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Hope A. Lane-Gavin, Health Equity Fellow
Loren C. Anthes, MBA, Treuhaft Chair, Sr. Fellow

Chairwoman Manchester, Vice Chairman Cutrona, Ranking Member Denson and members of the House Families, Aging, and Human Services Committee, thank you for the opportunity to provide proponent testimony today on House Bill 496. My name is Hope Lane and I'm a Fellow for Health Equity with The Center for Community Solutions, a nonprofit, nonpartisan think tank that aims to improve health, social and economic conditions through research, policy analysis and communication. I am joined today by my colleague Loren Anthes. Before we begin, please note we have provided copies of our research in addition to this testimony that can provide further details and analysis you may find useful.

We have had the opportunity to come before this body on numerous occasions this General Assembly to speak about our work in the maternal and infant health space and we are eternally grateful that this legislature recognizes how crucial this work is for our state and thus continues to prioritize public policy to make significant improvements.

For most of Colonial America and well into the 19th century, **all** births occurred in the home, an overwhelming majority of which were attended by *lay* midwives who also provided most of all medical care to the entire family with little to no formal training. Medical practice was not professionalized and most "doctors" were men and men did not attend births. Starting in the 20th century, the combination of medicine becoming professionalized in the United States and the rise in medical advances led to births becoming more institutionalized. This is why, in 1900, less than 5 percent of women gave birth in hospitals, but by the early 1920's up to 50 percent of women gave birth in hospitals.

While innovations in medicine meant there were many improvements in outcomes for complex deliveries, many Black and poor families did not have access to safe, well-funded and well-equipped hospitals nor health insurance and thus continued to use midwives for family planning and basic primary care. However, as institutional settings became more prominent in delivery, and as the medical industry became advanced, midwifery became more regulated, functionally prohibiting the practice as a readily available service to manage low-risk pregnancies. At the same time, there was a significant increase in the number of surgically-enabled deliveries, with cesarean section rates going from less than 2.5 percent in the 50s to over 30 percent by 2004. With this increased rate of c-sections, which is a major intrusive and invasive surgery, maternal mortality and morbidity also increased, with the risk of maternal death 3.6 times higher and risk of postpartum infection 5 times higher after a cesarean is performed.

This issue of access is still a problem, mind you, where in 2020, 1,095 counties in the United States lacked maternity care (no hospital offering obstetric care, no birth center and no obstetric provider), including 14 counties in Ohio. House Bill 496 is also an attempt to address the realities of health care provider shortages and maternity deserts by expanding and diversifying the perinatal workforce and

broadening what it means to have maternity care. House Bill 496 forces us to look at the midwives in our state, many of which are in this room, who have largely been accredited and recognized by a national board that are prepared, trained and able to care for those expecting and ask why we aren't utilizing their expertise to its full capacity to help address maternal and infant health outcomes in our state.

Studies have shown that those who received midwifery services experienced a lower chance of epidural usage, labor induction, labor augmentation, use of intravenous fluids, instrumental vaginal birth (forceps/vacuum), amniotomy (breaking of water) and episiotomy. Additionally, mothers who have access to midwifery services have a lower chance of preterm birth, are less likely to lose their babies under 24 weeks of gestation and the odds of severe maternal morbidity do not increase. So where are we in Ohio and how does HB 496 address these issues? I will ask my colleague Loren Anthes to finish our testimony by reviewing Ohio's current regulatory landscape and discuss the implications HB 496 has on cost containment and competition.

Thank you, Hope. Chairwoman Manchester, Vice Chairman Cutrona, Ranking Member Denson and members of the House Families, Aging, and Human Services Committee, thank you for the opportunity to provide proponent testimony today on House Bill 496. My name is Loren Anthes, and I'm a Sr. Fellow with The Center for Community Solutions. I will provide you with a brief overview of Ohio's regulatory landscape when it comes to midwifery and the benefits of the legislation in regards to cost efficiency and access.

