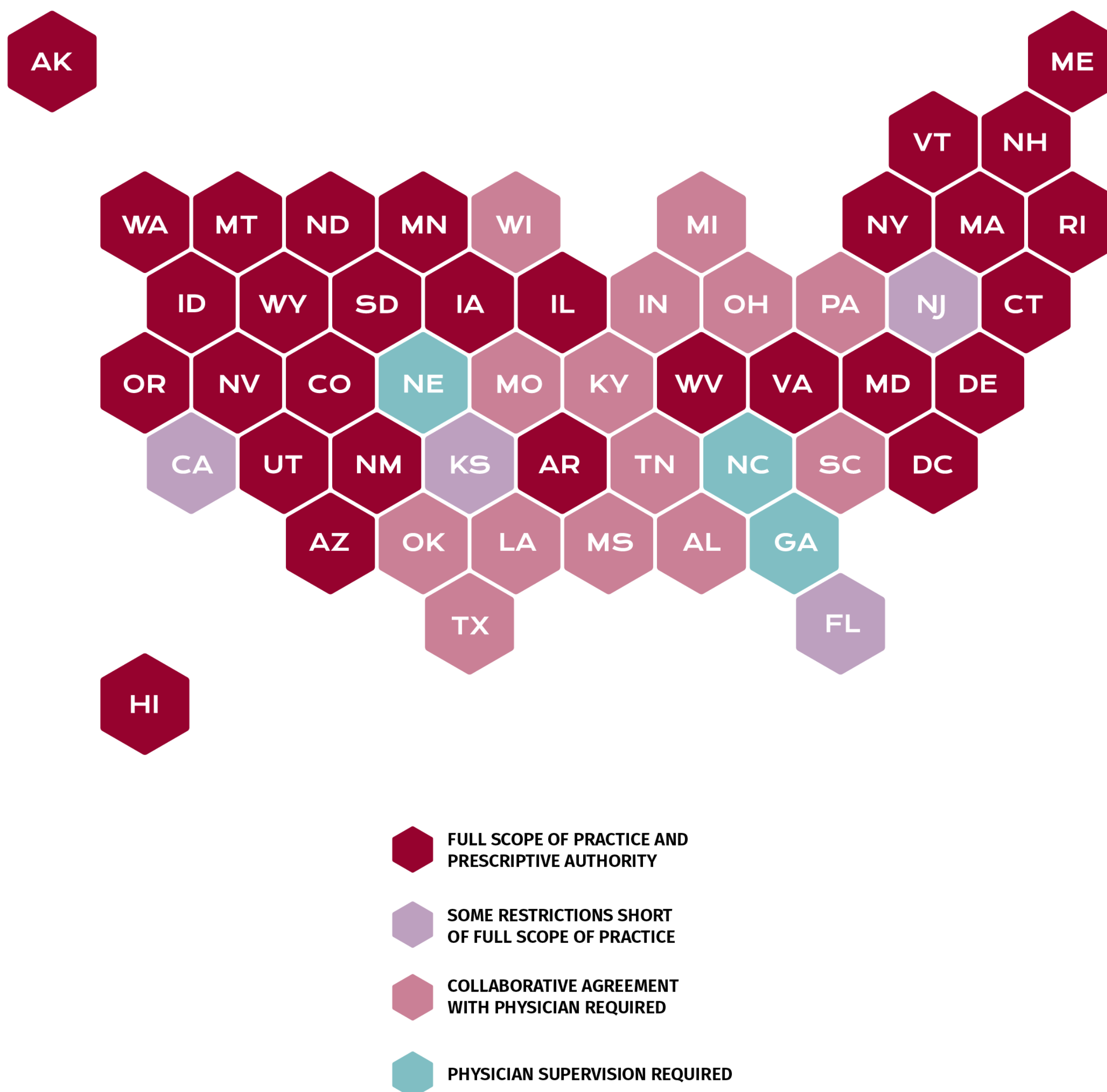
Lastly, unnecessarily restrictive practice acts that, for example, require these independent professionals to have physician supervision or a collaborative practice agreement, limit their prescriptive authority, or limit their reimbursement, are associated with reduced midwifery practice, and thus appear to limit the access of birthing people to midwifery care. For example, compared with restricted scope of practice, full scope is associated with more than twice as many CNMs/CMs per women of reproductive age and per total births, and fewer counties with no CNMs/CMs.[55]

