Final Report to Director

The Out of Hospital Births Workgroup (OOHBW) was established for the purpose of reviewing the recommendations created by the 2014 Licensed Direct Entry Midwives Staff Advisory Workgroup (LDMSW), with the goal of sharing information, revising previously made recommendations, and potentially developing new recommendations for the OHA to ensure access to safe and high quality birth options in the out of hospital setting. The intent of the workgroup is to expand its focus to Out of Hospital Birth services provided by all licensed provider types practicing within the scope of their licenses. Members of the sixteen-member Committee were appointed by the Director of the Oregon Health Authority. The workgroup was guided by the Triple Aim goals of improving population health, improving the individual's experience of care and reducing health-related costs. The final recommendations in this report aim to ensure maternal and infant health as well as to provide women with choice in prenatal care and birthing options.

Background: Historical and Policy Context for Direct Entry Midwifery and Out of Hospital Birth in Oregon

Out of Hospital Births in Oregon

Please see previous LDMSW Final Report, appendix 2, for a brief history of Direct Entry Midwifery and Out-of-Hospital Birth in Oregon up until January 1, 2014.

Since the publication of the April 2014 LDMSW Final Report to the OHA Director, parts of the Oregon Administrative Rules (OARs) for the OHA Health Licensing Office, Board of Direct Entry Midwifery, regarding licensure conditions and practice standards were modified (OARs 332-015-0000 – 332-025-0130). Beginning January 1, 2015 direct entry midwives were required to hold a license to practice in Oregon.

In November 2015, the Health Evidence Review Commission (HERC) approved the final version of the Coverage Guidance: Planned Out-of-Hospital Birth, and Prioritized List Guideline Note 153: Planned Out-of-Hospital Birth; see appendix 2, for location details. The Coverage Guidance includes an extensive evidence review (over 100 pages), conducted over a nearly two year period with extensive public input from stakeholders, and discussed at several public meetings per HERC protocol. The Coverage Guidance is meant for all payers, and is intended as recommendations, not a coverage determination. This Guidance concludes that:

> Planned out-of-hospital (OOH) birth is recommended for coverage for women who do not have high-risk coverage exclusion criteria as outlined below (weak recommendation). This coverage recommendation is based on the performance of appropriate risk assessments and the OOH birth attendant's compliance with the consultation and transfer criteria as outlined below.

> Planned OOH birth is not recommended for coverage for women who have high risk coverage exclusion criteria as outlined below, or when appropriate risk assessments are not performed, or where the attendant does not comply with the consultation and transfer criteria as outlined below (strong recommendation).

Guideline Note 153 consists of the criteria to be used by Oregon Health Plan (Medicaid) to determine whether pregnancies can be considered to be low-risk, as part of the process to prior authorize reimbursement for OOH birth services.

Beginning on January 1, 2015, OHP began a structured prior authorization process for reimbursement of OOH birth services for all licensed provider types practicing within the scope of their licensure. This process requires that the pregnancy meets the HERC criteria for low risk, appropriate and timely documentation is submitted, and that the service is medically appropriate for the member. Oregon Administrative Rules (OARs) define adequate documentation (OARs 410 120 1320, 410 120 1360, 410 130 0200, 410 130 0240, 332 025 0020, 332 025 0021, 332 025 0022, 332 025 0110, 332 025 0120, and medical appropriateness (OAR 410 120 0000). Except in cases where a CCO contracts with a provider of OOH birthing services, members originally enrolled in CCOs are automatically dis-enrolled and re-enrolled in Fee For Service Medicaid (FFS), for the duration of OOH birth services until 60 days post estimated delivery date (EDD). In the case of a CCO contracting with an OOH birth provider, the prior authorization process would be determined by the CCO.

