

**Coverage for Birth Center and Midwifery Services
Under Medicaid and the Health Insurance Marketplaces
A Discussion of Key Questions
Current as of October 5, 2013**

This paper seeks to provide answers, based on statute and regulation, to several specific questions regarding birth center and midwifery services under Medicaid and the soon to be operational health insurance marketplaces (both State and Federally Facilitated).¹

The particular questions are:

1. For individuals qualifying for Medicaid under the pre-2014 criteria, what are the requirements for coverage for birth center services under: a) Medicaid fee-for-service (FFS) and, b) Medicaid managed care organizations (MMCOs)?
2. For individuals qualifying for Medicaid under the expansion that takes place in 2014, what coverage for birth center services is available?
3. What coverage for birth center services is available to individuals who obtain insurance, either as individuals or through a small group, through the various health insurance market places (both state run and federally facilitated)?
4. What are the rules with regard to network adequacy and provider anti-discrimination for plans offered through the health insurance marketplaces?

1a. Birth Center Services under FFS Medicaid for the Non-Expansion Population

Section 1905(a)(28) of the Social Security Act (SSA), as added by Section 2301 of the Affordable Care Act (ACA), modified the law to define "medical assistance" available to Medicaid eligible individuals to include freestanding birth center services and other ambulatory services that are offered by a freestanding birth center that is licensed in the state. A specific definition of "freestanding birth center services" is provided in the statute. This requirement is effective with the passage of the legislation (March 23, 2010), although in cases where states would require a statutory change to include this in their Medicaid plan, provision is made to permit such change to take place at a later date.

Section 1902(a)(10)(A) of the SSA requires states to provide, among others, the services identified in 1905(a)(28) to various Medicaid eligible individuals, including pregnant women.

Within the regulatory part defining categories of "medical assistance" available under Medicaid (42 CFR 440 and subparts), there is not currently a reference to birth center services. States would have to rely on the statute to understand their obligation with regard to birth center services at this time. CMS did, however, issue an "Informational Bulletin" on March 25, 2011 that informed states of the requirements of 1905(a)(28) and indicated that "States will need to submit amendments to their Medicaid State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services in order to

¹ Note that the term "health insurance marketplace" is a term of current regulation and guidance. The statutory term is "exchange" and this term was also used in early regulation and guidance. References within this document to an "exchange" should be understood as a reference to a "health insurance marketplace."

comply with this provision." (see: <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CMCS-Info-Bulletin-March-2011-Final.pdf>).

So, very clearly, FFS Medicaid must cover birth center services, as defined under 1905(a)(28). The only caveat to this coverage requirement would be that in states that do not currently license or otherwise approve birth centers, the requirement to cover their services would not seem to apply since the language of Section 2301 of the ACA specifically provides for coverage of services provided by birth centers that are "licensed or otherwise approved by the state." According to the American Association of Birth Centers, the following states do not have any regulations with regard to birth centers: Idaho, North Dakota, Wisconsin, Michigan, Virginia, North Carolina, and Maine (see: <http://www.birthcenters.org/open-a-birth-center/birth-center-regulations> last accessed on October 5, 2013.)

1b. Birth Center Services Under Managed Care Medicaid for the Non-Expansion Population

Section 1932(a) allows states to require individuals receiving medical assistance under the state's plan to receive services from a managed care plan, if the managed care plan meets certain requirements, among which is a provision in 1903(m)(1)(A)(i), specifying that the managed care plan must make services it provides to its enrollees available to the same extent that such services are made available to Medicaid eligible individuals who are not enrolled in the plan.

The provisions of regulation implementing this statute are found at 42 CFR 438.210. The regulation specifies that to the extent the state contracts with an MCO to provide for certain services, the MCO must furnish those services "in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid."

Note that a managed care plan may not necessarily contract with a state to provide birth center services. In such a case, the service would be considered to have been "carved out" from the MCO's contract and would be covered under FFS Medicaid. It is not likely that a state would do that, though, as there is no economic incentive to take that route.

The conclusion is therefore quite clear that to the extent a managed care plan contracts with a state to cover birth center services, they should be the same as those available under FFS Medicaid.

2. Birth Center Services Under Medicaid Expansion

Section 1902(a)(10)(A)(i)(VIII) of the SSA, as added by the ACA, provides for Medicaid coverage, beginning January 1, 2014, for individuals under age 65, who are **not pregnant**, not entitled to or enrolled under Medicare, not eligible for Medicaid based on the pre-expansion qualification criteria, whose income does not exceed 138 percent of the federal poverty limit.

Note that the pre-expansion eligibility criteria for Medicaid coverage explicitly **include** pregnant women (see Section 1902(a)(viii)). Since the expansion population will not include pregnant women, the conclusion is that they would not be covered as such. This is an important distinction because the benefit package for the expansion population is defined in law differently from that of the pre-expansion population. Specifically, as required by Section 1902(k)(1), Medicaid coverage for the expansion population will consist of “benchmark” coverage described in Section 1937(b). Section 1937(b)(5) requires that as of January 1, 2014, “benchmark” coverage provide at least essential health benefits (EHB) as defined by the ACA. Effectively, the EHB sets a floor for Medicaid “benchmark” coverage. (See item 3 below for a more detailed explanation of the EHB).

