



June 24, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9942-NC
PO Box 8016
Baltimore, MD 21244-8016
Letter Submitted On-Line at www.regulations.gov

RE: CMS-2390-P - Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Mr. Slavitt:

On behalf of the American College of Nurse-Midwives (ACNM) I am pleased to submit these comments in response to the proposed rule titled “Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability,” published in the *Federal Register*, on June 1, 2015.¹ We hope that you find our comments helpful and look forward to your response in the final rule.

COMMENTS

a. Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards (§ 438.206, § 438.207, § 438.68, § 440.262)

In 438.68 and 438.206 CMS proposes important requirements related to provider network adequacy. We applaud the addition of more detailed requirements and support the agency in its efforts to ensure that Medicaid managed care plans have sufficient numbers and types of providers to serve the beneficiaries of this important program. ACNM is concerned, however, that the language of the proposal and the use of the Medicare Advantage and Qualified Health Plan structures as models may create expectations that do not reflect the intent of the Medicaid statute that the services of specific providers be included in the Medicaid package of benefits.

Background

Under the terms of Section 1903(m)(1)(A)(i) of the Social Security Act, a Medicaid managed care organization:

¹ 80 FR 31098

² CDC/NCHS, National Vital Statistics System. See: http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm

Makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, **to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization.** [emphasis added]

This statutory concept is also found in the existing regulation at 42 CFR 438.206, which reads:

(a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.

The benefit state plans are required to cover is defined under Section 1905(a) of the Social Security Act. Among those benefits are the services of CNMs and freestanding birth centers. The text at 1905(a)(17) and (28) defines these two benefit categories thus:

(17) services furnished by a nurse-midwife (as defined in section [1861\(gg\)](#)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

and

(28) freestanding birth center services (as defined in subsection [\(1\)\(3\)\(A\)](#)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection [\(1\)\(3\)\(B\)](#)) and that are otherwise included in the plan;

Note as well that Section 1902(a)(10) specifically requires that state plans must include coverage for medical assistance, including, among others, those services identified at 1905(a)(17) and (28).

The key point is that the benefit itself explicitly consists of the services of CNMs and freestanding birth centers. The statute does not say that the benefit consists of “maternity care services” that could potentially be provided by a range of different provider types. Nowhere is there contemplation in the statute that a state (or its contracted managed care organizations) may refuse to cover CNM or birth center services and instead substitute the services of some other provider(s) for the services of CNMs and/or birth centers.

In 2013, certified nurse-midwives (CNMs) and certified midwives (CMs) collectively attended 8.2 percent of all births in the US. However, the rate of CNM/CM attended births varies dramatically among states, for example, in eleven states, CNMs/CMs attended between 12 and 28 percent of all births. CNMs/CMs are therefore very significant providers of maternity care services.

Among births attended by CNMs/CMs, more than 42 percent were covered by Medicaid with

that figure ranging among states from 28 to 78 percent.² Medicaid is thus the most important payer with regard to CNM/CM maternity care services, a fact that holds true across all types of providers of maternity care.

Happily, the inclusion of CNMs/CMs as required Medicaid providers is a positive thing for payers, beneficiaries and providers as well. Extensive literature has demonstrated that CNMs/CMs tend to use fewer interventions than typical care, resulting in lower costs, while achieving similar or better outcomes.

A systematic review of U.S. studies comparing physician and CNM led care recently found 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.”³

A Cochrane review, conducted in 2013 concluded that women who had midwife-led continuity models of care were less likely to experience regional analgesia, episiotomy, and instrumental birth, and were more likely to experience no intrapartum analgesia/anaesthesia, and spontaneous vaginal birth. Further, the Cochrane review concluded that women who were randomized to receive midwife-led continuity models of care were less likely to experience preterm birth and fetal loss before 24 weeks’ gestation. The majority of studies included in their review reported a higher rate of maternal satisfaction in the midwifery-led continuity care model. Similarly there was a trend towards a cost-saving effect for midwife-led continuity care compared to other care models. The authors concluded that, “Most women should be offered midwife-led continuity models of care and women should be encouraged to ask for this option.”⁴

A study of Medicaid costs of midwifery care for low risk women in the state of Washington concluded that CNM led hospital based care cost the state 7 percent less than physician led care.⁵

Specific Recommendations

In the preamble discussion, CMS points to both the Medicare Advantage (MA) and Qualified Health Plan (QHP) network adequacy requirements as models to inform the provisions of its proposal. These programs require coverage of certain benefits that may be provided by a range of providers. For example, the Medicare program requires coverage of “medical and other health services” and QHPs are required to cover the essential health benefits package. Plans have some flexibility within these programs to use various provider types to render the required benefits. As outlined above, however, state Medicaid plans must include the services of CNMs and birth centers as must the managed care plans with which they contract to provide the Medicaid package of benefits. Flexibility is not provided to substitute the services of other provider types for those of CNMs and birth centers.

