## Approaches for Modernizing the Midwifery Profession:

# New Jersey's Regulatory and Licensing Structure


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# Introduction

## Midwifery care is an important part of a comprehensive, multidisciplinary set of solutions to health inequity in New Jersey.

The state statute governing midwifery in New Jersey is more than 100 years old with few amendments made over time. Its limited applicability to modern midwifery practice hinders the profession. Statutory and regulatory reform is needed for midwives in New Jersey to reach their full potential as key care providers to improve maternal and infant health and reduce health disparities in the State.[1] Modernized, evidence-based approaches to regulate the practice of midwifery in the State would expand the midwifery workforce, enabling more families to experience quality midwifery care.

### As this report explains, key changes can help facilitate a larger, more robust, more diverse midwifery workforce, improve quality of care, and reduce overall health care costs. Needed reforms include:

- **End New Jersey's prohibition of autonomous midwifery practice** – a ban that threatens care availability and health outcomes while promoting disparities.
- **Establish an independent midwifery board** structure to replace existing governance by the State Board of Medical Examiners. The independent board would set licensing standards and leverage research to govern and support evidence-based regulation of midwifery on par with other health professions in New Jersey.
- Based on their equivalent training and responsibilities, **give Certified Midwives the prescription-writing authority** that only Certified Nurse Midwives currently have in New Jersey.
- **Require reimbursement parity** for payers to cover all services provided by midwives.
- Make midwife-assisted home birth eligible for **Medicaid reimbursement**.
- **Revise birth records to improve accuracy** in reporting midwife-assisted birth including transitions from intended sites of birth.
- Make permanent the ability of **CPMs to have privileges in birthing centers** and the ability for **CMs to attend births in hospitals**.
- **Stimulate midwifery workforce development** through additional scholarships, clinical training placement sites and establishment of a CPM program in New Jersey.

The United States has the worst maternal health outcomes among peer nations. **New Jersey is among the worst-performing states**—with significant racial disparities across maternal mortality and morbidity.[2] While there is no single solution to address the multi-factorial causes of poor outcomes and disparities,[3] midwifery care is a recognized pillar of a high-functioning reproductive and women's health care system[4].

Licensing and regulation of professions can influence public and maternal health, especially through provider supply constraints and scope of practice limitation. Over time, licensing laws in the United States have limited the midwifery workforce and its potential. Proposals to modernize the midwifery regulatory structure are informed by research regarding peer states and countries, and organizations that have worked together to build consensus statements and develop model legislation and regulation.[5]

Midwifery regulation varies across states with respect to license type, degree of professional autonomy, and regulatory body (independent boards of midwifery; midwifery regulation by nursing or medical boards, state departments of health, occupational licensing and financial regulation).[6] This paper identifies and assesses ways to further state interests through modernizing New Jersey's legal and regulatory structures.[7]

This report (1) reviews New Jersey's midwifery licensing and regulatory structure; (2) assesses potential impacts of autonomous practice and an independent midwifery board; (3) identifies statutory and regulatory changes needed to effectuate evidence-based regulation of autonomous midwifery practice in New Jersey; and (4) considers workforce and market competition implications of autonomous midwifery practice.

# Licensing and Regulation in New Jersey

In New Jersey, most professional licensing boards responsible for regulating the health professions are housed within the Department of Law and Public Safety's Division of Consumer Affairs (DCA).[8] These governmental units are charged "to protect the public from fraud, deceit, misrepresentation, and professional misconduct in the sale of goods and services in New Jersey through education, advocacy, regulation, and enforcement."[9] New Jersey issues three types of midwifery licenses: Certified Nurse Midwife (CNM), Certified Midwife (CM), and Certified Professional Midwife (CPM).[10]

CNM and CM midwifery education, scopes of practice, and competencies are substantially similar across the nation. All states offer the CNM license, but CMs are licensed only in Arkansas, Colorado, Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia.[11] CM and other "direct entry" midwifery practice refers to the fact of entering the midwifery profession directly—without a separate nursing credential received prior. Certified Nurse Midwives receive nursing training in addition to midwifery and may be dually licensed as nurses and midwives.

