



December 22, 2014

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-19944-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

**RE: CMS-19944-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016**

Dear Ms. Tavenner:

The American College of Nurse-Midwives (ACNM) is pleased to submit the following comments regarding the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016” published in the *Federal Register* on November 26, 2014.<sup>1</sup> ACNM is the professional association representing the nation’s certified nurse-midwives (CNMs) and certified midwives (CMs) in the U.S. We hope that you find our comments helpful and look forward to your response in the final rule.

**COMMENTS**

**c. Network Adequacy Standards (§ 156.230)**

**1. Sufficient Access**

Discussion

ACNM strongly agrees with CMS’ statement at 79 FR 70726, “We believe that networks that provide sufficient access to benefits are a priority for issuers and consumers.” We are gratified that the agency “continues to take great interest in ensuring strong network access.”

Because publicly available documents do not provide clear or extensive detail about the inclusion of certified nurse-midwives and certified midwives in plan networks or the coverage of their services, ACNM recently conducted a survey of health insurers participating in the marketplace. We were able to survey 85 of 277 insurers that we identified as being marketplace participants. The following are key results of that survey:

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<sup>1</sup> 79 FR 70674

- Twenty percent of plans do not contract with CNMs to include them in their provider networks, even though CNMs are licensed to practice in all 50 states and the District of Columbia.
- Seventeen percent of plans do not cover primary care services offered by CNMs, even though ACNM standards defining the scope of practice for these providers, often incorporated by reference by state law, include primary care services.
- Fourteen percent of plans indicated they impose restrictions on CNM practice that conflict with their scope of practice under state laws and regulations.
- Twenty-four percent of plans will not cover CNM professional services provided in a birth center and 56% will not reimburse CNMs for home birth services.
- Fifty percent of plans do not pay CNMs the same amount paid to a physician when they perform and bill for the same service.
- Ten percent of plans that contract with CNMs do not list them in their provider directories, making them invisible to potential and current enrollees. Forty percent of plans listing CNMs in their provider directories list them under the obstetrician-gynecologist category, which may make it difficult for women searching for “midwives” to find them.
- Forty-seven percent of plans do not contract with birth centers to cover facility costs associated with births in that setting, despite studies showing very good outcomes and low costs associated with these facilities.
- Among those contracting with birth centers, 18% do not make a payment to the birth center for their services that is distinct from the payment made to the professionals working therein.
- Eight percent of plans contracting with birth centers indicated they did not list them in their provider directory.<sup>2</sup>

In 2013, nearly 11,500 CNMs/CMs in the US collectively attended approximately 321,000 births, or more than 8% of all births. In eighteen states they attended 10% - 27% of births.<sup>3</sup> Without question, CNMs/CMs are major providers of maternity and newborn care, a required essential health benefit. We remind the agency as well that hospital discharges for maternity and newborn care far outnumber those of any other major diagnostic category.<sup>4</sup>

The hallmark of midwifery practice is to focus on fostering normal physiologic birth, which emphasizes techniques that support the occurrence of innate, hormonally driven processes.<sup>5</sup> This

<sup>2</sup> The full survey report, included as an attachment to this letter, is also available at: <http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000004394/EnsuringAccessToHighValueProviders.pdf>

<sup>3</sup> CDC Vital Stats, Births - Available at: [http://www.cdc.gov/nchs/data\\_access/vitalstats/vitalstats\\_births.htm](http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm)

<sup>4</sup> Healthcare Cost and Utilization Project data from the Agency for Healthcare Research and Quality, available at: <http://www.ahrq.gov/research/data/hcup/index.html>

<sup>5</sup> “Supporting Health and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA and NACPM,” May 14, 2012, available at: <http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000272/Physiological%20Birth%20Consensus%20Statement-%20FINAL%20May%2018%202012%20FINAL.pdf>

practice differs significantly from that of physicians who are trained to use interventions to address complications. Multiple studies have validated that CNM/CM led care results in fewer inductions of labor, lower levels of analgesia, fewer cesarean births, fewer perineal tears, and fewer pre-term births.<sup>6</sup> The midwifery model of care, is thus qualitatively and empirically different than the prevalent medicalized model. It is because of midwives' unique approach that hundreds of thousands of women seek out this specific type of care every year. **The key point is that coverage by a plan of one type of maternity care provider does not equate to coverage of the other type.**

The provisions of Section 2706(a) of the Public Health Service Act state that:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate 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.

**It is a serious matter that a major provider of maternity and newborn care is being systematically excluded or discriminated against by plans participating in the exchanges.**

Regulators have a strong interest in ensuring that high-value, low cost providers are included in plan networks. Further, they have a legal responsibility to ensure plans do not discriminate against providers acting within the scope of their license.

### Recommendation

We understand that CMS awaits the outcome of the NAIC's development of a model act for states to use in ensuring network adequacy. As states implement that law, and as CMS seeks to ensure network adequacy in the FFM, we strongly recommend CMS establish criteria to ensure that insurers operating in the marketplaces include CNMs/CMs in their networks and provide full access to the services they are permitted to perform under applicable state law and regulation, for purposes of meeting the statutory requirement of providing timely and reasonable access to maternity and newborn care.

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<sup>6</sup> 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) e73–e81.

Sandall J, Soltani H, Gates S, Shennan A, Devane D, "Midwife-led continuity models versus other models of care for childbearing women (Review)," *The Cochrane Library*, 2013, Issue 8.

Petra ten Hoope-Bender, et. al., "Improvement of maternal and newborn health through midwifery," *The Lancet*, Published online June 23, 2014.

Elizabeth Schroeder, et. al., "Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study," *BMJ*, 2012;344:e2292.

Caroline S. Homer, et. al., "Community-based continuity of midwifery care versus standard hospital care: a cost analysis," *Australian Health Review*, Vol 24 • No 1, 2001.

Laurie Cawthon, MD, MPH, "Assessing Costs of Births in Varied Settings," presentation before the Institute of Medicine, March 7, 2013, available at: <http://www.iom.edu/~media/Files/Activity%20Files/Women/BirthSettings/6-MAR-2013/Cawthon%20PDF.pdf>

Davis, Lorna G., CNM, et. al., "Cesarean Section Rates in Low-Risk Private Patients Managed by Certified Nurse-Midwives and Obstetricians," *Journal of Nurse-Midwifery*, vol. 39, no. 2, March/April 1994, pp. 91-97.

Rosenblatt, RA, "Interspecialty differences in the obstetric care of low-risk women," *American Journal Of Public Health*, vol. 87, issue 3, March 1997.

## 2. Provider Directories

### Discussion

CMS has proposed to require plans to:

- Publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM.
- Update the directory information at least once a month, and that a provider directory will be considered easily accessible when the general public is able to view all of the current providers for a plan on the plan's public Web site through a clearly identifiable link or tab without having to create or access an account or enter a policy number.
- Ensure the general public is able to easily discern which providers participate in which plan(s) and provider network(s).
- Make this information publicly available on their web sites in a machine-readable file and format specified by HHS.

ACNM is strongly in favor of these proposed requirements. As noted above, our survey found that ten percent of plans that contract with CNMs do not list them in their provider directories, making it impossible for current or potential plan enrollees to find them as providers. Furthermore, many plans list CNMs under the obstetrician/gynecologist category, which may make it difficult for women who are searching for a "midwife" to find them within the directory. Additionally, of the plans in our survey that contract with birth centers (often staffed by CNMs), eight percent stated they do not list them in their provider directory.

In the course of our survey, conversations with plans uncovered the fact that several contract with physician groups that employ midwives and as a consequence, will cover the services of the midwives in those contracted groups, but will not separately list the midwives within their provider directory.

These incomplete directories, or categorization of midwives in the OB/GYN section are problematic. They obscure an important provider resource within the plans, which ultimately damages the plans themselves, as current and potential enrollees are unable to get a full picture of the value of the plan without clear information.

### Recommendation

We recommend CMS finalize its proposals with regard to plan networks. We further recommend that CMS clarify that a "complete" provider directory consists of all providers whose services are covered under the plan and that where a plan's contract is executed at a group level, the provider directory must list every provider covered under that contract, not simply the group as a whole.

## CONCLUSION

We thank CMS for the opportunity to comment on this important issue. Should you have any questions, please feel free to contact me at [jbushman@acnm.org](mailto:jbushman@acnm.org) or 240-485-1843.

Sincerely,

A handwritten signature in black ink, appearing to read "Jesse S. Bushman". The signature is fluid and cursive, with a long horizontal stroke at the end.

Jesse S. Bushman, MA, MALA  
Director, Advocacy and Government Affairs

**Ensuring Access to High Value Providers**  
**ACNM Survey of Marketplace Insurers Regarding**  
**Coverage of Midwifery Services**  
September 2014



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# Ensuring Access to High Value Providers

## ACNM Survey of Marketplace Insurers Regarding Coverage of Midwifery Services

September 2014

### EXECUTIVE SUMMARY

Under the Affordable Care Act (ACA), insurers offering coverage through the health insurance marketplaces are required to cover a specified set of “essential health benefits” (EHB). The ACA requires that the EHB consist of coverage for 10 basic categories of items and services, among which is “maternity and newborn care.”

Certified nurse-midwives (CNMs) and certified midwives (CMs) attend 8% of births occurring in the United States. In several states they attend between 10 and 20% of births and in New Mexico they attend more than 27% of births. They are a significant provider of maternity and newborn care.

Standardized documents available from plans offering coverage through the health insurance marketplaces are not sufficiently detailed for potential or actual enrollees to know whether the plans include CNMs/CMs in their networks, or the extent to which the plans may cover the services of CNMs/CMs.

