IssueBrief

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Access to Maternity Providers: Midwives and Birth Centers

Medicaid is an important coverage source for pregnant women, financing 42 percent of births in 2020, including 65 percent of Black and 59 percent of Hispanic births.[1] Medicaid pays for a greater share of births for women who are more likely to face health care disparities: women in rural areas, young women, women with lower levels of educational attainment, American Indian and Alaska Native (AIAN) women, Hispanic women, and Black women (Osterman et al. 2022). Additionally, 70 percent of women with Medicaid coverage are of reproductive age, between the ages of 15 and 49 years old (Moore et al. 2020).[2] Medicaid is required to cover certain pregnancy-related services, including prenatal care, delivery, and postpartum care (42 CFR 440.210). Certified nurse-midwife services and coverage for care at licensed birth centers are also mandatory Medicaid benefits under federal law.

There is an increased focus on maternal and child health due to poor health outcomes, especially among people of color. In 2020, 861 women died of maternal causes compared to 754 women in 2019 (Hoyert 2022). Compared to white non-Hispanic women, Black non-Hispanic women are more than three times as likely and AIAN women are twice as likely to experience a pregnancy-related death (Hoyert 2021). Disparities continue to be prevalent for the child after birth. The 2019 infant mortality rate for Black non-Hispanic, Native Hawaiian and Other Pacific Islander non-Hispanic, and AIAN non-Hispanic infants is roughly two times higher than the rate for white infants (Ely and Driscoll 2021). These disparities in maternal and child health stem from lack of access to quality care, gaps in health care coverage, unmet social needs, implicit bias and explicit discrimination from providers, and structural racism in health care (Peterson et al. 2019). Some researchers and advocates suggest that high-quality care and culturally congruent care may improve maternal and infant health (Sakala et al. 2020a).

The midwifery-led model of care, often practiced in birth centers, has been shown to improve maternal and child health outcomes (Moore et al. 2020). Studies have demonstrated better outcomes for both the mother and baby, including lower cesarean birth rates and a decline in preterm births and low-birthweight rates (Alliman et al. 2019). Studies also show that these improved outcomes were achieved at a lower overall cost to the Medicaid program (Courtot et al. 2020). However, the vast majority of Medicaid-financed births nationwide are attended by a doctor (90 percent) and occur in a hospital setting (99 percent).

This issue brief provides an overview of the role of certified nurse-midwives and birth centers in Medicaid and how beneficiaries use these services. It highlights the evidence demonstrating improved outcomes when midwives and birth centers are used. It then describes the policy issues and barriers to expanding access to midwives and birth centers, such as payment policies; contracting with managed care organizations; licensure, certification, and accreditation; scope of practice; and limited supply.[3]

Midwives

A midwife is a health care professional who assists the individual during the prenatal, birth, and postpartum periods with a focus on a holistic, patient-centered approach to the natural birthing process.[4] A midwife can practice in multiple settings, including a hospital, birth center, a clinic, or the patient's home. All midwives are trained in the midwifery-led model of care, which emphasizes patient education and psychosocial support. It is more time intensive than maternity care with an obstetrician, with a typical visit lasting at least 30 minutes. The midwifery-led model of care also aims to provide culturally appropriate and concordant care. This approach has

been shown to build trust between the provider and pregnant person and improves health care outcomes (ACNM 2022a, Dubay et al. 2020, Hill et al. 2018).

There are several types of midwives, including certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs), each with different educational and clinical experience requirements. CNMs must have a bachelor's degree in nursing. CMs are non-nurses with a bachelor's degree that have a background in a science or health-related field (e.g., public health, biology, or nutrition). As of 2010, a graduate degree is required for entry to midwifery practice as a CNM or CM. Both CNMs and CMs complete the same standards for education and certification in midwifery (ACNM 2022b). As of February 2022, there were more than 13,000 CNMs and CMs in the United States; the majority of which are CNMs (ACNM 2022a). On the other hand, CPMs must have a high school degree or equivalent and can enter the profession through vocational routes, including apprenticeship programs or educational programs accredited by the Midwifery Education Accreditation Council (Sakala et al. 2020a).

Medicaid coverage for midwives varies by state and is dependent on the scope of practice and licensure laws that each state establishes. As previously stated, CNM services are a mandatory Medicaid benefit (42 CFR 440.165). States may also choose to cover services provided by licensed midwives, such as CMs or CPMs under other licensed practitioner services (42 CFR 440.60). This optional benefit allows coverage of midwives who are not nurses, but are otherwise licensed by the state to provide midwifery services (CMS 2018). The District of Columbia, Maine, Maryland, New York, and Rhode Island cover CMs in their Medicaid programs (ACNM 2022b). Fourteen states and the District of Columbia include CPMs in their Medicaid coverage (Sakala et al. 2020a).[5] In the State Children's Health Insurance Program (CHIP), midwifery services are optional benefits that states may provide (CMS 2018).

