Barriers to Certified Nurse-Midwife (CNM) Care in California

What to keep in mind when reviewing this document:

- The following barriers represent the summary of PBGH's interviews with midwives, physicians, hospitals, payers, purchasers, billing specialists, malpractice insurers and professional associations.
- Barriers are grouped by the individual/organization whose behavior we seek to change. The first barriers listed in each section are internal barriers, i.e. barriers that are within the individual/organization's control. External barriers are called out separately and are those situations that affect the patient, physician, hospital, etc. but are outside of their influence.
- Barriers can be factual or perceived by the individual/organization. Both are included here as they will need to be addressed by potential solutions.
- These barriers are the first step in helping us identify strategies for intervention.

The following table is organized by individual/organization:

1. Consumer
    a. Patient
2. Provider
    a. Physician
    b. Midwife
3. Organization
    a. Hospital (administrative, financial barriers)
    b. Payer (Reimbursement, coverage and contracting barriers)
    c. Medical Training
4. Policy/Research
    a. Legislative/regulatory
    b. Supporting research

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Barriers	Support
1. Consumer	
a. Patient	
Patient does not seek care from a midwife due to lack of knowledge about their services. • Patient lacks knowledge about benefits and availability of midwifery care. • Patient does not know how midwifery care is similar to or differs from regular obstetric care. • Patient does not know that fewer interventions lead to higher quality care. • Patient lacks skill and confidence to seek out midwife-led care.	• CA OB/GYN • California Nurse-Midwives Association (CNMA) • California Hospital Patient Safety Organization (CHPSO) • Kaiser Northern CA • National Partnership for Women & Families (NPWF)
Patient does not seek care from a midwife due to misconceptions about the safety and outcomes of midwifery care. • Patient believes that midwifery is not as safe as obstetric care. • Patient doesn't know what sort of preparation, education, or certification are required to become a CNM. • Patient believes that midwife and obstetric care is equivalent with respect to achieving patient-centered birth outcomes.	• CA OB/GYN • CNMA • Maternity Neighborhood • NPWF
Patient does not have the self-efficacy to advocate to health plans, providers or employers to make midwifery more accessible. • Patient does not believe she has control over their pregnancy or birth outcomes. • Patient does not know what to expect from her maternity care experience and is not aware of her care options. • Patient lacks the knowledge about how to influence the system to create broader access to midwives. • Patient lacks self-efficacy to advocate for higher quality care with fewer interventions.	• NPWF
External barrier: Patient does not have an easy way to identify midwifery services or hospitals providing midwifery services in their community.	• CHPSO • Kaiser Northern CA
External barrier: Patient lacks a mechanism to express their experiences and care preferences.	• PBGH
2. Provider	
a. Physician	

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Physician does not go into practice with midwives and/or restricts midwifery access in hospitals. • Physician does not perceive problem with maternity care outcomes or believe change is warranted. • Physician believes he/she is the appropriate care provider for all patients, regardless risk-level. • Physician lacks knowledge about his/her role relative to those of midwives in the care of women during pregnancy and childbirth. • Physician lacks knowledge of the CNM scope of practice. • Physician does not know or value the benefits (e.g. outcomes, satisfaction) associated with midwifery's physiological approach to birth. • Physician believes that midwives deliver unsafe care to patients in the prenatal, postpartum, and labor and delivery contexts. • Physician believes he/she is at increased risk for malpractice issues if they work collaboratively with midwives. • Physician faces difficulties balancing his/her responsibility for medical risk with respect for standard midwifery practices in labor and delivery.	• NPWF • Kaiser Northern CA • Stanford Clinical Excellence Research Center (CERC) • California Maternal Quality Care Collaborative (CMQCC) • MemorialCare Health System • Mayo clinic • CA OBGYN • CNMA • SF Birth Center • Lucina Maternity Foundation • Prevail Insurance Management • Walker, et al., 2014, pg. 5
Physician perceives significant economic obstacles to working with midwives. • Physician lacks knowledge of fiscally successful models that have integrated midwives. • Physician believes that vicarious liability concerns will greatly increase malpractice insurance costs.	• MemorialCare Health System • CMQCC • Lucina Foundation
Physician perceives midwives as a market threat. • Physician, especially in private practice, believes that the market for patients is limited and so are fiscally threatened by midwives.	• Stanford CERC
Physician does not perceive the consumer demand for midwifery services.	• MemorialCare Health System • Kaiser Northern CA
Physician perceives logistical obstacles to identifying and hiring a midwife into a practice.	• CERC • CA OB/GYN • ACOG
External barrier: lack of hospital midwifery integration means a physician's only exposure to midwifery care could be in emergency transfer situations from out-of-hospital settings.	• MemorialCare Health System
b. Midwife	
Midwife is unable to negotiate higher rates of reimbursement from payers.	• Baby+Co