Based on a methodology from the National Nursing Centers Consortium, the American College of Nurse-Midwives (ACNM) conducted a survey of insurers offering coverage through the marketplaces to determine the inclusion of CNMs/CMs in their plan networks and the coverage of their services. ACNM identified 277 unique insurers, reached out to 232 of them, and was able to complete a survey with 85 insurers.

Key findings include:

- Twenty percent of plans do not contract with CNMs to include them in their provider networks, even though CNMs are licensed to practice in all 50 states and the District of Columbia.
- Seventeen percent of plans do not cover primary care services offered by CNMs, even though ACNM standards defining the scope of practice for these providers, often incorporated by reference by state law, include primary care services.
- Fourteen percent of plans indicated they impose restrictions on CNM practice that conflict with their scope of practice under state laws and regulations.
- Twenty-four percent of plans will not cover CNM professional services provided in a birth center and 56% will not reimburse CNMs for home birth services.
- Fifty percent of plans do not pay CNMs the same amount paid to a physician when they perform and bill for the same service.
- Ten percent of plans that contract with CNMs do not list them in their provider directories, making them invisible to potential and current enrollees. Forty percent of plans listing CNMs in their provider directories list them under the

- obstetrician-gynecologist category, which may make it difficult for women searching for “midwives” to find them.
- Forty-seven percent of plans do not contract with birth centers to cover facility costs associated with births in that setting, despite studies showing very good outcomes and low costs associated with these facilities.
  - Among those contracting with birth centers, 18% do not make a payment to the birth center for their services that is distinct from the payment made to the professionals working therein.
  - Eight percent of plans contracting with birth centers indicated they did not list them in their provider directory.

The survey also asked about inclusion of CMs in plan networks. Like CNMs, CMs obtain a master’s degree and go through specialized midwifery education. CNMs and CMs complete the same certifying examination administered by the American Midwifery Certification Board. The difference between CNMs and CMs is that the CMs enter their midwifery education with an undergraduate education other than nursing. Statutory and regulatory provisions authorize CNMs to practice in all 50 states and the District of Columbia and there are practicing CNMs in all of these jurisdictions. CMs are authorized to practice in 5 states, but are not currently present in all 5. Because of a small sample size, we were unable to draw significant conclusions about CMs.

Although ACNM does not represent certified professional midwives (CPMs), the survey asked insurers about their approach to these practitioners. CPMs are educated through a variety of mechanisms, some of which are accredited and some not. Many go through an apprenticeship model of training. They are required to have at least a high school education and they take a certifying examination administered by the North American Registry of Midwives (NARM). CPMs are currently authorized to practice in 28 states.

A number of significant studies in respected peer reviewed journals have demonstrated that CNMs/CMs, with their focus on normal physiologic birth, typically use fewer interventions during the birth process, have excellent outcomes and generally provide less costly care. Thus, CNMs/CMs provide exactly the kind of high value care insurers should be striving to make available to their enrollees. Insurers who fail to include CNMs/CMs in their provider networks, pay them inadequately, or do not advertise their availability to potential and current plan enrollees are losing the opportunity to experience the economic gains and increased customer satisfaction levels that midwifery care is proven to achieve.

Rigorous efforts by state and federal regulators are needed to address provider network shortcomings. Corrective action to adequately include coverage for one of the nation’s most important providers of maternity and newborn care may need to be mandated. On the bright side, action taken by plans to avoid potential penalties by ensuring appropriate inclusion of CNMs/CMs in provider networks and coverage of their services will result in increased value of the products they provide and an improved bottom line.

# FULL REPORT

## BACKGROUND

Under the Affordable Care Act (ACA), plans offered through the health insurance marketplaces, and many offered outside the marketplaces must provide coverage for “essential health benefits” (EHB). Under the law, the EHB is defined in very broad terms by reference to 10 basic categories of services that must be covered. One of these categories of required benefits is “maternity and newborn care.” In regulations implementing this section of the law, the Centers for Medicare and Medicaid Services (CMS) did not provide extensive detail regarding the exact types of services that constitute the EHB and instead chose to allow states to select an existing plan within their jurisdiction which would be the benchmark against which other plans would be measured. So long as an insurer’s plan covers benefits that were substantially equal to and actuarially equivalent to the benchmark plan, it will be considered to meet the EHB standard.<sup>7</sup>

CMS has made available brief descriptions of the benchmark plans in each state, but the details contained in these documents are very general and not specific enough to know what the plan’s approach to midwifery services might be.<sup>8</sup> For example, only 2 of the 2014 benchmark plans specifically note coverage for the services of certified nurse-midwives (CNMs) or certified midwives (CMs), only one mentions birth centers and many of them use general terminology to describe their coverage for maternity and newborn care that does not provide any insight into what types of providers might render those services and in which settings.

In establishing requirements for plan provider network adequacy, CMS has mostly deferred to state insurance departments to determine whether insurers are maintaining an adequate panel. The agency explicitly refused to establish requirements specifying particular types of providers that must be included in plan networks, instead requiring insurers to maintain a plan network of “a sufficient number and type of providers” to ensure that all covered services are available without delay.<sup>9</sup>

As a result of this situation, it is extremely difficult, if not impossible, for the average shopper visiting the federally facilitated marketplace or the state marketplaces to rely on that information to determine whether available plans include midwives in their provider networks, and/or cover the services they offer.

Certified nurse-midwives are educated in 2 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. Certified midwives 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.

According to CDC data, CNMs/CMs attend nearly 8% of all births occurring in this country and nearly 12% of vaginal births.<sup>10</sup> Because state practice environments vary, the percent of births attended by CNMs/CMs among the states also ranges, going as high as 27% in New Mexico. CNMs/CMs are significant providers of maternity and newborn care across the United States, and in many locations, provide greatly needed access to these services.

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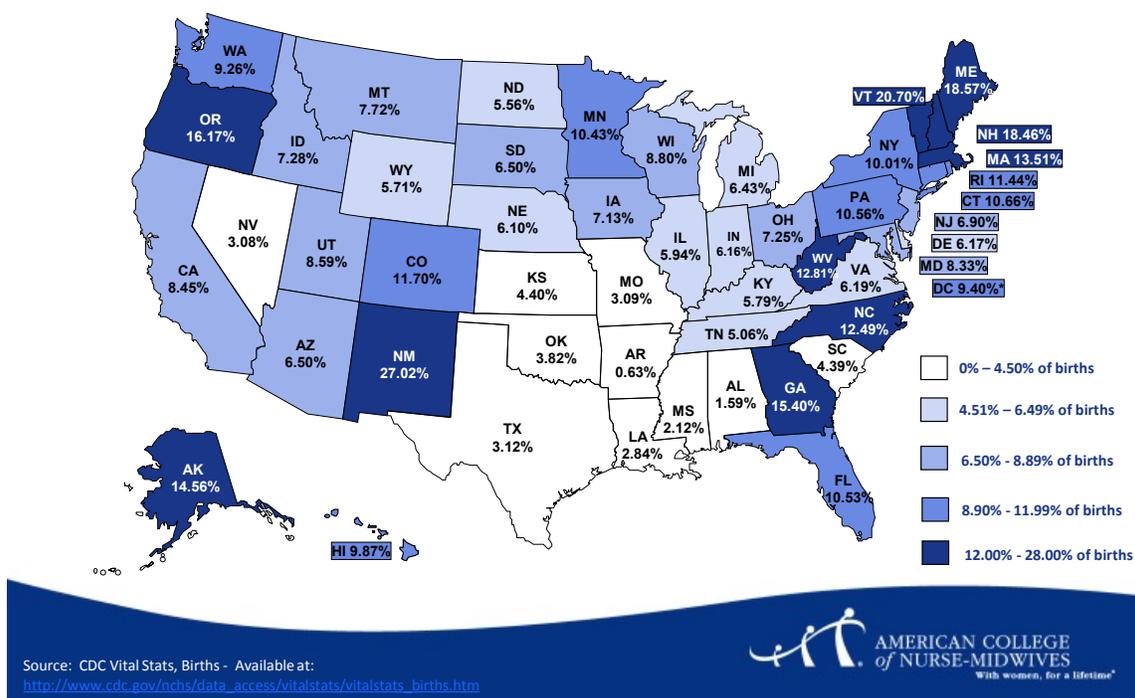
<sup>7</sup> 78 FR 12834

<sup>8</sup> Details on state benchmark plans are available at: <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>

<sup>9</sup> 45 CFR 156.230

<sup>10</sup> CDC Vital Stats, Births - Available at: [http://www.cdc.gov/nchs/data\\_access/vitalstats/vitalstats\\_births.htm](http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm)

## Percent of Births Attended by CNMs/CMs - 2012



CNMs/CMs specialize in fostering normal physiologic birth, assisting women and newborns to use the innate capacities of their own bodies in the birth process. Numerous studies have concluded that CNM/CM-led care results in fewer interventions, greater patient satisfaction, and a trend to lower costs.<sup>11</sup> Birth centers have also been shown to provide high value care.<sup>12</sup>

### SURVEY DESIGN

To determine the nature and extent of coverage for midwifery services under plans offered through the federal and state marketplaces, the American College of Nurse-Midwives (ACNM) conducted a survey of these plans. The

<sup>11</sup> See: 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) e73–e81., Sandall J, Soltani H, Gates S, Shennan A, Devane D, "Midwife-led continuity models versus other models of care for childbearing women (Review)," *The Cochrane Library*, 2013, Issue 8., Petra ten Hoop-Bender, et. al., "Improvement of maternal and newborn health through midwifery," *The Lancet*, Published online June 23, 2014., Elizabeth Schroeder, et. al., "Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study," *BMJ*, 2012; 344:e2292. See also, Caroline S Homer, et. al., "Community-based continuity of midwifery care versus standard hospital care: a cost analysis," *Australian Health Review*, Vol 24 • No 1, 2001., Laurie Cawthon, MD, MPH, "Assessing Costs of Births in Varied Settings," presentation before the Institute of Medicine, March 7, 2013, available at: <http://www.iom.edu/~media/Files/Activity%20Files/Women/BirthSettings/6-MAR-2013/Cawthon%20PDF.pdf>

<sup>12</sup> Susan Rutledge Stapleton, CNM, DNP, Cara Osborne, SD, CNM and Jessica Illuzzi, MD, MS, "Outcomes of Care in Birth Centers: Demonstration of a Durable Model," *Journal of Midwifery & Women's Health*, Volume 58, Issue 1, pp. 3–14, January/February 2013.



survey methodology was based on that of the National Nursing Centers Consortium (NNCC).

