REPORT

Workforce Supports: Improving Maternal Health Outcomes

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Workforce Supports: Improving Maternal Health Outcomes

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The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

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- Improve the quality and effectiveness of state legislatures.
- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

The conference operates from offices in Denver, Colorado and Washington, D.C.

Introduction

Maternal mortality rates are not improving in the United States and the number of counties with limited to no maternity care access continues to increase. Each year, more than 30,000 women experience severe maternal morbidity, an "unexpected outcome of labor and delivery that results in significant short- or long-term consequences to a woman's health." Multiple factors contribute to maternal mortality and severe maternal morbidity, including limited access to quality care.

Defining terms

Pregnancy-related deaths are defined as the death of a woman during pregnancy or within one year from the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

Centers for Disease Control and Prevention

Experts have identified increasing access to quality maternity care as one policy lever to reduce maternal mortality and morbidity for populations that are most at risk. Recruiting and retaining a strong and skilled maternal health workforce is one way to increase access, improve quality of care and reduce maternal mortality and morbidity. Supporting an integrated workforce that includes midwives may reduce workforce shortages, and experts identify scaling midwifery as one possible lever to reduce the maternity care crisis for women living in rural communities. Integrating doulas as a support during birth has also been identified as a possible way to reduce adverse birth outcomes.

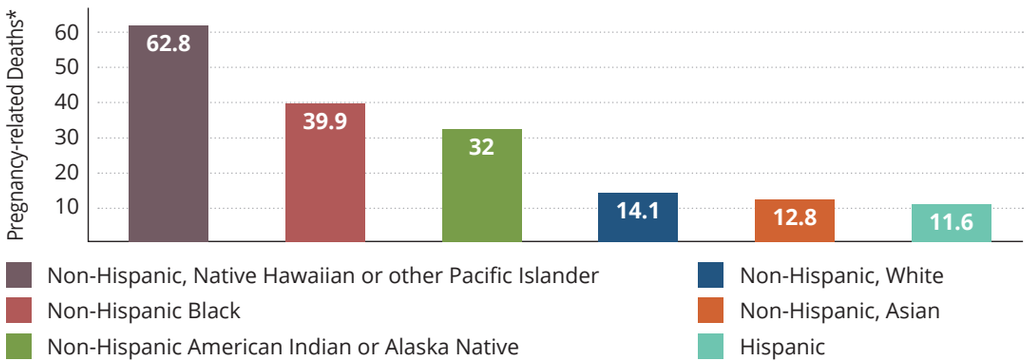
Obstetrician/gynecologists, midwives and doulas can play different, and important, roles in reducing health disparities in maternal morbidity and mortality, and improve access to care. This report highlights these three maternal health professions and related policy options available to state leaders to support and strengthen the workforce and improve maternal health outcomes.

Pregnancy-Related Mortality in the United States

Since 1987, when the Centers for Disease Control and Prevention (CDC) Pregnancy Mortality Surveillance System was implemented, there has been no improvement in the pregnancy-related death ratio in the United States. This data also reveals differences in pregnancy-related mortality ratios by race, ethnicity and geography. Non-Hispanic Native Hawaiian or Other Pacific Islander, Black, and American Indian/Alaska Native women are at least two to four times as likely to die from pregnancy-related causes as non-Hispanic white women. Pregnancy-related mortality is higher in rural counties than urban counties. A recent study found rural residents have a 9% greater likelihood of maternal mortality and severe morbidity than women living in urban areas. According to data from Maternal Mortality Review Committees (MMRCs) in 36 states, approximately 80% of pregnancy-related deaths are considered preventable.

Pregnancy-related Mortality Ratio by Race/Ethnicity

2017-2019



**Per 100,000 live births*

Source: Pregnancy Mortality Surveillance System, Centers for Disease Control and Prevention

Maternal Health Workforce

Experts identify access to a skilled maternal care workforce as an important factor to reduce maternal mortality rates and improve long-term health for women and newborns. The 2022 White House Blueprint for Addressing the Maternal Health Crisis identified workforce as one policy lever available to improve maternal health and access to care.