² CDC/NCHS, National Vital Statistics System. See: http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm

³ Meg Johantgen, PhD, RN, et. al., “Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008,” *Women's Health Issues* 22-1 (2012) e73–e81.

⁴ 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.

⁵ 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/CB05301C82F14099960F53DA8E48F36E.ashx>

ACNM does not believe that the preamble discussion or the text of the proposed regulation at 438.68 and 438.207 make it sufficiently clear that this is the case.

Given the nature of the statutory requirements of Title XIX, as well as the prevalence of CNM/CM attended births ACNM makes the following recommendations:

1. Revise 438.68(b)(1)(ii) to read:
“OB/GYNs and CNMs”
2. Revise 438.68(c)(1)(iv) to require that state network adequacy standards explicitly require plans to include in their networks providers whose services are statutorily mandated under Section 1902(a)(10), including CNMs and birth centers.
3. Revise 438.207(b)(a) to read:
“(1) Offers an appropriate range of preventive, primary care, specialty services, ~~and~~ LTSS, and the services of providers identified under Section 1902(a)(10), that is adequate for the anticipated number of enrollees for the service area.”

ADDITIONAL COMMENTS

ACNM recognizes that the proposed regulation does not treat the topic of birth centers and that consequently we cannot expect to see such regulation in the final rule. However, we believe that this important topic should be taken up by the agency.

Birth centers have a demonstrated track record of providing high quality, low cost care, exactly the type of care that CMS is vigorously seeking to support under a variety of programs. For example:

- A 2013 study looking at 15,574 planned birth center births found a cesarean rate of 6%, as compared to an expected 25% for similarly low-risk women in a hospital setting. This same study estimated that cost savings (based on Medicare payment rates) would amount to more than \$30 million.⁶
- A study by the state of Washington’s Department of Social and Health Services examining the cost to Medicaid of birth in various settings found that the cost of birth center birth among low risk women was 38% less than hospital birth for women of similar risk. These savings are partially due to the fact that the state’s facility fee to the birth centers was approximately \$600, an amount that is not sufficient to cover costs. When increased to a more reasonable amount, \$2,000, the total costs of birth center birth were still 13% lower than hospital birth, a very significant savings.⁷

⁶ 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*, vol. 58, no. 1, January 2013.

⁷ Laurie Cawthon, MD, MPH, “Assessing Costs of Birth in Varied Settings,” Washington State Department of Social and Health Services, March 7, 2013. Available at: <http://www.iom.edu/~media/Files/Activity%20Files/Women/BirthSettings/6-MAR-2013/Cawthon%20PDF.pdf>

- A study by the Urban Institute, published in CMS' own *Medicare & Medicaid Research Review* found that a birth center in Washington D.C. saved the Medicaid program an average of \$1,163 per birth in 2008 dollars.⁸

Although birth centers collectively attend a very small proportion of births (totaling 16,913 in 2013) the opportunity to access savings generated by these high value providers is substantial.^{9, 8}

As states take steps to increase the proportion of birth center births, they will realize reductions in their expenditures on maternity care. The studies mentioned above also demonstrate that high quality outcomes can be expected. It is therefore strongly in the interest of CMS to create a regulatory structure that facilitates the provision of this important Medicaid benefit.

Policy Considerations

Section 1905(a)(28) of the SSA, as amended by Section 2301 of the ACA added freestanding birth center (“FSBC”) services, and the professional services of birth attendants in birth centers, as a new category of “medical assistance.” The new section also included FSBC services as one of the services mandated by section 1902(a)(10)(A) for Medicaid-enrolled pregnant women.

To date, CMS has not promulgated regulations implementing Section 1905(a)(28). The lack of such regulations has resulted in incomplete, inconsistent and inappropriate implementation of this important new benefit. This situation prevents both fee-for-service (FFS) programs and Medicaid MCOs (MMCOs) from taking full advantage of the savings inherent in the birth center model of care. Given the prevalence of maternity care within Medicaid, failure to adequately implement this benefit is a shortcoming that merits immediate attention.

Why Regulation is Needed

The ACA was passed more than five years ago. Section 1905(a)(28) applies in situations where a state licenses or otherwise approves birth centers. There are currently 42 states that meet those criteria. According to the Medicaid.gov website, only 25 of these states have submitted state plan amendments to bring them into compliance with the requirements of Section 1905(a)(28). This prevents women who so desire from accessing the benefits to which they are legally entitled. Furthermore it increases costs to the states and the Federal government because it necessarily forces these women to choose an option that has been clearly demonstrated to cost more and to be associated with higher rates of interventions, all of which carry risks.