TABLE 1. Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives

	Certified Nurse Midwives (CNM)	Certified Midwives (CM)	Certified Professional Midwives (CPM)
Education requirements	Bachelor's degree in nursing and graduate degree in a midwifery education program	Bachelor's degree in science or health-related field and graduate degree in a midwifery education program	High school degree or equivalent and completion of an apprenticeship or educational program
Certifying organization	American Midwifery Certification Board (AMCB)		North American Registry of Midwives (NARM)
Medicaid coverage	Federally mandated in all 50 states, the District of Columbia, and the U.S. territories	Coverage in DC, ME, MD, NY, and RI	Coverage in AK, AZ, CA, DC, FL, ID, MN (birth centers only), NH, NM, OR, SC, VA, VT, WA, and WI
Licensure	All 50 states, the District of Columbia, and the U.S. territories	Licensed in DC, DE, HI, MD, ME, NJ, NY, OK, RI, and VA	Licensed in AL, AK, AZ, AR, CA, CO, DE, FL, HI, ID, IL, IN, KY, LA, MD, ME, MI, MN, MO, MT, NH, NJ, NM, NY, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, and WY
Prescriptive authority	All 50 states, the District of Columbia, and the U.S. territories	DC, MD, ME, NY, RI, and VA	CPMs do not maintain prescriptive authority

Source: ACNM 2022b.

Nationally, in 2019, about 9 percent of the 6.5 million women whose birth was covered by Medicaid had their birth attended by a CNM. Less than 1 percent were attended by another type of midwife. In 23 states, more than 10 percent of Medicaid births were attended by a CNM. Alaska and New Mexico had higher rates than the United States as a whole, with approximately 30 percent of births attended by a CNM (see Table A-1). In rural hospital settings, midwives attended about 30 percent of births (CMS 2019).

Overall, the demographic characteristics, such as age or education, of women whose birth was attended by a doctor did not meaningfully differ from those whose birth was attended by a midwife. However, there were some differences by race and ethnicity. Specifically, among mothers with Medicaid, the proportion of Black and Hispanic individuals was greater among those who gave birth with a doctor (34.0 and 33.3 percent, respectively) than the proportion of Black and Hispanic individuals who gave birth attended by a CNM (29.3 percent and 30.5 percent, respectively). Conversely, the proportion of white women and American Indian and Alaska Native women who gave birth with a CNM (57.3 percent and 4.1 percent, respectively) was greater than the proportion of white and American Indian and Alaska Native women who gave birth with a doctor (54.6 percent and 1.6 percent, respectively).[6]

An analysis of Medicaid-financed births demonstrates that among mothers who had a CNM as a birth attendant, there is increased access to prenatal care and improved birth outcomes. It is important to note that CNMs typically care for low-risk pregnancies due to scope of practice and supervision requirements. A larger percentage of mothers with Medicaid who gave birth attended by a CNM had nine or more prenatal care visits (77.2 percent), compared to those who gave birth with a doctor (75.9 percent). Mothers who are covered by Medicaid and gave birth attended by a CNM also had lower rates of preterm (5.1 percent) and low birthweight infants (4.5 percent), compared to those who gave birth with a doctor (11.7 percent and 10.2 percent, respectively).

Birth Centers

A birth center is a health care facility specifically for childbirth. Birth centers often specialize in the midwifery-led model of care and are predominantly staffed by midwives. Typically birth centers focus on low-risk pregnancies, and pregnant women are transferred to hospital settings as needed when severe medical risks occur. Birth centers that follow the midwifery-led model of care allow for more autonomy for the pregnant woman than may be available in a hospital setting. There are fewer medical interventions such as less frequent electronic fetal monitoring, a focus on non-pharmacologic comfort and pain management techniques during labor, and increased encouragement for skin-to-skin contact and early breastfeeding (Sandall et al. 2016). There are several types of birth centers: birth centers located within a hospital, birth centers located alongside hospitals, and freestanding birth centers (AABC 2022). In 2019, nine percent of CNMs or CMs attended births in freestanding birth centers (ACNM 2022a).