CPMs require extensive knowledge and experience in non-hospital birth settings such as home and community-based birth settings. As of 2023, CPMs are licensed or otherwise regulated in 36 states.[12,13] The CPM credential is competency-based and issued by the North American Registry of Midwives (NARM),[14] which is accredited by the National Commission for Certifying Agencies. Additional comparative analysis of license categories can be found in the New Jersey Health Care Quality Institute and Burke Foundation's report, "Delivering Better Care: Midwifery Practice in New Jersey."[15]

## Statutory[16] and regulatory framework and oversight

The Board of Medical Examiners ("BME" or "Board") oversees the practice of midwifery in New Jersey. The State does not have an independent midwifery board. Instead, the Midwifery Liaison Committee ("MLC" or "Committee") sits "under" the BME.

N.J.S.A. 45:10-1 defines the practice of midwifery in New Jersey as follows: "a person shall be regarded as practicing midwifery within the meaning of this chapter who attends a woman in childbirth as a midwife, or advertises as such, by signs, printed cards or otherwise," and N.J.S.A. 45:10-8 directs that "midwives shall always secure the immediate services of a reputable registered physician whenever any abnormal signs or symptoms appear in either mother or infant." Beyond that, the existing New Jersey statute provides no guidance, other than provisions enacted in 1991 authorizing CNMs to apply to the board for authority to prescribe drugs, subject to requirements that prescriptive authority[17] be delineated in standing orders and practice protocols developed in agreement between a CNM and a collaborating physician; and a 2021 law requiring bias training via continuing education. The 1991 provisions do not recognize the CMs' authority to prescribe, despite the similarity of midwifery education received by both CMs and CNMs. New Jersey denies CMs prescriptive authority under the existing regulatory structure.[18,19]

The governance of midwifery practice in New Jersey appears to have developed through regulations alone. Even the Midwifery Liaison Committee—responsible for regulating the practice of midwifery under supervision of the BME – was itself established by regulation, not statute. This is not typical for regulatory bodies. Typically, a statute creates and then delegates regulatory authority to a licensing board. In New Jersey, the legislature has failed to delegate autonomous regulatory authority to midwives, delegating it instead to physicians via the Board of Medical Examiners. Delegating such authority is an important element of the professional licensure dynamic. The existing governance structure establishes a supervisory role for physicians "over" midwives and precludes self-governance through an independent board.

## Current regulations[20]

New Jersey regulations describe their intended purpose as "[protecting] the health and safety of the public through licensure of midwives…" The rules prescribe standards for licensure, including renewal, suspension, or revocation of midwifery licenses in New Jersey. Functions of the MLC include: "1) Advising and assisting the Board [of Medical Examiners] in the evaluation of applicants for midwifery licensure and certified nurse midwife applicants for prescriptive authorization; 2) Investigating complaints against licensees and unlawful conduct by licensees; 3) Approving professional education programs; and 4) Advising and assisting the Board [of Medical Examiners] in drafting and reviewing rules to govern midwifery practice […]"[21]

New Jersey's statute and regulations prohibit autonomous midwifery practice through a requirement that "tethers" a midwife's practice to a specific physician. Regulations specify that "a licensee who practices without establishing clinical guidelines with a consulting physician commits professional misconduct as proscribed by N.J.S.A. 45:1-21(e)."[22] New Jersey midwives are required to establish written clinical guidelines with a "consulting physician" – defined as "a person who holds a plenary license to practice medicine and surgery in New Jersey, issued by the Board, who adheres to clinical guidelines with a licensed midwife."[23] Clinical practice guidelines are evidence-based protocols set as benchmarks for standards of care by national bodies *independent* of state licensing boards. Midwives follow clinical practice guidelines regardless of a supervisory or collaborating agreement requirement with a physician. New Jersey regulations reference guidelines regarding routine care; procedures; risk factors; circumstances prompting consultation, collaborative management, referral and transfer; parameters governing prescriptive authority, administration and dispensing of medications; and emergency assistance.[24]

## Rulemaking structure

The Committee's rulemaking process is established by the Board of Medical Examiners. Although the MLC engages in rulemaking, it lacks authority to enact a final rule without Board review, which involves secondary deliberation, potential modification, and final vote by the Board. Over time, the MLC has promulgated rules under BME supervision, including, for example, scope of practice expansions to include circumcision and colposcopy and to implement New Jersey's telemedicine and telehealth statute.

