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June 10, 2014

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9942-NC
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted electronically via http://www.regulations.gov

Re: Comments on the Request for Information Regarding Provider Non-Discrimination (CMS-9942-NC)

The National Association of Certified Professional Midwives (NACPM) appreciates this opportunity to comment on the request for information (RFI) [1] titled, "Request for Information Regarding Provider Non-Discrimination," collectively issued by the Departments of Labor, Health and Human Services (HHS), and Treasury (the Departments).

NACPM is the membership organization representing Certified Professional Midwives (CPMs) in the United States. CPMs, a rapidly growing segment of the midwifery profession, are primary maternity care providers trained to offer high-quality, evidence-based care to women during the childbearing year. In fact, approximately one in six midwives in the United States is a CPM.

CPMs are knowledgeable and skilled midwifery practitioners who have met the rigorous, national accreditation standards for certification set by the North American Registry of Midwives (NARM). In the United States, CPMs provide unique and critical access to normal physiologic birth, which profoundly benefits mothers and newborns. Although qualified to practice in any setting, they have particular expertise in providing care in homes and free-standing birth centers, and own or work in over half of the birth centers in the United States today.

[1] 79 Fed. Reg. 14051, March 12, 2014.

CPMs are licensed in 25 states, with legislative initiatives for licensure in a number of additional states. The credential establishes a national standard for quality assurance within the profession.

NACPM works to improve outcomes for childbearing women and their infants, developing and strengthening the profession, and informing public policy with the values inherent in CPM care. Studies have demonstrated that among low-risk women, planned home births resulted in lower rates of interventions without an increase in adverse outcomes for mothers or babies.[2] Additionally, the cesarean rate for women who intend to give birth at home is roughly 5.2 percent,[3] relative to just under 33 percent for the entire population.[4] Similarly, the safety and effectiveness of care provided in birth centers is well-documented, as evidenced in part by the low (six percent) cesarean rate among women electing to receive care in a midwifery-led birth center.[5] Unneeded cesareans increase risks for mothers and babies and result in additional complications and health care costs.

In these comments, we seek to articulate our concerns with the Departments' interpretation of section 2706(a) of the Public Health Service Act (PHSA), as added by section 1201 of the Affordable Care Act (ACA), via the issuance of Frequently Asked Question (FAQ) implementing guidance.[6] We write to underscore the importance of the explicit non-discrimination protections established by the ACA, and emphasize the need for consumer choice in health care by ensuring that these fundamental statutory protections are not diminished through sub-regulatory guidance or otherwise.

I. The FAQ Guidance Contradicts Congressional Intent to Protect Patients' Access to Covered Health Services from the Full Range of State Licensed and Certified Providers

The ACA's provider non-discrimination protections delineated at PHSA 2706(a) state that a:

> Group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of

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[2] Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D. and Vedam, S. (2014), Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. *Journal of Midwifery & Women's Health*, 59: 17–27. doi: 10.1111/jmwh.12172.

[3] Ibid.

[4] U.S. National Center for Health Statistics, Rates for Total Cesarean Section, Primary Cesarean Section, and Vaginal Birth After Cesarean (VBAC), United States, 1989-2012, available at http://www.childbirthconnection.org/article.asp?ck=10554.

[5] Stapleton, S., 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: http://nacpm.org/documents/Birth%20Center%20Study%202013.pdf.

[6] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

that provider's license or certification under applicable state law.[7]

This provision, which took effect on January 1, 2014, clearly prohibits health plans from discriminating against specific provider groups who are acting within the scope of their practice as per applicable state licensure or certification requirements. To mean anything, this must mean that plans may not effectuate wholesale exclusions of certain classes of provider from their networks or otherwise disparately treat provider types.

Congress recognized that these protections are important to ensure that a patient's right to access coverage from a full range of qualified providers is maintained. In this case, the ACA statutory language is both plain and unambiguous. It should not be interpreted so as to render it superfluous or meaningless. Unfortunately, this is exactly what the April 29, 2013 FAQ[8] does.

