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**Preliminary Comments of the
American Association of Birth Centers**

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Preliminary Comments of the American Association of Birth Centers

The American Association of Birth Centers (“AABC”) appreciates the opportunity to provide these Comments for the Federal Trade Commission Workshop “Examining Health Care Competition.” In its Comments, AABC will address current issues related to the regulation and operation of freestanding birth centers (“FSBCs”) and midwives in the United States, as well as broader issues that affect competition and consumer welfare in the U.S. market for maternity care services generally. We also wish to highlight both government policies and the actions and practices of private entities that may restrict market entry and competition by FSBCs and midwives, and deny choice to pregnant women and their families.

Information about the American Association of Birth Centers. The American Association of Birth Centers is a multi-disciplinary membership organization comprised of individuals and organizations that support the birth center concept. Its membership, in addition to freestanding birth centers throughout the U.S., includes certified nurse-midwives (CNMs), certified professional midwives (CPMs) and other licensed direct-entry midwives, physicians, nurses, Advanced Practice Registered Nurses (APRNs), consumers, and various state and national associations, businesses, and educational institutions that support AABC’s basic principles of high standards of care and safety, low rates of intervention in the process of natural childbirth, elimination of unnecessary costs, and the participation of qualified providers, particularly including all categories of midwives. As the nation’s most comprehensive resource on birth centers, AABC works on multiple levels to provide a national forum for birth center issues, to conduct ongoing research on normal birth and on maternity care in birth centers, to promote quality assurance systems for birth centers and health care professionals who provide services in birth centers, and to serve as a trade association for its birth center members. Our website is at www.birthcenters.org.

1. **Some Characteristics and Basic Information about Birth Centers.** The birth center is a freestanding facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman’s residence. Midwives in birth centers also provide prenatal, postpartum, well-woman, and newborn care and services. AABC and its members recognize that pregnancy and childbirth are healthy uncomplicated life events for most women and babies. In birth centers, midwives and staff function within a “wellness” model of pregnancy and birth, which means that they provide continuous, supportive care, and that interventions are used only when medically necessary. Birth centers are guided by principles of prevention, safety, cultural competency, sensitivity, cost effectiveness, and appropriate medical intervention if and when necessary. Most birth centers are located separately from hospitals, while a few are physically inside hospital buildings. Birth center members that are owned or located within a hospital must be governed separately and meet AABC Standards. Please note that the majority of so-called “birthing centers” owned by or located within hospitals are simply Labor and Delivery Units that have adopted some of the stylistic elements of birth centers, but do not necessarily provide the birth center model of care. Generic use of this term by hospitals can be confusing for consumers.

Birth centers are universally committed to woman-centered and family-centered care. In birth centers, the childbearing woman’s right to be the decision-maker about the circumstances of her birth is fully respected. For example, in birth centers, women are encouraged to eat if they are

hungry, move about and spend time in a tub as they wish, and push in whatever positions they find most comfortable. Birth centers midwives and staff attend to her needs, while diligently watching for signs that may fall outside the realm of wellness. AABC is dedicated to the promotion of the rights of healthy women and their families, in all communities and at all income levels, to give birth to their children in an environment which is safe, sensitive, culturally-competent, and cost-effective, with minimal intervention and with access to one's preferred choice of provider – midwife, family practice doctor, or OB/GYN.

Supply and Demand Factors. As of last year, there were 265 freestanding birth centers in the United States, located in 37 states and the District of Columbia. AABC recognizes that this is a relatively small number, but some of the reasons for the long-term stunted growth rate of birth centers, and the high percentage of birth center closures in prior years, are the reasons that have brought us to this Workshop. As will be discussed further, birth centers have struggled to overcome restrictive state laws and rules, exclusion from government and private payment mechanisms, and lack of cooperation, hostility, and – in some cases – actual refusals to deal on the part of local hospitals and physicians. While birth centers still confront many such problems, the greatly increased demand for out-of-hospital childbirth services, which has translated into strong consumer grassroots support for changing laws and dealing with other practice barriers, has helped our members and other birth centers to overcome many of these obstacles. Birth center growth trends are highly positive – the attached chart “Birth Centers Are Growing” indicates, in absolute numbers, a growth rate of 65% since 2004.

An Institute of Medicine workshop on Birth Settings, held in March 2013, gathered and published in a Workshop Summary¹ much of the existing demographic data on sharply increased demand for birth center and home birth services. The Report points out that,

beginning in 1989, “revisions of birth certificates made it possible to distinguish, for the first time, between types of out-of-hospital births, that is, whether the births occurred in homes or in birthing centers. The data, collected and published annually by the CDC, indicate that the total number of out-of-hospital births, both home and birthing center, after gradually declining between 1990 to 2004, began to increase rapidly from 2004 to 2010. Home births increased by 41 percent from 2004 to 2010, with 10 percent of the increase occurring in the last year; birthing center births increased by 44 percent over the same time period, with 14 percent of the increase occurring in the last year. In 2010, there were 31,500 home births and 13,166 birthing center births in the United States. Among out-of-hospital births, 67 percent are home births, 28 percent occur in birthing centers, and 5 percent are identified as “other” (which has an unclear meaning).