## MLC composition

The regulations state that the MLC will consist of "eight members who shall serve as consultants to the Board [of Medical Examiners] and who shall be appointed by the Board" meeting certain criteria and who are appointed to serve three-year terms with the opportunity for reappointment.

## The system's strengths

Governmental licensure and regulation of health professions helps the public verify education, experience and other provider credentials, codifies nationally-recognized standards for practice, and sets forth frameworks for discipline. These are functions that the public likely cannot efficiently perform on its own.

## The system's weaknesses

New Jersey's prohibition of autonomous midwifery practice impairs facility credentialing, reimbursement, and provider supply – which, in turn, threaten access and outcomes and contributes to health disparities. Research finds that legal requirements for mandatory supervisory agreements (that require formal collaboration with physicians) increase malpractice insurance costs and decrease provider supply without advancing quality of care or patient safety.[25] Populations hurt most by health disparities are more likely to suffer from the impacts of workforce shortages and resulting increased costs, which can include being priced out of midwifery care.[26] Rightsizing licensing, regulation, and reimbursement are part of broader efforts to undoing structural racism, improving public health and safety, and delivering consumer protection.

## Frameworks for assessment

For reference, at the national level, the Federal Trade Commission (FTC) focuses on competition with an eye to consumer protection and consumer benefit. The FTC notes that regulatory constraints may limit efforts to expand access to care, hinder the ability to address workforce shortages, limit integrated practice through use of collaborative practice requirements, and increase costs of care -- which ultimately reduces the availability and supply of midwifery services. FTC analysis shows that expanded provider supply tends to reduce costs of care even in well-served areas. The FTC urges legislators, regulators, and policymakers to apply an analytic framework to evaluate evidence in the context of provider licensure and scope of practice limitations.

Peer-reviewed research concludes that autonomous practice environments and reimbursement coverage increase the size of the workforce and improve health outcomes associated with midwifery.[27] By FTC and scholarly research standards, New Jersey's midwifery regulation appears to impede competition without corresponding health benefits. Global principles set forth by the International Confederation of Midwives to assist in assessing regulatory processes[28] are generally consistent with best practices for assessing and evaluating public health regulations. Assessment should, for example, consider the necessity, effectiveness, flexibility, proportionality, transparency, accountability, and consistency of regulation. Ongoing evaluation is required to ensure adherence to these principles in the face of evolving research that may inform the need to reform laws. Regulatory bodies can monitor emerging research and regulatory staff can conduct gap analyses to identify where regulations are at risk of lagging behind new developments.

# Elements and Impact of an Independent Board and Autonomous Practice of Midwifery

Midwives practice a profession that is different and distinct from medicine and nursing. New Jersey's statutes and regulations require changes that reflect the essential nature of midwifery's professional independence. Changing the legal landscape can also help achieve a more diverse and robust midwifery workforce. Increasing the availability and use of midwifery care with reimbursement parity and better integration of midwifery into maternal health systems have the potential to increase access to midwifery care, decrease overall costs of maternal health care, and improve quality. This section highlights public health and governance benefits of autonomy for midwives.

## Public health benefits of autonomous midwifery practice

### Autonomous midwifery practice is beneficial in several ways. It can:

- Make midwifery more available.
- Reduce costs associated with midwifery care.
- Offer maternal health care quality outcomes on par with or higher than physician-assisted birth.[29]

In addition, public health benefits associated with midwifery models of care include increased spontaneous birth and reductions in avoidable cesarean birth, reduced rates of episiotomy and forceps use, and reductions in preterm birth and overuse of technology.[30,31] It is important to note that midwives can, depending on their education and training, provide care across the lifespan. Midwifery care includes access to family planning and first-trimester abortion care, and results in increased rates of breastfeeding, and an overall focus on patient-centered care, satisfaction, and shared decision-making.