Although the availability of birth centers varies by state, section 2301 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required Medicaid coverage for care at birth centers in states that license the facilities (MACPAC 2020). Coverage of birth centers is not required in CHIP, but states may choose to cover them if the centers are recognized under state law (CMS 2018). There are currently 406 freestanding birth centers in the United States, with about 30 percent in rural areas.[7] The number has grown by 97 percent over the last decade (AABC 2022, Jolles et al. 2020). However, nine states do not license birth centers, although birth centers may still operate without a license in some states (NASEM 2020).[8]

The vast majority of Medicaid-financed births (99.4 percent) occurred in a hospital; less than 1 percent occurred in a freestanding birth center. Alaska had a greater share of births (4.3 percent) occur in freestanding birth centers than the rest of the nation (see Table A-2). Among mothers with Medicaid coverage, a smaller percentage of those who gave birth in a freestanding birth center were younger than 20 (2.8 percent), Hispanic (15. 8 percent), or Black (15.7 percent) compared to those with a hospital birth (9.1 percent, 33.1 percent, and 33.6 percent

respectively). Among mothers who are covered by Medicaid a larger share of those who gave birth at a freestanding birth center were white (76.3 percent) compared to those with an in-hospital birth (54.8 percent).

Mothers who are covered by Medicaid who gave birth in a freestanding birth center had more prenatal care visits and improved birth outcomes. The patient population of birth centers are generally low-risk. A larger percentage of mothers who are covered by Medicaid and gave birth in a freestanding birth center had nine or more prenatal care visits (84.3 percent), compared to those with a hospital birth (76.0 percent). Mothers with Medicaid who gave birth in a freestanding birth center had lower rates of preterm (0.7 percent) and low birthweight infants (1.4 percent), compared to those who gave birth in a hospital (11.1 percent and 9.7 percent, respectively).

Effects of Midwifery Model of Care

Research evaluating the midwifery-led model of care, including in a birth center setting, has shown that this method can improve both maternal and infant health and produce cost savings for Medicaid and result in other positive effects.[9] For example, overall costs of childbirth for low-risk women with midwife-led care were, on average, $2,421 less than births to low-risk women cared for obstetricians and the average Medicaid cost of care at a birth center was lower by $1,163 per delivery (Attanasio et al. 2019, Howell et al. 2014). The reduced cost can be attributed to fewer medical interventions under the midwifery model of care, such as less common use of epidurals, pain medication, and electronic fetal monitoring, and lower rates of cesarean section deliveries (Carlson et al. 2019, Sandall et al. 2016, Howell et al. 2014). Other benefits for women who gave birth at a midwifery-led birth center include: increased rate of spontaneous vaginal births, lower rates of episiotomy, improved initiation of breastfeeding, higher levels of satisfaction with their received the care, and better perinatal mental health outcomes (Jolles et al. 2020, CMS 2019).

BOX 1. Strong Start for Mothers and Newborns Initiative

The Strong Start for Mothers and Newborns (Strong Start) initiative tested and documented the positive effects on cost and outcomes of the midwifery-led model of care in birth centers. Funded by the Patient Protection and Affordable Care Act (ACA, P.L. 111148, as amended) from 2013 to 2017, Strong Start was a multi-site project to pilot evidence-based models to reduce the rate of preterm births, improve health outcomes for pregnant women and newborns, and decrease the total cost of medical care during pregnancy, delivery, and the infant's first year of life (CMS 2015).[10] Strong Start tested and evaluated enhanced prenatal care for women enrolled in Medicaid and CHIP. There were 47 birth centers included in the pilot program and 21 percent were located in rural locations (Jolles et al. 2020). As part of this model of care, birth centers developed referral systems to connect pregnant women to community resources to address their health-related social needs (Courtot et al. 2020).

An evaluation of Strong Start found that midwifery-led care in birth centers had better outcomes for women and infants compared to women who were risk-matched Medicaid beneficiaries receiving typical maternity care:

- Infants born to women served by Strong Start birth centers were 26 percent less likely to be born preterm and 20 percent less likely to be low birthweight than infants born to mothers in the comparison groups.
- Rates of cesarean deliveries were 40 percent lower for mothers served in Strong Start birth centers than for women in typical care.
- There were cost savings of $2,010 per birth for Medicaid beneficiaries receiving midwifery-led care at a birth center compared with Medicaid beneficiaries receiving typical care.
- Delivery expenditures were, on average, 21 percent lower and total expenditures from delivery until the infant's first birthday were 16 percent lower for women enrolled in birth centers than for women and infants in the comparison groups (Hill et al. 2018).

