

MAXIMIZING MIDWIFERY

to Achieve
High-Value
Maternity Care
in New York

CHOICES IN CHILDBIRTH + EVERY MOTHER COUNTS

Nan Strauss
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EXECUTIVE SUMMARY

In the parts of Europe that have the very best maternal health outcomes, they have a very high utilization of midwives and very low-tech obstetric care. The system is safest when low-tech care is combined with access to higher-tech obstetric care, when needed. In fact, midwives reduce risks for their patients because they utilize fewer risky interventions.

– DAVID KEEFE, MD, STANLEY H. KAPLAN PROFESSOR AND CHAIRMAN OF OBSTETRICS AND GYNECOLOGY, NYU LANGONE MEDICAL CENTER

“To a woman, giving birth is the most amazing experience she will ever have. It is so important to feel supported while you are doing this amazing thing, and I think midwives get that.”

– JESS, ITHACA, NY

Widespread integration of midwives is a key strategy to realize high-value maternity care. Yet national and state maternity care policies have largely overlooked the midwifery model as a potential strategy to achieve significant improvement in the quality, experience, and cost of maternity care. Most high-income countries with better maternal health outcomes and lower costs than the United States (US), including Britain, France, and the Netherlands, utilize midwives as the usual providers of maternity care.

THE NEED FOR CHANGE

Maternal deaths, considered an indicator of the health of the maternity care system overall, have been consistently higher in the US than in all other comparably wealthy countries and have risen over the last 25 years. Intractable disparities in pregnancy-related deaths between African American women and white women are widening.

African American women in NYC now face a risk of maternal death that is 12 times as high as non-Hispanic white women. Life threatening complications of pregnancy and birth have been rising steadily and now affect nearly 3,000 women a year in NYC alone. Severe maternal morbidity is estimated to result in additional costs exceeding \$17 million each year for NYC alone.

Childbirth is the most common reason for hospitalization in the US and Medicaid and private insurance spend more on maternal and newborn hospital care than for any other type of hospital stay. Yet maternity care has not been prioritized in health system reform efforts despite the potential for widespread impact and the existence of effective, evidence-based strategies that can be brought to scale.

HIGH-VALUE MATERNITY CARE

High-value care can be achieved by supporting patient-centered, evidence-based practices, while avoiding wasteful or unnecessary spending. This approach reflects the principles of the “Triple Aim” of health care improvement:

- 1) improving health outcomes for all members of our communities,
- 2) enhancing experience of and engagement in care
- 3) reducing the cost of care.

Health care delivery system reform efforts are leading to the implementation of value-based payment systems – payment structures that reward value rather than volume, including in NY State.

MIDWIFERY IS A HIGH-VALUE MODEL

NYS Licensed midwives are independent health care professionals who provide high quality care related to pregnancy and birth, as well as offering primary preventive reproductive care. Licensed midwives practice in hospitals, birth centers, homes, clinics and private practices.

“The rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused.”

– SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY. CONSENSUS STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE SOCIETY FOR MATERNAL-FETAL MEDICINE, MARCH 2014.

“It seems like so many decisions are attempts to avoid immediate risks, but which create other risks down the road. More evidence-based information needs to be in the hands of women.”

– ROCHESTER, NY

Hallmarks of the midwifery model include approaching pregnancy and birth as healthy, normal life events and seeking to support the physiologic processes of labor, childbirth, and breast-feeding. Midwifery emphasizes person-centered, comprehensive care, evidence-based practices, and shared decision-making and respectful treatment, generally reserving interventions for circumstances where they have been demonstrated to provide a benefit. By using medical procedures only when their benefits outweigh their harms, midwifery care may reduce avoidable complications and chronic conditions.

