AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Federal Maternity Care Shortage Area Legislation

TALKING POINTS

Maternity care facts in the U.S.:

- In 2011, there were approximately 3.95 million births in the United States. This is down 1% from 2010, marking the second consecutive year that there have been fewer than 4 million births nationwide in over a decade.

- Cesarean section, the most common operating room procedure in the country in 2009, was performed on 1.4 million women. The 2010 cesarean rate of 32.8% marked the first dip in the national rate in over a decade and the rate remained unchanged in 2011. The cesarean rate varied across states in 2010, from a low of 22.6% in Alaska to a high of 39.7% in Louisiana. It reached 46.7% in Puerto Rico. The 2010 cesarean section rate varied slightly by payer — from private insurance (35%) to Medicaid (32%) to uninsured women (31%).

- The rate of preterm birth rose from 10.6% in 1990 to an all-time high of 12.8% in 2006. It has since declined for five consecutive years to 11.7% in 2011. Across states, the 2010 preterm birth rate ranged from 8.4% in Vermont to 17.6% in Mississippi, and was 16.7% in Puerto Rico.

- The rate of low birthweight has risen fairly steadily over a quarter century. This rate was 6.7% in 1984, reached 8.3% in 2006, declined modestly in 2007 to 8.2%, and then again in 2011 to 8.1%. Across states, the 2010 low birthweight rate ranged from 5.7% in Alaska to 12.1% in Mississippi.

- All payers: Facility charges billed a combined total of $111 billion for “mother’s pregnancy and delivery” and “newborn infants” in 2010 (4).

- Medicaid. In 2010, 45% of all maternal childbirth-related hospital stays were billed to Medicaid. The two most common conditions billed to Medicaid as the primary payer in 2010 were pregnancy and childbirth (24%) and newborns (23%), which together comprised 47% of discharges billed to Medicaid.

- Private insurance. In 2010, 48% of all maternal childbirth-related hospital stays were billed to private insurers. The two most common conditions billed to private insurance as the primary payer in 2010 were pregnancy and childbirth (16%) and newborns (15%), which together comprised 31% of discharges billed to private insurance. Between 2000 and 2010, newborn discharges billed to private insurance decreased by 24%, and pregnancy and childbirth discharges decreased by 25%.

- Source: Childbirth Connections, http://transform.childbirthconnection.org/resources/datacenter/factsandfigures/

Establishment of a health professional shortage area (HPSA) designation specific to maternity care

- ***Improved access for women to full scope maternity care providers will result in improved outcomes for women and their newborns. It will also result in lower costs for maternity care delivery across the U.S. by enabling greater access to prenatal care and safe delivery options within local communities.***

- In a report issued in June of 2013, the Medicaid and CHIP Payment and Access Commission (MACPAC) highlights that having coverage for maternity services does not guarantee access to care. Access to maternity care professionals is a significant issue in many areas of the country due to the changing demographics of maternity care providers, variation among practice environments, and restructuring, regionalization and closure of many maternity care units.[1]

- The Bureau of Labor Statistics within the U.S. Department of Labor reports that as of May 2012 there were nearly 27,000 maternity care providers (5,710 certified nurse-midwives and 20,880 obstetricians/gynecologists) employed in the U.S.[2] The preliminary number of births for the United States in 2012 was 3,952,937 according to a recent report from the Center for Disease Control and Prevention within the U.S. Department of Health and Human Services.[3]

- In 2010, nearly 50 percent of U.S. counties had no OB/GYNs providing direct patient care and almost all of these counties also had no certified nurse-midwives (CNM) (ACOG 2013).

- Shortages of maternity care providers can result in long waiting times for appointments and/or long travel times to prenatal care and/or birthing sites. Obstetrics and gynecology have become

[1] MACPAC, "Report to the Congress on Medicaid and CHIP," June 2013, page 21-22.
[2] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment Statistics, May 2012.
[3] Centers for Disease Control and Prevention, National Vital Statistics Report, September 2013.

particularly prone to workforce challenges due to concerns surrounding professional liability, unpredictable working hours, declining medical student interest, reductions in the numbers of residency programs, and increasing sub-specialization by graduating residents. These factors have contributed to inadequate access to maternal and reproductive care, especially in underserved communities.

- H.R. 4385, the "Improving Access to Maternity Care Act of 2014" will establish maternity care health professionals shortage areas. It will take into account availability of full scope maternity care professionals and medical facilities, including birth centers.

- Establishment of a maternity care HPSA builds upon existing primary care, dental and mental health shortage designations. A designation for maternity care shortages will help identify and then address maternity care shortages and encourage more providers to practice in rural and urban underserved areas.

- The National Health Service Corp (NHSC) places health professionals in HPSAs across the nation. This legislation will enable the NHSC to place full scope maternity care providers, including midwives, obgyns, and family physicians, in hospitals, birth centers and other medical facilities to address demand for maternity care services.

National Health Service Corp

- The NHSC mission is to "build healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care."[4] The program incentivizes providers who practice in areas with health care provider shortages by giving them a scholarship or loan repayment benefits. There are two ways that a provider can be rewarded for providing care in a community with health professional shortages.

    - The scholarship program pays tuition and fees; provides a living stipend for students in accredited training programs; scholars must work in HRSA-approved community-based site following graduation for 2 to 4 years.

    - The loan repayment program offers eligible providers (including midwives and obgyns) up to $60,000 in loan repayment in exchange for 2 years of service in a NHSC site. In addition, providers have the option to extend their service at the NHSC site and received additional funds for loan repayment.

[4] "Mission and History." http://nhsc.hrsa.gov.