MEDI-CAL ACCESS TO COMMUNITY MIDWIFERY CARE: MIDWIVES' PERSPECTIVES

This policy brief summarizes the findings of a research study that included interviews with community midwives about their experiences with Medi-Cal.

Authors: Ariana Thompson-Lastad PhD, Mounika Parimi MSc, Sara Jhanjar BS, Jessica Harrison LCSW, PhD, Chanda Williams PhD, Tanya Khemet Taiwo CPM, PhD

WHAT IS MIDWIFERY?

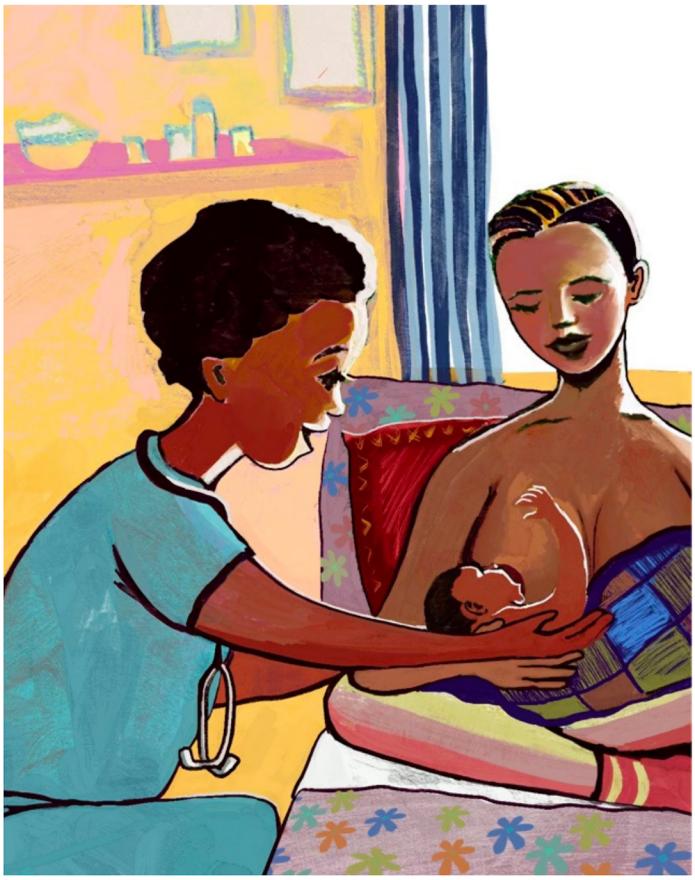
- A midwife is a licensed clinician who provides care throughout pregnancy, childbirth, and the postpartum period, including infant care for six weeks after birth.
- Two types of midwives are credentialed in California: 1) Certified Nurse Midwives (CNMs), and 2) Licensed Midwives (LMs) (many of whom also hold the national credential of Certified Professional Midwives).
- The term community midwife describes midwives with either credential who provide perinatal care in homes and free-standing birth centers. Only Certified Nurse-Midwives can provide care in hospitals.

"We see people at one day, three or four days, and one week in their home. And then at two weeks, sometimes four weeks, and definitely six weeks in the office. And there's flexibility to that, so if someone has a major breastfeeding issue going on, we might see them for extra visits, or the four-week visit is something that can be added in."

WHAT IS THE COMMUNITY MIDWIFERY MODEL OF CARE?

Community midwives typically provide continuity of care throughout pregnancy, birth and postpartum, as a solo practitioner or as part of a small group practice. This includes:

- Prenatal care on a similar schedule to hospital-based care, with longer visits (30+ minutes).
- Birth is planned at home or in freestanding birth centers. If hospital birth is needed, midwives often attend the birth for additional support.
- Postpartum and well-baby care for 6 weeks. Typically 5-8 visits, each one hour or longer, including some home visits. Additional contact is provided as needed.
- On-call availability 24 hours a day for urgent needs.
- Referrals to obstetric & pediatric clinicians or other needed support (e.g., doulas, lactation consultants) as needed.