Births in Oregon

During 2015, 46,102 births occurred in Oregon. Of these 2,035 (4.4%) planned an out of hospital birth (home birth or free-standing birthing center). Ultimately, 17% of those planned OOH births occurred in a hospital following transfer of care. As a result, 3.7% of all live births in Oregon in 2015 were delivered outside of the hospital setting.[i] Among births to women who planned out of hospital births, planned birth attendants included: Certified Nurse Midwives (25%), Direct-Entry Midwives (Total 59%, Licensed 52.3%, Unlicensed 6.7%) and Naturopathic Physicians (13.3%).[ii] Women who planned an OOH birth tended to be older, white, married, college-educated, self-pay, less overweight or obese pre-pregnancy, and less likely to smoke.[iii] Birth certificate data cited the Oregon Health Plan (Medicaid) as expected principal payer for 685 planned OOH births in 2015 (33.8% of all planned OOH births in the state).[iv]

Health System Transformation

Oregon's Coordinated Care Model began implementation in 2011. A foundation of this model, Coordinated Care Organizations (CCOs) serve as umbrella organizations that govern and administer care for Medicaid/Oregon Health Plan (OHP) members in the local community. Health care providers, hospitals, community members, and other stakeholders in the health

system participate in the governance of each CCO. Approximately 90% of current OHP members are enrolled in a CCO for their medical, behavioral and/or dental health services.

CCOs operate under a flexible global budget. Each CCO is accountable for health outcomes of the population they serve and can use the budget in a manner appropriate to the community and its needs.

At this point in time, OHA has confirmed one CCO has a current contract with a single provider (a CNM) to provide OOH birthing services. Reasons for this lack of contracting were discussed by the current workgroup, as described below.

Without CCOs contracting with OOH birth providers, women enrolled in Medicaid are constrained in their ability to choose OOH birth delivery within the Coordinated Care Model.

OOH Births Workgroup Composition

All members of the OOH Births Workgroup were appointed by the Director of the OHA based on their experience and perspectives regarding maternity services in Oregon. Members represented the areas of Out of Hospital Birth Providers, Hospital Affiliated Providers, Hospital Representative, CCO Clinical Leadership, and OHP Member Advocate. The sixteen members of the workgroup are listed below:

Member Name	Organizational Affiliation	OOH Births Representation
Silke Akerson, LDM	Oregon Midwifery Council	Out of Hospital Birth Provider
Monica Arce, CNM	Virginia Garcia Health Center	Hospital Affiliated Provider
Helen Bellanca, MD, MPH	Health Share of Oregon CCO	CCO Clinical Leadership
Melissa Cheyney, PhD, LDM	Oregon State University	Out of Hospital Birth Provider
Gregory Eilers, MD	Women's Healthcare Associates, LLC	Hospital Affiliated Provider
Sharron Fuchs, DC	Law firm of Tichenor and Dziuba	OHP Member Advocate
Ray Gambrill, MD	All Care CCO	CCO Clinical Leadership
Holly Jo Hodges, MD	Willamette Valley Community Health	CCO Clinical Leadership
Anna Jimenez, MD	Family Care CCO	CCO Clinical Leadership
Lauren Mackenzie, CNM	Women's Healthcare Associates	Hospital Affiliated Provider
Duncan Nielson, MD	Legacy Health	Hospital Affiliated Provider, Hospital Representative
Sara Ohgushi, ND	Independent Private Practice	Out of Hospital Birth Provider

Catherine Schaefer, CNM, ND	Private Practice	Out of Hospital Birth Provider
Everett Schlarb	Member	OHP Member Advocate
Terri Shank, RNC-OB	Samaritan Health	Hospital Representative
Thomas Wuest, MD, MMM	Trillium CCO	CCO Clinical Leadership

OHA Staff Support include: Jim Rickards, MD, MBA (OHA Chief Medical Officer), Kim Wentz, MD, MPH (Medicaid Medical Director), Brian Nieubuurt, JD (OHA Legislative Coordinator), Jeston Black (OHA Director of Government Relations), Lisa Bui, MBA (OHA Quality Improvement Director), Anna Stiefvater, RN (OHA Public Health Maternal Health Program). The workgroup met a total of four times from September 2016 – February 2017.

This report provides a summary of the workgroup recommendations.

Issue Identification

Through a facilitated process, the workgroup reviewed the extent to which the 2014 LDMSW Recommendations had been implemented and needs for further implementation, see Appendix 1 . With the 2014 LDMSW recommendations serving as the foundation for discussion, the 2016 OOHBW developed the following recommendations to improve access to high quality OOH birthing services, optimize infant and maternal birth outcomes, as well as to empower women with informed choices for prenatal and birthing care options.

