SB

91

POSITION PAPER

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

Position Paper

The Department of Health and Social Services supports SSSB 91 which would provide payment under Alaska's Medicaid program for direct entry midwife services.

Passage of SSSB 91 would provide another alternative for expectant mothers who depend upon the medical assistance program for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services.

Licensure of direct entry midwives was established following passage of HB 382 by the 17th Legislature. In the short time since, 10 direct midwives have been licensed; that number may be expected to reach up to 25 over the next year.

Draft regulations of the Division of Occupational Licensing indicate the direct entry midwife services must include appropriate prenatal care, the delivery, and post-partum care over the 6 weeks following the birth. The draft regulations are very specific about the type of care to be delivered and the times of delivery. Births delivered under a midwife's care typically take place within the home, at the midwife's office, or at a birthing center. AS 8.65.140 specifies a protocol for direct entry midwives to follow for determining when a "difficult" birth should be referred to a physician's care.

The literature on this topic and our consultation with other states indicates that where licensure of midwives has been instituted it was done to improve pregnancy outcomes through increasing the skill level of persons practicing midwifery, improving the awareness of expectant mothers of the impact of nutrition and similar activities, improving the accessibility to services, and by providing a professional alternative that is acceptable to those who choose to not pursue services from a more institutional source.

Data on the impact of licensed midwife services is very limited. Information from the Bureau of Vital Statistics indicates that of all births, 42% are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwive's Association indicate a much higher percentage of medicaid eligibility of 70% to 80%. (The accompanying fiscal notes assumes 50%)

A comparison of vital statistics to payment information also indicates that a large number of the births involving medicaid payment are of low birth weight. Under the draft licensure requirements for direct entry midwives some low birth weight

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pregnancies would be referred to a physician while others may be delivered by the mid-wife, having benefitted from the frequent lab test, nutrition counselling and referral for medical examination that are required.

Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services. The accompanying fiscal note estimates a net cost savings of $73,800 during FY94 and greater in following years. While this is a estimate based on no experience, the department certainly does not anticipate a requirement for additional funding as a result of SSSB 91.

The placement of direct entry midwife services as (1) in AS 47.07.035 is the appropriate placement. Of the optional services available under Medicaid, direct entry midwives services should have the lowest priority for payment because other alternative services are available.

Recommended by: Kimberly B. Busch

Kimberly B. Busch
Director
Div. of Medical Assistance

Date: 3-18-93

Approved by: Jay Livey for

Theodore A. Mala, MD, MPH
Commissioner

Date: 3-19-93

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Lauterbach
3/1/93

AMENDMENT

OFFERED IN THE SENATE BY SENATOR LEMAN

TO: SSSB 91

Page 1, line 1, after "Act":

Insert "prohibiting unfair discrimination against direct-entry midwives who perform services within the scope of their certification;"

Page 1, after line 4:

Insert a new bill section to read:

"* **Section 1.** AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, [OR] licensed clinical social worker, **or certified direct-entry midwife**."

Page 1, line 5:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly.

HOME DELIVERY.

MIDWIFERY WORKS. SO SHOULD MIDWIVES.

When Janet Podell became pregnant in 1989, she determined to have "the real thing"—the fully natural, satisfying birth experience that had eluded her when her first two children were born. Although midwives had assisted her in the two unmedicated births, the impersonality, tension, conflict, and pointless restrictions she experienced in the hospitals had left her feeling frustrated and violated. Both times, for example, she was separated from the baby and from her husband after the birth. After moving to western Massachusetts, Podell found a pair of midwives to attend her birth at home. What resulted was a qualitatively different experience: She felt as if she had really given birth under her own power, in an atmosphere of loving support.

BY ARCHIE BRODSKY

As Podell later recalled in *The Midwife Advocate*, the newsletter of Massachusetts Friends of Midwives: "I came away from my hospital births with a sense of helplessness. I came away from my home birth feeling that I had learned deep and amazing lessons about my own strength and resilience, about trusting my body and my instincts....What would happen in this fearful society of ours if all the mothers who gave birth had such an experience?"

Podell is one of many American women who have chosen to give birth outside of a hospital during the last 10 to 15 years. Disillusioned with the routine intrusiveness of conventional hospital obstetrics, they have voted with their feet by giving birth at home with the help of family, friends, and supportive attendants. Some of these women, inspired by the rediscovery of birth as a natural and social event, have become midwives themselves, learning their trade by working with more experienced midwives or with sympathetic physicians.

This social movement, until recently marginalized by organized medicine as a softheaded countercultural rebellion, is now finding common ground with mainstream economic and public-health concerns: the rapid escalation of health-care costs; the loss of obstetricians resulting from the epidemic of malpractice suits; and the high rate of infant mortality among the inner-city poor. Midwifery works, people want it, and it provides an answer to some urgent policy questions. But although midwifery has made progress in recent years, a variety of laws and regulations still prevent midwives from offering their services to everyone who could benefit from them.

The advantages of midwifery depend on a more thoroughgoing change than just plugging in one type of practitioner in place of another. If the law confines midwives to the role of obstetrical handmaidens working exclusively in hospitals under the direction of physicians, it will prevent them from making their full contribution. For the word *midwifery* really stands for a fundamentally different model of maternity care: different people doing different things, often in a different place.

Midwives reject the view that giving birth is a medical procedure like having a gall bladder removed. Instead, they understand it as a natural process that ordinarily does not require drugs, surgery, or high-tech equipment. Obstetricians, whose skills and techniques are best reserved for complicated births, are in most cases not well prepared to attend normal births. They know how to intervene but not how to support without intervening.