CA MIDWIFERY LAW TIMELINE

1974: California passed a state statute allowing nurse-midwives to become licensed within the state

1993: Licensed midwifery Practice Act estabilised the Licensed Midwife (LM) credential and authorized LMs to attend births in homes and birth centers

2013: AB 1308: Clarified scope of practice for licensed midwives; allowed them to continue attending vaginal birth after cesarean (VBACs) at home if certain criteria are met

2015: SB 407: allowed licensed midwifes to become Medi-Cal providers

2021: SB1237: Expanded Certified Nurse-midwife scope of practice, allowing CNMs to practice without physician supervision

2021: California Momnibus Act: requires Medi-Cal to cover prenatal and postpartum doula services

2023: Planned state budget to increase Medi-Cal reimbursement amounts for primary care, including maternity care

RESEARCH STUDY OVERVIEW

- Researchers from the UCSF Osher Center for Integrative Health conducted in-depth, semi-structured interviews with 23 California community midwives to understand experiences with Medi-Cal and barriers to becoming Medi-Cal providers.
- 15 of the 23 midwives identified as White, 4 as Black or African American, 3 as American Indian or Alaska Native (AIAN), 3 as Asian, 2 as Latino/a, Latinx, or Hispanic. Among them, 2 midwives identified as multiracial.
- We interviewed 17 Certified Professional Midwives/ Licensed Midwives and 6 Certified Nurse-midwives serving 20 counties in California.

COMMUNITY MIDWIVES' EXPERIENCES WITH MEDI-CAL

- All midwives interviewed want to offer care to people across the income spectrum, including those insured by Medi-Cal.
- Midwives view the midwifery model of care as a powerful tool to promote health equity by improving health outcomes and reducing rates of severe maternal morbidity and mortality.
- We interviewed midwives from five birth centers, all of whom have been Medi-Cal providers. Most homebirth midwives want to be Medi-Cal providers, but due to the barriers outlined below, are not currently able to be.
- Community midwives face barriers at all stages from signing up to be a Medi-Cal provider to obtaining reimbursement.

"The best way we can have an impact on health equity in California is to address all Medi-Cal clients. .....Maybe reform the system... just to give really good clinical care."

BARRIERS TO BECOMING A MEDI-CAL PROVIDER

1 **Cost of malpractice insurance is not compatible with midwifery model of care.**

- Midwives are required to have malpractice insurance secured *before* applying to be a Medi-Cal provider, in contrast to private insurance requirements.
- Malpractice insurance can cost at least $11,000 annually for homebirth practices, and $13,000-$80,000 annually for birth centers.
- Homebirth midwives often take 1-2 new clients per month, in order to provide personalized care. Liability insurance is too expensive for most homebirth midwives to afford.

"Even though Medi-Cal took nine months to process my application, I had to carry that malpractice without having a single client in my care that was in Medi-Cal without being paid to do so. So, I had to front that malpractice insurance way before I even got accepted and credentialed."

"So if you have one Medi-Cal client, the cost of taking that client supersedes how much you're actually getting paid back. My malpractice is $2,800 a month. So, if I don't make at least $2,800 a month, then I'm losing money. I'm actually paying to have those clients on my roster."

2 **The Medi-Cal midwife application process does not align with CA midwife licensing guidance.**

- Neither LMs nor CNMs require physician supervision to practice in California.
- However, on the Medi-Cal midwife application website midwives are asked the name of their physician supervisor.
- In addition, Medi-Cal credentialing can take many months after midwives initially apply.

"When we first sought out getting our credentials through Medi-Cal, it took a full year for all of us to get credentialed because the people who were working at DHCS and going through our applications had no understanding of our licensure process."

"Never in a million years will I ever see reimbursement for making a house visit No, not gonna happen. But that's the midwifery model of care right there."

3 **The current Medi-Cal perinatal care payment model is set up for hospital-based care.**

4 **Reimbursement amounts for Medi-Cal are too low to sustain community midwifery practice.**

- Many midwives reported charging a global fee of ~$8000 for prenatal, birth and postpartum care to self-pay clients, with variability by region and practice model.
- Medi-Cal reimbursement varies, but is generally far lower than this. If a client has to transfer to hospital care for any reason, then Medi-Cal reimbursement is split with the hospital, reducing further the reimbursement that midwives receive.

"Medi-Cal does not reimburse us a living wage. The number I've been quoted is $1,100 is what they'll pay for the total service. Yeah. our fee is $8,000 and Medi-Cal is paying us less than what a doula makes."

