B R I E F

Legal Bases for Medicaid Reimbursement for Direct Entry Midwifery Care in Colorado

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July 20, 2023

INTRODUCTION

Despite the fact that Direct Entry Midwives (DEMs) provide high-quality, evidence-based, and cost-efficient care, they remain excluded from Colorado Medicaid plans. This means that Colorado families who have the greatest need are being denied access to 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 it is also arguably illegal under Federal and State law. This brief explains why.

SUMMARY

Not only is providing Medicaid reimbursement for Direct Entry Midwifery good policy, it is legally required in the state of Colorado under state and federal law. The Colorado Department of Health Care Policy and Financing does have the authority to differentiate between which providers it will and will not reimburse, within limits.Both federal and state law require Colorado to reimburse the care offered by DEMs. Under federal law, states may not deny reimbursement for services that are mandatory for the categorically needy, which DEM care arguably is. Under state law, the state must reimburse eligible providers for labor and delivery services according to a set of specific criteria—all of which DEM care satisfies. Therefore, a denial of reimbursement for DEMs employed at birth centers in Colorado is arguably unlawful.

The Colorado Department of Health Care Policy and Financing has the authority to refuse to cover regulated providers, so long as the state plan provides coverage for mandatory services required by regulations, and offers such other services as it chooses on rational, nondiscriminatory basis. A refusal of coverage for DEM services would be a denial of mandatory services required by regulations, irrational, and arguably discriminatory.

Administrative action, such as the classification of DEMs as ineligible for Medicaid reimbursement, is presumed to be regular and valid and the burden is on the challenging party to present evidence sufficient to demonstrate the contrary. Colorado caselaw is somewhat limited when it comes to understanding the local standard for what would be deemed an arbitrary and capricious denial of Medicaid reimbursement. While the few relevant cases that shed light on that standard suggest that a denial of coverage for DEMs might not be considered arbitrary and capricious, those cases are also distinguishable in important ways.

Finally, the Harkin Amendment provides that private insurers cannot deny coverage for entire categories of licensed professionals, including DEMs. 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. The Harkin Amendment and Medicaid provider

nondiscrimination provisions do not provide a private right of action but provide a solid foundation for arguing that insurers–both public and private–cannot deny coverage for midwifery services solely because they are provided by DEMs. Additionally, the Senate's comments on the Harkin Amendment and statutory interpretation of the Affordable Care Act ("ACA") suggest that Congress intended to provide insurance coverage for alternative health carel providers like DEMs.

DISCUSSION

I. The Colorado Department of Health Care Policy and Financing Can Differentiate Between Which Providers It Will and Will Not Reimburse, but Must Reimburse Direct Entry Midwives.

The Colorado Department of Health Care Policy and Financing is not required to cover all services provided at an individual facility.[1] Medicaid regulations expressly permit participating states to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."[2] It is "the overall payment for all [...] facilities in a particular classification that is evaluated for statutory compliance for establishing reimbursement compensation rather than the adequacy of payment for any one component of a single facility."[3]

However, both federal law and Colorado state regulations impose limits on that authority, and require Colorado to reimburse licensed Direct Entry Midwives (DEMs) who are providing labor and delivery services within the scope of their practice. Specifically, under Co. Rev. Stat. § 25.5-4-425, 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.[4] This section will first explain why DEMs are eligible providers before demonstrating why DEM care meets each of the elements outlined in this provision.

A. DEMs Are Eligible Providers.

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 this article and Article 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.[5] Birth centers are institutions providing medical care authorized under Article V.[6]

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[1] 42 C.F.R. § 440.230(d); *see also* T.L. v. Colorado Dept. of Health Care Policy and Financing, 42 P.3d 63 (Colorado Ct. of App. Div. V, Oct. 25, 2001), *citing* Dodge v. Dept of Soc. Services, 657 P.2d 969 (Colo.App.1982).
[2] *Id.*
[3] Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1158, 1167 (10th Cir, Feb 22, 1988)
[4] CO Rev. Stat. § 25.5-4-425 (2021).
[5] CO Rev Stat §25.5-4-103 (2022).
[6] 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).

Therefore, so long as the birth center holds a valid license or certificate to provide that care and is enrolled under the state medical assistance program, it is eligible to receive Medicaid reimbursement for the services its employees offer.

When SB21-101 was signed into law in 2021, Direct Entry Midwives 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 DEMs it employs.

Furthermore, Direct Entry Midwives hold, "a current valid license or certificate to provide such services or to dispense such goods," this is what the Direct Entry Midwives Practice Act does.[7] While there has been confusion about whether Direct Entry Midwives in Colorado are "licensed," this is clearly an anachronism.[8] DORA has stated unequivocally that they regulate the profession, Further, the terms "license," "certificate," and "registration" are irrelevant as far as regulation goes, and Medicaid reimburses other providers whose statutory language is not "license." Without regulation there is no “direct entry midwife” program in Colorado and that program is how the state allows people to “provide such services.”

Although it is true that the state is not required to reimburse all services rendered at an otherwise eligible institution,[9] it may not deny Medicaid reimbursement for DEMs for two primary reasons. First, the services that DEMs provide to pregnant and postpartum individuals are a “mandatory service” for the “categorically needy” which a state must reimburse under 42 C.F.R. § 440.210(a). Second, the services that DEMs provide cannot reasonably be understood as lacking the characteristics delineated in Co. Rev. Stat. § 25.5-4-425.

B. The State Cannot Deny Medicaid Reimbursement for DEMs.

Although the state is not required to reimburse all services offered at an otherwise eligible provider facility, both federal and state law require Colorado to reimburse the care offered by DEMs.

1. Under federal law, the services that DEMs provide to pregnant and postpartum individuals are a “mandatory service” for the “categorically needy” which Colorado may not exclude from its Medicaid program.

a. Pregnant people and their babies are considered “categorically needy” under federal law.