ACNM accessed a list of plans available through the federally facilitated and state marketplaces. Since one insurer may offer multiple plans in a single state, we sorted the list to identify single issuers in each state. If an issuer sponsored plans in more than one state, it was counted once for each unique state in which it offered coverage and in the process of the survey the insurer was queried separately with regard to each of the states in which it offered coverage. We counted a total of 277 insurers using this method. During the course of our survey, we reached out to 232 of the 277 and were able to complete surveys with 85 (30.7% of the 277), located in 33 different states.

Questions were asked regarding inclusion in plan networks of CNMs, CMs, and certified professional midwives (CPMs). The survey asked about the nature of coverage for midwifery services, including whether the plan paid midwives at the same rate as physicians when they provide the same services, whether the plan imposed any limitations on what services midwives can provide beyond what is required by state scope of practice laws, and whether the plan covered primary care services offered by midwives. For CNMs/CMs, the provision of well-woman and primary care is typically included in their state defined scope of practice. The survey also inquired regarding coverage for birth center services.

## **SURVEY FINDINGS<sup>13</sup>**

### **Certified Nurse-Midwives (CNMs)**

#### ***Contracting***

A significant majority of plans responding to the survey do contract with CNMs (74%, with an additional 6% indicating that they do so “sometimes.” See Chart 1.) However 20% of plans indicated that they do not contract with CNMs. Some of the plans in the latter category indicated during the survey that they would contract with physician groups and if the group happened to include a CNM, his/her services would be covered. This policy, however, erects a significant barrier to CNMs’ abilities to establish their own practices.

It is concerning that such a large portion of plans refuse to contract with CNMs, and raises questions about provider discrimination, particularly in light of the requirement of Section 2706(a) of the Public Health Services Act which states that “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate 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.”

In some sense, however, this represents an excellent business opportunity for plans that do not currently include CNMs in their networks. The midwifery model of care results in fewer interventions, which directly translates into immediate savings for both insurers and their beneficiaries. Clearly the majority of plans have acknowledged the value of including CNMs in their networks and are realizing associated cost savings and quality outcomes. Plans without CNMs in their networks would do well to consider the advantages that their competitors realize by doing so and should take active steps to address that market shortcoming.

#### ***Scope of Coverage***

ACNM’s “Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives,” a professional standard setting document referenced by many states in scope of practice laws or regulations, defines midwifery scope of practice to include “the independent provision of primary care, gynecologic and family planning

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<sup>13</sup> Because not all plans were able to respond to every question, the results below present data only for plans that were able to respond to a given question. If the plan respondent did not know the answer to a question, or refused to answer it, we have not included that in the results displayed for that particular question.

services.”<sup>14</sup> While midwives are well-known for attending births, in surveys of ACNM’s membership, 53.3% of CNMs/CMs identify reproductive care and 33.1% identify primary care as main responsibilities in their full-time positions. Examples include annual exams, writing prescriptions, basic nutrition counseling, parenting education, patient education, and reproductive health visits.<sup>15</sup> Among surveyed plans, 17% stated that they do not cover primary care services provided by CNMs. (See Chart 2.) Similar to the question regarding coverage of primary care services, 14% of responding plans stated that they impose restrictions on services that CNMs can provide that conflict with state scope of practice laws and regulations. (See Chart 3.)

At a time when primary care providers are in short supply, it is a concern that plans are not taking advantage of the ability of the midwives within their networks to perform to the full extent of their education, certification, and legally recognized scope of practice.

### *Out-of-Hospital Birth*

The vast majority of births attended by CNMs occur in the hospital setting (just under 95% in 2012, according to CDC data). However, they do attend births occurring in birth centers and residences, and the number of such births has been steadily growing.<sup>16</sup> Despite the fact that birth center birth and home birth have legal status in virtually every state, there are significant barriers to insurance coverage for CNM services provided in these out-of-hospital settings. Nearly a quarter (24%) of surveyed plans will not reimburse CNMs for the professional services that they provide in birth centers and the majority (56%) will not cover home birth services provided by CNMs. (See Charts 4 and 5).

### *Reimbursement*

As noted above, Section 2706(a) of the Public Health Service prohibits insurers from discriminating against providers with regard to participation in the plan’s network or coverage of their services. This provision goes on to state that plans are not prohibited from varying reimbursement based on quality or performance, clearly indicating an intent that reimbursement, which greatly impacts coverage, not be based on arbitrary categories such as licensure. Thus, if multiple provider types may all perform the same service under their state scope of service requirements, an insurer could put itself at risk of engaging in discriminatory behavior if it chooses to reimburse these providers at different rates based purely on their licensure.

Fully half of the plans responding to our survey indicated that they do not pay CNMs at the same rate as physicians. (See Chart 6). A recent systematic review of studies comparing CNM and physician led care concluded that “there is moderate to high evidence that CNMs rely less on technology during labor and delivery than do physicians and achieve similar or better outcomes.”<sup>17</sup> There is therefore no justification for such a discriminatory approach on the part of insurers. Lower levels of reimbursement discourage CNM participation in plan networks and put them at an unwarranted economic disadvantage relative to other providers rendering the same services.

The preponderance of evidence shows that midwifery care results in lower costs.<sup>18</sup> This arises from reductions in low birth weight and preterm babies, less use of induction, epidural, and cesarean birth. All of these practices reduce

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<sup>14</sup> This document is 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>

<sup>15</sup> Kerri Durnell Schuiling, CNM, WHNP-BC, PhD, Theresa Ann Sipe CNM, MPH, PhD and Judith Fullerton CNM, PhD, “Findings from the Analysis of the American College of Nurse-Midwives’ Membership Surveys: 2006–2008.” *Journal of Midwifery & Women’s Health*, Volume 55, Issue 4, pp. 299-307, July/August 2010.

<sup>16</sup> Marian F. MacDorman, Ph.D.; T.J. Mathews, M.S.; and Eugene Declercq, Ph.D., “Trends in Out-of-Hospital Birth in the United States, 1990–2012,” NCHS Data Brief, No. 144, March 2014, available at: <http://www.cdc.gov/nchs/data/databriefs/db144.pdf>

<sup>17</sup> Meg Johantgen, PhD, RN, et. al, 2012.

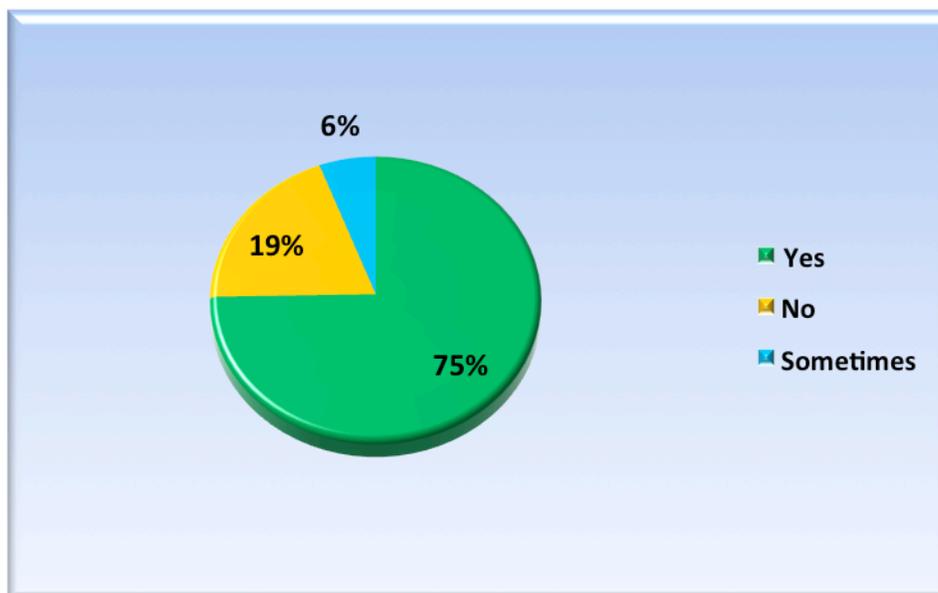
<sup>18</sup> Sandall J, Soltani H, Gates S, Shennan A, Devane D, 2013. Elizabeth Schroeder, et. al., 2012. Caroline S Homer, et. al., 2001. Laurie Cawthon, MD, MPH, 2013.

costs for insurers. Insightful insurers have realized the value of this care and are reimbursing appropriately.

