PBGH
PACIFIC BUSINESS GROUP ON HEALTH

issue brief

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Promoting Midwifery and High Value Care in Medi-Cal

Introduction

The Pacific Business Group on Health (PBGH) interviewed California Medicaid (Medi-Cal) plans across managed care models and geographies to explore opportunities to promote Medi-Cal access to midwives and high value care strategies in maternity. PBGH evaluated payer contracting and reimbursement practices, network requirements, quality incentives, and value-based payment. In order to capture the full landscape of payer practices in maternity, PBGH also interviewed large commercial health plans. From these interviews, we have developed recommendations to promote access to and use of midwives and high value strategies in Medi-Cal.

From the *Listening to Mothers in California* survey, we learned that most women would want or would consider a midwife for a future pregnancy.[1] Moreover, the main reason women who wanted a midwife did not have one was because they thought their insurance would not pay for a midwife. Clearly, insurance coverage is a key concern for women considering maternity care team and care location options. In addition, PBGH believes increasing midwifery utilization is a critical strategy to improve in maternal quality, affordability, and the patient experience.

During these interviews, we asked payers about their contracting and reimbursement practices for midwifery, separating out policies for Certified Nurse-Midwives (CNMs) and Licensed Midwives (LMs) when appropriate. CNMs are educated in both nursing and midwifery – they earn graduate degrees, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM.[2] They are credentialed to practice with prescriptive authority in all 50 states. Licensed Midwives, LMs, are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by the Midwifery Education Accreditation Council), and LMs take a national certification exam which is equivalent but not identical to the test administered by the AMCB. CNMs practice most often in the hospital, while LMs rarely practice in the hospital. In California, CNMs must practice with physician supervision (which remains undefined in statute, and does not mean the physician is physically present).[3]

Our interviews included the following payers: Inland Empire Health Plan, Partnership Health Plan, CalOptima, community Health Group of San Diego, L.A. Care, Santa Clara Family Health Plan, Blue Shield of California, Health Net, United Health Care, Cigna, Aetna, and Anthem. These health plans represent the diversity of California's population and the wide range in health plan structures in terms of size, level of delegation, and level of concentration of maternal delivery volume in network. These differences in size (1,000 to 20,000 annual births) and concentration (3 to 72 labor and delivery hospitals), as well as competition with other area health plans, impacts the payer's overall ability to drive improvements locally and regionally. Additionally, most of the health plans have at least some portion of their business management delegated to contracted health systems, medical groups, and independent physician associations, which can significantly affect a plan's capacity to influence changes in care delivery and performance.

Midwifery Contracting and Reimbursement Practices

Health plans have several levers to promote access to and utilization of midwives, including network adequacy and contracting, consumer access, and reimbursement rates.

Key Health Plan Levers

Network adequacy and contracting

Ensuring midwives and birth centers are available in network

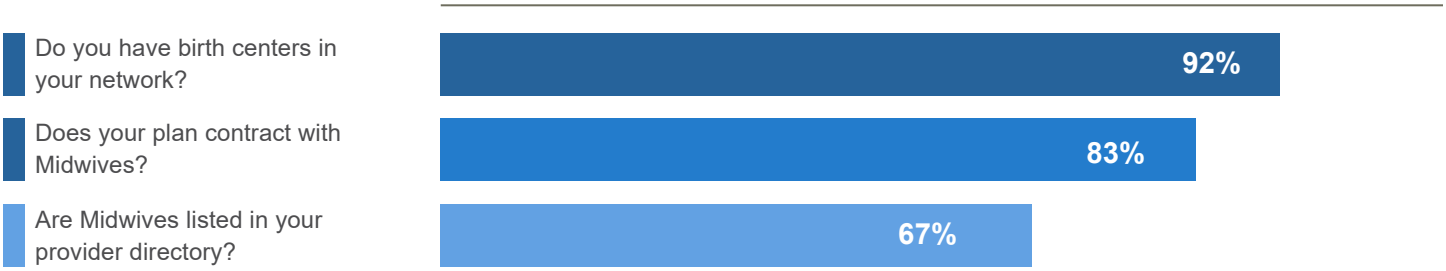
Reimbursement rates

Competitive rates of reimbursement to support the practice of midwifery and the financial viability of birth centers

Consumer access

Ensuring midwives are visible to the consumer

With these levers in mind, we asked health plans if they contract with midwives and birth centers, if midwives are listed in the provider directory, and what the reimbursement rates are for midwives and birth centers (compared to reimbursement practices for an OBGYN and hospital birth).