Consensus-based Recommendations

Recommendations are interconnected and often address overlapping issues of varying priority to the OOHBW. Some recommendations fall solely within the purview of OHA work, while others require work across state agencies, within Oregon's Coordinated Care model, or the healthcare delivery system (e.g. hospitals).

Recommendations for the Oregon Health Authority:

Recommendation #1: Coordinated Care Model Integration & Liability Insurance Assessment - Update an approach for including OOH Birth options in Oregon's Coordinated Care model by conducting an analysis of current affordable liability insurance options for OOH Birth Providers, including possible state-supported options.

The workgroup agreed that the incorporation of out of hospital birth providers into the CCO model is a strategy consistent with the Triple Aim. However, the absence of affordable liability insurance for OOH birth providers is a leading barrier to CCO credentialing for these practitioners.

The workgroup concluded that such an analysis is outside the scope of OHA alone, and that OHA needs to partner with the Department of Consumer and Business Services (DCBS) to perform such work. Therefore, the current recommendation is for a two-phased approach with community involvement, DCBS and OHA.

Phase I: Representatives of the three professional organizations whose members attend OOH births (Oregon Midwifery Council-OMC, Oregon chapter of American College of Nurse Midwives-ACNM, and Oregon chapter of American Association of Naturopathic Midwifes-AANM) will study available liability insurance options and provide this information to the OHA and DCBS.

Phase II: DCBS is the entity in state government which has involvement with medical liability insurance and could take the following actions regarding medical liability insurance as it relates to OOH births in conjunction with community input.

- DCBS could independently evaluate the current availability of liability insurance for licensed direct-entry midwives, certified nurse midwives, and naturopathic midwives, for out of hospital birthing services, including availability of coverage in the surplus lines market.
- This would include analysis of factors that limit availability or affordability and possible commercial and/or state solutions to address them; including but not limited to the work product from phase 1.
- For example, some states have considered possible solutions such as market assistance plans, joint underwriting associations, or purchasing groups.

Using data developed in Phase I and Phase II, OHA should work with DCBS and the OOH birth provider community in assessing and developing a pathway to liability insurance coverage.

Recommendation #2: Coordinated Care Organization Credentialing and Integrated System of Care Development. - OHA should provide informational resources to support CCOs' development of criteria for OOH birth provider credentialing and integrated systems of care to optimize maternal and infant safety and birth outcomes.

OHA will support CCOs in developing OOH birth reimbursement authorization methods based on Oregon Administrative Rules (OARs) for prior authorization, and the HERC's clinical guideline note for determination of coverage. Examples of possible strategies include providing CCOs with accurate information about the education and training of OOH birth providers and sharing information on established best practices for transfer from planned OOH birth setting to hospital-based care.

Recommendation #3: Prior Authorization Process Review - Regarding the current OOH Birth Fee-For-Service prior authorization (PA) process, OHA will support a workgroup to review aspects of the process relating to provider and member experience and satisfaction.

OHA will support a cross community workgroup to collaboratively review and make suggestions for improvement of the current PA process, with the goal of optimizing safety while improving PA process efficiency.

Recommendation #4: Maternity and Newborn Transfer Care & Support - OHA, in conjunction with OOH birth providers, CCOs, and hospital partners, will support development of best practices specific to Oregon for optimum intra-partum care including appropriate and timely transfer to hospital-based care when needed.

The workgroup recognizes the need for better care coordination before and during transition of care. While particular regions or health systems in Oregon have developed policies for transition of care across birthing settings, the workgroup recommends remaining CCOs and health systems adopt care transition policies and procedures. Specifically, learning collaboratives can be used to collect and improve existing transport plans and policies, and consider a standardized approach.

Exploring payment methodologies to ensure or clarify separate reimbursement before and after transfer could further incentivize timely and appropriate transfer of care by out of hospital birth providers. The workgroup recommends the discussion be raised by OHA within appropriate existing workgroups related to developing payment methodologies (e.g. CPC+, MACRA, SB231).

