HB 1211

Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE

House Bill 1211 (Delegate A. Kelly, *et al.*)
Health and Government Operations

State Board of Nursing - Midwives - Licensing and Regulation

This bill establishes the Midwifery Advisory Committee within the State Board of Nursing (BON) and the procedures for obtaining and renewing a license to practice traditional midwifery. The bill provides for the membership of the advisory committee, the application process, enforcement and hearing procedures, and fees associated with licensure. BON is required to adopt regulations for the licensure of midwives and the practice of traditional midwifery, and the bill establishes numerous restrictions and requirements pertaining to the practice of traditional midwifery. BON must report specified information to specified legislative committees by December 1, 2016. The licensure process established by the bill is subject to sunset review and, unless reauthorized, terminates July 1, 2023.

Fiscal Summary

State Effect: Special fund expenditures increase by $38.200 in FY 2015 for BON to establish regulations and begin the process of licensing midwives. Special fund revenues increase beginning in FY 2016 from new licensing fee revenues, presumably in an amount sufficient to cover costs. Future year expenditures reflect annualization and inflation. General fund revenues may increase minimally due to the bill's civil penalties.

(in dollars)	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
SF Revenue	$0	-	-	-	-
SF Expenditure	$38,200	$40,100	$41,700	$43,400	$45,200
Net Effect	($38,200)	($40,100)	($41,700)	($43,400)	($45,200)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: Meaningful.

Analysis

Bill Summary:

The Practice of Midwifery

"Practice traditional midwifery" is defined as providing primary maternity care consistent with a midwife's training, education, and experience to women and their newborn children throughout the childbearing cycle, and it includes identifying and referring women or their newborn children who require medical care to an appropriate health care practitioner. The practice of traditional midwifery includes providing the necessary supervision, care, and advice to a client consistent with national professional standards and based on the acquisition of clinical skills. The bill states that the practice of traditional midwifery includes:

- obtaining informed consent to provide services;
- obtaining a health history, including a physical examination;
- developing a plan of care for a client;
- evaluating the results of client care;
- consulting and collaborating with and referring and transferring care to a licensed health care practitioner, as appropriate;
- obtaining specified medications to administer to clients;
- obtaining food, food extracts, and dietary supplements; homeopathic remedies; plant substances that are not designated as prescription drugs or controlled substances; and over-the-counter medications to administer to clients;
- obtaining and using appropriate equipment and devices;
- obtaining appropriate screening and testing, including laboratory tests, urinalysis, and ultrasound;
- providing prenatal care during the antepartum period;

- providing care during the intrapartum period;
- providing care during the postpartum period;
- providing care during the newborn period;
- providing limited interconceptual services; and
- executing appropriate orders of a licensed health care practitioner.

The bill states that the practice of traditional midwifery does *not* include (1) the administration of a prescription drug to a client in a manner that violates the provisions of the bill; (2) assisting childbirth by artificial or mechanical means; (3) effecting any type of surgical delivery, except for an emergency episiotomy; (4) administering any type of epidural, spinal, or caudal anesthetic or any type of narcotic analgesia; or (5) the use of forceps or a vacuum extractor.

State Board of Nursing Regulation

BON must adopt regulations for the licensure of midwives and for the practice of traditional midwifery. BON must adopt regulations specifying approved types of instruments and procedures for the practice of traditional midwifery. BON has to establish reasonable cost-recovery fees for the issuance and renewal of licenses and other services it provides to licensed midwives. The regulations may not require a licensed midwife to practice traditional midwifery under the supervision of, or have an agreement with, another health care practitioner. Additionally, the regulations may not require a licensed midwife to be licensed as a nurse. The regulations may not limit the location where a licensed midwife may practice. A woman seeking traditional midwifery services cannot be required to be assessed by another health care practitioner.

The Midwifery Advisory Committee

The bill establishes a Midwifery Advisory Committee within BON. BON is to appoint the five members of the committee, with membership subject to numerous specified conditions based on position, experience, credentials, and other factors. The bill provides for the chairmanship, the length and number of terms, removal of members, and other procedures such as the constitution of a quorum and the filling of vacancies on the committee. Committee members are entitled to compensation and reimbursement.

The committee must develop and make recommendations to BON regarding regulations relating to the practice of traditional midwifery, including, among other things,

requirements for licensure and establishment of standards of care, the use of temporary permits pending qualification for licensure, licensure renewal and continuing education, and consistency with specified standards of practice.