A very recent (March 2014) Data Brief, published by the National Center for Health

¹“An Update on Research Issues in the Assessment of Birth Settings: Workshop Summary,” available at http://www.nap.edu/catalog.php?record_id+18368 (National Academies Press, 2013).

Statistics (NCHS) of the Centers for Disease Control (CDC),² updated birth center and home birth data through 2012, again showing significant increases. The report acknowledged that out-of-hospital births are “still rare” in the United States, but have shown a steady and significant increase. Total out-of-hospital births increased from 1.26% in 2011 to 1.36% in 2012, continuing the consistent upward trend since 2004. These results vary by state, ranging from a high of 3% to 6% in Alaska, Idaho, Montana, Oregon, Pennsylvania, and Washington (Alaska was highest at 6%), through 2% to 3% in states including Delaware, Indiana, Utah, Vermont, and Wisconsin, with the lowest levels (less than 0.4%), in Rhode Island, Mississippi, and Alabama. It is a matter of interest, but not of surprise, that the midwifery practice laws in five of the six states at the highest level all permit autonomous practice by CNMs and CPMs, and that Alaska, Oregon, and Washington also have reasonable unrestrictive regulations governing birth center licensure. Pennsylvania, Delaware, Indiana, and Utah all have large populations of religious communities that favor or require out-of-hospital birth as a religious or cultural practice.

As might be expected, the three states with the lowest levels of out-of-hospital birth have practice laws which prevent or discourage autonomous midwife practice: CNMs require physician collaboration agreements to practice in Alabama and Mississippi, while CPMs, whose education and certification are directed at home and birth center practice, practice on an underground unlicensed basis, if at all, in all three states, and are subject to prosecution in RI and AL, and none of these states has a single birth center. As the Commission has found with respect to Advanced Practice Registered Nurses (APRNs), state licensing laws and regulations governing midwives and birth centers that require a medical director, physician supervisor, or contracts with physicians or hospitals reduce access to these providers, and give hospitals and obstetricians virtual veto power over home birth and birth center practices in these states.

The business model for birth centers varies, including both small for-profit businesses, owned by one or more midwives, physicians, or other individuals, who also provide services at the facility, and non-profits, governed by or affiliated with non-profit groups or, in some cases, are owned by Federally Qualified Health Centers (“FQHCs) or rural health clinics. A list of these facilities, including both AABC members and non-members, is provided as an Attachment. The majority of birth centers are staffed by midwives, either CNMs, CPMs or other Licensed Midwives, or both (*see* Attachment, “Characteristics of Birth Centers in the United States” for data on ownership and staffing patterns). As these data indicate, the midwives at some birth centers also offer their clients the option of hospital birth, while others offer home birth services. Birth centers have the option of seeking accreditation from an independent entity, the Commission on Accreditation of Birth Centers (CABC) <https://www.birthcenteraccreditation.org>. The CABC has provided support, education, and accreditation to developing and established birth centers in the U.S. since 1985. Accreditation is also available to birth centers from the Joint Commission and the accreditation body for ambulatory surgical centers.

²MacDorman, MF, Mathews, T.J., Declercq, E., Trends in Out-of-Hospital Birth in the U.S.: 1990-2012, NCHS Data Brief No. 144; Hyattsville, MD: National Center for Health Statistics, 2014 (copy attached).

Although birth centers suffered many financial setbacks and closures during the 1990s (largely due to restrictive state laws, opposition from local hospitals or medical groups, or inability to secure or pay for malpractice insurance), the past ten years have witnessed a resurgence in popularity and an upwardly trending growth rate. As indicated above, data collected and published by AABC (see attached charts “Birth Center Are Growing, 1984 - 2014,” and “Birth Center Openings and Closings”) demonstrate a 35% increase in the number of U.S. birth centers between 2004 (170) to 2011 (230), and an overall 65% increase from 2004 to 2013 (265). AABC’s own membership, in addition to fully-operational centers, presently includes at least 50 birth centers in some stage of development. Birth center growth, however, tends to be concentrated in states with more favorable licensure laws and rules, such as Texas (more than 60), California and Florida (more than 25 each), Alaska (9), Washington (13), and Oregon (more than 10).

