September 18, 2020

To: Health Resources and Services Administration (HRSA), RFIComments@hrsa.gov
From: American College of Nurse-Midwives (ACNM)
Subject: Maternity Care Health Professional Target Area Criteria RFI

To Whom It May Concern:

On behalf of the American College of Nurse-Midwives (ACNM), I appreciate the opportunity to provide recommendations around the establishment of maternity care health professional target areas (MCTA) as required by the *Improving Access to Maternity Care Act* (P.L. 115-320; Public Health Service Act, Section 332(k)). Certified nurse-midwives are already full participants in the National Health Service Corps (NHSC) and are currently placed in designated primary care health professional shortage areas (HPSA). The establishment of the MCTA will enable midwives participating in the NHSC to provide primary and prenatal care, labor and delivery, and postpartum care to areas in critical need of access to maternal health professionals. The MCTA will allow the Health Resources and Services Administration (HRSA) to better target maternity care professionals to these areas. Having a clear picture of where maternity care providers, obstetrical hospital units, and free-standing birth centers are located in relation to childbearing people will ensure that qualified professionals will be sent by the NHSC to areas of critical need.

ACNM is the professional association that represents advanced practice certified nurse-midwives and certified midwives in the United States. With roots dating to 1929, ACNM sets the standard for excellence in midwifery education and practice in the U.S. and strengthens the capacity of midwives in developing countries. Our members are highly trained primary health care professionals who provide care for women throughout the lifespan, with an emphasis on pregnancy, childbirth, and gynecologic and reproductive health care. The ACNM and its members stand for improving access to midwifery care for people throughout the lifespan. We support policy solutions that ensure guaranteed health coverage and access to a full range of sexual and reproductive health services.

A large part of ACNM's policy mission is to promote and expand access to the midwifery model of care as practiced by certified nurse-midwives and certified midwives. The United States is in the middle of a growing maternal health crisis that is being exacerbated by COVID-19,

especially in rural and underserved areas. As such, we proactively support legislative and regulatory efforts that seek to expand access to midwives and midwifery-led care models.

Midwifery care provided by CNMs and CMs is evidence-based and can reduce maternal and neonatal mortality, rates of stillbirth, perineal trauma, instrumental births, intrapartum analgesia use, rates of severe blood loss, preterm birth, low birth weight, and neonatal hypothermia. Midwifery has been associated with more efficient use of resources and improved outcomes including increased rates of spontaneous labor, vaginal birth, and breastfeeding. Additionally, women who receive midwifery care have higher rates of satisfaction with care, pain relief in labor, and maternal–newborn interaction.[i]

When women are placed in an appropriate level of care with the appropriate provider, maternal mortality and morbidity rates decrease. Numerous studies show that better integration of CNMs/CMs practicing to the full extent of their education, clinical training and certification within a team-based care model with the patient at the center can help prevent maternal deaths, reduce racial disparities, improve maternal and neonatal outcomes and improve access to healthcare for all women, individuals and families.[ii]

Despite the role midwives could play in efforts to reduce maternal mortality and morbidity and improve overall health outcomes for women and their families, midwives and the midwifery-led care models remain regrettably underutilized in the United States health system. There are several reasons for this, including restrictive scope of practice language, inequity in third-party reimbursement structures, a shortage of clinical preceptors, financial barriers to midwifery education, and most of all, the narrow workforce pipeline.

Recommendations for Maternity Care Health Professional Target Areas

Recommendation 1: Increasing the NHSC Full-Time and Part-Time Loan Repayment Benefit

Current trends and inequities in maternal health show that we're not doing a good job of financing a system that supports high quality, equitable care during pregnancy and childbirth. The U.S. has the worst maternal death rate among industrialized nations and continues to face appalling racial and ethnic disparities, racism and implicit biases in the delivery of, and access to, maternal health care. The persistent and pervasive race-based disparities that have long existed in maternal and child health are unconscionable. Data from the Centers for Disease Control and Prevention (CDC) indicates the national maternal death rate in 2018 was 17.4 deaths for every 100,000 live births. This statistic is even more staggering for black women with 37.1 deaths for every 100,000 births, more than double the rate of white women at 14.7, and Hispanic women at 11.8.[iii] The causes for the escalating rates of maternal mortality and morbidity are complex, but include a shortage of qualified and diverse maternal and women's health clinicians. To ensure that women's health care needs are met, we need a robust maternal health workforce who can support people throughout their pregnancies, labor and delivery, and the postpartum period. Research has shown that patients tend to do better with providers that look like them.[iv] Culturally sensitive and racially congruent midwifery is proposed as a solution for improving maternal and infant health. However, there are currently too few aspiring midwives of color entering the midwifery education programs in the United States.[v]

Midwifery's future depends on the ability to attract Black, Brown, Indigenous and People of Color (BIPOC) to the profession and to provide meaningful and fulfilling professional opportunities for these groups. The aging of the nursing and midwifery workforce together with shifting demographics in the US (by 2050 the US population is projected to be majority "minority", with the working-age population becoming more than 50 percent persons of color in 2039), and the ability to recruit and retain talent from all backgrounds will be critical to the success and advancement of the profession.[vi] Greater racial diversity in the health care workforce will improve access to culturally appropriate care and the quality of patient-provider interactions for BIPOC and is an important intervention to help reduce the racial disparities that plague maternal and child health and disproportionately affect communities of color, many of which reside in currently designated primary care Health Professional Shortage Areas (HPSAs). Concerted efforts must be made to recruit, retain and increase the number of BIPOC students in midwifery education programs and increase the number BIPOC midwives who provide care in rural, frontier, low resource and under-served HPSAs and future MCTAs across the country.