■ **Obstetrician/Gynecologists:** A physician focused on the health of women before, during and after childbearing years. Diagnosing and treating conditions of the reproductive system and associated disorders, they are licensed to practice both medical and surgical care.

■ **Midwife:** Trained medical professionals who are experts in pregnancy, labor and postpartum care, and can support other aspects of reproductive health. Training and licensing differ by type of midwife.

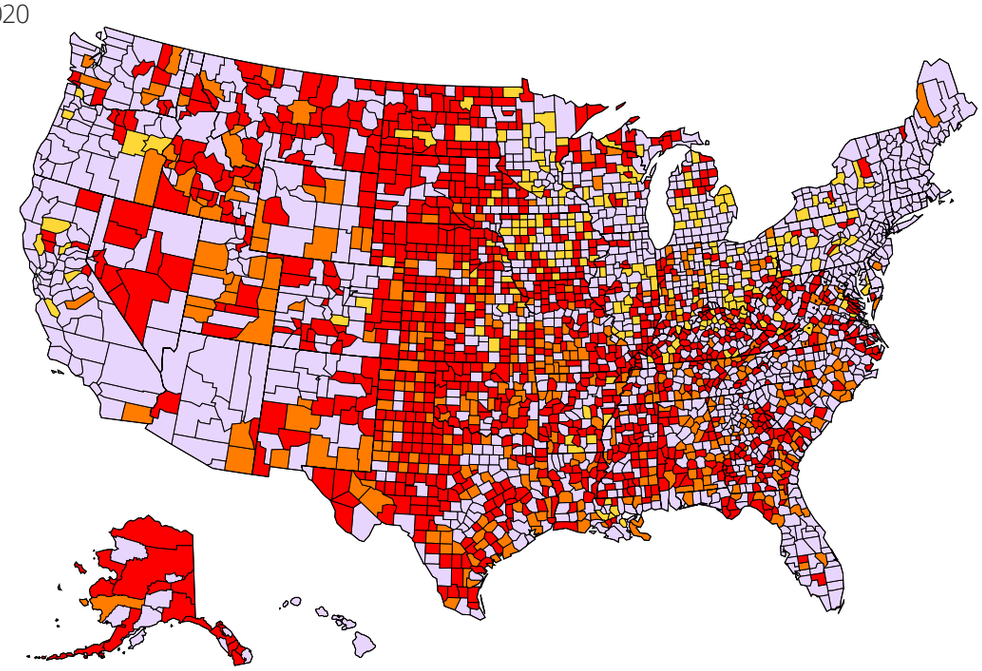
- Certified nurse midwives (CNMs) are midwives with a nursing degree. They are certified through the American Midwifery Certification Board and can legally practice in all 50 states and Washington, D.C.
- Licensed midwives, direct entry midwives and certified professional midwives may enter the profession through a pathway other than nursing. Many states provide licensure and certification for these midwives through state legislation.

■ **Doula:** A non-clinically trained professional who provides continuous physical, emotional and informational support to women before, during and shortly after childbirth.

Shortages and barriers to these professions exist. More than 2.2 million women of childbearing age live in maternity care deserts, counties without birth centers or hospitals offering obstetric care, and no obstetric providers. According to a report from the Centers for Medicare & Medicaid Services, less than half of U.S. women living in rural areas are within a 30-minute drive from a hospital with obstetric services and more than 10% drive 100 miles or more to receive care. Limited access to quality maternity care can contribute to an increased risk of maternal mortality for those living in maternity care deserts, women with lower-income and minority women.

Maternity Care Deserts

2020



Maternity care deserts (1,119)
Low access to care (373)
Moderate access to care (223)
Access to maternity care (1,427)

Source: Maternity Care Deserts Report, March of Dimes, 2022

It is projected by 2030 there will be a shortage of around 5,170 obstetricians to meet demand nationally. Similarly, a recent study found patient demand for midwives and doulas may be higher than the current workforce can provide. This study revealed 66% of Black women would want a midwife for a future birth, while 6% of participants had a midwife during labor and delivery. The same study showed at least 50% of women either wanted a doula or were interested in having a doula for a future birth, while 9% of births were attended by doulas.

