Summary Presentation
Maryland Midwives Work Group
American Association of Birth Centers
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American Association of Birth Centers (AABC) Membership

AABC is a multi-disciplinary membership organization comprised of individuals and organizations that support the birth center concept. The membership is very diverse and is comprised of Obstetricians, Certified Nurse-Midwives, Certified Professional Midwives, Pediatricians, Nurses, Doulas, Managers of the birth centers, Owners, Lactation Specialists, etc.

History of Freestanding Birth Centers

The first demonstration of a modern, licensed freestanding birth center was opened by the Maternity Center Association (now Childbirth Connection) in 1975 in New York City in response to consumer demand for an alternative to the medicalization of birth in the acute care hospital setting.

Freestanding birth centers ensure quality care through established systems such as state licensure, national standards, and accreditation by the Commission for Accreditation of Birth Centers (CABC). Currently 82% of states have regulations for licensing birth centers, including Maryland. The American Association of Birth Centers (AABC) established the National Standards for Birth Centers in 1985 and maintains these standards with regular reviews and revisions as necessary. The Standards are currently being revised and will be published by the end of 2012. The CABC, established in 1985, uses the National Standards for Birth Centers as the basis for accreditation. The American College of Obstetricians (ACOG) recognizes CABC accredited birth centers as one of the safest settings for birth. (ACOG Statement on Home Births-2.6.08).

For more than three decades, freestanding birth centers have consistently shown safety, satisfaction and savings. In the last five years birth centers have grown by 30 percent. There are now 240 freestanding birth centers in the United States and in 50% of the centers, births are done by the Certified Professional Midwives (CPMs).

A total of five Birth centers have closed in Maryland and, at present, only two remain open, both in Anne Arundel County. The first birth center in Maryland opened in Baltimore in 1981 and closed in 2004. Others that have closed are: Bethesda (1982-2007), Huntingtown (1993-2008), Frederick (1994-1998), Greenbelt (1996-1998).

Description of Freestanding Birth Center Services

The services described below exemplify the many services provided in freestanding birth centers; however, it is not an all-inclusive list. Freestanding birth center professional staff are on call 24/7 for their registered patients throughout the program of care to provide holistic care, often beyond those services described below.

Prenatal Care-Midwives practicing in birth centers spend considerably more time with their patients during prenatal care than OB/GYNs are able to spend. Visits usually last 30-60 minutes and contain a large teaching component. Group prenatal care is commonly offered in birth centers to encourage peer support and the building of the community. Listening to the baby's heartbeat, ordering standard laboratory tests, and making sure the baby is following an adequate growth curve takes only a few minutes. It takes more time, however, to form a trusting relationship between client and provider to address emotional and psychological needs during the prenatal visits. Preparation for labor and birth, danger signs vs. "common complaints", planning for after the baby is born, and breastfeeding information are all examples of educational topics covered in depth.

Labor and Delivery-Labor support is provided by midwives who have formed a relationship with the woman and her family during prenatal care. Unlike common hospital practice, where the health care provider is minimally involved in labor support, and provides hands-on-care for managing complications and the delivery unit, the midwife at the birth center stays with the woman throughout her labor and delivery. Care is not guided by a culture whereby staffing patterns and convenience often dictate birth practices, but rather by the changing needs of the woman, the woman's inherent desire for movement, nutritional support, involvement of her partner, and position for birth. Analgesic pain relief may be available if desired. Other medications such as antibiotics may be administered through an Intravenous line. Women present in labor at all hours of the day or night,

since medical inductions are not scheduled at a birth center. For the birth itself, there is always a plan to have a midwife and a nurse or other birth attendant at the delivery who are trained and certified in neonatal resuscitation.

Newborn Care- Care of the normal newborn involves immediate assessment and stabilization, positioning for optimal breastfeeding and bonding, administration of standard newborn medications, bathing, and assistance with the transition to home. Arrangements have already been made for referral to a pediatrician.

Postpartum Care- Much support and care is provided for the woman after the baby is born. Postpartum care in the birth center model includes immediate care, home visits, 1-2 week follow-up, and 6 week follow-up.