Recommendation #5: Comparative Cost Analysis - OHA should analyze related costs for planned out-of-hospital births including planned out-of-hospital births which are delivered in the hospital, and planned hospital based births including births unexpectedly delivered out-of-hospital. Analyses should include where possible both immediate and long-term costs of outcomes and care for women, infants and children. All costs should be considered including cost of liability insurance, facility costs (hospital or birthing center), NICU and ICU admissions, cost of care for morbidity, cost of years of life lost for differences in mortality, cost of additional procedures, etc.

As a continuation from the 2014 LDMSW recommendations, the OOH births workgroup supports the development of a cost analysis specific to Oregon. Study analysis may reference research from other states including costs of immediate and long-term outcomes and care for women, infants and children, recognizing that critical variables may differ across states.

Recommendation #6: Maternity care options member communication - OHA will develop guidance for communicating covered options for maternity care to Medicaid members for use by CCO's and FFS, including midwifery care in both the hospital and out-of-hospital settings.

Improving access to care and empowering women in choosing a care provider begins with education and outreach. The workgroup recommends that OHA provide guidance on the communication of information to Medicaid enrollees regarding all of the covered options for maternity care services. OHP's FFS program should work with its care coordination contractor and CCOs to ensure that materials are accurate, unbiased, available and distributed.

Recommendation #7: Maternity care benefit coordination - Support a system of integrated maternity care for the mother and baby across the state.

The OOHBW recognizes the need to improve the transitions of benefit coverage for the mother and baby. This includes, but is not limited to, coverage between FFS and CCOs, and between CCOs. Improving the enrollment and eligibility experience for members and the operational impacts to OHA and CCOs should be the goal. OHA will build upon existing work in the enrollment experience in ensuring seamless benefit transitions.

Recommendation #8: Reconvene the OOH Birth Workgroup at periodic intervals to assess progress on one or more of these recommendations and evaluate new opportunities for continued integration of OOH birth services within Coordinated Care Organizations (CCOs) within 3 years of adoption of recommendations.

Because full integration of OOH birth services in the Coordinated Care Model is ongoing and will take time, this group recommends that this OOH birth workgroup be periodically reconvened to evaluate progress on these recommendations and consider emerging best practices and data to support an integrated system of maternity care. Additionally the group may convene for ad hoc focused topics pertaining to out of hospital births (e.g. cost analysis report, liability insurance update).

Conclusion

The OOH Births Workgroup respectfully submits the above consensus-based recommendations for consideration by the Oregon Health Authority.

The following references were used in the development of these recommendations.

Appendix 1: Summary of the full 2014 LDMSW recommendations, with review and analysis.

Appendix 2: Resources Used

- HERC guideline note 153
- HERC coverage guidance
- 2014 LDMSW Final Report

Appendix 3: Oregon Vital Statistics, Annual report 2015, Section 2. Natality tables.

Appendix 1: Summary of the full 2014 LDMSW recommendations review and analysis

Recommendation #1: Identify a phased-in approach for including LDMs in Oregon's Coordinated Care Model and CCOs.

- Assessment – In process – Phased-in approach work is ongoing and addressed in new OOH Births recommendations #1 and #2

Recommendation #2: When LDM care is not available through a CCO, OHA should establish a Medicaid fee-for-service ("open card") option for women who choose to receive services from LDMs (for duration of pregnancy through 6 weeks post-partum).

- Assessment - Complete - Recommendation fulfilled and is addressed with a new recommendation regarding the preauthorization process in OOH Births recommendation # 3. Note: 6 weeks post-partum was an error in the previous recommendations; OAR has always stated this date would be 60 days post estimated due date (EDD).

Recommendation #3: For high risk births, require in-hospital delivery for Medicaid reimbursement. Exclude payment for planned out-of-hospital births when high-risk criteria exist. High-risk criteria should include, at minimum: presentation other than cephalic (e.g. breech), previous caesarian delivery, gestational age < 36 or > 43 weeks, multiple gestations, diabetes/uncontrolled gestational diabetes or gestational diabetes controlled with medication, pre-eclampsia, additional criteria included in the applicable provider or facility OARs.

- Assessment - Complete - Recommendation fulfilled with Medicaid prior authorization process based on HERC Coverage Guidance and Guideline Note 153 criteria for assessment of low risk pregnancy.

Recommendation #4: Provide information to Medicaid members regarding covered options for maternity care (including midwifery care).