Another evaluation of Strong Start found a reduction in racial disparities and an improvement in health outcomes. This Strong Start study evaluated mothers and newborns who were served at American Association of Birth Centers (AABC) sites. Among these individuals, fewer Black non-Hispanic women used birth centers compared to the national average, but when they did, their preterm birth rate was lower than the national average. Additionally, Black non-Hispanic women enrolled in the AABC Strong Start program experienced cesarean sections at a lower rate (15 percent) compared to the national rate (36 percent). Overall, the birth center model demonstrated lower rates of induction of labor, low birthweight infants, preterm births, and cesarean deliveries than rates reported nationally for Black non-Hispanic women and Hispanic women (Alliman et al. 2019).

Barriers to Expanding Access

Despite the evidence base for midwives and birth center services, state Medicaid programs that want to add or expand coverage and access for these services face numerous barriers. These barriers include: payment; contracting with managed care organizations; licensure, certification, and accreditation; scope of practice for midwifes; and limited supply. Some of these barriers are within the purview of Medicaid and others are not.

Payment

States determine the payment rate for midwifery services and birth centers, as they do with most other Medicaid services. There is broad variation in how midwives and birth centers are paid based on state payment policies. For example, midwives can be paid through maternity care bundle payments (i.e., a single fixed payment for a group of services) or via a specific fee schedule (i.e., payments made for each service). Midwives could also receive payment incentives for providing certain services, such as diabetes screening, depression screening, and postpartum visit attendance (NASHP 2022). Birth centers are paid via fee-for-service payments, global professional fees, or facility fees. Unlike in hospitals, few birth centers have participated in value-based care models (AABC 2021). Some in the midwife and birth center community have raised concerns with payment policy, which they suggest may limit access. These include:

A lack of payment parity between provider or setting types. Most Medicaid programs pay CNMs and CMs between 70 and 100 percent of physician rates, but not for all the same services or intensity of services.[11] As of 2013, 27 states and the District of Columbia pay both CNMs and CMs 100 percent of the physician rate (ACNM 2013a). In 23 states, CNMs are either required to practice under physician supervision, or as a condition of licensure, required to sign a collaborative practice agreement (ACNM 2022c). This may have implications for how much they are paid. Specifically, if the midwife is practicing under a physician who bills the midwife services as part of a physician's professional services, CNMs or CMs are paid based on 100 percent of the physician's contracted or fee scheduled amount. When services are not shared or split between a physician and a midwife, the midwife then bills under their own National Provider Identification number and the Medicaid payment may be less (Moore et al. 2020). Practitioners offering obstetric services can increase volume of patients to make up for lower payment rates. However, midwives practicing independently may be unable to do this by the nature of the services provided (Courtot et al. 2020).

There is not payment parity between birth centers and hospitals for the same type of delivery. One study of birth centers participating in state Medicaid programs found that in some states, birth centers were paid between 15 and 70 percent of hospital rates (Sakala et al. 2020a). For example, in 2011, the average Medicaid facility services payment for an uncomplicated vaginal birth at a birth center was $1,907 compared to $3,998 in a hospital (Stapleton et al. 2013). Additionally, midwives are typically compensated at higher rates in hospital settings than in birth centers, so advocates note that it may be more difficult to recruit midwives to work in birth centers. Due to lower payment rates from Medicaid, many birth centers find it challenging to sustain operations and remain financially solvent while serving Medicaid patients, especially in rural areas where patient volume is low. Some birth centers only accept self-pay patients or those with private insurance (Courtot et al. 2020, Sakala et al. 2020a).

Payment models may not compensate for the breadth of services provided under the midwifery-led model of care. State Medicaid programs may not pay for the types of services that are commonly provided by midwives or birth centers. The midwifery-led model typically involves more frequent and longer patient visits, as well as waiting longer for labor to naturally progress, compared to the traditional model of care. These visits address more than patients' clinical needs; this whole-person care approach seeks to address the social determinants of health and connect patients to social services. Medicaid typically offers global payment for all prenatal services that may not account for the breadth of services or length of visits (Courtot et al. 2020).

Birth centers identified challenges to Medicaid coverage as some of their services are not covered by certain states. Not all Medicaid programs cover and reimburse nonclinical services that birth centers provide, including lactation consultants or doulas. Additionally, some state programs limit the number of prenatal visits for low-risk pregnancies, which can run counter to how many birth centers have as their standard of care (Courtot et al. 2020).

Transfer agreements result in reduced payments for birth centers. Birth centers typically provide services for low-risk pregnancies, and in instances when complications arise during labor and delivery, mothers are transferred to hospitals. Transfer agreements are written agreements between birth centers and hospitals for the transfer of a mother or a newborn in the event of medical complications or an emergency situation. However, in the event of some hospital transfers, birth centers may not receive Medicaid payment at all for labor care or the payment may be reduced (Courtot et al. 2020).

