

Final Report to the Director

The Licensed Direct Entry Midwife (LDM) Staff Advisory Workgroup was convened in January 2014 by the Director of the Oregon Health Authority (OHA). The workgroup was established to provide recommendations regarding perinatal services provided to Medicaid enrollees by licensed, direct entry midwives. The workgroup was guided by the Triple Aim goals of improving population health, improving the individual's experience of care and reducing per capita costs. The final recommendations in this report aim to ensure maternal and infant health as well as to provide women with choice in prenatal care and birthing options.

Background: Historical and Policy Context

Direct Entry Midwifery in Oregon

Direct entry midwives (DEMs) typically enter the profession following an apprenticeship and training through self-study, a midwifery school, or a college- or university-based program. Education, experience, and training vary, but all DEMs practice independently in the state of Oregon. DEMs supervise labor and childbirth and provide prenatal, intrapartum and postpartum care to the mother and infant.

In 1993, voluntary licensure for DEMs in Oregon was first established through legislation that additionally enabled licensed direct entry midwives (LDMs) to receive reimbursement through medical assistance programs. The 1993 legislation also created the Board of Direct Entry Midwifery, which establishes and ensures compliance with regulatory standards.¹

House Bill 2380, passed during the 2011 regular legislative session, added two questions to the Oregon Birth Certificate in order to capture data on the intended location of the birth (e.g., home birth, hospital, etc.) and the intended birth attendant (e.g., direct entry midwife, MD, DO, etc.). With this information the Center for Health Statistics can now provide data to better understand birth outcomes in Oregon. The first report on out-of-hospital births in Oregon was published in October 2013.²

HB 2380 also added limited liability language to protect hospitals and physicians against risk following a patient transfer. It states that a person may not bring a cause of action against a licensed physician or hospital for injury to a patient that occurred as a result of care from a DEM, provided that the physician or hospital does not contribute to the injury or is otherwise negligent.

Mandatory licensure of direct entry midwives in Oregon was established in 2013 with passage of House Bill 2997, which requires any direct entry midwife practicing after January 1, 2015 to hold a license. Final licensure conditions will be established by a Rules Advisory Committee. However, the Board of Direct Entry Midwifery already requires that LDMs hold a certified professional midwife (CPM) credential from the North American Registry of Midwives, complete an examination, be certified in infant and adult cardiopulmonary resuscitation, have a written plan for transport of the patient, hold a

¹ Licensure rules, standards, and requirements for direct entry midwives can be found in [ORS 687.405](#).

² CD Summary, October 1, 2013, Public Health Division. Accessible at: <http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/2013/ohd6220.pdf>

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high school diploma (or equivalent), and attend and participate in, at a minimum: 25 assisted deliveries; 25 deliveries for which the LDM applicant was the primary care provider; 100 prenatal care visits; 25 newborn examinations; and 40 postnatal examinations for licensure.

Additionally, HB 2997 delegated authority to the Board of Direct Entry Midwives for any investigations following complaints, reviews, or other issues related to DEMs

Oregon Births

In 2013 the Oregon Public Health Division published its first report on birth outcomes by planned birth place and attendant.³ Nearly five percent of women who had a live, term birth in Oregon in 2012 (2,021 out of 42,011 or 4.8%) intended to deliver outside of the hospital (either at home or at a free-standing birthing center). Ultimately, 18% of those planned OOH births occurred in a hospital following transfer of care. As a result, 3.9% of all live term births in Oregon in 2012 were delivered outside of the hospital setting. Licensed direct-entry midwives were the planned birth attendant for 59.1% of the planned OOH births; unlicensed direct entry midwives were the intended birth attendant for an additional 9.7% of planned OOH births. Ultimately, 2.9% of total births in Oregon were attended by LDMs or DEMs in 2012. Women who planned an OOH birth tended to be older, white, married, college-educated, self-pay, less overweight or obese pre-pregnancy, and less likely to smoke.

The Oregon Health Plan (Medicaid) paid for 466 planned OOH births in 2012 (23.3% of all planned OOH births in the state). Currently there are 78 LDMs licensed in the state of Oregon. The vast majority of OOH births delivered by LDMs occur in counties with an urban hub, such as Deschutes County, as well as counties throughout the Willamette Valley (e.g. Washington, Clackamas, Yamhill, Multnomah, Linn, and Lane Counties).

Health System Transformation

Oregon's Coordinated Care Model began implementation in 2011. A foundation of this model, Coordinated Care Organizations (CCOs) serve as umbrella organizations that govern and administer care for Medicaid/Oregon Health Plan (OHP) members in the local community. Health care providers, hospitals, community members, and other stakeholders in the health system participate in the governance of each CCO. Nearly all OHP members are enrolled in a CCO for their medical, behavioral and dental services.

