



April 30, 2014

Mr. Donald S. Clark  
Secretary  
Federal Trade Commission  
Office of the Secretary  
Room H-113 (Annex X)  
600 Pennsylvania Avenue NW  
Washington, DC 20580

RE: FTC Health Care Workshop, Project No. P131207

Dear Secretary Clark:

On behalf of the American College of Nurse-Midwives (ACNM), I am pleased to provide comment in response to the notice entitled “Examining Health Care Competition,” published by the Federal Trade Commission (FTC) in the *Federal Register* on February 24, 2014.<sup>1</sup> We greatly appreciate the FTC’s examination of this topic and hope that our comments are of value to the Commission in this important endeavor.

ACNM is the professional organization for both Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) practicing in the US.

### **Statutory and Regulatory Barriers to CNM/CM Practice**

As the FTC is aware, the APRN community has long been involved in efforts to obtain full practice authority in each state. With the FTC, we take the position that CNMs/CMs should be permitted to practice to the extent of their accredited education and independent certification and that this background prepares them to practice midwifery as defined by our professional association.<sup>2</sup> Midwifery education programs are structured to reflect these national standards and are accredited by a national accrediting agency. Certification of CNMs/CMs in the United States is done through the American Midwifery Certification Board (AMCB). There is no state-based variation in education, certification or standards of practice and we do not believe that there should be state variation in how the practice of midwifery is treated.

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<sup>1</sup> 79 FR 10153

<sup>2</sup> See, “Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives,” published by the American College of Nurse Midwives, available at: <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Feb%202012.pdf> See also, ACNM’s “Standards for the Practice of Midwifery,” available at: <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards for Practice of Midwifery Sept 2011.pdf>

ACNM has reviewed state law and regulation to ascertain their impact on the practice of midwifery across the nation. Among the states and the District of Columbia, 26 require CNMs to work under physician supervision or have some sort of collaborative agreement with a physician in order to provide care. Currently five states recognize the CM credential and among them, one requires CMs to work under a contractual practice agreement.

In addition to these supervision and collaboration requirements, CNMs/CMs must deal with legal requirements regarding their ability to admit patients to a hospital or to be members of a hospital's medical staff. ACNM's analysis of state law and regulation shows that among the states and District of Columbia, all states but Maryland have laws and regulations that explicitly or implicitly allow CNMs (or CMs, where applicable) to obtain hospital privileges. Generally, their ability to do so is contingent upon hospital bylaws allowing them to do so. Participation on the hospital medical staff is more restricted than obtaining privileges. Our review of legal requirements shows that 34 states explicitly or implicitly allow CNMs to be included as members of hospital medical staff, while 17 explicitly or implicitly disallow such participation. Among the five states that authorize CMs to practice, four explicitly or implicitly allow them to be included on medical staff, while one explicitly disallows it.

More than 95% of the births attended by CNMs/CMs occur in the hospital setting. Therefore, barriers to their ability to admit patients to the hospital or to participate on the medical staff that establishes bylaws and policies for their institution can significantly impact their practice.

### **Non-Statutory/Non-Regulatory Policies Affecting Competition**

In its February 24, 2014 *Federal Register* notice, the FTC requested comment on "other factors that should be considered when analyzing the competitive implications of professional regulation in health care."<sup>3</sup> Our comments below respond specifically to this request.

Aside from lawmakers and regulators, there is another set of parties that have a significant impact on CNMs/CMs ability to practice. These parties include hospital governing bodies, hospital medical staffs, individual physicians, accrediting agencies, liability insurers and health insurers.

### **Hospital Governing Bodies**

Under 42 CFR 482.12, the Centers for Medicare and Medicaid Services (CMS) established a requirement that any hospital participating in the Medicare program must have "effective governing body that is legally responsible for the conduct of the hospital."<sup>4</sup>

Hospital governing bodies have wide authority to determine which providers can practice within the hospital and the limits of their scope of practice within that specific institution (which may or may not reflect the provisions of state scope of practice law and regulation, or education and certification). **It has been the experience of ACNM members that barriers to their ability to practice frequently arise from policies adopted by hospital governing bodies.**

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<sup>3</sup> 79 FR 10155

<sup>4</sup> 42 CFR 482.12.

Within the Medicare program, there is a requirement that all Medicare patients be under the care of a doctor.<sup>5</sup> This requirement arises from statute and hospital governing bodies do not have authority to modify this requirement.<sup>6</sup> This statutory language is original to the Social Security Act (signed in 1965) and it no longer reflects the fact that practitioners other than physicians admit and treat patients in the hospital.

