



January 8, 2015

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Letter via email to: FFEcomments@cms.hhs.gov

RE: DRAFT 2016 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Ms. Tavenner:

On behalf of the American College of Nurse-Midwives (ACNM) I wish to submit the following comments in response to the “DRAFT 2016 Letter to Issuers in the Federally-facilitated Marketplaces.”¹ We appreciate the opportunity for comment afforded by CMS and hope you find our feedback constructive and helpful.

BACKGROUND

ACNM represents the majority of the nation’s 11,500 certified nurse-midwives (CNMs) and certified midwives (CMs) who practice in all 50 states, the District of Columbia and the US territories. In 2013 CNMs/CMs collectively attended more than 8% of all births in the entire country and 12% of all vaginal births. In eighteen states they attended between 10% - 27% of births.² CNMs/CMs are thus major providers of maternity and newborn care, a required category of essential health benefits.

SPECIFIC COMMENTS

Section 3. Network Adequacy

i. Network Adequacy Standard

Under Paragraph i, Section 3 of the draft Letter, CMS describes in general terms the method used by the agency to ensure adequate plan networks. Specifically, the draft document cites to regulatory requirements that plans “maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.”³ CMS indicates it will use a “reasonable access” standard to evaluate provider network data,

¹ See: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf>

² CDC Vital Stats, Births - available at: http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm

³ 45 C.F.R. 156.230(a)(2)

“including information on its physicians, facilities, and pharmacies” submitted by plans, with specific focus on areas which have historically raised network adequacy concerns.

ACNM has several concerns with the description of the methodology provided under Section 3 of the draft Letter.

1. CMS references provision of data on “physicians, facilities, and pharmacies,” but says nothing about data on other types of providers such as CNMs/CMs.
2. There is not a mechanism described in the draft Letter through which CMS will determine whether an appropriate range of provider types are included in a plan’s network.
3. The specific areas of focus identified by CMS do not include maternal and newborn care.

We discuss each of these concerns below.

1. Inclusion of Providers other than Physicians, Facilities and Pharmacies

We note that Section 4.1 of Chapter 6 of the 2015 QHP Application Instructions contains a requirement that plans submit data on non-physicians included in their network. However, we do not see either in these instructions, nor in the draft Letter any sort of requirement that providers other than physicians should be included in a QHP’s provider network. As noted above, CNMs/CMs are major providers of maternity and newborn care, a required essential health benefit that all plans offering coverage through the FFM must provide.

Recommendation

We believe that failure to mention providers other than physicians in the draft Letter may be a simple oversight, but if not, we strongly recommend CMS establish requirements for inclusion in plan networks of CNMs/CMs, as well as other types of practitioners who are not physicians. Given the very large numbers of providers encompassed in these types and their pervasive presence in the health care system, we strongly recommend that both the final Letter and the application materials be revised to make clear that inclusion of these providers is an expectation and not an option. We believe that this is particularly true of CNMs/CMs who, as demonstrated by the statistics cited above are significant providers of a category of benefits that all plans operating in the marketplaces must provide.

2. Determination of an Appropriate Range of Provider Types Within Plan Networks

CMS cites to regulation requiring a sufficient number and types of providers in plan networks and indicates an intention to evaluate these criteria using a “reasonable access” standard. However, nowhere in this discussion is there any detail of about how the agency will determine if an appropriate range of provider types has been included in the plan’s network. How this determination will be made is a critical question that should be elucidated.

Because the draft Letter does not describe a mechanism for determining when an appropriate range of provider types has been included, we are concerned that plans may assert that inclusion of only physicians in their network would be sufficient to meet the need to cover maternity and newborn care, when in fact this is not the case.

The hallmark of midwifery practice is to focus on fostering normal physiologic birth, which emphasizes practices that support the occurrence of innate, hormonally driven processes.⁴ This practice differs significantly from that of physicians who are trained to use interventions to address complications as they arise. 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.⁵

The midwifery model of care is thus qualitatively and empirically different than the prevalent medicalized model. Midwifery fosters occurrence of normal birth, while physician care is more focused on addressing occurrence of complications. **For purposes of CMS' examination of plan network adequacy, the key fact to keep in mind is that physician-led maternity care and midwife-led maternity care, while complimentary, are not interchangeable. Inclusion of one type of maternity care within a plan's network does not equate to inclusion of the other.** The reality is that both types of maternity care are necessary and should be available through a plan's network.

