

Minnesota performs well on several key maternal health indicators compared to national averages, reflecting a generally supportive policy environment. However, these statewide outcomes mask persistent inequities in both outcomes and experiences of care for Black, American Indian, and immigrant families. The state also faces ongoing access challenges in rural communities, where hospital-based obstetric services have declined over the past decade.

Maternal Health in Minnesota At a Glance

Minnesota ranks among the top states in the country on several key maternal health indicators, including: **2nd lowest** maternal mortality rate; **14th lowest** preterm birth rate; **17th lowest** cesarean (C-section) rate.¹

On average, women in Minnesota travel **16.9 minutes** to the nearest birthing hospital. This travel time doubles (to 30+ minutes) for **38.6%** of women living in rural areas of the state (where roughly **30% of the overall population** lives).



95% of maternal deaths in Minnesota between 2017-2021 were found to be preventable.

Substance use disorder was the **primary cause** of nearly one-quarter (24.7%) of maternal deaths in Minnesota between 2017-2021, and a contributing factor in nearly half (49.3%).

Like the **U.S. overall**, mental health conditions are the **leading cause** of pregnancy-associated death in Minnesota.

Black Minnesotans make up 13% of the birthing population but account for **23% of pregnancy-associated deaths**, and American Indian Minnesotans comprise 2% of the birthing population but account for **8% of pregnancy-associated deaths**.

Minnesota has **more maternity care providers**² per 100,000 women of reproductive age (93.6) than the national average (78.9).

¹ Overall, the U.S. has a **much higher cesarean rate** than what the **WHO considers beneficial to mothers and families**. While this intervention can be lifesaving, its overuse can contribute to adverse maternal health outcomes.

² In this statistic, "maternity care providers" includes doctors of medicine (MDs), doctors of osteopathic medicine (DOs), and certified nurse-midwives (CNMs) practicing in obstetrics & gynecology.

Accessing Care

A state's laws and policies, and how they are implemented, shape families' lived experiences of accessing care.

15% of women ages 18-44 in Minnesota reported not having visited a provider for a routine healthcare visit in the past two years.

Over one-third of births in Minnesota (34%) are covered by Medicaid.

As of 2025, Minnesota does not offer **presumptive Medicaid eligibility** during pregnancy, preventing eligible pregnant women from having immediate coverage for perinatal care before going through the formal application process.

Minnesota was **one of the first 10 states** to extend Medicaid coverage to a full year after giving birth.

Minnesota is one of the "**most protective**" states for abortion access.



Midwife Rachel provides prenatal care for Demetria in the clinic room at Roots Community Birth Center in Minnesota. (Gather Birth Cooperative, 2023)

Key Policy Solutions

- + **Translate strong statewide outcomes into greater equity and access for Black and American Indian families.** Addressing disparities for Black and American Indian Minnesotans requires centering culturally grounded models of care, increasing access to support and wraparound services, and accountability mechanisms that reduce preventable harm across pregnancy and the perinatal period, including the first year postpartum.
- + **Enact presumptive Medicaid eligibility during pregnancy.** This change would expand timely access to perinatal care for families across the state.

Delivering Care

Understanding a state’s perinatal ecosystem—the network of providers caring for pregnant women and families—reveals how workforce conditions shape care access, experiences, and quality.

Obstetrician-Gynecologists (OB-GYNs)

- + There are **nearly 8x** as many OB-GYNs practicing in urban areas of Minnesota than there are in rural areas of the state.
- + **More than 50%** of non-OB-GYNs reported that they occasionally, frequently, or consistently “provide care that [an OB-GYN] might otherwise provide if they were available/accessible.”

Midwives

- + Minnesota is one of 11 states that recognizes all three formal midwifery pathways in the U.S.: **Certified Nurse Midwives** (CNMs), **Certified Professional Midwives** (CPMs), and **Certified Midwives** (CMs).
- + As of 2023, there are **~400 CNMs and CMs** in Minnesota, and midwives attend approximately **16% of all births** in the state.
- + CNMs have full **independent practice authority** in Minnesota.³
- + Minnesota has **Medicaid reimbursement parity** between doctors and midwives (meaning CNMs are paid 100% of the physician rate for the same services).