Despite the admittedly small numbers of women giving birth in birth centers or at home at the present time, what the authors of the NHCS Data Briefs have found most significant is the strong and growing rate of increase in out-of-hospital births. The 2014 Data Brief specifically points out that “[i]f this increase continues, it has the potential to affect patterns of facility usage, clinician training, and resource allocation, as well as health care costs.” AABC considers this assessment of its members’ competitive potential of great significance, particularly when coupled with recent survey data that indicates future birth setting preferences of women who have recently given birth. These survey data suggest that this demand trend is likely to continue at exponential rates. For over the past decade, the Childbirth Connection has conducted a series of periodic surveys of a representative sample of women who had recently given birth in hospitals in the U.S. These surveys and resulting reports, entitled *Listening to Mothers*SM I, II, and III, and follow up surveys on postpartum issues, entitled *New Mothers Speak Out*, were published in, respectively, 2002, 2006, and 2013, and are available on the Childbirth Connection website at <http://www.childbirthconnection.org/article.asp?ck=10068>

The 2013 *New Mothers Speak Out* survey, which involved a representative sample of women who gave birth in U.S. hospitals in 2011 or 2012, contains a series of questions for women who indicated they intended to have additional children. In response to the question, “For any future births, how open would you be to giving birth in a [freestanding] birth center,” 39% of respondents indicated that they “would consider this,” while an additional 25% stated they “definitely would want” to use a freestanding birth center (yes, this response rate is **25%**, not 2.5%). With respect to home birth – an option offered by some birth centers – the responses were similar: 18% of women who gave birth in hospitals in 2011 or 2012 “would consider” a home birth, while 11% “definitely would want” to give birth at home.³

These data represent an exciting opportunity to change the present pattern of routine hospital birth, but also pose a huge supply-side challenge. If 25% of the women represented by participants in this survey were to follow through on their interest in birth center delivery for their next baby, their numbers could well swamp the capacity of existing facilities.

³ Declercq, ER, Sakala, C, Corry, MP, Applebaum, S, Herrlich A. *Listening to Mothers*SM III: *New Mothers Speak Out*. New York: Childbirth Connection, 2013.

Furthermore, regardless of whether or not these women follow through on this intent, it is remarkable that such a large percentage of women know enough about freestanding birth centers – facilities that so far have made a relatively small market inroad – that they are willing to consider these options, or expect to be able to access them, next time around. These data suggest that birth centers, midwives, and home birth are poised to go mainstream – unless blocked from doing so by regressive laws and regulatory policies, exclusion from provider networks and payment mechanisms, government and private, and anti-competitive actions on the part of hospitals and physician groups. Significant change will be required in regulatory policy, payment patterns, and elimination of private restrictions to permit the supply of birth centers to increase sufficiently beyond present numbers in order to meet the increased consumer demand indicated by these survey data.

Two further factors about birth centers should be considered before moving on to discuss general market forces in maternity care – cost and quality. Since development of the birth center concept in the 1970s and early 80s – in a manifestation of the same market forces that fostered the development of ambulatory surgical centers and the hospice movement – birth centers have consistently demonstrated high levels of quality of care, with excellent outcomes for both mothers and babies, and high levels of client satisfaction. In January 2013, a landmark study⁴ published in the *Journal of Midwifery and Women's Health* demonstrated that birth centers provide high quality care and excellent outcomes for healthy pregnant women and their babies, and a reduction in unnecessary interventions, including a significant reduction in the rate of cesarean sections. The c-section rate for women in the study was only 6% – compared to an overall U.S. C-section rate of 25% for low-risk women. This means that the c-section rate for women who plan to give birth in birth centers is at least 4 times less than among low-risk women who plan to give birth in U.S. hospitals. The researchers estimated that, in this study, more than \$30 million was saved to private and government payors because of the 15,574 women who chose to give birth in birth centers. Another recent study, published in the same journal, demonstrates high levels of quality care and client satisfaction regarding prenatal care and childbirth services of midwives in the home birth setting. A copy of that study will be provided in followup comments.

A number of studies have indicated that birth centers are highly cost-effective and save money for government and private payors. In 2007, the State of Washington published a widely-circulated study that reported on excellent clinical outcomes and significant cost savings by the state Medicaid program had realized in a trial program to include midwifery, birth centers, and home birth in the state Medicaid program.⁵ A 2013 study of maternity care costs prepared by

⁴ Stapleton SR, Osborne C, Illuzzi J. Outcomes of care in birth centers: Demonstration of a durable model. *Journal of Midwifery and Women's Health*. 2013. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12003/full>.

⁵ Health Management Associates. Midwifery licensure and discipline program in Washington State: Economic costs and benefits. Washington State Department of Health, October 31, 2007. See powerpoint presentation at

Truven Health Analytics® for the Childbirth Connection, which is discussed in more detail in the next section of these Comments, found that the average charges and payment for the facility component of birth center services for mother and baby were significantly lower than hospital facility charges and payments for labor and delivery and newborn-related services.

