

## Milbank Quarterly in Conversation

### Episode 4: Removing Medicaid Barriers to Midwifery Care and Birth Centers

**Alan Cohen:** Hello. I'm Alan Cohen editor of *The Milbank Quarterly*. And this is *Milbank Quarterly in Conversation*. In this episode, I'll be talking with Bridgette Courtot, a senior research associate in the health policy center at the Urban Institute, whose work focuses on maternal and child health and on access to care for underserved populations. Her article in the December 2020 issue of the *Quarterly* looks at policy barriers in state Medicaid programs that limit access to midwives and birth centers. These barriers exist even though midwife care provided through birth centers, improves maternal and infant outcomes and also lowers costs for Medicaid.

Brigette, thank you for joining us today. Maternal mortality has been an issue of growing concern in the United States. How do US maternal outcomes compare with those of other nations?

**Brigette Courtot:** Well, the US is really going in the wrong direction in terms of maternal outcomes. We pay more for perinatal care than any other country, but our maternal and infant health outcomes are among the worst in the developed world. For instance, a report that was released last year by the Commonwealth Fund found that among 11 high income countries, American women had the greatest risk of dying from pregnancy complications. Our maternal mortality rate has more than doubled in the past couple of decades. And currently over 700 women a year die of complications related to pregnancy each year in this country. The majority of those deaths are preventable. There's also a significant morbidity. You hear a lot about mortality, a little bit less about morbidity, but around 50,000 women suffer from life-threatening complications of pregnancy each year. It's really a sobering picture, and it gets even more dismal if you think about disparities. There are major disparities in maternal health outcomes. For instance, Black women are dying from pregnancy-related complications at around three times, the rate of white women. And those disparities exist across the income spectrum.

**Alan Cohen:** Why did you decide to examine access to midwife care and birth centers among Medicaid beneficiaries?

**Brigette Courtot:** You may know that the Medicaid is the dominant payer in the US, so it covers more than 40% of births nationwide, and in some states that's as high as 60% or more. As the dominant payer in this arena, Medicaid really has an opportunity to move the needle when it comes to outcomes for moms and babies. Our study uses data from a national evaluation of a federal demonstration program for pregnant women enrolled in Medicaid and the Children's Health Insurance Program, which is typically called CHIP. The demonstration program that we evaluated was called Strong Start for Mothers and Newborns, and it operated from 2014 through 2017.

And it was testing whether alternative models of maternity care can improve outcomes for pregnant women enrolled in Medicaid and their babies, including addressing challenges of low birth weight and preterm birth, or preterm babies, in the United States. One of the three models that Strong Start was testing was midwifery care delivered through a freestanding birth center. Our evaluation of Strong Start is one of the largest examinations ever conducted of birth center care for women enrolled in Medicaid. We really wanted to take advantage of the wealth of data that was being collected on this type of care for a Medicaid beneficiary, through this evaluation, to take a close look at Medicaid participants' access to this kind of care, and also the experiences of birth centers under Strong Start.

**Alan Cohen:** What are the principal benefits associated with midwife care and birth centers?

**Brigette Courtot:** The midwifery model of care is women centered. Some of its tenets are that it's individualized, it takes a holistic approach, and it really emphasizes health education in minimizing interventions during pregnancy labor and delivery. A comprehensive review of midwifery-led care and outcomes that was done a few years ago, a Cochrane review, found that generally women who are in this type of care have higher levels of satisfaction, they're less likely to have a preterm birth, and they're more likely to have continuity of care, meaning that their births are more likely attended by a provider that they know and that they saw during the prenatal period. And they're less likely to have interventions like epidurals or instrumental birth, so that would be like a forceps birth. The midwifery model of care can really be practiced in any setting and is.

**Brigette Courtot:** Midwives do practice in hospitals, for instance but it's universally what's practiced in freestanding birth centers, which were the locales that we're studying under Strong Start. Those are independent entities. Compared to a hospital setting where midwives might practice, midwives have the ability to completely be faithful to the midwifery model in a birth center setting. The women who received prenatal care in birth centers some of the evidence there shows us that they are less likely to have C-section deliveries and less likely to have labor induction or continuous electronic fetal

monitoring. They also have access to non-pharmaceutical pain relief, like laboring and birthing and water, options that aren't available typically in a hospital setting,

**Alan Cohen:** Very interesting findings. Did you find that women enrolled in Medicaid were interested in these particular options?

**Brigette Courtot:** I'm really glad that you asked that because it's a really important finding as there can be an impression that these options are primarily appealing and used by higher income or privately insured women. But most of the Strong Start participants were all women who were enrolled in Medicaid; they specifically sought out this model of care. They told us that they were choosing birth center care deliberately because they preferred midwife providers. Some of them wanted a more natural birth experience, and in some cases, they were looking for certain pain relief methods or procedures that weren't available in hospitals. I mentioned waterbirth just a minute ago, nitrous oxide is another option. Some women told us they were looking for what typically isn't available in a hospital setting, or the option for vaginal birth after a previous cesarean section, it's sometimes called a VBAC. Some of the women in the program told us that they had a negative experience with a prior pregnancy or with a birth that was at a hospital when they were cared for by physicians, they were kind of explicitly seeking an alternative to that. There was lots of interest in these options among the women that were enrolled in the program.

**Alan Cohen:** Your article in *The Quarterly* referred to policy barriers. I was wondering if you could speak to what appeared to be the Medicaid policy barriers to making this care more widely available to women.