The committee must also make recommendations on a code of ethics, licensure requirements, and continuing education; review applications for licensure as well as advertising by licensed midwives and institutions that offer a midwife program and make recommendations to BON; maintain a list of all licensed midwives; at the request of BON, investigate complaints and conduct inspections; keep records of proceedings; submit an annual report to BON; and advise BON on matters relating to the practice of traditional midwifery.

Licensure Requirements and Application Procedures

Generally, an individual must be licensed by BON before the individual may practice traditional midwifery in the State. Exempt are individuals assisting at a birth in an emergency and licensed health care practitioners authorized to practice traditional midwifery, as well as students practicing traditional midwifery under the supervision of a licensed midwife. An applicant for licensure must:

- be age 21 or older and of good moral character;
- be a high school graduate or have completed equivalent education;
- submit to a criminal history records check (CHRC);
- hold a valid Certified Professional Midwife (CPM) credential granted by the North American Registry of Midwives (NARM);
- be certified to perform cardiopulmonary resuscitation and hold a current neonatal resuscitation certification;
- provide documentation of successful completion of a pharmacology course recommended by the committee and approved by BON; and
- have successfully completed a preceptorship with a preceptor who possesses specified experience.

If the CHRC reveals that a crime has been committed, the board must consider the age at which the crime was committed, the circumstances surrounding the crime, the length of time that has passed since the crime, subsequent work history, employment and character references, and other evidence that demonstrates that the applicant does not pose a threat to the public health or safety. BON may not issue a license if the CHRC has not been received. However, BON may waive the education and training requirements for an individual licensed in another state if the other state's licensure requirements are substantially equivalent to Maryland's and the applicant otherwise meets the qualifications for licensure.

BON must issue a license to any applicant who meets the requirements of the bill and pays the required license fee. A license may not be renewed for a term longer than two years. At least three months before a license expires, BON must send a renewal notice to the licensee, which must state the date on which the current license expires, the date by which the renewal application must be received, and the amount of the renewal fee. A licensee must submit to an additional CHRC every 12 years.

Among other requirements, a renewal applicant must provide satisfactory evidence of compliance with any continuing education or other competency requirements. The bill specifies that BON must require 20 continuing education units to be completed every two years, of which 4 units must relate to peer review. If a licensee fails to provide evidence of compliance with continuing education requirements, BON must place the licensee on inactive status.

BON must also place a licensee on inactive status if the licensee submits an application for inactive status and pays an inactive status fee. BON must reactivate a licensee on inactive status if (1) the licensee complies with the continuing education requirement; (2) pays to the reactivation fee; and (3) is otherwise entitled to be licensed. Likewise, BON must reinstate a licensee who has failed to renew a license if the individual is otherwise entitled to be licensed, complies with continuing education requirements, pays a reinstatement fee, and applies for reinstatement within five years. The bill establishes procedures and restrictions on the surrender of a license while an investigation or charges are pending against the licensee.

An individual may not represent to the public that the individual is authorized to practice traditional midwifery, unless authorized to do so. Additionally, a licensee may not advertise in a manner that is unreasonable, misleading, or fraudulent. Unless authorized to practice traditional midwifery under this subtitle, a person may not use the designation "midwife," "licensed midwife," or "L.M."

Enforcement and Hearing Procedures

The bill establishes 36 grounds under which BON may deny a license to an applicant, reprimand a licensee, place a licensee on probation, or suspend or revoke a license. Before BON takes disciplinary action, it must give the person an opportunity for a hearing before the board, unless the Administrative Procedure Act (APA) provides otherwise. BON must give notice and hold a hearing in accordance with APA. The person against whom action is being taken may be represented at the hearing by counsel. The bill authorizes BON to issue subpoenas and administer oaths. A court must compel compliance with a subpoena and may hold the person in contempt of court. If, after notice is provided, the person fails or refuses to appear, BON may hear and determine the matter. A hearing may not be stayed or challenged by procedural defects occurring prior to the filing of charges.

After BON conducts an investigation, it may issue an advisory letter to a licensee, which may be disclosed to the public. The issuance of an advisory letter is not a disciplinary action and may not be reported to any licensing entity, employer, or insurance company as a disciplinary action.

If BON finds grounds to suspend or revoke a license after a hearing, BON may impose a penalty of up to $5,000 in lieu of suspension, or in addition to a suspension or revocation; BON must adopt regulations to set standards for the imposition of penalties. Penalties are to be paid to the general fund.