How do birth centers save health care dollars? First of all, vaginal births in birth centers simply cost less. In 2011, the average Medicare/Medicaid facility services reimbursement for an uncomplicated vaginal birth in a hospital was \$3,998, compared with \$1,907 in birth centers. This factor alone would have accounted for a savings of \$27.2 million in the 15,574 births considered in the National Birth Study II. Even if birth center reimbursement were closer to payment for hospital births, the decreased use of interventions in birth centers would still translate into a significant cost-savings for insurance companies and government payors. Medicaid funds approximately 41% of all maternity care in the U.S and Tricare is also a significant payor of maternity care services.

In 2010, presented with information regarding the potential cost savings to be realized by the Medicaid program, Congress added a provision to the Affordable Care Act that amended the federal Medicaid law to add freestanding birth centers, as well as the midwives who provide professional services in birth centers, as Medicaid providers. This provision, section 2301 of the ACA, specifically mandates access to birth centers for low income pregnant women.⁶ Articles by consumers, public health professionals, and journalists following the publication of the Truven study specifically addressed the potential cost savings if more women chose birth centers instead of hospitals for maternity care. Attached are copies of articles from the *New York Times*, *Salon*, and *CNN Online*, all pointing out the advantages of greater utilization of birth centers.

Second, as noted above, the c-section rate in the NBCS II study was 6%, compared to 25% for low-risk women who give birth in U.S. hospitals, and an overall rate of 32.8% for all women in US hospitals. If the women who planned to give birth in birth centers had instead chosen hospital births, it is estimated that they would have experienced 3,000 additional – and unnecessary – cesareans. Instead, these c-sections were safely and effectively prevented, resulting in a potential cost-savings of at least \$4.5 million.

At the present time, childbirth is the number one cause of hospitalization in the U.S., accounting for one-fourth of all hospital discharges. But as of 2012, only 0.39% of American women give birth in birth centers, up from 0.36% in 2011 and 0.23% in 2004, an overall 56% increase. If even 10% of hospital births were shifted towards birth centers, significant cost-savings as great as \$2.6 billion could be realized, and more families would be receiving first-rate family-centered care.

<http://www.iom.edu/~media/Files/Activity%20Files/Women/BirthSettings/6-MAR-2013/Cawthon%20PDF.pdf> for a 2013 update by the original author.

⁶See § 2301 of the Affordable Care Act, codified at 42 U.S.C. §1396a(a)(10)(A); 42 U.S.C § 1396d(a)((28); and 42 U.S.C. § 1396d(1)(3).

The National Birth Center Study II confirms the findings of the original 1989 Birth Center Study,⁷ published in the *New England Journal of Medicine*, that midwifery-led care in birth centers is safe. We now have evidence from two large-scale U.S. studies, along with the added advantage of more than 35 years of birth center experience. These findings should encourage physicians and hospitals to partner with birth centers in their communities. Such partnerships would benefit hospitals through increased referral revenue and recognition, and would benefit patients by making transitions of care as seamless and patient-centered as possible.

Unfortunately, many physicians and hospitals refuse to enter into consulting or transfer relationships with midwives and birth centers that would allow for seamless transfers of care when necessary. Birth centers have also been excluded from various state perinatal transfer networks that have traditionally facilitated safe transfer from rural and community hospitals to hospitals with Level 3 NICU units and other specialist care.

What is the bottom line for policy-makers? Birth centers are a high-value option for maternity care that can complement as well as compete with the existing hospital-based system. Care that is provided in and by birth centers fully meets the "triple aim" vision of healthcare policy: improving the experience of care, improving the health of populations, and reducing per capita costs of health.⁸ Advocacy is needed to achieve change in restrictive regulations, to end private restraints on birth center growth and operation, and to convince employers, policymakers, and public and private payors to make midwife-led care in freestanding birth centers a viable alternative option to hospital birth for healthy women who desire less intervention in the birth process.

In these preliminary comments, we will touch on the following additional issues. AABC intends to file more comprehensive post-workshop comments, which we are in the process of coordinating with other health care entities and consumer organizations. In doing so, we hope to bring the full picture regarding the state of competition and consumer access in the maternity care market to the attention of the Commission and its staff:

- an overall description of the U.S. market for maternity care;
- regulatory factors that constitute barriers to entry or otherwise restrict the ability of birth centers and midwives to compete in the maternity services market;

⁷ Rooks, J., et al. Outcomes of Care in Birth Centers: the National Birth Center Study. *New England Journal of Medicine* **321**: 1808-1811, (Dec. 28) 1989. ("NBCS I")

⁸ Berwick DM, Nolan TW, Whittington J. The triple aim: Care, health, and cost. *Health Affairs*. 2008;27:759-769. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18474969>

- organized (and potentially concerted) opposition to birth centers and midwives by hospitals and physician groups, including refusals to deal;
- exclusion of birth centers and midwives from managed care provider panels, IPAs, HMOs, and ACOs;
- restrictions on output of services and other constraints on consumer choice (with a focus on forced c-section and denial of vaginal birth after cesarean (VABC.))
- the development of organized consumer advocacy for better access and better quality maternity care