Increasing provider choice has been shown to improve access and quality of care, shift perceptions of care and contribute to better health outcomes overall, especially for people of color. Increasing culturally competent providers can contribute to an increased use of health care services, including preventive care. Understanding opportunities to increase preventive care before, during and after pregnancy and labor are a few ways states can support women and reduce factors that can contribute to pregnancy-related complications and death.

Experts have recommended training and education for health professionals to help integrate culturally and linguistically appropriate services and reduce implicit bias, which includes thoughts and feelings that exist outside of conscious awareness and may contribute to negative health outcomes. A few states have also taken action to require training on implicit bias. Michigan requires health professionals such as nurses, physicians and midwives to receive implicit bias training upon licensing and registration renewal. Similarly, Connecticut requires hospitals to begin training staff who regularly work with pregnant or postpartum women on implicit bias. The MCH Navigator portal is a federally supported resource that provides emerging and established maternal health professionals with continuing education opportunities and online trainings.

Obstetrician/Gynecologists

To support obstetrician/gynecologists, states are implementing incentive programs, enhancing training and education opportunities to improve quality of care, and providing reimbursement for telehealth services.

Financial incentive programs are one way to encourage physicians to practice in rural communities and encourage preceptors who are experienced practitioners to train new physicians. Georgia allows rural physicians practicing in family practice, obstetrics and gynecology, pediatrics, internal medicine or general surgery to receive an annual tax credit for up to $5,000 for up to five years. Similarly, Maine's Rural Medical Access Program provides an annual rebate of at least $5,000 for physicians providing obstetrician and prenatal care in underserved areas.

Loan forgiveness programs are another way to incentivize health care professionals to practice in areas with less access to care. New Jersey and Hawaii include obstetricians as eligible providers for their loan repayment programs and Kansas's Bridging Plan is a loan forgiveness program for primary care, obstetricians and psychiatry residents. Each year, the program provides a financial incentive of at least $26,000 in exchange for a 36-month commitment to practice in eligible Kansas counties for up to three obstetrician residents. Maryland's Income Tax Credit for Preceptors provides up to a $10,000 tax credit annually for Maryland physicians, including obstetricians, who serve as preceptors that work in health care workforce shortage areas. Preceptors increase access to care in underserved areas because they ensure clinical training, so physicians can have experience in these geographic areas.

Improving quality of care is often cited as an important lever in reducing maternal mortality and morbidity, especially for women of color. After the Mississippi Maternal Mortality Review Committee (MMRC) identified chronic cardiac disease as a leading cause of preventable pregnancy-related death, the MMRC

worked with the perinatal quality collaborative to implement the Alliance for Innovation on Maternal Health (AIM) Severe Maternal Hypertension Bundle. AIM safety bundles provide best practices for clinicians to put into practice. The Severe Hypertension in Pregnancy Patient Safety Bundle focuses on equipping hospitals and physicians with the tools to manage pregnant and postpartum women with severe hypertension. Nearly all states and Washington, D.C., are enrolled in AIM. In 2019, Illinois required birthing facilities to conduct annual continuing education for obstetric providers, emergency department staff and any other staff that may care for pregnant or postpartum women. The bill requires the continuing education to include annual training on management of severe maternal hypertension and obstetric hemorrhage. The Massachusetts Child Psychiatry Access Program (MCPAP) is a system of regional behavioral health consultation teams designed to support providers caring for children with behavioral health needs. Within this system, the MCPAP for Moms initiative focuses on building the capacity of providers serving pregnant and postpartum women. The initiative provides obstetricians, midwives and primary care physicians with psychiatric consultation for behavioral health concerns, questions around medications when pregnant or breastfeeding, and referrals or connections to community-based services and supports regardless of type of health insurance or gender of the caregiver. Currently, Perinatal Psychiatry Access Programs exist in at least 27 states. At the federal level, the Health Resources and Services Administration's Maternal and Child Health Bureau supports real-time mental health consulting and care coordination and provider training, including obstetrician/gynecologists, in 12 states through the Screening Treatment for Maternal Mental Health and Substance Use Disorders program.