- Assessment - Ongoing - Work addressed in new OOH Births recommendation #6

Recommendation #5: Request that the Health Evidence Review Commission (HERC) develop a Coverage Guidance related to home birth, including evidence regarding: The maternal and fetal/neonatal/child health outcomes of home birth compared with birth in other settings, Appropriate candidates for home birth, Criteria for optimizing safety with regard to provider training, equipment, standards, consultation, and other systems of care.

- Assessment - Complete - Recommendation fulfilled with HERC adoption of Coverage Guidance and Guideline Note 153 November 2015. Coverage guidance reviews evidence regarding health outcomes and appropriate candidates for home birth. However, the HERC concluded that criteria regarding provider training, equipment, standards, consultation, and other systems of care was not within the purview of the HERC, and recommended this be part of implementation through Health Systems Division (then called the Medical Assistance Programs).

Recommendation #6: Analyze birth-related costs in Oregon by intended place of birth and provider. Comparative analyses should include immediate and long-term costs of care for women, infants and children.

- Assessment - Ongoing - Work addressed in new OOH Births recommendation #5

Recommendation #7: Work with CCO and hospital partners to explore payment methodologies that support optimum intrapartum care and appropriate and timely transfer.

- Assessment – In process –Current FFS process reimburses OOH Birth provider for care up to and including labor management prior to intrapartum transfer however additional work is needed per new OOH Births recommendation #4

Recommendation #8: Reconvene the LDM Staff Advisory Workgroup at periodic intervals to assess progress on these recommendations and evaluate new evidence and opportunities for continued integration of LDM services within Coordinated Care Organizations (CCOs).

- Assessment - Complete - New recommendation regarding future reconvening in new OOH Births recommendation #9

Recommendation #9: Study options for affordable liability insurance for licensed direct-entry midwives (LDMs), including state options such as a joint underwriting association.

- Assessment – In process - Work addressed in new OOH Births recommendation #1

Recommendation 10: Convene a multi-disciplinary workgroup consisting of a variety of stakeholders and experts including LDMs, CNMs, MDs, DOs, and the insurance division, to offer recommendations on overall maternity-related liability reform in the state of Oregon.

- Assessment – Overall maternity related liability reform is not within the purview of OHA. Liability insurance for licensed OOH birth providers is addressed in new OOH Births recommendation #1

Recommendation 11: Support a coordinated system of maternity care. Convene local learning collaboratives across the state to consider and implement best practices for CCO and hospital coordination and collaboration with LDMs, including an emphasis on timely transfer of care.

- ☐ Assessment – In process - Work addressed in new OOH Births recommendation #4

Recommendation #12: Support statewide efforts to reduce demand for high-risk out-of-hospital births by improving access to vaginal delivery options for breeches, twins, and vaginal births after caesarian section (VBACs).

- ☐ Assessment – In process – Workgroup concluded that this work is outside the scope of OHA but OHA could support community and health system efforts to address this.

Appendix 2: Resources

HERC Coverage Guidance: Planned Out-of-Hospital Birth
http://www.oregon.gov/oha/HPA/CSI-HERC/EvidenceBasedReports/Planned-out-of-hospital-birth-11-12-15.pdf

HERC Prioritized List Guideline Note 153: Planned Out-of-hospital Birth
http://www.oregon.gov/oha/HPA/CSI-HERC/EvidenceBasedReports/Prioritized-list-Planned-out-of-hospital%20birth.pdf

2014 Licensed Direct Entry Midwives Staff Advisory Workgroup Final Report
http://www.oregon.gov/oha/HPA/CSI/QIDocs/Midwifery-Report-2014.pdf

Appendix 3: Oregon Vital Statistics, Section 2. Natality Tables

[i] Oregon Vital Statistics, 2015 Annual Report, Table 2-38

https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume1/Documents/2015/Table0238.pdf

[ii] Oregon Vital Statistics, 2015 Annual Report, Table 2-38

https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume1/Documents/2015/Table0238.pdf

[iii] Oregon Vital Statistics, 2015 Annual Report, Table 2-39

https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume1/Documents/2015/Table0239.pdf

[iv] Oregon Vital Statistics, 2015 Annual Report, Table 2-39

https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume1/Documents/2015/Table0239.pdf