Generally, a person aggrieved by a final decision of BON in a contested case, as defined in APA, may appeal the decision to the Board of Review, and take any further appeal allowed by APA. A person aggrieved by a final decision of BON may not appeal to the Secretary or Board of Review, but may seek judicial review under APA procedures. An order of BON may not be stayed pending review.

BON must wait for one year to reinstate a license that has been suspended or revoked for a period of more than one year.

A person who violates any provision of the bill is guilty of a misdemeanor and on conviction is subject to a fine of up to $5,000 and/or imprisonment for up to one year.

Practice Requirements, Informed Consent, and Liability

Before initiating care, a licensed midwife must obtain a signed informed consent agreement from each client. The informed consent agreement must include specified acknowledgments, including the licensed midwife's experience; any insurance coverage

of the licensee; instructions for filing a complaint with BON; and a description of the procedures, benefits, and risks of home births.

If a client is determined to have 1 of 19 specified conditions, a licensed midwife must refer and transfer care to a licensed physician or licensed nurse who is a certified nurse midwife. Additionally, care of a newborn must be transferred to a hospital if a newborn is determined to have one of five specified conditions. If a client has been informed about a condition requiring transfer of care and the client declines the referral and transfer of care, the midwife either must terminate care or may continue care, but only if the client signs a waiver of medical consultation, collaboration, referral, or transfer from a licensed health care practitioner other than the licensed midwife.

In preparation to perform a vaginal birth after cesarean section, breech delivery, or delivery of multiple birth gestation, a licensed midwife must obtain informed consent and other specified documentation. Procedures specific to each delivery method must be followed – such as that a second licensed midwife must be in attendance for a delivery of multiple birth gestation and alerting the nearest hospital of the client and providing the hospital with prenatal records before undertaking a breech delivery or multiple birth gestation delivery.

Regardless of the type of birth or delivery, the bill requires a licensed midwife to develop a written plan for *each* client for emergency transfer and transport of an infant to a newborn nursery or neonatal intensive care nursery and a client to an appropriate obstetrical department or patient care area in a health care facility. Once the decision to transfer or transport a client has been made, the licensed midwife must call ahead to the health care facility or health care practitioner and inform them of the incoming transport. The Midwifery Advisory Committee, in consultation with Association of Independent Midwives of Maryland, must develop a form for use in all cases in which a transfer or transport occurs that includes the medical information needed by the health care facility or health care practitioner receiving the client.

A licensed midwife engaged in the private practice of traditional midwifery must display a notice written in layman's language that explains the U.S. Centers for Disease Control and Prevention's guidelines on universal precautions conspicuously in each office where the licensed midwife is engaged in practice.

Except for any willful or grossly negligent act, a licensed physician, health care facility, health care practitioners or emergency room personnel who work at a health care facility, or emergency medical technicians or ambulance personnel may not be held civilly liable for an action arising from an injury resulting from an act or omission of a licensed midwife, even if the person consulted with, or accepted a referral from, the midwife. A physician who consults with a licensed midwife but who does not examine or treat a

client of the licensed midwife may not be deemed to have created a physician-patient relationship with the client.

Sunset Review

The bill subjects the new licensure program to periodic review under the Maryland Program Evaluation Act, as with other health occupations boards, with a termination date of July 1, 2023 (consistent with that for BON).

Reporting Requirement

By December 1, 2016, BON must report, in consultation with the Midwifery Advisory Committee, to specified legislative committees on (1) the number of licensed midwives in the State; (2) the number and circumstances of all healthy and adverse birth outcomes attended by licensed midwives, as well as births where a transfer or transport was made; and (3) recommendations for the continuation and improvement of the licensure of midwives.

Current Law/Background: The profession of midwifery includes direct-entry midwives and nurse midwives. BON provides advanced practice registered nurse certification to nurse midwives, who must also be licensed registered nurses. Under board regulations, an applicant for certification as a nurse midwife must hold a current license to practice registered nursing in Maryland and complete a program in a clinical nurse specialty area accredited by a national certifying body that is specified or recognized by the board. According to the Department of Health and Mental Hygiene (DHMH), as of June 2010, certified nurse midwives in Maryland are no longer required to have a physician sign a collaborative agreement to provide clinical support to their attended births, but instead they must give BON a copy of a collaborative plan that lists a physician to whom they would transfer a patient in case of an emergency.