Doulas

Minnesota has actively **reimbursed doula care** under Medicaid since 2014, making it one of the first states in the country to adopt this benefit.

Key Policy Solutions

- + **Support a sustainable, integrated maternity care workforce.** Minnesota’s Medicaid reimbursement for doula care provides a strong foundation for expanding access to non-clinical support, but workforce sustainability and integration remain key challenges. Strengthening coordination across clinical and community-based providers can improve continuity and culturally responsive care.
- + **Translate expanded midwifery licensure into meaningful access.** Minnesota’s recognition of CM licenses creates an opportunity to expand the maternity care workforce, but licensure alone does not guarantee access. Reimbursement pathways, hospital privileging, employer uptake, and geographic placement will determine whether this policy change expands access to care, particularly in rural and under-resourced communities. Ensuring midwives can practice at the top of their license across care settings is essential to workforce stability and continuity of care.

³ Defined here as the ability to practice to their full scope without physician oversight.

The Context of Care

Place-based factors like geography, distance to care, and infrastructure play a critical role in shaping maternal health outcomes, especially in rural areas where limited maternity services are at risk of closure.

In December 2025, Minnesota was awarded **over \$193 million** in FY26 funding from the Center for Medicare and Medicaid Services (CMS)' Rural Health Transformation Program. The state's application proposed investments in community-based preventative care, rural workforce development, and regional healthcare infrastructure. Still, experts question the Program's ability to remediate the harms of H.R. 1's nearly \$990 billion in Medicaid cuts for rural health.

Between 2010-2022, 20-33% of short-term acute care hospitals in Minnesota **lost hospital-based obstetric services**.

19.5% of counties in Minnesota are classified as "maternity care deserts" (areas with zero obstetric care providers or facilities), nearly half the national average (32.6%).⁴



Birth Centers

- + Minnesota has **eight freestanding birth centers** (as of 2022).
- + No **Certificate of Need (CON)** is required to open a birth center in Minnesota. A CON is a state approval process some states require before new health facilities can be established, and an administrative hurdle that can make opening a birth center more difficult.

Key Policy Solutions

- + **Strengthen and stabilize rural maternity care access.** Sustaining obstetric services "close to home" can reduce delays in prenatal, labor & delivery, and postpartum care, and prevent remaining facilities from being overwhelmed.
- + **Invest in solutions that mitigate distance barriers.** Policies that support expanded access to care options like freestanding birth centers, telehealth services, and home visiting programs can offer additional pathways for families in rural areas to receive care.

⁴ Every Mother Counts uses the term "maternity care desert" to align with national data sources; however, we acknowledge the limitations of the term. We are committed to further conversation around the use of language that more accurately reflects structural differences in access to care.

Key Resources & Policy in Action

State-Based Resources

- + **Minnesota Department of Health – Women and Infant Health** oversees maternal mortality review, perinatal data, and statewide Maternal Child Health initiatives under the federal Title V Maternal & Child Health Block Grant.
- + **Minnesota Maternal Mortality Review Committee** produces detailed analyses of the state’s pregnancy-associated deaths to better understand root causes, preventability, and disparities.
- + **Minnesota Perinatal Quality Collaborative** is a statewide quality improvement network working with hospitals and providers.

Spotlight on Certified Midwife (CM) licensure

- + In 2025, Minnesota became one of 13 states (including Washington, D.C.) to recognize the CM credential, making it one of just 11 states that recognizes all three of the formal midwifery licensure pathways in the U.S. (CNM, CPM, and CM).
- + Each midwifery type has expertise in person-centered maternity care and supporting low-risk pregnancy and birth. CPMs have expertise in community birth (i.e. home births and births in freestanding birth centers). Both CNMs and CMs receive the same graduate-level training in midwifery and can provide care in hospital settings, but CNMs are required to become nurses first. Recognizing the CM credential can expand pathways to hospital-based midwifery care.
- + Minnesota’s recognition of the CM license expands access to the state’s midwifery workforce and has the potential to increase the supply and geographic distribution of licensed maternity care providers.
- + While having an additional pathway to midwifery is an exciting opportunity to expand access to this model of care in Minnesota, its impact will ultimately depend on how licensure translates into reimbursement, employment opportunities, and provider distribution across the state.



Roots Community Birth Center in Minnesota. (Gather Birth Cooperative, 2023)