

American Association of Birth Centers

America's Birth Center Resource



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July 27, 2015

Hon. Sylvia Burwell, Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201

Re: File Code: CMS–2390–P

Dear Secretary Burwell,

The American Association of Birth Centers (AABC), the national trade organization for freestanding birth centers, submits these comments on the proposed rule issued in the National Federal Register June 1, 2015 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.***

Background

AABC is a national membership association composed not only of birth centers, but also of individuals and organizations, including physicians, midwives, consumers, owners and several educational institutions, which support the birth center concept. AABC is the only national trade organization for freestanding birth centers (FSBCs). The birth center is a home-like facility, existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers are guided by principles of prevention, cultural sensitivity, safety, appropriate interventions only, and cost effectiveness. Birth centers provide family-centered and client-centered care for healthy women before, during, and after pregnancy, labor, and birth. Membership in AABC includes birth centers that are staffed by certified nurse-midwives (CNMs), certified midwives (CMs), certified professional midwives (CPMs) and other licensed midwives. Currently there are 300 birth centers in the U.S. and the number is growing rapidly.

Like other trade organizations, AABC sets the Standards for FSBCs and their operation. As the nation's most comprehensive resource on freestanding birth centers, AABC works on multiple levels to provide a national forum for birth center issues, to conduct ongoing research on normal birth and care in birth centers, to promote and maintain the

nationally recognized *Standards for Birth Centers*, and to develop and promote quality assurance systems for birth centers.

Network Adequacy, Medicaid Statute and Covered Providers

AABC collected survey data recently on how birth centers are contracted with Medicaid and Medicaid Managed Care Organizations (MMCOS). These data show that birth centers in a number of states experience barriers to participating in MMCOS. States where women who are Medicaid beneficiaries experience difficulty accessing care in birth centers include California, Georgia, Florida, New York, Colorado and Oregon.

The CMS proposed rule points to network adequacy requirements under the Medicare Advantage (MA) program, as well as those for Qualified Health Plans (QHPs) offered through the health insurance marketplace. Using these programs as models, however, is problematic from AABC's perspective. These programs define their benefits as certain types of services, which may be delivered by a range of provider types. **Federal Medicaid statute differs in that it mandates coverage of the services of specified provider types, notably birth centers and certified nurse-midwives.**

Medicaid statute requires in Section 1905 that pregnant enrollees are entitled to certain "pregnancy-related services."¹ Under federal law, states must cover all pregnancy-related services that fall within the law's 29 covered services. Birth centers and nurse-midwives are specified as covered services.² Thus, if CMS allows MMCOS to refuse to contract with birth centers, the Medicaid statute is not being followed. **AABC requests modifications to the proposed rule to make it clear that plans must cover the services of both birth centers and the licensed birth attendants who practice there and may not substitute in their stead the services of other provider types.**

Birth centers have a demonstrated track record of providing high-quality, low-cost care that meets the Triple Aim, 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.³
- 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.⁴

¹ United States Government. Social Security Act. 42 USC § 1396d(l)(3)(B); 2010.

² Markus and Rosenbaum, "The role of Medicaid in promoting access to high-quality, high-value maternity care.," *Women's Health Issues*, vol. 20, S67-S78. Available at: hsr.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1318&context=sphhs_policy_facpubs

³ 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. Available at <http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12003/full>

⁴ 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.⁵

Although birth centers collectively attend a small proportion of births (totaling 16,913 in 2013) the opportunity for states to access savings generated by these high value providers is substantial.^{6,7} 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.

Providing hospital maternity care services provided by physicians does not meet the mandated covered services of freestanding birth centers and their licensed birth attendants, and nurse-midwives.

According to AHRQ's HCUP data, in 2012, Medicaid covered 44.75% of the births occurring in this country (approximately 1.8 million). Previous studies have estimated the proportion of births covered by Medicaid in other years to be somewhat higher.⁸ Using cost data from a recent study by Truven Health Analytics, we estimate that in 2012 Medicaid spent approximately \$19 billion on maternity and newborn care through the first three month of life.⁹ According to AHRQ, hospital discharges for pregnancy and newborn care far outnumber those for any other major diagnostic category. Together, they accounted for more than 8 million discharges in 2012.¹⁰ In a recent presentation to AABC, Dr. Stephen Cha, Chief Medical Officer of the Center for Medicaid and CHIP Services noted that perinatal care accounts for most of the top ten reasons for hospital discharge among Medicaid beneficiaries. Clearly, perinatal care is a very significant component of the Medicaid benefit.

Other Policy Considerations

In 2010, Section 1905(a)(28) of the SSA, as amended by Section 2301 of the ACA, added FSBC services and the professional services of birth attendants in birth centers, as a new category of "medical assistance."¹¹ The section also included FSBC services as one of the services mandated by section 1902(a)(10)(A) for Medicaid-enrolled pregnant women.¹²

Section 1903(m)(1)(A)(i) of the SSA specifies that a Medicaid managed care plan:

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**

⁵ 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

⁶ 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>

⁷ 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.

