MEDICAID REIMBURSEMENT FOR CERTIFIED PROFESSIONAL MIDWIVES

INTRODUCTION

Despite the fact that Certified Professional Midwives (CPMs) provide high-quality, evidence-based, and cost-efficient care, they remain excluded from many Medicaid plans. This means that families who have the greatest need are being denied access to the care that is otherwise available to the general public and statistically shown to have some of the best outcomes. Not only is this unjust, but it is also arguably illegal under Federal law and some state laws. This brief focuses on Colorado but will have relevance in others states as well.

KEY POINTS

1. Under federal law, states cannot deny reimbursement for CPM services because they are "pregnancy-related care," which is a "mandatory service" for the "categorically needy."

2. The Harkin Amendment (Section 2706(a) of the Affordable Care Act) and Colorado's provider nondiscrimination provisions (Colo. Rev. Stat. § 10-16-107.7.) arguably prohibit private and public insurers from discriminating against CPMs as a group of licensed professionals.

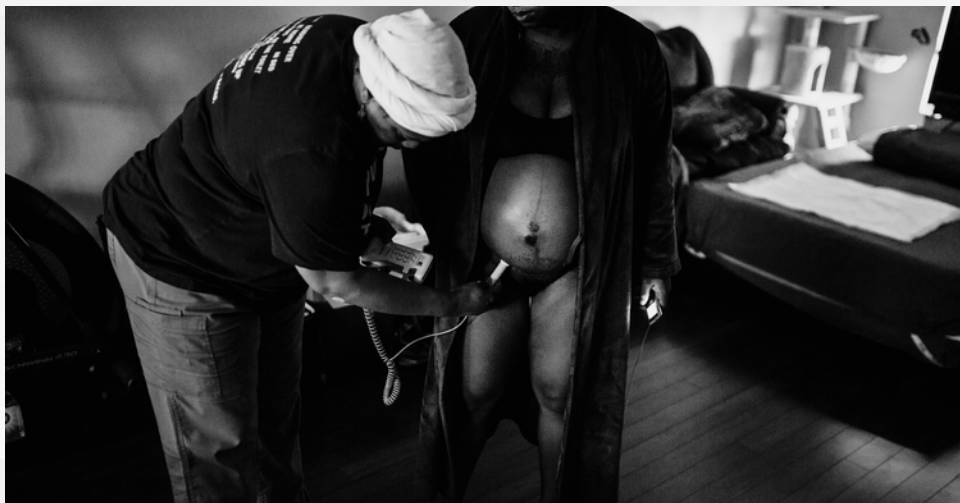
3. Under Colorado state law, CPM services must be covered because they are a form of labor & delivery care that (a) promotes high quality, cost-effective, and evidence-based care; (b) promotes high-value, evidence-based payment models; and (c) Prevents risk in subsequent pregnancies.

SIGNIFICANCE:

- **Obstetric racism & obstetric violence** are less prevalent in CPM care settings.
- **Birth equity cannot be achieved** if the most vulnerable families are unable to choose their providers.
- **CPMs are best-situated** to meet the needs of underserved communities.

CITATION:

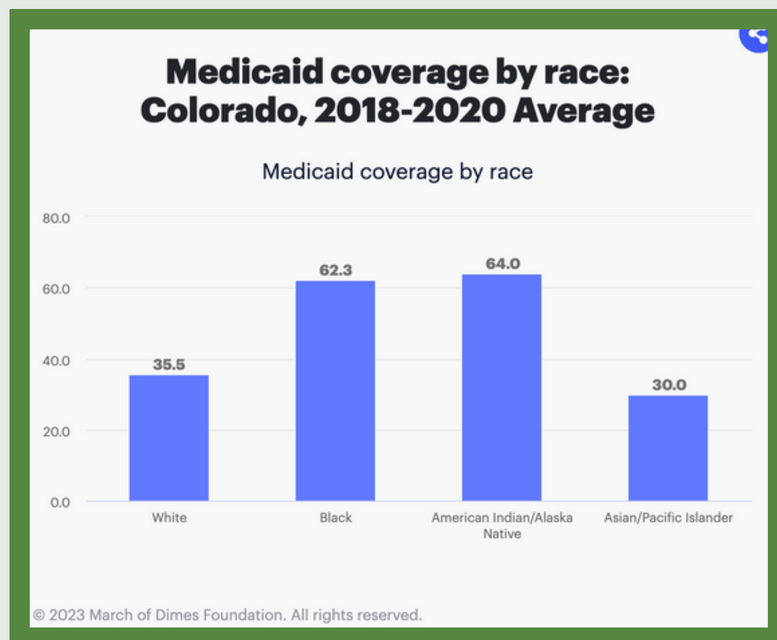
Elephant Circle, Medicaid Reimbursement for Direct Entry Midwives (2023).



