Maternal Health Equity in Medicaid: Midwifery-Led Model of Care

Policy Issues and Opportunities to Inform a National Strategic Plan

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There is growing political interest in preserving, restoring, and extending Medicaid coverage for services and supports for women, gender, and maternal health. As federal and state policymakers consider opportunities to improve outcomes, they have been exploring a myriad of options, including community-based models of care, such as doulas and midwives; extension of 12-month postpartum coverage; and access to sexual and reproductive health services. As policies are adopted and payment models are created, the Medicaid program will serve an important role in implementing these innovative changes, including evaluating health outcomes and assessing economic impact and sustainability. Although efforts are underway in almost every state across the United States, a national strategic agenda in maternal health in Medicaid that links all stakeholders and partners together has not been established. The lack of coordination creates inefficiencies in accomplishing shared goals. In response, the Institute for Medicaid Innovation partnered with the Aspen Institute to host a Medicaid policy summit in the fall of 2023. To inform the focus of the summit, a national survey was deployed and a focus group convened to ascertain the priority topics as identified by key stakeholders in Medicaid: federal and state policymakers, Medicaid health plans, national and state leaders, and most importantly, individuals with lived experience. The results of the investigative work identified the following priority topics: maternal mental health, doulas and perinatal community health workers, midwifery-led models of care, and prenatal-to-3.

Addressing the maternal mortality and morbidity crisis and improving maternal health equity in the United States will require a multipronged approach of coordinated efforts from a range of stakeholders using evidence-based strategies. One such strategy is increasing and improving access to midwifery-led models of

care. A midwife is a clinician who is trained to provide comprehensive services and, when practicing in a midwifery-led model of care, is the lead professional in the planning, organization, and delivery of perinatal and maternal care provided to an individual from initial booking through the early postnatal period.[1,2] There are three groups of nationally credentialed midwives in the United States—certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs)—as well as licensed midwives, who do not hold a national credential but are licensed by states. CNMs and CMs' scope of practice encompasses care during pregnancy, childbirth, and the postpartum period; life course sexual and reproductive health primary care; and care for the healthy newborn during the first 28 days of life. CNMs and CMs practice primarily in hospitals, with a growing number practicing in homes and birth centers. CPMs are community-based primary perinatal and maternity care providers whose scope of practice includes pregnancy, birth, and postpartum (including life course wellness care) and newborn care, in a birth center or home setting. Although there is a complex and varying landscape of educational pathways, licensure, regulation, and scope of practice among the types of midwives, all midwives are educated in the same perinatal and maternity care competencies to practice the midwifery-led model of care.[3] Research, including systematic reviews, indicates that midwifery care, regardless of credential, is associated with a lower likelihood of labor induction, fewer Cesarean sections, lower preterm birth rates, higher chest/breastfeeding initiation rates, and increased satisfaction of care and sense of autonomy for the individual giving birth.[3–5]

This issue brief outlines the policy issues and opportunities related to the midwifery-led model of care.

Policy Issues

Understanding the policy landscape and political factors impacting access to and coverage of midwives for those enrolled in Medicaid is key to developing solutions that successfully leverage the midwifery-led model of care to address poor maternal health outcomes in the United States.

Workforce

Persistent workforce shortages exist in perinatal and maternity care in the United States. During the COVID-19 pandemic, there was a substantial need for midwives as the demand for home and community births grew. Community births increased by 19.5% and planned home births increased by 23.3% due to concerns including contracting COVID-19 in hospitals, limitations on hospital support, and separation of parent and baby.[4] There is great interest and demand for midwifery care that remains unmet, especially for Black individuals.[5] In 2021, less than 12% of births in the United States had a midwife as the primary provider, and only 2% of births occurred in a nonhospital setting such as a freestanding birth center, clinic, or home.[6,7] Within the first 5 years of initial certification for CNMs and CMs, 30% left clinical practice. Almost half of CNMs and CMs left clinical practice within 10 years from initial certification.[8] Recently, 2,333 CNMs and CMs participated in one of the largest burnout studies conducted on a profession. Overall, midwives reported comparable stress levels to those of OB/GYNs and a higher rate of burnout compared to labor and delivery nurses.[8]

