
From: Karen Winstead <kawinstead@me.com>
Sent: Monday, July 10, 2017 4:46 PM
To: PTAC (OS/ASPE)
Subject: Public Comment on Bundled Payment for Birth Centers

Follow Up Flag: Follow up
Flag Status: Completed

I have been trying for years to get Medicaid and private insurance to do this or to provide their clients with a health savings account that allows the clients to spend their health care dollars on whatever type of maternity and newborn care they prefer. Our self-pay clients pay for a global package.

My fear is that this only applies to those birth centers "integrated with hospital systems". It might actually place those birth centers in regions like ours, where hospitals are unwilling or unable to allow nurse-midwives to practice, at a financial disadvantage. Hospitals and/or physicians that own birth centers would be able to get this special pricing while those owned by midwives in areas where physicians and hospitals are not willing to make any kind of formal agreement for care would not.

Our birth center does work with physicians and transfers to hospital care as needed but it depends on where the client is located and what the medical need is as to where we end up referring clients. We accompany clients to the hospital if it is an intrapartum transfer and have guidelines for transfer to the hospital. Our midwife or assistant stays with the client through delivery and assists with breastfeeding as needed. Even though we are with clients for the delivery, insurance, nor Medicaid will pay us because we don't actually "catch" the baby. Indeed, we have recently stopped taking Medicaid clients because it costs us more time and money than ever to do the billing and try to get paid by the MCOs/Virginia Medicaid. It's a losing proposition for us to work with government insurance including Tricare and Medicaid.

None of our local hospitals will allow their physicians or medical resident programs to be our "formal" consultants. But by current federal law they must accept our transfers in labor. All of our transfers have been smooth and without incident. Because we have no formal relationships with the physicians/hospitals, our midwives cannot apply for hospital privileges to be able to provide care for those clients choosing an epidural or needing some pitocin or for those who are higher risk like history of postpartum hemorrhage or c-section. They see the birth center as competition and/or a malpractice law suit waiting to happen and therefore want no formal link.

Until the laws change to grant Certified Nurse Midwives/Certified Midwives and Certified Professional Midwives the ability to practice independently and to have hospital privileges without being owned by the hospital or physician/group of physicians or have a formal consultative agreement, I expect midwives will still have the restraint of trade we currently face by our own state and federal statutes and regulations. This is part of "freeing the health care market" to do away with laws and regulations that cause restraint of trade and allow people to choose the health care they want and need. I vote for some sort of health savings accounts for all pregnant women that allow them to spend their health care dollars where they want with whatever provider they want. This would take it off the back of insurance companies and the government and cut down on administrative costs and insurance premiums.

My 2 cents.

Karen

Karen Winstead RN, CNM, MSN

President

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From: Andrea Eddy Koczela <aelaine23@gmail.com>
Sent: Wednesday, July 12, 2017 10:00 AM
To: PTAC (OS/ASPE)
Subject: Public Comment - PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE

Follow Up Flag: Follow up
Flag Status: Completed

Dear PTAC,

Please give this proposal your full attention. I think it is an admirable concept and one with the potential to transform the quality of labor & delivery in our country, as well as the ballooning costs of the industry. I strongly advocate its approval.

Best regards,

Andrea Koczela

From: Willow Midwives <cheryl@willowmidwives.com>
Sent: Friday, July 14, 2017 5:20 PM
To: PTAC (OS/ASPE)
Subject: Bundled Payment feedback

Regarding this proposal:

<https://aspe.hhs.gov/system/files/pdf/255906/BundledPaymentMNBirthingCenter.pdf>

As the midwife/owner of a freestanding birth center in MN I would like to share some concerns:

1. Birth Centers as presented are freestanding birth centers separate from hospitals which utilize a midwifery model of care. Physicians own birth centers on rare occasion as in the case of the author of the proposal. I believe that physician ownership changes the ideology of the birth center=midwifery model of care but does not enhance the model. Research clearly demonstrates that *independent midwifery practices* are at least as safe, are less expensive and provide better outcomes for vaginal birth, breast feeding, and patient satisfaction.
2. My birth center operates on a tight budget but we are able to operate with a positive cash flow under careful management. We currently DON'T get paid when a birth ends in a cesarean, but the physician who provides the surgery gets the payment. We manage our practice with that in mind knowing we will lose some revenue (regardless of hours of care we invested). None of us likes that fact and it makes little sense to us that our care is not valued/not paid. But the concept of having to PAY a hospital/provider for accepting our transfers of care would negatively affect our cash flow.
3. Risk criteria is not always objective though physicians and institutions try to make it seem so. One of the tenets of birth center care is relationship-building and knowing the "whole person". Sometimes this converts an otherwise high risk client into a lower risk one and sometimes it allows us to detect risk that physician model misses. I object to a universal risk criteria.
4. Many states use three different types of *licensed* midwives for birth center care. CNM's are the only acknowledged providers in this proposal. Excluding CM's and CPM's severely weakens the birth center model of care. This proposal excludes some birth centers from participation at the outset.
5. Integration within the hospital system as a component of the proposal is nebulous. We are independent, but consider ourselves well integrated into the system by our consultation and collaboration arrangements. The proposal fails to specify what "integrated" means and who defines integrated. Certainly, birth center care providers ought to be the ones who do, not less involved parties.
6. The proposal argues that birth centers have financial challenges. I disagree and believe that with prudent business practices birth centers are an excellent business opportunity for those with the expertise necessary to operate them. The barriers to birth center growth are the political environments in which they operate. Birth center opposition is strong from hospitals and providers who feel that birth centers compete with them for clients (often this argument comes under the guise of 'safety' but the data doesn't bear out their fears).
7. Birth centers are already demonstrating best practices and a care model that works. This proposal risks undermining the good work that we have begun.

Cheryl Heitkamp, CNM/Owner

See our REAL birth center!

"Like" Willow Midwives on Facebook!

We are writing in support of **A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services**, a proposal submitted to CMS by the Minnesota Birth Center.

This BirthBundle® proposal seeks to improve the quality and lower the cost of maternity care by providing low-risk pregnant women and their families greater access to the midwifery model of care in a birth center setting—a model that has been delivering better maternal and newborn outcomes at significantly lower cost than routine obstetric care here in Washington State for decades, according to two landmark reports. The first was a cost-benefit analysis released by the Washington State Department of Health in 2007 and the second was a critical examination of birth facility fees released by the Washington State Health Care Authority in 2017.

An independently conducted cost-benefit analysis released by the Washington State Department of Health (DOH) in October 2007 http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf indicated that licensed midwifery care results in cost savings to Medicaid of nearly half a million dollars biennially, and when private insurance companies are included in the analysis the savings to the healthcare system in Washington are over \$2.7 million. The DOH arrived at these numbers by analyzing Washington State Medicaid claims data from 2001-2004. Using the most conservative assumptions regarding c-section rates, the DOH determined that only 11.9% of women who had licensed midwives as their primary maternity care providers had cesarean sections compared with 23.9% of women on Medicaid who did not receive prenatal care from a licensed midwife (p.10). The report concluded that these differences result not only in substantial savings to the health care system but in lower medical risk

and costs to families (p.2).

The cost savings estimates determined by the DOH analysis are based solely on the costs of avoided c-sections and the report indicates that **these numbers may well underestimate the actual savings** since they do not take into account all the costs avoided by the significantly lower rates of medical intervention in planned home births and birth center births compared with hospital births (p.12). **When facility fees and costly procedures such as epidurals and continuous electronic fetal monitoring are factored into the equation, the actual savings conferred to the healthcare system by licensed midwifery care are substantially higher than the \$473,000 biennial figure in the report. Although additional research needs to be done to accurately calculate how much money licensed midwifery care saves the State of Washington, it is safe to say “millions of dollars a year.”**

The report cites “credible and recent studies that provided sufficient evidence to enable [them] to draw the conclusion that planned out-of-hospital births attended by licensed professional midwives (...) had similar rates of intrapartum and neonatal mortality to those of low-risk hospital births, and that medical intervention rates for planned out-of-hospital births were lower than for planned low-risk hospital births” (p.1). The report also noted, but did not quantify, many prospective costs that are avoided, due to the intensive level of prenatal and postpartum care provided by licensed midwives. These include higher breastfeeding rates and fewer low birth-weight babies, both of which are associated with better long-term health outcomes.

The DOH report further found that prenatal care provided by licensed midwives typically costs less than the care provided by other types of maternity care providers. Additionally, newborn costs for an out-of-hospital birth are generally lower (p.9). Of particular note was the finding that women who received prenatal care from licensed midwives were less likely to have a newborn with low birth-weight (less than

1800 grams) (p.4). This finding is significant since low birth-weight is associated with numerous subsequent health problems and possible unaccounted-for costs in the long term (p.9).

Women planning births with licensed midwives in Washington State receive comprehensive prenatal care and plan to deliver at home or in free-standing birth centers where they receive one-on-one labor support from professional midwives trained to provide intrapartum and postpartum care to low-risk women and newborns (pp. 1-2, 10). The DOH report found that over 87% of the time, transfer to a hospital is not required for these mothers or their newborns (p. 3). The majority of transfers from a planned birth center or home birth to a hospital are non-emergent, with maternal exhaustion being one of the most common indications. Overall, these women and babies receive lower rates of costly medical interventions—less electronic fetal monitoring, fewer episiotomies, lower rates of vacuum extraction and c-section (p.10)—with neonatal outcomes comparable to those of low-risk hospital births. In particular, the data analyzed in the DOH report indicates that the risk of cesarean section is half as low for women who received their primary care from licensed midwives (adjusted relative risk 0.49, confidence interval=0.45 – 0.53; p= 0.00) (p.4).

The 2007 DOH report was commissioned by the Washington State legislature to determine whether the economic benefits of licensed midwifery exceed the state's expenditures necessary to regulate the profession. The results were definitive. The report's literature review found "evidence of the safety of planned, low-risk, out-of-hospital births involving licensed midwives" (p.6) and the economic cost analysis, which focused "on differences in cost per delivery on birth setting" (p.6) clearly demonstrated that licensed midwifery care is cost-effective.

Ten years later, Washington State is still benefiting from the care that licensed midwives and freestanding birth centers provide. There are now over 170 licensed midwives in the state and 17 freestanding birth centers, all but one owned and operated by licensed midwives. Demand for this alternative model of maternity care is growing steadily. In order to scale up this high-value model of care, the Washington State Health Care Authority, in a report released to the legislature in October 2016, <https://www.hca.wa.gov/assets/program/2eshb-2376-birth-centers.pdf> recommended tripling the Medicaid reimbursement rate for the birth center facility fee from \$584 to \$1,742. This rate increase went into effect on July 1, 2017. Not only will it significantly contribute to the sustainability of the existing birth centers, but we anticipate it will enable licensed midwives in the more rural and underserved areas to open birth centers—areas where Medicaid covers up to 80% of the births and where access to this model of care has been very limited.

Why, in our letter of support for this BirthBundle® proposal, are we focusing so intently on midwifery care and birth centers in Washington State? For a couple of reasons: First, we believe that the innovative payment model put forth in this proposal represents an opportunity to demonstrate the kind of exemplary outcomes and cost savings that could be achieved **across the United States**, particularly in places, like Washington, where licensed midwifery care and birth centers are more integrated into the maternity care system. Second, although the Minnesota Birth Center model described in the proposal is owned by an obstetrician and staffed solely by certified nurse-midwives, it is important to note that the vast majority of the freestanding birth centers in the country are actually owned and operated by midwives: ~~by~~ certified nurse-midwives, certified professional midwives, and/or licensed midwives. According to the landmark National Birth Center Study II, the outcomes for mothers and babies in these settings are all comparable to the outcomes achieved in the Minnesota Birth Center. <http://www.birthcenters.org/?page=NBCSII>.