AIM 1: Improving Health Outcomes

Midwifery achieves outcomes that are as good as, or better than, the outcomes achieved by physicians, and research has identified no areas where outcomes are worse for either women or infants. **Key benefits include fewer unneeded medical interventions such as cesareans, episiotomies, serious lacerations, and epidurals, a higher likelihood of breastfeeding, and greater patient satisfaction.**

Cesarean Surgery

Cesarean rates are widely recognized as being too high, and quality improvement initiatives are prioritizing efforts to bring rates down. Rates are more than 50 percent higher than in 1995, 32.9 percent for NYC and 33.8 percent for NYS, just above the national rate of 32.0 percent. The sharp rise has affected all groups of women, without improving maternal or infant health.

Unnecessary cesareans increase health problems and extra costs, without improving outcomes for women or infants. Cesareans have been associated with an increased risk of serious short- and long-term complications for women and newborns. The risk of severe maternal complications is three times greater following a cesarean.

Integrating midwifery into the US health system could help reduce cesarean rates and the complications that result. Cesarean rates vary widely by hospital to a degree not fully explained by different patient populations – ranging from 17.8 percent to 54.4 percent for all cesareans in NYS, and from 6.7 percent to 43.0 percent for uncomplicated cesareans. Much of the difference may be attributed to the culture and model of care at individual practices and facilities, which suggests that efforts to lower rates can be effective.

AIM 2: Experience of Care

Women with midwifery care report increased agency and autonomy in decision making, compared with women cared for by a physician, and research documents that midwife-led care is more likely to result in a positive childbirth experience and a greater sense of satisfaction, control, and confidence than traditional care.

Women cared for by midwives in all settings are also less likely to report disrespectful or coercive care compared with those cared for by physicians and are more likely to report effective communication and engagement in decision-making.

Strong communication can ensure families are informed and prepared for birth which in turn builds confidence in their ability to make decisions about care options. Factors associated with these positive experiences of care include the midwifery model’s emphasis on client engagement in care decision-making, implementing a “relationship-based” model of care that fosters trust, respect, and emotional support.

AIM 3: Reducing Costs

Expanding midwifery care has the potential to significantly reduce Medicaid and private insurance spending on maternity care, and can enhance the value of care that hospitals provide. Payments for maternal and newborn care in NYS alone totaled nearly \$4 billion in

“I didn’t want to be a patient – I wanted to have a baby.”

– BUFFALO, NY

2014 for approximately 238,000 births. Half of the state's births are covered by Medicaid, accounting for approximately \$1.25 billion in spending.

Midwifery care lowers costs by avoiding the overuse of interventions, which eliminates:

- Unnecessary and non-beneficial interventions (including primary cesareans)
- Avoidable short- and long-term complications and chronic conditions for women and newborns that sometimes result
- Repeat cesareans in subsequent pregnancies

Additional cost savings are achieved by increased breastfeeding and by a reduction in the number of people who decide to use epidural pain relief.

The sharp rise in cesarean rates has been a key driver of escalating maternity care costs. Cesarean births are reimbursed at higher rates than vaginal births, and because they require additional staff and medical treatment and longer hospital stays for recovery.

The cost of a cesarean is approximately one and a half times that of a vaginal birth, for both public and private payers. Average payments by private insurance in 2010 were approximately \$27,866 for a cesarean and \$18,329 for a vaginal birth – a difference of \$9,537 per birth. Medicaid payments averaged \$13,590 for a cesarean and \$9,131 for a vaginal birth – a difference of \$4,459. Because medical costs have risen steadily in the intervening period, these figures are conservative, and current numbers are substantially higher.

If in 2015, the cesarean rates were the same as in 1995, 25,900 cesareans could have been avoided in NYS, 13,300 of which would be in NYC. With 53 percent of births in NYS covered by Medicaid savings could reach an estimated \$61 million per year for NYS Medicaid and \$106 million per year for private insurance. Savings for births in NYC alone would be expected to reach \$36 million for Medicaid and \$47 million for private insurance. This potential annual savings would reflect only the savings on the current cesarean surgery, not future savings from repeat cesareans or later complications.

