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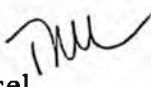
240 Main Street, Suite 500
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MEMORANDUM

December 12, 1991

SUBJECT: Midwifery Services - Medicaid Coverage
(Work Order No. 7-LS1633D)

TO: Representative Niilo Koponen
ATTN: Shari Paul

FROM: Terri Lauterbach 
Legislative Counsel

Enclosed is a new draft of your request relating to Medicaid coverage of lay midwifery services.

This draft takes a new approach to the issue. I have determined, based on further research, that it may not be necessary for the state to apply for coverage of these services through the waiver process. They could, instead, be covered as optional state services.

The optional coverage (rather than waiver coverage) of lay midwives might be possible because they are (or will be when the regulations are in place) registered by the state to perform services within a defined scope of practice. This is the way chiropractors' and clinical social workers' services are covered, for instance. They are licensed by the state to perform services within a specific scope of practice.

Coverage of licensed practitioners is allowed under a provision of federal law that allows a state to cover

medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (42 U.S.C. 1396d(a)(6))

This provision of federal law is one that I thought existed at the time I did your earlier drafts but I could not at that time find it. I apologize for not finding it sooner; I realize that some confusion could have been avoided.

legal services memo

Alaska State Legislature
Representative Niilo Koponen

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House District 21

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POSITION PAPER

HB 381 "An Act relating to the coverage of registered lay midwives' services under Medicaid.."

The intent of this legislation is to provide Medicaid reimbursement for registered lay midwives once regulations have been completed by the Department of Health and Social Services. These regulations would allow midwives to become registered in the State therefore being able to receive Medicaid funds. More important is the passage of HB 382 which would set up a licensing board for midwives which in turn would allow for Medicaid reimbursement. Coverage of licensed practitioners is allowed under a provision of federal law that allows a state to cover "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law." (42 U.S.C. 1396d(a)(6)).

New Mexico is one of the only states to provide Medicaid reimbursement for licensed midwives. The States Medicaid Advisory Committee approved this coverage bearing in mind that it would increase the availability of prenatal care. The Commission felt that it would also provide "access to care for women who may be willing to seek the services of a midwife and for women who live in areas of the state underserved by physicians and hospitals."

The State of Alaska meets a similar criteria. In many parts of the state there are shortages of obstetricians and gynecologists. Medicaid reimbursement would also offer an alternative for women who may be willing to seek midwifery services due to it being a more affordable type of licensed prenatal and postnatal care. The Medicaid program finances a limited amount of individuals, many of whom do not have any form of insurance coverage.

Sponsor Statement

NEW MEXICO

New Mexico has a longstanding history of acceptance of midwifery care. In 1921 when the Bureau of Public Health was organized, midwives were encouraged to provide health care to mothers and babies. Public health nurses, responsible for midwifery education, traveled throughout the state teaching classes in asepsis, physiology of labor and birth, infant resuscitation, control of hemorrhage, and other obstetric-related topics. After the direct-entry midwife completed these classes, she was issued a diploma and a bag with the necessary tools for her work.

The original 1922 regulations governing midwifery practice were revised periodically to reflect changes in the standards of obstetric care. In 1922 midwives were required to use silver nitrate eye drops for the newborn. In 1944 midwives were required to secure physician assistance if the baby was not born within 18 hours for a first birth, and within 12 hours for a second or subsequent birth. In 1945 nurse-midwife and registered "lay" midwife regulations were defined, maintained, and revised separately. In 1960 recommendations were made for pregnant women to receive prenatal care from physicians. Additional instructions were added regarding babies in abnormal positions, prolonged ruptured membranes, bleeding, babies weighing less than five and a half pounds, and requisite postpartum care. This 1960 version of the regulations remained unchanged for 20 years.

Until the 1950s the majority of babies in New Mexico were born at home with midwives in attendance. Much of the state is rural, relatively poor, and sparsely populated. In addition, homebirth was customary within traditional Hispanic and Native American cultures. In 1937, 800 midwives were practicing. In the mid-1960s the nurse-midwife responsible for midwifery training retired, and training and registration of new midwives was discontinued.

In the mid-1970s midwifery re-emerged in New Mexico. In 1978, midwives approached the state to update the regulations and to rein-

stitute the registration process. Since the New Mexico Public Health Law had maintained midwifery regulation as a duty of the state health agency, midwives had legal support for their request. The Maternal Health section of the Department of Health and Environment was also supportive of the new regulations as a means to avert the potential problems of unregulated practice.