Should the Center for Medicare and Medicaid Services choose to fund the BirthBundle® proposal—and we enthusiastically support the agency doing so—we strongly urge that future efforts to scale up this project include birth centers that are owned and managed by **all ~~any~~ midwives who are contracted with Medicaid.**

Thank you for taking the time to consider our comments.

Sincerely,

Audrey Levine, Legislative and Health Policy Chair
Midwives' Association of Washington State (MAWS)

Neva Gerke, President, Midwives' Association of Washington State
(MAWS)

Comment [JAM1]: I'm stumbling over this one. Couldn't we just say midwives rather than "any midwives." Somehow it seems to diminish rather than strengthen the punch of the last sentence and, although I think it's meant to refer to the three categories of regulated midwives it doesn't clearly say that and sound more like "just anybody" kind of midwives. Maybe I'm wrong but that's how it's hitting me.

Assessing Costs of Births in Varied Settings

Laurie Cawthon, MD, MPH
Washington State
Department of Social and Health Services

March 7, 2013



Births in Washington State

- ▶ **How many?** 86,956 in 2011
- ▶ **Where?** 3.1% at home or in free-standing birth centers
- ▶ **From 2004 to 2011:** number of home births increased nearly two-fold; proportion increased from 1.1% to 1.9% of total births
- ▶ **From 2000 to 2011:** number of births in birth centers also increased nearly two-fold; proportion increased from 0.7% to 1.2%
- ▶ Medicaid covers 50% of total Washington births.
- ▶ Washington is one of approximately 11 states with Medicaid reimbursement for direct-entry midwives



Out of Hospital Births in Washington State

Background

1981	Midwifery licensing law revised (education & practice standards)
1986	Birth center licensing law enacted
1987	WA Medicaid reimburses for birth center births
1989	Maternity Care Access Act (First Steps) implemented
1990	First Steps Database created for program monitoring & evaluation
1995	Every Category of Provider Law enacted (re. health plan contracts)
1996	Planned Home Births (HB) report published
1997	Home Birth Task Force report published
2001	HB Pilot Project allowed Medicaid reimbursement
2006	HMA publishes Midwifery Economic Costs and Benefits study



Required Data Elements

Birth Certificate	Birth Certificate	Medicaid Claims
Attendant At Birth	Birth Place Type	Maternal & Infant Claims
Certifier Name & Title	Hospital	ICD-9 codes
MD/DO	Freestanding Birth Ctr.	CPT codes
Hospital Administrator	Home Birth	Providers' NPI
CNM/CM	Clinic/Doctor's Office	Expenditures
Other Midwife	Other (specify)	
Other (specify)		

- Medicaid claims (fee for service) and vital records are linked at the individual level for Medicaid mothers and their infants.
- Vital Records also provide: maternal risk factors, birth weight, method of delivery, fetal and infant deaths.
- Birth Attendants' licensure/specialty was verified and typical delivery location determined.

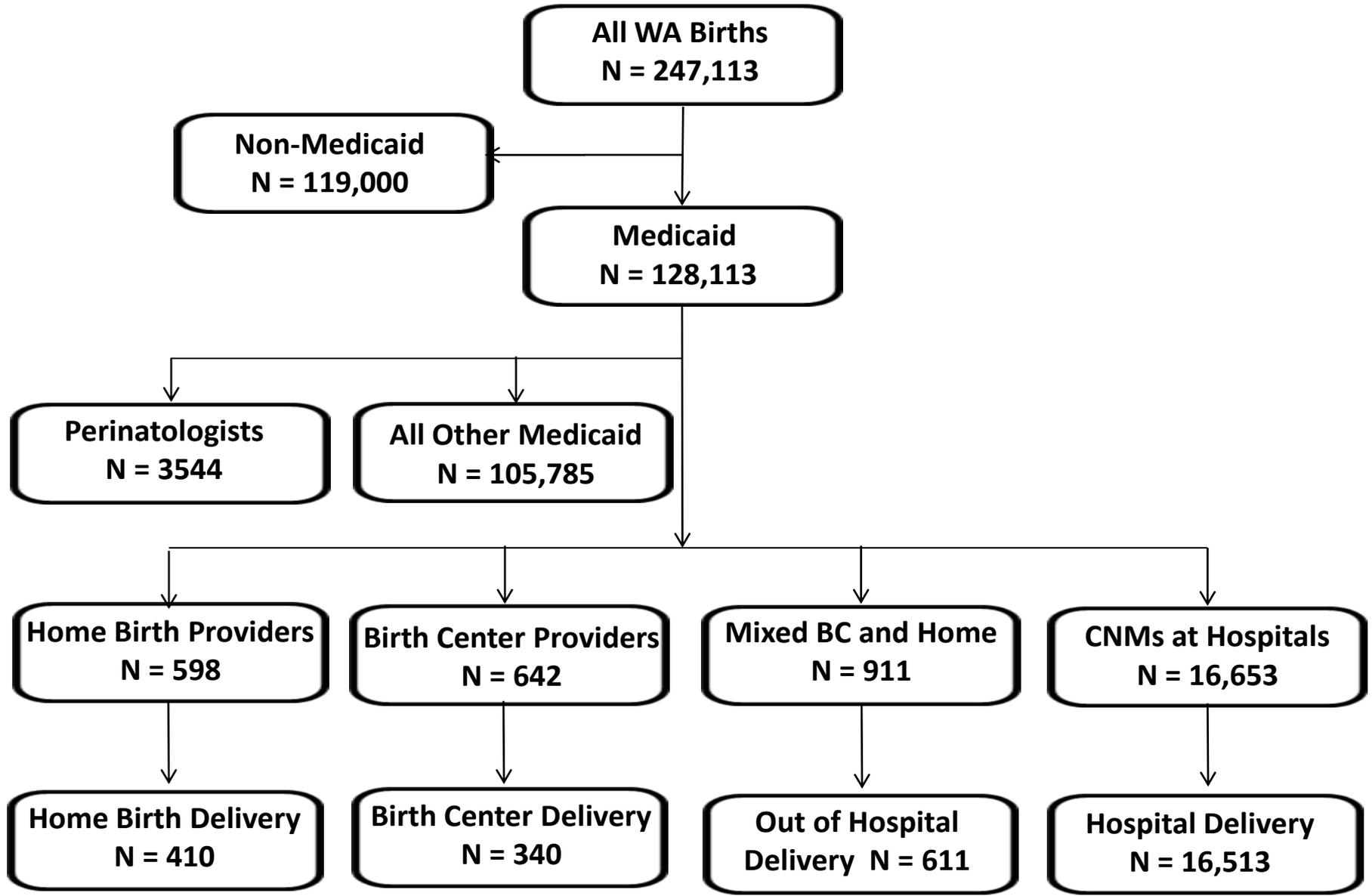


Licensure and Typical Delivery Location For WA Providers of Out of Hospital Births

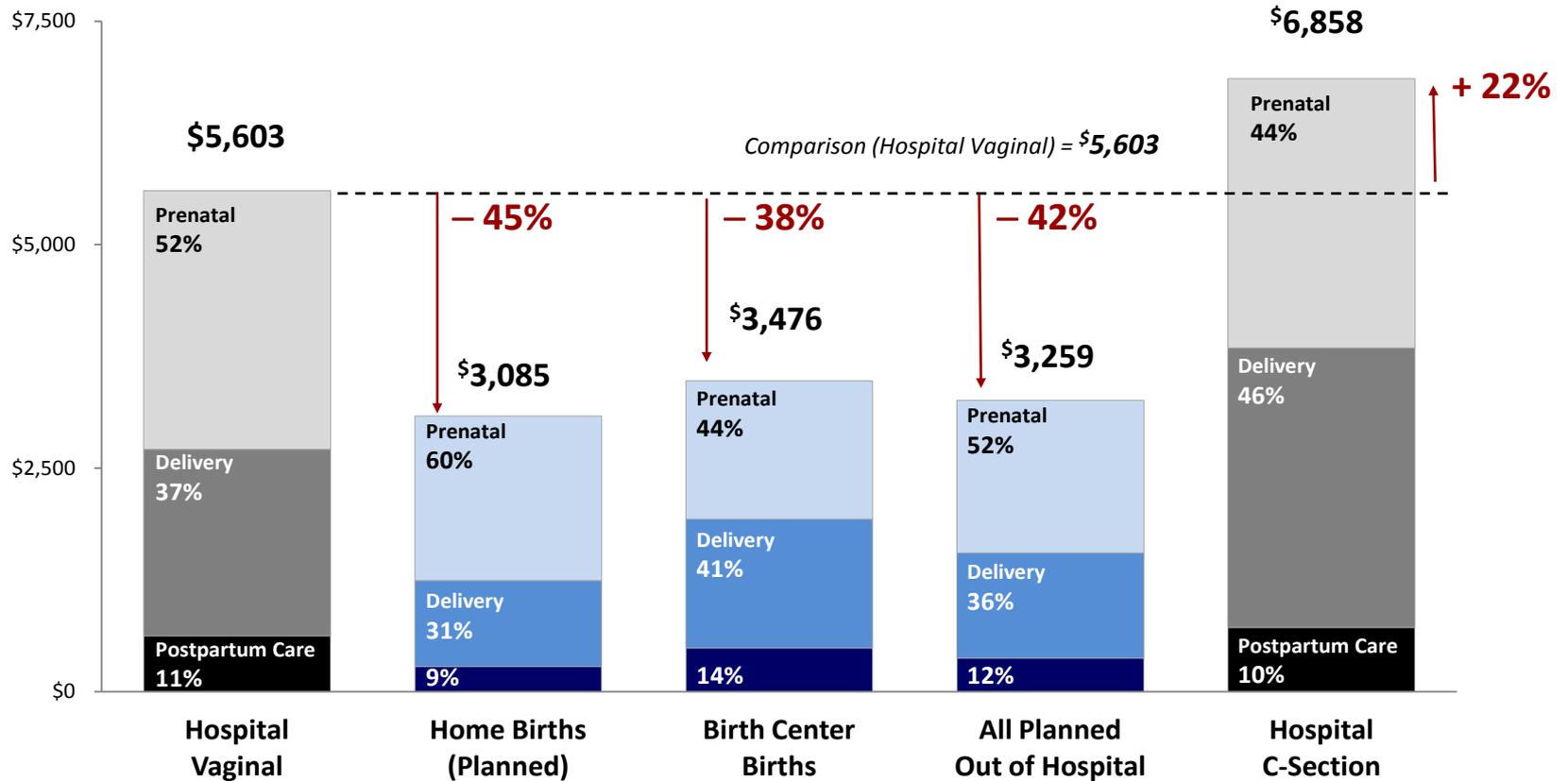
Typical Delivery Location	Licensed Midwife (LM)	Certified Nurse Midwife (CNM)
Home	72	8
Birthing Center	16	1
Mixed (Home and Birth Center)	33	5
All Out of Hospital	121	14



Prenatal Care Providers and Achieved Birth Place for Washington State Women Who Gave Birth 2010-2012