- Immediate care includes any necessary stabilization of the patient. Medications to prevent or control hemorrhage may be given. Suturing of any tears sustained in the birth process is performed under local anesthesia. Nursing of the baby usually begins in the first half-hour with careful staff attention to proper positioning and latch. The patient is assisted to the commode, and may elect to shower. Nutritional support is provided. In-depth teaching prior to discharge is done to review critical safety topics and follow-up plans. Discharge to home typically occurs at 4-12 hours after the birth.
- Home Visits are conducted once or twice after discharge from the birth center. At the home, the newborn metabolic screen and hearing screen, as required by law, are administered. The infant's weight is checked, jaundice is evaluated, and breastfeeding issues are explored. The home environment is assessed for safety and the support system of the mother is evaluated. The mother and family members and friends are again educated to lay the baby on its back and not to sleep with the infant.
- Typically an office visit is conducted at 1-2 weeks to evaluate breastfeeding again, and to see that proper healing is taking place.

In addition, this visit provides an opportunity to evaluate the woman's emotional state and have early recognition and treatment of postpartum depression, if necessary.

- The six-week postpartum visit is often referred to as the family planning visit. A complete physical exam is performed and completion of the

healing process is assessed. Contraception is explored and a prescription is written or an appointment for a contraceptive device procedure is scheduled if desired by the patient. Again, postpartum depression screening is conducted and treatment is initiated if needed.

Quality of Care

The AABC Perinatal Data Registry, originally known as the AABC Uniform Data Set, will publish a study regarding Birth Center outcomes 2007-2010: "Demonstration of a Durable Model" in the Journal of Midwifery and Women Health in the January/February 2013 volume. The Data again shows the high quality of outcomes for births in freestanding birth centers.

When CMS releases its grant money for the Strong Start Initiative, all participating birth centers will be required to participate in beta testing so that their Strong Start data are in the new version.

Barriers to Opening and Sustaining Birth Centers in Maryland

I. Licensure Requirements-The current license law requires that CNMs have a written agreement with an obstetrician on file with the State. Many obstetricians refuse to agree to be the collaborating physician. This is because they are not paid for collaboration, among other reasons. In addition, the pregnant woman has a right to decide who her consulting physician should be and which provider her insurance plan will pay for and, if necessary, which hospital(s) she may be transferred to for services.

II. Payment

A. **State Medicaid Managed Care Organizations(MCOs)-** The State of Maryland is in violation of two federal mandates: one that requires Medicaid to reimburse the professional fees of the nurse midwife in any setting(42 CFR Sec.) including home births, and a second mandate that requires payment for the freestanding birth center facility service fee. [Section 2301 of ACA added freestanding birth center services as new paragraph (28) of section 1905(a) of the Social Security Act (now codified as 42 USC Section 1396d(a)(28) and 1396(a)(10)(A)]. Furthermore, the CMS rules require that "the {state Medicaid] plan must provide that the nurse-midwife may enter into an independent provider agreement without regard to supervision or association with physician or other health care provider.(42 CFR Sec.440.165) unless required by State law.

B. Private Sector Managed Care Organizations in Maryland-The MCO's will pay for the professional fees in many instances, but many have a history of refusing to pay for the facility service fee. This managed care and insurance plan discrimination against midwives and freestanding birth centers persists despite reliable evidence that the facility component of birth center services is often one-third or less than hospital facility charges. This does not take into account cost savings from a decrease in cesarean sections and decreases in infant low birth weight and pre-maturity rates.

III. Malpractice Insurance/Myth of Vicarious Liability- Except for the early eighties, malpractice insurance has been available, but very expensive. Maryland ranks in the top 5 states for cost of coverage. All policies have been claims-made since the early nineties. This means that insurance coverage is being purchased up to the infants' age of 18. The total malpractice insurance premiums for Special Beginnings Birth and Women's Center in Arnold, MD is $120,000.(claims-made). For the first time premiums dropped $2,000 per nurse midwife.

The instability of the reinsurers and the largest reinsurer in the world pulling out of the medical malpractice market place(Lords of London), caused a major crisis in the early 2000s, driving premiums up significantly. Obstetrical claims remain one of the highest areas for medical malpractice litigation.