In addition to reducing cesareans, expanding the midwifery model of care has the potential to contribute to long term cost savings by:

- **Reducing repeat cesareans:** Nine out of 10 births following a cesarean are repeat cesareans, so avoiding the primary cesarean prevents future surgeries.
- **Reducing the use of epidural analgesia**
- **Increasing breastfeeding rates** which improves the health of women and infants and results in health care savings for women and infants
- **Reducing preventable complications and chronic conditions:** Cesareans increase the risk of severe, life-threatening complications and chronic conditions that may result in a lifetime of increased medical costs. By reducing use of cesareans, midwives can reduce spending on these long-term adverse effects.

MIDWIFERY IMPROVES HEALTH EQUITY

The positive outcomes of the midwifery model have been documented in a wide range of communities and settings, including with underserved populations. Midwives are more likely than physicians to engage women in decision-making and less likely to engage in disrespectful behaviors overall. Moreover, midwives are also less likely to treat women differently based on race, ethnicity, and income. However, physicians were reported to have exhibited more disrespectful behavior to women of color and low-income women.



The midwifery model can play a role in reducing disparities in health outcomes. African American women have the highest cesarean rates of any group and lower than average breastfeeding rates. Because of the midwifery model’s success achieving good results with both of these outcome measures, it may be an effective strategy to reduce disparities. Midwives have lower rates of poor outcomes, such as low birthweight and infant mortality, even though midwifery clients are disproportionately young, less educated, low-income, and from communities of color.

MAXIMIZING MIDWIFE-LED CARE

We have a huge workforce shortage in maternal health. Having systems of care that appropriately take care of the majority of low-risk women is definitely the way to go. When you look at it that way, midwives become the obvious solution.”

– NEEL SHAH, MD, MPP, ASSOCIATE PROFESSOR OF OBSTETRICS, GYNECOLOGY AND REPRODUCTIVE BIOLOGY, HARVARD MEDICAL SCHOOL

Realizing the potential benefits of expanded access to midwifery care requires identifying barriers and implementing changes at all levels of the health care system. Policy and regulatory efforts can either expand access to midwives’ services or further hamper it. In states where regulations support the practice of midwifery, midwifery workforces are larger and midwives attend a greater proportion of births. Midwives need to be more widely available in hospitals, reimbursed at appropriate rates, supported in providing the full range of services that they are qualified and licensed to perform, and educated in sufficient numbers to meet communities’ needs.

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) agree that, “To provide highest quality and seamless care, Ob/Gyns and CNMs/CMs should have access to a system of care that fosters collaboration among licensed, independent providers.” Both professional associations have jointly stated their support for a practice environment where both Ob/Gyns and CNMs/CMs have access to hospital privileges and equivalent reimbursement from private payers and government programs. These are just two of the areas where policy changes can support high-value care.

Currently, midwives are not being utilized as widely as would be advantageous, because many facilities lack midwives, midwives are often restricted from providing care to the extent of their qualifications, and low reimbursement rates hamper the financial viability of private midwifery practices.

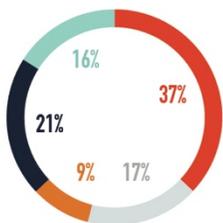
Availability of Midwives in Hospitals

Nearly half of NYC hospitals with maternity units have no midwives attending births (18 of 39) as well as more than one-third of hospitals in NYS (46 of 125). Midwives attended 10.1 percent of all births in NYS in 2015, but access to midwives varies widely depending on the individual’s insurance coverage and location.

The greatest concentration of midwives in NYS attend births at NYC’s Health and Hospitals (H+H) facilities, which mostly serve people who are enrolled in Medicaid or are uninsured. Most H+H hospitals, 8 of 11 (73%), had midwives regularly attending births – all at rates above the state average (15% to 67% of births). In contrast, most NYC private hospitals, 15 of 28 (54%) had no midwives attending births, and of the 13 private hospitals with midwives, nearly half of those had low rates of midwife attended birth (2% to 7%).