KERI ROSEBRAUGH

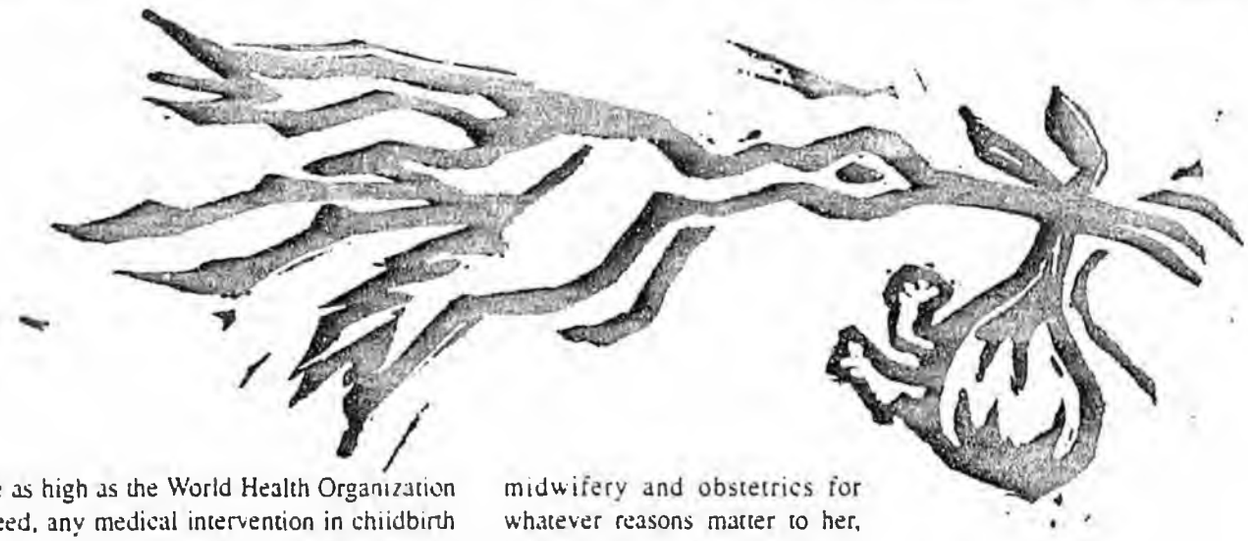
The high-tech, interventionist approach of obstetricians is illustrated by the widespread use of electronic fetal monitoring. EFM—which records fetal heart tones and the pressure of uterine contractions, either through electrodes passed through the birth canal and attached to the baby's scalp or through a transducer placed on the mother's abdomen—may have a legitimate rationale in high-risk births. But from the beginning it was marketed indiscriminately to physicians hungry for precise diagnostic information.

As a result, by the mid-1970s most U.S. hospitals had adopted EFM for routine use, without any controlled studies showing it to be more effective than traditional, noninvasive methods of listening to the baby's heart. Now studies published in the last two years in such prestigious publications as the British journal *The Lancet* and *The New England Journal of Medicine* have shown that, in the absence of specific indications for its use, EFM not only has no demonstrated benefit in reducing childhood disabilities but may even be dangerous.

EFM plays a major role in the futile cycle of defensive obstetrics brought on by malpractice hysteria. For legal protection the physician uses the monitor so he can show, if anything goes wrong, that he "did all he could." But with the monitor readings a matter of record, his actions will be further scrutinized to see if he once again "did all he could" in response to an abnormal reading.

Alarmist reactions to insignificant variations in monitor readings contribute to the current 24-percent cesarean-section rate in the United

BY CONFINING MIDWIVES TO THE ROLE OF OBSTETRICAL HANDMAIDENS, THE LAW PREVENTS THEM FROM MAKING THEIR FULL CONTRIBUTION TO THOSE WHO WANT IT.



States (a rate twice as high as the World Health Organization recommends). Indeed, any medical intervention in childbirth tends to necessitate further intervention by disrupting the normal physiology of labor and by immobilizing, enervating, disabling, and dispiriting the mother.

A midwife strives to avoid such intervention. Rather than "deliver" the baby, she brings out the birthing woman's own physical and emotional strength—resources left untapped or suppressed by standard obstetrical practices. This is more than touchy-feely rhetoric. It translates into concrete clinical expertise: an appreciation of the variations of normal labor, of the way some problems can correct themselves with time, of the influence of emotional support and a sense of well-being during labor, and of many nonchemical, noninvasive means of encouraging progress.

An obstetrician's highly specialized knowledge represents only a narrow segment of the whole range of knowledge relevant to childbirth. A midwife draws upon a traditional body of knowledge that guides her both in forming a supportive bond with a pregnant woman and in shaping a positive experience of—and attitude toward—birth. In addition to emphasizing prenatal education and preparation, she comes to know the woman, her environment, and the way she lives, and thus can better understand her reactions and assist her during labor.

Podell writes: "The midwives gave me all the room I needed, but they were never distant; they were always right there, offering energy, a sip of juice, a word of encouragement. Their presence comforted me and gave me confidence. One thing I didn't understand....Without internal exams, how could they tell how the labor was progressing?...They said my body would know what to do and when. And to my very great surprise, they were right."

Instead of pain medication, midwives use noninvasive methods, physical as well as psychological, to help women cope with pain. The midwifery model in its pure form does not allow the use of anesthetic or analgesic drugs in normal births, since these medications interfere with the natural process of labor. Home-birth attendants avoid the use of such drugs entirely, since the safety of a home birth depends on supporting the natural process and not creating added risks. In hospitals, on the other hand, nurse-midwives sometimes make pragmatic compromises, giving pain medication to women who want it in order to make other benefits of midwifery available to them.

It should always be a woman's right to choose between midwifery and obstetrics for whatever reasons matter to her, including her preferences regarding pain medication. At the same time, as the midwifery model comes to be more widely known and better understood, more women may approach the pain of childbearing in a positive way, as Podell did: "The labor was short, intense, and sweet. It wasn't any less painful than the others, but I tried to put all my concentration on welcoming the pain, on assenting to open up. Away from the interference of the hospital, comfortable in my own familiar house, I felt a lovely sense of freedom. I wasn't anybody's patient. I was myself, doing a task I had really been preparing for since childhood."

