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INTRODUCTORY REMARKS

December 8 HCR Webinar

Thank you for joining us for the sixth and last in our series of health reform webinars. My name is Dr. Jerry Joseph, Immediate Past President of ACOG, and joining me again today is Lucia DiVenere, ACOG's Senior Director of Government Affairs.

Our intent in offering this series is to give you detailed practical information about the new health reform law, including changes that will affect your practices and your patients. Before we start, let me review a few "housekeeping" points:

- If you're listening in by phone, please be sure to **mute** your line for everyone's benefit.
- You can submit **questions** throughout the webcast, using the form shown on your screen. We'll answer your questions at the end, and please include your **email address** so we can get back to you if we run out of time.
- If you experience any **technical issues** during the webcast, please use the help button shown on your screen.
- Please note that these slides are available for download at ACOG's health reform center at www.acog.org.

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We're looking today at provisions in the Affordable Care Act that relate to non-physician providers, specifically midwives.

Through the changes we'll discuss this week, Congress intends to increase access to maternity care and find cost savings at the same time, in these cases by encouraging use of non-hospital settings and non-physician providers to care for pregnant Medicaid patients.

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As we've seen in previous sessions, a number of themes weave through the provisions of the Affordable Care Act. Congress and the White House wanted to ensure that we get more bang for our health care bucks, meaning quality care at lower cost.

There's also heavy emphasis on primary care, counteracting the health system trend toward specialty care. Some provisions in the Act are intended to address anticipated physician workforce shortages.

These three themes, low cost quality care, primary care, and physician shortages, which are very related, are the background for the non-physician provider elements of the health reform law. You'll see this in detail as we go through the three provisions that most affect ob-gyn care.

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This year, 2010, two changes are made to how free-standing birth centers are staffed and paid under the Medicaid program, both intended to increase the number of births at these centers.

First, some background, 41% of all US births are paid for by Medicaid, as high as 60% in some states, and only as low as 28% in others. And many state governors are struggling with the cost of their Medicaid programs.

A free-standing birth center is a healthcare facility, staffed by nurse-midwives, midwives and/or obstetricians, for mothers in labor, who may be assisted by doulas and coaches. Should additional medical assistance be required, the mother can be transferred to a hospital. Some hospitals are adding birth centers to their facilities as an alternative to high tech maternity wards.

A birth center presents a home-like environment, often with queen-sized beds to accommodate both mother and father, and birthing tubs or showers for water births.

Birth center care is covered by major health insurance plans, including Medicaid in most states. There are fewer than 200 free-standing birth centers today in the US, generally located in the 32 states that have birth center regulations. Some birth centers meet accreditation standards as well.

So what are the two changes in the health reform law?

Before this law, Medicaid was authorized to pay hospitals and other facilities operated by and under the supervision of a physician. No payments were authorized for services provided

in an ambulatory care center, including a free-standing birth center, operated by other health professionals.

Now, Medicaid will pay for births at state accredited centers regardless of whether the center is operated by or under the supervision of a physician.

The second change authorizes Medicaid to pay for services of any health provider in a birth center, as long as the individual is practicing within the state's scope of practice. This could allow Medicaid payments for certified professional midwives and doulas, in addition to ob-gyns and certified nurse midwives.

Let's get some background on the different kinds of midwives, so we can better understand these provisions.

ACOG supports the work of certified nurse midwives. These skilled providers, along with nurse-practitioners and physicians' assistants, account for about 5% of the total prenatal visits in the US, with nearly all of these visits occurring in obstetricians' offices.

There's a big difference in training and skill level between a certified nurse midwife and a certified professional midwife, called direct entry or lay midwives in some states. Today's 11,000 CNMs are required to have a nursing background. The 1,300 CPMs practicing in this country are not.

CNMs practice primarily in ob-gyn offices and hospitals, CPMs practice primarily in birth centers and private homes. CNMs are licensed in all 50 states, CPMs are not. CNMs meet the educational and professional standards used by the American

Midwifery Certification Board, the only midwifery certification recognized by ACOG. CPMs do not.

ACOG opposes federal, state, or private insurance recognition of certified professional midwives (CPMs) We stand with the American College of Nurse Midwives in our position that recognition as a professional midwife in the U.S requires (1) successful completion of a formal education program accredited by an agency recognized by the US Department of Education; (2) national certification; and (3) licensure in the state in which services are provided.

While some CPMs have completed formal accredited academic programs, others have completed apprentice programs with no minimum educational requirement or qualified faculty oversight. At least half of current CPMs have been trained through apprentice routes. This is the group we have the most concerns about, for the safety and health of our patients.

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At least 26 states license the least trained midwives to perform home births.

As noted previously, CPMs, also called lay or direct entry midwives, generally have only apprentice training and limited education, are not required to have a nursing background, and most practice in a birthing center and/or private homes. It is this group that we have the most concerns about, for the safety and health of our patients.

Lucia, why are we seeing CPMs gain greater acceptance, then? Help us make some sense out of this.

CPMs have been waging this battle for increased recognition for 30 years. Three factors, really, are behind the increasing interest in supporting CPM care in the state legislatures and in Congress.

First, some data suggests high quality maternity outcomes by these low cost providers, a combination that's music to a lawmaker's ears in a year when everyone's trying to cut government budgets.

Second, women in pockets of the US are very enthusiastic about their midwives and the specifically non-physician, non-hospital care they receive during their pregnancies and deliveries. These women show up and rally on behalf of CPMs in Congress and the state houses. From a lawmaker's point of view, these laws give women another option that they say they want.

And third, there thankfully are few horror stories of care gone bad, mostly because ob-gyns and hospital emergency

departments stand ready in any dire circumstance. Our health care system doesn't have a good way today of adequately capturing these instances and bringing them to light in a meaningful way.

ACOG is holding a hard line against increased recognition and authorization of care by CPMs.

Let's take a look at slide 6.

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Today, certified nurse midwives are paid at 65% of the Medicare physician rate for the same services.

In 2011, Medicare will pay certified nurse midwives at the same rate as physicians for the same service, another attempt to increase access to lower cost quality care.

In 2007, ACOG's President and leadership committed ACOG's support of equal payment, in part because CNMs are part of many ob-gyn practices and higher reimbursement for our partners benefits our practices, and in part because CNM services allow physicians to expand their own patient care.

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Some CNMs will also receive small Medicare bonus payments in 2011 – 2015.

CNMs whose primary care service charges (E&M codes) account for at least 60% of their Medicare allowed charges will receive 10% Medicare bonus payments, part of Congress' effort to address the shortage of primary care providers.

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And the last provision we'll examine today kicks in in 2014, the year when the state insurance Exchanges begin operation.

This provision requires that all health insurance plans offered through an Exchange must pay any health care provider recognized under state law for services covered under that plan, even if the insurer doesn't contract with that provider.

Once again, our concern is with certified professional midwives, also called lay midwives or direct entry midwives. This provision may force private insurers to cover maternity care provided by some of our nation's least qualified providers.

We're already hard at work in Congress and within the House of Medicine to fight this provision of the law.

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That brings us to the end of our webinar series. I hope it's been helpful and informative.

Please type in any additional questions and submit them now with you e-mail address in case we do not have time to answer them before time expires.

Remember that these slides can be found on ACOG's Health Reform Center at ACOG's home page-----www.acog.org, where our webinars are archived and can be viewed at any time.

Thank you for being with us today and we hope you and your family will have a joyous and peaceful holiday!