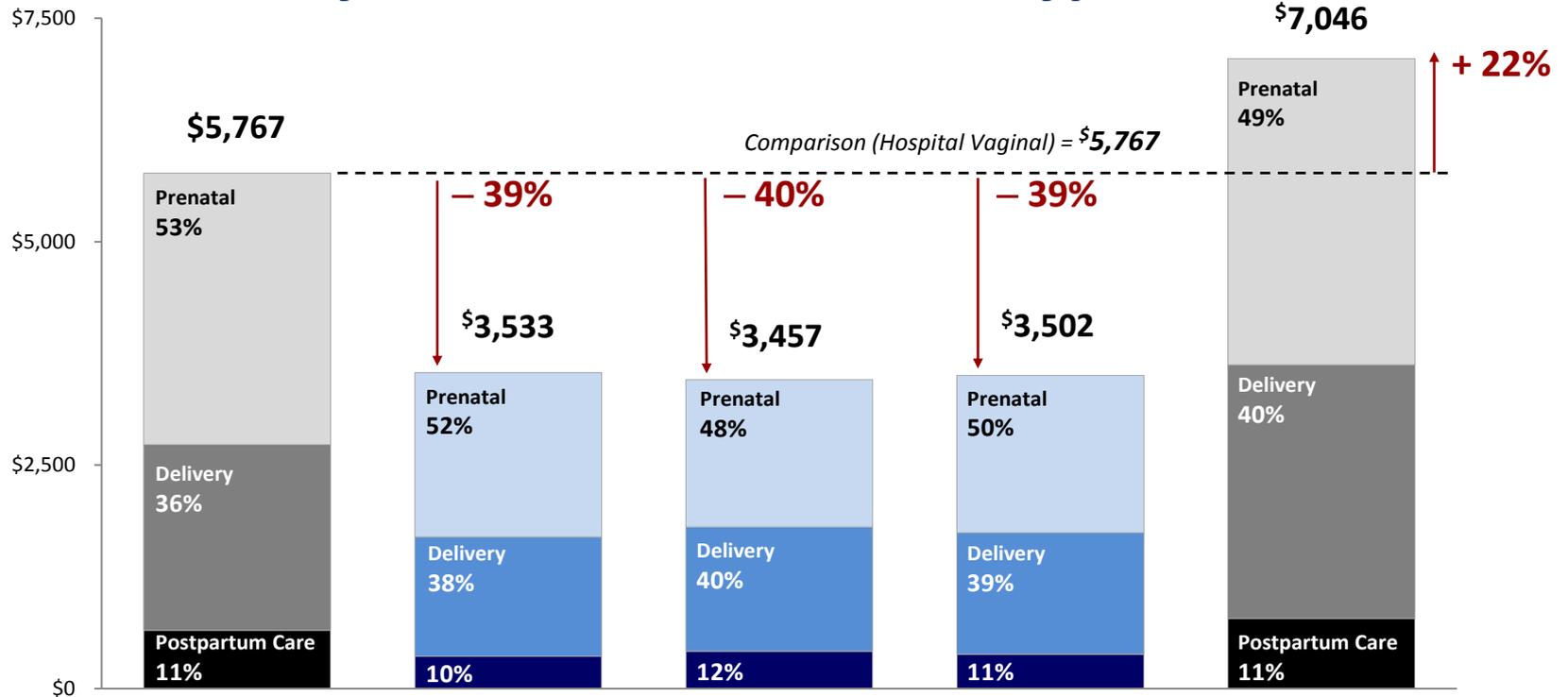
Average Medicaid Expenditures: Low Risk Births By Achieved Birth Place Type



	N = 14,259	N = 102	N = 82	N = 184	N = 2,558
Prenatal Care	\$ 2,892	\$ 1,842	\$ 1,545	\$ 1,709	\$ 3,011
Delivery	\$ 2,086	\$961	\$ 1,441	\$ 1,175	\$ 3,127
Postpartum	\$625	\$282	\$490	\$ 375	\$ 719
TOTAL	\$ 5,603	\$ 3,085	\$ 3,476	\$ 3,259	\$ 6,858



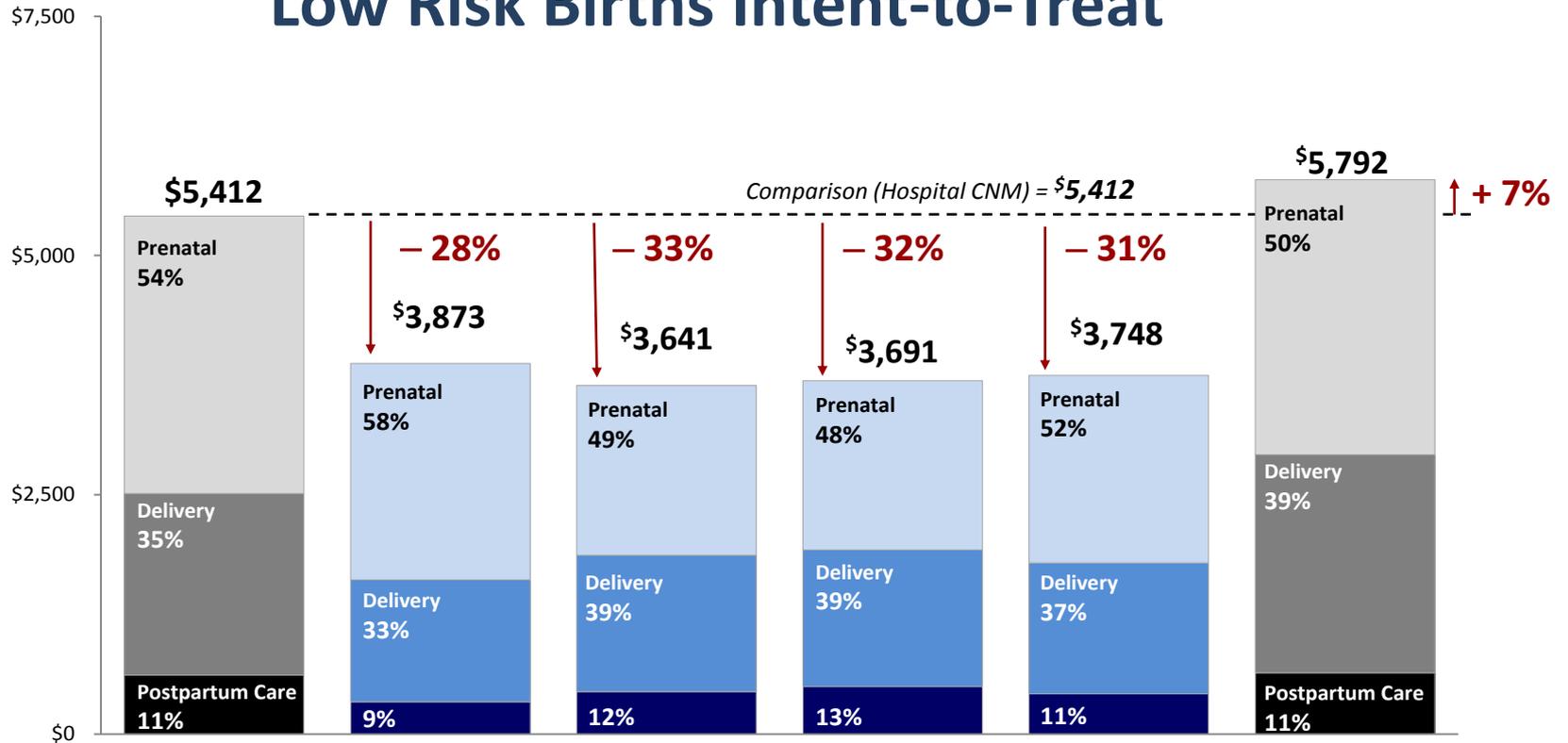
Average Medicaid Expenditures: By Achieved Birth Place Type



	Hospital Vaginal <i>N</i> = 26,061	Home Births (Planned) <i>N</i> = 162	Birth Center Births <i>N</i> = 112	All Planned Out of Hospital <i>N</i> = 274	Hospital C-Section <i>N</i> = 10,343
Prenatal Care	\$ 3,036	\$ 1,836	\$ 1,645	\$ 1,758	\$ 3,424
Delivery	\$ 2,077	\$1,335	\$ 1,392	\$ 1,358	\$2,835
Postpartum	\$653	\$ 363	\$420	\$ 386	\$787
TOTAL	\$ 5,767	\$ 3,533	\$ 3,457	\$ 3,502	\$7,046



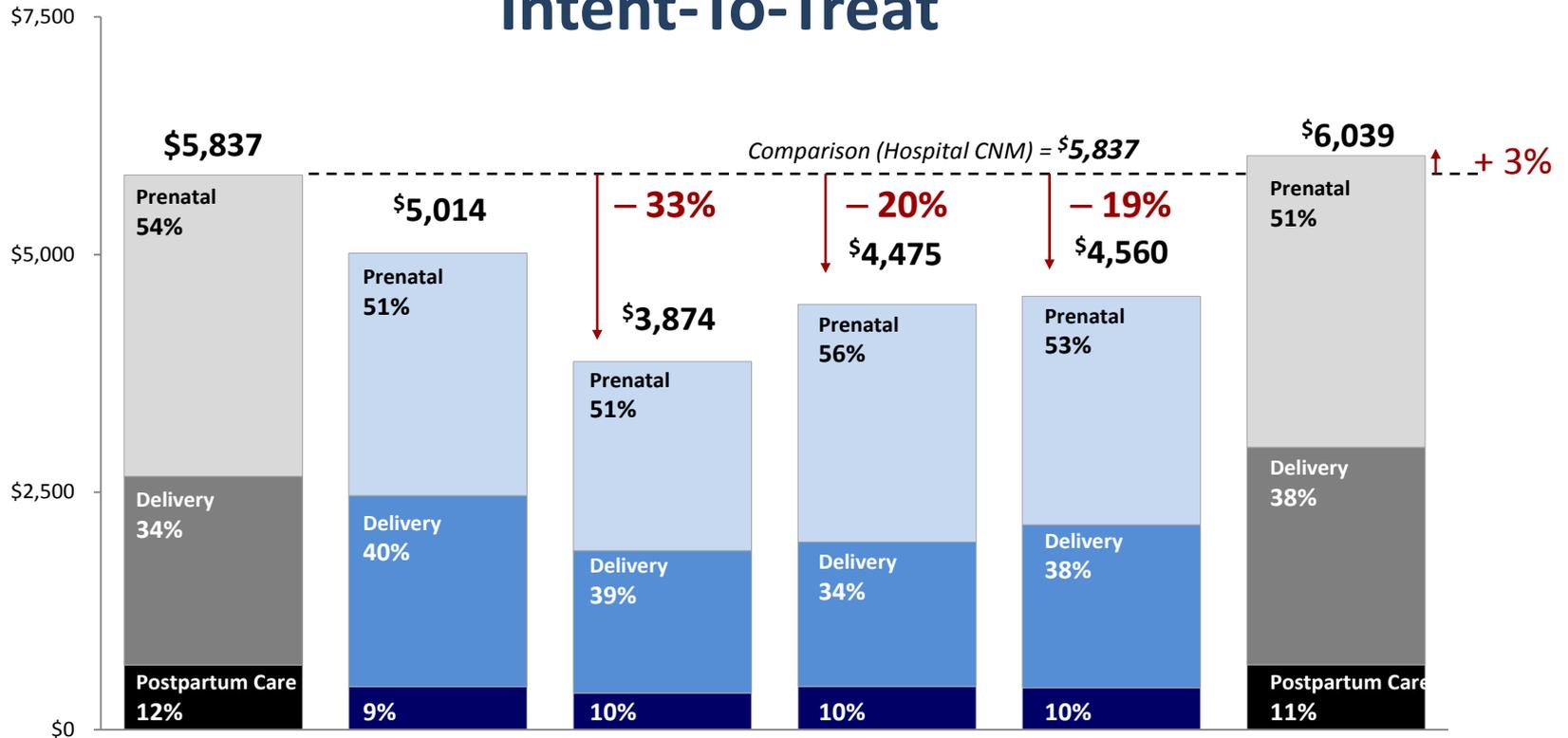
Average Medicaid Expenditures: Low Risk Births Intent-to-Treat



	Hospital CNM <i>N</i> = 2,323	Home Births (Planned) <i>N</i> = 101	Birth Center Births <i>N</i> = 70	Mixed <i>N</i> = 93	All Planned Out of Hospital <i>N</i> = 264	Hospital Other <i>N</i> = 14,261
Prenatal Care	\$ 2,899	\$ 2,262	\$ 1,773	\$ 1,766	\$ 1,958	\$ 2,873
Delivery	\$ 1,898	\$ 1,276	\$ 1,424	\$ 1,428	\$ 1,369	\$ 2,279
Postpartum	\$ 615	\$ 335	\$ 444	\$ 497	\$ 421	\$ 640
TOTAL	\$ 5,412	\$ 3,873	\$ 3,641	\$ 3,691	\$ 3,748	\$ 5,792