Title XIX requires participating states to provide medical assistance to the “categorically needy”—individuals who qualify for Medicaid because they receive some form of federal cash

[7] CO Rev Stat § 12-20-101-114 (2023).

[8] There are many anachronisms on this issue, another one of them is the term “direct entry midwife” that term made more sense when the program was started in the early 1990s, but since then the national credential Certified Professional Midwife has been created and all but one of Colorado direct entry midwives have the national credential. This isn’t an accident, Colorado law requires the Certified Professional Midwife credential and has for over a decade. Nonetheless, we use the term “direct entry midwife” or “DEM” throughout – since that is the term in Colorado statutes.

[9] CO Rev Stat § 25.5-4-401 (2010) (“the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.”).

assistance (*e.g.,* Aid to Families with Dependent Children or Supplemental Security Income).[10] While states have considerable flexibility in determining the scope of their Medicaid coverage,[11] Title XIX requires states to cover at least seven general categories of medical services for categorically needy individuals.[12] Pregnant people and their babies constitute one of these general categories that federal law deems "categorically needy."[13]

b. DEM services are mandatory services that states must cover when accessed by "categorically needy" individuals.

The state may not deny certain kinds of healthcare to people who are "categorically needy." The care provided by DEMs belongs to these "mandatory coverage" categories. First, Under 42 C.F.R. § 440.210(a), "pregnancy-related services and services for the other conditions that might complicate the pregnancy;" and "all services under the plan that are pregnancy-related for an extended postpartum period" are coverage categories for which Medicaid reimbursement may not be denied.[14] DEM care is pregnancy-related. Furthermore, DEM care is not duplicative of services provided by obstetricians or even Certified Nurse Midwives. DEMs are the only Colorado perinatal care providers trained in community birth, which also means that they are specially trained in recognizing and supporting the physiology of pregnancy through labor and birth in a way that seeks to prevent pregnancy-related complications. People will not be guaranteed this same model of care in a hospital or with obstetricians and nurse-midwives. Furthermore, survey data illustrates that people in community birth settings, staffed by DEMs, are more likely to be respected and have their informed consent honored. Such care is clearly the kind of mandatory service to which Medicaid clients are entitled.

It is true that participating states are not required to fund *all* medical services falling under one of the mandatory coverage categories.[15] Title XIX "confers broad discretion on the States to adopt standards for determining the extent of medical assistance" offered in their Medicaid programs.[16] Additionally, federal Medicaid regulations expressly permit participating states to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."[17] It is "the overall payment for all [...] facilities in a particular classification that is evaluated for statutory compliance for establishing reimbursement compensation rather than the adequacy of payment for any one component of a single facility."[18]

It is therefore within a state's authority to deny reimbursement for certain services- even those falling within a mandatory coverage category- offered at a facility that is otherwise considered an eligible provider. For example, in *Bethesda Foundation of Nebraska v. Colorado Dept. of Health Care Policy and Financing*, the court found that the state could legally deny

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[10] 42 U.S.C. § 1396a(a)(10)(A)(i) (2023); 42 C.F.R. § 436.100–128 (2012).
[11] *See* 42 C.F.R. § 430.0; *Beal v. Doe,* 432 U.S. 438, 444, 97 S.Ct. 2366, 2370–71, 53 L.Ed.2d 464 (1977),
[12] 42 U.S.C. § 1396a(a) (2023); *id.* § 1396d(a)(1)–(5), (17), (21) (2022); 42 C.F.R. § 440.210 (2012).
[13] 42 CFR § 436.3 ("Categorically needy refers to families and children, aged, blind or disabled individuals, and pregnant women listed under subparts B and C of this part who are eligible for Medicaid.")
[14] 14, 501 OVERVIEW OF MEDICAID SERVICES*, citing* 42 C.F.R. § 440.210(a).
[15] Beal v. Doe, 432 U.S. at 441, 97 S.Ct. at 2369.
[16] *Id.* at 444, 97 S.Ct. at 2370–71.
[17] 42 C.F.R. § 440.230(d); *see also* T.L. v. Colorado Dept. of Health Care Policy and Financing, 42 P.3d 63 (Colorado Ct. of App. Div. V, Oct. 25, 2001), *citing* Dodge v. Dep't of Soc. Services, 657 P.2d 969 (Colo.App.1982).
[18] Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1158, 1167 (10th C ir, Feb 22, 1988)

reimbursement for the costs incurred by a specific wing of a nursing home facility a small number of intensive management patients ("IMPs") needed more intensive care than other patients. Despite the fact that these services were mandatory for a group- seniors- who are considered "categorically needy," because the facility as a whole remained profitable despite the inadequate coverage for that wing, the court reasoned that the state had used its discretion reasonably:

> The reimbursement rate was based upon and took into consideration plaintiffs' actual costs in providing services needed by all of its patients, including the IMPs. In addition, there is no evidence that necessary services cannot be provided to IMP patients by other available and qualified providers, should plaintiffs be unable to continue their present patient mix. Thus, under the circumstances here, the Colorado rate structure and classification system has not been demonstrated to have been arbitrarily or capriciously established or applied.[19]

Theoretically, a court could apply the same reasoning in the context of DEM care. It could find, for example, that if an eligible birth center or home birth practice remained profitable as a whole, even in the absence of DEM reimbursement, then the state would not have violated its obligation to provide a mandatory service for the categorically needy.

Nonetheless, there are important restrictions on states in their exercise of this discretion. One of those restrictions is particularly relevant here: Title XIX requires participating states to establish "reasonable standards ... for determining ... the extent of medical assistance under [their Medicaid] plan which ... are consistent with the objectives of [Title XIX]."[20] Denying Medicaid coverage for the services administered by DEMs cannot be viewed as reasonable or consistent with the objectives of Title XIX, which is to "provide services to program recipients to same extent, or as nearly as possible, as those services are available to general public."[21] Because the perinatal care provided by DEMs at birth centers is care that is otherwise be covered for a member of the general public,[22] to deny Medicaid coverage in these cases would be inconsistent with the objectives of Title XIX. Indeed, some Medicaid members in Colorado opt out of the covered services and instead pay out of pocket to access DEM services. This fact underscores that DEM services are available to the general public, and by denying coverage to Medicaid members, Colorado is violating this Title XIX requirement.