2. The Market for Maternity Care Services in the United States.

The Childbirth Connection is a nearly 100 year-old research-and-advocacy think tank (formerly known as the Maternity Center), which has gathered and published data and conducted and commissioned studies and reports on maternity care in the United States (www.childbirthconnection.org). Its many useful publications include a two-page fact sheet with key data about demand, supply, and payment factors in the maternity care market. According to its 2012 Fact Sheet, a copy of which is attached, 3,953,590 births occurred in the U.S. in 2011; in 2012, the number was similar, 3,952,841 births (749 fewer).⁹

Data from 2009 indicate that care of women in childbirth was the single most common reason for hospitalization, with 23% of hospital discharges involving childbearing women and their babies. In that same year, 6 of the 10 most common hospital procedures performed, including cesarean section delivery, were maternity-related. C-section, in fact, was the most common operating room procedure in the country that year, involving 1.4 million women. The rate of c-section delivery, which had been steadily climbing toward 1/3 of all U.S. births, dipped slightly to 32.8% in 2010 and remained at that rate through 2012. The 2010 c-section rate varied by payor (with private payors at the highest rate, and uninsured women at the lowest) and by state, from a low of 22.6% in Alaska to 39.7% in Louisiana, and 46.7% in Puerto Rico.¹⁰ Similar numbers are reported for 2012. The national rate of vaginal birth after c-section (VABC.) was only 9.2% in 2010, down from a high of 35.3% in 1997.

Personnel. Approximately 10,000 Certified Nurse-Midwives (CNMs) presently practice in the U.S; the majority provide hospital-based maternity services (96-97%) and are employed by hospitals or physician groups (www.midwife.org). More CNMs would be able to practice independently of physicians, and thus provide greater choice, if restrictive practice laws and

⁹“Births: Final Data for 2012”, Joyce A. Martin, M.P.H.; Brady E. Hamilton, Ph.D.; Michelle J.K. Osterman, M.H.S.; Sally C. Curtin, M.A., and T.J. Mathews, M.S., Division of Vital Statistics.

¹⁰Interestingly, in 2012, Alaska reported the highest rate of midwife-attended out-of-hospital birth (home and birth center) at 6%, while Louisiana was among the lowest.

regulations that require physician supervision (California, Florida, and North Carolina) or collaborative agreements or practice guidelines were amended or repealed. CNM practice in hospitals is also constrained by hospital and medical staff rules that deny them independent admitting privileges, require physicians to co-sign orders or patient histories, or require physicians to “sponsor” or take responsibility for the performance of the CNM. Such restrictions exist in nearly every hospital in the U.S. Few if any hospitals grant autonomous clinical privileges, except in the District of Columbia, where a local statute (*see* DC Code §§44-507, 44-509) prohibits hospitals from discriminating against five categories of non-MD health professionals, including CNMs. These regulatory and hospital restrictions prevent birth center midwives from obtaining privileges at local hospitals for seamless transfer of patients, and prevent hospital-based midwives from making a significant difference in prices charged, services offered, or level of interventions in hospital-based maternity care.

As of 2011, when the American College of Obstetricians and Gynecologists (ACOG) issued a major study on the OB/GYN workforce, the number of Obstetricians is declining, as is the number of medical students choosing residencies in obstetrics. Additionally, there is a growing phenomenon of OB/GYNs dropping the obstetrics side of their practice after an average of 14 years. All these factors point to an overall decline in the number of Obstetricians.

More than 2,000 Certified Professional Midwives (CPMs) have been certified by the North American Registry of Midwives (“NARM”) to date, and are presently in practice in the United States (www.narm.org). CPMs specialize in out-of-hospital birth, both home and birth center, and typically do not seek clinical privileges to work in hospitals. CPMs are not nurses and enter into the study and practice of midwifery directly, so are often called, generically, “direct-entry” midwives. At the present time, only 28 states license or provide statutory recognition for CPMs, leaving 22 states and the District of Columbia where CPMs are subject to administrative, civil, or criminal sanctions for providing midwifery services. These regulatory issues will be considered in more detail in the next section.

Maternity care is a significant component of health care spending. In 2010, combined facility charges (hospital and birth center, not including professional fees) were \$111 billion. Medicaid pays an average of 45% of charges, with the two most common conditions billed to Medicaid were pregnancy and childbirth (24%) and newborn care (23%). That same year, 48% of all maternity-related charges were billed to private payors. Birth centers and home birth, as discussed above, are still a small percentage of all births, fewer than 2% total, but (as discussed above) are growing at a rapidly-increasing rate.