After public hearings, the new Regulations Governing the Practice of Lay Midwifery were instituted in 1980. Regulations called for an advisory board comprised of one physician, one CNM, one consumer, and two licensed midwives. Educational avenues include apprenticeships, self-study, and formal education. State regulations also govern standards of practice, approved and unapproved practice, recordkeeping, the nature of physician/midwife consultation, and emergency measures.

The regulations have been revised three times since 1980. In 1981, the use of pitocin and episiotomy as emergency measures was approved. In 1987, emergency use of IVs was approved. The continuing education requirement was increased to 30 hours every two years. Provisional status was deleted and senior apprentice status added.

The advisory board added an official from the health department. In recognition of midwives' substantial licensing requirements and their scope of practice, their title was changed from "Registered Lay Midwife" to "Licensed Midwife."

In 1981, insurance companies in New Mexico were required to offer third-party reimbursement to all licensed midwives. In 1989, licensed midwives also began receiving Medicaid reimbursement (currently \$484.69 for total obstetric care, which is 77 percent of physician reimbursement).

New Mexico continues to license a significant number of midwives who practice in other states. In 1988, 120 midwives were registered with the state. Of this number, 35 practice in New Mexico.

New Mexico Midwives Association (NMMA) has yearly conferences

and publishes a quarterly newsletter. Association meetings are held every two months. Because most of the tasks of regulation and certification of midwifery are handled through the state with the advice of the New Mexico State Midwifery Advisory Board, the NMMA is able to work on other projects such as the recent successful Medicaid reimbursement efforts. The climate of acceptance and respect for New Mexico midwives has fostered a thriving midwifery community that has made homebirth a viable option for families in this state.

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The New Mexico Midwife
(NMMA newsletter)
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For a copy of state regulations:
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State of New Mexico
HUMAN SERVICES DEPARTMENT



HUMAN SERVICES REGISTER

I. DEPARTMENT

NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT

LICENSED MIDWIFE SERVICES

III. PROGRAM AFFECTED

(TITLE XIX) MEDICAID

IV. ACTION

FINAL REGULATIONS

V. BACKGROUND SUMMARY

The New Mexico Human Services Register Vol. 11, No. 69, November 17, 1988, proposed Medicaid reimbursement for licensed midwife services. Thirty-nine persons attended the public hearing on December 28, 1988. Of these, thirteen presented testimony. In addition, written comments were received prior to and following the public hearing.

Testimony at the public hearing was overwhelmingly in favor of Medicaid reimbursement to the licensed midwife. The only opposing testimony was from a representative of the New Mexico section of The American College of Obstetricians and Gynecologists (ACOG). They opposed Medicaid payment to licensed midwives, and supported in-hospital births. They also offered to work with the Human Services Department to support clinics throughout New Mexico for prenatal care with subsequent delivery in the hospital. In addition, they indicated support for extension of hospital privileges to the Certified Nurse Midwife.

The Department also requested its Medicaid Advisory Committee to review the issue and provide a recommendation. The Advisory Committee concluded that Medicaid reimbursement of licensed midwives would increase the availability of prenatal care. In particular, it would provide access to care for women who may be willing to seek the services of a midwife and for women who live in areas of the state underserved by physicians and hospitals. The Medicaid Advisory Committee also recommended that licensed midwives be required to obtain malpractice insurance and that the physician sponsoring the midwife must be a Medicaid provider. However, it is the opinion of the Department's General Council that we cannot require liability coverage for licensed

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midwives when such coverage is not a requirement for other Medicaid providers. In addition it is the Department's position that the relationship between the midwife and the sponsoring physician should be designated in the licensing regulation, if appropriate, rather than in the reimbursement guidelines.

Based on the oral and written testimony provided the Department will reimburse licensed midwives for services, including home delivery, under the Medicaid program. Reimbursement will be on the basis of a fee schedule. Actual rates will be proposed in a future Human Services Department Register.

VI. REGULATIONS

The regulations are contained in Section 310.19, Midwife Services.

VII. EFFECTIVE DATE

These regulations are effective September 1, 1989.