We are particularly concerned about this point because of information we obtained through a survey of health insurers participating in federally facilitated and state marketplaces. In 2014, ACNM conducted a survey of such insurers, to inquire regarding the inclusion of CNMs/CMs in provider networks and coverage of their services.⁶ We have appended a copy of our survey report to these comments. Key findings include the following:

- 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.

⁴ "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/00000000272/Physiological%20Birth%20Consensus%20Statement-%20FINAL%20May%2018%202012%20FINAL.pdf>

⁵ 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.

Marian F. MacDorman and Gopal K. Singh, "Midwifery care, social and medical risk factors, and birth outcomes in the USA," *J Epidemiol Community Health*, 1998; 52: 310-317.

⁶ A copy of the final survey report is available at:

<http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/00000004394/EnsuringAccessToHighValueProviders.pdf>

- 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.
- 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.
- Eight percent of plans contracting with birth centers indicated they did not list them in their provider directory.

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 purely on the basis of the type of license they hold.

Federal and state regulators have a strong interest in ensuring that high-value, low cost providers are included in the networks of plans operating in their states. Further, under the provisions of Section 2706(a) of the Public Health Service Act they have a legal responsibility to ensure that plans do not discriminate against providers acting within the scope of their license.

Recommendation

ACNM strongly recommends that CMS put into place a mechanism for determining that plans have a sufficient range of all provider types, including CNMs/CMs. ACNM recommends the standard that should be used consist, at a minimum, of state scope of practice laws for the various professions. Specifically, if a state, through its scope of practice laws, has allowed a given provider type to render a particular category of health care services and covered benefits under a plan fall into such category, plans should be required to include a sufficient number of providers of that type to ensure access to their services.

For example, given that maternity and newborn care is a required essential health benefit, and under existing state scope of practice laws and regulations both physicians and CNMs/CMs are permitted to render maternity and newborn care, plans should be required to include a sufficient number of both physicians and CNMs/CMs in their provider networks, or make their services available out-of-network at a cost to the beneficiary that is equal to the in-network rate.

3. Specific Areas of Focus Which have Historically Raised Network Adequacy Concerns

CMS notes that in its review of network adequacy, the agency will focus on specific areas that have raised concern in the past, including:

- Hospital systems,
- Mental health providers,
- Oncology providers,
- Primary care providers, and
- Dental providers, if applicable

ACNM is concerned that CMS does not mention maternal and newborn care as an area of focus in this examination. According to the HCUP data from the Agency for Healthcare Research and Quality, in 2013 there were nearly 8.1 million hospital discharges for maternal and newborn care, a number which far outpaces that of any other major diagnostic category.⁷ Birth is therefore the most common reason for hospitalization and plans should be making adequate provision for its coverage. Given the results of our survey we are concerned that plans are not including an adequate number or range of maternal care providers in their networks.

Recommendation

CMS should include maternal and newborn care as an area of specific focus when reviewing plan networks.

ii. Provider Directory Links

Under Paragraph ii of Section 3 of the draft Letter, CMS reviews several proposals contained in the 2016 Payment Notice proposed rule for modifying requirements related to provider network directories. 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.

⁷ See: <http://hcupnet.ahrq.gov/HCUPnet.jsp>

Recommendation

We recommend CMS finalize its proposals with regard to plan networks directories. 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 have advocated strongly for inclusion of CNMs/CMs in plan networks. It is important to note that the studies of CNM/CM care that we have cited have demonstrated not only high quality outcomes associated with their care, but also low costs. **Thus, the inclusion of CNMs/CMs in plan networks will in fact ultimately benefit the plans, their enrollees and the federal government as a payer of premium and cost sharing subsidies because these providers render the very type of high value care most sought after by plans.**

We thank CMS for the opportunity to comment on this important document and look forward to the final Letter. Should you have any questions about the issues we have raised, please do not hesitate to contact me.

Sincerely,

/JSB/

Jesse S. Bushman, MA, MALA
Director
Advocacy and Government Affairs
American College of Nurse-Midwives
8403 Colesville Road, Suite 1550
Silver Spring, MD 20910
jbushman@acnm.org
240 485-1843