The beneficial effects of the laboring woman's sense of well-being, comfort, and control are enhanced in the home or (to a lesser degree) in the home-like setting of a midwife-run birth center. In the words of the prominent Dutch obstetrician G.J. Kloosterman: "The advantages of home confinements are that in her own home the expectant mother is not considered a patient, but a woman, fulfilling a natural and highly personal task. She is the real center around which everything (and everybody) revolves. The midwife or doctor and the maternity aide nurse are all her guests, there to assist her. This setting reinforces her self-respect and self-confidence."

This endorsement of home birth runs counter to the prejudices of most Americans, who have been led to believe that the

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best outcomes occur when childbirth is managed by obstetricians in hospitals where medical technology is readily available and where there is little hesitation about using it. This view equates safety with active technological intervention carried out by highly specialized personnel in an institutional setting.

Proponents of this position offer three main arguments. First, they cite the decline in maternal and infant mortality that coincided with the shift to medicalized, institutionalized childbirth in this century. But such a sweeping historical comparison is meaningless because it disregards many other changes that occurred at the same time: better nutrition, sanitation, and personal hygiene; fewer large families and closely spaced children; the development of antibiotics; and improvements in diagnosis, risk assessment, and instrumentation. Contemporaneous comparisons, such as one conducted by the New York Academy of Medicine from 1930 to 1932, have almost invariably shown that midwife-attended or home births have outcomes as good as or better than physician-attended or hospital births.

British statistician Marjorie Tew, in her 1990 book *Safer Childbirth? A Critical History of Maternity Care*, uses data from the special British birth surveys of 1958 and 1970 to make detailed comparisons—regional, historical, and individual—of the outcomes of home vs. hospital birth and of high-intervention vs. low-intervention birth in populations closely matched for risk factors. Tew concludes that increased hospitalization and obstetrical intervention cannot be credited with improving the safety of childbirth. To her, in fact, the weight of the evidence suggests that these changes have done more harm than good.

Second, opponents of midwifery argue that mortality statistics show babies are at greater risk if they are born outside a hospital. This fallacious comparison, first made in a 1978 press release by the American College of Obstetricians and Gynecologists, rests on raw statewide figures showing that the risk to a baby's life was two to five times greater in an out-of-hospital birth. But the "out-of-hospital" category included not only intentional home births, but also late miscarriages, premature and precipitous births, and unplanned home births. Such undifferentiated data say nothing about the safety of planned, properly attended home births.

Finally, when forced to confront the lack of statistical evidence in their favor, proponents of orthodox obstetrics say, "OK, so the differences in safety are too small to show up in the data. But even one unnecessary infant death is too many—especially if it's yours." This argument, while highly effective in inducing fear and guilt in parents, fails to take into account the countervailing risks of medicalized birth, such as infections resulting from hospital sepsis or from unnecessary surgical procedures and the many complications that can result from interfering with the progress of labor.

Opponents of midwifery also ignore a large body of evidence that low-intervention maternity care by midwives results in outcomes as good as or better than those of hospital births. Since 1925, for example, the Frontier Nursing Service in Kentucky has provided outstanding maternity care to a poor, geographically remote population. The service, whose midwives attended nearly all births at home (sometimes on horseback) until the late 1960s, has compiled an outcome record that compares favorably with that of mainstream America.

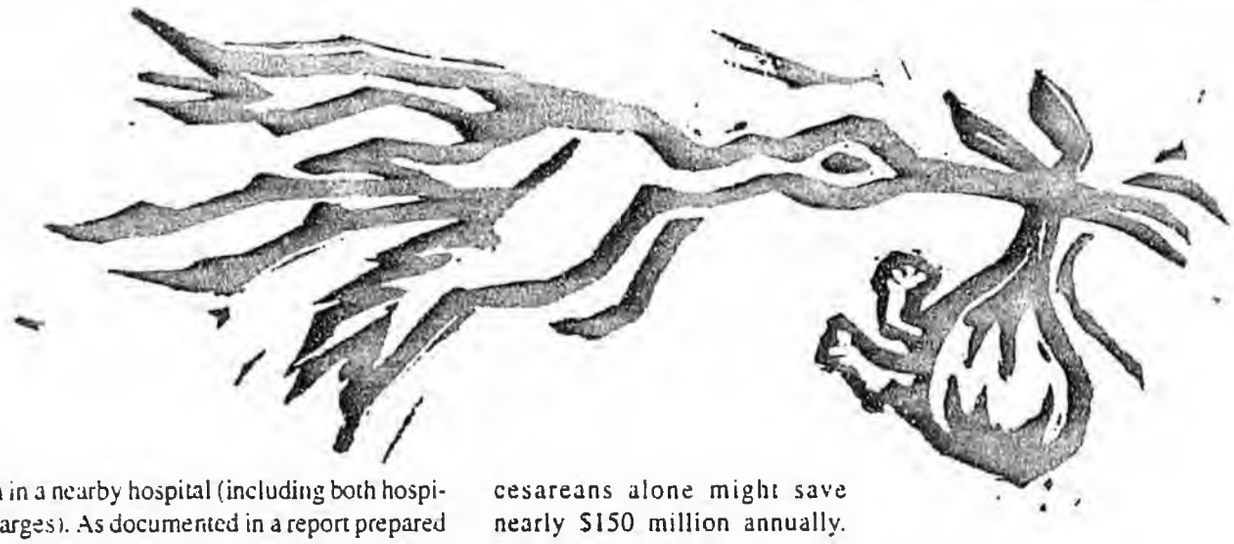
In a remarkable real-life experiment in Madera County, California, neonatal mortality dropped from 24 to 10 per 1,000 when nurse-midwives were introduced into a poor agricultural area in 1960. Pressure from the state medical association ended the program in 1963. Midwives were replaced by obstetricians, whereupon neonatal mortality rose to 32 per 1,000. The number of women receiving no prenatal care doubled.