If left unmodified, the FAQ effectively allows non-grandfathered group health plans and health insurance issuers to routinely and unlawfully discriminate against entire groups of providers operating within the scope of their state-issued license or certification. NACPM echoes the concerns asserted by Congress in the July 11, 2013 Senate Appropriations Committee Report 113-71[9] regarding the potential of the FAQ to undermine a patient's fundamental right of provider choice via the wholesale exclusion by plans of specific provider classes.

As the Committee directs, "the goal of this provision is to ensure that patients have the right to access covered health services from a full range of providers licensed and certified in their State."[10] This does not imply that health plans must contract with every provider in the service area. What it does mean, as the Senate Appropriations Committee clarified, is that plans may not exclude "whole categories of providers" from coverage if there is no bona fide performance or quality consideration to support that exclusion.

As members of the advancing CPM profession, we are all too familiar with the practice of plans per se denying network inclusion of provider types based on false suppositions or ignorance about the expertise or experience underlying a particular path to licensure. This is discrimination in its most obvious form, and Congress prohibited it with section 2706(a).

We are furthermore concerned that the FAQ, which states that in the absence of "any further guidance," health plans and issuers are to rely on "a good faith, reasonable

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[7] See http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
[8] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.
[9] See p. 126, available at http://www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf.
[10] Ibid.

interpretation of the law,"[11] invalidates these statutory patient protections via its general deference to plans. In essence, the FAQ, as constructed, defers the interpretation and implementation of this critical statutory mandate to plans at their varying discretion and without any necessary administrative enforcement mechanisms to ensure plan compliance.

Furthermore, the Departments' FAQ has the potential to inadvertently discriminate against patients' access to cost-effective, quality maternity care provided by CPMs. This has significant and widespread implications for maternity care, given the potential of the Departments' sub-regulatory guidance to jeopardize the applicability of laws and regulations enacted by 25 states to-date where CPMs are legally authorized to practice.

In these states, whether to avoid unnecessary, risky interventions more common in hospital-based care or for other reasons, including their preferences relating to the highly personal experience of childbirth, mothers have a right to choose out-of-hospital births performed by CPMs. Congress enacted section 2706(a) to protect that right and CMS' FAQ would nullify it.

II. The FAQ Guidance Effectively Exacerbates the Potential for Discrimination in Provider Reimbursement

The FAQ weakens and undermines the reimbursement component of section 2706(a) by allowing plans to establish rates based on "market standards and considerations,"[12] adding a clause foreign to the statute's text and intent. While the statute appropriately includes a limited exception to the nondiscrimination provision by allowing health plans to vary "reimbursement rates based on quality or performance measures,"[13] consistent with standard practice, the FAQ appears to allow any type of reimbursement discrimination without regard to its justification. This clause undermines the intent of the ACA and paves the way for health plan payment discrimination against groups of providers.

If all that section 2706(a) mandates is that plans pay in-network providers for the covered services delivered, then it was an entirely superfluous exercise by Congress. By the contracts themselves, plans must pay in-network providers for services rendered at the negotiated rate. Congress did not have to act to guarantee that.

Instead, under CMS' reading, the section would give plans broader discretion to deny payment, potentially to in-network providers but certainly to entire classes of providers, based on "market…considerations."[14] As mentioned above, this sets a dangerous precedent by giving plans the ability to further discriminate against whole categories of

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[11] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.
[12] Ibid.
[13] See http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
[14] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

professional providers operating within their respective state licensure or certification.

III. The FAQ Guidance Limits the Access and Choices for Women Seeking High Quality, Cost-Effective Maternity Care

As enacted by the ACA, health plans offered in the individual and small group market must offer a comprehensive benefits package known as essential health benefits (EHBs).[15] Maternity and newborn care is a requisite element of the EHB package, and as such, health plans must cover maternity and newborn care to sell plans in the insurance marketplaces, and states expanding Medicaid must provide these benefits to newly-eligible enrollees.[16] These services are clearly defined within the CPM scope of practice and furthermore recognized in all states where CPMs are licensed. To unduly allow health plans to exclude whole categories of providers, as the FAQ suggests, undermines a woman's basic right to choose from the full array of state-licensed and certified maternity care providers authorized to provide this vital component of the EHB package.