## Independent midwifery board

Independent midwifery board structures facilitate self-governance for midwives on par with that enjoyed by other health professions. Such a structure in New Jersey could be expected to expand the state's midwifery workforce because professional autonomy would provide a more attractive practice environment and enable reimbursement by entities that require it. This could be achieved through out-of-state midwives expanding their practice to include New Jersey or from higher numbers of New Jersey students that consider health professional careers opting to pursue midwifery. Independent practice may also encourage additional midwifery education programs to establish options for New Jersey. At the same time, separation from the Board of Medical Examiners would enable greater self-determination for midwives. More specifically, an independent board directed by midwives would increase focus on midwifery-specific issues and cause those in decision-making roles to be more familiar with midwifery competencies and the evidence base on which practice considerations are best determined.

# Changes Needed to Achieve Modernization

## A new midwifery statute

Legislation is required to comprehensively reform the overarching structure governing midwifery practice in New Jersey. Regulations alone cannot fix the foundational problems in the state's midwifery policy. A new midwifery statute could leverage research to govern and support evidence-based regulation of the practice of midwifery. It would also establish an independent Board of Midwifery, outline autonomous practice, and delegate authority to the Board to set evidence-based licensing standards. Regulations typically put "flesh on the legislative bone" and the extent to which certain features of modernized midwifery regulation belong in statute or regulation can be contemplated alongside establishing a new legislative landscape to ensure a holistic approach to policy development.

## Regulatory self-governance via a new Board of Midwifery

A statutorily-created Board of Midwifery would enable self-governance of the profession through structure, licensure, and regulation. After statutory enactment, as noted above, a Board of Midwifery would engage in rulemaking. A regulatory transition plan could be established for the period between the statute's effective date and completion of the initial rule to avoid uncertainty. Board composition reflecting diverse mixes of races, gender identities, ethnicities, years in practice, midwifery license type (CNM, CM and CPM) and ways of thinking is often more representative of the populations midwives serve. Best practices for board appointments include transparency and accessibility regarding how the appointments process works, composition of the board, establishment of criteria and expertise required for appointment, and regularly-updated and publicly-posted board membership lists. Today there is no national midwifery license or any interstate licensing compact for midwives. With an independent midwifery board, New York State competes with New Jersey in the labor market for midwifery services in certain locations.

## Autonomous practice[32]

"Autonomous" practice regulation recognizes midwives as independent practitioners of midwifery.

### Autonomous midwifery practice has the benefits of:

- Eliminating the requirement for formal supervision by physicians.
- Not requiring a contract with a physician while still allowing clinical practice guidelines to establish and maintain collaborative relationships (e.g. with physicians and hospitals).
- Requiring notice to patients of the parameters of collaboration and referral.

"Full practice authority" or "independent practice authority" are also terms that broadly refer to "[autonomous] practice to the full extent of their education, clinical training, and certification."[33]

As of June 2023, CNMs have "full practice authority" in 27 states and the District of Columbia, three states require physician supervision, and "the remaining 20 states require a signed collaborative practice agreement with a supervising physician as a condition of licensure for a subset of nurse-midwifery services (e.g., the intrapartum period or for prescriptive authority)."[34]

There is broad agreement among the American College of Nurse Midwifery and the American College of Obstetricians and Gynecologists that CMs should be regarded as independent practitioners, because of their equivalent midwifery education, and therefore, regulated equivalently to CNMs[35].

CPMs also are candidates for autonomous practice. CPM training and scope is narrower than that of CNMs or CMs, which is an important point of clarification but does not preclude autonomous practice for CPMs[36].

Removing the mandatory supervisory agreement provides all these benefits without eliminating adherence to clinical practice guidelines or standards of care.

## CNMs and CMs

The American College of Nurse Midwives (ACNM) and the American College of Obstetricians/Gynecologists (ACOG) support integrated care delivery between midwives and OBGYNs[35]. Midwives regularly collaborate with physicians through integrated practices and through adherence to clinical practice guidelines for physician collaboration, consultation, and referral -- all of which are core to midwifery practice. Importantly, integrated care delivery appears to increase upon removal of the requirement for written supervisory agreement. Given the comparable education between CNMs and CMs, the two midwifery licenses should be effectively identical. To the extent CNMs want to hold a nursing license in addition to their midwifery license, dual licensure is available, and the separate nursing license would continue to be issued by the Board of Nursing.

