

Midwifery Workgroup Kickoff Meeting

October 5, 2026

9am-11am

Department of Medical Assistance Services (DMAS)

600 East Broad St.

Richmond, VA 23219

Conference Rooms A and B

Virtual Access Link for Public:

<https://teams.microsoft.com/meet/267957061447563?p=kMj67vFf7Qb0JjHVbP>

Meeting Minutes

Council Member Attendance	Voting Record
	Y=Yes, N=No, A=Abstain, M1= Motion, M2= Second
<i>Italicized</i> = Absent	By-laws and Virtual Meeting Policy
Voting Members	
Allie Atkeson, DMAS, Co-chair	Y
Dr. Vanessa Walker Harris, Virginia Department of Health (VDH), Co-chair	Y
Hope Richardson, Office of the Secretary of Health and Human Services (SHHR)	Y
Mindy Eckstein, Virginia Rural Health Association (VRHA)	Y
Sara Crow, Aetna	Y
Keana Gates, mother	Y
Kathryn Haines, Virginia Interfaith Center for Public Policy	Y
Elizabeth Kielb, March of Dimes (MOD)	Y
Degra Nofsinger, CPM, LCM, Virginia Midwives Alliance (VMA)	Y
Misty Ward, CPM, LCM, Virginia Birth Center Alliance	Y
Kelly Dodson, Humana	Y
David Brown, Department of Health Professions (DHP)	Y
LeaAnna Miller, proxy for Kate Becker, CPM, New Life Midwifery	Y
Andrianna Ross, CPM, River City Midwifery	Y
Dr. Nichole Wardlaw, DNP, CNM, FACNM, Jamii Birth & Wellness Services	Y
Dr. Lee-Ann Parker, RN, MSN, CNM, American College of Nurse Midwives (ACNM)	Y
Dr. Casey Self, United Healthcare	Y
Heidi Dix, Virginia Association of Health Plans (VAHP)	Y

Dr. Natalie Feldman, Anthem	Y
Tanyatta Green, proxy for Jamie Edwards, Sentara	Y
Nytasha Stevens, proxy for Nikiya Ellis, Diverse Birth Collective	Y

Internal Workgroup Agency Staff Attending: Sonya Kibler (DMAS), Michelle Watts (DMAS), Nicole Brickhouse (DMAS), Jacklyn Brown (DMAS), Jessica Mackenzie (DMAS), Jennifer Macdonald (VDH)

Other Agency Staff Attending: Tekeila Parran (DMAS), Estelle Kendall (DMAS), Heath Kirby (DMAS), Elizabeth Howe-Huist (DMAS), Emily Roller (DMAS), Anna Garrett (DMAS), Isabelle Drayer (DMAS), Marina Hench (DMAS)

Virtual Participants Attending: (Note: This is not a complete list): Scott Cannady (DMAS), Katie Page (American College of Nurse Midwives)

Welcome, Introductions and Workgroup Mandate

Meeting Called to Order at 9:00 am

Introductions of workgroup members were made. A quorum was established.

Allie Atkeson provided a review of the meeting agenda and the charge of the workgroup.

- *The Department of Medical Assistance Services and the Virginia Department of Health shall convene a workgroup to address barriers that prevent certain licensed midwives (CPMs) and licensed certified midwives (CMs) and licensed certified nurse midwives (CNMs) from contracting with managed care organizations (MCOs) through Cardinal Care.*
- Workgroup membership requirements were reviewed.
- The workgroup shall present recommendations and budget requests to the General Assembly by 12/1/2027.

Review Bylaws and Virtual Meeting Policy

Jessica Mackenzie, Senior Policy Analyst, DMAS, presented draft work group by-laws and virtual meeting policy to the workgroup. Workgroup voted to accept by-laws and virtual meeting policy by voice vote.

Overview of Licensed Midwives in Virginia

David Brown, Director, DHP, provided an overview of licensed state midwives.

- There are three different types of licensed midwives in Virginia. Provided information on their relative training programs and the relevant regulatory bodies:
 - Certified Nurse Midwife (CNM)
 - Licensed Certified Midwife (LCM)
 - Licensed Professional Midwife (LPM)
- Also detailed were requirements, practice and prescribing rights for each license type. Presentation also provided links to the Code of Virginia and Virginia Administrative Code for each license type and the DHP 2021 Report on Midwifery Licensing Entity.

Discussion:

- Community midwife, as a type, is missing in the presentation.
- Medications included on the Virginia Board of Medicine Midwifery formulary were discussed.

Utilization of Licensed Midwives in Virginia

Sonya Kibler, Maternal and Child Health Program Analyst, DMAS, presented on the utilization of midwifery service by Medicaid members.

- Approximately 3,200 births are attended by a midwife provider each year in Virginia Medicaid
- Virginia is on par with the national avg (9-10%) for percent of midwife assisted births among all live births. Highest: Tidewater and Charlottesville. Lowest: Southwest (SW)
- There were more CNMs than CPMs in all regions of the state in both state Fiscal Years (SFY) 25 & 26. The number of CNMs and CPMs enrolled as Medicaid providers increased slightly from 508 (SFY25) to 558 (SFY26)
- 95% of Medicaid midwife-assisted births were full term in both SFY25 and SFY26.
- 83-97% of babies born in all regions were normal birth weight in SFY25 & SFY26
- Four of six regions showed an increase in the numbers of members receiving mental health (MH) screenings by midwives in SFY25 & SFY26.
- The number of midwives conducting MH screenings increased in all regions except SW in SFYs 25 & 26.
- Birthing centers are not licensed and accredited in Virginia, and they are not reimbursed through Medicaid. As a result, there is zero utilization data on birth center facilities, although midwifery services performed at such facilities may be billed to Medicaid.