We believe it is critical that CMS act expeditiously to require compliance with this provision of law. To impose such a requirement, states need the guidance available through a final

⁸ Embry Howell, Ashley Palmer, Sarah Benatar, and Bowen Garrett, “Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center,” *Medicare & Medicaid Research Review*, vol. 4, no. 3, 2014. Available at: http://cms.gov/mmrr/Downloads/MMRR2014_004_03_a06.pdf

⁹ Marian F. MacDorman, Ph.D.; T.J. Mathews, M.S.; and Eugene Declercq, Ph.D., “Trends in Out-of-Hospital Births in the United States, 1990–2012,” NCHS Data Brief, No. 144, March 2014. Available at: <http://www.cdc.gov/nchs/data/databriefs/db144.pdf>

⁸ Martin JA, Hamilton BE, Osterman M, Curtin SC, Matthews T. Births: final data for 2013. *National vital statistics reports: from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System* 2015;64(1):1.

regulation.

Section 1905(a)(28) contains new terms of art that are not presently defined in regulation. Specifically, “freestanding birth center” and “freestanding birth center services,” and “birth attendant.” Furthermore the statute provides for “separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center,” without elucidating how those payments will be determined and what they are separate from.

Because there has not been a thorough, public discussion of these terms, nor a final regulation to provide clarity, there is no common, consistently applied implementation of this new benefit. Some states that license birth centers still do not reimburse their facility services separately from the professional services of midwives working in the birth centers. Birth centers in Georgia and Colorado report that they are not reimbursed separate professional and facility services payment in these states. Both these states have approved State Plan Amendments. We believe the language of the statute is clear in requiring separate payment to the free standing birth center and the providers working therein. Thus, the failure of Georgia and Colorado to provide a facility service payment fails to comply with the requirements of the statute.

The American Association of Birth Centers (AABC) informs us they have received reports that many MMCOs refuse to contract with birth centers and include them in provider networks. A survey of health plans conducted by ACNM in 2014 found that 47 percent of plans refused to contract with birth centers.¹⁰ Although this survey targeted plans participating in the health insurance marketplace, ACNM is concerned that these same practices may be occurring in the organization’s Medicaid line of business. AABC has received reports that medicaid MCOs in California, Oregon and Missouri state that they already cover maternity care in a hospital or with OB/GYNs so that it is not necessary for them to cover birth centers.

Women who are Medicaid and CHIP beneficiaries have the statutory right to access birth center care if desired. As noted above, Section 1903(m)(1)(A)(i) of the SSA requires states to ensure that MMCOs provide all services covered under their State plans. Neither a state nor a MMCO can argue that because they cover physician and hospital services associated with birth they have met the requirement to cover CNM, birth center or birth attendant services. The statute contains no provision that allows for the substitution of one benefit category for another.

AHRQ data, as well as recent studies indicate that Medicaid covers nearly half of all births in the country.¹¹ MACPAC data indicate that 48% of adults covered by Medicaid are covered under a comprehensive managed care plan.¹² When those two figures are taken together, it is reasonable to conclude that 20-25% of all births in this country are covered by a MMCO. Their behavior thus has a significant impact on the overall quality and cost of perinatal care in this country.

¹⁰ The full survey report is available at:

<http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000004394/EnsuringAccessToHighValueProviders.pdf>

¹¹ See: <http://hcupnet.ahrq.gov/>. See also: Markus, et. al., “Medicaid Covered Births, 2008 to 2010, in the Context of the Implementation of Health Reform,” *Women’s Health Issues*, vol. 23, issue 5, e273-e280. Available at: <http://www.whijournal.com/article/PIIS1049386713000558/fulltext#tbl1>

¹² Medicaid and CHIP Access and Payment Commission, MACSTATS, June 2014, available at: <http://www.macpac.gov/macstats>

The state Medicaid FFS and MMCO programs need to have clear regulations defining the new birth center and birth attendant services, as well as the parameters for paying for this required benefit. We strongly recommend that CMS take action to promulgate regulations to implement this new benefit and to provide states and MMCOs with the guidance they need to ensure that they provide this important benefit.

CONCLUSION

We thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding our comments, please reach out to me directly.

Sincerely,

/JSB/

Jesse S. Bushman, MA, MALA
Director, Advocacy and Government Affairs
240 485-1843
jbushman@acnm.org