## Licensure qualifications

Qualifications for licensure must be established as a matter of law and are typically identified in statute with additional detail offered in regulations. Education, training and certificate examination, and pharmacology education for prescriptive authority are all examples of elements of licensure qualifications.[37] General statutory establishment of qualification categories is frequently coupled with regulations that feature additional detail and allow for more flexibility to adapt to professional, scientific, or clinical advancements over time. States have legal authority to establish licensure qualifications and state practices differ but typically incorporate national standards.[38]

## Clinical practice guidelines

Clinical practice guidelines for midwifery are set by national bodies that exist outside of state statutory or regulatory structures.[39] Statutes or regulations may incorporate such guidelines by reference and may highlight specific elements including, for example, physician collaboration, consultation, and referral. State regulators may modify clinical practice guidelines in state regulations, resulting in variation across states in scopes of practice allowed under state law. New Jersey's regulatory structure specifies that CNMs and CMs are to follow clinical practice guidelines set by the American College of Nurse Midwives; CPMs are to follow guidelines established by NARM.[40] The incorporation of these practice guidelines[41] would likely remain unchanged under a new statute.

## Prescriptive authority for CNMs and CMs

CNMs have prescriptive authority in every state. CMs have it in New York, Rhode Island, and Maine—likely explained by the fact that many states do not have the CM credential, since it is more recently established. CMs are well suited to prescriptive authority as they receive equivalent midwifery education to CNMs. As noted above, the difference is that CNMs also have nursing training, which is not relevant to the prescriptive authority determination for midwives. New Jersey can easily correct the inconsistent prescriptive authorization to grant such authority to CMs in statute. CPMs do not have and are not contemplated to have prescriptive authority, but may be authorized by state law to dispense and administer certain medications, for example, those prescribed by a collaborating physician, CNM or CM.[42]

## Discipline and enforcement

Violations of professional standards can necessitate discipline and enforcement. In New Jersey, such functions are performed by boards within the structure of the state Department of Law and Public Safety, consistent with the Uniform Enforcement Act.[43] It is assumed that a new midwifery statute would direct the midwifery board to operate similarly to existing statutory structures.

## Increase in home birth

Before modern medicine, births originally took place in the home. Then, interest in home birth dipped over time due to the development of the obstetrics field, introduction of medical interventions such as anesthesia and forceps to the birthing space, and increased use of hospital usage[44]. The interest in home birth is beginning to grow once more. Home birth in the United States increased by 19% in 2020, according to the Pew Research Center.[45] For those able to access home birth, planning for the need to transfer to a hospital is a recognized part of clinical practice. Some hospital-based providers express frustration at a lack of advance planning for home births that necessitate emergency hospital admission.[46] Clear advanced planning offers the benefit of seamless transition for patients and providers. Although New Jersey home birth providers may have relationships and/or collaborating agreements with hospital-based providers, the state has the option to require such planning. Core elements of evidence-based approaches to home birth include informed, regular communication during the prenatal period; advance planning, including emergency transportation and staffing preparation; notice procedures; record sharing; documentation; and evaluation mechanisms to ensure quality control and improvement.[47] Washington state's "Smooth Transitions[48]" program is considered a national model and is available for adoption in statute and regulation by New Jersey. Similar parameters can be introduced via legislation and fleshed out in a dual-agency regulatory process at the Department of Health (for hospitals and birth centers) and by professional licensing boards, namely a new midwifery board, at the Department of Law and Public Safety.

## Vital records

Vital records are a valuable source of public health data.[49] Research indicates the extent to which midwives serve as birth attendants might be underreported.[50] It is important to ensure accurate reporting and recording of the categorical sites of birth and the birth attendant on birth records. For example, systematic birth attendant data collection should list CNM, CM, or CPM as options.[51] Birth record clerks may need additional training to ensure accurate reporting. In addition, today it is difficult to quantify the number of planned deliveries expected to occur at home that eventually become transferred to hospitals. Accurate reporting of midwife-attended birth and adding a question regarding the "planned place of birth" can increase knowledge of the frequency with which changes to the planned site of birth are required and also help improve data integrity. Statutory modification of the long-form birth certificate to include updated questions is an option available to improve accuracy of birth data. To further enhance accuracy of vital records, New Jersey can also consider eliminating the current statutory bar to midwives signing certificates of fetal death. Data reporting structures require updating to accurately reflect the prevalence of midwife-led care and to account for transitions in birth plans.