### Provider Directories

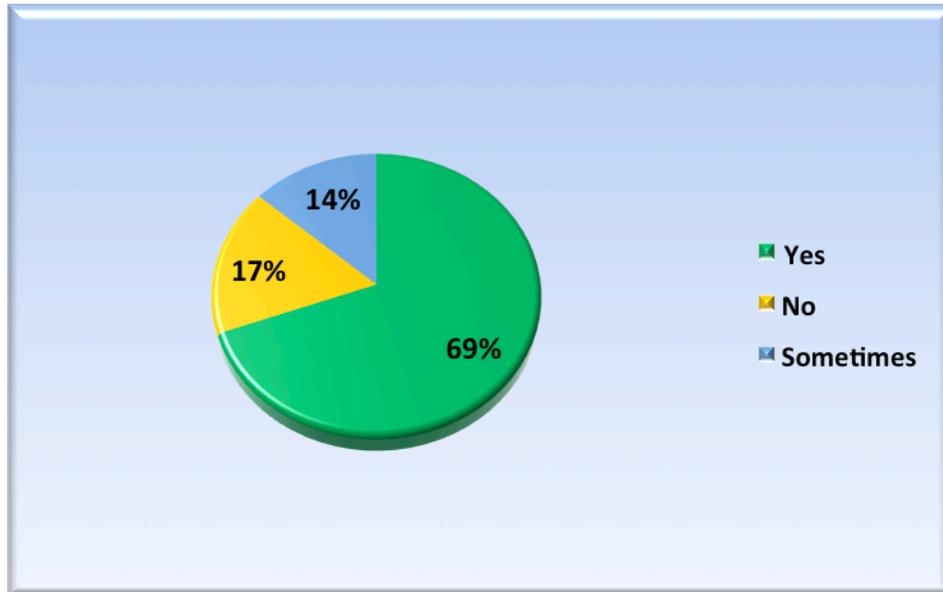
Interestingly, 10% of plans contracting with CNMs do not list them in their provider directories. (See Chart 7.) During the survey process, several indicated that when they contract with a physician group that includes CNMs, they list the physician group in their provider directory, but not the individual CNMs. Unfortunately, this renders midwives invisible to women considering enrolling in the plan as well as current enrollees. It would be in the plans' best interest to advertise their availability, as midwifery-led care is associated with higher levels of patient satisfaction, and their presence in plans' networks could prove a marketing advantage.<sup>19</sup> Finally, while many plans that contract with CNMs (40%) list them in the obstetrician-gynecologist portion of their provider directory, most (60%) list them in some other category (See Chart 8). To ensure that prospective and current plan enrollees are able to find midwives in their plan's network, plans that cross list CNMs in both the obstetrician-gynecologist and midwifery categories are most likely to ensure that their enrollees understand the true value of their plan.

**Chart 1: Do you contract with certified nurse-midwives as network providers for your plans? (N=87)**

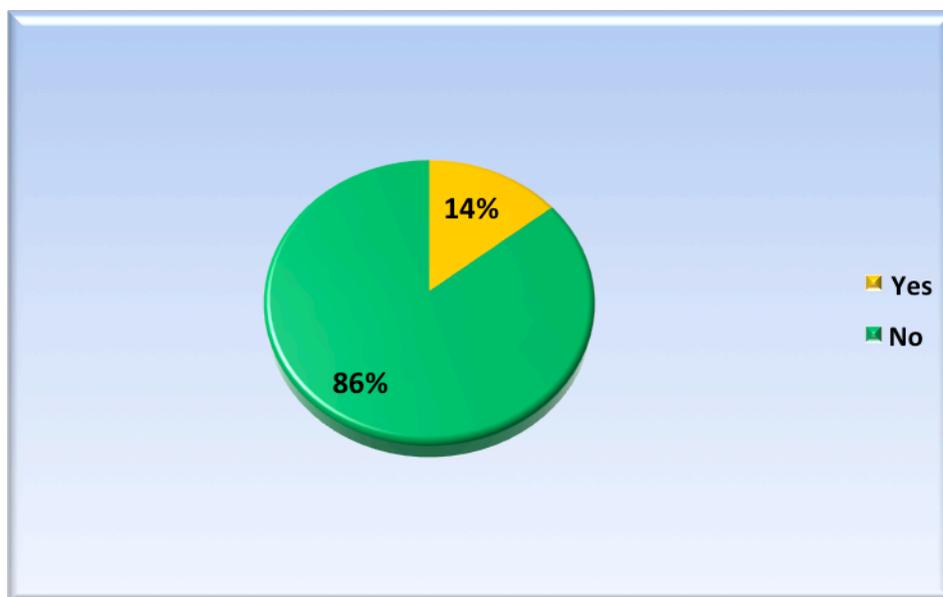


<sup>19</sup> Petra ten Hoop-Bender, et. al., "Improvement of maternal and newborn health through midwifery," The Lancet, Early Online Publication, 23 June 2014, available at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60930-2/fulltext#article\\_upsell](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60930-2/fulltext#article_upsell)

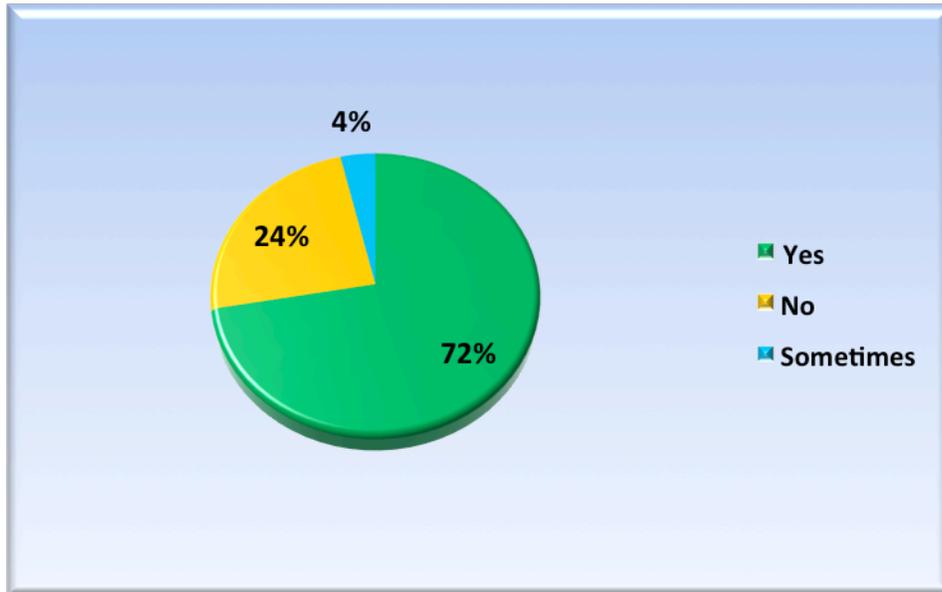
**Chart 2: Do you cover primary care services provided by certified nurse-midwives? (N=59)**



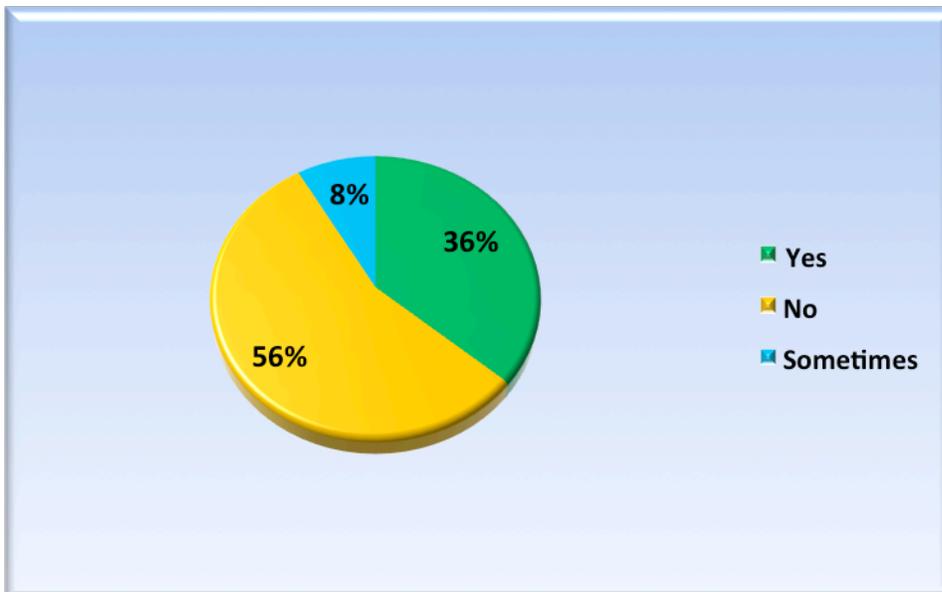
**Chart 3: Do you impose any restrictions on what certified nurse-midwives can do, beyond those imposed by state scope of practice laws and regulations? (N=56)**



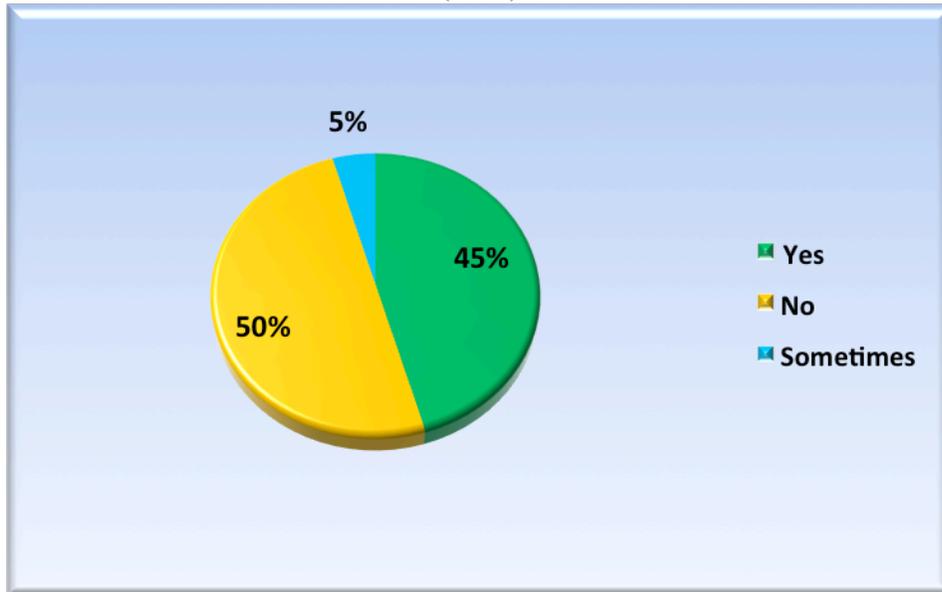
**Chart 4: Do you cover services of certified nurse-midwives provided in birth centers? (N=54)**