Courts have developed two general tests to determine whether a service offered only in part, or with other limitations, is nonetheless sufficient in "amount, duration, and scope." First, a

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[19] Bethesda Foundation of Nebraska v. Colorado Dept. of Health Care Policy and Financing, 902 P.2d 863, 866 (Colo. Ct. Of App., Div. II, Feb. 23, 1995).

[20] 42 U.S.C. § 1396a(a)(17).

[21] Geriatrics, Inc. v. Colorado Dept. of Social Services, 712 P.2d 1035, at 1040 (Colorado Ct of App Div. III, May 30, 1985), citing Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

[22] Indeed, private insurance plans tend to cover this care both at home and at a birth center, or offer a gap exception in the event that DEM care was excluded from the plan in question. *See e.g.* Advising Congress on Medicaid and CHIP Policy, ACCESS TO MATERNITY PROVIDERS: MIDWIVES AND BIRTH CENTERS: ISSUE BRIEF (May 2023), https://www.macpac.gov/wp-content/uploads/2023/05/Access-to-Maternity-Providers-Midwives-and-Birth-Centers.pdf; Brigitte Cortot et al., *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a Hugh-Value Model of Care*, 98 MILBANK QUARTERLY 1091 (Sept. 2020); Rebecca Dekker, *Evidence Confirms Birth Centers Provide Top-Notch Care*, AM. ASS'N FOR BIRTH CTRS. (Jan. 31, 2013), https://www.birthcenters.org/news/nbcs2.

limited service meets the sufficiency requirements of the federal regulations if the service is distributed in a manner bearing a rational relationship to the underlying federal purpose of providing the service to those in greatest need of it.[23] Second, a limited service is sufficient in amount, duration, and scope if it adequately meets the needs of "most" individuals eligible for Medicaid who have a medical need for the particular Medicaid service.[24]

Here, limiting midwifery services to those offered by CNMs, the majority of whom practice in hospitals in Colorado, does not bear a rational relationship to providing that care to those in the greatest need of it. Significant data shows that all people are underserved in U.S. hospitals for perinatal care, 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[25]) have the greatest need for community birth care. DEMs are the only perinatal care providers trained in community birth including birth centers, and birth centers have better outcomes—particularly among groups who experience higher levels of stigma and discrimination in healthcare settings (who are also disproportionately represented among Medicaid recipients).[26]

We know that the current system is inadequate to meet the needs of most pregnant and postpartum people who are eligible for Medicaid. The providers and facilities currently reimbursed are clearly inadequate in amount, duration, and scope. Investing in DEMs has been shown at the national scale to radically improve birth equity. The state therefore should offer reimbursement because doing so is evidence-based, and the status quo is not adequate in amount, duration or scope.

2. Under state law, DEM services must be covered because they satisfy each of the elements that Colorado law cites as characterizing care for which reimbursement may not be denied.

The state department is both authorized and obligated to establish rules for the payment of providers. Specifically, CO ST §25.5-401(2) states that the state Medicaid program "may include provisions that encourage the highest quality of medical benefits and the provision

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[23] *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 Service*s,* 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).

[24] *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).

[25] *See* March of Dimes, *Health Insurance/Income: Data for Colorado* (last update: Dec. 2020), https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=652&lev=1&slev=4&obj=1&sreg=08

[26] *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/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity.

thereof at the least expense possible."[27] In fact, Colorado has a special provision pertaining to providers of healthcare services related to labor and delivery, that provides that "The state department shall 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.[28] The care that DEMs provide satisfies each of these elements.

a. DEM care is high-quality, cost-effective, and evidence-based care.

DEM care satisfies the first element of the test established in CO ST §25.5-425 that the state must consider when determining whether it is obliged to cover a certain form of labor and delivery care. DEM care has been globally recognized as a model for perinatal care in which patients have the highest level of satisfaction, as well as positive outcomes.[29] Research shows that "midwifery care provides equal or better care and 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."[30] Community-based and DEM-led midwifery services are especially effective in these respects.[31] Indeed, a 2023 Cochrane review found that planned home births that are attended by a midwife (regardless of whether they are a CNM or DEM)- for people experiencing low-risk pregnancies- is equally safe, if not safer, than planned hospital birth.[32] 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 DEM care is associated with lower rates of medical intervention, less involvement from fewer personnel, and fewer complications.[33] Finally, DEM care is evidence-based. American midwifery education provides two pathways to midwifery practice. One is pursued through graduate education for the CNM/CM credential, and the other is pursued through didactic education with apprenticeship for the CPM credential (DEMs in Colorado are required to have the CPM credential).[34] Although there are several routes to becoming a midwife, all midwifery

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[27] CO Rev Stat § 25.5-4-401 (2010).
[28] CO Rev. Stat. § 25.5-4-425 (2021).
[29] *See* World Health Organization, *Midwifery Education and Care* (last accessed May 26, 2023), https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/midwifery.
[30] National Partnership for Women and Families et al., *Improving Our Maternity Care Now Through Midwifery* (Oct. 2021), https://nationalpartnership.org/wp-content/uploads/2023/02/improving-maternity-midwifery.pdf.
[31] *Id.*
[32] Ole Olsen & Jette Clausen, *Planned Hospital Birth Versus Planned Home Birth*, 12 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 3 (2023), https://www.cochrane.org/CD000352/PREG_planned-hospital-birth-versus-planned-home-birth.
[33] *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)..
[34] Penny Marzalik et al., *Midwifery Education in the U.S.: Certified Nurse-Midwife, Certified Midwife and Certified Professional Midwife*, 60 Midwifery 9-12 (May 2018). *See also,* CO Rev Stat § 12-20-104(4)-(5).

