AMERICAN COLLEGE of NURSE-MIDWIVES
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June 10, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9942-NC
PO Box 8016
Baltimore, MD 21244-8016

RE: CMS-9942-NC: Request for Information Regarding Provider Nondiscrimination

Dear Ms. Tavenner:

I am writing on behalf of the American College of Nurse-Midwives (ACNM), the national professional organization representing the interests of certified nurse-midwives (CNM) and certified midwives (CM) practicing in the United States, in response to the "Request for Information Regarding Provider Non-Discrimination" (RFI) published in the *Federal Register* on March 12, 2014.[1] We hope that you find our comments helpful. We encourage CMS, as well as the Departments of Treasury and Labor to issue a proposed regulation implementing this important provision of the Public Health Service Act.

Background on Midwifery

Within the United States there are several different paths to practicing midwifery, including that of the Certified Nurse-Midwife (CNM), the Certified Midwife (CM) and the Certified Professional Midwife (CPM). ACNM represents CNMs and CMs.

CNMs are educated in two disciplines: midwifery and nursing. 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. CMs are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by ACME, and pass the same national certification examination as CNMs to receive the professional designation of CM.

Nationwide, as of February 2014, there were 10,866 CNMs/CMs with active certifications through AMCB. In 2012, these CNMs/CMs collectively attended 313,846 births, or 7.94 percent

[1] 79 FR 14051

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of all births. They attended 11.7 percent of all vaginal births in 2012. (These figures likely undercount actual events, as it is known that birth certificate data tends to underreport CNM attendance at births). Of those births, 94.9 percent occurred in a hospital setting and 43.6 percent were covered by Medicaid.[2]

CNMs/CMs specialize in fostering normal physiologic birth. They use techniques, skills and tools designed and proven to support and promote a woman's normal physiologic processes. Their practice patterns are characterized by lower rates of intervention than the typical medicalized model of birth in the United States. They are less likely to induce labor, to use epidurals, or to see their clients experience perineal lacerations or delivery via cesarean.[3] For payers and patients, this results in lower costs and high levels of patient satisfaction.

General Comments

ACNM recognizes the difficulties faced by policymakers in regulating on Section 2706(a). Achieving a balance between the goals of patient access to care and controlling premiums is a challenging proposition. One mechanism through which insurers can control premiums is through utilizing very restricted provider networks. ACNM is concerned, however, that this practice may result in inappropriate limitations on care for the women our members serve.

To understand the approach of insurers to midwifery, ACNM has been conducting a nationwide survey of health insurers that offer coverage through the Health Insurance Marketplaces. We gathered names and contact information for 277 plans, identified using information provided by HHS through www.healthcare.gov and through the various state operated Health Insurance Marketplaces.[4] We made multiple attempts to contact the provider contracting departments within each of these organizations. To date, we have been able to survey 69 plans. An analysis of those 69 responses yields the following key pieces of information:

- 14.3% of plans do not contract with CNMs to include them in the plan's provider network.
- 12.1% of plans that contract with CNMs do not cover primary care services provided by CNMs. (ACNM's "Standards for the Practice of Midwifery"[5] and "Definition of

[2] Data on the number of CNMs/CMs with active certifications was provided to ACNM by AMCB. The other statistics in this paragraph are drawn from the CDC's Vital Stats on Births, available at: http://www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm

[3] Meg Johantgen, PhD, RN, et. al., "Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008," *Women's Health Issues,* 22-1, 2012 pp. e73-e81. See also, Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2013, Issue 8. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub3. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub3/abstract;jsessionid=D710F193874D908678D83905A7DA3069.f02t03

[4] Specifically, we filtered the list available at: https://www.healthcare.gov/health-plan-information/ to obtain a list of all unique insurance issuers in each state.

[5] Available at: http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards_for_Practice_of_Midwifery_Sept_2011.pdf

Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives"[6] both stipulate that CNMs/CMs can and do provide primary care services. A majority of state scope of practice laws either explicitly or implicitly reference these documents thus legally allowing CNMs/CMs to provide primary care.)

- 22.4% of plans contracting with CNMs will not cover their services when provided in a birth center.
- 36.0% of plans contracting with CNMs will not cover home birth services provided by CNMs.
- 35.1% of plans contracting with CNMs pay them at a lower rate than they pay physicians.
- 8.8% of plans contracting with CNMs do not list them in their provider directories.
- 39.7% of plans do not contract with birth centers.

Maternity and newborn care is a required category among the essential health benefits. Data on hospital discharges gathered by the Agency for Healthcare Research and Quality show that discharges for pregnancy and newborn care far outnumber those associated with any other major diagnostic category. For example, in 2011, there were 8.2 million such discharges. The next largest grouping of discharges, for circulatory system issues, numbered approximately 5.3 million.[7]

It is a very serious problem that significant numbers of health plans are preventing or curtailing access to a major provider of the most common type of health care in the United States. A medicalized model of birth is not the same thing as an approach that emphasizes and supports normal physiologic birth and the two are therefore not interchangeable.[8] Coverage for the one does not amount to coverage of the other. Women who seek a normal birth and providers who will support them in that goal will be stymied in their desires if their plan simply does not cover the services of CNMs/CMs, or if that plan discourages participation by CNMs/CMs in the provider network because the plan reimburses CNMs/CMs at rates lower than those provided to physicians, purely on the basis of licensure and not for reasons of quality or performance.