Direct-entry midwifery refers to an educational path that does not require prior nursing training to enter the profession. NARM issues the national, competency-based CPM credential. As of January 2012, more than 2,000 midwives nationally held CPM certification. CPMs offer primary maternity care to women in private homes or birth center-based practices. The CPM credential allows multiple routes of entry into the profession. Aspiring midwives can attend a midwifery program or school or apprentice with a qualified midwife and complete an evaluation process that verifies an individual's experience and skills. Individuals must then sit for the NARM written examination. Recertification is required every three years and includes a continuing education requirement.

Although NARM offers certification as a CPM, CPMs are guided by the National Association of Certified Professional Midwives (NACPM) Standards for Practice and the Midwives' Model of Care™ based on the fact that pregnancy and birth are normal life events. Midwife care includes (1) monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; (2) providing the mother with individualized education, counseling, and prenatal care; (3) continuous hands-on assistance during labor and delivery and postpartum support; (4) minimizing technological interventions; and (5) identifying and referring women who require obstetrical attention. According to NACPM, the application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

According to the Midwives Alliance of North America, nurse midwives practice legally in all 50 states and the District of Columbia. More than one-half of all states (including Delaware and Virginia) recognize CPMs in statute. In 2007, the Washington State legislature commissioned a cost-benefit analysis from the Washington Department of Health on licensed midwifery care. That analysis found that licensed midwives save the State of Washington at least $473,000 per biennium in cost offsets to Medicaid when women give birth at home or in freestanding birth centers. This was a conservative estimate that reflects only avoided costs associated with licensed midwives' lower cesarean section rates. When facility fees and medical procedures such as epidurals and continuous electronic fetal monitoring are factored into the equation, the actual savings to Medicaid biennially are approximately $3.1 million. These savings occur with licensed midwives attending fewer than 2% of births in Washington State.

During the 2012 interim, DHMH convened the Midwives Workgroup at the request of the House Health and Government Operations Committee, with a report published in January 2013. The workgroup was charged with (1) analyzing the shortage of certified nurse midwives and barriers in nurse-midwifery practice; (2) evaluating consumer concerns and motivations surrounding the birthing process; (3) conducting a review of current legislation and regulations in other states concerning the licensing, educational requirements, and scope of practice of CPMs; and (4) reviewing available evidence regarding the safety and outcomes of births attended by CPMs, certified nurse midwives, and obstetricians, as well as the safety of home births and birth centers compared to hospitals.

The report noted that data on the number of CPMs and certified midwives in Maryland is limited because they are not licensed to practice in the State. However, the percentage of U.S. births occurring at home increased between 2004 and 2009 after decreasing from 1990 to 2004. In Maryland, although there are 214 certified nurse midwives licensed to practice in Maryland, fewer than half actually practice full-scope midwifery, and only 4 currently attend home births. Thus, 97% of all births attended by certified nurse midwives in the State occur in hospitals.

The workgroup did not adopt consensus recommendations due to diverse views on how to best address the increased demand for licensed, safe home birth services in Maryland. DHMH did recommend further exploration into why so few certified nurse midwives practice midwifery. Additionally, DHMH reaffirmed its support of the Joint Statement on Planned Home Births issued in 2012 (as endorsed by BON, the Maryland Association of County Health Officers, and the Maryland Affiliate of the American College of Nurse-Midwives), which states that (1) during the course of prenatal care, a pregnant woman considering a home birth should consult with a licensed physician or licensed certified nurse midwife in order to be assessed as a candidate for a home birth; (2) to ensure the health and safety of the mother and infant, all planned home deliveries must be attended by a licensed physician or licensed certified nurse midwife; and (3) it is unlawful for a physician or midwife to practice in Maryland without a valid Maryland license.

While the workgroup *did not* reach consensus, the report provides a wide range of options regarding the various charges of the workgroup. The options presented included, among many others:

- establishing an independent midwifery board for licensure, regulation, and oversight of midwives, including CPMs;
- adopting the certified professional credential as the model for licensure of direct-entry midwives in Maryland;
- requiring that NARM certification be the educational requirement for CPM licensure in Maryland; and
- requiring a minimum level of education and training for all midwives according to standards set by the American Midwifery Certification Board.