credentials are associated with excellent birth outcomes and high rates of reported patient satisfaction.[35] Both models produce qualified and skilled clinicians who achieve core midwifery competencies.[36] Both CNM/CM and DEM education programs are accredited by national agencies, comply with state regulations, and meet International Confederation of Midwives (ICM) standards.[37] Unlike other midwifery education trajectories, however, DEMs prepare for their career through specialized and hands-on learning through apprenticeship models that focus exclusively on perinatal care.[38] This arguably makes them uniquely situated to meet the needs of pregnant and birthing people who are experiencing healthy pregnancies, as their care is not shaped by hospital emergency protocols that are irrelevant at best, and harmful at worst, in the context of a low-risk pregnancy or birth. Because their training prepares them to treat pregnancy and childbirth as a natural physiological event rather than a medical emergency, they intervene less—often achieving better outcomes.[39] DEM care therefore satisfies each of the elements enumerated in CO ST §25.5-425(a).

b. DEM care promotes high-value, evidence-based payment models.

There is not yet a standard high-value, evidence-based payment model for perinatal services.[40] Efforts have been made in Colorado, and nation-wide to find one, but there is not yet a model that exists and has been tested and found to be high value. Nonetheless, there is good data about what is low-value, and what services are over and under used in perinatal care.

In 2020, Colorado's Center for Improving Value in Health Care released a report on "Low Value Care in Colorado," defined as "health care services that provide little or no benefit to patients, have the potential to cause harm, incur unnecessary cost to patients, or waste limited health care resources." Since part of how value is determined is the nexus between cost and risk, the risk of procedures can make them low-value. One example related to childbirth was given in the report: “One example of high risk care is elective induction of labor or Cesarean-section prior to 39 weeks gestation. Newborns from these early deliveries have an increased risk of mortality, non-fatal birth outcomes such as respiratory complications, sepsis and cerebral palsy as well as long-term developmental disabilities.”[41] This example of high risk, low value care is not provided by DEMs.

One critical thing that makes DEM care “high value” is that it is by definition low-intervention. There are not excessive or wasteful procedures being done. In 2010, a “2020 Vision for A High-Quality, High-Value Maternity Care System” was written. Toward that vision it states, "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

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[35] *See id., citing* Cheyney et al., 2014, Sandall and Soltani, 2016, Stone et al., 2016, Stapleton et al., 2013.
[36] *Id.*
[37] *See id., citing* Cheyney et al., 2014, Sandall and Soltani, 2016, Stone et al., 2016, Stapleton et al., 2013.
[38] https://www.meacschools.org/resources/aspiring-midwives/
[39] BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE (National Academies Press, 2020), https://www.ncbi.nlm.nih.gov/books/NBK555484/
[40] Avery MD, Bell AD, Bingham D, et al. Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing. Washington, DC: National Partnership for Women & Families; 2018. https://www.nationalpartnership.org/Blueprint.
[41] Ctr. for Improving Value in Health Care, LOW VALUE CARE IN COLORADO: REPORT (Mar. 2020), https://civhc.org/wp-content/uploads/2020/03/Low-Value-Care-Public-Report_FINAL.pdf

demonstrated need."[42] This approach defines the DEM practice. The seminal work “Evidence Based Maternity Care: What It Is and What It Can Achieve,” identifies overused and underused practices in perinatal care. DEMs provide care that never engages in the overused practices listed and excels at those listed as underused.[43]

While Colorado continues to strive for a high value, evidence based perinatal care payment model, it is clear that DEMs should be part of that model. So much data supports this,[44] that it would be hard to argue that DEM care does not support a high value, evidence-based payment model.

c. DEM care prevents risk in subsequent pregnancies.

Higher rates of medical intervention are associated with higher risks in subsequent pregnancies. For example, according to the American College of Obstetricians and Gynecologists (ACOG), cesarean sections place the birthing person at greater risk of hysterectomy (having one’s uterus removed)[45] and uterine rupture along the scar line in subsequent pregnancies.[46] It also increases the risk of significant complications for the fetus in future pregnancies, including miscarriage, prematurity, oxygen deprivation, and stillbirth including unexplained stillbirth.[47] The more cesarean sections a person has, the higher their risks of placenta previa (where the placenta is over the cervix) and placenta accreta (where the placenta grows deeply into the uterine wall) become.[48] Because DEM care entails, on average, significantly lower rates of these sorts of interventions even after transfers to other providers due to conditions that fall outside the DEM scope, it prevents risk in subsequent pregnancies. The DEM model of care also places a greater emphasis on the autonomy and dignity of the birthing person.[49] 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.

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[42] Martha Cook Carter et al., *2020 Vision for a High-Quality, High Value Maternity Care System*, 20 WOMEN’S HEALTH ISSUES S7 (Jan. 2010), https://www.whijournal.com/article/S1049-3867%2809%2900139-X/fulltext

[43]Carol Sakala & Maureen Corry, *Evidence-Based Maternity Care: What it Is and What it Can Achieve*, MILBANK MEMORIAL FUND (2008), https://nationalpartnership.org/wp-content/uploads/2023/02/evidence-based-maternity-care.pdf

[44]Nat’l Partnership for Women & Families, *Materniry Care in the United States: We Can-And Must-Do Better* (Feb. 2020), https://nationalpartnership.org/wp-content/uploads/2023/02/maternity-care-in-the-united.pdf, https://nationalpartnership.org/wp-content/uploads/2023/02/improving-our-maternity-care-now.pdf

[45] *See* Am. Coll. Of Obstetricians & Gynecologists, *Vaginal Birth After Cesarean, supra* note XX, at e111.