CCOs operate under a flexible global budget. Each CCO is accountable for health outcomes of the population they serve and can use the budget in a manner appropriate to the community and its needs.

To date, CCOs have not credentialed or contracted with LDMs. Leading reasons for this include, but may not be limited to, lack of LDM liability insurance coverage and uncertainty regarding safety and

³ <https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/planned-birth-place.aspx>

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outcomes for home delivery. Without LDM reimbursement by CCOs, women enrolled in Medicaid are greatly constrained in their ability to choose delivery by a LDM.

Since 2012, the Oregon Health Policy Board (OHPB) and the OHA have received substantial public input requesting access to midwifery care as part of Oregon’s Coordinated Care Model, including 137 comments submitted during a public forum (summary of comments available at link below).⁴ Currently, the only opportunity for women with Medicaid coverage to obtain covered services by an LDM is through a CCO exemption called the “third trimester rule.” This rule allows women who enroll in Medicaid during their third trimester of pregnancy to continue with their established prenatal provider on a fee-for-service basis. This rule will sunset on June 30, 2014. Recommendations put forth by this staff advisory committee will be considered by OHA when addressing the future of this policy.

The LDM Staff Advisory Workgroup

All members of the LDM Staff Advisory Workgroup were appointed by the Director of the OHA based on their experience and perspectives regarding maternity services in Oregon. The ten members of the workgroup are listed below:

Name	Affiliation/Region
Duncan Neilson, MD <i>Chairperson</i>	Obstetrician-Gynecologist, Chief of Women’s Health Services, Legacy Health
Silke Akerson, LDM, CPM	President, Oregon Midwifery Council; Two Rivers Midwifery
Melissa Cheyney, PhD, LDM, CPM	Chair, Board of Direct Entry Midwifery; Associate Professor, Anthropology, OSU
Shafia Monroe, MPH, DEM, DT	President and CEO, International Center for Traditional Childbearing (ICTC); President and CEO, Shafia Monroe, Consulting
Kelley Kaiser, MPH	CEO, InterCommunity Health Network CCO
Doug Flow, PhD	CEO, All Care Health Plan
John Sattenspiel, MD	Senior Medical Director, Trillium Community Health Plan
Dominique Greco, MD	Family Physician, Providence Seaside Hospital
Kate Pelosi, CNM	Women’s Healthcare Associates
Monica Arce, CNM	OB Lead Clinician, Virginia Garcia Memorial Health Center

Additional workgroup participants include: Holly Mercer (Executive Director, Oregon Health Licensing Agency), Wally Shaffer (Medical Director, Division of Medical Assistance Programs, OHA), Chris Barber (Quality and Clinical Services Director, OHA), Dana Hargunani (Child Health Director, OHA; lead workgroup staff), Stephanie Jarem (OHA; workgroup staff). The workgroup met a total of five times between January and April 2014. This report provides a summary of the workgroup recommendations.

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<http://www.oregon.gov/oha/OHPB/2013MeetingMaterials/December%202011,%202012%20Summary%20of%20Public%20Input.pdf>

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Issue Identification

Through a facilitated process, the workgroup identified the following priority issues for consideration regarding direct entry midwifery: safety, liability insurance, access, systems of care (care coordination/team-based care), reimbursement, cost containment/cost effectiveness, credentialing, cultural competency, and choice. During the course of their meetings, the workgroup reviewed existing research and other state and national policies regarding DEM services, and heard multiple presentations to guide their work.

Consensus-based Recommendations

The LDM staff advisory workgroup recommends the following set of consensus-based recommendations to integrate LDMs into Oregon's Coordinated Care Model. The recommendations are interconnected and often address multiple overlapping priority issues. The first recommendations are directly related to the Oregon Health Authority. The remaining recommendations will require participation or direction by entities beyond the Oregon Health Authority but are necessary for moving this work forward:

Recommendations for the Oregon Health Authority:

1. Identify a phased-in approach for including LDMs in Oregon's Coordinated Care Model and CCOs.

The workgroup agreed that the incorporation of LDMs into the CCO model is a strategy consistent with the Triple Aim. However, the absence of affordable liability insurance for LDMs is the predominant barrier to CCO credentialing for these practitioners. A phased approach over time is therefore necessary to achieve integration of LDMs into Oregon's Coordinated Care Model. See Diagram 1 for a high-level timeline depicting a phased-in approach towards integration.

2. When LDM care is not available through a CCO, OHA should establish a Medicaid fee-for-service ("open card") option for women who choose to receive services from LDMs (for duration of pregnancy through 6 weeks post-partum).