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• Midwife does not have the knowledge of the reimbursement negotiation process. • Midwife does not have the time or skillset to negotiate better reimbursement rates.	• Beach Cities Birth Centers • Larsen Billing Service
Midwife who practices above the CNM scope of practice perpetuates a negative reputation among physicians for the entire profession. • Midwife perception of low-risk is variable.	• MemorialCare Health System • Stanford CERC
Midwife does not value collaborative practice with physicians. • Midwife does not believe that integrated care will be as successful as midwife-only care. • Midwife feels disrespected and/or undervalued by physicians or hospitals. • Midwife believes that a physiological birth is not possible in the hospital setting. • Midwife lacks time or confidence to seek the independence, risk, or autonomy that an integrated care model requires and prefer to continue to operate in a hierarchical structure with obstetricians (accept status quo). • Midwife lacks the knowledge and experience to work or negotiate change in a medical model.	• MemorialCare Health System • UCSF
Midwife lacks confidence, knowledge, and/or ability to effectively organize to advocate for midwife-led maternity care. • Midwives are outnumbered by physicians in a given practice and thus unable to voice their concerns over standard practice or introduce midwifery practices. • Midwife lacks information about the respective benefits of midwifery and physician care and thus is unable to advocate for their practices. • Midwife lacks knowledge of the training and scope of practice of physicians and over-infer about MDs being an authority. • Midwife does not know how to speak the language of "medical model" and thus unable to effectively communicate or rise in ranks of leadership.	• CA OB/GYN • UCSF
3. Organization	
a. Hospital	
Hospital administrative barriers	
Hospital's policies treat all births as if they are high risk. • Hospital administrators lack knowledge of the CNM scope of practice for low-risk women. • Hospital administrators do not know or value the benefits (e.g. outcomes, satisfaction) associated with midwifery's physiological approach to birth. • Hospital administrators highly value the needs and perspectives of their physician staff.	• American College of Nurse-Midwives (ACNM) • Stanford CERC • SF Birth Center • Beach Cities Midwifery • Ariadne Labs

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• Hospital administrators prefer highly medicalized care from obstetricians that manages risk aggressively, even when not necessary or appropriate.	• Walker, et al., 2014, pg. 5
Hospital's bylaws restrict admitting privileges for midwives. • Hospital leadership is predominantly made up of physicians who write bylaws. • Hospital administrators and leadership believe midwives provide unsafe care to laboring women. • Hospital administrators highly value the preferences of their physician staff.	• ACNM • Kaiser Northern CA • CA OB/GYN
Hospital does not adopt policies that allow midwives to practice at top of their license (as outlined in ACNM Healthy Birth Initiative).	• CA OB/GYN
Hospital is reluctant to collaborate or partner with birth centers, preventing safe and timely transfers. • Hospital restricts physicians from providing oversight to midwives in birth centers citing liability concerns. • Hospital believes birth centers will only transfer patients in emergency situations.	• Lucina Foundation • Beach Cities Midwifery • Best Start Birth Center • MemorialCare Health System • SF Birth Center
External: Hospital staffing structures vary dramatically making it difficult to identify/adopt turnkey solutions.	• Ariadne Labs • PBGH
Hospital financial barriers	
Hospital believes that implementing collaborative practice with midwives is not economically viable. • Hospital lacks knowledge of integrated models outside of laborist/staffing models which can be expensive for hospitals to maintain. • Hospital believes that since midwives usually have a smaller caseload, hiring more physicians will be more profitable.	• CMQCC • Marin General • CHPSO
Hospital competitive payment structures hinder collaborative practice between physicians, particularly laborists, and midwives.	• Mayo Clinic • MemorialCare Health System
External: FFS environment in many CA hospitals makes it challenging for midwives to practice a physiological approach.	• Marin General • Ariadne Labs • Walker, et al., 2014, pg. 6
b. Payer	
Payer reimbursement barriers	
<u>Private and public payers</u> lack consistent policies and procedures around contracting with midwives. • Payer lacks knowledge of the different types of midwives.	• Larsen Billing • Best Start Birth Center • Beach Cities Midwifery

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• Payer lacks knowledge of the outcomes and cost savings associated with midwifery care. • Payer lacks knowledge about the midwifery scope of practice. • Payer does not perceive the consumer demand for midwifery services.	
Medi-Cal reimbursement for professional and/or facility services is too low to cover costs.[1]	• ACNM review of state Medicaid fee schedule • Larsen Billing
Commercial reimbursement for midwifery services varies widely. • Commercial contracts often reimburse less for midwifery services than phyisican services.	• Best Start Birth Center • Credence Medical Practice Management • ACNM, 2014, pg. 4 • ACNM, 2014, pg. 5 • Walker, et al., 2014, pg. 5
"Incident to"[2] billing hides midwifery services in claims data, making it difficult to attribute costs and outcomes to midwives.	• CNMA • Best Start Birth Center • Marin General Hospital
Birth centers, in particular, struggle to achieve financial stability due to: • Low Medi-Cal reimbursement (see above) • Commercial plans generally bundle reimbursement making contracting challenging as reimbursement will likely cover professional OR facility fees, rarely both. • Commercial plans do not reimburse for newborn care at birth center. • Commercial plans do not reimburse for any care if patient is transferred to hospital.	• Best Start Birth Center • SF Birth Center • Baby+Co • Beach Cities Midwifery
External barrier: The segmented nature of health plans (public and private) strains contract negotiations.	• Best Start Birth Center
External barrier: health plans are slow to adopt payment innovations or changes.	• PBGH
Payer coverage and contracting barriers	
Medi-Cal reimbursement process is complex and time consuming.[3]	• Larsen Billing
Medi-Cal process to become an approved birth center (or provider) is tedious and time consuming.	• SF Birth Center • Baby+Co