In June 2013, as part of a three-part series on health care costs, the New York Times published the attached article, “American Way of Birth: Costliest in the World,” which reported in part on the Truven Healthcare Analytics report *The Cost of Having a Baby in the United States*, the 2013 report on maternity care costs commissioned by Childbirth Connection, the Catalyst for Payment Reform, and the Center for Health Care Quality and Payment Reform. Among the information revealed by the report was the statistic that “from 2004 to 2010, the prices that insurers paid for childbirth . . . rose 49 percent for vaginal birth and 41 percent for cesareans, with average out-of-pocket costs rising fourfold.” The article also reported that:

“Better care, better outcomes, and lower costs in health care are all possible through use of innovative delivery systems, supported by value-based payment systems and effective performance measurement. One of the greatest opportunities for improving health care value is in maternity care, which impacts everyone at the beginning of life and about 85% of women during one or more episodes of care. Most childbearing women are healthy, have healthy fetuses, and have reason to expect an uncomplicated birth, yet routine maternity care is technology-intensive and expensive: combined maternal and newborn care is the most common and costly type of hospital care for all payers, private payers, and Medicaid.”

The entities that commissioned the Truven report believe that “significant improvements in quality and savings in costs can be achieved by reducing unwarranted practice variation and the overuse of some interventions and under use of others. High performing maternity care providers and settings such as FSBCs, and the outcomes for the women and families they serve, demonstrate the potential for dramatic improvement in care, outcomes, and value relative to usual care and population norms. Childbirth Connection’s multi-stakeholder, deliberative project, *Transforming Maternity Care*, developed two consensus reports: “2020 Vision for a High - Quality, High-Value Maternity Care System” and a “Blueprint for Action” to chart the path toward such a system. See <http://transform.childbirthconnection.org/about/> From its inception, the project’s key informants and Steering Committee members understood that a multi-faceted strategy, including payment reform, changes in benefit structures, public education, and provider engagement, is essential for successfully driving needed improvement.

The Truven report on the “Cost of Having a Baby in the United States” clarifies that significant savings can be achieved by advancing priority Blueprint recommendations. The Catalyst for Payment Reform (CPR) is a nationwide nonprofit coalition of large national employers and public payers, including several state Medicaid agencies. The study’s sponsoring organizations understand that maternity care is in need of significant payment reform, both to remove the perverse incentives for unnecessary intervention in labor and delivery and to increase incentives for better adherence to rigorous clinical guidelines. To help purchasers work with health plans towards this goal, CPR created its Maternity Care Payment Reform Toolkit, which is available at <http://www.catalyzepaymentreform.org>. The Center for Healthcare Quality and Payment Reform (CHQPR, at www.chqpr.org/) has been working since 2009 to educate physicians, hospitals, health plans, employers, consumers, and policy makers about the barriers to higher quality, more affordable health care created by current payment and delivery systems, and ways to overcome those barriers. CHQPR understands that one of the best opportunities for making health care more affordable and improving the health status of the public is through improving the way maternity care is delivered in America. These groups commissioned this report to focus the attention of all stakeholders on the need to better align maternity care payment and quality. Links to these studies and other resources about ways to improve payment and delivery of maternity care are available on the Childbirth Connection website.

3. Regulatory Issues.

As health care facilities, freestanding birth centers are typically licensed by the same division of state government that licenses hospitals, ambulatory surgical centers, nursing homes

and other facilities. Eleven states do not license or regulate birth centers – Idaho, Iowa, Louisiana, Maine, Michigan, New Mexico, North Carolina, North Dakota, Virginia, Vermont, and Wisconsin. Unlicensed birth centers exist in each of these states except North Dakota, and Vermont, but unlicensed facilities cannot be recognized as Medicaid providers, so licensure is a goal for birth centers in states that lack such laws. Unfortunately, many state licensing laws or regulations, like the laws governing APRNs, are unduly restrictive, and can result in limiting the number and restricting the growth of FSBCs in that state. AABC staff and members are working, on a state-by-state basis, to identify restrictive laws and/or rules and advocate for amendment. AABC and its members in the various states intend to call upon the Commission’s competition advocacy program for assistance in educating legislators and administrative agencies on the anti-competitive effects of unduly restrictive laws and the procompetitive benefits that can result if birth centers are given greater autonomy.

Regulatory restrictions on birth centers take many forms. Although 39 states and the District of Columbia have some form of licensing for birth centers, some of these states, regrettably, classify birth centers as a type of ambulatory surgical center or hospital (Arizona, Connecticut, Missouri, New York), an inappropriate designation that leads to over-regulation, unnecessarily-restrictive regulatory criteria, and fewer birth centers. Connecticut and Missouri, for example, each have only one licensed birth center, while New York – which has over 300 licensed midwives – has only two birth centers in the entire state. Several state laws subject freestanding birth centers to Certificate of Need standards and proceedings, with predictable results – Georgia and Iowa, which have CON laws, have only one birth center each, and the first birth center applicant in Kentucky recently lost its CON hearing and cannot open for business. Iowa has a similar requirement, which one of our developing members is presently confronting.