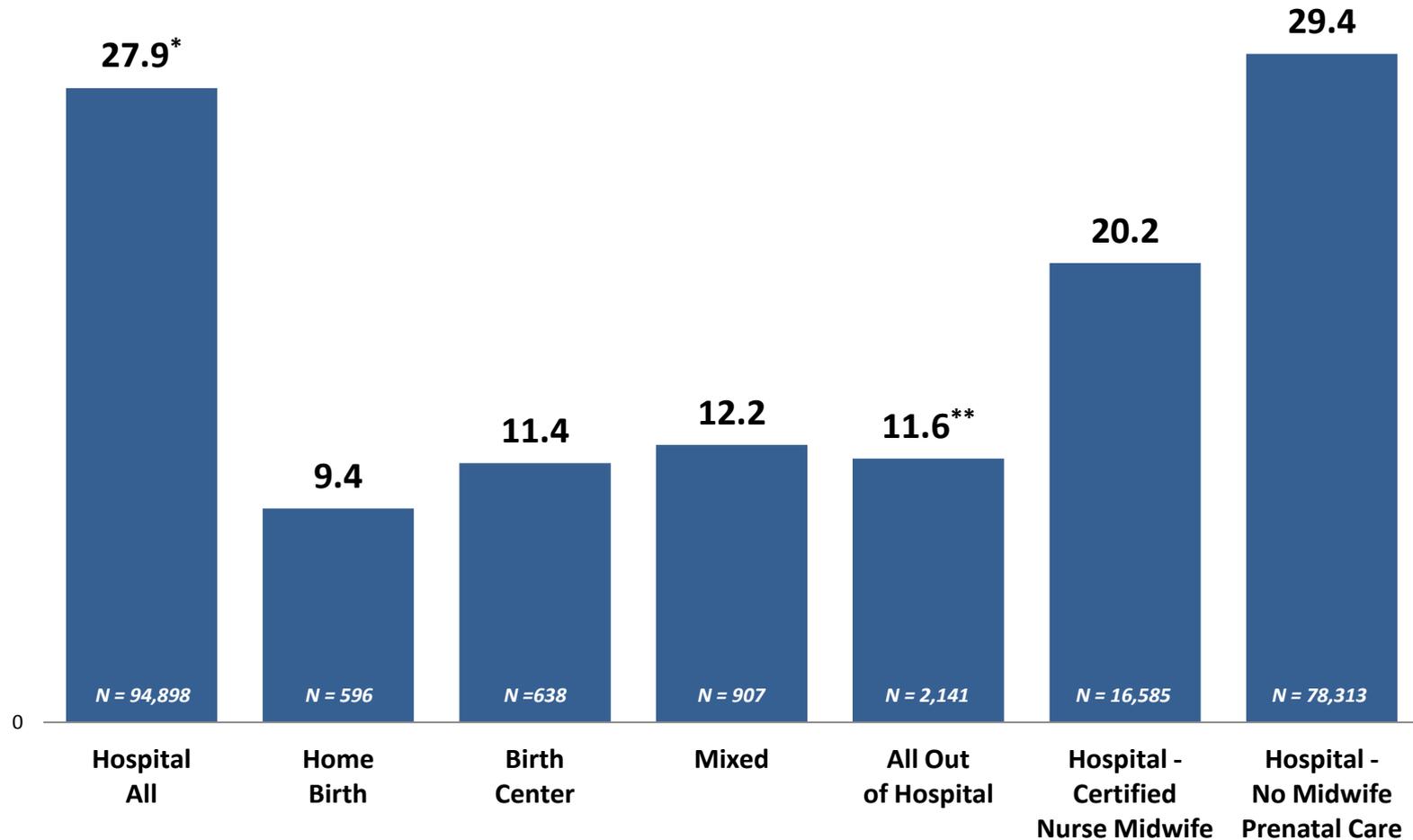
Average Medicaid Expenditures: Intent-To-Treat



	Hospital CNM	Home Births (Planned)	Birth Center Births	Mixed	All Planned Out of Hospital	Hospital Other
	<i>N</i> = 4,785	<i>N</i> = 182	<i>N</i> = 101	<i>N</i> = 159	<i>N</i> = 442	<i>N</i> = 30,571
Prenatal Care	\$ 3,170	\$ 2,549	\$ 1,988	\$ 2,499	\$ 2,403	\$ 3,067
Delivery	\$ 1,985	\$ 2,012	\$ 1,499	\$ 1,519	\$ 1,717	\$ 2,288
Postpartum	\$ 682	\$ 453	\$ 387	\$ 457	\$ 440	\$ 685
TOTAL	\$ 5,837	\$ 5,014	\$ 3,874	\$ 4,475	\$ 4,560	\$ 6,039



Cesarean Delivery Rate (%): Intent-To-Treat



* All Hospital = No Prenatal Care by Midwife + Certified Nurse Midwife

** All Out of Hospital = Home + Birth Center + Home and Birth Center (Mixed)



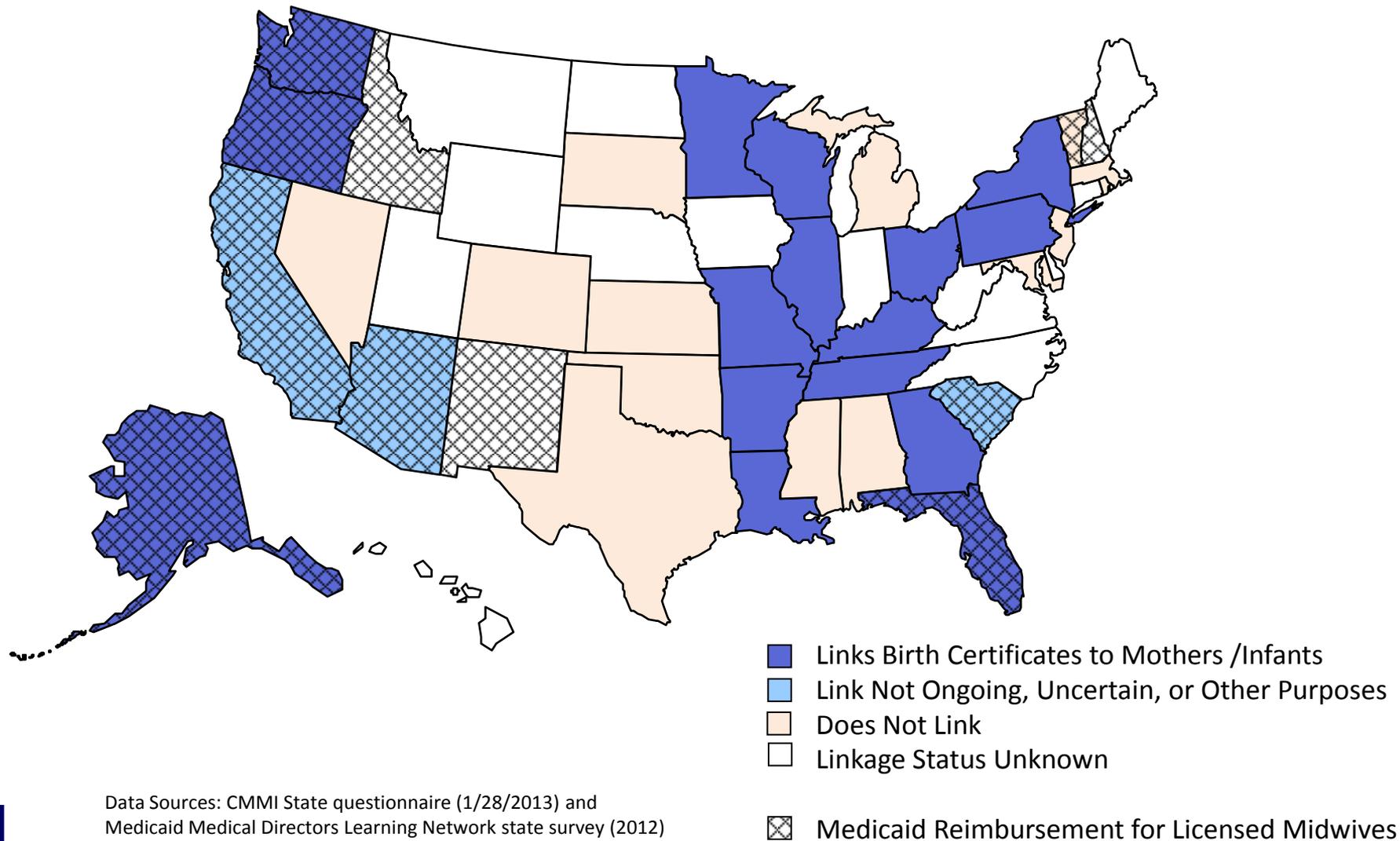
Assessing Costs of Births in Varied Settings

Future Directions?

- **Extend analysis to other states with linked Medicaid claims and vital records and Medicaid reimbursement for out of hospital births**
 - Increase Ns
 - Study different states' models of care/reimbursement
 - Describe insurance issues for mother-infant dyad
- **Use medical record review or detailed analysis of claims data to identify timing of transfer of care, emergency transport expenses**
 - Explore outliers and remove as appropriate
- **Include birth outcomes and infant medical care expenditures together with maternal expenditures**
 - Compare transfer and C-section rates for nulliparous and multiparous women



Current Medicaid-Birth Certificate Linkage and Medicaid Reimbursement for Licensed (Direct-Entry) Midwives



Data Sources: CMMI State questionnaire (1/28/2013) and Medicaid Medical Directors Learning Network state survey (2012)
<http://mana.org/statechart.html>



CONTACT INFORMATION:

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Prashant Nayak

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July 20, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC),
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W. Washington, D.C. 20201
PTAC@hhs.gov

Public Comment – A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services.

Dear Committee Members,

I reviewed the above proposed model which is currently open for comments. Following are my notes for your consideration:

It is a widely held view that FFS reimbursement leads to low-value health care¹. Payment models other than FFS that are themselves disconnected or “in-organic” also lead to fragmented non-optimal care. Payment models that are more holistic and “organic” are expected to encourage more coordination and “appropriate care” at the appropriate setting and will lead to person-centered care.² The current FFS model of reimbursement is outdated and does not take quality into account in paying for health care services.

The most common surgery in the United States is a C-section and according to Consumer Reports³ approximately 50 percent of those are unnecessary. One of the biggest risk factor for having a C-section is your hospital according to a recent Consumer Reports article: “While being overweight, diabetic, or older can make it more likely for a woman to have a C-section, the biggest risk factor is the hospital a mother walks into to deliver her baby, and how busy it is,” says Neel Shah, M.D., an assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School, who has studied C-section rates in the U.S. and around the world.

A new Consumer Reports investigation of more than 1,300 hospitals across the U.S. echoes Shah's findings. It reveals that C-section rates for low-risk deliveries in the U.S. vary dramatically from hospital to hospital, even between those located in the same communities." The current health care ecosystem is built to optimize the FFS reimbursement system. As an actuary, who has experience with various bundled payment programs having worked with clinicians, operations, finance, and contracting at the Cleveland Clinic, I support this proposed model. Furthermore, as someone whose partner chose to have a midwife deliver both babies to reduce the risk of an avoidable C-section and receive more coaching and support during the pregnancy and delivery and ensure excellent post-partum care, I personally advocate the above bundled payment model. My partner and I made the decision to forego the traditional choice of an ob-gyn, despite vehement opposition from both our families. However, despite studies that show newborns delivered by C-section, are more likely to develop obesity, asthma and type 1 diabetes when they get older,⁴ cultural resistance to alternative, non-traditional birthing is still a barrier to natural birthing options. As more mothers with low-risk pregnancies desire natural birthing options with midwives and doulas, our payment system needs to be in alignment with the goals that we desire to attain.