State Fiscal Effect: Based on the workgroup's study of midwifery in 2012, BON advises that 24 individuals are likely to seek licensure under the bill's provisions; however, BON further advises that the number could double if midwives from surrounding states also apply for licensure. Assuming approximately 25 individuals seek licensure, the Department of Legislative Services (DLS) advises that special fund expenditures increase by $38,204 in fiscal 2015, which accounts for the bill's October 1, 2014 effective date. This estimate reflects the cost of hiring one part-time permanent administrator to help BON establish regulations, establish the committee, and license midwives. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses. The estimate includes $9,000 for compensation and reimbursement for committee members but does not factor in any computer programming costs (which are not required by the bill). The committee is simply required to maintain a *list* of licensees.

BON advises that the bill necessitates hiring 11 full-time employees at a cost of $1,079,264 beginning in fiscal 2015. BON's estimate is based on the 24 individuals it expects to seek licensure and includes approximately $451,000 for electronic licensure, computer programming, and developing paper and electronic applications for midwives. It also assumes significant resources for investigating and prosecuting complaints. DLS disagrees.

DLS advises that BON can accomplish the bill's requirements with one part-time administrative employee, even if the number of individuals seeking licensure is greater than anticipated. BON advises that it will likely take at least a year to develop regulations; although the bill is prescriptive in terms of required regulations, the Midwifery Advisory Committee (which must be appointed and meet) is required to have input into many of the regulations. Thus, DLS agrees that regulations likely take several months to promulgate. Since midwives are not authorized to practice in the State until regulations are developed, there is no need for investigators or prosecutors to be available initially. To the extent complaints are received, special fund expenditures may increase beginning in fiscal 2016 to hire a contractual investigator and an assistant Attorney General on a part-time basis to investigate complaints and take disciplinary actions as needed. Any such cost has not been factored into this estimate.

Position	0.5
Salary and Fringe Benefits	$24,616
Committee Compensation	9,000
Operating Expenses	4,588
Total FY 2015 State Expenditures	**$38,204**

Under the bill, the board is authorized to set *reasonable* fees for the issuance and renewal of licenses for midwives sufficient to produce funds to approximate the cost of maintaining the licensure program and other services provided to midwives. Upon the bill's effective date, October 1, 2014, midwives must be licensed to practice midwifery in the State. However, because BON advises that it likely will not have the regulations promulgated before July 1, 2015, special fund revenues for BON increase beginning in fiscal 2016 when licensure begins.

The bill does not specify whether licensure is annual or biennial; however, it limits renewal to a term of no longer than two years. Thus, biennial licensure is assumed. BON did not provide an estimate of what it expects to charge midwives for licensure and renewal fees. Based on DLS cost estimates and assuming that approximately 25 midwives wish to be able to practice in Maryland, BON would need to charge *at least* $3,132 ($1,566 per year) to *cover* the expenditures of the board for the fiscal 2015 and 2016 biennial period. Additional revenues would be required to cover any necessary investigative services and communication with licensees. To the extent that the number

of licensed midwives increases to 50 by the second biennial licensure renewal period (fiscal 2017 and 2018), licensure fees may be able to decrease to a minimum of $1,702 ($851 per year).

This estimate assumes cost recovery rather than reasonableness of fees charged. If BON cost estimates are used with the same 25 licensees, the initial licensure fee would have to be set at $75,000. BON currently licenses (or certifies) almost 300,000 individuals with 77 full-time regular and 4 contractual positions authorized in the Governor's proposed fiscal 2015 operating budget. BON's fund balance (projected to be more than $1.5 million at the end of fiscal 2015) is likely sufficient to cover necessary costs associated with licensing midwives as proposed in the bill at a fee that is more in line with fees charged nurses. The board charges $110 for biennial renewal fees for registered nurses and licensed practical nurses.

Small Business Effect: Costs for direct-entry midwives who must obtain licensure in order to practice in Maryland increase significantly because of likely high licensure and renewal fees.

Additional Information

Prior Introductions: Other legislation to regulate midwives has been considered recently. HB 1056 of 2012 would have established a separate board within DHMH to license midwives; HB 1056 was heard by the House Health and Government Operations Committee, but no further action was taken on the bill. HB 1202 of 2013 would have established a pilot program for CPMs to practice in Maryland; HB 1202 was heard by the House Health and Government Operations Committee and was subsequently withdrawn.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene; Office of Administrative Hearings; Midwives Alliance of North America; National Association of Certified Professional Midwives; Health Management Associates, *Midwifery Licensure and Discipline Program in Washington State*: *Economic Costs and Benefits*; Department of Legislative Services

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