"You physically can't even perform the services for the money that they're reimbursing to you."

"If the client transfers in labor, which is often when we work the hardest and the longest, we get paid about half, because Medi-Cal needs to pay the hospital for the birth. It becomes very little money for what we're offering."

5

The reimbursement process is unpredictable and difficult to navigate.

- Midwives find the process of reimbursement difficult, and due to low reimbursement, are often unable to pay for professional billing support.
- Claims are cumbersome to file and often rejected.
- Managed care plans vary widely in their reimbursement processes, and it is not feasible for a single midwife to contract with up to nine managed care plans per county.

"We can't keep floating my business to keep waiting for policies and reimbursements to catch up for the work that I'm putting in... and every midwife will tell you this takes a huge toll on us physically as well."

"It's been hard. We opened the practice assuming it would be easy to accept Medi-Cal. We did 15 births, for free, and never got reimbursed...15 is a lot in our small practice."

"I can't pay a biller $25 an hour to get back $25 worth of a claim. It doesn't make any sense."

"There's just so much work, and you don't even get reimbursed until at least six months later."

6

Timing of reimbursement is a barrier given low volume of care.

- By the time a midwife can request reimbursement, they have already provided most of the care.
- Midwives commonly wait months before receiving payment once reimbursements are approved.

"So technically you have performed all that work, 90% of the work before you can even bill for it. So that has been problematic as well, because you're expected to have the overhead and just put in all the work before you even get any kind of reimbursement."

Community Midwife Medi-Cal Reimbursement

$ 0 - 2,800 per birth

*according to birth center and homebirth midwives who accepted Medi-Cal

7

Unique challenges of birth centers and home birth.

- Freestanding birth centers face specific challenges related to Medi-Cal. Birth centers that wish to be licensed by the State of California report that in some cases, birth center licensure has taken 2 to 4 years to complete. Because licensing happens at the local health department level, the processes for licensure in each jurisdiction vary widely. Licensure carries no assurance of compliance with safety or quality standards but focuses heavily on the physical space.
- CDPH rules do not align with national birth center accreditation standards, and are extremely complex. For example, DHCS requires midwives to become CPSP providers. To be a CPSP provider, DHCS requires midwives to have a physician supervisor even though this is not required for them to practice by law.
- Birth centers can request Medi-Cal reimbursement for facility fees, providing higher overall reimbursement. However, midwives reported that facility fee reimbursement is frequently denied, and sometimes leads to all reimbursement for a given patient being denied. Even with facility fee reimbursement, freestanding birth centers struggle to be financially sustainable if they primarily serve people insured through Medi-Cal. This has led to several recent birth center closures.
- Home birth midwives are not able to apply for facility fee reimbursement, meaning their reimbursements are especially low.

"It just seems so silly to have to have two different accreditation licensing groups for one birth center when the one for the state is really outdated and had no input from birth centers, as far as I can tell."

"Even though Medi-Cal said that we could be providers they still had a lot of barriers that were not taken down. Even though they adjusted their policy, they didn't adjust a lot of other things."

Given all the above barriers to becoming Medi-Cal providers, relatively small numbers of community midwives are able to provide care to people insured through Medi-Cal. Most midwives offer sliding scale payment to people with lower incomes; however, this affects their ability to sustain their practice at a living wage.

"So far, I've decided that I would rather offer a sliding scale and try and serve more people that way than deal with being a Medi-Cal provider."

" We have a sliding scale, and I do try, particularly for our BIPOC clients and particularly our Black clients because of Black maternal mortality, try to make it work no matter the financial situation. So we do try to really be as available to the community as much as we can."

RECOMMENDATIONS TO IMPROVE MEDI-CAL PATIENTS' ACCESS TO COMMUNITY MIDWIFERY CARE

REGISTRATION PROCESS

- Update outdated policies and websites that inaccurately state that midwives need physician supervision to practice.
- Update Licensed Midwife CPSP provider registration process to no longer require physician supervision.
- Streamline Medi-Cal credentialing. Currently, midwives report that obtaining an application and obtaining licensing can take many months, while they are simultaneously required to maintain expensive liability insurance during this process.
- Train DHCS staff on midwifery licensure and reimbursement.
- Work directly with midwifery organizations to address the barriers created by requiring costly malpractice insurance.