Policymakers can take many steps to increase access to midwives and the freedom of midwives to practice according to the full scope of their education and competencies. Although certified nurse-midwives are licensed to practice and reimbursed by Medicaid in all 50 states, the District of Columbia, and the U.S. territories, many practice acts place unnecessary restrictions on these autonomous practitioners. These include written agreements with physicians and even requirements for physician supervision (Figure 1).

Among the nine states that currently regulate certified midwives, Medicaid pays for their services in just four states, and just four states authorize them to practice according to the full scope of their education and competencies. Restrictions include requirements for written agreements with physicians, failure to authorize prescriptive authority, and limiting practice to just community-based maternity services versus the primary care, well-woman care, and hospital-based services within their competencies and education (Figure 2).

Currently, 16 states and the U.S. territories do not regulate certified professional midwives. Among the jurisdictions that legally recognize them, Medicaid programs do not pay them in 19 states (Figure 3). Current statutes authorize highly variable scopes of practice. [56]

FIGURE 1. CERTIFIED NURSE-MIDWIVES (CNMs): SCOPE OF PRACTICE



Note: Certified nurse-midwives are licensed to practice and reimbursed by Medicaid and Medicare in all 50 states and the District of Columbia.

Source:
American College of Nurse-Midwives. "Quick Reference: Practice Environments for Certified Nurse-Midwives as of April 2021," https://campaignforaction.org/wp-content/uploads/2021/01/certified-nurse-midwives-Practice-Environment-4-2021.pdf