**Brigette Courtot:** Overall, we found that that the women enrolled in the program in this type of care had good outcomes in terms of the things we were looking at: preterm birth, low birth, weight, and cost. But we found that despite the interest that I just talked about, despite birth centers' proven abilities to serve these patients effectively, there were many barriers that stood in the way of Medicaid beneficiaries having broad access to the birth center care. Reimbursement as a barrier was front and foremost for a lot of the birth centers. That's probably not surprising for you as someone who knows a lot about Medicaid. This issue of low reimbursement is definitely not unique to birth centers, but one thing that is a little different for birth centers is that they're usually small businesses, right?

**Brigette Courtot:** They serve a limited patient panel. It's more difficult for them to absorb unmet cost or to pass them on to other patients. That's just not as much of a viable strategy for birth center, like it

might be for a larger health care provider. We found that some of the birth centers were really limiting their Medicaid business because of the low reimbursement rates. In the most extreme case, one of the participating centers by the end of the demonstration, which I mentioned, was several years long, had stopped serving Medicaid patients entirely because their payments were upside down. They were spending more providing the care that maybe they were receiving in reimbursement and they couldn't make it work any longer; now they needed to pay their bills.

**Brigette Courtot:** Reimbursement was the biggest barrier that we heard about, but it definitely wasn't the only one. We heard that birth centers are sometimes unable to get contracts with Medicaid managed care organizations. And that's a problem because managed care is the dominant delivery system for pregnant women in Medicaid. The final one that I'll mention, which I think is pretty interesting is, value-based care reforms, which a lot of people are discussing in Medicaid, and lots of Medicaid programs are pursuing a system that is more value-based. This could be an area where midwives and birth centers could really excel because there's evidence that they provide high-quality care at a lower cost, but that can be a challenge for these providers. We heard during our case studies for the Strong Start evaluation that these types of reforms aren't often set up for birth centers to participate.

For instance, births are covered as inpatient services, but birth centers are typically classified as outpatient settings. There's kind of a disconnect there and some of the value-based programs also don't really have a mechanism for midwives to be primary accountable providers. That designation, in some programs, has to go to a physician and, in freestanding birth centers, which are midwife-led, that can be a problem too. So that is kind of just typically the way that those programs are set up. It's not in a way that birth centers can participate.

**Alan Cohen:** What about state licensure and scope of practice laws? Did you find that those were barriers as well?

**Brigette Courtot:** Yes, definitely. Certainly the state scope of practice allows nurse midwives to practice. There are two different paths for midwives that have training as a nurse, and then become a nurse midwife. Then there's the direct entry midwives who train as midwives right from the start. In a number of states, direct entry midwives are not licensed. Only a fraction of Medicaid programs do have those providers as participating providers in their programs. So that can be a barrier certainly with scope of practice and even for nurse midwives who practice in our Medicaid providers in all the states there can be limitations on what they're able to do.

**Brigette Courtot:** Sometimes they have to practice under a physician and those rules are pretty stringent. For instance, while we were doing the Strong Start study, there was a regulation that a birthing center was battling against, which would have required a physician to be present at the birth center at all times, which is unrealistic for the way that birth centers are run. Typically, they have an agreement with a physician. A physician is their backup in case there are complications, or complex pregnancies that midwives aren't qualified to handle. Then they would work with a physician—that kind of relationship is typical. The requirement that a physician would be present at the birth center at all times is not typical and not really workable for birth centers. So that's one example of a regulatory barrier that the state was trying to put into place and that the birth center was battling with to try and keep its doors open.

**Alan Cohen:** Yeah, these are all formidable barriers and certainly low Medicaid reimbursement has been a problem that dates all the way back to the inception of the Medicaid program. What do you think state health policymakers can realistically do to address these barriers?

**Brigette Courtot:** One possibility is looking at some form of cost-based reimbursement, like what federally qualified health centers receive. There actually was a bipartisan sponsored piece of legislation, called the Babies Act, a federal proposal, that hasn't really moved since 2019.. It's a demonstration program to really look at a handful of states paying birth centers, like federally qualified health centers are paid with concert of a cost-based reimbursement basis.

**Alan Cohen:** Great. Thank you. So what is your next research project?

**Brigette Courtot:** Right now, I am leading the qualitative data collection for another large national evaluation that I'm really excited about. It's called the Maternal Opioid Misuse (MOM) model. It has a nice acronym. The MOM model is like Strong Start in that it's a demo program run out of the Center for Medicare and Medicaid Innovation, CMMI, which is part of the Centers for Medicare and Medicaid Services. MOM is a multi-year initiative and it got started at the beginning of this year. Its goal is really to address fragmentation of care for pregnant and postpartum Medicaid beneficiaries with opioid use disorder. Some of the women involved in Strong Start were also women who had opioid use disorder and were in recovery. So we learned a little bit about this issue then and it's really exciting that we're working on this evaluation now. Ten states have MOM awards, and they'll provide coordinated care and evidence-based care for pregnant women and infants who are in Medicaid and in CHIP with the goal of improving the care that they receive and improving their outcomes and reducing costs at the same time.

**Alan Cohen:** Sounds like a very interesting project. We'll look forward to seeing the findings from that study as well. And, Brigitte, thank you very much for taking the time to speak with us today, and thank you for your intellectual contributions to *The Milbank Quarterly*.

**Brigitte Courtot:** Thanks very much. I really appreciate the opportunity to share the work we're doing at Urban.