Midwifery programs are having an important impact among the urban poor as well. With one-third of its largely black and Hispanic clients classified as high-risk, the North Central Bronx Hospital midwifery service has the lowest cesarean-section rate in New York City and lower-than-average rates of low birth weight and perinatal and neonatal mortality. In a well-controlled study involving low-income women in a Houston hospital, published in 1991 in *The Journal of the American Medical Association*, the continuous companionship of a *doula*—a woman trained to provide labor support—shortened the duration of labor, cut the cesarean-section rate in half, and reduced the need for other interventions along with the incidence of maternal fever and prolonged infant hospitalization. And the *doula* provides only part of a midwife's comprehensive skills and services.

Two years ago the National Birth Center Study reported on birth outcomes for nearly 12,000 women admitted to freestanding birth centers in the United States, three-fourths of them operated by midwives. In this largely low-risk population, the low overall perinatal-neonatal mortality rate of 1.3 per 1,000 was comparable to that of low-risk hospital births. Moreover, it was achieved with minimal intervention (most notably, a 4.4-percent cesarean-section rate), low morbidity, and high levels of satisfaction. Similar findings were obtained in a review of more than 3,000 out-of-hospital (mainly home) births attended by licensed direct-entry midwives in Arizona between 1978 and 1985.

Further evidence comes from Holland, where the national health-care system deliberately reversed a trend toward American-style hospital births a decade ago. In a study published recently in the British journal *Midwifery*, researchers who analyzed all Dutch births in 1986 found that, at all risk levels after 32 weeks' gestation, perinatal mortality was "much lower under the noninterventionist care of midwives than under the interventionist management of obstetricians." And this is in a country with an ethnically diverse population (including guest workers).

Studies also find that midwifery is much less expensive than conventional obstetrics. The cost-effectiveness of the midwifery model follows from its reliance on natural processes and settings rather than on expensive technology. In one of the first demonstrations of the cost-saving potential of midwifery, Blue Cross/Blue Shield estimated that its costs for a birth in the Maternity Center Association's Childbearing Center in Manhattan in 1976-77 averaged only 37.6 percent of the cost of an



uncomplicated birth in a nearby hospital (including both hospital and physician charges). As documented in a report prepared for the Federal Trade Commission, Blue Cross/Blue Shield's decision (against formidable opposition) to authorize reimbursement for the center was a major breakthrough in making the freestanding birth center a viable concept in the United States.

Since then, this initial indication of the savings to be achieved through broader application of the midwifery model has been borne out by other research, most notably a Health Insurance Association of America (HIAA) study published in 1989. These savings can be realized in a number of ways:

Lower fees. According to the HIAA study, the average physician's fee for a normal pregnancy and birth is $1,492, while a midwife's fee averages $994. A midwife's fee typically covers more time spent before, during, and after the birth and includes comprehensive services that otherwise would require a team of providers.

Lower site-related costs. According to the HIAA study, a normal birth involving a one-day stay in a birth center costs $2,111, compared with $3,233 for a one-day hospital stay. (These figures include practitioners' fees.) Since the average length of stay in a hospital is longer than in a birth center, the difference in practice is even greater. Thus, the average hospital cost for a normal vaginal delivery is $2,842 in addition to the physician's fee of $1,492, for a total of $4,334.

In a home birth there are no site-related expenses. In Australia, for example, an estimate published in the journal *Family Physician* indicated that insurers and families might save AS83 million a year if 30 percent of births took place at home. Of course, the cost of maintaining hospital backup for cases requiring transfer must be factored into the overall costs of out-of-hospital birth services. But such on-call auxiliary services require only a fraction of the institutional resources routinely used and paid for under the present system.

Reduced use of technology. Midwives rely much less on technical procedures that entail material costs, increased practitioners' fees, and (often) longer hospital stays. A birth by cesarean section costs an average of $7,186, compared to $4,334 for a vaginal birth in a hospital. Since midwife-attended births have a cesarean-section rate 50 percent to 70 percent lower than physician-attended births in comparable populations with equivalent outcomes, the savings to be realized from this aspect of the midwifery model are enormous. If all of New York state's hospitals operated in the manner of the North Central Bronx midwifery service, the reduction in cesareans alone might save nearly $150 million annually. Ending the indiscriminate use of other specialized procedures, such as electronic fetal monitoring, ultrasound, IVs, and episiotomy, would also save money.

Lower training costs. The Congressional Office of Technology Assessment calculated that the cost of training a certified nurse-midwife in 1985 averaged $16,800, compared with $86,100 to train a general physician, let alone an obstetrician. Since midwifery training is more appropriate for a large majority of births, there is great potential for savings here.

Lower liability costs. As of 1987, 71 percent of obstetrician-gynecologists had been named in one or more liability claims, compared with 10 percent of nurse-midwives. Direct-entry midwives (those not trained and regulated by the nursing profession) are even more rarely sued. Why these disparities? First, obstetricians deal with more complicated cases with a greater likelihood of a tragic outcome. Second, obstetricians have deeper pockets. (Like physicians, certified nurse-midwives—registered nurses with additional training in midwifery—have malpractice insurance; direct-entry midwives generally do not, except in states where they are licensed.)

Third, and perhaps most important, people who choose a midwife (especially a direct-entry midwife) commit themselves to sharing the risks and responsibili-

AS OF 1987, 71 PERCENT OF OBSTETRICIAN-GYNECOLOGISTS HAD BEEN NAMED IN ONE OR MORE LIABILITY CLAIMS, COMPARED WITH 10 PERCENT OF NURSE-MIDWIVES.

ties of birth. Rather than expect a guaranteed perfect outcome, they participate with an understanding of nature's uncertainties. The midwife actively encourages this informed participation. And because she establishes a relationship of trust, full and open communication, and emotional support, the midwife does not leave her clients feeling abandoned and resentful in the event of a tragic outcome.