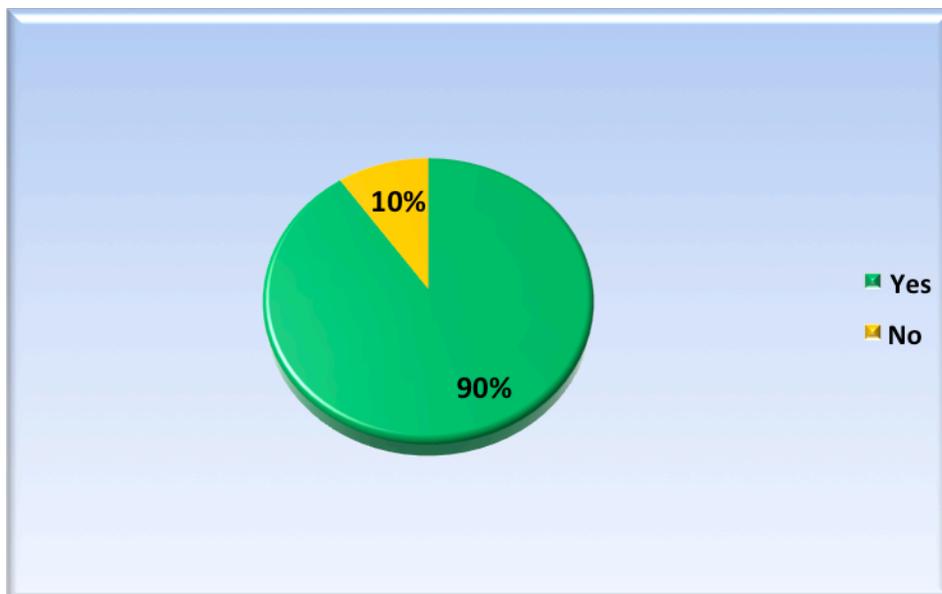
**Chart 5: Do you cover home birth services offered by certified nurse-midwives? (N=36)**



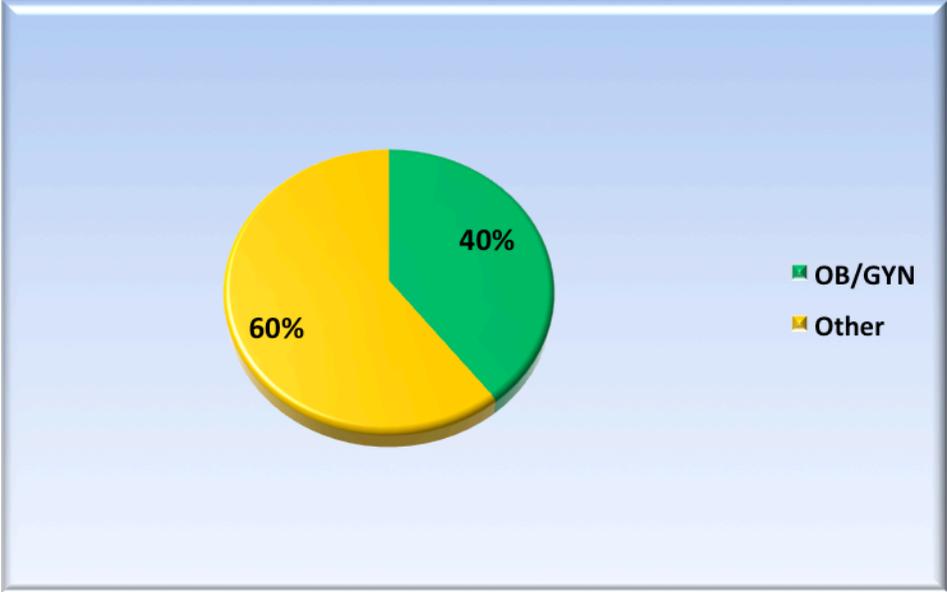
**Chart 6: Do you reimburse certified nurse-midwives at the same rate at which physicians are reimbursed? (N=44)**



**Chart 7: Does your provider directory list all certified nurse-midwives with whom you contract? (N=62)**



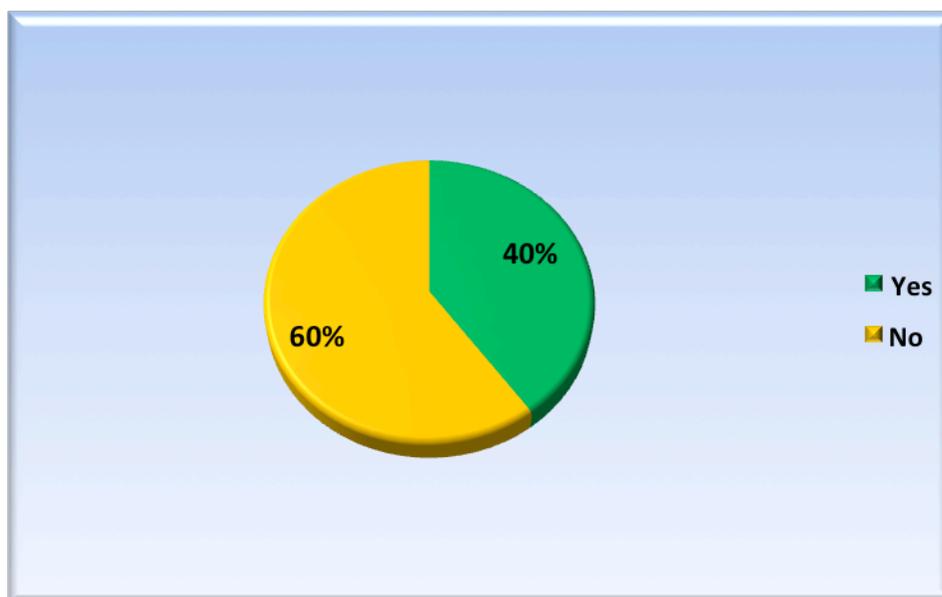
**Chart 8: If your provider directory does include certified nurse-midwives with whom you contract, are they listed under the obstetrician-gynecologist category, or are they listed under some other category? (N=43)**



## Certified Midwives (CMs)

Legal provisions make it possible for CMs to practice in 5 states, but they are not currently present in all 5 of those states. Our survey was only able to contact a limited number of plans in the states where CMs might potentially practice, and not all of these plans responded to every question in the survey. Thus we are only presenting data related to a single question around contracting with CMs. As can be seen in Chart 9, the majority of plans in this category do not contract with CMs. This raises all of the aforementioned concerns around provider discrimination. It also highlights the business opportunity that insurers are letting slip through their fingers by failing to contract with providers who provide high value, cost effective care.

**Chart 9: Do you contract with certified midwives as network providers for your plans? (N=6)**



## Certified Professional Midwives (CPMs)

A certified professional midwife (CPM) is an individual who has followed a path to midwifery practice that differs from that of the CNM or CM. Typically certified professional midwives complete an apprenticeship model of education and unlike CNMs/CMs are not required to obtain an advanced degree as a prerequisite for certification. They are only required to have a high school education or equivalent in order to sit for the certification exam, administered by the North American Registry of Midwives (NARM). CPMs are authorized to practice in 28 states.<sup>20</sup> Nationwide, CPMs attended less than 1% of all births and the majority of those they attend take place in a birth center or residence. ACNM does not represent CPMs, but opted to include questions about these providers in the survey given their legal status in a majority of states.

About two-thirds (65%) of plans surveyed, that were located in states where CPMs are authorized to practice, indicated they do not contract with CPMs. (See Chart 10.) Thirteen percent of plans impose restrictions on what CPMs can do that go beyond those in state scope of practice laws or regulations. (See Chart 11.) Insofar as they are licensed providers within a given state, this certainly raises questions about potential provider discrimination.

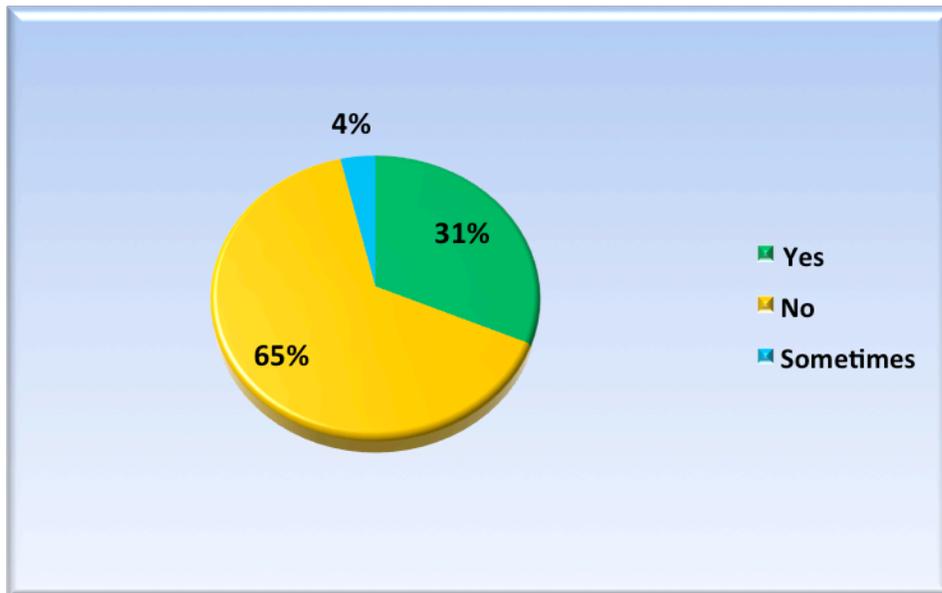
Interestingly, when considering plans that cover CPM services and plans that cover CNM services, those covering CPM services are more likely to cover birth center and home birth services (88% and 50% respectively as opposed to 72% and 36% among plans covering CNM services). (See Charts 4, 5, 12, and 13.) Further, among plans covering CPM services, a larger percentage (64%) pay them at the same rate as physicians than do plans that cover CNM services. (See Chart 14.)