Contracting with Medicaid managed care organizations

Birth centers and midwives may face challenges in contracting with managed care organizations (MCOs). State Medicaid agencies do not require MCOs to include birth centers in networks. Prior CMS guidance encouraged the inclusion of freestanding birth centers in MCO networks. However, this was not mandated as long as the networks included access to maternity services for beneficiaries in at least one appropriate care setting, such as hospitals or physician-based practices (CMS 2016). MCOs also cited low patient volume as a reason for not including birth centers in-network (Courtot et al. 2020). Birth centers may have limited negotiating power when contracting with MCOs, so birth centers may not be included in-network.[12] Starting in 2017, all MCOs must include at least one freestanding birth center in the provider network to the extent the state licenses or recognizes freestanding birth centers under state law.[13] If the services are not included under a state's managed care contract, the services must be provided or arranged by the state directly (CMS 2016).

Birth centers and midwives also encounter challenges with the administrative process of contracting with MCOs. The administrative staff at birth centers and midwives may not have the expertise or capacity to contract with individual MCOs, submit claims and prior authorizations, and track reimbursements. These additional administrative tasks can be burdensome for birth centers with smaller staff (Courtot et al. 2020).

Midwives who are not employed by a hospital can be contractually affiliated with an MCO. This contractual agreement includes a defined payment for midwifery services. MCOs can include midwives in-network and list them in their provider directory. Providers, including midwives, note that these directories are often outdated (Moore et al. 2020).

Licensure, certification, and accreditation

State agencies and other entities that are distinct from the state Medicaid agencies establish and implement policies and procedures for licensure, certification, and accreditation for midwives. Legal recognition of the different types of midwives varies by state, and there are different regulations related to education and training pathways (Moore et al. 2020). The American Midwifery Certification Board certifies CNMs and CMs after they have completed their training (ACNM 2022d). All states, the District of Columbia, and the territories license CNMs. Nine states and the District of Columbia license CMs.[14] The North American Registry of Midwives certifies CPMs.

CPMs are licensed in 37 states and the District of Columbia, and only practice in birth centers or home settings (ACNM 2022b).[15] Licensure limits how midwives can practice because it may preclude them, for example, from having admitting privileges to medical facilities or prohibits them from obtaining and administering certain medications (NASEM 2020).

Birth centers are also subject to licensure and regulatory requirements. Freestanding birth center services are only mandatory if the state licenses the center or recognizes it as a provider under state law (CMS 2016). Forty-one states license freestanding birth centers and some states allow them without licensure (AABC 2019). To receive payment from Medicaid, a birth center must be licensed. Accreditation, however, is voluntary and occurs through the Commission for the Accreditation of Birth Centers (CABC) or the Joint Commission. Building and operating freestanding birth centers has certain state regulatory requirements, such as obtaining credentialing or establishing emergency transfer agreements with hospitals. Some freestanding birth centers have challenges securing transfer agreements or contracting with hospitals and acute care facilities because of limits on physical distance, which is especially difficult in rural areas (Moore et al. 2020). In some states, birth centers may be required to have a medical director or supervising physician. Physicians may not want to sign a written agreement due to potential liability concerns (AABC 2022).

Scope of practice for midwives

Each state has its own regulations defining the scope of midwifery services. In 44 states, CNMs are regulated by a board of nursing. In the remaining states, other boards of midwifery, medicine, or public health regulate CNMs, CMs, and CPMs (Jefferson et al. 2021). Scope of practice is determined by the state licensure requirements set by these regulating bodies and not by the Medicaid program. CNMs are considered primary care providers under federal law and have prescribing authority in all 50 states and the territories. CMs have prescribing authority in 6 of the 10 jurisdictions in which they have legal authority to practice (ACNM 2022b).[16] Some states require physician supervision for prescribing, but not for other midwifery practice areas (Walker et al. 2014).

Three states require physician supervision and 20 require a collaborative agreement from a partnering physician rather than allowing CNMs to practice independently (ACNM 2022c).[17] Without a collaborative agreement with a physician, CNMs or CMs may be denied hospital credentialing or admitting privileges. These contractual agreements can also restrict the number of CNMs or CMs that can partner with a particular physician (ACNM 2013b).

CPMs and CMs can also be regulated differently from CNMs. For example, New Jersey's hospital regulations limit admitting privileges to midwives with a nursing license, which restricts which midwives can practice in a hospital. In Delaware, Oklahoma, and Hawaii, CMs and CPMs are regulated similarly to each other, therefore limiting CMs to practice in birth centers or attend home births (Jefferson et al. 2021).