[46] *See* Mayo Clinic Staff, *C-Section:Risks*, MAYOCLINIC.ORG, (last accessed: Sept. 3, 2020), https://www.mayoclinic.org/tests-procedures/c-section/about/pac-20393655#:~:text=If%20there%20is%20a%20surgical,would%20after%20a%20vaginal%20delivery.

[47] *See* Am. Coll. of Obstetricians and Gynecologists, the Soc’y for Maternal-Fetal Med., *Management of Stillbirth*, ACOG OBSTETRIC CARE CONSENSUS 10, (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth.

[48] *See* Mayo Clinic, *C-Section: Risks*, *supra* note 43.

[49] *See e.g.* Bridget Basile Ibrahim, et al., *Inequities in Quality Perinatal Care in the United States During Pregnancy and Birth After Cesarean*, 17 PLoS ONE e0274790 (2022), https://doi.org/10.1371/journal.pone.0274790;

II. Although the Department of Health Care Policy and Financing May Refuse to Cover Certain Regulated Providers, It May Not Deny Reimbursement for DEM Services.

States have substantial discretionary authority under Medicaid Act to devise and implement Medicaid plan which equitably and efficiently serves needs of Medicaid eligible population, as long as the plan provides coverage for mandatory services required by regulations, and offers the, optional, services on rational, nondiscriminatory basis.[50]

Currently, Colorado Medicaid provides coverage for mandatory services related to pregnancy in two ways: through physicians and certified nurse midwives who have hospital-based practices, through certified nurse midwives who have birth center practices (there are no MDs who have birth center based practices though there could be). This excludes two forms of mandatory services related to pregnancy: midwives who have home-based practices (of all credentials), and direct entry midwives who have birth center practices. Because perinatal care offered at homes and birth centers is a mandatory service required by regulations,[51] and singling out DEM providers as ineligible would be both irrational and discriminatory,[52] denying coverage for DEM care at birth centers falls outside the scope of this discretionary authority. Reimbursement therefore should not be denied.

Although the "Freedom of choice" provisions of Medicaid Act authorizes states to deny certain services, it does not apply to mandatory services under Medicaid Act.[53] While the law is clear that freedom of choice provisions do not in any way affect a provider's right to reimbursement or payment under Medicaid,[54] and states may, under Title XIX, deem certain providers as unqualified to provide the services included in the State plan,[55] special protections apply to patient choice in the context of family planning services—which DEMs provide. Indeed, in *Rx Pharmacies v. Weil*, the Court stated that "the State shall not restrict the choice of the qualified person from whom the individual may receive [family planning services]."[56] This, combined with the reasons outlined above, provides a strong basis in the law for deeming DEM care offered in homes and birth center settings a mandatory service that the state plan must cover. It can't be overstated – DEM care supports people who are experiencing a physiologic process – this is exactly the kind of mandatory service contemplated. To deny people access to providers who will safeguard their bodies, a service that cannot be guaranteed by other providers, is to deny Medicaid members their full humanity.

States are free to formulate class-wide Medicaid reimbursement regulations based on costs of rational groupings of providers and facilities.[57] The reasonableness of these regulations is characterized not as pinpoint, but rather as "zone or range in which state may consider relevant

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[50] Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

[51] *See* discussion of mandatory care for the categorically needy above.

[52] *See* discussion of DEM care above.

[53] Social Security Act, §§ 1902(a)(10), 1902(a)(10)(A), (a)(23), 1905(a)(1–5, 17), as amended, 42 U.S.C.A. §§ 1396a(a)(10), 1396a(a)(10)(A), (a)(23), 1396d(a)(1–5, 17). Warr v. Horsley, 705 F.Supp. 540 (M.D.Ala.1989)

[54] *See* 42 U.S.C. § 1396a(a)(23)

[55] RX Pharmacies Plus, Inc. v. Weil, *citing* S.Rep. No. 744, 90th Cong., 1st Sess. (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 3021.

[56] RX Pharmacies Plus, Inc. v. Weil, *citing* Public Service Co. of Colo. v. Federal Energy Regulatory Comm'n, 754 F.2d 1555, 1567 (10th Cir.1985).

[57] Bethesda Foundation of Nebraska v. Colorado Dept. of Health Care Policy and Financing, 902 P.2d 863, 866 (Colo. Ct. Of App., Div. II, Feb. 23, 1995).

factors and data in determining reasonableness and adequacy of reimbursement rate."[58] The Supreme Court has defined this as a "zone or range in which a State may consider the relevant factors and data and determine a valid reimbursement rate which is reasonable and adequate. The state must articulate 'a rational connection between the facts found and the choice made.'"[59] For example, rather than using a traditional fee-for-service model, Colorado Medicaid reimburses primary care providers who serve 500 ACC members or more using an Alternative Payment Model that rewards performance towards goals like closing disparities and improving patient health outcomes because "traditional fee-for-service payment models reward volume over health outcomes or quality performance, and do not incentivize care providers to prioritize affordability results or patient health outcomes like closing health disparities."[60] Even though the payment model differs significantly from the payment models that have historically been implemented by state Medicaid programs, it is within a reasonable zone because it is rationally connected to a series of public health goals that the agency is reasonably permitted to consider in setting its reimbursement rates.

Both CNMs and DEMs are eligible providers. Each provides mandatory services related to pregnancy. Both are authorized to provide that care in homes and birth centers, though only DEMs are trained specifically in how to provide that care in homes and birth centers. And yet, only DEMs are excluded from reimbursement. To single out DEMs as ineligible for reimbursement when they are administering the same services (supporting a physiologic process), in the same facilities, as other covered providers cannot be considered rational. This is especially true given that they have comparable outcomes.[61] Additionally, although states do have "wide latitude" to reach their own determinations about what constitutes a reasonable reimbursement rate, they are required to "promote participation by efficiently and economically operated facilities."[62] Because DEM care, on average, is less expensive, and involves significantly less medical intervention than is statistically true for other perinatal care models,[63] reimbursing birth centers that employ DEMs promotes participation by efficiently and economically operated facilities.