UNDER FEDERAL LAW,
DENYING MEDICAID COVERAGE FOR CPMS IS ILLEGAL

Under federal law, Title XIX, states may not deny reimbursement for services that are "mandatory for the categorically needy." **Pregnant people and their babies are groups that federal law deems "categorically needy," and "pregnancy-related care" is a "mandatory service" for which states cannot deny Medicaid reimbursement** under 42 C.F.R. § 440.210(a). Although states have some discretion in determining the scope of Medicaid coverage, they must distribute the mandatory services in a manner bearing a "rational relationship" to the underlying federal purpose of providing the service to those in greatest need of it. [1] Additionally, a limited service is only sufficient in amount, duration, and scope if it adequately meets the needs of "most" individuals who are eligible for Medicaid and who have a medical need for the particular Medicaid service. [2] In other words, denying coverage for CPM care would only be lawful if 1) the denial bore a rational relationship to serving the neediest families, and 2) the existing care alternatives were sufficient in amount, duration and scope to meet the needs of the neediest families. They are not.

Significant data shows that all people seeking perinatal care are underserved in U.S. hospitals, and Black and Indigenous communities are most underserved. It therefore stands to reason that all pregnant people, and especially Black and Indigenous people (who are overrepresented as Colorado Medicaid members) have the greatest need for community birth care. CPMs are the only Colorado perinatal care providers trained in community birth, and they have statistically better outcomes—particularly among these same groups, who experience higher levels of stigma and discrimination in healthcare settings. [3]



Denying coverage for CPM care therefore does not bear a rational relationship to the purpose of providing perinatal care to the families who are in the greatest need.

We also know that the providers and facilities currently reimbursed are clearly inadequate in amount, duration, and scope. Despite having the most costly perinatal care in the world, we have among the worst outcomes, CPM care is not duplicative of other existing models of care because of how different their training and outcomes are compared to Certified Nurse Midwives (CNMs) or Obstetrician Gynecologists (OBGYNs). Investing in CPMs has been shown at the national scale to radically improve birth outcomes, and birth equity.

SO WHAT IS THE HARKIN AMENDMENT?

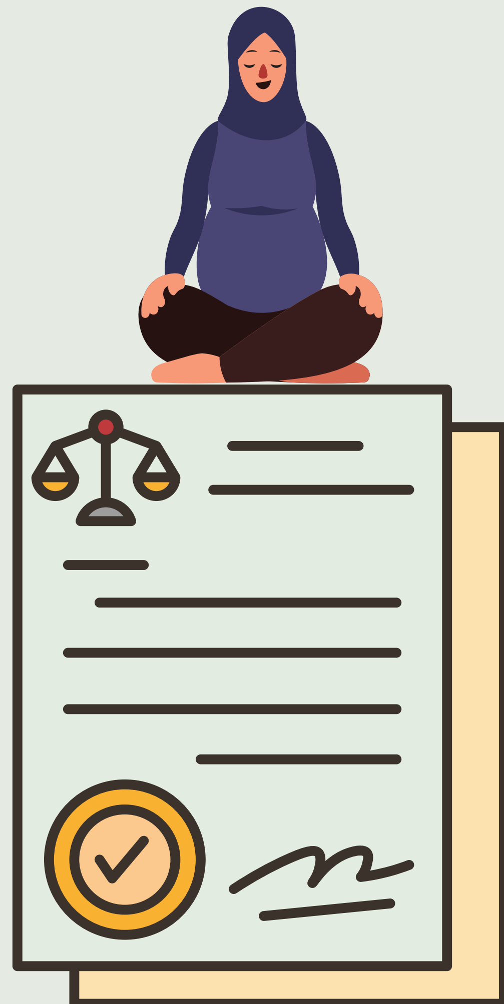
Section 2706(a) of the Affordable Care Act, also known as the Harkin Amendment, provides an additional basis, under federal law, for arguing that Medicaid must cover CPM care under federal law.

The Harkin Amendment prohibits private insurers from denying coverage for entire categories of licensed professionals, including CPMs. Even though the Harkin Amendment does not specifically apply to Medicaid or Medicare, there are similar provider nondiscrimination provisions in the Social Security Act and Medicare regulations that are nearly identical to the Harkin Amendment. Section 2706(a) does not require insurers to "contract with any health care provider willing to abide by the terms and conditions," and thus, allows for discretion in contracting. Under Section 2706(a), insurers may also establish "varying reimbursement rates based on quality or performance measures." However, Section 2706(a) does prohibit private insurers from discriminating against entire categories of licensed professionals.