Having a maternal health workforce that is diverse and able to match the racial and ethnic composition of the population served is an important step in eliminating racial maternal health disparities. Only 7% of CNMs and CMs identify as Black, while 86 percent identify as white.[9] The bipartisan Midwives for MOMS Act of 2023 (H.R. 3768) in the 118th Congress aims to increase the number of midwives (CNMs, CMs, and CPMs), diversify the midwifery workforce racially and ethnically, and overall increase access to care. The bill supports midwifery schools, programs, students, and preceptors, providing funding preference to those who racially or ethnically diversify the workforce and those with intent to serve in an area with a maternal health professional shortage.[10]

Payment

Title 42 U.S.C. § 1396, which established the Medicaid and CHIP Payment and Access Commission, requires Medicaid to cover services in birth centers and those provided by CNMs, while other types of midwives are not explicitly included.[11] There is a complex national landscape for public and private reimbursement for CPMs that too often results in a lack of access to their care, in part due to a lack of licensure in several states.[12] In 20 states, Medicaid reimburses CNMs at a lower rate than physicians for the same services.[13] In hospital settings, midwives are reimbursed at higher rates compared to birth centers.[14] The CNM reimbursement rate varies by the Medicaid managed care organization in various states.[13] This can create a substantial financial challenge for midwives to provide care.[15] Due to low reimbursement rates, and in order to remain financially sustainable, many midwives can only take a small percentage of individuals enrolled in Medicaid or none at all, especially those operating a birth center in a rural area.[14] Furthermore, these inequitable reimbursement rates negatively impact individuals enrolled in Medicaid because they have decreased access to midwifery care compared to their privately insured counterparts.

Medicaid payment models are based on global billing codes that do not take into account the holistic care provided by midwives, which include more time-consuming activities such as more frequent and longer visits and longer labor that progresses naturally. To be reimbursed at an increased rate, many midwives use "incident to" billing, which allows services provided by CNMs to be reimbursed at 100% of the physician rate by billing under a physician's name and national provider identifier number.[16] In this scenario, the role and impact of midwives on birth outcomes become invisible in data collection activities since the work is attributed to physicians. Additionally, to be reimbursed, Medicaid may require midwives who practice in nonhospital settings to pay for their own malpractice insurance, which in such a small market can be a financial hardship.

Data and Quality

Although decades of data-driven evidence supporting midwifery-led models of care exists, data and quality measures can be challenging for midwives in the United States. Many practices do not have standardized tracking and reporting on financial and clinical outcomes. Quality measures in perinatal and maternity care generally emphasize outcomes, many of which are hospital-focused, such as admission to neonatal intensive care unit, Apgar scores, Cesarean section, and instrumental birth.[17] Since quality metrics are not designed to reflect the midwifery clinical care process, there are barriers in measuring the quality of midwifery care.[18] In the United States, data are too often not systematically collected on intended birth

attendant credential or the intended place of delivery; they are, instead, collected on the attendant and setting in which the birth occurred. Unfortunately, there are no data to adequately and systematically determine the type of provider who cared for an individual at other points throughout the prenatal period and pregnancy, nor are there nationwide data on the number of individuals who may have intended a different birth setting.

Delivery System

The cascade of unwanted and unneeded medical interventions in the United States, also referred to as the "overmedicalization of pregnancy and birth," along with the underuse of beneficial interventions, such as midwifery care, has made childbirth more difficult and less safe for both the birthing individual and infant.[19] These interventions disrupt the normal physiology of pregnancy, labor, and birth because they interfere with hormones that naturally advance labor and birth. This often leads to complications, including increased risk of Cesarean section, infection, maternal mortality, and severe morbidity for the birthing individual and increased likelihood of breathing problems or asthma and stillbirth for the infant.[20-24] An interdisciplinary collaborative care model is one in which obstetricians, family physicians, midwives, and residents are in frequent respectful communication to care for the patient as a team.[25] The collaborative care model is an important step in a cultural shift that de-emphasizes the medicalization of pregnancy and childbirth, which is necessary to improve maternal health outcomes.