VIII. PUBLICATION

Publication of these regulations approved on August 15, 1989
by:



ALEX VALDEZ, SECRETARY
HUMAN SERVICES DEPARTMENT

State of New Mexico

MEDICAL ASSISTANCE PROGRAM MANUAL

Subject

MIDWIFE SERVICES

Section 310.19

Page 1

Date 09-01-89

310.19 - MIDWIFE SERVICES310.1901 - Legal Base 42 CFR 440.165310.1902 - Eligible Providers

A. Individuals currently licensed by the Board of Nursing as registered nurses and registered with the Public Health Division of the Health and Environment Department as a certified nurse midwife.

B. A licensed midwife, registered as a licensed midwife by the New Mexico Health and Environment Department.

C. Licensed birth centers when the service is performed by an individual meeting the criteria under A. or B. above.

D. Physicians, physician groups, clinics, or professional groups associated with institutions will be subject to the policies of this section when the service is performed by a certified nurse-midwife or licensed midwife meeting the criteria or under A. or B., above.

A New Mexico Medical Assistance Program Provider Application must be properly completed and accepted by the Department.

310.1903 - Services310.190301 - Covered Services

A. Routine prenatal care, delivery, and postnatal care to women with essentially normal pregnancies, may be provided by certified nurse midwives or licensed midwives within the scope of their practice as defined by state law and regulations.

B. Individual completed trimesters and/or the delivery may be covered when the patient has not been under the care of one provider for the entire prenatal, delivery, and postnatal periods.

C. Laboratory and radiological services related to essentially normal pregnancies are covered. These services may be billed separately, except for routine chemical urinalysis.

310.190302 - Non-Covered Services

Accommodation charges are not reimbursable for midwife services.

State of New Mexico

MEDICAL ASSISTANCE PROGRAM MANUAL



MIDWIFE SERVICES

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310.190303 - Service Limitations

Payment will not be made to the provider for oral medications or medications such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the recipient. Payment for drugs will be limited to injectable medication administered in conformance with Department injectable medications criteria. Certain injections are considered inappropriate or ineffective in most situations and payment for these injections is automatically denied by the fiscal agent. If the provider feels that payment should be made in a specific instance for a given injection, a request for re-review should be submitted to the NMMRA with adequate documentation to support the request. If the NMMRA approves the injection for payment, an adjustment request should be submitted to the fiscal agent with the NMMRA re-review decision attached.

310.1904 - Reimbursement

Billing for services rendered must be according to the provider's customary charge. The customary charge refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.

Reimbursement shall be based on one global fee to be paid for routine prenatal care, delivery and postnatal care. Routine laboratory charges and service related to false labor will be included as part of the global fee. The New Mexico Medical Assistance Program reimbursement for such charges will not exceed the Department's current payment schedule as described in the Section 304.9, Reimbursement.

Reimbursement will be made at the lesser of the following:

- A. The provider's billed charge, or
- B. The Department's payment schedule for the specific service or procedure.

In the event that services rendered include only prenatal care and not the delivery, include only one or two trimesters of care, or include only the delivery. Payment made for each completed trimester and/or the delivery will be made at an apportioned rate. Total payment made to multiple providers will not exceed the total single global fee.

In the event that services rendered include a combination of services performed by both a midwife and physician in the same group practice as defined under Eligible Providers (310.1902 above) reimbursement will be made according to the reimbursement policy of this section for each entire trimester during which the certified nurse midwife or licensed midwife rendered a service.

THE NEW MEXICO MEDICAID PROGRAM

One of the most important programs administered by the Human Services Department is the Medicaid program. In many ways the problems with the Medicaid program mirror the problems which we are all facing in the state with regard to the availability of affordable and adequate health care. The program which has an authorized budget of \$291 million for fiscal year 78 is growing at a rate which will make it increasingly difficult to finance in future years. Although 72% of all program expenditures are federal funds and the remaining 28% are state funds, the state will be required to significantly expand its investment in the program to meet new federal mandates and to meet the medical assistance needs of the state's low income population.

As you are aware, the Medicaid program finances health care for persons eligible for Aid to Families with Dependent Children (AFDC); and persons who are blind, elderly and disabled and eligible for Supplemental Security Income (SSI) or require nursing home care. Recently Medicaid eligibility was expanded to include pregnant women and children in households with incomes, at or below the federal poverty standard.

The expansion of eligibility is only one of the factors which have caused annual increases of Medicaid expenditures of approximately 16%. The Medicaid program budget ten years ago was approximately \$61 million compared to the nearly \$300 million expected to be spent next year. Growth in the program may result in a \$1 billion expenditure level within the next decade. Other factors resulting in increased program expenditures are the following.