For women living in maternity care deserts or lower access communities, telehealth is a tool obstetricians can consider to deliver pregnancy-related services without an in-person visit. Remote visits through phone call or video may allow for fewer in-person visits. Research suggests fewer prenatal visits are safe for low-risk pregnancies and at-home monitoring for chronic conditions like high blood pressure and diabetes. At least 37 state Medicaid programs provide reimbursement for some type of remote patient monitoring, though often with restrictions. Common restrictions can include limiting the types of conditions or devices that are reimbursable or only reimbursing home health agencies. Where possible, states have the opportunity to ensure obstetricians can maximize their use of state Medicaid programs for telehealth. Some state Medicaid programs specifically address obstetrical care in their telemedicine laws. New York Medicaid recently expanded coverage for remote patient monitoring during pregnancy and up to 84 days postpartum and in 2022, Alabama extended Medicaid coverage to include daily monitoring for patients diagnosed with gestational diabetes.

Midwives

In 2021, around 12% of United States births were attended by a midwife. Midwifery care can be associated with lower rates of cesarean and preterm birth, and newborns with higher birth weight. The increased integration of midwives into the workforce can help increase the overall number of maternal health providers, improve birth outcomes for women and infants and increase patient provider choice. States can consider further integration through policies related to scope of practice and licensure laws, examining Medicaid reimbursement rates, supporting birth centers and other locations where midwives practice and incentivizing participation in this profession.

States may set licensure and certification requirements for a variety of midwife occupations. Depending on the level of education or certification, different pathways exist for licensure of midwives. All states allow certified nurse midwives (CNMs) to practice if they hold the CNM designation. Certified Nurse Midwives receive the professional designation of CNM by passing a national certification examination administered by the American Midwifery Certification Board.

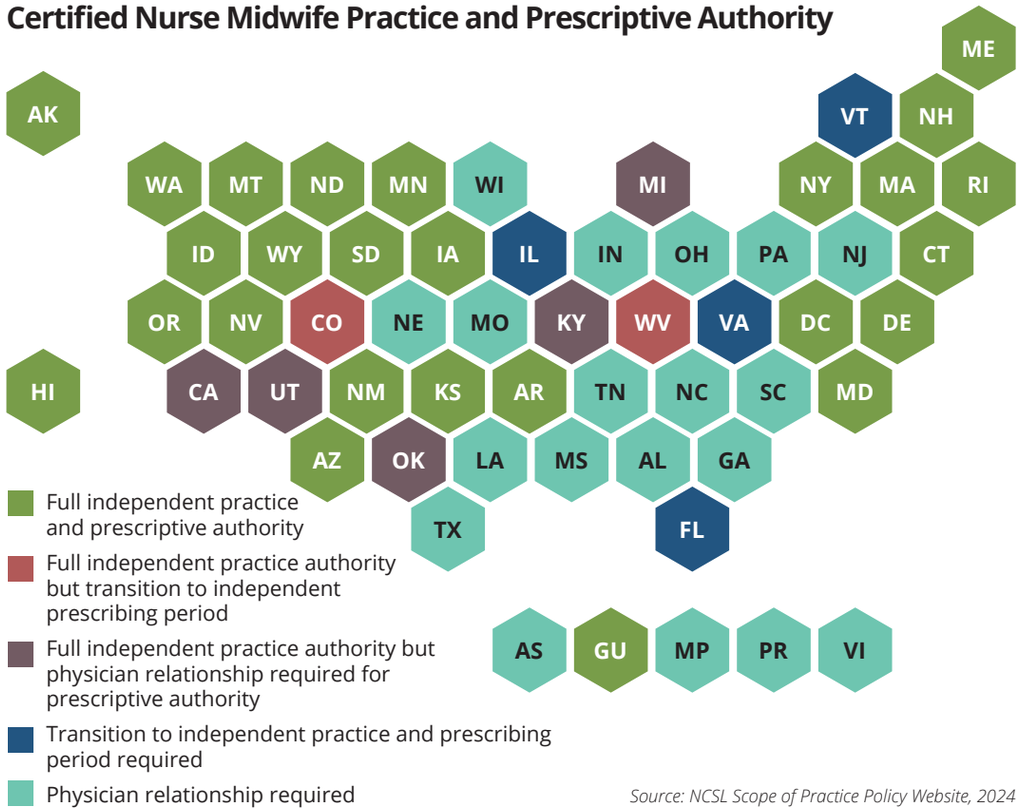
Scope of Practice

Scope of practice refers to the activities and procedures that a provider or professional with a specific level of education, training or competency is authorized to engage in as defined by state professional regulatory boards, typically with guidance or instruction from the state legislature. States set their own scope of practice standards, which may be informed by factors such as access to care, safety, professional competency, cost and more. Scope of practice requirements vary widely from state to state.