A small group of CPMs face the same problem as CNMs when it comes to being listed in provider directories. Six percent of plans indicated that they do not separately list CPMs in their directory. (See Charts 15 and 16.)

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<sup>20</sup> For a clear explanation of the distinctions between education and licensure of CNMs, CMS and CPMs, see the comparison chart prepared by ACNM, available at: <http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000001031/cnm%20cm%20cpm%20comparison%20chart%20march%202011.pdf>

**Chart 10: Do you contract with certified professional midwives as network providers for your plans? (N=54)**



**Chart 11: Do you impose any restrictions on what certified professional midwives can do, beyond those imposed by state scope of practice laws and regulations? (N=54)**

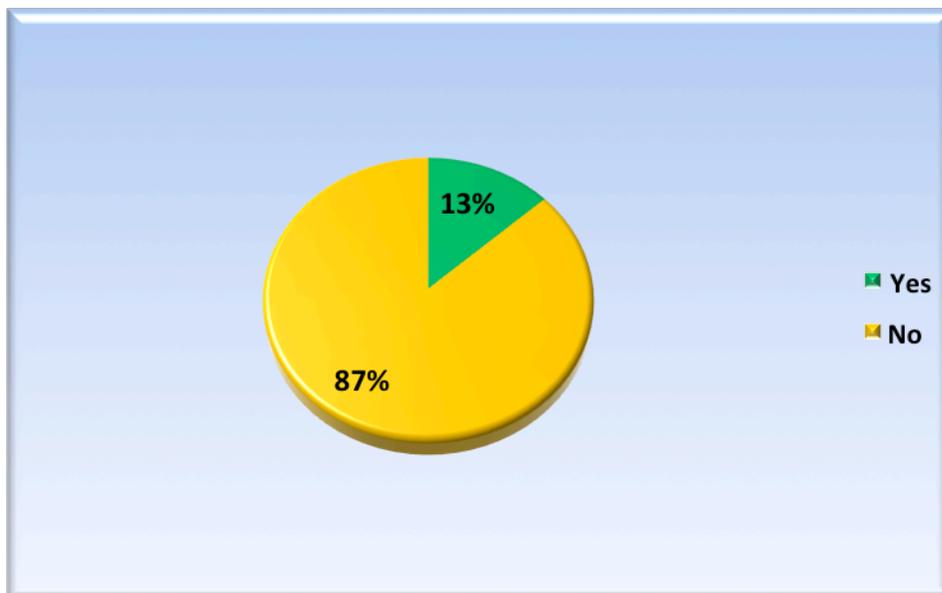


Chart 12: Do you cover services of certified professional midwives provided in birth centers? (N=17)

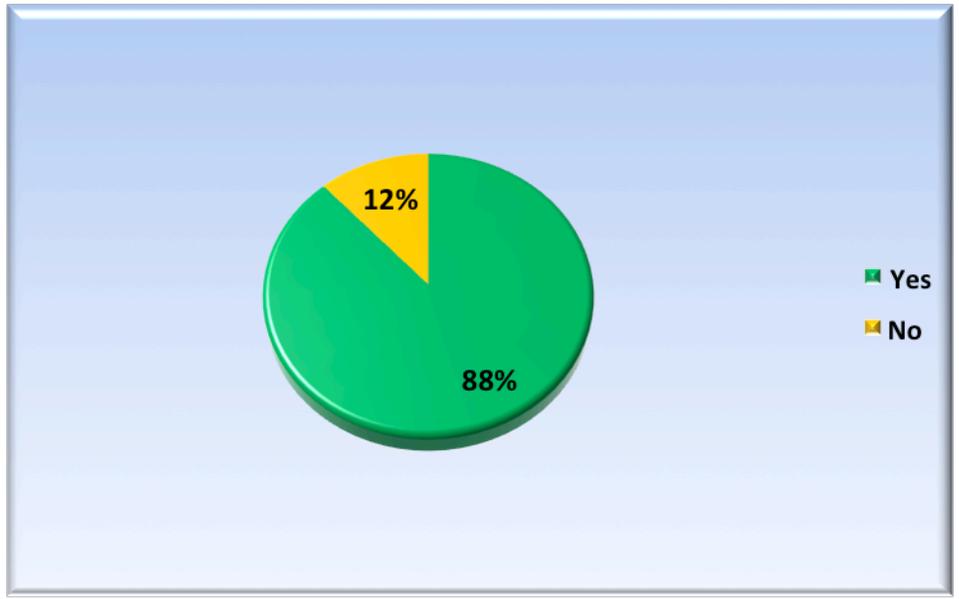
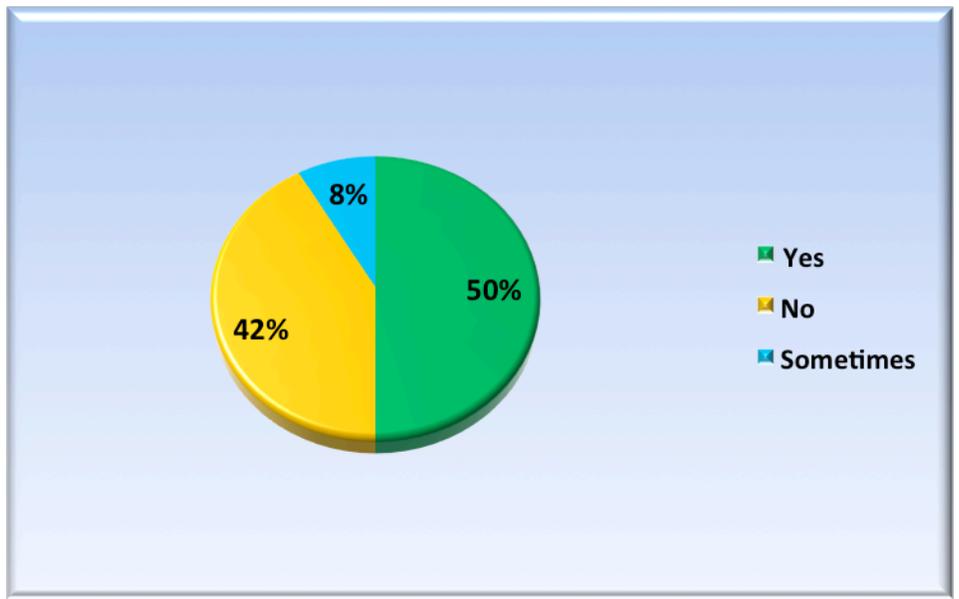
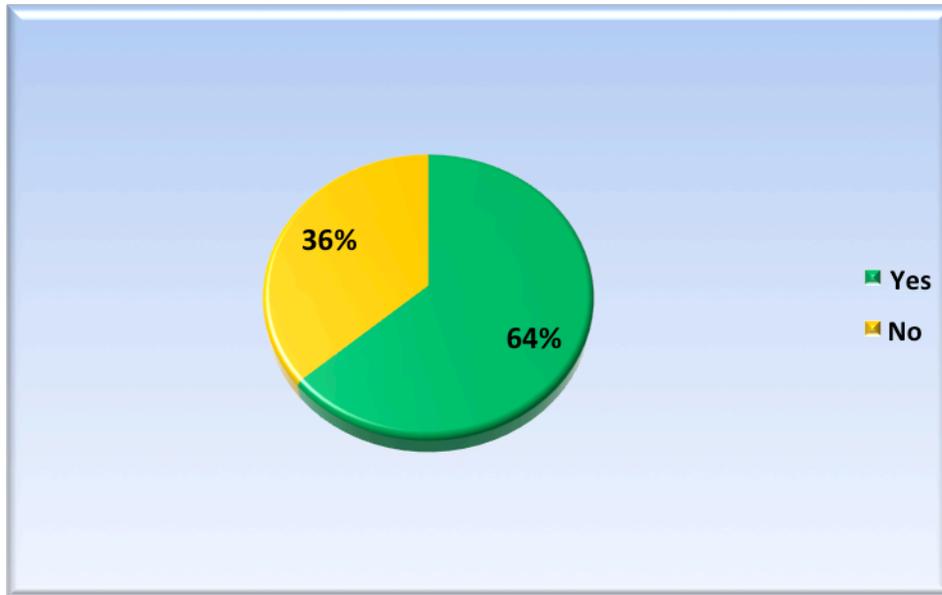