- Higher costs for medical care. The inflation rate for medical services is approximately double that of the Consumer Price Index;
- Changes in utilization patterns. In recent years, the 89,000 to 92,000 New Mexicans eligible for Medicaid at any given time have increased the use of their Medicaid cards.
- The large uninsured population. An estimated 375,000 New Mexicans have no health insurance coverage and an equal number have insurance which is inadequate to meet their needs. When persons are unable to finance medical services received, providers must increase their charges to those who pay including private insurers and the Medicaid program.
- The aging of the population. The Medicaid population like the population at large is becoming an increasingly older population. The fastest growing segment of the population is that 75 years of age and older. The older one becomes, the more one consumes in medical services including hospital, physician, pharmacy and nursing home services. A good example of this reality is a comparison of consumption patterns among the Medicaid recipient population. Although AFDC recipients comprise approximately 70% of the eligible population, these generally young and healthy recipients and their children utilize 30% of program resources. The elderly, blind, and disabled making up 30% of the recipient population use about 70% of Medicaid expenditures.

Recently, Congress passed a number of measures which will have the impact of greatly increasing Medicaid expenditures. The following is a summary of these items.

The Family Support Act of 1988 - This law requires the Department to establish an AFDC program for unemployed parents. Currently, only families with an absent parent or a disabled parent are eligible for AFDC benefits and hence Medicaid benefits. Under the new law, effective October 1, 1990, intact families meeting AFDC eligibility standards will be eligible. This is expected to increase the number of families covered under Medicaid by between 2,500 and 4,000. It is estimated that this will increase annual Medicaid expenditures between \$5.9 million and \$9.5 million (as well as increase AFDC payments between \$9.9 million and \$15.8 million). The law also requires extension of Medicaid coverage for AFDC cases closed due to employment. Under current policies Medicaid coverage is provided to AFDC persons who are employed for four months following case closure. The Family Support Act will require twelve months of coverage following case closure.

The Nursing Home Reform Act - This law which became effective in 1988 and has major provisions which will become effective in 1989 and 1990, seeks to establish minimum standards for nursing home care primarily through mandated staffing and training requirements. The law also requires that costs for meeting these standards be paid in part by the Medicaid program. Medicaid program expenditures for the implementation of this Act are expected to increase significantly because of this

legislation. Costs associated with implementation of this Act could be as much as \$19 million annually.

The Medicare Catastrophic Coverage Act - This law requires the Medicaid program to pay premiums and deductibles for Medicare eligible individuals with income below the federal poverty level including deductibles for pharmacy purchases up to \$600 beginning in 1991. Currently, Medicare does not cover prescription drugs. For provisions of the law which became effective January, 1989, the Department estimates additional expenditures of ~~\$7.9~~^{\$5.0} million during the 78th Fiscal Year. Because of this legislation, Medicaid will pay the Medicare premiums, deductibles and coinsurance (20% of services financed through Medicare), for an increasing number of Medicare eligibles.

In addition to these items, there are a number of bills in congress designed to expand Medicaid eligibility for pregnant women, children, and technologically dependent children. All three bills appear highly likely to pass according to federal funding sources. One bill would mandate Medicaid coverage for prenatal services to pregnant women with incomes at or below 185% of the federal poverty level. If this bill passes, Medicaid will be paying for nearly half of all births in New Mexico. It is likely that congress will mandate some expansion of Medicaid coverage for prenatal services beginning this fall. Specifically, New Mexico may be required to provide Medicaid prenatal services to women with incomes at or below 125% of poverty in FY 79. This would cost an additional \$10 million to expand coverage to women with incomes at or below 185% of poverty would require an additional \$26 million.

Because of the federal mandates and the aging of the population, the future demands placed on the program will be prohibitive. A study recently released by the Brookings Institute estimates a 227% increase in Medicaid expenditures nationally for nursing home services within the next 30 years. Currently in New Mexico, we are spending nearly \$100 million for these services. The question isn't "if" expenditures will increase, but is "when" they will increase. Because of these ominous trends, everything must be done to make the Medicaid program as efficient as possible. The Department, in implementing the new federal initiatives, will do all possible to contain costs, and ensure that program resources are used in the most effective way possible.

The Medicaid program may expend as much as \$300 million during the coming fiscal year. We cannot afford to make this level of expenditure without carefully examining what is being paid to providers. It is essential that we do all possible to leverage the program's enormous purchasing power to get the most economical products and services for recipients.