As with laws for Advanced Practice Registered Nurses, at least half of the states require some form of physician involvement with birth center operations, either a medical director or a physician who is contracted with the FSBC in a collaborating/consulting/referral capacity. Such agreements are typically required for obstetrician consultants, but some states also require an agreement with a pediatrician. Additionally, some state laws or rules mandate written transfer agreements or arrangements with a local hospital. In our members’ experience, it is very difficult, and often impossible, to find a physician who is willing to sign an consulting or referral-acceptance agreement. Hospitals, which are often direct competitors of birth centers, are likewise typically unwilling to enter into transfer or transport agreements, even those such arrangements improve patient care by providing for more seamless transfers when necessary. Hospitals typically provide the chief (and often only) opposition to granting certificates of need for new birth centers, which was the case in last year’s CON in Kentucky, presently on appeal.

Another problem with the laws of some states is that they do not recognize all categories of midwives as acceptable clinical directors or birth attendants. At the present time, only 28 states license or recognize the certification of Certified Professional Midwives. In the other 22 states and the District of Columbia, CPMs and other “direct-entry” midwives¹¹ practice on an

¹¹ The term “direct entry” indicates that the midwife has not trained first as a nurse but, rather, entered the study and practice of midwifery directly, either through one of several schools

unlicensed basis or are prohibited from practice. In those states, CPMs are typically not yet recognized as qualified providers in the state birth center law or regulations. As these states change their laws to license CPMs, the birth center laws must also be amended. However, at least four states (Colorado, Missouri, New Jersey, Wyoming) that already license or recognize Certified Professional Midwives nevertheless do not permit them to serve as a clinical staff in licensed birth centers (a fifth, California, amended its birth center law to include all licensed midwives in late 2013). Another typical problem area in birth center regulation is the imposition of unnecessary and burdensome architectural and structural requirements, more suited to a hospital or ambulatory surgical center than a birth center, which can be adequately and safely regulated under the relaxed building and fire code provisions applied to a medical office.

By the end of the Comment period, we hope to have collected from our members several specific examples of barriers to entry and other regulatory problems that have restricted consumer access to birth centers or limited their ability to provide services. However, we will mention here a few of the worst examples. Last year, the South Carolina Department of Health and Environmental Control offered a new interpretation of its existing rule that required birth center midwives to have a consulting agreement with an obstetrician. Some of the six birth centers in the state managed to satisfy that provision by finding a physician in another geographic area of the state, who wasn't subject to local pressures, to serve that role. But, in 2013, DHEC informed the birth centers that the consulting physician had to come physically to the birth center to provide consultation, and that OB consultation must be secured before any patient could be transferred to a hospital. This requirement is not only impossible to meet - because no physician would be willing to do this - but actually very dangerous for patients. If transport is needed in an emergency situation (post-partum hemorrhage for example), the time lost waiting for the OB consultant to arrive could further compromise the patient's condition.

Another example is Missouri, where the state agency insists on holding birth centers to the much stricter standards of ambulatory surgical centers, standards unnecessary for safety or quality in FSBCs. The owners of one of our member FSBCs, a husband-and-wife-owned small business that purchased and renovated a house, cannot afford to make the burdensome structural changes that state rules require. A state advisory panel on small business advocacy has urged the licensing urgency to waive these restrictions without success. The only concession the agency offered is to permit the birth center to remain unlicensed, with fewer birthing rooms, but this would prevent the center from qualifying as a Medicaid provider. Utah likewise offers legal but unlicensed status to FSBCs that cannot meet its overly restrictive facility standards, but also limits the number of birthing rooms. Without licenses, these FSBCs cannot accept Medicaid

of midwifery in the U.S. or by apprenticeship. Direct entry midwives who pass the rigorous written and hands-on certification examination of the North American Registry of Midwives are certified as CPMs (www.narm.org). Details, including a comprehensive map and chart, regarding the present state of licensure and regulation of CPMs in the U.S. is available at <http://pushformidwives.org/cpms-by-state>, <http://pushformidwives.org/2012/04/29/pushchart/>

clients; restrictions on the number of birthing rooms limits their effectiveness as a competitor against local hospitals. Another example comes from the State of Mississippi, whose facility rules require birth centers to have a transfer agreement with a hospital. When our developing member satisfied that rule by agreement with a local community hospital, the agency changed its rule to make it more restrictive by requiring the transport hospital to have a Level II nursery.

AABC staff is aware of at least two birth centers that have succumbed to paying significant “consultant fees” to an obstetrician simply to get his signature on such an agreement. These fees, which amount to many thousands of dollars per month, are paid simply to secure the necessary signature on the agreement. If and when actual services are provided, the OB can bill and be paid separately by government or private payors.