Indeed, the Harkin Amendment, prohibits "group health plans" and health insurance issuers "offering group or individual health insurance coverage" from discriminating "with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

In Colorado, **CPMs are licensed** by the Department of Regulatory Agencies Division of Professions and Occupations. When they attend clients during pregnancy, birth and postpartum they are, "acting within the scope of [their] license or certification under applicable state law."

Therefore, under the Harkin Amendment; Medicare and Medicaid provisions; and Colorado state insurance law, **insurers may not deny coverage for CPMs solely on account of their licensure.**



UNDER COLORADO STATE LAW,
DENYING MEDICAID COVERAGE FOR CPMS IS ILLEGAL

The Colorado Department of Health Care Policy and Financing is not required to cover all services provided at an individual facility. However, Co. Rev. Stat. § 25.5-4-425 provides that the "state department must reimburse all eligible providers that provide health-care services related to labor and delivery within the scope of the provider's practice in a manner that: (a) Promotes high-quality, cost-effective, and evidence-based care; (b) Promotes high-value, evidence-based payment models; and (c) Prevents risk in subsequent pregnancies.

CPMs are eligible providers & their services satisfy the elements of Co. Rev. Stat. § 25.5-4-425.

Why are CPMs eligible providers under Co. Rev. Stat. § 25.5-4-425?

Under Colorado's Health Care Policy and Financing Law §25.5-4-103, an eligible "provider" means any person, public or private institution, agency, or business concern who is 1) providing medical care, services, or goods authorized under Articles IV, V and VI of this title and 2) holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods and who is 3) enrolled under the state medical assistance program. Birth centers are institutions providing medical care authorized under Article V. [4]

When SB21-101 was signed into law in 2021, CPMs became authorized to provide labor and delivery services in birth centers. Therefore, if a birth center is properly licensed and enrolled under the state medical assistance program, it may receive Medicaid reimbursement for the care administered by the CPMs it employs. Furthermore, the Direct Entry Midwives Practice Act renders CPMs licensed within the meaning of the statute, because under it, CPMs hold "a current valid license or certificate to provide such services or to dispense such goods." While there has been confusion about whether CPMs (called "Direct Entry Midwives" In statute) in Colorado are "licensed," DORA has stated unequivocally that they regulate the profession, and this confusion is unwarranted. **CPMs are both licensed, and eligible providers under the statute.**

Why does CPM care satisfy each of the elements under Co. Rev. Stat. § 25.5-4-425?

- **CPM care is high-quality, cost-effective, and evidence-based care.** Globally recognized as the model for perinatal care in which patients have the highest level of satisfaction, CPM care has also been shown to have **equal or better outcomes** compared to physician care on many key indicators, including higher rates of spontaneous vaginal birth, higher rates of breastfeeding, higher birthing person satisfaction with care, and lower overall costs. It is also a model of care that is **comparatively low-cost**.This is due to a number of factors, including- but not limited to- the fact that CPM care is associated with lower rates of medical intervention, less involvement from fewer personnel, and fewer complications. [5] Finally, CPM care is **evidence-based.** Both CNM/CM and CPM education programs are accredited by national agencies, comply with state regulations, and meet International Confederation of Midwives (ICM) standards. Unlike other midwifery education trajectories, however, CPMs prepare for their career through specialized and hands-on learning through apprenticeship models that focus exclusively on perinatal care in the community setting. Because their training prepares them to treat pregnancy and childbirth as a natural physiological event rather than a medical emergency, CPMs intervene less—often achieving better outcomes.

- **CPM care promotes high-value, evidence-based payment models.** This is partly due to the fact that CPM care is, by definition, low-intervention. There are not excessive or wasteful procedures being done. In 2010, "2020 Vision for A High-Quality, High-Value Maternity Care System" stated that "intervention in the physiologic processes of pregnancy and childbirth must be shown to do more good than harm. Higher levels of care are only appropriate for those with a demonstrated need." This approach defines the CPM practice. The seminal work "Evidence Based Maternity Care: What It Is and What It Can Achieve," identifies overused and underused practices in perinatal care. CPMs provide care that never engages in the overused practices listed and excels at those listed as underused.