Health Plan	Contracts with Midwives	Midwives Listed in Provider Directory	Contracts with Birth Centers
Aetna (commercial only)	•	•	•
Anthem	•	•	•
Blue Shield of California			•
CalOptima	•	•	•
Cigna (commercial only)	•	•	•
Community Health Group of San Diego	•	•	•
Health Net	•		•
Inland Empire	•	•	•
L.A. Care	•		•
Partnership Health Plan	•	•	•
Santa Clara Family Health Plan	•		
United Health Care	•	•	•

In our interviews, a few key themes emerged:

1) Contracting

Availability of midwives in network is a necessary condition for women seeking a maternal care provider. Under Medi-Cal managed care, women must seek from networked providers for services to be covered. As a result, midwives must be part of the network to ensure access.

Almost all health plans contract directly with midwives, with Blue Shield of California as the exception. Medi-Cal plans are required to contract with at least one Certified Nurse-Midwife (CNM)/Licensed Midwife (LM) and at least one birth center if they are available in the plan's catchment area and willing to accept offered rates, in accordance with the All Plan Letter 18-022.[4] However, health plans were largely unable to determine the exact number of nurse-midwives providing care in their network. Many of these plans noted that their delegated medical groups, community clinics or network hospitals may have nurse-midwives on staff, but the claims often come in under the physician's name, since billing midwifery services "incident to" a physician often means a higher reimbursement rate, or come in under the delegated entity. Thus, health plans are unable to determine how many midwives are effectively in network or attend births for their population.

Licensed Midwives can practice independently (not under physician supervision), which would mitigate these data issues. However, some health plans hesitate to contract with LMs due to concerns about variation in quality of care and lack of integration with OBs and hospitals when its needed. While many LMs have worked to decrease variation in practice and to establish relationships with hospitals and physicians, this perception remains.

2) Consumer Access

Midwives need to be not only available in Medi-Cal networks, they also need to be a visible option to women seeking care. All the health plans interviewed that contract with midwives cite that these providers are visible to consumers in their online provider directories. This finding is encouraging, since these online directories serve as a menu of options for consumers. However, as plans do not have full information about the midwives delivering services in their network under delegated arrangements and/or in clinics and hospitals that employ midwives, it may be hard for consumers seeking midwife care to find it using these directories.

3) Reimbursement and provider incentives

While we learned that most Medi-Cal plans contract with midwives and include midwives in their provider directories; the actual reimbursement for midwives evidenced a range of payer practices.

Several plans reported reimbursing at the same rate for midwives as physicians, noting that the actual rate varies by contract (100% or some slight variation of the Medi-Cal fee-for-service rate). However, other plans reported reimbursing midwives between 80% and 90% the rate of reimbursement for physicians.

Health plans consistently reported lower rates of reimbursement for birth centers compared to hospital births. Many of the plans noted that for birth center births, the professional fee is the same or similar, but the facility fee is less, since it is based on simply the APR-DRG and the per diem rate. Health plans reported that birth center reimbursement was anywhere from 30% to 50% less than hospital reimbursement.

Network Requirements

New regulations encourage change in the industry. The binding guidance of the All Plan Letter 18-022 ensures that at the very least, Medi-Cal plans must attempt to contract with Certified Nurse-Midwives, Licensed Midwives, and birth centers. While there is much room to improve and expand this basic network requirement, this APL was a significant victory for Medi-Cal families looking to access a midwife for their maternity care.