Although CMS has recognized that the requirement that Medicare patients be under the care of a physician does not apply outside the Medicare program, using their authority to establish their own bylaws hospitals may apply this requirement across all patient types, regardless of insurance type.<sup>7</sup> This results in barriers to practice for APRNs who would otherwise be able to admit and treat patients, including CNMs and CMs. **We urge the FTC to recommend to the Congress and CMS that this provision of the Social Security Act be updated to reflect the modern practice of medicine in hospitals by providers other than physicians.**

### **Hospital Medical Staff**

In a recent revision to its hospital conditions of participation regulations, CMS received comment that:

Medical staffs must be representative of all types of health professionals who have privileges, including Advanced Practice Registered Nurses (APRNs) and Certified Nurse Midwives/Certified Midwives (CNMs/ CMs).

Non-physician members of the medical staff must be accorded the same rights and protections as physician members, including full voting privileges, membership on committees, ability to appeal, and due process.<sup>8</sup>

In its response, CMS refused to accept these comments. Instead, the agency stated:

The current requirements and the revisions contained in this rule are written to allow a hospital's governing body the greatest flexibility in determining which categories of non-physician practitioners that **it chooses** to be eligible for appointment to the medical staff.

The rule is intended to encourage hospitals to be inclusive **when they determine** which categories of non-physician practitioners will be eligible for appointment to their medical staff [emphasis added].<sup>9</sup>

The Joint Commission accredits 82 percent of the nation's hospitals and its accreditation is accepted by Medicare as proof of a hospital meeting the Medicare Conditions of Participation. The Joint Commission has established accreditation standards for hospital medical staff

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<sup>5</sup> 42 CFR 481.12(c)(1).

<sup>6</sup> Social Security Act Section 1861(e)(4).

<sup>7</sup> See Section A-0066 of Appendix A of the State Operations Manual, available at: [http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf) Accessed March 28, 2014.

<sup>8</sup> 77 FR 29045.

<sup>9</sup> 77 FR 29047.

membership that are used in this process. These standards say that, “The governing body and the medical staff define medical staff membership criteria, which, **as deemed necessary by the governing body and the medical staff**, may include licensed independent practitioners and other practitioners” [emphasis added]. Furthermore, “The criteria used to determine which licensed independent practitioners are eligible to participate in the oversight process is developed by the organized medical staff.”<sup>10</sup>

Membership on and full voting rights within a hospital’s medical staff are critical to ensuring appropriate relationships among providers who admit and treat patients in a hospital. The medical staff develops bylaws which dictate which provider types are allowed to be part of the medical staff, the type and scope of care they may provide and what kind of supervision they may be subject to. Further, hospital bylaw may be structured to allow certain providers to admit patients and treat them, but not participate on the medical staff.

The key point for the FTC to understand is that although state laws and regulations may allow APRNs to have admitting and treating privileges at a hospital and may permit APRNs to be included on a hospital’s medical staff, hospitals may choose to be much more restrictive than state law or regulation when it comes to determining which provider types may admit patients or be on medical staff. Existing medical staff may use their privileged position to exclude other provider types from either practicing in the hospital or joining the medical staff. **ACNM members have reported to our offices that this anti-competitive practice does indeed take place.**

In 2011, ACNM conducted a survey of its members to inquire regarding their experience with obtaining hospital admitting privileges or membership on medical staff. The results are revealing. Among the nearly 1,900 respondents:

- 69.5% had hospital privileges, 30.5% did not.
- Among those with hospital privileges, 29.7% had full medical staff membership, 70.3% did not.
- Among those with hospital privileges, 20.7% had full voting rights on the medical staff, 79.3% did not.
- Among those with hospital privileges, 57.7% were able to participate on medical staff committees, 42.3% were not able to participate.
- Among those with hospital privileges, 33% had due process rights in application, appointment, and dismissal from the staff, 21.7% did not and 45.3% indicated that this question did not apply in their case.
- 14.8% of respondents to the survey indicated that they had been denied access to a credentialing application or been told that they could not apply for clinical privileges because the hospital would not consider sending or receiving an application from a midwife.
- 45.5% were told that in order to obtain hospital privileges they had to be employed by a physician practice or by the hospital.

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<sup>10</sup> “Hospital Accreditation Standards,” MS-1, The Joint Commission, 2012.

- 65.4% were told that in order to obtain hospital privileges or practice on the medical staff, they had to accept limitations such as supervision or co-signature requirements or restricted scope of practice that other clinicians on the medical staff did not have.
- 5.4% indicated that they had had their privileges revoked or suspended for reasons other than legal proceedings involving alleged malpractice, for example, some midwives have told us they lost privileges when a new chief of the medical staff was hired, thus loss of privileges had nothing to do with the midwives' abilities as clinicians.

In free text response, major themes that emerged from this survey include:

- Long delay in responding to applications for privileges or participation on medical staff – possible barrier erected by hospitals?
- Supervision requirements act as a barrier because physicians do not want to assume the perceived liability of supervising a midwife.
- Hospital policies affect patient care.
- Supervision makes care delivered by midwives invisible.