A question arises as to what happens when a woman, who is not pregnant, who qualifies for EHB-based Medicaid coverage under the expansion criteria later becomes pregnant. Presumably, at that point, her eligibility would be based on the pre-expansion criteria and she would have the option of either EHB-based or pre-expansion Medicaid coverage. In fact, the statute, at 1937(a)(2)(B) prohibits a state from requiring certain populations of pregnant women from obtaining coverage through a benchmark plan.

In a recent final regulation, HHS stated that with regard to individuals who are subject to the exemption from requiring that they obtain coverage through an EHB-based plan, they should have the option of selecting either EHB-based or regular Medicaid coverage. (78 FR 42203). In a separate final regulation, CMS indicated in the preamble that States must inform women who become pregnant, after entering EHB-based Medicaid expansion coverage, about the availability of coverage under the pre-expansion benefit package and must allow them to choose that option. However, CMS does not expect states to shift women from expansion to pre-expansion coverage if they become pregnant. (77 FR 17149).

3. Birth Center Services under the Health Insurance Marketplaces

Under Section 1301 of the ACA, plans offered through the health insurance marketplaces must cover essential health benefits (EHB). In addition, under Section 2707 of the Public Health Services Act (PHSA) as amended by the ACA, as of January 1, 2014, insurance issuers offering coverage in the individual and small group markets outside of the health insurance marketplaces must ensure that their coverage includes the EHB. Hence, the EHB package will impact three separate populations, the Medicaid expansion population, those obtaining coverage through the health insurance marketplaces, and individual and small group plans outside of the health insurance marketplaces.

EHB is defined under Section 1302 of the ACA and includes 10 specific categories, one of which is “Maternity and newborn care.” The law is not more descriptive than this however it does require that the scope of EHB coverage be equal to the scope of “a typical employer plan, as determined by the Secretary.”

In the regulation implementing this section of the law, the Department of Health and Human Services (HHS) chose to let states select a benchmark plan, from among ten different options, that would, for that particular state, define the EHB (see 45 CFR 156.100). Note that if a state

does not choose to implement a health insurance marketplace, nor select a benchmark plan, the Federal government will do so on its behalf, selecting one particular option among the ten available. If the benchmark plan does not provide adequate coverage for all ten statutory categories of care, that insufficient category would be supplemented by including, in its entirety, coverage for that category offered by another one of the benchmark options (see 45 CFR 156.110). In the preamble discussion of this regulatory text, commenters specifically requested that HHS define the categories of benefits in more detail. However, consistent with its approach in this and many other regulations associated with implementation of the ACA, HHS chose to use an approach that provides flexibility to the states in defining the EHB. (see 78 FR 12843).

Also included in this regulation are provisions related to non-discrimination. Specifically, a benchmark plan may not include discriminatory benefit designs, i.e., designs that discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. In addition, an insurance issuer providing EHB may not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation. (see 45 CFR 156.125). These anti-discrimination standards do not specifically protect pregnant women, nor do they guarantee coverage of birth center or midwifery services, but if it is found that in a given state there is very limited coverage of birth center and/or midwifery services, this language could be used as the basis of a complaint to the state (or federal government, in the case of federally facilitated marketplaces).

Finally, although the EHB will be used to define benefits available under plans subject to the EHB requirements, plans are allowed to vary their benefit within each of the categories, so long as the variation results in benefits that are "substantially equal" and are actuarially equivalent. Determination of whether such variation meets the standards established under the regulation will be made by the states. (see 45 CFR 156.115). Thus, if an EHB benchmark plan does not cover out of hospital birth, any other plan based on that benchmark could conceivably meet the standard established by that benchmark by offering coverage that similarly excludes out of hospital birth. If it were going to include coverage for out of hospital birth, the plan would have to take the affirmative step of varying its benefit and having the state review and approve such variation. Further, under the provision allowing plans to substitute substantially equal benefits, a plan subject to the EHB requirement might argue that it does not have to offer coverage for out of hospital birth, even when the EHB benchmark includes such coverage. Whether or not such an argument would be accepted would be determined by the state (or the federal government in the case of federally facilitated marketplaces).

HHS has provided a list of EHB benchmark plans in each state, with details about the coverage offered under these plans (see: <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>) ACNM has reviewed this material to determine whether it offers specific detail on coverage for midwifery and out of hospital birth services. Unfortunately, these materials are not sufficiently detailed to determine, definitively, whether or not such services are covered. In general, it is probable that midwifery services will be covered, but it is not absolutely clear. What is more unclear is whether the services of birth centers or home births will be covered. Only one state's benchmark plan (Arizona) explicitly provides for coverage of birth centers. One state, Connecticut, explicitly excludes home birth. The other states' benchmark plans general describe their coverage of maternity services as "inpatient" services.

