



Recommendations to Increase Access to Midwifery Care

*Improving Our Maternity Care Now Through Midwifery** 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. 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.

**These recommendations are excerpted from National Partnership for Women & Families, *Improving Our Maternity Care Now Through Midwifery*, October 2021, available at <https://www.nationalpartnership.org/midwifery/>*

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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.