Lower health-care costs after birth. The costs of childbirth pale beside those of taking care of premature and sick infants and children. According to the HIAA survey, it costs nearly $1,000 a day to keep a baby in a neonatal intensive care unit; a 30-day stay can cost $30,000. Hospitals that bear these often uncompensated costs should heed the documented success of midwifery programs, over a range of settings and income levels, in reducing the incidence of low birth weight, which is directly associated with prematurity. To the extent that midwives' emphasis on a healthy environment during pregnancy can reduce the short- and long-term effects of malnutrition, smoking, heavy drinking, and drug use on maternal and child health—in some cases preventing lifelong disability—the contribution of midwives to reducing health-care costs may be incalculable.

In the case of midwifery, the evidence is overwhelming that better care can cost less. Indeed, the American system of obstetrics is so inappropriate and inefficient that only as a protected monopoly could it have gained and held its dominant position. It could not have survived, and cannot now survive, in a free market. But the monopoly is well entrenched by law.

Direct-entry midwives are legal in some states, illegal in others. In a plurality of states their legal status is uncertain. But if a state's medical-practice act includes childbirth among the conditions exclusively reserved for medicine, then direct-entry midwifery is presumed to be illegal. And in the Catch-22 of midwifery regulation, some states (such as Rhode Island) won't let midwives practice without a license but won't license them either.

This patchwork of laws resulted in part from deliberate efforts by organized medicine to create a protected monopoly and in part from an unconscious societal assumption that midwifery had disappeared. During the past few decades, midwifery has been allowed back in a limited role in the form of certified nurse-midwives. CNMs practice legally in every state, but their scope of practice—indeed, their ability to practice at all—is often severely restricted when physicians withhold the requisite institutional or logistical support.

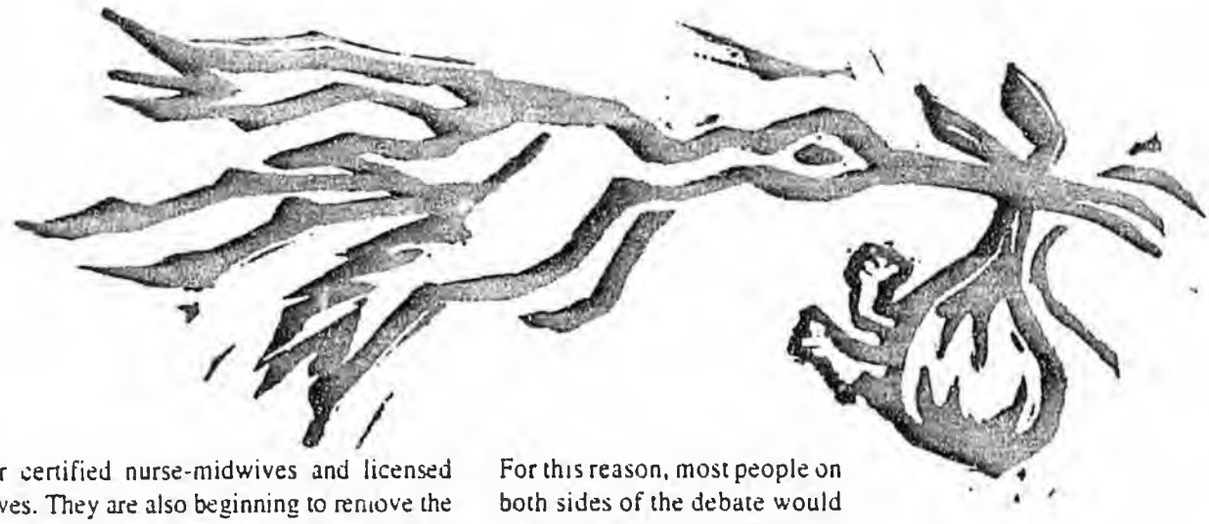
Direct-entry midwives are often prosecuted for practicing either medicine or midwifery without a license. Sometimes these prosecutions help clarify the legal status of midwives. In 1990, after charges were brought against a Pennsylvania midwife who attended Amish clients, a judge ruled that state law did not prohibit the unlicensed practice of "lay" midwifery. But in Illinois in 1991 a court decision calling for clarification of the state's medical-practice act led to legislation that included childbirth within the scope of the act. Midwives have also suffered setbacks in Southern states such as Alabama, where public-health departments have forcibly retired the experienced "granny" midwives who often were the only providers of maternity care for the rural or urban poor. In Arkansas, public outcry over such action persuaded the legislature to legalize direct-entry midwifery. In Georgia, however, recently issued regulations have made the practice of direct-entry midwifery a felony.

A decade ago in REASON, Sarah Foster documented the various tactics that the medical establishment uses to intimidate and exclude midwives ("Up Against the Birth Monopoly," September 1982). In one of the more prominent cases to have occurred since then, a local obstetrician pilloried nurse-midwife Debby Sweeney in front of her students at the Medical College of Georgia School of Nursing in 1986, falsely charging that she was practicing medicine illegally and endangering her patients. The obstetrician's group practice prevented Sweeney from continuing to teach in one of the hospitals affiliated with the college, complaining that they "could not allow their patients to be exposed to students who are being instructed by one who advocates the home delivery concept." Sweeney had run afoul of the medical establishment by advertising her home-birth practice.

Such anticompetitive tactics thus far have limited the availability of qualified attendants for out-of-hospital births and deprived women and families of information about birth options. Unless a woman happens to know someone who knows the local midwife, she may see and hear only horror stories about home birth.

Reform is coming, however. Many prestigious institutions are calling for more widespread adoption of midwifery or a low-intervention approach to childbirth. These include the World Health Organization, the European Economic Community, the Institute of Medicine, the Office of Technology Assessment, the General Accounting Office, the American Public Health Association, and the National Commission to Prevent Infant Mortality. The strongest advocacy has come from the women's health movement. A detailed position paper issued jointly in 1990 by the Women's Institute for Childbearing Policy, the National Women's Health Network, the National Black Women's Health Project, and the Boston Women's Health Book Collective argues for a midwifery-based maternity care system that favors out-of-hospital birth settings.