Furthermore, the FAQ flies in the face of separate but parallel implementation efforts aimed at expanding patient access via the provision of comprehensive provider networks – including with respect to maternity care providers specifically – as a result of the broader section 2706(a) mandate. For example, recently, the Federal Employees Health Benefits (FEHB) Blue Cross Blue Shield (BCBS) Benefit Plan announced that, for the 2014 plan year and subject to certain criteria, it "now cover[s] any licensed medical practitioner for covered services performed within the scope of that license," explicitly citing the ACA non-discrimination mandate at section 2706(a) as justification for such change.[17] BCBS notes that, "[p]reviously, benefits for certain medical practitioners were limited to services performed in Medically Underserved Areas (MUAs)."[18] Thus, the Departments' FAQ, as constructed, effectively negates the interpretation rendered by the largest employer-sponsored group health plan in the country and potentially jeopardizes patients' access to the full array of state-licensed and certified providers offering these covered services.

This has profound implications with respect to patients' ability to access quality maternity care, given that the United States already has a significant shortage of maternity care providers, especially in rural areas. Roughly half of U.S. counties have no obstetrician (OB) provider and this shortage will be exacerbated as more OBs retire, fewer physicians specialize in OB, and the overall projected demand for women's health care services increases.[19] By 2030, the shortage rate could reach 18 percent while many rural areas are

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[15] See Overview of Essential Health Benefits at Healthcare.gov, available at https://www.healthcare.gov/glossary/essential-health-benefits/.
[16] Ibid.
[17] See p. 17, available at http://www.fepblue.org/downloads/2014%20SBP%20BROCHURE%20100413_032414_N%20%282%29.pdf.
[18] Ibid.
[19] Rayburn, W. F. (2011). The Obstetrician-Gynecologist Workforce in the United States: Facts, figures, and implications, 2011. American Congress of Obstetricians and Gynecologists.

already struggling to meet the demand for maternity care.[20] CPMs play a critical role in helping to fill this shortage, and they will continue to do so, provided their profession is not unduly excluded by health plans.

The financial ramifications of the statutory underpinnings of the nondiscrimination provision cannot be overstated, especially when it comes to the cost-effective maternity care option provided by CPMs. States have demonstrated savings when utilizing CPMs in their Medicaid programs. For example, Washington State saved almost $500,000 in cesarean section reductions alone over a two-year budget cycle with licensed midwives attending just two percent of the births.[21]

Midwives provide services that lead to high-quality health outcomes. One study found, "women who received models of midwife-led care were nearly eight times more likely to be attended at birth by a known midwife, were 21 percent less likely to experience fetal loss before 24 weeks' gestation, 19 percent less likely to have regional analgesia, 14 percent less likely to have instrumental birth, 18 percent less likely to have an episiotomy, and significantly more likely to have a spontaneous vaginal birth, initiate breastfeeding, and feel in control."[22] These improved outcomes are the hallmarks of safe, effective maternity care.

Potentially limiting access to these high-quality providers would diminish quality and increase costs at a time when our healthcare system can afford these least. Women deserve options in maternity care, including access to the high-quality, cost-effective care that CPMs can deliver. If left unmodified, the FAQ allows for widespread access and payment discrimination for entire groups of professional providers, like CPMs.

IV. Conclusion

In closing, we wish to reiterate our concerns regarding the Departments' interpretation[23] of the ACA's provider nondiscrimination provision and the potential the implementing FAQ guidance has to jeopardize patients' access to cost-effective, quality maternity care. We urge the Departments to rectify the FAQ in a manner that does not otherwise undercut this important patient-centered provision of the ACA.

We appreciate the Departments' consideration of our comments. Should you have any questions about our specific comments, we would be happy to provide additional

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[20] Ibid.
[21] Health Management Associates (2007), Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits, available at http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf.
[22] Sandall J., Devane D., Soltani H., Hatem M., Gates S. (2010). Improving Quality and Safety in Maternity Care: The Contribution of Midwife-led care. Journal of Midwifery and Women's Health, 55 (3), pp. 255-261.
[23] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

information and may be reached via the contact information that follows. Thank you again for the opportunity to comment on this important matter.

Sincerely,

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