FIGURE 2. CERTIFIED MIDWIVES (CMs): REGULATION, MEDICAID REIMBURSEMENT, AND SCOPE OF PRACTICE

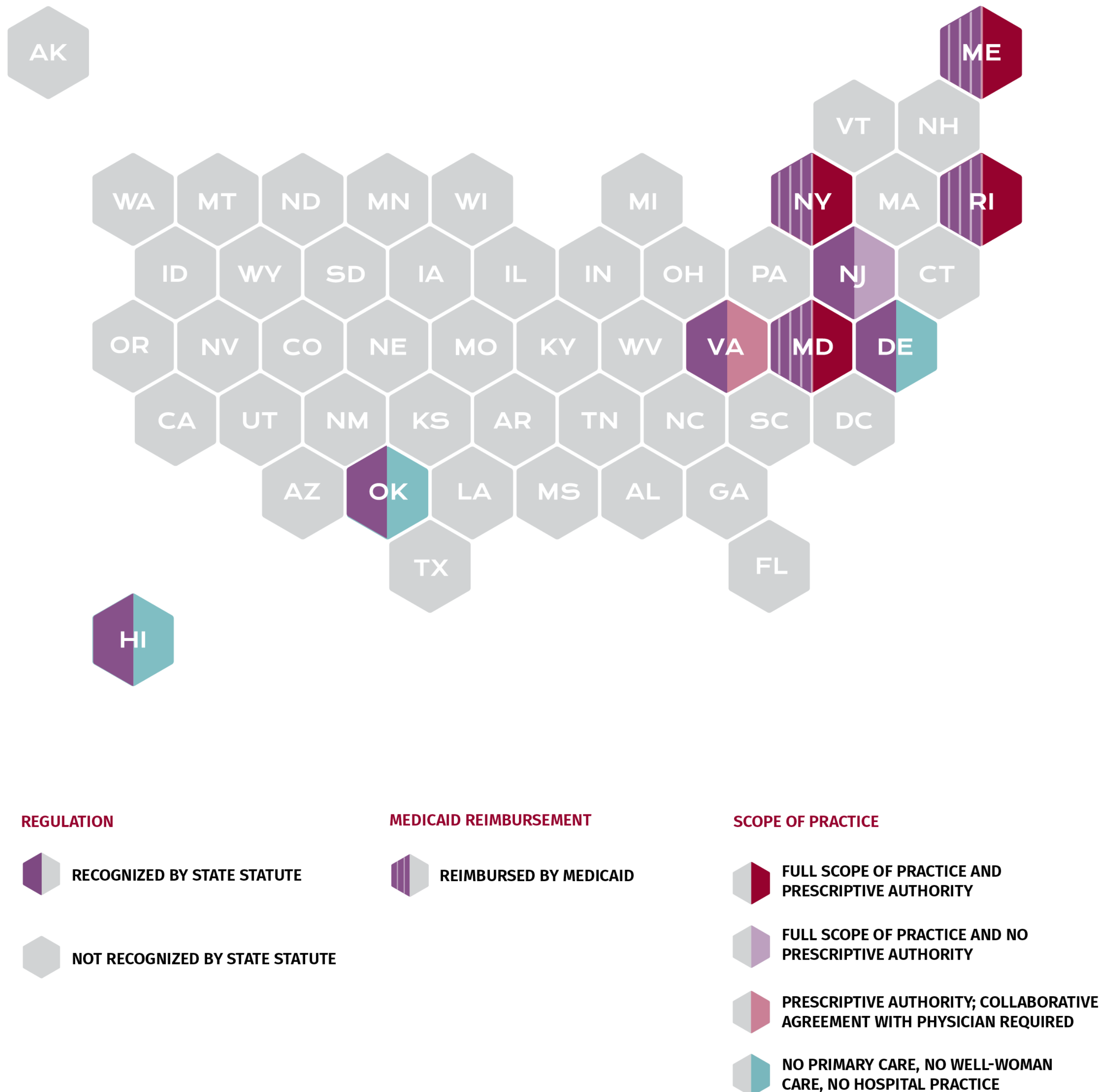


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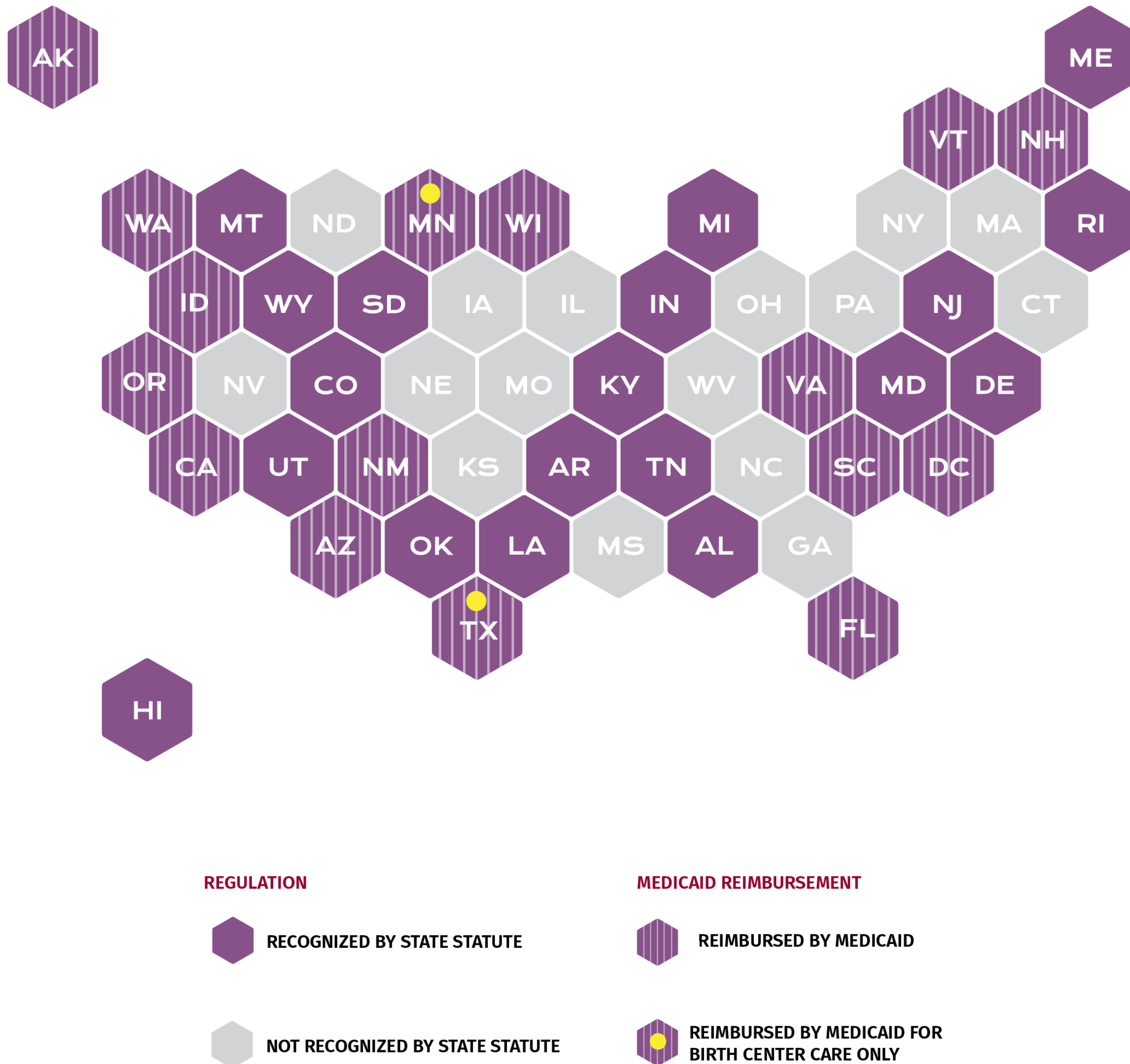
FIGURE 3. CERTIFIED PROFESSIONAL MIDWIVES (CPMs): REGULATION AND MEDICAID REIMBURSEMENT