**The FTC should be aware that this facility level anti-competitive behavior is occurring and should encourage both CMS and state policymakers to establish requirements to prevent it.**

### **Individual Physicians**

In states where physician supervision or collaboration is required, in return for providing such supervision or collaboration, physicians may impose restrictions on CNM/CM practice that go beyond those established under state law and regulation and that prevent midwives from practicing to the extent of their training and certification.

This may occur because the physician is uncomfortable with midwives, may not fully understand their training and certification, or, most importantly, because he or she is concerned about vicarious liability for patients being served by the midwife while under his or her supervision or collaboration. Finally, physicians may simply refuse to provide supervision or collaboration when they perceive the midwives as a competitive threat and know that state laws prohibit the midwives from practicing without physician supervision or collaboration. Alternatively, they may charge exorbitant fees for providing such supervision or collaboration, which can have the same practical as an outright refusal. **Removal of state supervision and/or collaboration requirements would allow midwives to take responsibility for the care they provide and would remove the incentive that physicians have to restrict midwives' scope of practice based on liability concerns.**

### **Health Insurance Carriers and Malpractice Insurers**

ACNM has received reports of health insurers requiring midwives to be employed by network hospitals and/or to work under physician supervision in order to be included in the plan's provider network. We have also heard reports that insurance carriers require midwives to obtain liability insurance to specified levels in order to attend out of hospital births (e.g., birth center or home births). Contacts within the insurance trade association have confirmed that it is not

common practice for health insurance carriers to require their network providers to carry specified levels of malpractice insurance. This practice, specific to midwives providing out of hospital birth, is therefore somewhat unique and can pose a barrier to their ability to practice if premiums are too high.

Health insurers may also impose restrictions on which services midwives can provide, refusing to pay for them even if those services are included within the midwives' scope of practice as defined under state law and/or regulation.

ACNM has also heard from its members that some malpractice insurers may require midwives to comply with collaboration requirements developed by the insurer in order to obtain malpractice coverage. Our members have also reported that in situations where a midwife is required to maintain a supervisory or collaborative relationship with a physician, these physicians may have to pay higher malpractice premiums to their own insurer, or may be refused coverage by the malpractice insurer. **Thus, even though state laws and regulations or hospital bylaws may permit midwives to practice to the extent of their training, the imposition of supervision or collaboration requirements by liability insurers or health insurance companies can have a detrimental impact on their ability to actually do so.**

The FTC should also be aware that state malpractice laws may also play into this situation. For example, if a state limits non-economic damages under a medical malpractice suit, but applies such limits with respect to actions against physicians, not other provider types, the providers not so protected would potentially face significant hurdles in obtaining malpractice insurance, thus limiting their ability to practice.

### **“Incident-To” Billing and Reduced Payment Rates**

Under the Medicare program, auxiliary personnel within a medical practice may bill under the name and number of a physician when certain conditions are met. This practice is known as ‘incident to’ billing.<sup>11</sup> For many years, CNMs were paid under Medicare at 65 percent of physician payment amounts. Thus, there was an enormous financial incentive for midwives working in a mixed physician/midwife practice to bill under the physician's number because doing so would result in payment at 100 percent of the physician payment amount. In 2010 the Affordable Care Act increased CNM payments to 100 percent of physician amounts, thus removing the financial incentive for CNMs to bill their services to Medicare beneficiaries in an incident to fashion. However, many state Medicaid programs and commercial insurers continue to pay CNMs/CMs at a percentage of physician rates.

Physicians in such mixed practices, or hospitals that manage such practices, may feel it necessary to impose restrictions on CNM/CM practice, or require supervision or collaboration beyond what state law allows in return for allowing them to bill under the physician's number because of concerns over liability. Where payment differentials exist, they may economically lock in such an unequal relationship even when state laws and regulations do not require it to be in place, and even if the providers involved do not necessarily want it.

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<sup>11</sup> See Section 60.1, Chapter 15, Medicare Benefit Policy Manual, available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

**We recommend that the FTC encourage the Congress and state lawmakers to set a single pay rate for a given service and pay that rate to any provider who is appropriately educated, certified and licensed to provide such a service.** This will help alleviate the challenges described above. It would also have the salutary effect of making it possible to clearly identify who the rendering provider is, which will facilitate accurate attribution of care for purposes of measuring quality outcomes.

## **Conclusion**

We encourage the FTC to consider these other factors that impact freedom to practice for the APRN community and develop recommendations to the Congress, CMS and state policymakers to address them. We would be happy to meet with the FTC to further discuss any of these issues and ideas for their resolution.

We appreciate the opportunity to comment on this important topic. Should you have any questions related to our comments, please feel free to contact me at [jbushman@acnm.org](mailto:jbushman@acnm.org), or 240 485-1843.

Sincerely,

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American College of Nurse-Midwives