States may also license their midwives to work in particular settings such as home-birth settings. Home births are defined as a birth occurring in a private residence.

States may also modify the practice and prescriptive authority of certified nurse midwives. State laws vary on practice and prescriptive authority, as shown in the map below. At least 24 states and two territories, including Arkansas and Alaska, give CNMs full practice authority without supervision or collaboration requirements. In at least two states, Colorado and West Virginia, certified nurse midwives have full practice authority, but gain independent prescriptive authority after a transition period. Some states require certified nurse midwives to have a supervisory or collaborative agreement with a physician. The agreement determines the practices that require certified nurse midwives to consult with a physician or that require supervision by a physician. In Maine, certified nurse midwives with current and valid certification can independently practice within the scope of practice and national standards set by the American College of Nurse-Midwives.

Certified Nurse Midwife Practice and Prescriptive Authority



Source: NCSL Scope of Practice Policy Website, 2024

Some midwives enter the profession through a pathway other than nursing. They may be referred to as licensed midwives, direct entry midwives or certified professional midwives in state legislation. Research suggests that formal state licensure processes for these additional types of midwives may increase access to midwifery care in community settings. Illinois passed the Midwife Practice Act, allowing certified professional midwives to go through a licensing process permitting them to provide care in the state. Certified professional midwives are nationally licensed through the North American Registry of Midwives and at least 36 states and Washington, D.C., have some form of licensure process for certified professional midwives.

Some research suggests integrating midwives into health systems has shown higher rates of physiologic birth, less obstetric intervention and fewer adverse neonatal outcomes. Practice and prescriptive authority are two factors allowing further integration of midwives into the maternal workforce. States may permit midwives without nursing degrees to provide certain services or administer medications that can be used to prevent infections or stop hemorrhage, a leading cause of maternal mortality. For example, Montana permits midwives to administer IVs, antibiotics to prevent infections in infants, oxygen and prescription

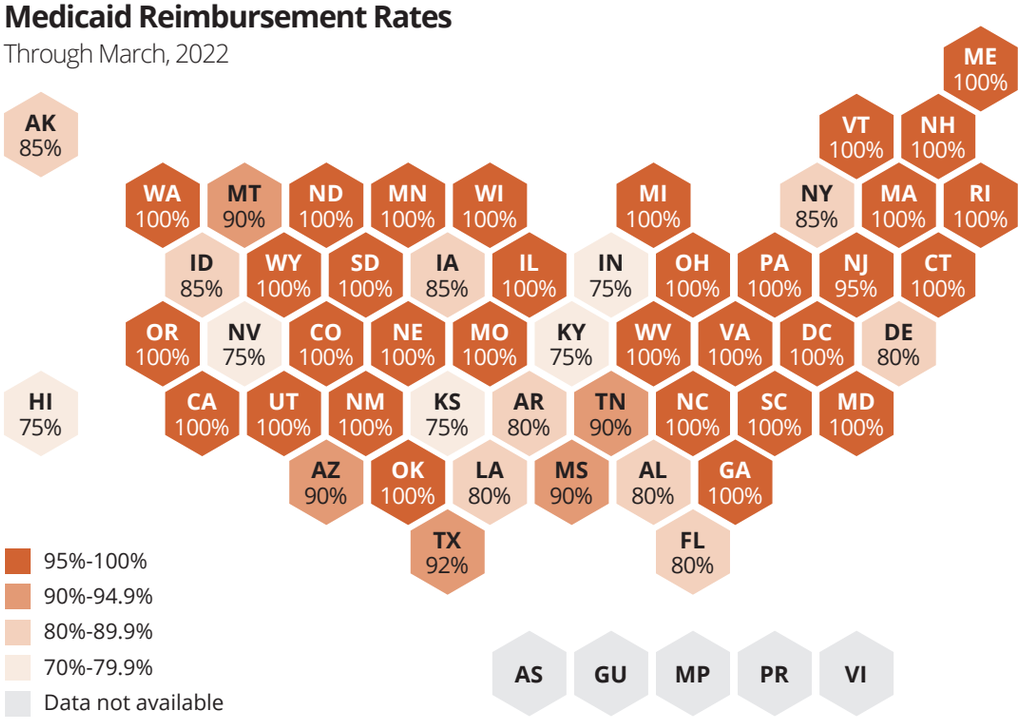
drugs that help stop hemorrhage. Iowa permits licensed direct entry midwives to obtain and administer certain drugs, including anti-hemorrhagic medications to control postpartum bleeding, local anesthetics and antibiotics. Iowa also permits midwives to order labs and ultrasounds at all health care facilities. Colorado permits direct-entry midwives to administer additional medications like group B streptococcus prophylaxis, which prevents a common infection in newborns. Some states may consider midwife scope of practice to increase accessibility of maternal health care.