These regulatory restrictions are not evidence-based. They constitute significant barriers to entry for new birth centers, essentially a toll that must be paid to a competitor for permission to enter the market. Inability to comply with such rules are often the primary reason why FSBCs have failed. Our followup comments will include statements from several of our members regarding specific, and representative, regulatory problems in their respective states.

4. Privately-imposed Restrictions, Refusals to Deal, Exclusion from Provider Networks, and Denials of Coverage.

Birth centers, including physicians and midwives who own or work for birth centers, have been subjected to exclusion and restrictive practices by other participants in the maternity services market, including local hospitals, hospital obstetric departments, emergency room physicians, managed care organizations, and other health plans. One of the reasons why regulatory physician-consultant requirements are so onerous is that most obstetricians will not enter into such agreements with FSBCs, and those who do are often harassed by or suffer retaliation from their fellow physicians. Several obstetricians who provides consultant services for local birth centers and midwives have lost their hospital privileges or been subjected to unnecessary peer review by the other members of the OB department. Another obstetrician, this one the owner of a new birth center, was informed by the only pediatrician group on the hospital’s staff that its members would not examine or provide care for newborns delivered by this OB following transfer from the birth center. Birth center midwives are routinely denied admitting privileges at local hospitals. Some of our members have found that, following the transfer of a client to a local hospital, false and harassing complaints have been filed with the nursing board, midwifery board, or birth center licensing agency by hospital staff, even though the transfers were appropriate and not the result of poor care.

Denial of Access to Payment. While managed care and other new payment models offer the promise of better care and reduced costs, birth centers have routinely been rebuffed in their efforts to participate in provider networks of managed care organizations (MCOs) and other health plans. For example, the new accountable care organizations (ACOs or CCOs) being used by the Oregon Medicaid agency have universally refused to contract with any FSBCs or licensed midwives as providers, even though federal Medicaid law mandates the inclusion of FSBCs and all midwives as Medicaid providers, and Oregon state law prohibits discrimination against any category of licensed provider. Managed care organizations in some counties in California and

Texas have likewise refused to contract with birth centers or licensed midwives. In some California counties, the MCOs contract exclusively with pre-formed physician IPAs. Since the IPAs refuse to include FSBCs or midwives, our members are effectively excluded from both Medicaid and private managed care networks in these counties. As with regulatory problems, we will provide member statements with particular examples in our follow-up comments.

5. Restrictions on Output and Consumer Choice

We are working with colleague organizations to bring to the Commission's attention facts relating to the national problem of hospitals that refuse to provide vaginal birth after cesarean (VABC.) or vaginal breech delivery, even though the majority of contemporary evidence-based studies indicate that, in most cases, the risk of these deliveries is no greater than, and often less than, that for cesarean delivery. We anticipate that various consumer groups, such as the International Cesarean Awareness Network (ICAN www.ican-online.org/), Improving Birth (<https://www.improvingbirth.org/>), Citizens for Midwifery www.cfmidwifery.org/), 0 Human Rights in Childbirth (www.humanrightsinchildbirth.com/), and Our Bodies Ourselves (www.ourbodiesourselves.org/), and advocacy/study organizations such as Childbirth Connection, Lamaze International (www.lamazeinternational.org/), and the Coalition to Improve Maternity Services (CIMS, at www.motherfriendly.org/) to file comments or letters of support in time for the April 30, 2014 deadline.

Likewise, we expect comments to be added by several national and local grassroots organizations that are working for CPM licensure and for other state regulatory change, or who otherwise advocate on behalf of greater consumer autonomy and choice of non-physician providers. Among these groups are the Big Push for Midwives (www.pushformidwives.org/), Birth Networks (www.birthnetwork.org/), each of which is a coalition of state grassroots consumer groups, and local social-media-based support groups like North Carolina's Where's My Midwife? ([Www.wheresmymidwife.org](http://www.wheresmymidwife.org/)), South Carolina's Save Charleston Birthplace (<http://www.savecbp.org/>), and California Families for Access to Midwives (<http://www.cafamiliesformidwives.org/>), to name a few of representative examples of the hundreds of such consumer groups that have proliferated online and offline. These groups are using social media to organize, share information, and supplement traditional grassroots activities in order to achieve regulatory change and to confront private restrictions on access to birth centers and midwives.

Conclusion

AABC greatly appreciates this opportunity to provide Comments on the present state of competition – or the lack thereof – in the market for maternity care services, and to describe what birth centers are doing to survive in that market and effectuate positive change by lowering costs, and increasing quality, safety, access, and patient satisfaction. We look forward to the Workshop and request that the undersigned Ms. Fennell, AABC’s Policy Analyst, be permitted to present information at the Workshop about birth centers and maternity care services. We would also appreciate the opportunity, after the Comment period has closed, to meet with Bureau of Competition staff for more in-depth discussion and, if you consider it helpful, to introduce staff to experts on various aspects of the maternity services market.

Respectfully submitted,

American Association of Birth Centers

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