Recommendation: As noted above, we recognize the tension between access and cost control, however, we do not believe that the practices we have learned about through our survey are supported by the language of Section 2706(a). We recommend that the Departments of Health and Human Services, Treasury and Labor (the "Departments") issue regulations stipulating that:

- Where a plan is required to cover a certain benefit, either under provisions related to the essential health benefits or because of a separate state or federal insurance mandate, it

[6] Available at: http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Feb%202012.pdf

[7] Source: http://hcupnet.ahrq.gov/HCUPnet.jsp Last accessed 1/24/14

[8] For a concise discussion of normal physiologic birth and the techniques that disrupt or support it occurrence, see "Supporting Health and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM," available at: http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000272/Physiological%20Birth%20Consensus%20Statement-%20FINAL%20May%2018%202012%20FINAL.pdf See also the information and tools available at www.birthtools.org

must include in its provider network providers of all types who are permitted to deliver the required covered service under applicable state scope of practice laws.

- Plans should not be allowed to contract with token providers from each of the provider types allowed under state law to deliver the required covered services. CMS and states reviewing network adequacy should ensure that an appropriate number and mix of each provider type are included in plan networks to make their services reasonably available to the plan's anticipated beneficiary population.

We believe that these recommendations will ensure that the requirements of Section 2706(a) are met, while still giving plans flexibility to select which individual providers they will contract with.

Comments Specific to the FAQ

ACNM has three specific concerns with the content of the FAQ issued by the Departments.

First, the FAQ states that:

> For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

We are concerned that the phrase "reasonable medical management techniques" is not sufficiently defined and may open up avenues toward provider discrimination not envisioned by the statute. Indeed, the language of the law does not include this phrase.

Recommendation: The Departments should revise the FAQ to remove this language until such time as clearly articulated regulations can be established through a notice and comment process.

Second, the FAQ states that:

> This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

As the Departments themselves have pointed out in this RFI, the language of Section 2706(a) states that nothing prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." The term "market standards and considerations" does not appear in the language of the law. ACNM is very concerned that the Departments have issued this non-statutory language, which has no clear definition or meaning and which was never subjected to a notice and comment process. This language opens up an avenue that plans or insurers could conceivably use to vary payment to providers based on factors not envisioned in the law (note above information from our survey indicating that 35.1% of plans do not reimburse CNMs at the same rate as physicians).

Certainly, under the auspices of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* executive branch agencies are entitled to issue reasonable interpretations of the law. However, if the Congress has not spoken directly to a precise question at issue and the intent of the Congress is clear, that is the end of the matter. Section 2706(a) clearly states which factors may be taken into account by plans or insurers to vary provider payment and they are "quality or performance measures." The statute does not give the Secretary any flexibility to establish other factors, such as "market standards and considerations."

Recommendation: This language should be removed from the FAQ immediately and it should not be proposed for inclusion in any forthcoming regulation. In any regulation defining the type of quality or performance measures that may be used to vary provider reimbursement, the Departments should prohibit plans from defining "quality or performance measures" in a fashion that precludes provider success based on factors, such as licensure, that are not related to the performance of the service itself. We recommend the Departments require plans to use quality and performance measures that have been established through an open, public process, such as the endorsement process used by the National Quality Forum. Finally, the Departments must be clear in any proposed regulation that insurers may not arbitrarily pay one type of provider a lower rate than another type of provider for the same service, when both are allowed to deliver that service under applicable state scope of practice laws. Payment differential based on licensure is not permitted under the terms of Section 2706(a).

Third, the FAQ states that:

> [Section 2706(a)] does not require plans or issuers to accept all types of providers into a network.

The language of 2706(a) prohibits a plan from discriminating "with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." The law specifies further that the plan is not required to "contract with any heath care provider willing to abide by the terms and conditions for participation established by the plan or issuer." This language envisions plan treatment of individual providers. It does not permit plans to refuse to contract with entire categories of providers who are licensed within a state where the plan may operate. We are very concerned that the language of the FAQ could be read to imply that plans may refuse to contract with entire categories of providers based purely on licensure (note the survey data above indicating that 14.3% of plans do not contract with CNMs). We do not believe that the statute provides an avenue by which plans may refuse to contract with all providers in a given type when those providers are allowed, under applicable provisions of law, to provide the services which the plan covers.

Recommendation: As noted above, we recommend that where a plan is subject to coverage requirements, either because of a requirement to provide essential health benefits, or because of state or federal insurance mandates, the plan should be required to include in its network all types of providers whose state licenses allow them provide the mandated covered services. Until regulations can be established making such provision, this statement in the FAQ should be

removed, or revised in such a way that it does not envision plans discriminating against entire classes of providers.

Summary

An FAQ, as you know, does not have the force of law and is not created through a process that allows public comment. An FAQ is insufficient for implementing this important statutory provision. We respectfully request that the Departments coordinate a rulemaking on Section 2706(a) and that you take our recommendations into account when formulating proposed regulations. Until such time as regulations are finalized, we recommend that you immediately revise the existing FAQ to address the concerns we have identified above.

Should you have any questions, please feel free to contact me at jbushman@acnm.org or 240-485-1843.

Best Regards,

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American College of Nurse Midwives