The proposed model represents a movement away from volume to value. Bundled payments have been shown to improve quality and decrease costs by encouraging delivery of "appropriate care" and dis-incentivizing care that is not medically necessary. Value that takes into account, patients' preferences and desired outcomes is likely to lead to a reduction in avoidable C-sections and lead to healthier mothers and babies with less chronic conditions.

Some of the lessons learned from my experience with bundled programs that also will apply to this proposed model include:

- Using a transparent open source bundle definition
- Quality outcomes that impact payment
- Risk stratification of the population
- Education of stakeholders
- Credibility of the population
- Opportunity for providers to take manageable risk
 - Carve outs
 - Stop-loss provision
 - Nominal downside risk
- Opportunity for hospitals to participate in risk-sharing arrangement along with clinicians
- Using patient reported data to help measure the value of the program

For this proposed birth center model to qualify as an Advanced APM, the model must meet the following three Quality Payment Program requirements:

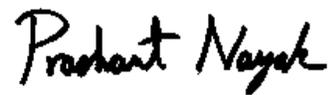
1. Use of an Electronic Medical Record
2. Link payment to certain quality measures comparable to Merit-Based Incentive Payment System
3. Bear a certain amount of greater than "nominal" financial risk or qualify as a Medical Home Model

The model may begin with only upside risk, however it will need to transition to a two-sided risk model to meet the above requirements. In addition, to drive high-value maternity care the model will need to link payments to the recommended set of quality performance measures listed below.

- **Gains in Patient Activation Scores** (NQF 2483) is a person-reported outcome measure of growth in skills and knowledge for managing one's health care. Increasing activation level is associated with improvement in personal behaviors and clinical outcomes, cost of care and patient experience ratings. This measure could be collected from pregnant women in the first and third trimesters of pregnancy. Increasing activation during this period would help prepare women for giving birth and becoming a parent. As it has not yet been reported for use during pregnancy, it would be prudent to test its performance in maternity care before tying scores to payment.
- **Screening for Clinical Depression and Follow-Up Plan** (NQF 0418) is being re-specified for 2018 to include prenatal and postpartum women. This common concern in pregnancy and the postpartum period can be debilitating to women and adversely impact infant care and family life.
- **Cesarean Birth** (NQF 0471, Joint Commission PC-02), cesareans in first-birth low-risk women, is a fairer quality indicator than other cesarean measures. Reducing avoidable cesareans is a leading maternity care quality improvement issue. Mothers and babies are likely to benefit from the many practices that support "intended vaginal birth."
- **Vaginal Birth After Cesarean (VBAC), Uncomplicated** (AHRQ IQI 22) measures cesareans in low-risk women with a history of cesarean. It would be reasonable to limit use to birth centers with access to hospitals with 24/7 surgical coverage for women with one or two past cesareans.
- **Unexpected Complications in Term Newborns** (NQF 0716) measures problems that develop during birth or in the stay after birth in babies that should be thriving. It is a "balancing measure" that addresses concerns about possible unintended harm of overzealous cesarean reduction or other unsafe practices and can help prevent underuse of needed cesareans and stinting.
- **Exclusive Breast Milk Feeding** (NQF 0480/2830, Joint Commission PC-05) at facility discharge is relevant to many mothers and babies. Breastfeeding is a preventive practice with many short-term benefits for babies and significant longer-term benefits for both mother and child.
- **Contraceptive Care-Postpartum** (NQF 2902) is a measure of receiving a moderately or highly effective method of contraception either in the facility after childbirth (as many women do not get a postpartum visit) or during postpartum office visits within 60 days after birth. This highly effective clinical preventive service fosters healthy birth spacing. (Short inter-pregnancy intervals have been associated with increased risk of preterm birth, low birthweight, stillbirth and early newborn death.) It increases the likelihood that any subsequent maternity care episode involves an intended pregnancy.

The proposed bundled payment model if designed appropriately to meet the goals of the patients, providers and payers, will lead to improved quality of care and reduced costs to the healthcare ecosystem.

Sincerely,

A handwritten signature in black ink that reads "Prashant Nayak". The signature is written in a cursive, slightly slanted style.

Prashant Nayak, ASA, MAAA

actuary.art@gmail.com

Additional comments on the proposed model:

Particularly compelling is ACOG's own impressive identification of appropriate care for low-risk women in this year's Committee Opinion. This list of practices aligns very well with what birth centers typically provide as a matter of course as summarized in their conclusion below:

"Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor. In addition, some women may seek to reduce medical interventions during labor and delivery. Satisfaction with one's birth experience also is related to personal expectations, support from caregivers, quality of the patient-caregiver relationship, and the patient's involvement in decision making. Therefore, obstetrician-gynecologists and other obstetric care providers should be familiar with and consider using low-interventional approaches, when appropriate, for the intrapartum management of low-risk women in spontaneous labor."

<https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Approaches-to-Limit-Intervention-During-Labor-and-Birth>

Clinical leaders also delineate current problems and identify birth center solutions in this Lancet paper:

<https://www.ncbi.nlm.nih.gov/pubmed/27642026>

The birth center is in an excellent position to be the accountable entity, to coordinate care across the episode and to make the needed shift from current excess of resource use in the brief intrapartum window to needed resources to provide tailored support to pregnant and postpartum women before and after birth. The sparse dollars that now fall to providers for outpatient visits are inadequate for meeting the needs of many women and families at this time (e.g., helping them find a smoking cessation program and following up to be sure it is helping, referrals for food shortage or housing issues, helping with mental health).

The model integrates well three high-performing forms of maternity care: midwifery care, birth center care and doula support. All of these forms of care typically do a much better job than usual care of eliminating overuse *and* underuse and landing in the sweet spot of highly appropriate, beneficial care that is generally very appreciated by childbearing women.

This model deals well with the impending ob-gyn shortage as noted in the [ACOG workforce shortage report](#), reserving physicians for practicing at the top of their education and licensing, and making similar use of midwives and doulas. This model addresses these concerns and if we need more personnel, it will be much quicker and less expensive to bring on midwives, NPs, doulas, *and* we can expect that they will provide highly appropriate care.

ACOG workforce shortage report

<https://www.acog.org/~media/BB3A7629943642ADA47058D0BDCD1521.pdf>.

I commend the submitters for recognizing that Certified Professional Midwives have been making high-quality contributions to the care women in birth centers. This also can play an important role in addressing workforce shortages.

I appreciate the system of “primary” maternity care, which we have not particularly had, with highly trained specialists caring for essentially healthy women and newborns.

References:

¹Use of low-value care in Medicare is substantial

<http://www.medpac.gov/-blog-/medpacblog/2015/05/21/use-of-low-value-care-in-medicare-is-substantial>

²Alternative Payment Model (APM) Framework Refresh

<https://hcp-lan.org/groups/apm-refresh-white-paper/>

³Consumer Reports: Your Biggest C-Section Risk May Be Your Hospital

<http://www.consumerreports.org/c-section/your-biggest-c-section-risk-may-be-your-hospital/>

⁴BMJ: Time to consider the risks of caesarean delivery for long term child health

<http://www.bmj.com/content/350/bmj.h2410>

Childbirthconnection.org: How does maternity care led by physicians compare to care led by midwives?

<http://www.childbirthconnection.org/healthy-pregnancy/choosing-a-care-provider/collecting-information/>

Childbirthconnection.org: How does maternity care compare in hospitals versus birth centers?

<http://www.childbirthconnection.org/healthy-pregnancy/choosing-a-place-of-birth/collecting-information/>

Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health (2016) outlines the health and cost benefits of doula care and details federal, state and local strategies to increase insurance coverage.

<http://www.nationalpartnership.org/research-library/maternal-health/overdue-medicare-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf>

The Cost of Having a Baby in the United States (2013) analyzes costs related to maternity care across a number of variables.

<http://www.nationalpartnership.org/research-library/maternal-health/the-cost-of-having-a-baby-in-the-us.pdf>

Cochrane Review: Continuous Support for Women during Childbirth (2017 review), a systematic review of the research literature, concludes that all women should have continuous support during labor.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub6/full>

Vaginal or Cesarean Birth: What Is at Stake for Women and Babies? A Best Evidence Review (2012) focuses on adverse consequences of cesarean and adverse outcomes that may be intrinsic to labor or vaginal birth.

<http://www.nationalpartnership.org/research-library/maternal-health/vaginal-or-cesarean-birth-what-is-at-stake.pdf>

Evidence-based Maternity Care: What It Is and What It Can Achieve

<http://www.nationalpartnership.org/research-library/maternal-health/evidence-based-maternity-care.pdf>

From: Kate Saumweber Hogan, CPM, LM <midwifekate@twincitiesmidwifery.com>
Sent: Thursday, July 20, 2017 4:06 PM
To: PTAC (OS/ASPE)
Subject: Three Professional Midwifery Organizations' Response to the Bundled Payment Birth Center Proposal

Dear PTAC,

We are writing on behalf of the Minnesota State Chapter of NACPM (National Association of Certified Professional Midwives), Washington State Chapter of NACPM, and MCCPM (Minnesota Council of Certified Professional Midwives) in response to the proposal: A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services.

The BirthBundle as a method of payment for freestanding birth centers recognizes the good outcomes produced by the midwifery model of care. Midwives provide excellent care to women and babies in the prenatal, intrapartum, and postpartum time period and it is important to recognize that these are not distinct times, but are fluid and flow into one another. The current reimbursement many birth centers receive does not recognize this. In some locations, birth centers are able to be reimbursed for maternal care, but not newborn care, even though this care is provided. In some locations, should a transfer to the hospital become needed, the payment that the birth center is able to recoup is shockingly low for the amount of care and effort put into providing safety and continuity.

Barriers to success

It is important to note the regulatory and political atmosphere in which many midwives currently practice. It would be wonderful if the BirthBundle became an option for care reimbursement. The hope is that it won't set a precedent for becoming the ONLY method for reimbursement to birth centers. While birth centers that are well-connected with doctors and have CNMs with hospital privileges may have an easy time finding hospitals to subcontract with them to get payments, there are many freestanding birth centers that do not have this ability. In a large city with many hospitals, there would be an incentive for hospitals to react favorably to this system as it gives them a competitive edge. In a rural setting in which there may only be 1 hospital, the hospital could easily choose to simply not work with the birth center on payment for transfers and transports. It can be exceedingly difficult, or even impossible, in rural areas for well qualified providers to get hospital privileges and it is impossible to get hospital privileges if a birth center is CPM run and without CNMs or doctors on staff. If the BirthBundle became the only method of payment for freestanding birth centers, what would happen to these small centers and the women they currently serve?

Eligible providers

The proposal recognizes the importance of midwives in increasing access to high-quality care and meeting the needs of the childbearing population. The proposal acknowledges the role of Certified Professional Midwives (CPMs) in providing maternity care outside of a hospital setting. It is important to note that the majority of these community-based births are, in fact, attended by CPMs who have specialized training in providing care outside of the hospital setting. CPM inclusion in future maternity care improvement is vital, as both the workforce providing the care, as well as the providers with the expertise to train an expanding workforce. Additionally CPM education is more affordable which allows a greater diversity of providers to enter the

midwifery workforce. All midwives should be recognized as autonomous providers not needing to be employed under the direction of physicians.

Cautions

Overall the BirthBundle proposal is a step in the right direction of both asserting midwifery care as a benchmark of quality care that is in line with our global health care community. In order to prevent the pitfalls of a fragmented system which is not single payer it will be important to protect care providers from being shut out of offering care because payers choose to only contract or pay on the “bundle”. For a birth center without hospital privileges or owned by a non-physician or in an area without this option, it is feasible that payers will avoid contracting with the birth center. This can cause undue burdens on providing care for many practices to be successful.