III. The Facts Here are Distinguishable from Cases Where Agency Denial Was Upheld and Not Considered Arbitrary and Capriciouss.

Administrative action, such as the classification of DEMs, is presumed to be regular and valid and the burden is on the challenging party to present evidence sufficient to demonstrate the contrary.[64] The caselaw is somewhat limited when it comes to understanding the standard for

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[58] Reivitz, 733 F.2d at 1233 (citing Federal Power Commission v. Conway Corp., 426 U.S. 271, 96 S.Ct. 1999, 48 L.Ed.2d 626 (1976)); accord Friedman v. Perales, 668 F.Supp. 216 (S.D.N.Y.1987).
[59] Baltimore Gas, 462 U.S. at 105, 103 S.Ct. at 2256.
[60] Colorado Dept. of Health Care Financing, VALUE BASED PAYMENTS, HCPF (last accessed July 17, 2023), https://hcpf.colorado.gov/value-based-payments; Colorado Dept. of Health Care Financing, ALTERNATIVE PAYMENT MODELS, HCPF (last accessed July 17, 2023), https://hcpf.colorado.gov/alternative-payment-model-1-apm-1.
[61] Ole Olsen & Jette Clausen, *Planned Hospital Birth Versus Planned Home Birth*, 12 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 3 (2023), https://www.cochrane.org/CD000352/PREG_planned-hospital-birth-versus-planned-home-birth.
[62] Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1158, 1169 (10th C ir, Feb 22, 1988)
[63] *See e.g.* Jane Sandall et al., *Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women*, 2016 COCHRANE DATABASE SYST. REV. (Apr. 2016).
[64] *See People v. Gallegos,* 692 P.2d 1074 (Colo.1984). *See also* § 24–4–105(7), C.R.S. (1988 Repl.Vol. 10A).

what constitutes an arbitrary and capricious denial of Medicaid reimbursement in Colorado. However, the few relevant cases that shed light on that standard suggest that a denial of coverage for DEMs may be upheld and not considered arbitrary and capricious. In *Bethesda Foundation of Nebraska v. Colorado Dept. of Health Care Policy and Financing*, for example, the Colorado Court of Appeals found that the state did not act arbitrarily or capriciously when it failed to adequately reimburse a nursing facility for the actual costs of the care required by a group of patients who required more intensive care than the other patients in the facility. It reasoned that "we have found no precedent, and none has been cited, in which, as here, a reimbursement rate has been successfully challenged based upon the claimed inadequacy of reimbursement to cover actual costs of a small number or percentage of patients in one wing of an otherwise profitable nursing home."[65] The court further reasoned that "there is no evidence that necessary services cannot be provided to IMP patients by other available and qualified providers. Thus, under the circumstances here, the Colorado rate structure and classification system has not been demonstrated to have been arbitrarily or capriciously established or applied."[66] Here, a court could find that CNMs are other, available and qualified, providers who could provide the same services as DEMs.

Still, there are important factors to consider, which distinguish the coverage refusal in *Bethesda* from the exclusion of Medicaid coverage for DEM care. Because of the reasons stated above, CNMs and DEMs are fundamentally different models of care—unlike in the nursing home in Bethesda, where the providers who cared for the IMPs were the same providers who cared for the other patients in the facility. Although equally rigorous, the education pathways are different for CNMs and DEMs, and the DEM model of care is arguably better suited to meet the needs of Medicaid members who have been failed by the status quo. This is because CNMs are trained, and practice within, a system that is known to have disparate, negative effects on both the quality of care and birth outcomes of Black, Indigenous and other birthing people of color. While DEMs train in community-based settings through apprenticeship and hands-on learning, CNMs train in clinical settings that reinforce methodologies and risk assessment frameworks that have been proven to be harmful for communities of color. It is also the case that the nursing home in Bethesda was able to retain the employees who provided care to the IMP patients, even without reimbursement for the actual costs that this care entailed. In contrast, the lack of Medicaid coverage for DEM care means that facilities won't employ DEMs even though they provide comparatively high-quality care that is better suited to meet the needs of the communities who face the greatest obstacles to health equity. In other words, the lack of Medicaid coverage is shaping, and compromising, people's access to care. This was not true in *Bethesda*, where no patient was denied access to the care they needed as a result of the lack of coverage.

Further, here have been instances when a denial of Medicaid reimbursement has been found to be arbitrary and capricious. Although these cases are distinguishable from the situation at hand, there are elements that might be relevant in understanding why reimbursement is required for DEM care . In *Ohlson v. Weil*, for example, the court found that it was arbitrary and capricious for the Department to exclude coverage for a medically necessary back brace from its definition of "durable medical equipment." Such a determination, the court found "lacked reasonable basis in law and was unwarranted by record" because it was at odds with the state's

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[65] Bethesda Foundation of Nebraska v. Colorado Dept. of Health Care Policy and Financing, 902 P.2d 863, 866 (Colo. Ct. Of App., Div. II, Feb. 23, 1995).
[66] *Id.*

coverage of other similar devices, such as wheelchairs. Here too, the exclusion of DEM care is arguably at odds with the state's coverage of the similar care offered by CNMs. While the state could argue that this distinction is rational, given the differences in both education and scope of practice possessed by CNMs compared to DEMs, this rationale could be challenged on the grounds that there is no legitimate, evidence-based, reason for granting Medicaid coverage for one credential and not the other. Indeed, as discussed above, both models are characterized by high-quality outcomes and patient satisfaction rates. It is therefore unlikely—but possible-- that a court could find that there is no rational basis for offering Medicaid reimbursement for CNMs and not DEMs.

IV. The Harkin Amendment Provides a Basis for Arguing that Private and Public Insurers Cannot Discriminate Against the Profession of Direct Entry Midwives.