# Considerations Relevant to New Jersey's Midwifery Practice Landscape

## Reimbursement for midwifery care

Consumer choice of caregiver and birth setting is an important part of evidence-based maternal health care. The American Public Health Association "supports efforts to increase access to out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers, through recognition that legally-regulated and nationally certified direct-entry midwives can serve clients desiring safe, planned, out-of-hospital maternity care services.[52]" Meaningful access to care often depends on affordability and insurance coverage -- not on autonomous practice alone.[53] Anecdotal reports suggest that some midwife-attended births are submitted for reimbursement as physician-attended births in order to secure a higher rate of reimbursement for the birthing facility. Regulators can take this opportunity to clarify rules regarding documentation of the birth provider of record and the importance of accurate claims submissions.

In addition, CPM care focused on out-of-hospital births is subject to highly-variable reimbursement patterns. Recent research finds that only 13 states include CPMs in state Medicaid plans. Private carriers are mandated to cover CPM-based care in only six states. Such uneven reimbursement leads to disparate access to a birth setting of choice and CPM-based care.[54] New Jersey Medicaid does not reimburse for midwife-assisted home birth, which limits access for lower-income New Jerseyans dependent on Medicaid coverage.[55]

## Admitting privileges

New Jersey hospitals and birthing centers are licensed and regulated by the state Department of Health (DOH). The DOH facility-licensing structure is separate from the licensing and regulation of health care professionals, which, with limited exceptions, occurs by the professional licensing boards housed within DCA as described above. Midwives in New Jersey face a variety of barriers to admitting privileges, including a recommendation from the Joint Commission that only providers with independent practice authority be granted such privileges in addition to a variety of hospital or health system rules.[56] Privileging rules strengthen access to care and are an important consideration for expanding availability of midwifery. Such changes could be accomplished via legislation and fleshed out via regulation. The chart below accounts for a waiver in effect in New Jersey.[57] Current reports from practitioners indicate that, although existing law allows CMs to work in hospital settings, many hospitals do not credential these care providers. Autonomous practice and reimbursement parity are factors that likely would increase credentialing.

### Current Sites of Midwifery-Assisted Delivery Care in NJ

**(by license type)**

| | Hospital | Birth Center | Home |
|---|---|---|---|
| **CPM** | | ✓ (*via waiver*) | ✓ |
| **CM** | ✓ | ✓ | ✓ |
| **CNM** | ✓ | ✓ | ✓ |

## Training and workforce development

As a recent Government Accountability Office (GAO) report makes clear, midwifery education scholarships and compensated clinical training placements are needed.[58] The New Jersey, New York, Pennsylvania and Connecticut region includes more midwifery programs than clinical training sites for learners. Fiscal and political support for additional clinical training placements, including increased supply of preceptors, is required to the midwifery workforce to achieve its potential. New Jersey can, for example, make permanent the midwifery scholarship and clinical placement funding first included in the FY 2023 budget.[59]

At the same time, establishing a direct entry midwifery CM and CPM education program within New Jersey could help increase and diversify the state's midwifery workforce.

There is only one midwifery education program in New Jersey—a master's and doctoral program at Rutgers University. In addition, medical schools and obstetric residency training programs do not regularly offer didactic or clinical training models that integrate midwifery practice. Such models of care teach collaborative practice incorporating midwifery within care teams[60] and help provide pathways toward more collegial practice environments.[61] New Jersey programs have the option to incorporate integrated care, even if accreditation requirements (which set curricular "floors") do not require it. Considerations around barriers to clinical placements and employment for CMs and CPMs in New Jersey must be considered simultaneous to efforts to increase educational opportunities to avoid creating new programs for individuals who would not find post-graduate employment in New Jersey.