The great stone face of the birth monopoly is visibly cracking. Hospitals hit hard by the loss of obstetricians are advertising for midwives. HMOs, after considerable resistance, are incorporating midwifery services. Boston will be joining New York, San Diego, and other localities in setting up a public out-of-hospital birth center for low-income women. At the federal level, direct reimbursement for midwives has been mandated for the armed services, Civilian Health and Medical Programs of Uniformed Services (CHAMPUS), and Medicaid. One by one, state governments are authorizing limited prescrip-



tion privileges for certified nurse-midwives and licensed direct-entry midwives. They are also beginning to remove the statutory and regulatory barriers to direct third-party reimbursement for midwives.

In a major breakthrough, Ontario recently recognized midwifery as an independent, self-regulating profession authorized to practice in the home, birth center, or hospital. Ontario's action set a precedent for Canada, which had made no provision for midwifery in its national health-care system. In the United States, legislative efforts continue in New York, California, and other states to legalize midwifery as an independent profession.

Licensing clearly is preferable to illegality; however, in states where midwives currently are unregulated, midwives and their supporters are divided over whether it is better to be licensed or to continue on a laissez-faire basis. Midwives who oppose licensing consider midwifery a "spiritual art," in the words of Ohio midwife Kimberly French, that cannot be regulated by uniform standards as medicine is. "Would we be willing to give up certain aspects of our craft in exchange for certification, such as handling breech births, vaginal births after cesareans, and twins?" asks French in the periodical *Friends of Homebirth*. "What about the woman who is left with no other option but a cesarean if we, as midwives, were restricted...by law?"

Furthermore, opponents of licensing are reluctant to exclude midwives who might not meet the formal criteria established by the law. "I feel strongly," writes Maine midwife Jill Breen in *The Midwife Advocate*, "that there always will and should be a place for the apprentice-trained midwife, the community-called midwife, the non-medically-oriented midwife."

With few exceptions, midwives who support licensing do so not to protect their hard-won turf or to save the public from unqualified practitioners, but because they are weary of their denigrated status as "lay practitioners." They are interested not so much in excluding others as in including themselves in the professional health-care system. Longtime Oregon midwifery advocate Alan Solares, whose arguments against licensing were influential a decade ago, has now changed his position. He addresses the concerns of many midwives today who feel that "they cannot fairly compete in a health-care system based increasingly on third-party payment."

Implicit in Solares's argument is the assumption that, in today's highly professionalized society, the benefits of third-party reimbursement, public visibility and trust, and secure hospital backup cannot be obtained without some concession to "professional standards" and "consumer protection." For this reason, most people on both sides of the debate would welcome a system of voluntary certification such as New Hampshire's, which sets standards for certification but does not bar uncertified midwives from practicing as long as they do not claim to be certified. But this is not a likely prospect in many states.

For now, midwives and others who seek to open up the health-care market will continue to face rear-guard obstacles such as unequal access to reimbursement, regulatory mechanisms that place competing practitioners under the control of physicians, an information monopoly that can frustrate informed choice even when more overt restraints are halted, and a long accumulation of prejudice against non-technological alternatives to conventional health care. The hardest obstacle, however, may well be a certain faintheartedness in the American public, an ingrained reliance on "consumer protection" even at the expense of consumer choice.

IN THE CATCH-22 OF MIDWIFERY REGULATION, SOME STATES WON'T LET MIDWIVES PRACTICE WITHOUT A LICENSE BUT WON'T LICENSE THEM EITHER.

Archie Brodsky, a senior research associate at the Harvard Medical School's Program in Psychiatry and the Law, is a former president of Massachusetts Friends of Midwives and co-author of Medical Choices, Medical Chances *and* Home Birth: A Practitioner's Guide to Birth Outside the Hospital. *The author is indebted to Carol Sakala of the Women's Institute for Childbearing Policy for some of the information in this article.*

Dollars and Sense: Midwifery Care is Cost-Effective Care

Midwifery Fact Sheet

- The average professional fees of midwives are lower than those of physicians. Therefore, midwifery care can offer a cost-effective, quality-assured alternative to otherwise prohibitive and escalating maternity fees across the state.

- Midwives use fewer expensive technologies to provide safe care. Consequently, client charges are significantly lower. Comparisons of midwifery care and physician care have shown that midwives have equally good outcomes, while using fewer interventions. [1,2,3]

- Midwifery care is preventive care. Midwives spend time to provide education, information and social support to their clients. All of these factors have been cited as significant contributors to reducing adverse outcomes, especially prematurity and low birthweight. [7,8]

- Midwives are able to offer a choice of birth settings. Out-of-hospital births, either at home or in a licensed birth center, offer the low-risk, healthy woman a safe option at considerable savings. The cost of an out-of-hospital birth is 50% to 70% less than a hospital birth. [3] Recognizing these substantial savings in health dollars, a majority of private health insurance plans now encourage midwife-attended out-of-hospital birth by reimbursing 80- 100% of these charges. [12,13]

Midwives Association of Alaska
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Anchorage, Ak, 99501 (907) 274-1222

Published by Midwives Association of Alaska, the professional midwifery organization serving the Alaskan childbearing population.
1/93

Birth Outside the Hospital

Midwifery Fact Sheet

Trends in birth setting.

In 1940, 50% of births in this country took place at home, with a doctor or midwife in attendance. By 1960, birth had been moved almost exclusively into the hospital. During the 1970's, a notable increase in out-of hospital births signaled a new debate among consumers and health professionals on the appropriate place for labor and birth.

Today, approximately 1% of American families choose to give birth outside the hospital. These families choose home birth, or delivery in a free-standing birth center (not a hospital facility). The majority of out-of-hospital births, in Alaska, as well as throughout the United states, are attended by midwives.

Reasons for out-of-hospital birth

Why do families choose out-of -hospital birth? A number of consistent themes emerge from the literature including:

- increase of control over the childbirth experience;
- avoidance of unnecessary medical routines and interventions;
- continuous care by a known and supportive birth attendant;
- labor and delivery among loved ones and in familiar surroundings;
- avoidance of the high cost of hospitalization.