Risk Criteria

It is noted that an addendum of risk criteria is included with the proposal. It is important to note that the risk criteria submitted is for the author’s practice. Birth centers accredited by the Commission for the Accreditation of Birth Centers (CABC) follow a different set of risk criteria as determined by the American Association of Birth Centers (AABC). This risk assessment is based on a multi-disciplinary group of CPMs, CNMs, and physicians in a review of current evidence. Excessively exclusionary risk criteria can and does limit access to those patients most in need of the time and attention given by midwives to mitigate their risk. It is urged that risk criteria establishment remain determined by CABC accreditation.

In the state of Minnesota, there are a few small birth centers who have become Essential Community Providers, designated as such by the State of Minnesota for their important work with underserved populations. One of these birth centers, Roots, works with a predominantly African-American population, a community that experiences disproportionate sub-optimal outcomes including preterm birth, associated neonatal mortality, low nutritional status and high stress due to institutionalized racism. Many patients come to the start of care with anemia, a history of preterm birth, or gestational diabetes discovered through screening. By working with a community-based provider to understand their individual as well as their community needs, outcomes can be improved for these women and their babies, even without heavy integration into the medical model of care.

Example

A 23-year old African American patient pregnant with her first baby presents for care at 20 weeks after being instructed by hospital-based clinic that she was high-risk and should be prepared to have a preterm baby and a cesarean. Hgb at onset of care was 9.0. She received one-to-one midwifery care that was culturally centered and helped her identify self-care practices that accessible in a dense urban area with violence. Hgb at term was 11.0, she had a normal vaginal delivery at 40 weeks 2 days and gave birth to a healthy full birth weight baby girl.

Another birth center in the state of Minnesota that holds a designation of an Essential Community Provider is River Valley Birth Center, which is located in a rural area of the state. This birth center serves a very high population of Medicaid clients who struggle to have access to maternity care due to the small number of rural maternity care providers. In a location in which women have very few options for care, their care may be directed by the whims of the one provider they can find who is taking new patients.

Example

A 21-year old patient, pregnant with her second child presents to the birth center as a new patient at 35 weeks of pregnancy after being told by her physician that he would only consider delivery by c-section due to her elevated BMI of 40. This woman had easily birthed her first baby vaginally and understood that her higher BMI

put her at greater risks for surgical complications. In the limited time she received prenatal care from the birth center, she was able to improve her nutrition dramatically and begin an exercise program. At 39.2 weeks of pregnancy she went into spontaneous labor and vaginally birthed a 6lb 2oz vigorous baby girl after 4 hours of active labor. She maintained many of the important lifestyle changes of improved nutrition and exercise and began her 3rd pregnancy with a BMI of 36. Lack of access to options for second opinions in a rural location force many women to accept the offerings of one specific provider or hospital system regardless of whether these are evidence-based practices.

The BirthBundle is an option that works well for birth centers that are already highly integrated with the medical model, but if birth centers become required to become highly integrated with the medical model in order to be paid then this method will serve to close more birth centers and cause additional barriers to women accessing the amazing care that midwives provide during the entire childbearing year.

Thank you,

Kate Saumweber Hogan, CPM, LM
Certified Professional Midwife
Licensed Midwife
President of the Minnesota Chapter of NACPM (National Association of Certified Professional Midwives)

Erin Kaspar-Frett, CPM, LM
Certified Professional Midwife
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Katherine Dexter, LM, CPM
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Erika Urban, CPM, LM
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From: Mary Lawlor <lawcing@yahoo.com>
Sent: Thursday, July 20, 2017 6:45 PM
To: PTAC (OS/ASPE)
Subject: Public Comment – [A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care]

To Whom It May Concern,

I am writing today on behalf of the National Association of Certified Professional Midwives (NACPM) in strong support of the *Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services*, submitted by the Minnesota Birth Center. Implementation of the BirthBundle® proposal will improve outcomes and the health of pregnant women and their babies, while significantly lowering costs. We write in support of this proposal based on its merits, and also because we believe that including midwives and midwife-led birth centers in alternative payment and innovative care delivery models will be key to providing critical solutions nationwide to the problems of cost and quality in maternity care. We endorse the vision of the authors of the BirthBundle® proposal that “regulations will ultimately be revised to permit this model, and others like it, to serve the nearly 2,000,000 mothers each year whose care is covered by Medicaid.” (p. 3)

NACPM, too, is preparing for this future and has developed *A Bundled Payment Proposal to Improve Maternity Care Outcomes and Lower Costs*, that proposes to test a value-based payment and a service delivery model to improve the quality and lower the cost of maternity care by providing women and their families with access to the full range of type of care provider and birth setting options. NACPM’s paper is cited in the appendix on maternity care implementation resources of the HCP-LAN White Paper on the Clinical Episode Payment model for Maternity Care, released in 2016, which makes a compelling case for implementing new models of payment for perinatal care, such as Minnesota Birth Center’s BirthBundle® proposal.

Certified Professional Midwives (CPM), a rapidly growing segment of the midwifery profession, are primary maternity care providers, nationally certified, currently licensed in 31 states and included in state Medicaid programs in 13 states. CPMs are trained to offer high-quality, evidence-based care to people during the childbearing year, incorporating best practices to foster normal physiologic birth. CPMs may qualify to provide care in all settings, with special training and qualifications for community-based service in homes and free-standing birth centers. As experienced community-based service providers, and as owners and/or providers in approximately half of all birth centers in the U.S. today, Certified Professional Midwives will be needed to play a vital role in efforts to scale up the bundled payment model for maternity care.

A large proportion of women who currently give birth in hospitals would meet criteria for giving birth in community settings and, further, are interested in or open to considering those settings. If only a small percent of those 98.6 percent of U.S. births in hospitals were shifted to community settings, savings and health benefits for women and babies could be significant. While most women give birth in hospitals attended by obstetricians, a growing number are choosing to give birth at birth centers or at home attended either by Certified Nurse midwives or Certified Professional Midwives. In 2013, more than 56,000 births took place outside the hospital, 18,219 of which occurred in free-standing birth centers.

Maternity care is a key driver of health care costs in the U.S. today. Care of childbearing women and newborns is the number one reason for hospitalization in the U.S. Maternal and newborn hospital admissions account for

almost a quarter of all hospital stays, and total estimated maternal and newborn charges for hospital alone were approximately \$126 billion in 2013. Hospital maternal and newborn charges increased by 90% in the decade from 2003 to 2013, while the total number of births decreased by 4% over the same period.

As the BirthBundle® proposal describes, midwives and midwife-led birth centers have a critical role to play in lowering these costs and improving outcomes by reducing the over-use of expensive technologies and addressing the underuse of many beneficial forms of care for healthy mothers and newborns. Evidence is increasing that the type of professional who manages the birth and the site of birth impacts value. While 98.6 percent of births occur in hospitals, we increasingly understand that birth in community settings, including midwife-led birth centers, are beneficial and less expensive alternatives to hospital births for healthy women.

A 2007 study in Washington State found that community-based births, including those in midwife-led birth centers attended by Certified Professional Midwives resulted in fewer low-birth weight babies and much lower cesarean section rates, while delivering substantial savings to the state budget. A more recent study examined whether birth center care would reduce Medicaid costs and found an average savings of \$1163 per birth, or \$11.6 million in savings per 10,000 births per year. This same study found that in the District of Columbia the difference in Medicaid costs between a vaginal birth in a birth center and one in a hospital was \$3,281. A national study of average total payments for women and babies over the full episode of maternity care in 2010 documented significant costs for both commercially insured women and babies (\$18,329 for vaginal and \$27,866 for cesarean births) and for those covered by Medicaid (\$9,131 for vaginal and \$13,590 for cesarean births).

The BirthBundle® proposal, in addition to providing solutions to cost and quality of maternity care, points to the role of midwives and midwife-led birth centers in addressing the serious and on-going shortage of obstetrical providers. Midwife-led birth centers are ideal training sites for scaling up the number of midwives to meet the critical need for providers, including Certified Nurse Midwives as well as Certified Professional Midwives, who, as the proposal points out, are already playing a significant role in attending mothers in birth centers. (p. 15)

NACPM urges you to accept and implement the Minnesota Birth Center's BirthBundle® proposal. We further urge you to take advantage of the opportunity afforded by midwives and midwife-led birth centers to address the needs of childbearing women and infants at large in our country, and lower costs and improve the quality of maternity care in the U.S. by addressing and adjusting regulations to permit this model and similar models to be available to all mothers and infants insured by Medicaid.

Thank you for considering our comments.

Sincerely,

Mary Lawlor, CPM, LM, MA
Executive Director
National Association of Certified Professional Midwives
www.nacpm.org

<http://nacpm.org/about-nacpm/coalitions-initiatives/about-nacpmcoalitions-initiativesbundled-payment-proposal/>

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July 20, 2017

Ms. Angela Tejada

Physician-Focused Payment Model Technical Advisory Committee
Office of The Assistant Secretary for Planning and Evaluation
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Comments on A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services

We are writing to comment on the proposal for a Single Bundled Payment using midwife-led birth center practices proposal as referenced above.

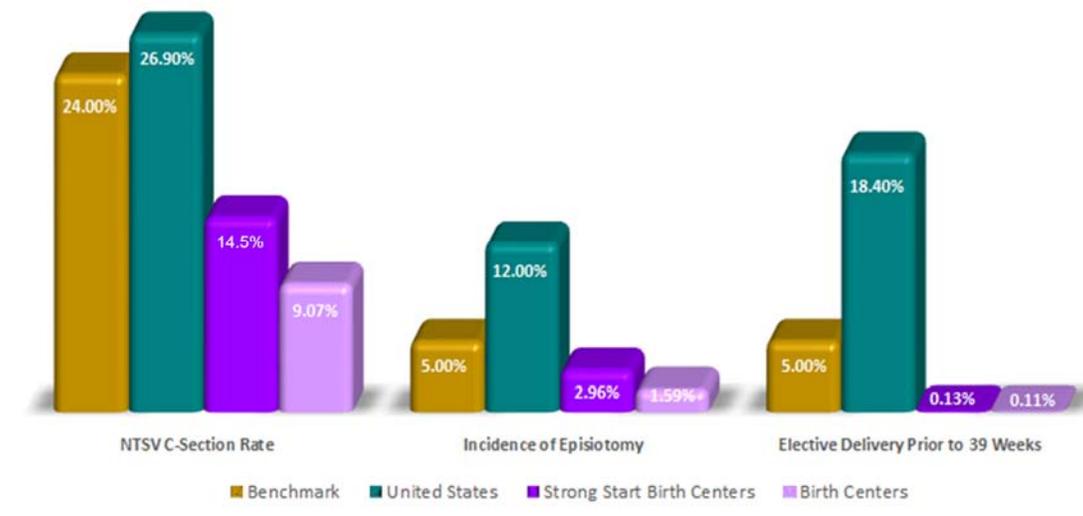
The American Association of Birth Centers (AABC) welcomes this PTAC proposal for a bundled payment model using midwifery-led birth centers as the primary site for full scope maternity care. This model of care has demonstrated high quality clinical outcomes for both mother and newborn, extraordinary levels of consumer satisfaction, and significant costs savings from lower use of medical interventions. This care results in lower rates of cesarean sections for generally healthy women at lower risk of complications. Providing opportunities for birth centers to participate in bundled payment models may help to encourage Medicaid payers to contract with birth centers. This would improve access to for women with Medicaid coverage —should this option of bundled payment model be available through Medicaid in the future.

Through the CMMI funded Strong Start for Mothers and Newborns Initiative AABC birth centers provided care to over 14,000 Medicaid beneficiaries in birth centers. Preliminary data show that when care is provided to Medicaid beneficiaries in birth centers, rates for poor outcomes such as preterm birth, low birth weight, and primary cesarean rates are cut in half from the national rates for these costly complications. These data demonstrate that birth center care should be more accessible to Medicaid beneficiaries to improve population health and to save Medicaid costs.