Supply

There are limited numbers of midwives and birth centers to serve the population. There is simultaneously a demand for increased training of and retention issues with midwives in rural and traditionally marginalized communities (Sakala et al. 2020b). More than half of U.S. counties lack a single nurse-midwife (Brigance et al. 2022). According to a survey from the American Midwifery Certification Board (AMCB), about 85 percent of AMCB-certified CNMs and CMs identify as white and 90 percent identify as non-Hispanic (AMCB 2021).

In some states, regulatory requirements limit the supply of the number of birth centers. Certain state regulation and licensure laws, including Certificate of Need (CON) requirements may make it difficult to qualify for licenses (AABC 2014). Some states use CON laws to regulate the establishment and expansion of new facilities, and may require freestanding birth centers to receive approval from regulators and to comply with specific structural facility requirements. For example, some state regulations require freestanding birth centers to follow surgical center facility requirements, such as having larger birthing rooms and wide doorways and hallways to accommodate

stretchers and gurneys. For many birth centers, the cost of making these changes to comply with these requirements are prohibitive. In the 38 states without CON laws, 6 states have zero or one birth center. However, in the 12 states with CON laws, 9 of them have zero or one birth center. (AABC 2019).

Endnotes

[1] MACPAC uses the term pregnant women as this is the term used in the statue and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[2] All states are required to provide Medicaid coverage for pregnant women with incomes at or below 133 percent of the federal poverty level (FPL). As of July 2021, the median eligibility threshold was 195 percent FPL (MACPAC 2021). Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of: (1) 133 percent FPL or (2) the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116). As such, there are 19 states that have a mandatory minimum eligibility threshold for pregnant women above 133 percent FPL (MACPAC 2014).

[3] The findings in this brief are informed by interviews with subject matter experts, including organizations that represent midwives and birth centers, as well as organizations focused on improving birth outcomes and birth equity for women of color.

[4] The natural birthing process refers to having a vaginal delivery with minimal medical intervention (Courtot et al. 2020).

[5] The 14 state Medicaid programs that cover CPMs are Alaska, Arizona, California, Florida, Idaho, Minnesota (birth centers only), New Hampshire, New Mexico, Oregon, South Carolina, Virginia, Vermont, Washington, and Wisconsin (Sakala et al. 2020a).

[6] This analysis compares the demographic characteristics of women who gave birth with particular attendants (e.g., doctors and midwives) and in different settings (e.g., hospitals and birth centers). It does not examine the rates of midwife or birth center births by particular demographic characteristics (e.g., Black mothers). As an example, American Indian and Alaska Native births represent a larger share of births attended by a midwife (4.1 percent) compared to the share of American Indian and Alaska Native births attended by a doctor (1.6 percent). However, this does not mean that more American Indian and Alaska Native births were attended by a midwife. There were approximately 62,000 American Indian and Alaska Native births attended by a doctor and 16,000 American Indian and Alaska Native births attended by a midwife. Note that the significance of this difference was not tested and therefore may not be statistically significant.

[7] It is unclear how many of the 406 freestanding birth centers are state licensed.

[8] As of 2019, the nine states that do not have birth center licensure and regulation are Alabama, Idaho, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, and Wisconsin (AABC 2019).

[9] The midwifery model of care can be practiced in multiple settings, including birth centers, hospitals, and home births.

[10] Strong Start funded enhanced services through three evidence-based, prenatal care models: birth centers, group prenatal care, and maternity care homes. The initiative served approximately 46,000 women.

[11] The ACA required Medicare payment for CNMs to be increased to 100 percent of the physician fee schedule. There is no such requirement for Medicaid (Courtot et al. 2020).

[12] Medicaid beneficiaries may want to use a birth center, but if the birth center is not in-network, the beneficiary would have to pay out of pocket. Medicaid beneficiaries typically cannot afford these costs and therefore access to birth centers are limited (Courtot et al. 2020).

[13] This is only mandated if there is a freestanding birth center in the MCO's contracted service area.

[14] The nine states, plus the District of Columbia, that CMs have legal status to practice are: Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, and Virginia (ACNM 2022b).

[15] The 37 states are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. Technically speaking, CPMs in Missouri are legally authorized by state statute and are not licensed (The Big Push for Midwives). Illinois Medicaid began covering CPMs in 2023 (Illinois Stat. § 225 ILCS 64 2022).

[16] The six jurisdictions where CMs have prescriptive authority are: District of Columbia, Maine, Maryland, New York, Rhode Island, and Virginia (ACNM 2022b).

[17] The three states that require physician supervision are Georgia, Nebraska, and North Carolina. The 20 states that require collaborative practice agreements are Alabama, Arkansas, California, Delaware, Florida, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin (ANCM 2022c).