How they will apply that, in practice, is yet to be seen. Further, one must keep in mind that the variation from the benchmark allowed by CMS could result in a variety of coverage determinations among plans offered through the marketplaces, that could differ from the specifics of the benchmarks.

4. Network Adequacy and Benefit and Provider Non-Discrimination under Health Insurance Marketplaces

Network Adequacy

Under 45 CFR 155.1050, the health insurance marketplaces are responsible for ensuring that plans offered through the health insurance marketplaces maintain an adequate provider network. HHS further provided at 45 CFR 156.230 that these plans must ensure that their networks:

- are available to all enrollees,
- include essential community providers (which are a specified set of facilities, notably FQHCs and certain hospitals that serve a disproportionate share of low income Medicare and Medicaid beneficiaries), and
- maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay.

CMS received comment that the agency should require plans to cover specified types of providers, including “women’s health care providers,” but they declined to do so, stating that “mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services.” Notably, in this same discussion, the agency indicates that “nothing in the final rule would preclude an Exchange from identifying specific provider types that are particularly essential in a State.” 77 FR 18419.

CMS left monitoring of network adequacy up to the health insurance marketplaces and encouraged them to work with their state departments of insurance, to the extent that such departments already monitor insurance issuer network adequacy within the state. The agency stated that, “We anticipate that Exchanges will identify a variety of tools and strategies to monitor QHP compliance with all certification standards, including standards related to network adequacy. Accordingly, we are not prescribing specific oversight and enforcement strategies in this final rule.” 77 FR 18409

Consequently, there is no explicit statutory or regulatory requirement that health insurance marketplaces plans include either birth centers or midwives in their networks. Whether they do or not will depend on the network adequacy requirements and review imposed by the various states (or the federal government to the extent that states cede that function to them).

CMS has provided [sub-regulatory guidance](#) related network adequacy for federally facilitated and state partnership marketplaces. (Note that sixteen states and DC will operate their health insurance marketplaces independently, seven will share responsibilities with the federal government and the remainder will let the federal government take entire responsibility for operation of a health insurance marketplace within their jurisdiction).

In this guidance CMS states that in 2014, it will allow states to take responsibility for network adequacy determinations when such states have existing mechanisms for evaluating whether plan networks meet the regulatory standards established for health insurance marketplaces.

Where states do not have such mechanisms in place, CMS will rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited insurance issuers will be required to submit an access plan as part of their application.² Further, CMS will further monitor network adequacy, for example, via complaint tracking or gathering network data from any QHP issuer at any time to determine whether the QHP's network(s) continues to meet these certification standards.

Benefit Non-Discrimination

The regulation, at 45 CFR 156.225, states that plans may not “employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.” In the sub-regulatory guidance mentioned above, CMS indicated that:

To ensure non-discrimination in benefit design, CMS will identify outliers with regards to QHP [qualified health plan] cost sharing (e.g., co-payments and coinsurance) as part of its QHP certification reviews. Identification as an outlier does not necessarily indicate that a QHP benefit design is discriminatory; rather, CMS will use the outlier identification to target QHPs for more in-depth reviews.

The agency further indicated that this cost-sharing outlier analysis would focus on specific benefits, among them “pregnancy and newborn care.” Further, as part of its review, CMS will look at language in the plan's application related to “explanations” and “exclusions” to identify discriminatory practices or wording that may indicate a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices (e.g., language indicating that the coinsurance rate for a particular benefit is higher for enrollees with certain health issues).

Although this guidance indicates that CMS will focus on cost sharing, it is conceivable that this part of the review may also look at whether certain services (e.g., birth center services) are outright excluded, although whether the agency will be looking particularly at that service is not known from the content of their guidance at this point.

Provider Non-Discrimination

Section 2706 of the PHSA, as amended by the ACA, stipulates that issuers offering group or individual 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.” The section clarifies that plans are not required to contract with any willing provider, or to pay their contracted providers a uniform rate.

² The access plan in the application was developed based on the National Association of Insurance Commissioners' (NAIC) Managed Care Plan Network Adequacy Model Act. The Model Act is available at: <http://www.naic.org/>

The Department of Labor, in conjunction with HHS and the IRS issued an FAQ document indicating that this non-discrimination language in the law would not be put into regulation, as it is self-executing. However, they did make some statements regarding this provision, notably that “This provision does not require plans or issuers to accept all types of providers into a network.” (see: <http://www.dol.gov/ebsa/pdf/faq-aca15.pdf>) Conceivably, that could be read to allow plans to exclude coverage of birth centers and/or midwives. However, that FAQ would not provide a legal basis for such action and it is questionable as to whether the DOL indeed meant that plans could exclude every provider in a given class.

If you have questions about this document, please contact Jesse Bushman, ACNM’s Director of Advocacy and Government Affairs, at jbushman@acnm.org.