Lack of third-party reimbursement can be a barrier to practicing midwifery care and, in many states, licensure allows midwives reimbursement by Medicaid and commercial plans. At least 18 states and the District of Columbia include reimbursement for midwives without a nursing degree by their state Medicaid plans. Wyoming passed legislation requiring Medicaid coverage for services provided by midwives who do not have a nursing degree but have been licensed through the state. Maine requires insurance coverage for licensed individuals who are referred to as certified midwives. Iowa requires coverage for maternity services provided by midwives and does not allow plans to require a copayment, deductible or coinsurance that is greater than that required for maternity services by other providers.

All states require Medicaid reimbursement for certified nurse midwives and have discretion over reimbursement rates. Research suggests reimbursement rates can present challenges to providing care, especially when providing for families with lower incomes. Most Medicaid programs pay certified nurse midwives between 70% to 100% of the state physician reimbursement rates. At least 30 states and the District of Columbia pay certified nurse midwives 100% of the physician rate.

Certified Nurse Midwives/Certified Midwives Medicaid Reimbursement Rates

Through March, 2022



Source: American College of Nurse-Midwives, 2022

Colorado passed legislation requiring both commercial insurers and Medicaid to reimburse labor and delivery health care providers in a way that promotes high-quality, cost-effective care, prevents risk in subsequent pregnancies and does not discriminate based on the type of provider or facility. In 2023, Louisiana passed legislation requiring the department of health to implement a Medicaid reimbursement rate for midwifery services that is at least 95% of the amount reimbursed to licensed physicians for providing the same health services in pregnancy and childbirth.

Birth centers are health care facilities specifically for childbirth and often specialize in the midwifery model of care. Women who participate in birth center care often have lower rates of preterm birth, babies with low birth weight and lower rates of cesarean births compared to women with similar risk profiles who receive typical perinatal care. States may enhance support for midwives by allowing reimbursement and licensure for practicing in settings outside of hospitals, including individual homes and birth centers. For example, Montana added certain home births to Medicaid-covered services, allowing reimbursement for services provided outside of hospital settings. Colorado also passed legislation allowing direct-entry midwives to practice in licensed birth centers. Connecticut passed legislation creating a licensure category for freestanding birth centers and allows birth centers to operate in the state. Before the Connecticut legislation, birth centers were required to be licensed as a maternity hospital, requiring a certificate of need. The certificate of need process has been cited as a barrier for birth centers because it makes it more difficult for birth centers to gain licenses. In 2023, South Carolina and West Virginia also amended certificate of need regulations to exclude birth centers.

Finally, states may consider initiatives to expand, train and educate midwifery as a profession. Louisiana requested the state nurses association to create the nursing maternal mortality and preterm birth task force. This task force, among other things, will identify ways to increase the number of practicing midwives and develop guidelines for integrating midwifery services into current health care practices. In 2021, California enacted the Midwifery Workforce Training Act to increase the number of students receiving education and training as a certified nurse midwife or a certified midwife. The bill builds upon existing state contracts with medical schools and hospitals to add programs to train midwives for licensure. Iowa's Maternal Health Innovation Program, supported by the Health Resources and Services Administration, helped to create the state's first certified nurse midwife education program. Arizona allows fees to be waived for midwifery licensing if the family income does not exceed 200% of the federal poverty guidelines.