A. Background: The Harkin Amendment and its Application to Direct Entry Midwifery

1. The Harkin Amendment

Section 2706(a) of the Affordable Care Act, also known as 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."[67] 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.[68] Under Section 2706(a), insurers may also establish "varying reimbursement rates based on quality or performance measures."[69] However, Section 2706(a) does prohibit private insurers from discriminating against entire categories of licensed professionals.

The legislative intent behind 2706(a) was to "ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State."[70] The original guidance issued by the Department of Labor, the Department of Health and Human Services, and the Department of the Treasury (collectively, Departments) in 2013 indicated that the Harkin Amendment did not require insurers to accept all types of providers into a network.[71] However, the Senate Appropriations Committee raised concerns about this interpretation, for it contradicted the legislative intent behind 2706(a) and permitted insurers to "exclude from participation whole categories of providers operating under a [s]tate license or certification."[72]

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[67] 42 U.S. Code § 300gg–5(a).
[68] *Id*.
[69] *Id*.
[70] S. Rep. No. 113-71, at 126 (2013), https://www.congress.gov/congressional-report/113th-congress/senate-report/71.
[71] *Affordable Care Act Implementation FAQs - Set 15*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, (Apr. 29, 2013), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.
[72] *FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXVII)*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (May 26, 2015), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvii.pdf; *see also*, S. Rep. No. 113-71 *supra note* 4.

In response to the Senate's concerns, the Departments reversed course, and on May 26, 2015, issued new FAQ guidance that expressly superseded the 2013 guidance, which no longer applies.[73] This 2015 guidance is more responsive to concern about provider discrimination than the 2013 guidance, mapping out a process for implementing Section 2706(a) that will be consistent with the purpose and legislative history of the provision. It states, "until further guidance is issued, the Departments will not take any enforcement action" against insurers with respect to implementing 2706(a) "as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision."[74]

In December 2020, federal spending legislation required the Departments to issue proposed regulations regarding the implementation of 2706(a) on or before January 1, 2022.[75] While the Departments did not meet this deadline and no proposed regulations have since been issued, they did host a listening session regarding the implementation of 2706(a) on January 19, 2022.[76] It is expected that the Departments will issue new proposed regulations implementing Section 2706(a) soon.

2. Provider Nondiscrimination Provisions in Medicaid and Medicare

While Section 2706(a) only applies to private insurers and not Medicaid, similar provider nondiscrimination provisions exist in Medicare and Medicaid legislation. For example, Section 1932(b)(7) of the Social Security Act prohibits Medicaid managed care organizations from discriminating "with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification."[77] However, there is a qualification: Section 1932(b)(7) allows Medicaid managed care organizations to "limit provider inclusion to maintain quality of care and to control costs consistent with the needs of its enrollees and its responsibility to provide access to covered services to them."[78] Section 422.205 of the Medicare Advantage plan regulations is very similar to the provider nondiscrimination provision of the Social Security Act, but it additionally requires that a Medicare Advantage organization furnish written notice to any provider or group of providers that are denied inclusion in the network.[79]

3. State-Specific Provider Nondiscrimination Provisions and Midwife Licensure

[73] *Id*.
[74] *Id*.
[75] *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. BB, Title I, § 108 (2020) (CAA-21).
[76] *LISTENING SESSION REGARDING PROVIDER NONDISCRIMINATION UNDER SECTION 2706(A) OF THE PUBLIC HEALTH SERVICE ACT*, DEPARTMENT OF LABOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF THE TREASURY, (Jan. 19, 2022), https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/listening-session-regarding-provider-nondiscrimination-under-section-2706a-of-the-phs-act.pdf.
[77] 42 U.S. Code § 1396u–2(b)(7).
[78] *Id*; see also CENTERS FOR MEDICAID AND MEDICARE SERVICES, (Aug. 31, 2009), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109a.pdf.
[79] *See* 42 CFR § 422.205.

Many states have also passed their own provider non-discrimination laws that mimic the Harkin Amendment.[80] In fact, in 2013, Colorado passed a law that is nearly identical to Section 2706(a) of the ACA, but it has yet to be interpreted by the courts.[81] In Colorado, DEMs are licensed by the Department of Regulatory Agencies Division of Professions and Occupations[82] And when they attend clients during pregnancy, birth and postpartum they are, "acting within the scope of his or her license or certification under applicable state law."[83] Therefore, under the Harkin Amendment; Medicare and Medicaid provisions; and Colorado state insurance law, insurers may not deny coverage for DEMs solely on account of their licensure.

B. Analysis and Applicability to Direct-Entry Midwifery Coverage

The Harkin Amendment and provider nondiscrimination provisions of Medicaid, Medicare, and state law have rarely been interpreted by courts–often because these provisions do not establish a private right of action. However, the legislative intent behind the provisions and the statutory interpretation of the ACA suggests that DEMs, if licensed in a state, should be covered by insurers–both private and public–in that state.

In the rare cases in which the Harkin Amendment and other provider nondiscrimination provisions have been brought before federal courts, courts have concluded that Section 2706(a) of the ACA and these other provider nondiscrimination provisions do not establish an express or implied private right of action.[84] Only the state or the U.S. Department of Health and Human Services can bring a claim under the provider nondiscrimination provisions.[85] Courts have therefore dismissed almost all Harkin Amendment and provider nondiscrimination claims, since nearly all claims have been brought by private parties. Thus, DEMs or patients may be unable to directly bring claims under these provider nondiscrimination provisions in courts, unless the state nondiscrimination provisions establish a private right of action.