Health plan network requirements, such as provider performance on quality metrics, are key drivers of change. Studies have shown that areas with more midwives integrated into the health system evidence significantly higher rates of physiologic birth, less obstetric interventions, and fewer adverse neonatal outcomes.[5] However, a narrow provider network strategy is not always available to health plans facing network adequacy challenges in rural areas.

PBGH recommends that health plans work with purchasers to ensure high standards for network requirements. For example, Covered California requires that participating plans only contract with hospitals that meet certain quality and safety targets, including achieving the Healthy People 2020 NTSV (nulliparous term singleton vertex) or "low-risk" C-section target rate of 23.9%. Aligning contracting standards with nationally recognized targets sends a strong message to the provider community that purchasers, and consumers, demand high quality and refuse to pay in-network rates for anything less.

Quality Measurement

Another important strategy for health plans is to promote professional standards and drive improvement in their networks through quality measurement and data transparency. Public reporting promotes healthy competition among providers and educates consumers on their care options.

Health plans can take leadership and leverage change through hospitals. Inland Empire Health Plan and Partnership Health plan heavily incentivize their network hospitals to participate in the California Maternal Quality Care Collaborative (CMQCC) and to submit data to the Maternal Data Center. Significant financial incentives are tied to hospitals' performance on CMQCC metrics such as NTSV C-section rate. Other plans, such as Health Net and Blue Shield of California, are following suit and starting to include quality incentives for performance on the NTSV C-section metric in their contracts. Health plans can leverage hospital participation in CMQCC to create powerful incentives for improvement on NTSV C-section and other key maternity metrics.

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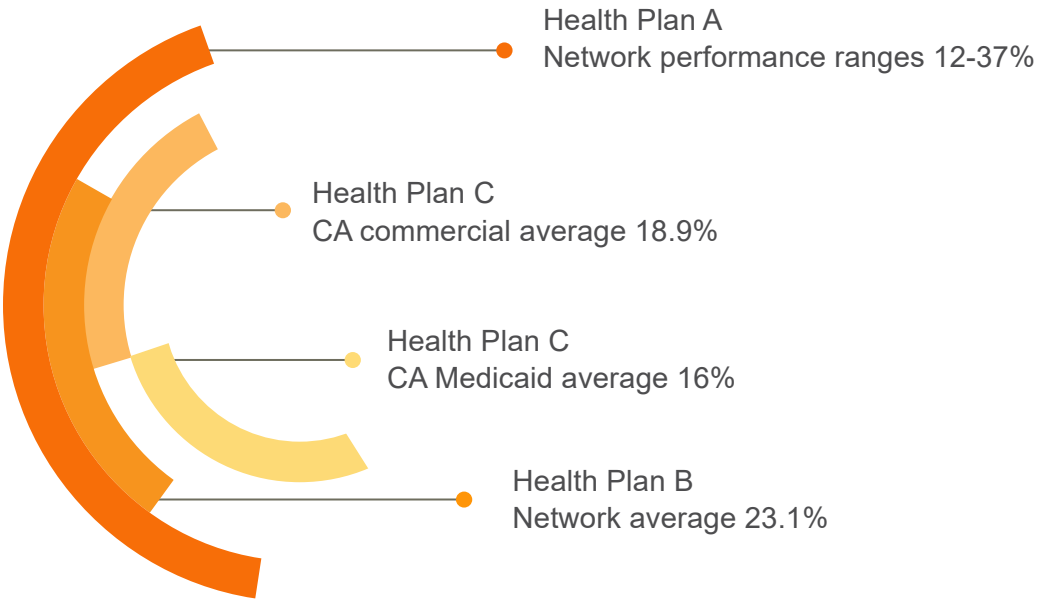
The newly published %CNM deliveries metric on CalHospitalCompare could be a new opportunity for plans to promote and incentivize midwifery utilization in their networks. This %CNM deliveries metric first needs a target, and second, any incentives for achievement must be substantial enough to influence the bottom line for hospitals and providers.

