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Before the Ohio House Children and Human Services Committee
In Support of House Bill 537

Chair, Vice Chair, Ranking Member, and distinguished members of the Committee:

Thank you for the opportunity to submit written testimony in support of House Bill 537, which would create a licensure pathway for Certified Professional Midwives and Certified Midwives in Ohio. My name is Dr. Melissa Cheyney. I am a Distinguished Professor at Oregon State University, a former nationally certified and licensed midwife, and a researcher who has spent more than two decades studying the outcomes, safety, and policy dimensions of community birth in the United States. I have authored or co-authored more than 125 peer-reviewed publications on these topics. I directed the largest prospective data registry on midwife-attended community births in this country and served as a committee member on the National Academies of Sciences, Engineering, and Medicine's *Birth Settings in America* consensus study. I submit this testimony not as an advocate but as a scientist, to share what the evidence tells us about the relationship between midwifery licensure, health system integration, and maternal-infant outcomes, and why that evidence is directly relevant to Ohio.

The research is clear: planned community births attended by credentialed midwives produce favorable outcomes

The central question for this Committee is whether credentialed midwives practicing in community settings (homes and freestanding birth centers) deliver care that is safe for Ohio families. My research program has been dedicated to answering that question rigorously.

In 2014, my team published the largest prospective study of planned home births in the United States: outcomes for 16,924 women who planned midwife-attended home births between 2004 and 2009, drawn from the MANA Statistics Project registry (Cheyney et al., *Journal of Midwifery & Women's Health*, 2014). The findings documented that low-risk women receiving CPM-led care experienced a 93.6% spontaneous vaginal birth rate, a 5.2% cesarean rate compared to the national hospital average of approximately 32%, and an intrapartum transfer rate of 10.9%. Only 4.5% of women required epidural analgesia or oxytocin augmentation. The episiotomy rate was 1.4%. Neonatal outcomes were consistent with the best available international evidence on planned out-of-hospital birth: intrapartum mortality of 1.30 per 1,000 (dropping to 0.85 per 1,000 when higher-risk conditions were excluded), and NICU admission of just 2.8%. Breastfeeding rates at six weeks exceeded 97%. These findings demonstrated that when credentialed midwives attend planned community births for appropriately screened women, intervention rates are dramatically lower without an increase in adverse outcomes.

In December 2024, my colleague Dr. Marit Bovbjerg and I, with collaborators, published the largest study to date comparing planned home births to planned birth center births in the United States (Bovbjerg et al., *Medical Care*, 2024). Analyzing more than 110,000 births from two national registries across all 50 states, we found no clinically meaningful difference in neonatal

mortality between planned home and planned birth center settings for low-risk pregnancies. The combined intrapartum and neonatal death rate was 1.40 per 1,000 for home births versus 1.48 per 1,000 for birth center births. Transfer rates were comparable or lower for home births. This study is significant because it directly challenges the assertion that birth centers are categorically safer than home births. For low-risk individuals receiving care from credentialed midwives, both community settings produce comparable outcomes.

Our 2018 study on rural community birth further strengthens this evidence. Nethery, Gordon, Bovbjerg, and I examined outcomes for rural women planning community births and found no significant differences in maternal or neonatal outcomes compared to non-rural women, even when those rural women lived farther from hospital backup (Nethery et al., *Birth*, 2018). This finding has direct implications for states like Ohio, where the closure of rural maternity units is accelerating.

Licensure and integration are the conditions under which community birth is safest

The question is not whether community birth occurs in Ohio. It does, in every state. The question is whether it occurs within a regulated, integrated system that maximizes safety. My research, and the consensus of the National Academies, point to a clear answer: it must.

In 2020, the National Academies of Sciences, Engineering, and Medicine released *Birth Settings in America: Outcomes, Quality, Access, and Choice*, a congressionally mandated consensus study on which I served as a committee member. That report concluded, in Conclusion 7-6, that the inability of nationally certified midwives, including CPMs, to access licensure and practice to the full extent of their scope in all jurisdictions "is an impediment to access across all birth settings." The report further found, in Finding 6-5, that community births are safest when they are part of an integrated, regulated system with seamless transfer, appropriate risk assessment, and well-qualified providers, and noted that such systems are not yet widespread in the United States.