Safety: What the Studies Say

For most people concerned with childbirth, a central issue is safety. What do we know about the relative risks of childbirth in various settings? Studies reporting outcomes from well-organized out-of-hospital birth practices, both in the U.S. and abroad, show very low rates of adverse outcomes for mothers and infants. Holland, for example, where 35% of deliveries take place in the home, has one of the lowest perinatal mortality rates in the world. There is no evidence that birth in the hospital is safest for women at low medical risk. [3,4]

Some early reports on outcomes of out-of-hospital births were misleading because they compared hospital and non-hospital births without determining whether these births were planned and/or attended by a qualified person. In other words, late miscarriages, premature births, taxi cab deliveries, and other unexpected out-of-hospital births were included in the outcome data. [5,6]

Other studies which considered these factors found that the neonatal mortality rates of the planned out-of-hospital births with a qualified attendant averages 4/1000, below the national rate, while for the unplanned groups the rates averaged 97/1000. [7,8,9]

In controlled studies, those births planned to occur outside the hospital with midwives in attendance were associated with lower rates of obstetrical interventions than births planned to occur in the hospital with physicians and other care providers. In some studies, planned out-of-hospital births also had lower rates of complications than the hospital births. [10,11,12]

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Several authors have estimated that the probability of an emergent complication arising during an out-of-hospital labor, in a well-screened, healthy population of women, in which the loss of time in transit to a hospital could increase the risk of an adverse outcome, would be less than 1 in 1,000. [13,14]

Midwifery Practice Ensures Safety

Midwives attending out-of-hospital births ensure optimum safety for their clients by:

- Accepting into care only women who have no pre-existing medical conditions, who want to have natural labor and birth (without medical interventions or pain medication) and who are experiencing a normal pregnancy;
- Providing comprehensive prenatal care that includes on-going screening for complications, education, support and personal attention;
- Ensuring continuous, one-to-one care during labor, carefully monitoring the progress of labor, and maternal/fetal condition;
- Maintaining the skills and equipment needed for treating emergent and unexpected conditions, such as hemorrhage or neonatal resuscitation;
- Establishing consultation and referral relationships with obstetricians and pediatricians who can provide hospital treatment if indicated.

In summary, an out-of-hospital birth that is planned, with a well-trained attendant, is a safe, satisfying, and economical choice.

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What do international experts say about midwifery?

"...I came to see that midwifery wasn't just a way of substituting cheaper obstetrical care for the poor and deprived...I discovered that the countries with the lowest infant mortality rates in the world also had medical care systems in which the whole of normal obstetrical practice was carried on by midwives."

George A. Silver, M.D.
Professor Emeritus of Public Health, Yale University

Source: The Next Fifty Years of Nurse-Midwifery Education, Maternity Center Association, New York, 1983, page 66.

"...there is evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the U.S. one finds the highest obstetrical intervention rates as well as serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation."

Marsden G. Wagner, M.D.
Maternal and Child Health Officer for the European Region, World Health Organization

Source: "Infant Mortality in Europe: Implications for the United States; Statement to the National Commission to Prevent Infant Mortality". *Journal of Public Health Policy, Winter 1988: 473-484.*

"Midwifery provides a balance between the family and medical perspectives on birth. To negotiate and balance the different meanings and perspectives of birth within the health care system, it is essential for midwives to have a legitimate and powerful role within the system. Midwifery should be powerful enough to influence both the nature and delivery of services. This, I believe, would greatly enhance maternity care, which ultimately is the crux of the matter..the safe, loving and skilled care of women, their babies and their families at one of the most important points of life...birth."

Leslie Page
Director of Midwifery, Oxfordshire, England

Source: "The midwife's role in modern health care" in *The Midwife Challenge*, Sheila Kitzinger, ed. Pandora: London, 1988, page 259-260.

"The midwife must be able to advise the expectant mother, give her moral support, to make her enthusiastic for a natural childbirth, and above all, to supervise her in such a way that all minor and major abnormalities are recognized or at least suspected as early as possible. I am convinced that she is able to do this as well as a doctor, and very often better...Without the presence and acceptance of the midwife obstetrics becomes aggressive, technologic, and inhuman."

G.J. Kloosterman, M.D.
Former President, International Federation of Obstetricians and Gynecologists

Source: "The Midwife: Her Task and Responsibility in a Technologic World" in *The Five Standards for Safe Childbearing*, David Stewart, ed. NAPSAC International: Marble Hill, Missouri, 1981, pages 157-158.

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date:
Title: An Act providing for coverage of midwife services under Medicaid
Sponsor: Leman
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-facility
COMPONENT SERIAL NO. 00229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	65.0	75.8	88.3	102.9	119.9	139.8
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	65.0	75.8	88.3	102.9	119.9	139.8
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	32.5	37.9	44.2	51.4	59.9	69.9
1003 GF Match	32.5	37.9	44.1	51.5	60.0	69.9
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	65.0	75.8	88.3	102.9	119.9	139.8

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). Cost figures for hospitals, physicians, midwives, and claims processing are identified in the attachment.

Prepared by: Dave W. Williams, HPIII DW Kim Bruce Phone: 465-5826
Division: Medical Assistance Date: Mar. 18, 1993

Approved by Commissioner: Theodore A. Mala, MD, MPH Date: 3-19-93
Agency: Department of Health & Social Services

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Passage of SB 91 would provide another choice to expectant mothers who are dependent upon medical assistance for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services. Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services.

There are now 10 licensed direct entry midwives in Alaska; a number which might grow to 25 over the next year. The estimated number of births that will be delivered by these professionals during FY94 is 250 of which an estimated 125 would be eligible for reimbursement under the medical assistance program. Of the 125 eligible for Medicaid an estimated 50%, or about 60 births, would be shifted from hospital and physician care to direct entry midwife care.

