



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/00000000051/Standards for Practice of Midwifery Sept 2011.pdf](http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000051/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>.