Federal, state, and local regulations make it challenging for midwives to be fully integrated into the care delivery system.[21-24] Limitations on the ability of midwives to practice to the full scope of their credential can vary by type of midwife and state. CNMs are legally recognized to practice in every state and Washington, D.C., and CMs are legally recognized to practice in 10 states.[26] Thirty-six states plus Washington, D.C. license CPMs.[27] The scope of practice for all midwives can be limited even when they are licensed.[22, 23] Limitations on scope of practice for CNMs include a requirement by some states to have a collaborative agreement with physicians, which stunts midwifery integration because it requires that CNMs have an established professional relationship with a physician to supervise them.[15]

Policy Opportunities

Numerous Medicaid policy opportunities are specific to the midwifery-led model of care, including addressing midwifery workforce issues, achieving equitable rates of reimbursement, improving data and quality measures, and providing opportunities to fully integrate midwifery into the health care system.

Workforce

Several policy opportunities at the state and federal level address the midwifery workforce issues. Increasing Medicaid coverage of midwives can improve reproductive health care shortages and address perinatal health outcomes. The following actions could improve outcomes in this area:

- Enact Medicaid **reimbursement parity**.
- Encourage states to provide midwives the **right to medical staff privileges**, and to permit them to practice independently (no collaborative agreement mandated by legislation).
- **Encourage states to license all nationally credentialed midwives**, including CNMs, CMs, and CPMs.
- Enact relevant provisions of the bipartisan **Midwives for MOMS Act of 2023** (H.R. 3768) in the 118th Congress.
- Support **funding for preceptors to train student midwives** and mitigate CMS support for institutions that do not allow midwife providers to train student midwives.

Payment

To support the midwifery-led model of care, states have an opportunity to remove barriers to support equitable rates of reimbursement, including:

- Utilize the Medicaid 1115 demonstration waivers and state plan amendments to **reimburse all nationally credentialed midwives**, including CNMs, CMs, and CPMs.
- Adjust reimbursement rates for CNMs, CMs, and CPMs to match **reimbursement rates for physicians**.
- Implement **alternative payment models that account for the midwifery model of care** that include compensation for data collection and tracking.

Data and Quality

States have many opportunities to improve data and quality measures in midwifery-led care including:

- **Develop quality measures that capture the impact of midwifery care.**
- **Mandate systematic data collection and reporting on perinatal and maternal health metrics** across all care settings, including data pertaining to the pregnant individual (e.g., race and ethnicity, socioeconomic status, language); outcome data (e.g., maternal mortality, Cesarean birth, low birth weight); and clinician and setting data (e.g., identification of all clinicians at all stages of the perinatal phase).
- **Require hospitals to capture midwife-specific data** through changes in billing systems.
- **Develop new approaches to evaluate the cost and quality of care provided by midwives**. If reimbursement at 100% of physician rates is guaranteed, "incident to" billing under a physician's national provider identifier number should be removed.

Delivery System

Delivery system reform offers a significant opportunity to integrate midwifery-led models of care into health care delivery systems including:

- **Integrate** midwifery**-led care throughout the care continuum.**
- **Allow** midwives **to practice at the top of their license.**
- **Increase access to midwifery services in all settings**, including hospitals, **freestanding** birth centers, community and home births, community clinics, among other similar settings.
- Employ a **collaborative care model** in hospitals among obstetricians, midwives, and family physicians to **increase a culture of safety, patient-focused care, and interdisciplinary education**.

Looking Ahead: Prioritizing Midwifery-Led Models of Care

This issue brief provides an overview of salient policy issues and opportunities specific to midwifery-led models of care. It provides essential background information to support the establishment of a national 5-year policy strategic plan informed by all Medicaid partners and stakeholders to support increased access and coverage to evidence-based maternal health services and supports that reduces inequities, respects the preferences of individuals with Medicaid insurance, centers care in the community, and strengthens the safety net for families. The Medicaid partners and stakeholders participating in the development of a national 5-year strategic plan will lead, colead, and/or support the commitments that are developed to chart a path forward.

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