This finding is quantified by the Midwifery Integration Scoring System (MISS) study I co-authored (Vedam et al., *PLOS ONE*, 2018), which scored all 50 states on scope of practice, autonomy, governance, and regulatory environment for midwives. States with higher MISS scores had significantly lower cesarean rates, lower preterm birth rates, lower neonatal mortality, and higher breastfeeding rates. Nearly 12% of the variation in neonatal death across the United States was attributable to how well midwives were integrated into each state's healthcare system. Ohio scored 20 out of 100 on this index, ranking 46th out of 50 states.

That number is not an abstraction. Ohio's current regulatory framework, in which CPMs operate without licensure, without insurance reimbursement, and without formal mechanisms for hospital collaboration or transfer, is associated with the kind of fragmented, unintegrated system that produces worse outcomes for families. H.B. 537 would begin to change that.

Without licensure, midwives cannot easily establish collaborative relationships with physicians. They cannot participate in quality improvement programs, report outcomes through state-mandated mechanisms, or bill insurance. That means families who want this care must pay entirely out of pocket, which creates a profound equity barrier. Licensure is the structural prerequisite for integration, and integration is the condition under which community birth is safest.

Ohio faces a maternal health crisis that demands expanded access to care

The urgency of this legislation is underscored by Ohio's maternal and infant health outcomes. Ohio's maternal mortality rate stands at approximately 25.4 per 100,000 live births, above the national average. Ohio's infant mortality rate of 7.2 per 1,000 live births ranks 48th in the nation. The preterm birth rate is 11.0%, earning a grade of D from the March of Dimes. Thirteen Ohio counties are classified as maternity care deserts with no hospital, birth center, or obstetric provider, and 24 counties lack a single OB-GYN. Six rural maternity wards in Ohio closed within a two-year period, and 11 additional rural hospitals are at risk of closure.

The racial disparities are especially pronounced. Black women in Ohio die at 2.5 times the rate of white women from pregnancy-related causes. Black infant mortality is 2.4 times the white rate, and that disparity has widened over the past decade. The Giving Voice to Mothers study, which I co-authored (Vedam et al., *Reproductive Health*, 2019), found that one in six women nationally experienced mistreatment during maternity care, but rates were dramatically lower in community birth settings (5.1%) compared to hospitals (28.1%). Women of color were at least twice as likely to report mistreatment in hospital settings. Expanding access to midwifery-led community care offers one evidence-based pathway to address these disparities.

The federal Strong Start for Mothers and Newborns Initiative, administered by the Centers for Medicare and Medicaid Services, tested birth center midwifery care for Medicaid populations and found a 40% reduction in cesarean births, a 26% reduction in preterm birth, and cost savings of $2,010 per mother-infant pair in the first year of life. For Black participants specifically, the preterm birth rate in Strong Start birth centers was 5.1%, compared to 13.8% nationally. These outcomes are not marginal improvements. They represent the kind of transformative change that Ohio families, particularly those in underserved and rural communities, deserve access to.

CPMs are well positioned to serve in settings where the current system is failing. Unlike hospital-based providers, CPMs are not dependent on facility infrastructure. As my team has documented, they are often the only perinatal care providers available in rural areas where hospitals have closed maternity units. Developing a midwifery workforce is less resource-intensive than recruiting and retaining obstetricians willing to sustain rural practice. Licensure enables CPMs to participate in Medicaid reimbursement, which would extend access to the nearly 40% of Ohio births covered by Medicaid and to families in the 13 counties currently designated as maternity care deserts.

Recommendation

The evidence from my research, from the National Academies consensus study, from federal demonstration programs, and from the experience of the 37 states and the District of Columbia that already provide CPMs a legal pathway to practice all point in the same direction. Licensure of Certified Professional Midwives and Certified Midwives improves safety by enabling integration, expands access in communities where access is most scarce, reduces health disparities, and lowers costs. Ohio's current framework, in which CPMs practice without regulation, without collaborative agreements, without data reporting requirements, and without insurance reimbursement, serves no one well. It does not protect families. It does not improve outcomes. And it leaves Ohio as an outlier among states that have recognized the evidence and acted on it.

I respectfully urge the Committee to advance H.B. 537 and provide Ohio's families with the regulated, integrated, evidence-based maternity care options that the science supports.

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