Currently, Certified Nurse Midwives (CNM) are the only legally-enabled professional midwife type to practice in Ohio. As established in Ohio Revised Code (ORC) Section 4723.41, there are several requirements for CNMs, including licensure as an advanced practice nurse with an application for practice in the specialty concurrent with a license fee. Also, as a provider designated in Ohio's State Plan in Medicaid, CNMs are eligible for Medicaid reimbursement, which pays for half of all childbirths in our state. Beyond CNMs, then, the de jure professionalization of Certified Midwives (CMs) and Certified Professional Midwives (CPMs) does not exist in Ohio, significantly limiting the freedom of Ohioans to select their delivery setting and birthing options. As such, midwifery is under the functional authority of hospitals, meaning deliveries are concentrated in institutional settings versus community-based or home-based settings. Under this system, we have created a regulatory environment defined by significant barriers to entry for these trained clinicians to offer their services in our state, reducing access and options for families.

In 2018, a multidisciplinary team of maternal and infant clinical experts produced a study called the Access and Integration Maternity Care Mapping (AIMM) Study. The point of AIMM was to evaluate the statistical relationship between the integration of midwives into delivery processes and assess the impact in terms of outcomes. Through this work, the group developed the Midwifery Integration Scoring System (MISS), where higher scores indicate greater integration of midwives across all settings. Using reliable indicators in the Centers for Disease Control-Vital Statistics Database, the MISS identifies the correlation coefficients between integration scores and maternal-newborn outcomes by state. When looking at Ohio, we rank 46th out of 50 states in regards to midwifery integration. States that ranked highly, including Alaska, Arizona, Montana, New Mexico and Washington state have successfully integrated midwifery into the normal course of care and reimbursements for a generation and their

outcomes prove such. I should also note Ohio ranks 46th in the number of infant deaths it has and 39th in infant mortality rate. And despite our best efforts to protect infants and mothers through policy, we continue to see high rates of infant and maternal deaths in Ohio. A major reason for this challenge is because Ohio does not have a pathway to clinical integration for Certified Professional Midwives or Certified Midwives.

Beyond the benefit in outcomes that Hope noted, cost savings are apparent when midwife legalization is made possible in community-based settings. Currently, there is a wide variance in expense associated with normal delivery and cesarean sections in Ohio and across the United States, especially when compared to other industrialized nations. This variance is difficult to explain in concrete terms, but the expense generally is driven by an institutional approach to delivery. To explain the scale of this problem, realize that the cost of hospitalizing moms and babies for birth in the United States is .6 percent of our GDP, which is the entire GDP of Hungary, or nearly $130 billion annually. The reason being, as complex medical facilities, tertiary medical centers like hospitals have high fixed costs with high salaried practitioners, complex equipment and large campuses with significant infrastructure. And, while there is certainly an advantage to have these resources for high-risk medical interventions, it's important to appreciate the level of need for the entirety of a hospital's resources is not always necessary for effective, efficient delivery.

This is borne out in the data as well, which suggests services for low-risk births are significantly less expensive when performed by a midwife. For example, in a 2019 University of Massachusetts study, researchers found that childbirth costs for low-risk women with midwife-led care were, on average, $2,262 less than births to low-risk women cared for by obstetricians. Similarly, in a 2019 study from the American Journal of Managed Care, data from 2010 indicated average facility charges for freestanding birth centers were $2,277, while hospitals charged an average facility fee of $10,166 for an uncomplicated vaginal birth – an 87.7 percent difference. In Ohio, the average price for normal delivery, one of the most common services performed in a hospital, is $16,106. For a c-section, it's $21,431. For some hospitals, the rates of c-sections are as high as 70 percent, with the average around 32 percent, nationally, and most industrialize nations at 28.1 percent.

We believe the bill's sponsor has done a laudable job accommodating the concerns and feedback of professionals in the field, ensuring safety and autonomy are preserved. As a result, House Bill 496 achieves a number of policy goals to improve the delivery landscape in Ohio by developing policies that will increase access, lower costs and achieve better outcomes. Chairwoman Manchester, Vice Chairman Cutrona, Ranking Member Denson and members of the House Families, Aging, and Human Services Committee, thank you for the opportunity to provide testimony. We'd be happy to answer whatever questions you may have.