# Financial Considerations for New Jersey Midwives

## Licensing fees

Each state sets its own registration and licensing fees; license renewal may be required on annual, biennial or triennial basis. New Jersey renewal occurs on a biennial registration basis. It is important to note that licensing and registration fees may be used to fund or defray costs associated with the licensing board and its staff. The Midwifery Liaison Committee in New Jersey has received administrative and other support from the Board of Medical Examiners by virtue of being a committee under the structure of the BME. If the state were to establish an independent midwifery board, it would be expected that the board would be independent from other boards and, as a result, would need to be self-supporting. The International Confederation of Midwives includes within its global standards that "the midwifery regulatory authority is funded by members of the profession.[62]" Although DCA and the Department of Law and Public Safety, in which it sits, provide staffing and a variety of other support to the boards, the budget needed to create an independent midwifery board would need to be established.

Most likely, the budget for setting up an independent board structure with independent practice authority, means New Jersey midwives would see a license fee increase due to administrative costs associated with establishment of new, independent board and board staff. This might be a worthwhile tradeoff, but should be accompanied by transparency with respect to the expected cost increase and potential variability of impact of increased costs on New Jersey's midwifery workforce. Although states set licensure costs, which include a variety of factors depending on board structure and administrative agency configuration as well as general geographic variation in terms of cost of living and costs of business, it might be useful to note the following licensing and registration fees in states indicated below.

State licensing fees vary. The chart below includes New Jersey fees and offers a comparison of key components of state fees at the time of this writing. (Note that states included in the chart all offer the CNM license, but other license types and features may vary. States may charge additional fees including for state examination, prescriptive authorization, and background checks. These additional fees beyond initial licensure and renewal are excluded from the chart below for ease of comparison).

### Midwifery license fees by state:

| | New Jersey[63] | Washington[64] | Oregon[65] | New York[66] | California[67] | Texas |
|---|---|---|---|---|---|---|
| **License or Initial Fees** | **License Application** $125 | **Initial Application** $541 | **Initial Application** $800 or $450* | **Initial fee** $322 | **Initial fee** $450 | **Initial fee** $195[68] |
| **Additional Fees** | **Prescriptive Authority** $50<br>**Background Check** $19.37 | **State Examination** $155 | N/A | N/A | N/A | N/A |
| **Renewal Frequency & Fees** | **Biennial** $135 (even year) or $270 (odd year) | **Annual** $541 | **Annual** $800 | **Triennial** $322 | **Biennial** $300 | **Biennial** $390[69] |

* As of 2020, Oregon offers $350 discount for certain direct entry midwifery license applicants

## Potential funding sources and budget considerations

New Jersey could elect to reduce or waive the midwifery licensing fee for the first two years of a new Board. This would accomplish two aims: Ease the burden on midwives serving lower-income clients who experience disproportionate burden of the likely-to-increase registration fees and incentivize midwives from other states to consider applying for a New Jersey license.[70] It might be possible to do this via a bridged cross subsidy from license fee surpluses within DCA or through the maternal health innovation center at the Economic Development Authority[71]. This waiver idea could work only if there is another source for fiscal support for the new midwifery Board infrastructure, since DCA will experience staffing and administrative cost increases associated with the new Board.

## Malpractice insurance

The requirement—or absence of one—for health care providers to carry professional liability insurance, also known as "malpractice insurance," is another issue in the foreground of autonomous practice for midwives and other health care providers. New Jersey law does not currently require midwives to hold malpractice insurance. In many instances, malpractice coverage is required and offered through an integrated practice arrangement with a hospital. In this way, the consulting physician's policy premium may lessen, in whole or in part, the midwife's liability exposure. Midwives in states with autonomous practice are typically required to have malpractice insurance. The introduction of such a requirement in New Jersey would represent a shift in midwifery law with such potentially-significant impacts as: (1) a new cost for New Jersey midwives who do not now carry independent professional liability insurance, with the corresponding benefit of limiting exposure to liability; (2) increased preference among midwives for group or integrated practice to absorb malpractice costs through shared policies and the ability to collectively-negotiate rates; (3) to the degree existing practice agreements in which physicians[72]—but not midwives—hold malpractice insurance, the introduction of liability insurance parity could offer some relief to physician burden.