These outcomes are due in large part to the midwifery-led model of care provided in birth centers. Midwifery-led care has consistently achieved such outcomes in multiple studies and systematic reviews.^{1,2,3} Primary care providers in birth centers in the U.S. are midwives, including certified nurse-midwives, certified midwives, and certified professional midwives.^{2,3}

Increasing the use of alternative payment models in birth centers is one way to improve access to birth centers and to mutually benefit payers or health systems. Birth centers are often small businesses, either privately owned or nonprofits, that are not usually a part of large health systems. Inclusion of birth centers within payer networks would improve the network’s overall quality measures such as cesarean, labor induction, and episiotomy rates, (Figure 1) and yield cost savings that result from these outcomes.

Figure 1. Quality Measures in Birth Center Care compared to National Data



The birth center is an innovation in maternity care that fits well in an alternative payment model framework. With a 40-year history of demonstrating high-quality care, better outcomes and cost savings for low-risk women, as well as excellent patient satisfaction, the birth center should be accessible to more women in the U.S.^{4,5} While the majority of women in the U.S. experience medically low-risk pregnancies, the existing maternity care system is poorly designed to provide women sufficient access to the birth center, an evidence-based care model that is supportive of physiologic birth processes.^{2,3} Encouraging low-risk women to choose birth center care would reduce cesarean rates and improve other outcomes, important goals in improving maternal outcomes in current and in subsequent pregnancies.^{2,3,4,5}

Recently, the ACOG/SMFM Obstetric Care Consensus Statement “Levels of Maternal Care” recognized the birth center as an appropriate level of basic maternity care in the US.⁶ Studies of processes and outcomes of birth center care clearly support that birth centers are a safe model of care for low-risk women when associated with a health system able to provide hospital care.^{2,3,4,5}

AABC Comments

- 1) The birth center model described in this proposal represents larger types of birth centers that have more resources to partner with area consultant hospitals and to take on more economic risk associated with women who are transferred. AABC would encourage flexibility in what is included or not included in the bundle, the role of physicians (need not be that of owner or employee of the birth center), and staffing of types of midwives. These factors will vary depending on urban vs rural locations and size and ownership of the birth center.
- 2) The model described is dependent on hospitals or health systems being willing to partner and collaborate. If a hospital does not want to subcontract or wants higher rates than public program reimbursement would allow, then this model would not work.
- 3) Smaller birth centers who may not be able to carry the risk associated with this proposal could benefit from other alternative payment model components. These would include value based payments, incentives for providing enhanced prenatal care, or payments for value based outcome measures.
- 4) Quality metrics should be an important part of alternative payment models and the measures should be chosen because of their impact on population health. Quality measures for maternity care include number of prenatal visits, cesarean birth rate, elective delivery before 39 weeks, preterm birth and low birth weight rates, breastfeeding initiation and continuation, NICU admissions, readmissions, perineal integrity, and completion of the 6-week postpartum visit. Participating birth centers would track process and outcome data by entering data prospectively in the AABC Perinatal Data Registry™ or other comparable data set.
- 5) Adding birth centers to networks of hospital midwifery providers and other maternity providers will improve the overall quality measure profile and lower costs of care. If low-risk women are educated and encouraged to choose the birth center, significant savings will result.
- 6) Incentivizing high quality midwifery model care is an alternative payment model that would help to make birth center care sustainable. This care is time and education intensive, which contributes to better outcomes. Incentivized payment for enhanced care services and quality outcomes in recognition of increased provider time would assist in making the model sustainable. Low-risk women should be informed and encouraged to choose the birth center option. Birth centers would track processes of care and outcomes in AABC Perinatal Data Registry™ and report to the contracted health plan or system on a quarterly basis.
- 7) Comments on specific sections of the proposal:
 - Page 4 Model Review states "*The HCP-LAN White Paper on the Clinical Episode Payment model for Maternity Care* was released in 2016. It provides comprehensive background information and makes a compelling argument for what we refer to as the perinatal episode. Minnesota Birth Center's model of care was included and referenced as one of the maternity care initiatives in the draft report. The final paper is a powerful argument for implementing new models of payment for

perinatal care." It should be noted that the referenced proposal did not include payment to the hospital or physician professional fees in the hospital. The proposed model or Baby Bundle (BB) has added the hospital piece. The Baby & Co proposal in the HCP LAN did not include hospital or ultrasounds and labs. On page 8 there is a follow up, "An exciting extension of the BB includes some professional and facility fees when hospitalization is required" but no specifics regarding which professional fees.

- It is not clear the BB includes coordination of care of mom (and newborn) between the professional and specialist consults, ultrasound, labs, childbirth education, doulas, lactation support, referrals, etc. There is a reference to coordinating care on page 7 at the end of the second paragraph but later states that BB is not intended to manage the patient.
- Page 7 references this model can be used without midwives as the primary providers and allowing OB and family practice groups instead. While a small percentage of birth center providers are physicians, to be true to the model, care must be provided in the midwifery model of care.
- BB requires CNM privileges at the hospital which will exclude some birth centers who do not deliver at the hospital or who are not able to obtain hospital privileges. In these cases it could be more effective if birth center midwives could transfer to midwives at the hospital when appropriate.
- Top of Page 10 - need to add "whether at the birth center or affiliated hospital" otherwise a mom who labors in the birth centers could decide to go to a different hospital and would be payable in the BB.
- Appendix A - update list of specialists to include consulting obstetrics, MFM, pediatrics and neonatal physicians as referenced in the description of services. Codes are not inclusive, missing 59510 for a physician delivery and postpartum care and 59421 is not a consult code any longer,
- What is a fair perinatal bundled payment amount? The proposal references historical rates of Medicaid as the benchmark. Why isn't the benchmark using comparison pricing to the hospital? Medicare doesn't have birth center facility rates so need to use average national commercial rates for lesser payment options.
- Page 14 discusses offsetting of small number of complicated births in the hospital from savings with the outliers based on cost exceeding a certain amount. The proposal should name the exclusions to keep the payment within normal limits for normal birth events.
- Page 16 - Patient Choice - "All of these are positively addressed in our model" – It is important to specify Shared Decision Making in all aspects of the model of care.
- Page 16- Patient Safety – It would strengthen this section to refer to the AABC Standards for Birth Centers.
- Page 16 - Next paragraph - BB referenced as a model of care but it is defined in the top of page 10 as a "valuable clinical service product imbedded in a new payment model."

American Association of Birth Centers

AABC is a national membership association composed not only of birth centers, but also 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 birth centers.

The birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. The birth center is and not a hospital. Birth centers are an integrated part of the health care system and are guided by principles of prevention, sensitivity, safety, appropriate medical intervention and cost-effectiveness. While the practice of midwifery and the support of physiologic birth and newborn transition may occur in other settings, this is the exclusive model of care in a birth center. The birth center respects and facilitates a woman's right to make informed choices about her health care and her baby's health care based on her values and beliefs. The woman's family, as she defines it, is welcome to participate in the pregnancy, birth, and the postpartum period.

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 340 birth centers in the U.S and the number is growing.

AABC sets the Standards for Birth Centers and their operation, like other trade organizations. As the nation's most comprehensive resource on 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 *AABC Standards for Birth Centers*, and to develop and promote quality assurance systems for birth centers.

Commission for the Accreditation of Birth Centers

National accreditation based on the *AABC Standards for Birth Centers* is provided by the Commission for the Accreditation of Birth Centers (CABC). The CABC is the only accrediting organization dedicated exclusively to the quality of the operation and services of all birth centers regardless of ownership, primary care provider, location, or population served. When a birth center seeks accreditation by the CABC, they are measured against the rigorous, national *AABC Standards for Birth Centers*. There are currently 107 CABC accredited birth centers with 10 more in process of accreditation.

We appreciate the opportunity to comment on the PTAC Proposal on Bundled Payment for midwife-led birth centers. This proposal provides evidence and informs concerning the integration of birth centers into the larger network of hospital and physician providers. Adding birth centers to alternative payment models would improve the choice, value and quality of the maternity care system for Medicaid beneficiaries, should this option become available in the future.

Sincerely,



Lesley Rathbun, MSN, CNM
President

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- ¹ Sandall, Jane, et al. Midwife-led Continuity Models versus Other Models of Care for Childbearing Women. *The Cochrane Library* (2016).
- ² Stapleton, S. R., Osborne, C. and Illuzzi, J. (2013), Outcomes of Care in Birth Centers: Demonstration of a Durable Model. *Journal of Midwifery & Women's Health*, 58: 3–14. doi:10.1111/jmwh.12003
- ³ Alliman J, Phillippi J. Maternal Outcomes in Birth Centers: An Integrative Review of the Literature. *Journal of Midwifery & Women's Health*. 2016;61(1):21-51. doi:10.1111/jmwh.12356.
- ⁴ Howell, E., Palmer, A., Benatar, S., & Garrett, B. (2014). Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center. *Medicare & Medicaid Research Review*, 4(3), mmrr2014-004-03-a06. <http://doi.org/10.5600/mmrr.004.03.a06>
- ⁵ Washington State Health Care Authority. Reimbursement for Births Performed at Birth Centers. (10.15.2016). Olympia, WA.
- ⁶ American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. Obstetric Care Consensus No. 2: Levels of Maternal Care. *Obstet Gynecol*. 2015;125(2):502-15. doi:10.1097/01.ACOG.0000460770.99574.9f



July 20, 2017

Ms. Angela Tejada
Physician-Focused Payment Model Technical Advisory Committee
Office of The Assistant Secretary for Planning and Evaluation
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Request for Comments on A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services

Dear Ms. Tejada:

On behalf of the American College of Nurse-Midwives (ACNM), I write to provide comments and recommendations in support of the proposal for establishing a “Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services.” Midwives are experts on supporting women’s innate capacities to birth. ACNM believes that implementing a bundled payment model for independent, integrated midwifery care in accredited birth centers will yield better care, better health, and lower costs. To that end, we recommend the committee consider the following recommendations to foster the best outcomes for pregnant women and their babies under this proposed payment model:

- Include ACNM-endorsed Best Practice Guidelines on Transfer from Planned Home Birth to Hospital;
- Recognize the Certified Midwife (CM) Credential Within the Bundle, as Both Certified Nurse Midwives (CNMs) and CMs are Certified by the American Midwifery Certification Board (AMCB);
- Support CNM/ CM Full Scope of Practice Language in Proposed Physician Focused Payment Model Scope; and
- Ensure the Postpartum Care Plan Includes Contraceptive Counseling.

Midwifery Supports Women Throughout the Lifespan, Promotes Safety and Healthy Birth Outcomes, and is a Significant Part of the Solution to the Health Care Cost Problem

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 an emphasis on pregnancy, childbirth, and gynecologic and reproductive health care. CNMs are independent health care providers with prescriptive authority in all 50 states and Washington, D.C.

CNMs and CMs are nationally certified by the American Midwifery Certification Board (AMCB)¹ and the profession has required a master's degree for entry into practice since 2010. Private health insurance plans typically cover midwifery services as do the Medicare and Medicaid programs. Midwifery services are a mandatory service under the Medicaid program, as more than half of all births each year are financed by the program.

Today there are some 12,000 CNMs/CMs in the U.S. These midwives attend over 330,000 births in the U.S. annually. Nearly all midwifery births occur in the hospital, with some in birth centers and others in homes. Midwives promote healthy physiologic birth. By doing so, they help reduce the incidence of unnecessary caesarean sections and other interventions. Healthy physiologic birth means healthier moms and newborns, fewer complications and side-effects, and much lower health care costs.

Research findings demonstrate the many ways that midwives and midwifery contribute to positive health outcomes and help address the national problem of health care cost growth. Comparing national benchmarking data of 90 midwifery practices to national survey and birth data on obstetric procedures, women receiving care from CNMs/CMs had lower than the national average rate for episiotomy (3.6% compared to 25%). They also experienced lower than the national average rate for primary cesareans (9.9% compared to 32%), and higher than the national average rate of breastfeeding initiation (78.6% compared to 51%). CNMs and CMs also have lower cesarean birth rates, producing significant cost savings and avoiding the complications associated with major abdominal surgery.