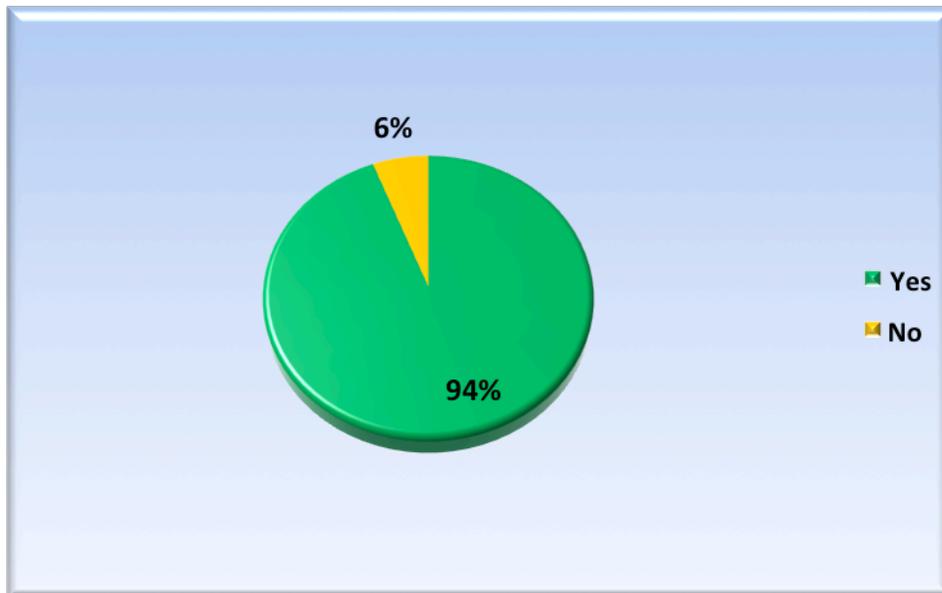
Chart 13: Do you cover home birth services offered by certified professional midwives? (N=12)



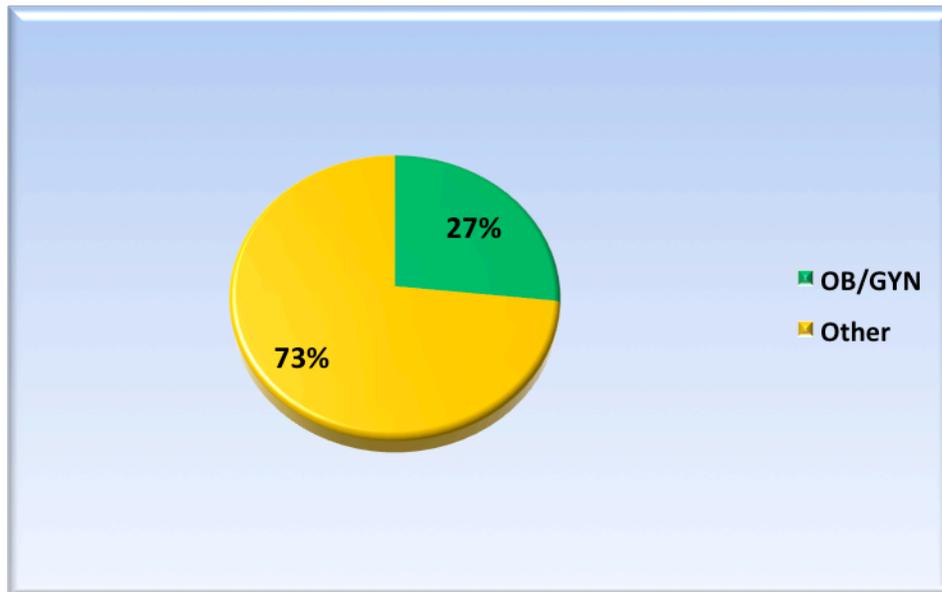
**Chart 14: Do you reimburse certified professional midwives at the same rate at which physicians are reimbursed? (N=11)**



**Chart 15: Does your provider directory list all certified professional midwives with whom you contract? (N=17)**



**Chart 16: If your provider directory does include certified professional midwives with whom you contract, are they listed under the OB/GYN category, or are they listed under some other category? (N=15)**



## Birth Centers

Freestanding birth centers are homelike facilities existing within a health care system with a program of care designed to foster normal physiologic birth. They provide prenatal, birth, postpartum and newborn care to women with normal pregnancies and use low levels of intervention. Studies have demonstrated that birth center services provide high quality care to the women they serve.<sup>21</sup> In addition, studies have shown very large savings associated with birth center care.<sup>22</sup> The large majority of birth centers are led by CNMs and/or CPMs.

Despite clear evidence of the significant savings associated with birth center care, just under half (49%) of surveyed plans indicated they contract with birth centers, with another 4% stating that they do so sometimes. (See Chart 17). Thus, there is a clear business opportunity for marketplace plans in the form of increased contracting with birth centers. In addition, there is the question of provider discrimination with regard to insurers that systematically exclude birth centers from their networks.

With regard to payment to birth centers, a significant proportion (18%) of insurers contracting with birth centers do not make a separate payment to the birth center, apart from what they pay the professionals working in those birth centers. (See Chart 18). This is a very puzzling approach to reimbursement. When services are rendered inside a facility, separate payments are made to the facility and to the professionals working therein. To draw a comparison, it would be exceedingly odd for an insurer to argue that when one of its beneficiaries is admitted to a hospital, ambulatory surgery center, or skilled nursing facility, the insurer need only pay the physicians and other practitioners working within the facilities, but make no payment to the facility itself. It is doubtful that such a policy

<sup>21</sup> Susan Rutledge Stapleton, CNM, DNP, Cara Osborne, SD, CNM and Jessica Illuzzi, MD, MS, "Outcomes of Care in Birth Centers: Demonstration of a Durable Model," *Journal of Midwifery and Women's Health*, article first published online: 30 Jan. 2013, available at: <http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12003/full>

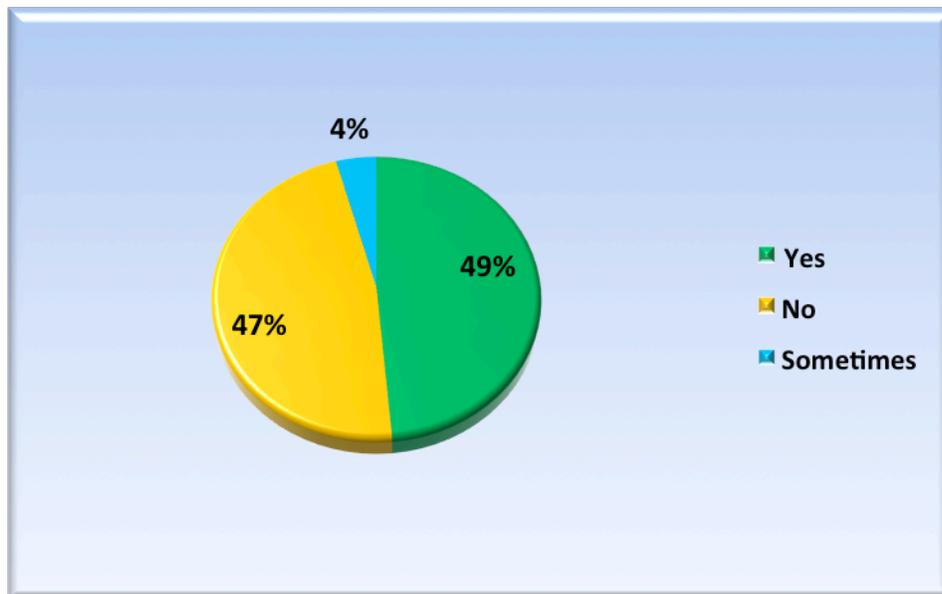
<sup>22</sup> Laurie Cawthon, MD, MPH, 2013.

would prove attractive to any consumers as they would be left to pay the facility fees themselves and certainly no facility would want to enter into an arrangement that provides zero coverage for their services. This shortsighted practice with regard to birth centers discourages the more cost effective providers of maternity care services from participating in the plan's network, which ultimately works to the detriment of these plans and their beneficiaries.

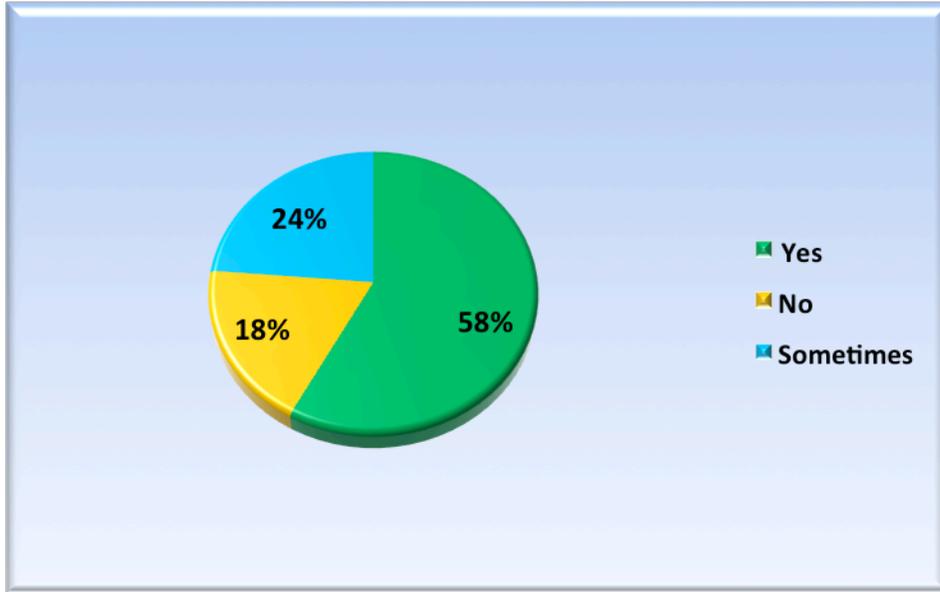
Birth centers are accredited through the Commission for the Accreditation of Birth Centers (CABC). Insurers including birth centers in their networks show a clear preference for accreditation, with 60% saying that they require CABC accreditation. (See Chart 19.)