The extent to which it would result in meaningful financial impact on New Jersey midwives is uncertain and would likely depend upon practice arrangement, with the biggest cost increase on midwives who practice independently and/or in home settings and do not now hold malpractice coverage. Overall, an actuarial analysis is required to more precisely predict costs associated with establishing a malpractice insurance requirement for midwives in New Jersey.

## Evaluation of impact of changes in the law

Research-based evaluation of any major statutory and regulatory changes is integral to gold standard health policymaking. Although expected outcomes of proposed changes are identified in this document, it is necessary to conduct some form of ongoing evaluation to facilitate revisions as may be necessary. The State has the opportunity to document baseline features, track changes over time, and evaluate to identify impact and needed modifications.

# Conclusion

## New Jersey would be a healthier, more equitable place to live if the structure governing midwifery were modernized.

Needed reforms require legislation and regulations that reflect the contemporary health care landscape and recognize the presence of wide health disparities brought about by years of discriminatory policies and practices. Midwives have much to offer; helping them make their work more widely available and sustainable is in the interest of every New Jerseyan.

# Endnotes

1 (N.J.S.A. 45:10-1 and continuing through 45:10-8).

2 This paper assumes familiarity with The NJHCQI/ Burke Foundation Report "Delivering Better Care: Midwifery Practice in New Jersey" published June of 2022 ("Delivering Better Care"). The New Jersey Health Care Quality Institute, & The Burke Foundation. (2022, June). Delivering Better Care: Midwifery Practice in New Jersey. https://www.njhcqi.org/wp-content/uploads/2022/06/Delivering-Better-Care-Midwifery-Practice-in-New-Jersey-Report_2022.pdf

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7 This paper does not address payment reform other than to recognizes that payment structures are significant levers to advance both equity and access; for analysis of these considerations, see the Quality Institute report.

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10 "Certified midwife (CM)" means a person who is or ever was certified by the American Midwifery Certification Board (AMCB) or its successors as a certified midwife. "Certified nurse midwife (CNM)" means a person who is a registered nurse and who is or ever was certified by the American College of Nurse Midwives (ACNM) or the AMCB or their successors as a certified nurse midwife. "Certified professional midwife (CPM)" means a person who holds certification from the North American Registry of Midwives (NARM) or its successor. New Jersey Administrative Code Title 13 Law and Public Safety Chapter 35 Subchapter 2A Limited Licenses: Midwifery. https://www.njconsumeraffairs.gov/regulations/Chapter-35-Subchapter-2A-Midwifery-Liaison-Committee.pdf

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16 N.J.S.A. 45:10-1 et seq

17 Prescriptive authority refers to permission, under law, for health care providers to prescribe medication. Prescriptive authority may vary by health care professional license type and may also vary by type of medication (i.e. controlled substance scheduling) expressed via a "formulary" functioning as a list of medications that may or may not be prescribed. Health care providers without independent prescriptive authority may be authorized to order, dispense and administer certain medications pursuant to a supervisory and/or collaborative arrangement with another provider (e.g. a physician) who holds prescriptive authority.

18 Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions among Professional Midwifery Credentials in the U.S. American College of Nurse-Midwives. (n.d.). https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf

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*See, for example*:
**ACOG/ ACNM:** "ACOG's Joint Statement of Policy with the American College of Nurse-Midwives supports full scope, autonomous practice for certified nurse-midwives (CNMs) and certified midwives (CMs) and birth center accreditation and licensure" Joint Statement of Practice Relations between ACNM and ACOG. American College of Obstetricians and Gynecologists. (n.d.). https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/joint-statement-of-practice-relations-between-ob-gyns-and-cnms
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**Center for American Progress:** Eliminating Racial Disparities in Maternal and Infant Mortality A Comprehensive Policy Blueprint "Collaborative agreements hamper access to midwifery care when a midwife cannot identify a physician willing to sign the agreement. This can be cause for denial of payment, even if the services provided are within the midwife's scope. The requirement of a formal agreement with a physician can also limit the availability of midwives in a particular state or hospital, leading to limitations on opportunities to practice midwifery as well as access to midwifery care for women and families in need. Similarly, the lack of authority to prescribe also imposes challenges for midwives as the requirement prevents them from building independent practices…"
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# Approaches for Modernizing the Midwifery Profession: New Jersey's Regulatory and Licensing Structure

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