Among the 234 midwifery practices reporting on 97,158 births in ACNM's 2013 benchmarking data, the median rate of cesarean procedures was 11.8%. In 2014 the Centers for Disease Control and Prevention determined there were 2,699,951 vaginal deliveries and 1,284,551 cesarean deliveries or 32.2% of all births. Midwives can create cost savings within the health care system through high quality, evidence-based care that is in alignment with national recommendations for appropriate rates of cesarean delivery and intervention utilization.

¹ American Midwifery Certification Board, www.amcbmidwife.org.

Physiological Birth is Evidence-Based and Optimal Care for Mothers and Babies

ACNM supports proposals that expand access to midwifery care and encourage normal physiologic labor and birth. Normal physiologic labor and birth has positive short- and long-term health implications for the mother and infant. Optimal physiologic function of the neuroendocrine system enhances the release of endogenous oxytocin and beneficial catecholamines in response to stress. These hormones promote effective labor patterns and protective physiologic responses, including enhanced endorphin levels, facilitation of cardio-respiratory transition and thermoregulation of the newborn, successful lactation, and enhanced bonding behavior between the mother and infant.^{2 3 4 5} When there is optimal physiologic functioning, women are less likely to require interventions to artificially augment labor, which can potentially interfere with their ability to cope with pain. When labor progresses spontaneously there is a reduced likelihood of fetal compromise or need for instrumental/surgical intervention.

For most women, the short-term benefits of normal physiologic birth include emerging from childbirth feeling physically and emotionally healthy and powerful as mothers. Their infants will benefit from the ability of their mothers to respond to their needs and from the lack of exposure to medications that can affect neurological behavior. Long-term outcomes include beneficial effects for the woman's physical and mental health and capacity to mother, enhanced infant growth and development, and potentially diminished incidence of chronic disease. Together, these outcomes are beneficial to the family and society through enhanced family functioning and cost effective care. Importantly, a focus on these aspects of normal physiologic birth will help to change the current discourse on childbirth as an illness state where authority resides external to the woman to one of wellness in which women and clinicians share decisions and accountability.⁶

Informed Choice and Shared Responsibility Are Key When Choosing a Birth Setting

ACNM supports the right of every family to experience childbirth in a safe environment where human dignity and self-determination are respected. Every woman has the right to make an informed choice regarding the place of birth that best meets her and her newborn's health needs.^{7 8 9} Midwives provide maternity care in all settings in the United States, including hospitals, birth

² Moore E, Anderson G, Bergman N. Early skin-to-skin contact for mothers and their healthy newborn infants. *Cochrane Database Syst Rev.* 2007; Jul 18 (3):CD003519.

³ Fourer M. Creating birth space to enable undisturbed birth. In Fahy K, Fourer M, Hastie, C, eds. *Birth Territory and Midwifery Guardianship. Theory for Practice, Education and Research.* New York, NY: Elsevier; 2008:57-77.

⁴ Unvas-Moberg K. *The Oxytocin Factor. Tapping the Hormone of Calm, Love, and Healing.* Cambridge, MA: Da Capo Press; 2003.

⁵ Taylor S, Klein L, Lewis B, et al. Biobehavioural responses to stress in females: tend-and-befriend, not fight-or-flight. *Psychological Rev.* 2000; 107:411-429.

⁶ Kennedy HP, Nardini K, McLeod-Waldo R, et al. Top-selling childbirth advice books: a discourse analysis. *Birth.* 2009;36(4):318-324.

⁷ American College of Nurse-Midwives. Our philosophy of care. <http://www.midwife.org/Our-Philosophy-of-Care>.

⁸ American College of Nurse-Midwives. Position statement. Home birth. <http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000251/Planned-Home-Birth-Dec-2016.pdf>.

⁹ Bogdan-Lovis E, de Vries RG. Ethics and the architecture of choice for home and hospital birth. *J Clin Ethics.* 2013;24(3):192-197.

centers, and homes. ACNM supports the choice of families to give birth in a birth center and the role of CNMs and CMs to provide care in all birth settings.

The goal in selecting a birth setting is to identify the environment that best meets the health and social needs of the woman and her newborn. A woman with a favorable prognosis for a normal, healthy labor, birth, and postpartum course may desire the documented health benefits associated with a planned home birth attended by a midwife with appropriate education and skills.

Midwives provide care independently in the home for healthy women during pregnancy, labor, and birth within the parameters of setting-specific, clinical practice guidelines. Midwifery care in any setting includes ongoing clinical assessments that inform risk evaluation and clinical decision making throughout pregnancy, labor, birth, and the initial newborn and postpartum period.¹⁰¹¹ Consistent with the ACNM Standards for the Practice of Midwifery, each midwifery practice develops comprehensive clinical guidelines that address access to consultation, collaboration, and referral that includes a process to facilitate transfer of care if necessary.

ACNM recommends the use of the midwife's clinical practice guidelines as a key component of the discussion and shared decision-making process between a woman and the midwife and between the midwife and consultant physician when considering birth setting. The decision to give birth at home is made within the context of the woman's philosophy, culture, and family. The midwife contributes skills, experience, educational preparation, professional accountability, clinical judgment, professional ethics, relationships with other health care professionals, and knowledge of community and professional standards. Clear, transparent, and ongoing shared decision making between the midwife and the woman and her family is an essential component of care throughout the pregnancy, labor, and birth.

As the PTAC considers implementation of the bundled payment for comprehensive low-risk maternity and newborn care provided by independent midwife-led birth center practices that are clinically integrated with physicians and hospital services, ACNM recommends:

1. Include ACNM-endorsed Best Practice Guidelines on Transfer from Planned Home Birth to Hospital

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting. ACNM recommends inclusion of the ACNM-endorsed *Best Practice Guidelines on Transfer from Planned Home Birth to Hospital*¹² within the clinical scope of the proposed physician focused payment model (PFP). Midwifery

¹⁰ American College of Nurse-Midwives. Position statement. Collaborative management in midwifery practice for <http://www.midwife.org/index.asp?bid=59&cat=3&button=Search&rec=58>.

¹¹ American College of Nurse-Midwives. Standards for the practice of midwifery. [http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards for Practice of Midwifery Sept 2011.pdf](http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards%20for%20Practice%20of%20Midwifery%20Sept%202011.pdf).

¹² Home Birth Summit. Best practice guidelines: transfer from planned home birth to hospital. <http://www.homebirthsummit.org/best-practice-transfer-guidelines/>. Published 2013. Accessed November 10, 2015.

management during births outside of the hospital setting include planning for unexpected contingencies in order to provide timely interventions and seamless access to consultation, interprofessional collaboration, and respective hospital-based health care providers when needed.¹³ Coordination of care and communication of expectations during transfer of care between settings is integral in improving health outcomes. Variations in guidelines may occur based on local standards, regulations, available transportation, access to integrated systems of care, and/or the skill and experience of the midwife, hospital-based consultants, and other health care professionals as needed. As such, integration of care across birth sites, access to interprofessional collaboration, and respectful care are key components for the provision of high-quality services.

2. Recognize the Certified Midwife (CM) Credential Within the Bundle, as Both CNMs and CMs are Certified by the American Midwifery Certification Board (AMCB)

ACNM recommends that the bundle include and recognize both the Certified Nurse Midwife (CNM) and Certified Midwife (CM) licensing credential. The CNM and CM credentials are recognized as identical in all aspects of midwifery education and practice by ACNM and the American College of Obstetricians and Gynecologists (ACOG). Both CNMs and CMs are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass the same national certification examination as CNMs to receive the professional designation of CM.

CNMs and CMs must demonstrate that they meet the *Core Competencies for Basic Midwifery Practice*¹⁴ of the ACNM upon completion of their midwifery education programs and must practice in accordance with *ACNM Standards for the Practice of Midwifery*.¹⁵ ACNM competencies and standards are consistent with or exceed the global competencies and standards for the practice of midwifery as defined by the International Confederation of Midwives. To maintain the designation of CNM or CM, midwives must be recertified every 5 years through AMCB and must meet specific continuing education requirements. The Certified Midwife is a valuable addition to the maternal health and primary care workforce in the United States.

3. Support CNM/ CM Full Scope of Practice Language in Proposed Physician Focused Payment Model Scope

ACNM recommends that the bundle include full scope of practice language for CNMs and CMs. Midwifery as practiced by CNMs and CMs encompasses a full range of primary health care services

¹³ Vedam S, Leeman L, Cheyney M, et al. Transfer from planned home birth to hospital: improving interprofessional collaboration. *J Midwifery Womens Health*. 2014; 59(6): 624-634. Doi:10.1111/jmwh.12251.

¹⁴ American College of Nurse-Midwives. Core Competencies for Basic Midwifery Practice. <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000050/Core%20Comptencies%20Dec%202012.pdf>.

¹⁵ American College of Nurse-Midwives. Standards for the Practice of Midwifery. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000051/Standards for Practice of Midwifery_Sept_2011.pdf.

for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. These services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers.¹⁶

The PFFM clinical scope as drafted problematically limits CNM/CM scope in ways that would be expected to impair women's access to care, and to increase health care costs without improving quality. The PFFM clinical scope includes language that would preclude midwives from treating mothers with preexisting complications or complications that develop during pregnancy. It states that mothers with these types of complications would be referred to physician care. The evidence clearly demonstrates that midwives commonly manage and treat women with a wide range of risk factors (e.g., gestational diabetes, women seeking a vaginal birth after cesarean (VBAC)). Treatment of women with these risk factors is still within ACNM's approved scope of practice guidelines for midwifery care and should be included in the finalized bundled payment model.

4. Ensure the Postpartum Care Plan Includes Contraceptive Counseling

One of the most important contributions to women's health has been the availability of affordable, effective and safe contraception. The Alliance for Innovation on Maternal Health, in which ACNM is a Core Partner, recommends that every clinical setting optimize counseling models, clinical protocols, and reimbursement options to enable timely access to desired contraception from birth to the comprehensive postpartum visit. By helping women control the timing, number, and spacing of births, family planning has many benefits for a woman and children she may have in the future. Planned pregnancies, which for most women require contraception, allow women to optimize their own health before pregnancy and childbirth. An unintended pregnancy may have significant implications for a woman's health, sometimes worsening a preexisting condition, such as diabetes or hypertension. Planned pregnancies improve the overall health and well-being of children as well. Adequate birth spacing lowers the risk of low birth weight, preterm birth, and small-for-gestational age babies. As such, ACNM recommends that the finalized payment bundle specifically include the service of contraception counseling and/or initiation during the post postpartum care period.

¹⁶ American College of Nurse-Midwives. Definition of Midwifery and Scope of Practice for Certified Nurse Midwives and Certified Midwives.
<http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Feb%202012.pdf>.

We applaud the Minnesota Birth Center for submitting this proposal to the PTAC. Furthermore, we thank PTAC for the opportunity to comment and make recommendations on this proposed bundle. ACNM believes that to provide the highest quality seamless care, physicians and midwives should have access to systems of care that foster collaboration among licensed independent providers. We encourage the PTAC to review ACOG's committee opinion on *Approaches to Limit Intervention During Labor and Birth*.¹⁷ Obstetrician–gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that are associated with minimal interventions and high rates of patient satisfaction. We believe this model proposed by Minnesota Birth Center, as modified with ACNM's recommendations, could serve as a blueprint for others to utilize when developing similar patient centered initiatives with independent midwifery practices, physician-owned practices and hospitals.

Thank you for the opportunity to provide comments to this proposal. If you have questions, please contact Amy Kohl, ACNM Director of Advocacy and Government Affairs, at akohl@acnm.org.

Sincerely,



Frank J. Purcell
Chief Executive Officer



Lisa Kane Low, PhD, CNM, FACNM, FAAN
ACNM President

¹⁷ American College of Obstetricians and Gynecologists. Committee Opinion on Approaches to Limit Intervention During Labor and Birth. <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Approaches-to-Limit-Intervention-During-Labor-and-Birth>.