REIMBURSEMENT

- Increase reimbursement for Medi-Cal providers, including community midwives. Provide reimbursement that values the community midwifery model of postpartum care. Midwives typically provide 5-8 hour-long appointments during the post-partum period, including postpartum and well-baby care.
- Simplify the claims process. A straightforward billing process with timely reimbursement is essential for community midwives to become Medi-Cal providers.
- Update midwife provider manuals and involve both Nurse-Midwives and Licensed Midwives in the process
- Work with midwives to develop model contracts and payment models that align with community midwifery care, then incentivize managed care plans to use these model contracts & payment models.

EQUITABLE ACCESS

- Leverage expansion of Medi-Cal coverage to 12 months postpartum by reimbursing community midwives to provide comprehensive postpartum care after birth in any setting.
- Include both Certified Nurse-Midwives & Licensed Midwives in all stages of DHCS Birthing Care Pathways and Postpartum Care Pathways.
- Incentivize California hospitals to develop transfer agreements with local community midwives to support better integration between community midwifery care and hospitals.
- Require California hospitals to commit to integration of CNMs who have privileges within their facilities. Ensure that they are able to operate according to the scope of their license.
- Follow the lead of Sacramento CDPH and others who provide scholarships for Black midwifery students and other midwives of color.
- Provide state funding to expand midwifery education programs in California (including Licensed Midwife education within the community college system) and pay midwives to be preceptors for students.

"It's the whole way that we're being with clients and our whole model of care... that is what's saving people's life."

"My whole model is designed to preempt complications, to address things as they're arising, talk through them, troubleshoot them, whether it's a mental health thing or a physical wellbeing thing so that things don't snowball into bigger issues. That's the whole midwifery model right there."

QUESTIONS & FEEDBACK

Ariana Thompson-Lastad, Ph.D.
Assistant Professor UC San Francisco, Osher Center for Integrative Health & Department of Family and Community Medicine
Ariana.Thompson-Lastad@ucsf.edu

University of California San Francisco

UCSF Osher Center for Integrative Health

ACKNOWLEDGEMENTS

Thank you to: the midwives who participated in this study & shared feedback on early findings. Members of the CA Midwifery Learning Collaborative. Angela Aguilar, Jessie Blumin, Maria Chao, Sarah Garrett and Jennifer James for feedback. Funders included the Hellman Fellows program; UCSF Family & Community Medicine research funds; UCSF-Kaiser Department of Research Building Interdisciplinary Research Careers in Women's Health (K12HD0521630); National Institute of Minority Health and Health Disparities (K01 MD015766), and National Center for Complementary & Integrative Health (T35AT010592, 5T32AT003997). The content is solely the responsibility of the authors and does not necessarily represent the official views of the funders. *Illustrations by Wilhelmina Peragine www.wilhelminaperagine.com*

REFERENCES

- 1974: Nurse Midwives https://www.chcf.org/wpcontent/uploads/2019/10/CaliforniasMidwivesScopePracticeLawsImpactCare.pdf
- 1993: California Association of Licensed(CALM) https://calmidwives.org/core-documents/
- 2013: Summary of the Licensed Midwifery Practice Act: https://www.mbc.ca.gov/Licensing/Licensed-Midwives/Practice-Information/
- 2015: California law allows midwives to care for Medi-Cal patients https://www.healthcaredive.com/news/california-law-allows-midwives-to-care-for-medi-cal-patients/406434/
- 2021: SB 1237 Bill https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB1237
- 2021: Black Women for Wellness Action Project, https://bwwactionproject.org/ca-momnibus-benefits/
- 2023: California Budget deal, https://calmatters.org/politics/2023/06/california-budget-deal-what-you-need-to-know/
- Nurse Midwife Application Page https://www.dhcs.ca.gov/provgovpart/Pages/NurseMidwifeApplicationInformation.aspx
- Community birth 1. Cheyney M, Bovbjerg ML, Leeman L, Vedam S. Community Versus Out-of-Hospital Birth: What's in a Name? Journal of Midwifery & Women's Health. 2019;64(1):9-11. doi:10.1111/jmwh.12947