Furthermore, dicta in some cases have suggested that the provider nondiscrimination provisions do not require insurers to cover *any and all* services just because they are rendered by a state-licensed provider.[86] For instance, in *A.H. v. Microsoft Corp. Welfare Plan*, the court

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[80] *See, e.g.*, Utah Code Ann. §31A-22-618; Wash. Rev. Code §48.43.045; *see also*, John Blum, *Non-Discrimination and the Role of Complementary and Alternative Medicine*, BLOOMBERG LAW, (Apr. 24, 2014), https://news.bloomberglaw.com/health-law-and-business/non-discrimination-and-the-role-of-complementary-and-alternative-medicine.

[81] *See* Colo. Rev. Stat. § 10-16-107.7.

[82] COLORADO OFFICE OF DIRECT-ENTRY MIDWIFERY REGISTRATION, https://dpo.colorado.gov/Midwives.

[83] Colo. Rev. Stat. § 10-16-107.7.

[84] Courts have held that the Harkin Amendment does not establish a private right of action. *See, e.g.*, A. Z. v. Regence Blueshield, 333 F. Supp. 3d 1069, 1083 (W.D. Wash. 2018); Ass'n of N.J. v. Horizon Healthcare Servs., Inc., 2017 WL 2560350 (D.N.J. June 13, 2017); Dominion Pathology Labs., P.C. v. Anthem Health Plans of Va., Inc., 111 F. Supp. 3d 731, 736 (E.D. Va. 2015); Vorpahl v. Harvard Pilgrim Health Ins. Co., No. 17-cv-10844-DJC, 2018 U.S. Dist. LEXIS 121316, at *15 (D. Mass. July 20, 2018). Courts have also established that the provider nondiscrimination provision of the Social Security Act does not establish a private right of action. *See, e.g.*, *C.S. Sewell, M.D.P.C. v. Amerigroup Tenn., Inc.*, No. 2:17-cv-00062, 2018 U.S. Dist. LEXIS 211113, at *18 (M.D. Tenn. Dec. 14, 2018); *Med. Diagnostic Labs., LLC v. Horizon Healthcare Servs.*, No. 2:18-616 (WJM), 2018 U.S. Dist. LEXIS 68922, at *5 (D.N.J. Apr. 24, 2018).

[85] *See* Caitlin McCartney, *The Patient Protection and Affordable Care Act and Choice in Childbirth: How the ACA's Nondiscrimination Provisions May Change the Legal Landscape of Childbirth*, 24 AM. U.J. GENDER SOC. POL'Y & L. 337, 356 (2015); 42 U.S.C. § 18041.

[86] *See* A.H. v. Microsoft Corp. Welfare Plan, No. C17-1889-JCC, 2018 U.S. Dist. LEXIS 94537, at *21 (W.D. Wash. June 5, 2018); *see also*, Vorpahl v. Harvard Pilgrim Health Ins. Co., No. 17-cv-10844-DJC, 2018 U.S. Dist.

found that the Harkin Amendment "merely requires that insurers not discriminate against state-licensed providers when their services are covered by a healthcare plan."[87] However, many states require insurers to cover midwifery services by Certified Nurse Midwives,[88] so even considering this limitation suggested by dicta, the Harkin Amendment should require that insurers cover the midwifery services of DEMs.

While there are no court cases that directly apply provider nondiscrimination provisions to DEM services, an Oregon patient has been able to successfully receive private insurance coverage for her DEM and home-birth after a months-long battle with Oregon state insurer regulators and medical insurer PacificSource.[89] After reviewing the 2015 FAQs regarding the implementation of Section 2706(a) of the ACA,[90] PacificSource agreed that its members going to a Licensed Direct Entry Midwife could receive benefits under their policy.[91] This success story suggests that other private insurers in other states that provide licensure to DEMs may follow suit.

The legislative intent behind the Harkin Amendment and the statutory interpretation of the ACA provide further support for Medicaid coverage of DEMs. The Senate explicitly questioned the Departments' original Harkin Amendment guidance that allowed insurers to exclude whole categories of providers from their policies, and clarified that the purpose of the Harkin Amendment was to "ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State."[92] This strongly suggests that insurers should cover DEMs in the states in which they are licensed. Additionally, sections of the ACA beyond the provider nondiscrimination provision address access to alternative medicine. For instance, Section 3502 of the ACA focuses on establishing "community health teams to support the patient-centered medical home," suggesting that the drafters of the ACA were attempting to improve access to "licensed complementary and alternative medicine practitioners," such as DEMs.[93] For all the aforementioned reasons, the Harkin Amendment and other provider nondiscrimination provisions provide a basis for arguing that private and public insurers cannot discriminate against the profession of DEMs.

LEXIS 121316, at *14 (D. Mass. July 20, 2018) (finding that the Harkin Amendment "only prohibits an insurer from discriminating against a provider by denying coverage for services provided by a health care provider who is licensed to provide an otherwise covered service.").

[87] *Id*.

[88] *Midwife Medicaid Reimbursement Policies by State*, NATIONAL ACADEMY FOR STATE HEALTH POLICY, (Apr. 28, 2023), https://nashp.org/midwife-medicaid-reimbursement-policies-by-state/.

[89] John Weeks, *Obamacare forces insurer to cover Oregon home-birth*, INTEGRATIVE PRACTITIONER, (Apr. 6, 2017), https://www.integrativepractitioner.com/practice-management/news/obamacare-forces-insurer-cover-oregon-home-birth.

[90] *See* FAQS, *supra* note 6.

[91] *See* John Weeks, *supra* note 22.

[92] S. Rep., *supra* note 4.

[93] 42 U.S.C. § 256a-1; *see* Chelsea Stanley, *The Patient Protection and Affordable Care Act: The Latest Obstacle in the Path to Receiving Complementary and Alternative Health Care?*, 90 IND. L.J. 879, 889 (2015).

CONCLUSION

Direct Entry Midwives (DEMs) provide high-quality, evidence-based, and cost-efficient care. By excluding them from Colorado Medicaid plans, the state shuts out the Colorado 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 enumerated above- it is also arguably illegal under Federal and State law.