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RECOMMENDATIONS TO INCREASE ACCESS TO MIDWIFERY CARE

Midwives have a distinctive, dignifying, person-centered, skilled model of care and an exemplary track record. They are an important part of the solution to the nation's need for a higher-performing maternity care system and shortage of maternity care providers. However, there are barriers to enabling more childbearing people and families to experience benefits of midwifery care and to diversifying the profession of midwifery.

Federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3352 and S. 1697 in the 117th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (CNMs, CMs, CPMs) by supporting students, preceptors, and schools and programs. It would give funding preference to programs supporting students who would diversify the profession and who intend to practice in underserved areas.
- Mandate equitable payment for services of CMs and CPMs recognized in their jurisdiction by Medicaid, the Child Health Insurance Program (CHIP), TRICARE (the military health care program), the Veterans Health Administration (VHA), the Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service, and make CMs and CPMs eligible to qualify for federal loan repayment from the National Health Service Corps.
- Mandate that hospitals cannot deny admitting and clinical privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sexual orientation, gender identity, language, and disability status in critical indicators of maternal and infant health – including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

- In all relevant deliberations, consistently engage early and proactively with community-based midwives bringing a birth justice framework. This involves their meaningful decision-making roles in shaping federal policy priorities and strategies, and diverse representation that reflects the demographic makeup of adversely affected communities.

State and territorial policymakers should:

- In jurisdictions that currently fail to recognize them, enact CM and CPM licensure. For CMs, these include all of the territories, the District of Columbia, and all states except Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, and Virginia. Jurisdictions that have yet to recognize CPMs through licensure are: Connecticut, Georgia, Iowa, Illinois, Kansas, Massachusetts, Missouri, Mississippi, North Dakota, Nebraska, North Carolina, New York, Nevada, Ohio, Pennsylvania, West Virginia, and all U.S. territories.
- Amend unnecessarily restrictive midwifery practice acts to enable full-scope midwifery practice, in line with their full competencies and education as independent providers who collaborate with others according to the health needs of their clients.
- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for services of CMs and CPMs licensed in their jurisdiction, mandate payment at 100 percent of physician payment levels for the same services. Currently, Delaware, Hawaii, New Jersey, Oklahoma, and Virginia recognize CMs but do not pay for their services through Medicaid. States that regulate CPMs yet fail to pay for their services through Medicaid are: Alabama, Arkansas, Colorado, Delaware, Hawaii, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota (does not pay for home birth services), Montana, New Jersey, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas (does not pay for home birth services), Utah, and Wyoming.