With acknowledgement that the ultimate goal is to incorporate LDMs into Oregon's coordinated care system, this recommendation aims to provide an interim solution that protects a woman's choice in birthing options. CCOs would not be required to contract with or credential LDMs, but LDMs could still provide maternity care to Medicaid enrollees and receive reimbursement for services in low risk situations (see recommendation #3 below).

This recommendation enables Medicaid enrollees to choose the fee-for-service "open card" option at the onset of pregnancy in low-risk situations, and ensures that the woman is receiving consistent care throughout the entire pregnancy which can increase safety and quality of care.

The workgroup acknowledges that a fee-for service option would likely include all aspects of a women's care during this perinatal time period (e.g. not just maternity services). Further work will

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be needed to ensure that care is coordinated during any transition between “open card” and prior/future CCO coverage for Medicaid enrollees.

3. **For high risk births, require in-hospital delivery for Medicaid reimbursement. Exclude payment for planned out-of-hospital births when high-risk criteria exist. High-risk criteria should include, at minimum:**
 - **presentation other than cephalic (e.g. breech),**
 - **previous caesarian delivery,**
 - **gestational age < 36 or > 43 weeks,**
 - **multiple gestations,**
 - **diabetes/uncontrolled gestational diabetes or gestational diabetes controlled with medication,**
 - **pre-eclampsia,**
 - **additional criteria included in the applicable provider or facility OARs**

The safety of a mother and fetus throughout the pregnancy and birth is central to this workgroup’s efforts. In addition to examining the Public Health Division’s 2013 report on planned OOH births, the workgroup discussed additional research on safety and outcomes. The workgroup gave particular attention to two recently published articles from the Journal of Midwifery & Women’s Health, both of which explored the Midwives’ Alliance of North America’s National Data Registry for midwife-led births (see Appendix A).

The workgroup agreed that OOH birth can be safe in the right, low-risk situations. The workgroup recommends that OHA apply high-risk criteria to determine whether a Medicaid enrollee is eligible to have an OOH birth attended by an LDM. These criteria were informed by existing rules for LDM licensure and free-standing birthing centers, in addition to existing evidence relating to OOH outcomes. Ultimately, those deemed low risk would be eligible to choose the “open card” option listed in Recommendation #3.

4. **Provide information to Medicaid members regarding covered options for maternity care (including midwifery care).**

Improving access to care and empowering women in choosing a care provider begins with education and outreach. The workgroup recommends that OHA provide information to Medicaid enrollees regarding all of the covered options for maternity care services.

5. **Request that the Health Evidence Review Commission (HERC) develop a Coverage Guidance related to home birth, including evidence regarding:**
 - **The maternal and fetal/neonatal/child health outcomes of home birth compared with birth in other settings**
 - **Appropriate candidates for home birth**

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- **Criteria for optimizing safety with regard to provider training, equipment, standards, consultation, and other systems of care**

The HERC reviews medical evidence, promotes evidence-based medical practices and establishes coverage guidance for high priority issues. With newly published articles and a clearer set of data on Oregon home births, a fresh review of the evidence would be timely and useful to consumers, practitioners, CCOs and the state.

6. **Analyze birth-related costs in Oregon by intended place of birth and provider. Comparative analyses should include immediate and long-term costs of care for women, infants and children.**

A better understanding of the immediate and long-term costs of births (by intended place of birth and provider) would help decipher the true costs and benefits related to midwifery care. The workgroup recognizes that some effects are difficult to quantify (e.g. the costs savings associated with higher rates of breastfeeding).

The State of Washington Department of Health conducted a review on the economic costs and benefits of the midwifery licensure and discipline program in the state. This workgroup recommends that a similar study and analysis be conducted for the state of Oregon.

7. **Work with CCO and hospital partners to explore payment methodologies that support optimum intrapartum care and appropriate and timely transfer.**

The workgroup acknowledges that bundled payments for maternity services may represent an unintended deterrent to timely and safe transfer of care to a hospital when indicated. Exploring new payment methodologies or other opportunities to unbundle reimbursement could further incentivize timely and appropriate transfer of care by out-of-hospital providers including LDMs.

8. **Reconvene the LDM Staff Advisory Workgroup at periodic intervals to assess progress on these recommendations and evaluate new evidence and opportunities for continued integration of LDM services within Coordinated Care Organizations (CCOs).**

Because full integration of LDM services in the Coordinated Care Model will take time, this group recommends that this staff advisory workgroup be periodically reconvened to evaluate progress on these recommendations and consider emerging best practices and data to support an integrated system of maternity care.

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Recommendations the Oregon Health Authority could support:

9. Study options for affordable liability insurance for licensed, direct-entry midwives (LDMs), including state options such as a joint underwriting association.