Many obstetricians still believe that if they collaborate or consultant with a midwife, that this exposes them to vicarious liability. Again a recent case before the Superior Court of the District of Columbia Civil Division found that no vicarious liability existed in transfer of care.(Ilyaas Gilbert, et al., Plaintiffs, vs. Family Health and Birth Center, Inc. et al., Defendants, Case no: 05-CA- 7696). In the early eighties, some malpractice carriers were charging obstetricians an additional surcharge fee if they consulted or collaborated with a midwife. This is no longer the done. In 1991, the DC Insurance Commissioner ruled that no actuarial evidence existed to support such surcharges.

IV. Hospitals Refusal to Grant Admitting Privileges and Consequences for Pregnant Women- Maryland Hospitals frequently refuse to grant admitting privileges to nurse midwives from our Birth Centers and to other

midwives in independent practice. Anne Arundel Hospital does grant admitting privileges to the midwives from the two Birth Centers. However, the hospital is now requiring a written agreement among the physician, birth center and hospital. Typically, 5-10% of laboring women are transferred to the hospital.

The main reason for transfer is failure to progress in labor. If the midwife does not have privileges at the hospital, this results in lack of continuity of care. Women from across the country tell us in surveys that, upon transfer from birth center to hospital, many physicians and registered nurses in these hospitals criticize them for making the choice of the birth center; the women also complain that the hospital personnel do not understand their needs or wishes. Please refer to Family Health and Birth Center's statement to the National Academy of Sciences' Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care, January 17, 2011, Cynthia B. Flynn, CNM, PhD, past President AABC). This is a birth center model where the midwives have admitting privileges to Washington Hospital Centers and serve a very high risk population.

V. Certificate of Need (CON) Denials-Many hospitals oppose freestanding birth centers in the certificate of need process. As described earlier, birth center services are very different from the services provided by hospitals, and should not be barred from opening by the CON process.

VI. Nursing Board-The State Nursing Board has not given certified nurse-midwives or certified nurse practitioners the leadership they need to advance these professions; the Board does not appear to support CNM or NP independent practice – meaning not just scope of practice, but operating their own businesses. When the Board receives a compliant, it often acts far too quickly to suspend the license of the practitioner.
The Medical Board does not proceed against physicians in this fashion. When an OB has an infant or mother death, a premature infant, or some other adverse outcome, the Medical Board investigates, but takes the position that the physician under investigation is innocent until found guilty, unless there is a pattern of poor outcomes and complaints.

VII. Nursing Board's Opposition to Licensing CPMs-The Nursing Board has made public its position that it does not support licensure of CPMs.

Proposed Areas for Legislation and other initiatives :

1. Remove the collaboration requirement for CNM and Nurse Practitioner licensure.
2. State should enforce federal mandates for payment to CNMs and for facility services in birth centers. Please note that once the CPMs are licensed in the State of Maryland, the federal law also requires Medicaid payment of CPM professional fees in the Birth Center, and the state may not discriminate against CPM/LM-owned or -staffed birth centers.
3. Malpractice-real Tort Reform-not just reform of the insurance market place; educate physicians about the myth of vicarious liability.
4. Pass legislation modeled after the District of Columbia admitting privilege law.
5. Exempt freestanding birth centers from certificate of need requirements
6. Create a new board just for midwives, both CNMs and CPMs.
7. The State should do a study to determine the maternity shortage areas: this was not addressed in the Work Force Study Report to the MD Assembly. Knowing the Maternity shortage areas will bring additional midwives and obstetricians to the workforce in our State. The State and various individuals will be eligible for additional opportunities for grant funding.
8. Administration to support all the above recommendations.

Future Concerns: Exchanges: Harkin Amendment

Highlights of the Harkin Amendment in the Affordable Care Act

- First Federal provider non-discrimination law applicable to non-government programs.
- Includes State Exchanges.
- Applies across categories of providers.
- First provider non-discrimination law applicable to self-insured ERISA plans.
- Excludes Federal Programs (Medicare, Medicaid, and TriCare).
- Excludes some “grandfather group health plans”.

While this is not a any willing provider law, we look forward to assuring that the Maryland Health Exchange honor women’s right to chose their provider and place of birth.

Attachments:

National Academy of Sciences' Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care, January 17, 2011, Cynthia B. Flynn, CNM, PhD, Past President American Association of Birth Centers.

House Bill 1056: Health Occupations-Licensed Midwives Before the Committee on Health and Government, Maryland Assembly, March 14, 2012.