Doulas

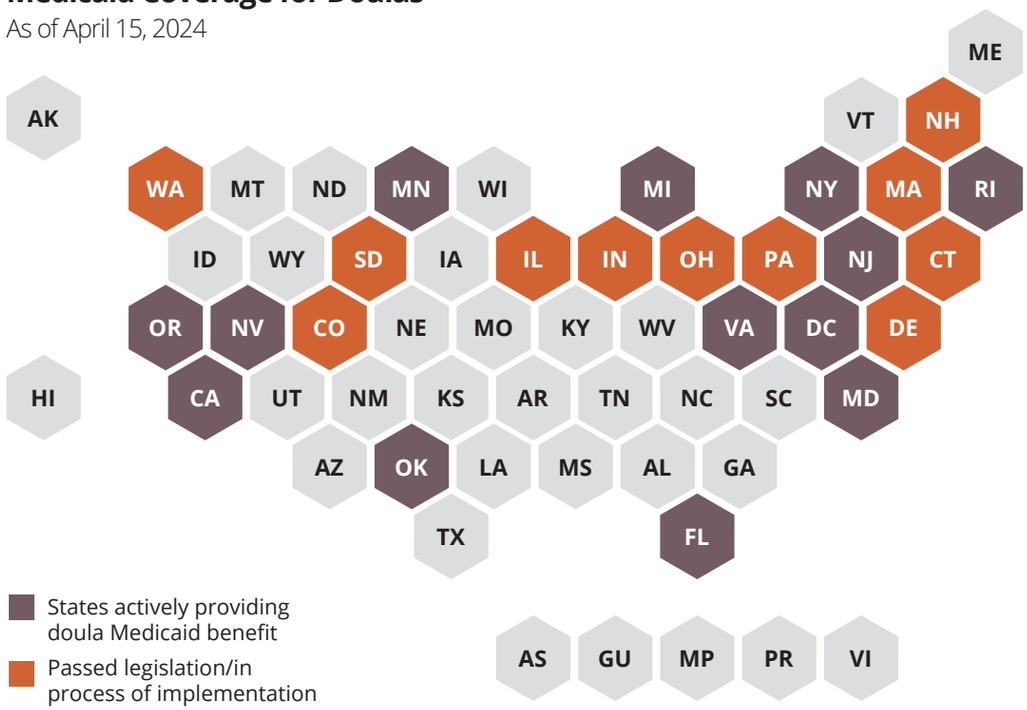
A doula provides non-medical, individualized physical and emotional support during pregnancy, childbirth and the postpartum period. Doula care can be associated with better outcomes for the mother and newborn, contributing to lower rates of pre-term birth, cesarean deliveries and other birth complications. Doulas are also associated with positive birth experiences and higher rates of breastfeeding initiation. Research suggests doulas can improve communication between providers and patients, and effective communication has been identified as a vital component to increasing quality of care and patient safety.

Barriers to doula care may include lack of coverage for doula care, patient and provider awareness of doulas, and lack of access to doulas in the community. States can support doulas by allowing a range of certification requirements, considering commercial insurance and Medicaid coverage for services, increasing the locations where doulas can work and/or considering opportunities to reduce barriers to enter the doula workforce.

Currently there is no national certification, licensing or credentialing requirement for doulas to provide care. More than 80 national and community organizations train and certify doulas. States have a choice on which organizations, training and education programs doulas complete for certification. Oklahoma requires doulas to possess a birth doula, postpartum doula, full-spectrum doula or community-based doula certification from one of 18 nationally or internationally recognized certifying organizations. A few states have created flexibility in their training requirements. After a doula stakeholder workgroup identified barriers to certification as one possible barrier to entering the profession, California created the Experience Pathway for certification. This option allows doulas with at least five years of practice and client testimonials, or professional letters of recommendation to enroll as a Medicaid provider without completing a training program.

