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Re: Draft All Plan Letter regarding Access requirements for freestanding birth centers and the provision of midwife services.

Dear MCQMD officials:

The attached comments are provided jointly by the California Association of Licensed Midwives (CALM) and the California Nurse-Midwives Association (CNMA), the state professional societies for, respectively, Licensed Midwives (LMs) and certified Nurse-Midwives (NMWs)[1] in California. CALM, CNMA, and our members submit these comments to the PMMB of the Managed Care Quality and Monitoring Division to provide feedback, as requested, on the draft All Plan Letter (APL), "Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services," which will supersede APL 16-017.

For the purposes of this document, reference to "midwifery services" or "midwifery care" includes prenatal, intrapartum, lactation and postpartum care, care of the newborn, family-planning care for the mother and interconception reproductive health care.

[1] CNM is a trademarked credential that can only be used by individuals who are nationally certified. To refer to BRN-certified individuals, NMW is the right abbreviation, or just spell out certified nurse-midwife. See: http://www.midwife.org/The-Credential-CNM-and-CM and https://www.rn.ca.gov/applicants/ad-pract.shtml#nmw

CALM and CNMA wish to express their appreciation for the policy direction expressed in the proposed draft. This policy change is greatly needed. At the present time, as this year's Network Adequacy survey has no doubt confirmed, more than 90% of the Medi-Cal MCPs in this state have no LMs or FBCs in their respective networks. Likewise, NMWs report that, unless the midwife is employed by a physician group practice or hospital, prospective clients face barriers to access the services of nurse-midwives. Both groups are cautiously pleased with the proposed APL, which will update APL 16-017 in a way that is intended to ensure that Medi-Cal beneficiaries enrolled in MCPs will have guaranteed access to the services of midwives in all settings—home and birth center as well as hospital. We provide the following comments to fill in gaps and improve clarity.

As you know, CALM members and their clients have struggled to achieve access since 2013 when LMs were first recognized as eligible Medi-Cal providers. During this time, we have met with near-universal noncompliance on the part of the MCPs and their physician-dominated IPA networks. As advised by MCQMD officials, we have pursued MER requests, continuity of care grievances and appeals, and complaints to the Department of Managed Health Care in order to achieve compliance by the MCQMD plans with federal and state law. For the past year, CALM members and their clients have also reported each denied network application and each refused prior authorization of out-of-network LM services of by email to Mr. Nau, Ms. Smiley, and/or Ms. Brooks, as DHCS officials had previously advised us to do. We were told last year that the Department could not take action to enforce compliance with the law unless we could demonstrate network inadequacy. CALM members have done so, as additionally confirmed by your own survey (APL-18-005).

Looking forward to good working relationship with MCQMD, CALM and CNMA provide the following points as feedback on the specifics of the proposed draft:

This APL should make it very clear that MCPs are required to ensure adequate access to midwifery services in home, hospital and freestanding birth center.

<u>Background and Rationale:</u>

Medi-Cal beneficiaries are entitled to access midwife services regardless of birth setting, including home, birth centers and hospitals. Since there is no such restriction based on setting in midwives state law for scope of practice, it is a violation of federal law for a plan to impose such a restriction. LMs have had serious problems with MCP medical directors refusing to approve home birth. The most recent such example occurred last month, when Partnership Health Plan approved an LM for one of its networks, but informed her it would not cover home

or birth center birth (after insisting she raise her malpractice coverage to 1M/3M in order to have her application processed).

Improving access to midwife services, both LM and NMW, is an important step toward reducing health disparities and improving the maternal and child health in California. Numerous studies and reports demonstrate the benefits of midwife care. In the ground breaking study "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes"[2] researchers demonstrate a strong correlation between increased integration of midwifery services to improved maternal child health care within a given state. Further, their research found that improving access to midwifery care to be significantly correlated reduction in race based disparities in maternal child health[3]. This research was inclusive of LM and NMW. Similarly the "Battling Over Birth," report published by Black Women Birthing Justice[4] found improving access to midwifery care, both LM and NMW, to be a key recommendation towards addressing the race based disparities in maternal child health faced by black women. Further, in public statement last week the Democratic members of the U.S. Congress Joint Economic Conference recognized the Value of Midwifery in Maternal and Infant Care[5].