PERCENTAGE OF NY STATE HOSPITALS

by rate of midwife-attended births, 2015



- None (less than 1%)
- Below Average (1%–7%)
- Average (7%–14%)
- Above Average (14%–34%)
- High (34%–73%)

Provider Shortages

Substantial parts of NY State and City are designated as Health Provider Shortage Areas by the federal government. Currently, however, maternity care shortages go unrecognized, because obstetricians are counted in the same category as primary care providers. Many rural and urban areas would benefit from identifying maternity-care specific shortage areas and allowing midwives to fill these gaps.

Workforce Growth and Diversification

Workforce development, expansion, and diversification require resource allocation, initiative, and planning in order for maternal and newborn care systems to meet the growing need for a diverse midwifery workforce. Educational programs need the resources to be able to accept more – and more diverse – students into their programs, which in turn requires improving the availability of clinical education sites, as well as developing and strengthening interdisciplinary training between physicians and midwives.

Coordinating inter-disciplinary didactic and clinical learning opportunities would promote and enhance professional collaboration and increase the availability of interdisciplinary education. In addition, the US healthcare education system is designed to reimburse facilities for Graduate Medical Education (GME), or the education and training of physicians. The US does not currently provide similar equitable support for the education and training of midwives.

Low Reimbursement Rates

A review of state Medicaid fee schedules conducted by ACNM indicates that the amount that LMs are reimbursed for their fee-for-service Medicaid clients is lower than in several neighboring states. In 2015, the average **Medicaid reimbursement for a normal vaginal delivery (CPT 59400) in New York was \$1,463 compared with \$2,610 in Connecticut (78% higher), \$2,025 in Pennsylvania (38% higher), \$1,738 (19% higher) for Massachusetts, and \$1663 in Vermont (14% higher).**

Reimbursement rates have dropped precipitously over the last five years, and some midwives in private practice report no longer being able to accept Medicaid payment. The \$1,400 reimbursed for approximately 13 prenatal visits, labor and birth, and a postpartum visit provided over 10 or 11 months is not enough to cover the cost of overhead, even without accounting for the midwife's income.

Inequitable Reimbursement between Midwives and Physicians

In NYS, outdated policies allow midwives to be reimbursed at 85 percent of what a physician would receive for the provision of identical services. The Patient Protection and Affordable Care Act established equal pay (100% of physician rates) for LMs under Medicare, which is generally used as the benchmark for other payers. Most states' Medicaid programs now reimburse LMs at 100 percent of physician rates, and ACOG supports full reimbursement equity for midwives.

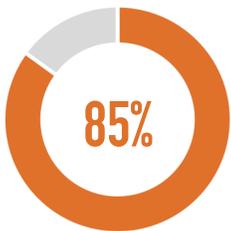
Higher reimbursement rates would likely result in a higher proportion of births being attended by LMs. The savings that result from midwives' lower intervention rates would be expected to surpass the increased costs from higher reimbursement rates.

Limitations to Providing Independent, Full Scope Care

NYS licensure laws recognize midwives as independent maternity care practitioners, yet in practice, midwives' autonomy is restricted by the facility or practice where they work. Restricting the scope of care and constraining midwives to work below their licensure is not sustainable at a time when economic efficiency and high-value practices have

MIDWIVES ARE REIMBURSED

by NYS Medicaid at



of PHYSICIAN RATES

for identical services

become top priorities. As the shift towards value-based payment strategies advances, high-value care will require that all health care professionals are working at the top of their scope and training.

Community-Based Childbirth

Increasingly, women in NYS have sought alternatives to hospital-based care during labor and childbirth, with all out-of-hospital births (in birth centers, homes, or other settings) increasing 54 percent between 2004 (0.74%) and 2012 (1.14%). Yet many women who want this option have difficulty finding available providers in their area or finding a birth center nearby. Greater integration of home and birth center births into the health care and health care insurance systems will achieve optimal care and safety for people who are seeking an out of hospital birth.