C-section rates have been on the rise in the U.S. over the past several decades, and many payers are taking steps to monitor performance. Several managed Medi-Cal plans – Inland Empire, CalOptima, and Partnership Health Plan – as well as the national health plan United Health Care are tracking variation in NTSV C-section rates across their networks. NTSV C-section rates are difficult to calculate from claims data, which creates a barrier for many health plans. The availability of this data has been a major driver of improvement on the NTSV C-section metric in California. While NTSV C-section rates are typically calculated at the hospital level, hospital participants of the California Maternal Quality Care Collaborative (CMQCC) can see provider-level performance and have used this to support efforts to reduce variation and improve performance. Since CNM-attended births tend to have fewer interventions such as C-sections[6], PBGH recommends increasing midwifery utilization and physician-midwife collaboration.



Other payers have decided to track a non-risk-adjusted C-section rate for hospitals in their networks. For example, Cigna has constructed an index measuring primary Cesarian delivery rates using the Agency for Healthcare Research and Quality methodology (AHRQ IQI #33 specifications.) While the Joint Commission and AHRQ measures are commonly used to define low-risk C-sections, the Society for Maternal Fetal Medicine recommends another metric – the SMFM definition. This claims-based metric is appealing because it does not rely on hospital resources for data collection.[7] Aetna utilizes this SMFM definition to track C-sections across their networks. The lack of consistency in C-section measurement creates a barrier for measurement and improvement, since most providers contract with many health plans.

Payers also measure performance through claims at the provider level. Health plans consistently reported tracking performance on perinatal care measures that are part of the Healthcare Effectiveness Data and Information Set (HEDIS), such as timely visits for Prenatal and Postpartum Care and the proposed new measures of Prenatal and Postpartum Depression Screening and Follow-up. Payers are tracking general population health metrics such as Tdap (influenza and diphtheria and pertussis) vaccinations, chlamydia screening, blood pressure screening, diabetes screening (gestational and postpartum), Hepatitis B screening, and smoking cessation. Many of these are required measures that are part of the managed care accountability set (MCAS)[8] that Medicaid managed care plans are evaluated annually. In addition, historically some measures, including timely prenatal care, have been tied to auto-assignment in counties with multiple plans. This results in higher performing plans receiving a higher percentage of those members who enroll in managed care but do not select a plan.[9]

Payers are also responding to population-specific quality improvement needs through physician quality measurement. For example, Los Angeles County experienced a rise in syphilis and congenital syphilis rates in 2018,[10] and in response, L.A. Care partnered with the LA County Department of Public Health to increase syphilis and sexually transmitted disease screening rates in the third trimester. This effort demonstrates that while tracking performance and comparing targets at the national level is important, health plans are uniquely positioned to respond to local concerns. (BRIGHT SPOT– ask LA Care to present best practice)

However, attribution for maternity-related quality measures (other than NTSV C-section) is complicated in Medi-Cal managed care, as patients are assigned to a primary care physician but not to a specific maternity provider. Under Medi-Cal fee-for-service, most plans will see who the designated provider is using global obstetric CPT codes, but under capitated or delegated arrangements, it may be harder to ascertain.

Maternal Mental Health

Health plans are increasingly turning their attention to behavioral health in maternity care in response to both consumer advocacy efforts and new policy regulations. California Assembly Bill 2193, which went into effect on July 1, 2019, requires obstetric providers to confirm screening for maternal depression. This new law shines light on an important issue, but implementation of the policy has been varied. Many plans had already included maternal depression screening in their provider performance tracking programs, aligning with the US Preventative Services Task Force recommendation "that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions."[11] Some payers, such as Partnership, Inland Empire, and Cigna have attached incentives to performance on perinatal depression screening. Many other plans, such as CalOptima and Health Net, are developing robust data tracking and incentive programs to focus on perinatal mood and anxiety disorders in 2020.