Discussion:

- Tracking claims and the necessity to bill the MH screening separate is imperfect. There is a specific list of CPM codes and MH screening is not on their list. In practice, patients are screened in every trimester and there is no way to bill for it. For many CPT codes, you need to change provider type to bill. Can CNMs bill as primary care?
- Access to care for MH services who receive midwifery services in fee for service vs. managed care is a challenge.
- The Affordable Care Act contains strong language for reimbursement to birthing centers, if they are licensed by the state. Virginia does not meet that requirement.
- Informal partnership with Hospitals (MOUs) may be opportunity and may be a workaround for regulatory constraint.
- Percent of midwives who participate in Medicaid 75% midwives is high – how does this correlate to other professions (e.g. doctor, dentists) and could this be because midwives may work in hospital settings?

Action items for next meeting:

- Generate and present map of midwives in the state
- Present data on where births attended by midwives occur and broken down further by population demographics
- If possible, break out metrics on hospital vs community-based midwifery services
- An insurance broker will be participating in one focused meeting to discuss challenges noted.

Current MCO Exemption Process

Jackie Brown, Nurse Case Coordinator, DMAS, presented information on the midwife exemption process.

- For those members who would like to receive midwifery care an exemption must occur. Once exemption is approved, the member will transfer to fee-for-service (FFS) and at 60 days postpartum, will transfer back to MCO coverage.
- Once member is placed into FFS, the CPM is authorized to bill Medicaid directly for prenatal and delivery services.
- From August 2025 – August 2026, 247 members created midwife exemptions.

Discussion:

- The exemption process takes than 15 days, per DMAS, once a request is made. Feedback from midwives is that they are not getting them from enrollment brokers directly.
- The impact of global billing going away is that unbundling of codes will allow DMAS to be able to better track evaluation and management (E/M) codes.

Action items for next meeting:

- Present exemption data by midwife type.

State Medicaid Reimbursement Models

Allie Atkinson, Senior Program Advisor, DMAS, presented on state models for Medicaid reimbursement for midwifery services.

- State Medicaid programs have various coverage and reimbursement models across midwifery provider types and birthing centers.
- Medicaid is required to cover services by CNMs. States can choose to cover CPMs or certified midwives under other licensed practitioner services.
- Currently 23 states cover CPMs in their Medicaid program, and 6 states cover services certified midwives.
- The Affordable Care Act requires Medicaid to cover services at birth centers in states where they are licensed. Virginia is among six states that do not license birth centers; therefore, they are not reimbursed a facility fee by Medicaid. New facilities would be subject to the state certificate of public need (COPN) process according to the 2013 Joint Commission on Health Care report.

Discussion:

- VDH Office of Licensure (OLC) may be able to answer questions about a COPN process.

Action items for next meeting:

- Update Birth Center Licensure and Medicaid Recognition map to accurately reflect Virginia's status (source: American Association of Birth Centers)

Open Discussion

Open discussion focused on challenges that weren't already discussed. This will enable future meeting planning to include applicable subject matter expertise to speak to these.

- MCO credentialing
- MCOs require malpractice insurance and a limit. Two of the MCOs do not cover home birth. Obtaining malpractice insurance is a barrier. Only three companies nationwide offer insurance for home births and cost is prohibitive. In other states, exchanges are provided.
- MCO requirement of an overseeing physician. This is not required for licensure.
- Admitting privileges to hospital is a challenge.
- No clear roles between MCO/DMAS – often seen “passing the buck” between the two entities which creates barriers and frustration for members and providers.
- Limitation of FFS creates lack of access to mental health and physical therapy services and durable medical equipment (DME) (e.g. breast pump, diabetic equipment, blood pressure cuffs). Midwives are not listed as provider type to order DME.
- MCOs include social determinant of health incentives in their plans which are noted included in FFS: transportation, diapers, care coordination services, access to medical apps.
- After 60 days postpartum, with the transfer back to MCO, members may lose continuity of care.
- Mother recounted lived experience with losing coverage over administrative barriers and had to pay out of pocket expenses.
- Medical education such as diabetes and/or diet education require a referral by a DO or MD.
- Pain relief reimbursement is zero and can be a substantial cost to the midwife.

- Need to understand any criteria for high risk factors and co-caring physician – Because only one provider can bill for labor and delivery, often the community midwife isn't reimbursed for her time and effort for labor services when a hospital transfer is made.
- Midwives state an inability to gain privileges in the hospitals because hospitals state midwives need to have a supervisory physician. – Can private hospitals negate a regulator?
- There are very few written MOUs between a midwife and hospital because of assumed liability. It's common practice for midwives, at any occurrence of a transfer to a hospital, to send medical records to hospitals and complete a warm handoff to describe the situation, background, assessment and recommendation ("SBAR"). Are there specific hospital policies to make the transfer safer so teams can be cohesiveness and understand that the midwife is a capable member of the team?
- It'd be helpful for DHP and DMAS to use the same language for types of midwives.

Public Comment

There were no verbal or written public comments.

Closing

Presentations will be posted publicly on DMAS and Town Hall websites.

Meeting materials and a poll to set next meeting date in December will be sent to workgroup members

Meeting was adjourned at 11:00am by Co-Chair Dr. Walker Harris.