Malpractice insurance, a prerequisite for providers interested in contracting with CCOs, continues to be unaffordable for the majority of LDMs practicing in the state. Estimates obtained from the leading LDM liability insurance carrier indicated the premium cost for the \$1,000,000/\$3,000,000 coverage limit commonly required for healthcare providers would likely exceed 25% of an LDM's total annual income. Facing similar barriers, a number of other states have explored options to increase affordability, such as the Washington Joint Underwriting Association.

This workgroup addressed the issue of liability insurance from a variety of perspectives. Another option that was considered was to implement a liability affidavit/document, modeled after documents from New Mexico, intended to hold the state (and CCOs, if/when applicable) harmless from any claims, demands and actions resulting from services provided to a client by a LDM. Ultimately, the workgroup determined that more information and input from legal experts would be necessary to understand whether this approach offers the intended protections.

10. Convene a multi-disciplinary workgroup consisting of a variety of stakeholders and experts including LDMs, CNMs, MDs, DOs, and the insurance division, to offer recommendations on overall maternity-related liability reform in the state of Oregon.

Access to affordable liability insurance is not limited to DEMs, and can be particularly difficult for any maternity care provider in the state of Oregon. It is recommended that a subsequent workgroup be formed to address access to affordable liability insurance for all Oregon maternity providers.

11. Support a coordinated system of maternity care. Convene local learning collaboratives across the state to consider and implement best practices for CCO and hospital coordination and collaboration with LDMs, including an emphasis on timely transfer of care.

In 2012, 18.8% of the planned OOH births in Oregon were delivered in a hospital. The need for transfer arises regularly, and a smooth transition of care from one provider (LDM) to another will have a positive impact on safety and the experience of the patient and care team. While LDMs are currently required to have a written transport plan for their patients, additional opportunities for improvement exist including more collaborative relationships with hospitals.

The workgroup heard many examples of collaborative, innovative partnerships and positive relationships that have been established in the state between LDMs and hospitals, Certified Nurse Midwives (CNMs), or other providers who are invested in improving transfer of care. Locally-driven learning collaboratives would provide support and structure for sharing these experiences and

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building a coordinated system that encourages safe, high-quality births in all communities across the state.

- 12. Support statewide efforts to reduce demand for high-risk out-of-hospital births by improving access to vaginal delivery options for breeches, twins, and vaginal births after caesarian section (VBACs).**

This workgroup acknowledges that improved access to vaginal delivery within hospital settings (e.g., for breech, twin, and previous caesarian deliveries) may prevent women from attempting to deliver these higher-risk births outside of the hospital. The workgroup recommends that OHA support statewide efforts to improve access to vaginal delivery.

The LDM Staff Advisory Workgroup respectfully submits the above, consensus-based recommendations for consideration by the Oregon Health Authority.

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Diagram 1: **Proposed phased-in approach for including LDMs in Oregon’s Coordinated Care Model and CCOs (Recommendation #1)**

Short-term Actions

Changes to Medicaid policy

- Establish a Medicaid fee-for-service (“open card”) option for women who choose to receive services from LDMs (for duration of pregnancy through 6 weeks post-partum). (Rec #2)
- Incorporate recommended high-risk criteria for OOH births into the Medicaid coverage and reimbursement model (Rec #3)
- Provide information to Medicaid members regarding covered options for maternity care (including midwifery care) (Rec #4)

HERC Review

Request that the Health Evidence Review Commission (HERC) develop a Coverage Guidance related to home birth (Rec #5)

Intermediate Actions

State-level research and analysis

- Convene a multi-disciplinary workgroup to offer recommendations on overall maternity-related liability reform in the state of Oregon. (Rec #11)
- Study options for affordable liability insurance for licensed, direct-entry midwives (Rec #9)
- Analyze birth-related costs in Oregon by intended place of birth and provider (Rec #6)

Collaboration with CCO and hospital partners

- Convene local learning collaboratives across the state to consider and implement best practices for CCO and hospital coordination and collaboration with LDMs, including an emphasis on timely transfer of care (Rec #10)
- Explore payment methodologies that support optimum intrapartum care and appropriate and timely transfer. (Rec #7)
- Support statewide efforts to reduce demand for high-risk out-of-hospital births by improving access to vaginal delivery options for breeches, twins, and vaginal births after caesarian section (VBACs) (Rec #12)

Long-term Actions

Progress and evaluation (Rec #8)

Reconvene the LDM Staff Advisory Workgroup at periodic intervals to:

- assess progress on these recommendations, and
- evaluate new evidence and opportunities for continued integration of LDM services within Coordinated Care Organizations (CCOs).

Final vision

LDMs are incorporated into Oregon’s Coordinated Care Model as a maternity care provider for low risk out-of-hospital births

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Appendix A: References

References:

- HB 2380 (2011 session)
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