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APPENDIX

TABLE A-1. Birth Attendant among Medicaid Births, by State, 2016-2019

State	Physician[1]	Certified nurse midwife[2]	Other midwife[3]	Other
Total	**90.3%**	**8.7%**	**0.3%**	**0.7%**
Alabama	98.3*	1.0*	N/A	0.7*
Alaska	64.5*	29.9*	5.2*	0.4*
Arizona	92.1*	7.7*	0.0*	0.3*
Arkansas	99.3*	0.1*	N/A	0.5*
California	93.6*	5.9*	0.1*	0.5*
Colorado	77.4*	21.3*	0.3*	1.0*
Connecticut	88.9*	10.9*	N/A	0.2*
Delaware	84.4*	13.8*	0.2*	1.6*
District of Columbia	90.4	8.6	0.2*	0.8
Florida	85.3*	12.9*	1.1*	0.7
Georgia	85.4*	12.5*	0.2*	2.0*
Hawaii	89.8*	9.7*	0.1*	0.4*
Idaho	88.1*	10.7*	0.9*	0.4*
Illinois	89.7*	9.6*	0.1*	0.6*
Indiana	92.1*	6.8*	0.6*	0.5*
Iowa	89.3*	10.4*	0.0*	0.3*
Kansas	93.8*	5.8*	0.1*	0.4*
Kentucky	91.9*	7.7*	0.1*	0.2*
Louisiana	96.5*	3.2*	0.1*	0.2*
Maine	78.2*	21.6*	N/A	0.2*
Maryland	86.3*	12.9*	0.1*	0.8*
Massachusetts	79.6*	19.1*	0.9*	0.4*
Michigan	90.3	9.0*	0.3	0.4*
Minnesota	85.6*	13.7*	0.1*	0.6*
Mississippi	97.2*	2.3*	N/A	0.5*
Missouri	95.5*	4.1*	0.0*	0.4*
Montana	86.1*	12.8*	0.1*	1.0*
Nebraska	92.7*	6.9*	N/A	0.5*
Nevada	93.3*	4.5*	0.3	1.9*
New Hampshire	76.0*	21.8*	1.6*	0.6*
New Jersey	89.4*	9.6*	0.0*	1.0*

State	Physician[1]	Certified nurse midwife[2]	Other midwife[3]	Other
Total	**90.3%**	**8.7%**	**0.3%**	**0.7%**
New Mexico	68.7*	29.7*	1.0*	0.7
New York	87.0*	12.4*	N/A	0.6*
North Carolina	87.0*	12.2*	0.3*	0.6*
North Dakota	92.2*	7.6*	0.1*	0.1*
Ohio	91.0*	8.6*	0.1*	0.3*
Oklahoma	96.5*	2.9*	N/A	0.6*
Oregon	78.4*	20.0*	0.6*	1.0*
Pennsylvania	87.2*	12.3*	N/A	0.5*
Rhode Island	86.7*	13.1*	0.1*	0.1*
South Carolina	94.8*	4.4*	0.3	0.5*
South Dakota	91.2*	7.8*	N/A	1.1*
Tennessee	92.7*	5.9*	0.8*	0.6*
Texas	96.0*	2.9*	0.4*	0.8*
Utah	89.5*	10.0*	0.1*	0.4*
Vermont	73.0*	24.0*	2.3*	0.8
Virginia	91.8*	7.6*	0.4*	0.2*
Washington	84.0*	7.9*	2.5*	5.6*
West Virginia	88.4*	11.0*	0.2*	0.3*
Wisconsin	88.8*	11.1*	N/A	0.1*
Wyoming	95.3*	3.9*	0.5	0.3*

Notes: Limited to births paid for by Medicaid. Percent columns are calculated based on number of births. State is mother's legal state of residence recorded on the birth certificate. Total number of births may not be consistent across breakdowns due to missing values and/or suppression. Cells marked "N/A" were suppressed by CDC WONDER because the number of births was less than 10.

*Difference from national percentage is statistically significant at the 0.05 level.

Cells marked "N/A" were suppressed by CDC WONDER because the number of births was less than 10.

[1] Physician is defined as doctor of medicine or doctor of osteopathy.

[2] Certified Nurse Midwife is defined as certified nurse midwife (CNM), certified midwife (CM), and advanced practice registered nurse (APRN).

[3] Other midwife is defined as a midwife other than CNM/CM, and includes certified professional midwife (CPM).