- **CPM care prevents risk in subsequent pregnancies.** Higher rates of medical intervention are associated with higher risks in subsequent pregnancies. Because CPM care entails, on average, significantly lower rates of intervention, it prevents risk in subsequent pregnancies. The CPM model of care also places a greater emphasis on the autonomy and dignity of the birthing person. This leads to lower rates of mistreatment and coercion during the course of perinatal care, which in turn, prevents medical mistrust, increases the likelihood that the birthing person will seek perinatal care in the future, and as a result, lowers risk in subsequent pregnancies. **Therefore, CPM care satisfies all of the elements under the statute, and Colorado is required to cover it.**

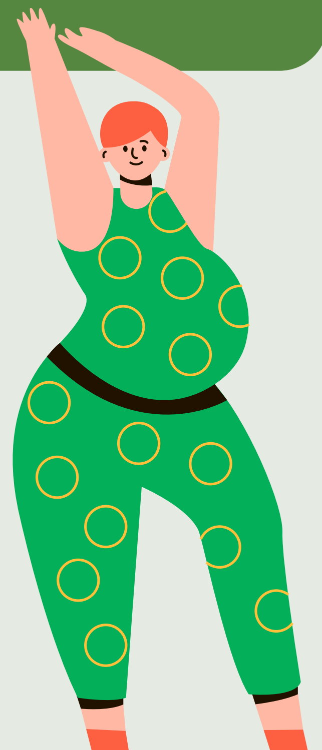
CONCLUSION

Certified Professional Midwives provide high-quality, evidence-based, and cost-efficient care. By excluding them from Medicaid plans, the state shuts out the families who have the greatest need from accessing the care that is available to the general public and statistically shown to have some of the best outcomes. Not only is this unjust, but- for the reasons listed above- it is also arguably illegal under Federal and State law.

POLICY RECOMMENDATIONS

REIMBURSE MIDWIVES IN ALL SETTINGS

CLARIFY: DEMS ARE CPMS & LICENSED PROVIDERS



WORKS CITED

1. *See* White v. Beal, 555 F.2d 1146 (3d Cir.1977) (discussing earlier version of amount, scope, and duration regulations); *see also* Ledet v. Fischer, *supra* (if a state chooses to provide an optional service, the state may limit it to those most medically needy); Anderson v. Director, Department of Social Services, 101 Mich.App. 488, 300 N.W.2d 921 (1980) (exclusion of root canal treatment did not violate § 440.230(b) because dental services were provided to those in greatest medical need).
2. *See* Charleston Memorial Hospital v. Conrad, 693 F.2d 324 (4th Cir.1982) (limit on the number of days the state would cover in-hospital care met federal regulations because the coverage nonetheless met the medical needs of most recipients); Curtis v. Taylor, 625 F.2d 645 (5th Cir.1980) (limiting reimbursement for physician visits to three per month met the purpose of the required service because all Medicaid recipients were treated equally and most did not need more than three visits per month); Ralabate v. Wing, No. 93–CV–0035E(H), 1996 WL 377204 (W.D.N.Y. June 27, 1996) (defendant provided medical assistance in the form of custom wheelchairs to most eligible Medicaid patients); Sobky v. Smoley, 855 F.Supp. 1123 (E.D.Cal.1994); King v. Sullivan, 776 F.Supp. 645 (D.R.I.1991) (intermediary care service sufficient because most eligible recipients were offered the service).
3. *See e.g.* Jill Alliman, Kate Bauer & Trinisha Williams, *Freetanding Birth Centers: An Evidence-Based Option for Birth,* 31 J.PERINATAL EDUC. 8 (Jan. 2022); Laurie Zephyrin, Shanoor Seervai, Corinne Lewis & Jodie G. Katon, *Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity*, THE COMMONWEALTH FUND (Mar. 4, 2021), https://www.commonwealthfund.org/publications/issuebriefs/2021/mar/community-models-improve-maternal-outcomes-equity.
4. As used in article 4, 5 and 6 of Colorado Title 25. Health Care Policy and Financing, "clinical services" includes birth centers. See CO Rev Stat § 25.5-5-301 (2020).
5. *See e.g.* P. Mimi Niles and Laurie Zephyrin, *How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis*, COMMONWEALTH FUND (May 2023). https://doi.org/10.26099/3qm1-3914, citing Molly R. Altman et al., *The Cost of Nurse-Midwifery Care: Use of Interventions, Resources, and Associated Costs in the Hospital Setting*, 27 WOMEN'S HEALTH ISSUES 434-440 (July 2017); MARCH OF DIMES,POSITION STATEMENT — MIDWIFERY CARE AND BIRTH OUTCOMES IN THE UNITED STATES (2019); Daphne N. McRae et al., *Is Model of Care Associated with Infant Birth Outcomes Among Vulnerable Women? A Scoping Review of Midwifery-Led Versus Physician-Led Care*, 2 SSM — POPULATION HEALTH 182–93 (Dec. 2016); Jane Sandall et al., *Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women*, 9 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 1-101 (Apr. 28, 2016); Brigette Courtot, Ian Hill, Caitlin Cross-Barnet, and Jenny Markell, *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*, THE MILBANK QUARTERLY (Dec 2020). https://doi.org/10.26099/3qm1-3914.