Network Adequacy Requirement: time-and-distance standards should be developed to meet network adequacy standards for midwifery services and FSBs on the same or similar basis as for OB/GYNs and hospital-based maternity services. Any other standard compromises safety, and creates barriers and disincentives to access care.

Background and Rationale:

With respect to time-and-distance standards, CALM and CNMA agree with and adopt the comments provided on this subject by MCH access. Clearly, time-and-distance standards under Knox-Keene, as they apply to OB/GYN providers, should also apply to LMs, NMWs, and FBCs, provider categories licensed and recognized under California law. No legal basis exists for excluding these provider categories from these state access and adequacy standards.

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[2] Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., ... & Kennedy, H. P. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PloS one*, *13*(2), e0192523.
See also Pro Publica report on the research:
https://www.propublica.org/article/midwives-study-maternal-neonatal-care

[3] See "Impact of race and integrated midwifery" http://www.birthplacelab.org/key-findings/

[4] http://www.blackwomenbirthingjustice.org/battling-over-birth

[5] https://www.jec.senate.gov/public/index.cfm/democrats/2018/9/the-value-of-midwifery-in-maternal-and-infant-care)

The proposed APL sets forth the Managed Care Plan network adequacy requirements as follows:

"MCPs are required to provide their members with access to FBC services. In accordance with CMS requirements and in order to achieve an adequate provider network, each MCP must include at least one FBC in the provider network, to the extent that FBCs are available in the MCP's contracted service area."

> "MCPs are also required to provide their members with access to both CNMs and LMs as providers of services permitted within each practitioner's scope of practice. As part of maintaining an adequate provider network, MCPs must attempt to contract directly with at least one CNM and at least one LM in the MCP's contracted service area. MCPs must document efforts to include at least one of each provider type in the provider network."

We agree that federal and state law, as well as the MCP Contracts, require the MCPs to provide enrollees with access to FBC services, and to both LM and NMW services in all birth settings. We further agree that network adequacy standards regarding FBCs, LMs, and NMWs are equally applicable to those entities, such as IPAs, with which MCPs may contract, and that MCPs will be held responsible, and liable for sanctions, for violations of these standards by the MCP itself or an IPA with which the MCP contract. Members of CALM and CNMA will educate their respective members so that those midwives and their clients will be able to bring any and all violations of these standards to the attention of MCQMD officials expeditiously and accurately, in accordance with the guidance recently set forth in. APL 18-003[6] and APL 18-005[7]

We are concerned, however, that a minimum standard of one each per network for FBCs, LMs, and NMWs will itself be inadequate to ensure access. This standard does not clarify whether each IPA that contracts with an MCP must also comply with this one-per-network standard. Our understanding of applicable federal and state law and rules is that, inasmuch as each IPA covers a discrete geographic area and each is considered a network, this standard

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[6] APL18-003: NETWORK ADEQUACY STANDARDS FOR TIMELY ACCESS TO CARE FOR ROUTINE AND SPECIALIST APPOINTMENTS
https://www.dhcs.ca.gov/services/Documents/MDSD/2018%20DAPLs/APL_18-003_NETWORK_ADEQUACY_TIMELY_ACCESS_1-9-18.pdf

[7] APL 18-005 NETWORK CERTIFICATION REQUIREMENTS
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-005.pdf

applies to each IPA, with which the MCP contracts, and that the MCP is responsible for assuring that each such IPA is also in compliance. Otherwise, beneficiaries enrolled in a noncompliant IPA would lack real access, as required by applicable federal and state law and regulations.

As you are of course aware, the county-wide geographic areas covered by these counties are too large for a single provider of the service to be considered adequate for all enrollees, throughout the county, who might wish to access the service. This is especially problematic for maternity services, which consist of prenatal care, a frequently-accessed service comparable to Primary Care or routine OB Care, as well as intrapartum and postpartum care, which is subject to minimum distance standards as a safety and quality measure. Pregnant enrollees who choose an LM or CNM should have no greater barriers or other difficulties to access prenatal and postpartum care than pregnant enrollees who choose an OB/GYN. Having to travel long distances to the only LM, NMW, or FBC in the County can become a disincentive to receiving adequate prenatal care. Even if the midwife makes home visits for some or all of the care, providers should not be expected to spend inordinate amounts of time traveling over a geographically large or heavily-trafficked county to provide that care.