FY94 Costs:
Medicaid Facility
A survey completed last year of the uncomplicated Medicaid births shows that a course of prenatal care by current licensed providers, with a hospital birth, averages about $5,000. Based on that survey and updated information the average cost for the hospital portion of services for a birth is calculated as $3,000. The cost of medicaid facility services would be reduced by $180,000 for the 60 births shifted away from hospitals under this bill.

Medicaid Non-facility
Non-facility costs would increase under the bill by the cost of the 125 birthing services provided by direct entry midwives, the cost of any birthing facilities involved, and be reduced by the alternative cost of physician fees for prenatal, delivery, and post-partum care. Direct entry midwife services are costed at an average of $1,480 per birth (80 percent of the $1,850 average general public rate). Physician costs are estimated at $2,000 per birth for pre-natal, delivery, and post-partum.

Midwife services	$1,480 X 125 = $185,000
Physician fees	$2,000 X 60 = (120,000)
Net Medicaid Non-facility	$ 65,000

Claims Processing
Based on current experience, the addition of a new provider category and services to the Medicaid Management Information System (MMIS, claims payment system) will require $30,000. Another $1,500 cost is required for development of a provider manual. These first year costs for changes to the system receive a 75% federal match and require 25% state general funds.

Additional contractual costs will be incurred for processing the claims submitted by nurse midwives. The cost is shown as $6.23 per claim. This fiscal note assumes that the midwives will submit 2 to 3 claims per month more than would be done by physicians and the submissions would cover 5 months. For the 125 births the cost for claims processing would be approximately $9,700.

NOTES:

The Alaska Midwive's Association reports a range of fees for service of $1,400 to $2,300 with a statewide, non-weighted average fee of $1,350.

Current statistics from the Bureau of Vital Statistics indicate that approximately 42% of births are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwive's Association indicate a much higher percentage of medicaid eligibility of 70% to 80%.

This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NET	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date:
Title: An Act providing for coverage of midwife services under Medicaid
Sponsor: Leman
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facility
COMPONENT SERIAL NO. 00230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	(90.0)	(104.9)	(122.2)	(142.5)	(166.0)	(193.5)
1003 GF Match	(90.0)	(104.9)	(122.3)	(142.5)	(166.1)	(193.6)
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). Cost figures for hospitals, physicians, midwives, and claims processing are identified in the attachment.

Prepared by: Dave W. Williams, HPIII DW
Division: Medical Assistance
Phone: 465-5826
Date: Mar. 18, 1993

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 3-19-93

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Passage of SB 91 would provide another choice to expectant mothers who are dependent upon medical assistance for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services. Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services.

There are now 10 licensed direct entry midwives in Alaska; a number which might grow to 25 over the next year. The estimated number of births that will be delivered by these professionals during FY94 is 250 of which an estimated 125 would be eligible for reimbursement under the medical assistance program. Of the 125 eligible for Medicaid an estimated 50%, or about 60 births, would be shifted from hospital and physician care to direct entry midwife care.

FY94 Costs:
Medicaid Facility
A survey completed last year of the uncomplicated Medicaid births shows that a course of prenatal care by current licensed providers, with a hospital birth, averages about $5,000. Based on that survey and updated information the average cost for the hospital portion of services for a birth is calculated as $3,000. The cost of medicaid facility services would be reduced by $180,000 for the 60 births shifted away from hospitals under this bill.

Medicaid Non-facility
Non-facility costs would increase under the bill by the cost of the 125 birthing services provided by direct entry midwives, the cost of any birthing facilities involved, and be reduced by the alternative cost of physician fees for prenatal, delivery, and post-partum care. Direct entry midwife services are costed at an average of $1,480 per birth (80 percent of the $1,850 average general public rate). Physician costs are estimated at $2,000 per birth for pre-natal, delivery, and post-partum.

Midwife services	$1,480 X 125 = $185,000
Physician fees	$2,000 X 60 = (120,000)
Net Medicaid Non-facility	$ 65,000

Claims Processing
Based on current experience, the addition of a new provider category and services to the Medicaid Management Information System (MMIS, claims payment system) will require $30,000. Another $1,500 cost is required for development of a provider manual. These first year costs for changes to the system receive a 75% federal match and require 25% state general funds.

Additional contractual costs will be incurred for processing the claims submitted by nurse midwives. The cost is shown as $6.23 per claim. This fiscal note assumes that the midwives will submit 2 to 3 claims per month more than would be done by physicians and the submissions would cover 5 months. For the 125 births the cost for claims processing would be approximately $9,700.

NOTES:

The Alaska Midwive's Association reports a range of fees for service of $1,400 to $2,300 with a statewide, non-weighted average fee of $1,850.

Current statistics from the Bureau of Vital Statistics indicate that approximately 42% of births are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwive's Association indicate a much higher percentage of medicaid eligibility of 70% to 80%.

This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NET	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date:
Title: An Act providing for coverage of midwife services under Medicaid
Sponsor: Leman
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing

COMPONENT SERIAL NO. 00243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	41.2	11.3	13.2	15.4	17.9	20.9
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	41.2	11.3	13.2	15.4	17.9	20.9
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	28.5	5.6	6.6	7.7	9.0	10.5
1003 GF Match	12.7	5.7	6.6	7.7	8.9	10.4
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	41.2	11.3	13.2	15.4	17.9	20.9

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). The FY94 cost includes one-time costs for $30,000 changes to the Medicaid Information System and $1,500 for development of a provider manual. Costs continuing over fiscal years are for an FY94 claims processing cost estimated to include 2 to 3 claims per month for 5 months for each birth. The cost of each claim is estimated at the current $6.23. Growth in utilization is estimated at 11% and inflation at 5% per year. Federal participation is shown at 75% for claims processing. Additional information and cost figures for hospitals, physicians, midwives, and claims processing are identified in the attached notes.

Prepared by: Dave W. Williams, HPIII DW Kim Burns Phone: 465-5826
Division: Medical Assistance Date: Mar. 18, 1993

Approved by Commissioner: Theodore A. Mala, MD, MPH Date: 3-19-93
Agency: Department of Health & Social Services

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This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NET	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

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