Medicaid Coverage for Doulas

As of April 15, 2024



Source: NCSL, 2024

The Office of the Assistant Secretary for Planning and Evaluation has suggested payment and ease of enrolling in insurance arrangements may affect access and availability of doula services. Rhode Island, Louisiana and Utah passed legislation to require private health insurance plans to cover doula care. Louisiana passed legislation for health insurance plans to cover maternity services provided by a doula up to $1,500 per pregnancy. Additionally, Utah passed legislation allowing doula services to be covered in the state employee health plan. At least 24 states and Washington, D.C., will reimburse for doula services or are in the process of implementing Medicaid coverage for doula services. Oklahoma allows doulas to receive reimbursement for up to eight prenatal or postpartum visits per pregnancy, including visits conducted by telehealth. Virginia offers a $50 value-based incentive payment if a doula performs at least one postpartum service visit and the patient is seen by an obstetric clinician for one postpartum visit after a labor and delivery claim. Additionally, they offer a $50 value-based incentive payment if the doula performs at least one postpartum visit and the newborn is seen by a pediatric clinician for

one visit. Nevada authorized the department of health to establish an incentive program to pay doulas who provide services to Medicaid recipients in rural areas.

Research suggests higher reimbursement may also increase access to doulas, especially for families with lower income because it reduces the out-of-pocket costs. State legislatures and Medicaid agencies have broad discretion in setting and adjusting reimbursement rates for doulas and may consider adjusting reimbursement rates as a way to expand and diversify the profession. In 2019, Minnesota nearly doubled its original reimbursement rate. In 2022, the Centers for Medicare & Medicaid Services approved Oregon's state plan amendment to increase doula reimbursement rates. After Rhode Island lawmakers passed H5929A and S484A in 2021 requiring both Medicaid and state-governed private insurance to cover doula services, Rhode Island's executive office of health and human services began a public comment on reimbursement rates. Based on the input from community members, including doulas, the state increased the Medicaid doula reimbursement rate more than 40%. Delaware's legislation specifically requires the division of Medicaid and medical assistance to set a reimbursement rate for doula services that "support a livable annual income for full-time practicing doulas." Several other states, including Georgia, Iowa and Tennessee, have started a pilot program or study to bet-

Access for Women Experiencing Incarceration

Some states have passed legislation to increase access to doulas for women who are incarcerated. In 2023, Oregon passed legislation requiring the department of corrections to establish a doula program for pregnant and postpartum women in custody at one of the correctional facilities. Oklahoma permits access to doula care services during labor for women in correctional facilities. Washington requires the department of corrections and jails to make reasonable accommodations for doula services and midwives to inmates who are pregnant or who have given birth in the last six weeks.

ter understand doula Medicaid reimbursement rates. One task of the Iowa pilot project was to study reimbursement rates and to understand the potential cost savings of doulas. Tennessee passed legislation to create a Doula Advisory Committee tasked with recommendations for the department of health on reimbursement rates if the state passed doula Medicaid coverage. Three doulas are a part of this committee, ensuring that doula voices are included in the reimbursement rate process.

Finally, states can increase awareness of doulas, and reduce financial barriers to training and certification. Some states encourage increasing access to doulas by creating doula registries and other programs to increase awareness of doulas. For example, New York requires the department of health to create a doula registry with the purpose of "promoting doula services to Medicaid recipients." Massachusetts's Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Investment Program aims to increase the number of Black birthing people who are informed about the benefits of doula care and offered the opportunity to work with doulas. In 2020, the legislature appropriated $500,000 to birth centers and birthing hospitals to facilitate this goal. Washington State Department of Health created the Birth Equity project. Grantees receive up to $200,000 per year for a total of 2 1/2 years. A past grantee, Tulalip Tribes, used part of their funding to start a tribal doula training program. Tennessee created the doula services advisory committee to inform the creation of core competencies and standards, reimbursement options and evidence-based programs for the doula workforce and support communities facing birth disparities. Colorado legislation created a doula scholarship program that grants funds to people who cannot afford doula training and certification programs.

Conclusion

State legislatures play an important role in ensuring mothers and infants have access to quality maternity care. There are a variety of policy options available to state legislators to support and bolster the obstetric workforce and incorporate midwives and doulas into the maternal care system.

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