Midwife-Led Birth Centers

Birth centers are a safe, cost-effective option for healthy low-risk pregnancies and low-intervention births. Midwife-led birth centers are supported by ACOG as an appropriate and safe birth setting. While California has 24 birth centers, Texas has 62, and Florida, 29, NYS accounts for the third largest number of births but has just three freestanding birth centers - two in Brooklyn and one in Buffalo.

The Centers for Medicare and Medicaid Services (CMS) estimates an average savings of \$1,163 per birth in a birth center compared with the cost at a hospital, savings that are consistent with the value-based payment goals articulated in NYS's plans for Medicaid Payment Reform.

Planned Home Birth Options and Safety

Research confirms that for healthy women with low risk pregnancies, planned home birth with a licensed midwife is a safe option. Planned home births have much lower rates of routine interventions that lack scientific evidence and result in high rates of satisfaction and positive health outcomes. Well-designed studies have demonstrated that planned home births achieve excellent perinatal outcomes.

CONCLUSION

Considering the substantial public funding at stake, the pressing need for improvement, and the well-established evidence that supports the midwifery model of care, this is a critical moment to integrate midwives in innovative and value-focused efforts to bring care systems in line with best practices. **By recognizing and advancing midwifery as a value-based care strategy, New York State can demonstrate its leadership by increasing the availability of midwives and the midwifery model of care in all birth settings while achieving the “triple aim” of improving health outcomes, enhancing care experiences, and increasing the value of pregnancy-related care.**

KEY RECOMMENDATIONS

The United States Congress should pass the Improving Access to Maternity Care Act, S.783, introduced by Sen. Tammy Baldwin (D-WI) and Sen. Lisa Murkowski (R-AK), which directs the Health Resources and Services Administration (HRSA) to identify areas of the country with shortages of maternity care providers (including midwives) in order to fill those gaps.

Federal funding by the Health Resources and Services Administration for provider education should be expanded to include midwifery:

- Provide financial support for the education of midwives, comparable to that provided for medical education, to facilitate the expansion of the educational pipeline.
- Establish a distinct education grant for midwifery from the Health Resources and Services Administration, which currently supports graduate medical education and nursing.
- Allow CNMs/CMs to be reimbursed for supervising and teaching medical residents, medical students, and student midwives.

The Centers for Medicare and Medicaid Services (CMS) should support the establishment of a Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey that is specific to maternity care, in order to more accurately and valuably assess patient satisfaction with their childbirth care.

NYS Medicaid should adopt the Medicare policy of compensating midwives at 100 percent of the physician rate for the same services and reimburse birth center facility fees.

Medicaid managed care plans and private insurers should

- **Reimburse midwives at 100 percent of the rate physicians receive for identical services.**
- Reimburse birth centers for their facility fees.
- Empanel midwives without added requirements of written practice agreements or other restrictions beyond those required by state law.
- Increase awareness of midwifery services by including them in their provider networks and ensuring they can be identified.

The NYS Department of Health and the NYC Department of Health and Mental Hygiene should

- Adopt strategies to increase the utilization of midwives as a strategy to achieve high-value care and to reduce health disparities.
- Develop and implement appropriate and targeted regulations for midwifery birth centers based on national standards developed by the American Association of Birth Centers and the Commission for the Accreditation of Birth Centers.

Hospital administrations should ensure that all maternity units have both physicians and midwives providing the full spectrum of care, with full admitting privileges and presence on medical advisory boards and membership in medical staff decision-making bodies.

Physicians should commit to:

- **Providing optimal care to all women by adopting practice standards that are closely aligned with the midwifery model of care**
- Developing full and respectful collaboration with midwives in their role as independent licensed providers.

Medical education and midwifery education programs should develop interdisciplinary education and clinical training opportunities for both midwives and physicians, to support more collaborative care that will foster respect for the value of each discipline's contributions towards excellent maternal health outcomes.