Likewise, once the enrollee goes into labor, the FBC or home birth midwife should be accessible, as a matter of safety as well as convenience, to that enrollee at no greater distance than a network hospital with L&D service. To the extent that greater distances are required, the risk of unattended home births or unattended in-transit births rise.

Additionally, a minimum of 1LM and 1 NMW is an unsafe standard as midwives who practice in the out of hospital setting require back-up midwives to be available to care for their clients in the event of family emergencies, two clients in labor simultaneously and other unforeseen events.

CALM and CNMA recognize that statutory network adequacy standards do not require MCPs to contract with every midwife or FBC that is eligible for Medi-Cal. We also recognize that the proposed standard provides that, to the extent that there is no in-network LM, NMW, or FBC, plans must provide and pay for care on an out-of-network basis. We urge MCQMD to develop, or at least agree to work toward development, of a formula along the lines of those set forth in the attachments to APL18-005, so that pregnant enrollees will have with better access than one-per-plan. In the meantime, to the extent that an enrollee is unable to access the single LM, NMW, or FBC in any network, due to either geographic, transportation, or provider capacity problems, out-of-network access to another LM, NMW, or FBC must be granted without delay. CALM and CNMA are more than willing to work with the MCPs, IPAs, and MCQMD staff members to identify LMs, NMWs, and FBCs on a county- or zip code- basis. A list of all

presently-licensed LMs in good standing is located on the website of the Medical Board of California, and can be filtered by county. Additionally, the California Board of Registered Nursing can also provide such a list for NMWs and can be requested through their website via the public information/licensee list portal. We also ask that these resources be mailed to plan members with maternity care information and made available at the DHCS website. See for example New Mexico's Medicaid Birthing Options Program website.[8]

References to "CNM" throughout the APL should be changed to "NMW."

CNM is a trademarked credential that can only be used by individuals who are *nationally* certified. To refer to nurse-midwives who are certified by the California Board of Registered Nursing, NMW is the correct abbreviation and certified nurse-midwife is acceptable[9].

Specific quotations of the LM and NMW scope should be removed:

State law is broader for both LMs & NMWs than is described in the current APL and the fact that the two licenses are different is already well clarified in the preceding paragraph.

The updated version of the APL states

> "Under state law, CNMs are permitted to "attend cases of normal childbirth," whereas LMs are permitted to "attend cases of normal pregnancy and childbirth, as defined" and must adhere to a detailed set of restrictions and requirements when a patient's condition deviates from the legal definition of normal."

Excerpt from the B & P Code Section 2507 for LMs is as follows: The license to practice midwifery authorizes the holder to attend cases of normal pregnancy and childbirth, as defined in paragraph (1) of subdivision (b), and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn." Recommend removing this sentence. The relevant language from the B & P Code for NMWs is nearly identical, and is found in Section 2746.5 (a): "The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn."

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[8]https://www.molinahealthcare.com/members/nm/en-US/hp/medicaid/centennialovw/coverd/services/Pages/birthopt.aspx#

[9] See: http://www.midwife.org/The-Credential-CNM-and-CM and https://www.rn.ca.gov/applicants/ad-pract.shtml#nmw

In both cases, care during pregnancy, the postpartum period and family planning care as well as childbirth is encompassed, a point that is obscured by the shorter quotes used in the draft APL.

We urge MCQMD to factor in the following points with respect to the FBC/Midwives Policy set forth in this APL and to make corrections or clarifications accordingly:

MCP "applicable professional standards" and "quality of care concerns." We are concerned that MCPs may set unreasonably restrictive barriers or may claim "quality of care" concerns that are, in reality, simply different professional standards or approaches to maternity care between the focused physician-hospital model of care and the holistic physiologic birth model used by midwives. For example, as indicated above, we are aware of instances when Plan or IPA Medical Directors have refused to approve birth in the community, at the client's home or in a birth center, simply because some physicians are philosophically opposed to the concept of out-of-hospital childbirth, or based on unreasonable and unjustified fear of vicarious liability. These non-clinical concerns cannot be permitted to override federal and state requirements that the full scope of practice of both categories of midwives, as authorized by the California legislature and regulated by California government agencies (the MBC for LMs and the BRN for NMWs). Since California practice law authorizes midwives to attend community birth in homes and birth centers, federal and state law and regulations, the State Plan, as amended by SPA 15-018, and MCP contracts with DHCS all require the MCPs and their contracted IPA networks to cover community birth services in home or FBC.