Other plans are developing care management resources to support providers in their ability to screen, treat, and refer patients to treatment. The Aetna Maternity Program has an embedded behavioral health specialist to actively manage members with perinatal mood and anxiety disorders. This strategy is appealing to health plans with extensive resources and a large geographical or national presence; however, building a care management team is a challenge to smaller local health plans who already have difficulty identifying behavioral health specialists in their area.

The largest barrier for both referring providers and patients is the lack of access to behavioral health specialists. For managed Medi-Cal plans, specialty mental health benefits and substance use are administered by the county, while mild to moderate mental health benefits are part of the plan's responsibility. Due to provider shortages, often patients with acute symptoms are addressed in a timely manner, while patients with mild-to-moderate conditions experience a long waiting period. This fragmented structure creates major challenges for data collection, provider communication, and consistency in care delivery.[12]

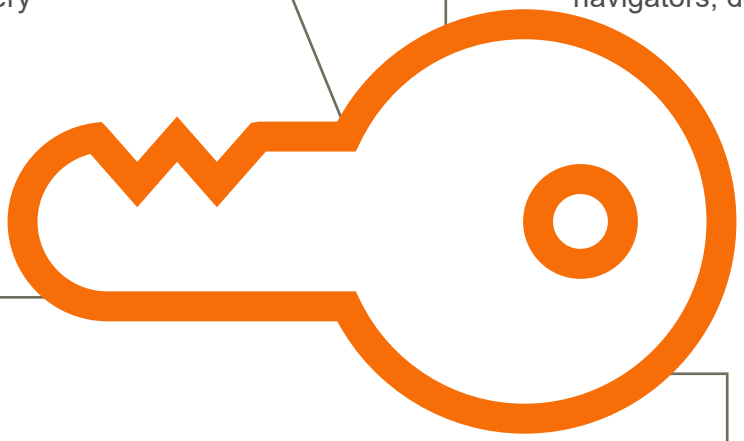
Despite public attention, utilization of mental health benefits during pregnancy and the postpartum period was reportedly very low compared to other populations (this was true for both the California managed Medi-Cal plans and the national commercial plans interviewed.) **This surprisingly low utilization highlights the need for health plans, purchasers, and community organizations to develop consumer engagement strategies to educate individuals on the benefits of early and aggressive screening and treatment.**

Bundled Payment & Learnings from Commercial Payers

An emerging trend in value-based care is episode-based bundled payment, and several commercial health plans, including Cigna and United, have created bundled payments for maternity. Although there is no consumer cost-sharing in Medi-Cal, some of the learnings from bundled payment in the commercial space could translate into the public space. The bundled payment strategy encourages payer/provider collaboration, resulting in many key benefits:

Applying a blended case rate to the delivery price: one set price for births, regardless of vaginal or C-section mode of delivery

Shifting funding to enhance prenatal and preventative services (e.g. behavioral health services,care navigators, doula care)



Removing the incentives for unnecessary medical interventions and encouraging physiologic birth

Promoting the use of midwives

The Department of Health Care services is encouraging value-based payment in Medi-Cal for maternity, and several Medi-Cal health plans are using or considering a blended case rate. PBGH recommends this strategy as a preliminary step to implementing a maternity bundled payment model. In addition, many Medi-Cal plans would consider developing a maternity bundle. The biggest challenge is that contracting is not standard throughout the state, and each provider organization and hospital contract and network is unique. Moreover, the delegated arrangements within plans adds another layer of complexity. Although a bundled payment strategy offers several benefits, significant on-the-ground effort would be needed to tackle the existing contract layers to develop, implement, scale, and spread a maternity bundle in Medi-Cal.

Challenges and Recommendations

Our findings indicate wide variation in contracting practices and reimbursement policies for midwives amongst managed Medi-Cal plans, and several plans have acknowledged that this topic is not a priority.