[1] Although Medicare and Medi-Cal FFS reimburse midwifery services at 100% of the physician rate, commercial and Medi-Cal managed care plans reimburse at <100% of the physician fee schedule for midwifery care (vaginal delivery is $1,089, 5th lowest in country as of 2015)

[2] Lower reimbursement creates incentive to bill midwifery services incident to a physician in order to get the higher physician reimbursement rate for services rendered by a midwife. As a result, services rendered by midwives in medical practices are not attributed to them, impeding transparency effort such as reporting usage, outcomes and cost data, and potentially diminishing the value of the midwife and can restrict their scope of practice.

[3] Even though CNMs are a mandated Medicaid benefit, payment cannot be submitted via one claim, but requires multiple claims for each service provided.

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• Health plans value the services of their physician staff and will prioritize physician applications over midwifery ones.	• Beach Cities Midwifery • Best Start Birth Center
<u>Medi-Cal and commercial plans</u> do not make CNMs easy to locate in provider directories, if at all.[4]	• Kaiser Northern CA • Blue Shield of CA • Marin General Hospital • ACNM, 2014, pg. 6 • CNMA
<u>Commercial</u> plans adopt a scope of practice for CNMs that is stricter than the state regulation.	• Kaiser Northern CA • ACNM, 2014, pg. 5 • Walker, et al., 2014, pg. 5
c. Medical Training	
Physicians and midwives lack exposure to each other's practice or examples of collaborative care in medical training.	• UCSF • CA OB/GYN
Physician is trained to believe that one clinician "owns" a patient from prenatal care to birth.	• NPWF
External barrier: there is a limited supply of CNMs and CNM training programs to meet growing demand.[5] [6]	• CNMA • ACNM, 2015, pg. 5-6
External barrier: Limited funding and opportunities for preceptors make it difficult to expand training programs.[7]	• CNMA • Walker, et al., 2014, pg. 7 • ACNM, 2015, pg. 3
4. Policy/Research	
a. Legislative/regulatory	
California's physician supervision regulation creates a physician-CNM hierarchy that limits CNMs from expanding their practice.[8] • Policy makers lack knowledge of the link between physician supervision legislation and outcomes (see Yang et al., 2016).	• Stanford CERC • SF Birth Center • Baby+Co • ACNM • Marin General Hospital

[4] Midwives may only be listed under OB/GYN; according to ACNM national plan survey, 10% of plans do not list midwives in provider directories.
[5] Even though capacity at ACME-accredited programs has increased 23% from 2010-2014, qualified applicants in that same time period increased by 30% (only three programs in the state: UCSF, CSU Fullerton, SDSU). Largest graduating class is 16.
[6] With ~800 CNMs employed (2010), in order to increase vaginal CNM attended births from current 11% (2014) to 20% (ACNM goal), would need ~650 more CNMs in California.
[7] CDPH cut CNM Education out of their Maternal Child Health budget in 2010; OSHPD Song-Brown funding supports education of OB/GYN residency programs but nurse-midwifery education is not eligible for funding; HRSA funding for advanced practice nursing education is limited to one grant per University per year.
[8] This is particularly restrictive when there are no or insufficient physician coverage.

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	• Best Start Birth Center • CNMA • Beach Cities Midwifery • Walker, et al., 2014, pg. 3
"Physician supervision" is required but not well-defined in regulation leading to varied interpretations which impacts CNM scope of practice.[9,10]	• SF Birth Center • Baby+Co • Best Start Birth Center • CNMA • ACNM • Marin General Hospital • Beach Cities Midwifery • CNMA, 2014
b. Supporting Research	
Tracking quality data for midwives is not feasible with the current EHR because it is difficult to attribute birth outcomes to a delivering provider.	• Stanford CERC • Kaiser Northern CA • Mayo Clinic
The literature does not analyze the revenue implications of incorporating midwives into a hospital or physician group.	• Anthem • CMQCC

[9] A written collaborative agreement between a physician and midwife is not required in California.

[10] Example of this in practice: birth centers having to put together Standardized Procedures with physician sign-off (required by CNA).

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