The cost of midwifery education is a barrier to many aspiring and prospective midwives. Increased access to financial aid and scholarships, and further investment in federal grant funding is integral to making nursing and midwifery education a viable option for many communities, including those who identify as BIPOC. ACNM supports efforts to increase the number of midwives of color and diversify the maternity care workforce with individuals who represent the lived and cultural experiences of the people they serve. As such, we recommend that HRSA consider increasing the initial award amounts for loan repayment for maternity care professionals deployed to the MCTA under both the full-time and half-time options to ensure that midwives and other providers are able to pay off all their student loans in return for their service.

Recommendation 2: Measure Provider Adequacy with Provider to Birth Ratios to Determine Population to Provider Ratio in MCTA.

Childbirth is the most common reason for hospitalization in the U.S. An estimated half a million rural pregnant people give birth in U.S. hospitals annually. Unfortunately, many birthing people living in rural America experience challenges accessing maternity services due to closing hospitals, closing obstetrics units, and provider shortages. An increasing number of rural pregnant people are experiencing long travel distances to service providers and increasing rates of nonindicated induction and C-sections. Research on the impacts of these trends suggest that the consequences of limited access to maternity care may lead to negative health outcomes for rural pregnant people and their infants.[vii] Measuring provider adequacy with provider to birth ratios will accommodate the variation in fertility rate between regions of the country to ensure midwives and other obstetrical providers are available to attend all deliveries in the MCTA. The World Health Organization (WHO) defines adequate workforce as 6 midwives per 1000 births, with back up obstetrician(s).[viii] This measure was successfully used to evaluate obstetric provider misdistribution in Georgia and throughout the United States. [ixxxi]

Recommendation 3: Use Primary Care Service Areas (PCSAs) as Geographic Units of Measure.

Primary care service areas have been successfully used to measure distribution of obstetric services. This geographic unit of measure was successfully used to evaluate obstetric provider misdistribution and examine associations between provider variations and geographic variations in perinatal quality measures in Georgia.[xii] [xiii]

Recommendation 4: Promoting Expansion and Development of Freestanding Birth Centers Withing Federally Qualified Health Centers in Rural and Frontier Areas.

Birth centers act as a sexual and reproductive health clinic, provide delivery care for persons at low risk, can be centers of telehealth for antenatal care of persons with high-risk conditions, and can facilitate transfer to the appropriate level of care for unexpected situations during pregnancy, labor, or the postpartum period. A midwife stationed at a birth center can provide primary care for women aged 14 and older. Birth Centers provide high quality care with lower rates of cesarean, which results in lower Medicaid costs.[xiv] Furthermore, birth centers identify and transfer pregnant people whose health status changes from low to high risk during pregnancy.[xv] Overall, there are no differences in maternal or neonatal outcomes for people with low-risk pregnancies who plan a community (birth center or home) birth in rural areas compared to urban areas.[xvi]

In 2012, the U.S. Department of Health and Human Services launched the Strong Start for Mothers and Newborns Initiative, which sought to reduce preterm births and improve outcomes for newborns and pregnant people. The initiative consisted of a public-private partnership and awareness campaign to reduce the rate of early elective deliveries prior to 39 weeks, and a funding opportunity to test the effectiveness of specific enhanced prenatal care approaches to reduce the frequency of premature births among pregnant Medicaid or Children's Health Insurance Program (CHIP) beneficiaries at high risk for preterm births. Pregnant people who received prenatal care provided predominantly by midwives in Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start. In particular, rates of preterm birth, low birthweight, and cesarean section were lower among Birth Center participants and costs were more than $2,000 lower per mother-infant pair during birth and the following year.[xvii]

Recommendation 5: Use of Already Validated Perinatal Quality Measures.

ACNM recommends use of already validated perinatal quality measure to identify areas in most of maternity care providers. HRSA should consider identifying populations in need by disparity ratios with quality metrics such as ratio of black to white primary cesarean rate, or preterm birth rates. Geographic variations in validated quality measures have been identified by comparing the measure by maternal county of residence rather than delivery hospital.[xviii] Disparity ratios in other sectors have been validated, for example, the residential segregation index. [xix]

Thank you for the opportunity to provide recommendations for the criteria necessary to establish a maternity care target area. Please do not hesitate to contact me at akohl@acnm.org or 703/585-4569 with any questions or further clarification needed around the information provided.

Sincerely,

Amy M. Kohl
Director, Advocacy and Government Affairs
American College of Nurse-Midwives

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[ii] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523
[iii] https://www.cdc.gov/nchs/maternal-mortality/index.htm
[iv] https://www.nber.org/papers/w24787
[v] https://onlinelibrary.wiley.com/doi/full/10.1111/jmwh.13070?af=R
[vi] http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005329/Shifting-the-Frame-June-2015.pdf
[vii] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf
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