These plans consistently referenced a few challenges, including the level of delegation within their networks and the ability to credential providers or ensure providers are meeting professional standards. Many of the plans we interviewed are highly delegated, thus, they have less insight into the contracting decisions made by delegated groups. However, they could still require contractually the inclusion of midwives in their network. For Medi-Cal, the supervising physician needs to be a Medi-Cal participating and credentialed provider. In some cases, the midwife groups have found a supervising physician but not one who is willing to contract with a Medi-Cal Plan. Essentially, the physician supervision requirement creates a barrier for Medi-Cal consumer access to CNMs while having no added effect on quality or safety, and variation (or perceived variation) in professional standards pose a challenge to health plans contracting with LMs.

However, the implementation of quality measurement with significant incentives, and the move toward value-based payment are essential tools to promote not only midwifery but also high value care in general. Implementing a blended case rate and having one set price for both vaginal and C-section modes of delivery reduces the financial incentive for unnecessary interventions such as C-sections and improves outcomes by having the entire care team working collaboratively under a shared budget and common quality goals. Moreover, PBGH recommends that purchasers explore prospective bundled payment methodologies - setting a price target and paying for the entire episode upfront. This brings the whole team together to plan how they will deliver care most effectively, rather than having them continue in a “fee-for-service” model in which each provider on the team bills separately. This makes the cost of maternity care for both purchasers and patients more predictable – with fewer surprises.

Given the existing barriers, we recommend a few ways **health plans** could promote midwifery utilization, including:

- Equalizing reimbursement rates for midwives with obstetricians
- Increasing reimbursement rates for birth center births (the facility fee)
- Developing quality performance incentives encouraging midwifery utilization – general quality metrics such as NTSV C-section rates, or more specific quality metrics such as %CNM deliveries, or requiring a certain proportion increase in CNM deliveries over a designated period of time – both for hospitals and for delegated groups
- Support the full practice authority for Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs), to the full extent of their training and licensure
- Offering the equivalent of PPS-wraparound payment for FQHC-employed CNMs who do deliveries (since, if an FQHC employs a CNM, they are incentivized to have that CNM only do prenatal care because they cannot get a top-up payment if they deliver services off-site)

Given that about 40% of Medi-Cal births happen under fee-for-service Medi-Cal[13], we recommend a few levers available to the Department of Health Care Services (DHCS) to promote midwifery, both as a purchaser governing plan behavior (e.g. All Plan Letters, quality measures, etc.), and as the plan for fee-for-service Medi-Cal births:

- Including NTSV C-section rate in EAS External Accountability (EAS) measure set and measuring disparities
- Equalizing reimbursement rates for midwives with obstetricians
- Increasing reimbursement rates for birth center births (the facility fee)
- Increasing network adequacy requirements for CNMs and LMs and accredited birth centers beyond just one per region (consider current physician network adequacy standards when determining midwifery network adequacy standards)

Although our analysis focuses on recommendations for Medi-Cal plans, we are exploring ways in which Medi-Cal plans and commercial plans can work together in a market. Commercial plans could implement tactics which are not available to Medi-Cal, such as benefit design incentives. A few commercial plans indicated that although such benefit design does not currently exist to steer consumers to midwives, there may be some opportunity to promote midwives, particularly within accountable care organizations (ACOs) where there is already shared risk. In addition, commercial plans could test certain innovations such as paying for a laborist to provide backup to midwives and to the regular nursing staff, and considering requiring hospitals to provide physician back-up for midwives. Finally, PBGH recommends that both Medi-Cal and commercial plans consider multi-payer solutions to promote midwifery integration.

PBGH's Transform Maternity Care program is dedicated to promoting high value maternity care for all. We believe that increasing midwifery utilization will improve maternal quality, affordability, and the patient experience in California and the U.S. Since there are a number of operational, cultural, and financial considerations regarding midwifery expansion, PBGH has developed several resources (available to download on our website: **pbgh.org/midwifery**) to support providers on this journey.

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- Blue Shield of California
- Health Net
- United Health Care
- Cigna
- Aetna
- Anthem

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