As with CNMs and CPMs, a small portion of plans (8%) do not list all birth centers with which they contract in their provider directories. (See Chart 20.) Birth centers are growing in popularity. A plan's failure to make it clear to the shopping public or to its existing enrollees that it includes birth centers in its provider network is likely to lose these individuals to other plans in which coverage of birth centers is made clear to the public and current enrollees. Again, this represents a business opportunity for these insurers.

**Chart 17: Do you contract with birth centers to cover their services? (N=70)**



**Chart 18: Do you make a separate payment to birth centers for their facility services, apart from payments made to the professionals working in the birth centers? (N=38)**



**Chart 19: If you include birth centers in your provider network, do you require that they be accredited by the Commission for the Accreditation of Birth Centers in order to be included in your network? (N=20)**

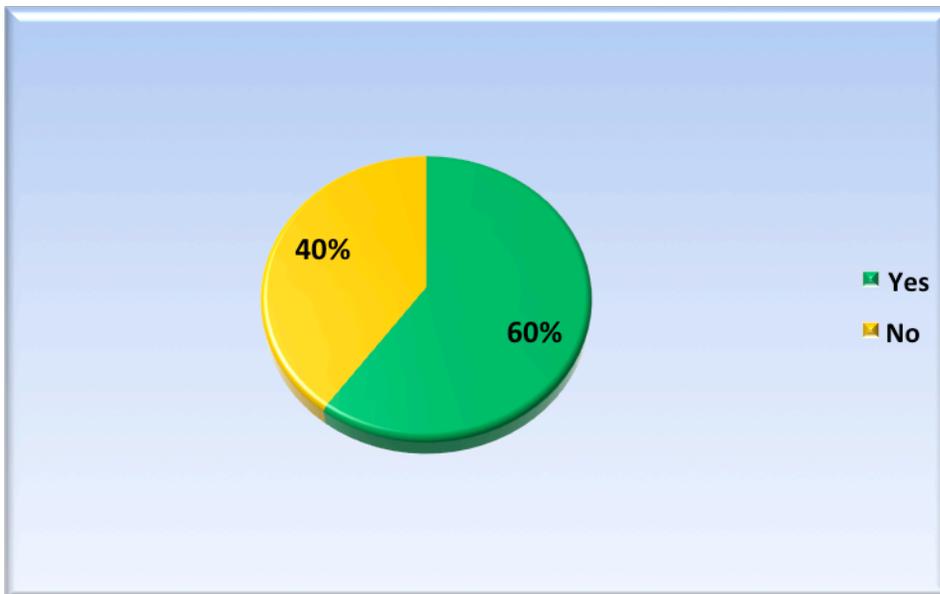
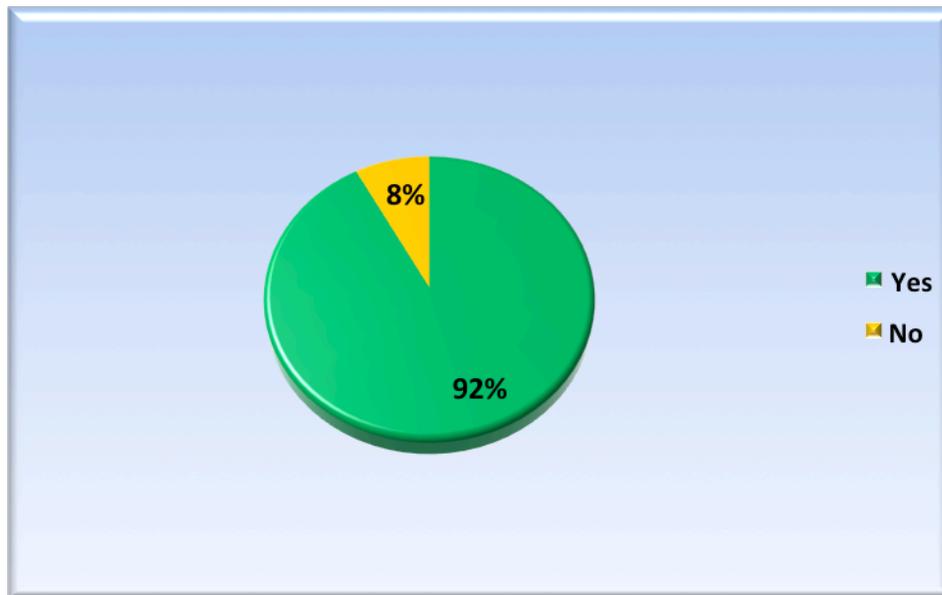


Chart 20: Does your provider directory list all birth centers with which you contract? (N=38)



## CONCLUSION

### Consumers

Consumers need to be aware that many plans do not cover the services of CNMs/CMs/CPMs, birth centers, or home birth. If they seek midwifery care or desire to give birth in a birth center or at home, they need to contact their plan and make specific inquiry regarding such coverage. To ensure they have access to and coverage for these services, women who are already pregnant may need to switch plans if an enrollment opportunity presents itself during the course of their pregnancy. Further, consumers need to be aware that plan reimbursement policies may actually discourage participation by midwives. They can help with this by contacting their plans to let them know how important this option is to them, or simply by switching to a plan that does offer this coverage.

### Insurers

Costs for birth are not insignificant. A study by Truven Health Analytics found that in 2010, for a vaginal birth and the first 3 months of infant care, commercial insurers paid an average of \$18,329. With a cesarean birth, these costs ballooned to \$27,866. Further, with cesarean birth, insurers pay a larger proportion of the overall costs (90% vs. 87%).<sup>23</sup> According to the Agency for Healthcare Research and Quality, in 2011 there were nearly 8.2 million hospital discharges for maternity and newborn care, far outnumbering discharges for any other major diagnostic

<sup>23</sup> “The Cost of Having a Baby in the United States,” Truven Health Analytics MarketScan® Study, January 2013, available at: <http://transform.childbirthconnection.org/reports/cost/>



category.<sup>24</sup> Costs for maternity and newborn care run into the tens of billions of dollars each year. Clearly, commercial insurers have a serious interest in birth outcomes and in ensuring that the most cost effective, highest value maternity care is available to their enrollees.

As the studies cited in this report show, CNMs/CMs have consistently been shown to provide care that results in high quality outcomes, at low costs – precisely the kind of providers that insurers should be actively seeking to include in their networks.

Although there is no uniformly accepted definition of low risk pregnancy, most health care professionals would agree that normal pregnancies account for the vast majority (probably more than 75%). Since midwives attend 8% of births nationwide, the business opportunity to take advantage of the savings they can generate for insurers is very substantial.

This survey shows that insurers have opportunities in this area. They can actively seek to contract with CNMs and CMs, ensure they are paid equitably for the services they provide, and make sure that prospective and current enrollees are able to easily find them within the plan’s provider network. Further, by advertising the availability of midwifery care both in and out of the hospital as options, they will increase market share by attracting women seeking this type of care and, as shown in studies, will realize increased levels of enrollee satisfaction. These increased levels of patient satisfaction will help the plan perform well with regard to the quality rating system they all will participate in.

### Policy Makers

For policy makers, the key questions raised by this survey also relate to ensuring value. A review of regulations dealing with the marketplaces clearly shows a strong concern on the part of policy makers to ensure that plans have the flexibility to provide low cost, high value products. To allow plans the flexibility needed to produce high value products, regulators have been very careful about proscribing the types of providers that must be included in a plan’s network or the specific services that must be covered.

Certainly, narrow networks and performance-based reimbursement are tools that can be used to ensure availability of affordable premiums. However, policy makers should consider whether insurers who categorically refuse to contract with CNMs/CMs purely because of the licenses they hold are not engaging in provider discrimination. Policy makers also have a duty to ensure that women have access to clear, complete data about the options available to them so that they can make an informed choice. This sort of information encourages healthy competition and ensures access to a variety of safe, effective choices in maternity care. CNMs/CMs are major providers of maternity care in the United States, and maternity and newborn care are required elements of the essential health benefits package that must be covered by every plan offering coverage through the health insurance marketplaces, as well as many plans offered outside the marketplace. Policy makers should ensure that insurers include CNMs/CMs working in hospitals, residences, and birth centers in their provider networks.

A similar question must be raised when insurers choose to use licensure, rather than performance or outcomes, as the basis for determining reimbursement. The language of Section 2706(a) of the Public Health Service Act does not envision this practice and policy makers should take steps to ensure it does not occur.

Happily, the evidence demonstrates that inclusion of CNMs/CMs and birth centers in plan networks will generate high value care for plan enrollees, precisely the goal policy makers are seeking to accomplish. This is one of the rare situations in which legal requirements, good public policy and business acumen are well aligned. Policy makers should ensure that regulations, guidance, and network adequacy algorithms require inclusion of CNMs/CMs and birth centers in plan networks as well as coverage for the full range of services that midwives are educated, certified, and licensed to provide.

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<sup>24</sup> See: <http://hcupnet.ahrq.gov/HCUPnet.jsp>



## CONTACT

The American College of Nurse-Midwives (ACNM) is the professional association that represents certified nurse-midwives (CNMs) and certified midwives (CMs) in the United States. With roots dating to 1929, ACNM sets the standard for excellence in midwifery education and practice in the United States and strengthens the capacity of midwives in developing countries. Our members are primary care providers for women throughout the lifespan, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. ACNM reviews research, administers and promotes continuing education programs, and works with organizations, state and federal agencies, and members of Congress to advance the well-being of women and infants through the practice of midwifery.

Questions about this report may be raised with Jesse Bushman, ACNM's Director of Advocacy and Government Affairs, at [jbushman@acnm.org](mailto:jbushman@acnm.org) or 240 485-1843.