- In all relevant deliberations, consistently engage early and proactively with community-based midwives bringing a birth justice framework. This involves their meaningful decision-making roles in shaping state and local policy priorities and strategies, and diverse representation that reflects the demographic makeup of adversely affected communities.

Private sector decisionmakers, including purchasers and health plans, should:

- Incorporate clear expectations into service contracts about access to, and sustainable payment for, midwifery services offered by providers with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of maternity care provided by midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.
- In relevant policy deliberations, consistently engage early and proactively with community-based midwives bringing a birth justice framework. This involves their meaningful decision-making roles in shaping private sector policy priorities and strategies, and diverse representation that reflects the demographic makeup of adversely affected communities.

Resource Directory

Midwifery Care

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Midwifery Organizations

- *American College of Nurse-Midwives (ACNM)*
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- *Center for Indigenous Midwifery*
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This report was produced in partnership with the following organizations:

The National Partnership for Women & Families

For 50 years, the National Partnership for Women & Families has worked to advance every major policy impacting the lives of women and families. The National Partnership works for a just and equitable society in which all women and families can live with dignity, respect, and security; every person has the opportunity to achieve their potential; and no person is held back by discrimination or bias. The National Partnership's robust maternal health programming focuses on transforming the maternity care system to be equitable and high-performing, and effectively and respectfully meeting the current needs of childbearing families, especially those experiencing the ongoing effects of centuries of racist and inequitable social policies and conditions.

American College of Nurse-Midwives

The American College of Nurse-Midwives (ACNM) is the professional association that represents advanced practice midwives (Certified Nurse-Midwives and Certified Midwives) in the United States. ACNM's members are primary health care clinicians who provide evidence-based midwifery care for women and gender-nonconforming people throughout the lifespan, with an emphasis on pregnancy, childbirth, gynecologic, and reproductive health care. ACNM works to promote equity, diversity, and inclusion throughout the midwifery profession and across the care continuum to ensure better health care outcomes for the people midwives serve. The ACNM and its members stand for increasing access to advanced practice midwives and midwifery-led care models and support policy solutions that ensure guaranteed health coverage and access to a full range of sexual and reproductive health services.

National Association of Certified Professional Midwives

The National Association of Certified Professional Midwives (NACPM) represents Certified Professional Midwives (CPMs) in the U.S. As holders of one of three nationally recognized midwife credentials, CPMs are primary perinatal care providers. They provide unique and critical access to normal physiologic birth, which profoundly benefits birthing people and their newborns. As community-based midwives offering care in homes and free-standing birth centers, CPMs have a vital role to play in providing services in communities most affected by inequities in birth outcomes, where the need is most urgent, the outcomes the poorest, and services currently most limited. Founded in 2001, NACPM directs its influence toward improving outcomes for all childbearing people and their infants; developing, strengthening, and diversifying the profession; and informing public policy with the values inherent in CPM care.

National Black Midwives Alliance

The National Black Midwives Alliance is the only professional alliance of Black midwives in the United States. Its goal is to have a representative voice at the national level that clearly outlines the various needs of Black midwives. The alliance represents all pathways to midwifery, including traditional, licensed, student, and retired Black midwives representing a range of practice experience from hospital and clinic, to home and birth center settings. NBMA's objectives include increasing the number of Black midwives and access to Black midwives so as to have more providers who can impact perinatal health disparities, raising public awareness about the existence and contributions of Black midwives, and eliminating barriers to the profession while supporting educational pathways for Black student midwives.

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