Source: MACPAC analysis of Natality on CDC WONDER Online Database, 2016-2019

TABLE A-2. Birth Setting among Medicaid Births, by State, 2016-2019

State	Hospital	Freestanding birth center	Home birth[1]	Clinic/doctor's office	Other
Total	**99.4%**	**0.2%**	**0.0%**	**0.4**	**0.1**
Alabama	99.7*	N/A	N/A	0.2*	0.1*
Alaska	93.9*	4.3*	0.2*	1.6*	N/A
Arizona	99.7*	0.1*	0.0*	0.1*	0.0*
Arkansas	99.7*	N/A	N/A	0.2*	0.1*
California	99.6*	0.2*	0.0	0.2*	0.1*
Colorado	99.1*	0.4*	N/A	0.5*	0.1
Connecticut	99.4	0.2*	N/A	0.4*	0.1
Delaware	99.0*	0.7*	N/A	0.3	0.1
District of Columbia	99.3	0.2	N/A	0.3	0.2*
Florida	98.6*	0.6*	0.0	0.7*	0.1*
Georgia	99.6*	0.1*	N/A	0.3*	N/A
Hawaii	98.9*	N/A	N/A	0.7*	0.4*
Idaho	97.7*	1.2*	N/A	1.1*	0.1
Illinois	99.7*	N/A	N/A	0.2*	0.1*
Indiana	99.8*	N/A	N/A	0.2*	N/A
Iowa	99.7*	N/A	N/A	0.3*	0.1
Kansas	99.3	0.4*	N/A	0.3*	0.0*
Kentucky	99.6*	0.0*	N/A	0.2*	0.1*
Louisiana	99.7*	0.1*	N/A	0.2*	0.1*
Maine	99.4	N/A	N/A	0.4	0.1*
Maryland	99.3	0.2*	N/A	0.3	0.1*
Massachusetts	99.5*	0.1*	N/A	0.3*	0.1
Michigan	99.6*	0.0*	N/A	0.3*	0.1
Minnesota	99.1*	0.5*	N/A	0.4*	0.1*
Mississippi	99.8*	N/A	N/A	0.2*	0.0*
Missouri	99.4	0.3*	N/A	0.2*	0.1*
Montana	98.9*	0.5*	N/A	0.5*	N/A
Nebraska	99.8*	N/A	N/A	0.1*	0.0*
Nevada	99.6*	N/A	N/A	0.3	0.1
New Hampshire	97.9*	1.0*	N/A	1.2*	N/A
New Jersey	99.6*	N/A	0.0*	0.3*	0.1*
New Mexico	98.4*	0.5*	N/A	1.0*	0.2*
New York	99.2*	0.1*	0.0*	0.6*	0.2*
North Carolina	99.3*	0.4*	0.0	0.3*	0.0*
North Dakota	99.6*	N/A	0.2*	0.3	N/A
Ohio	99.7*	0.0*	0.0*	0.2*	0.1*
Oklahoma	99.7*	N/A	N/A	0.2*	0.1*
Oregon	98.4*	0.7*	N/A	0.8*	0.1*
Pennsylvania	99.3*	0.3*	N/A	0.3*	0.1*
Rhode Island	99.6*	N/A	N/A	0.4	N/A
South Carolina	99.4	0.3*	N/A	0.3*	0.0*
South Dakota	99.6*	N/A	N/A	0.4	N/A
Tennessee	99.6*	0.1*	N/A	0.2*	0.0*

State	Hospital	Freestanding birth center	Home birth[1]	Clinic/doctor's office	Other
Total	**99.4%**	**0.2%**	**0.0%**	**0.4**	**0.1**
Texas	99.7*	0.2*	N/A	0.1*	0.0*
Utah	99.6*	0.1*	N/A	0.2*	0.1*
Vermont	97.5*	N/A	N/A	2.5*	N/A
Virginia	99.4*	0.1*	N/A	0.5*	0.0*
Washington	97.1*	1.2*	N/A	1.6*	0.1*
West Virginia	99.5*	0.1*	N/A	0.3*	0.2*
Wisconsin	99.3*	0.2	N/A	0.5*	N/A
Wyoming	99.1*	N/A	N/A	0.9*	N/A

Notes: Limited to births paid for by Medicaid. Percent columns are calculated based on number of births. State is mother's legal state of residence recorded on the birth certificate. Total number of births may not be consistent across breakdowns due to missing values and/or suppression. Cells marked "N/A" were suppressed by CDC WONDER because the number of births was less than 10.

*Difference from national percentage is statistically significant at the 0.05 level.

Cells marked "N/A" were suppressed by CDC WONDER because the number of births was less than 10.

[1] Home birth includes planned and unplanned home births.

Source: MACPAC analysis of Natality on CDC WONDER Online Database, 2016-2019