⁸ Markus and Rosenbaum, "The role of Medicaid in promoting access to high-quality, high-value maternity care.," *Women's Health Issues*, vol. 20, S67-S78. Available at: hsr.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1318&context=sphhs_policy_facpubs

⁹ "The Cost of Having a Baby in the United States," *Truven Health Analytics*, January 2013. Available at: <http://transform.childbirthconnection.org/reports/cost/>

¹⁰ See: <http://hcupnet.ahrq.gov/HCUPnet.jsp>

¹¹ United States Government. Social Security Act. 42 USC § 1396a(a)(10)(A)

¹² United States Government. Social Security Act. 42 USC § 1396a - State plans for medical assistance

individuals (eligible for medical assistance under the State plan) not enrolled with the organization.
[emphasis added]

This statutory requirement was implemented through 42 CFR 438.206(a). Further, through 42 CFR 438.207(b) CMS has required that states ensure their MMCOs have networks adequate to provide the benefit.¹³

To date, CMS has not promulgated regulations implementing Section 1905(a)(28) regarding FSBCs. 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 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 over five years ago. Section 1905(a)(28) applies in situations where a state licenses or otherwise approves birth centers.¹⁴ There are currently 42 states that meet those criteria. Birth centers in several states, including Georgia, California, Missouri, Oregon and South Carolina have notified us that MMCOs refuse to contract with them, or reimburse them incorrectly. This prevents women who so desire birth center care 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 that it is critical that CMS act expeditiously to require compliance with this provision of law. To impose such a requirement, states need the direction available through guidance or regulation.

Section 1905(a)(28) contains new terms that are not presently defined in regulation.¹⁴ Specifically, “freestanding birth center,” “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. AABC members in Georgia and Colorado report that they are not reimbursed a separate professional and facility services payment in these states. Both these states have approved State Plan Amendments. We believe that the language of the statute is clear in requiring separate payment to the freestanding 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.

We have received reports from our members that many MMCOs refuse to contract with birth centers and include them in provider networks. MMCOs in California, Oregon and Missouri state that they already cover maternity care in a hospital or with OB/GYNs so it is not necessary for them to cover birth centers. Women who are Medicaid and CHIP beneficiaries have the right to access birth center care if desired.

¹³ Markus and Rosenbaum, “The role of Medicaid in promoting access to high-quality, high-value maternity care.,” *Women’s Health Issues*, vol. 20, S67-S78. Available at: hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1318&context=sphhs_policy_facpubs

¹⁴ United States Government. Social Security Act. 42 USC § 1396(l)(3) (A), (B), & (C)

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.¹⁵ Neither a state nor an 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.¹⁶ MACPAC data indicate that 48% of adults covered by Medicaid are covered under a comprehensive managed care plan.¹⁷ When those two figures are taken together, it is reasonable to conclude that 20-25% of all births in this country are covered by an MMCO. Thus, their behavior has a significant impact on the overall quality and cost of perinatal care in this country.

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 believe that the present effort by CMS to revisit its regulations with regard to MMCOs is an ideal time to both implement this new benefit and to provide MMCOs with the guidance they need to ensure that they provide this benefit in a manner that is consistent with the FFS program.

Birth centers and birth attendants are mandated covered providers in Medicaid statute. Services provided in birth centers are not the same as hospital maternity care. For MMCOs to provide access to obstetric care in a hospital does not meet the mandate for access to freestanding birth centers (FSBCs) and their birth attendants.

Conclusion

Under federal law, states' Medicaid programs must include all pregnancy-related services that are mandated as covered services including birth centers and nurse-midwives.^{15,18} Thus, if CMS allows MMCOs to refuse to contract with birth centers, the Medicaid statute is not being followed. AABC requests modifications to the proposed rule to make it clear that plans must cover the services of both birth centers and the licensed birth attendants who practice there and may not substitute in their stead the services of other provider types. Following federal mandates for covered services for pregnant women will benefit Medicaid beneficiaries and States with high value, high quality maternity care provided by freestanding birth centers.

Please contact Kate Bauer, AABC Executive Director with questions about these comments at 215.234.8068 or katebauer@birthcenters.org.

Sincerely,



Lesley Rathbun, MSN, CNM, FNP
President, American Association of Birth Centers

¹⁵ United States Government. Social Security Act. 42 USC § 1396(l)(3) (A), (B), & (C)

¹⁶ See: <http://hcupnet.ahrq.gov/>.

¹⁷ Medicaid and CHIP Access and Payment Commission, MACSTATS, June 2014, available at: <http://www.macpac.gov/macstats>

¹⁸ Markus and Rosenbaum, "The role of Medicaid in promoting access to high-quality, high-value maternity care.," *Women's Health Issues*, vol. 20, S67-S78. Available at: hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1318&context=sphhs_policy_facpubs