Appropriate standards of care. APL 17-019 provides guidance regarding appropriate standards for MCPs to use for credentialing professional provider categories, including LMs and NMWs, as network providers. To the extent that MCPs may be unfamiliar with national and state standards for midwife education, certification, experience, and competence, CALM and CNMA are in the process of developing guidelines that MCPs can use for evaluating the professional credentials of each category midwife applicants. We are more than willing to conduct and participate in education sessions, site visits to FBCs, and other cooperative measures to improve communication and understanding between our profession and the plans.

We do not, however, consider high levels of malpractice insurance a justifiable barrier for excluding community midwife providers. Community midwives in home birth and birth center practices typically maintain relatively low client loads so that greater time and attention can be provided to each individual client. Furthermore, most community midwives restrict their practice to care of pregnant clients and their newborns during the maternity cycle, although NMWs may also provide some primary care and interconception for women and some

gynecological services. Neither category of midwives typically earns sufficient practice income to be able to afford premiums for malpractice insurance at levels above the $100,000/$300,000 levels required by DHCS for fee-for-Service providers. If MCPs are permitted to require $1M/$3M levels or higher as a condition of network provider status, this requirement may well result in *de facto* exclusion of midwives from networks, depriving enrollees of access.

The out-of-network alternative. In the wake of successful MER and grievance appeals, some CALM members report that a few MCPs have begun to approve LM services on an out-of-network basis at the enrollee's request. Until such time as a satisfactory formula has been developed, we propose that the out-of-network option should continue to be available even after a plan satisfies the one-per-network standard proposed by this APL. This continuing option will ensure that enrollees have truly ***accessible*** options if they choose to receive midwife or FBC services for their pregnancy and childbirth.

IPAs and other delegates. We are pleased that this proposed APL also specifies the obligation of MCPs to enforce these federal and state requirements within the IPAs with which they contract and other delegates. For many years, both in Medi-Cal and in the private insurance markets, physician-controlled IPAs and their medical directors have presented a nearly-solid barrier against inclusion of midwives and birth centers in the networks they control or on an out-of-network basis. Midwives and FBCs present a small-but-growing competitive threat to the market dominance over maternity services presently held by obstetricians and hospitals. Nevertheless, as the recently-published Listening to California Mothers survey revealed, a significant percentage of Californians who recently gave birth in hospitals have expressed a strong interest in community birth with a midwife at home or in an FBC for their next pregnancy. IPAs must not be allowed to safeguard the market share of their members by denying Medi-Cal enrollees the access to the FBCs, LMs, and NMWs to which they are entitled by federal and state law. CALM and CNMA will cooperate with the MCPs by promptly bringing any such denial, refusal, or other barrier to network provider status or to out-of-network access to the attention of the MCP and MCQMD so the problem can be rectified before the enrollee experiences too long a delay. We will look to MCQMD to apply the CAPs and other sanctions indicated in APL 18-003 and 18-005 to deal with IPA and MCP noncompliance.

Client/Enrollee education. We particularly applaud this aspect of the proposed APL. It is vital that Medi-cal MCP enrollees be made aware of the various provider options available to them for care of their pregnancy, childbirth, family planning, and well woman needs. CALM and CNMA are both ready and willing to work with the plans and with DHCS officials to develop suitable consumer education materials to advise pregnant enrollees of their rights of access and options for care within the Medi-Cal program. In a previous example, we provided the

brochure developed for the New Mexico Medicaid program in 2007 by that state's LM and NMW societies.

Stakeholder/Managed Care Advisory Committee. This feedback on the proposed APL is being provided by the two state professional societies of Licensed Midwives, CALM, and Certified Nurse-Midwives, CNMA. These two organizations consists of Medi-Cal providers of important maternal child healthcare services. We respectfully request to be included in the stakeholder communications to the Managed Care Advisory Committee.

CALM and CNMA appreciate DHCS's attention to these essential maternity care access issues. We look forward to continued dialogue and cooperation toward increasing Medi-Cal beneficiary access to maternity care in all settings.

Sincerely,

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