AMERICAN COLLEGE of NURSE-MIDWIVES
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June 6, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1345-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

File Code: CMS-1345-P

Dear Administrator Berwick:

On behalf of the American College of Nurse-Midwives (ACNM), I am pleased to submit these comments regarding Section 3022 of the Affordable Care Act's notice of the proposed rule-making for the Medicare Shared Savings Program/Accountable Care Organization (ACO), [Fed. Reg. Vol. 76, No. 67, pp.19528 – 19654].

ACNM is the professional association that represents certified nurse-midwives (CNMs®) and certified midwives (CMs®). While midwives support efforts to improve care coordination and efficiency within Medicare and other health care programs, ACNM is concerned about the potential for the proposed ACO rules to negatively effect senior women and women with disabilities covered under Medicare. Additionally, recognizing that these rules are likely to affect delivery of health services to women beyond Medicare, ACNM urges the Centers for Medicare and Medicaid Services to proceed extremely cautiously in adopting a final rule on ACOs.

CNMs are federally recognized as primary health care providers to women throughout the lifespan. CNMs and CMs perform physical exams, prescribe medications including contraceptive methods, order laboratory tests as needed, provide prenatal care, gynecologic care, labor and birth care, as well as health education and counseling to women of all ages.

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Care by CNMs and CMs incorporates all of the essential factors of primary care and case management that include evaluation, assessment, treatment and referral as required. The model of health care practiced by CNMs and CMs is focused on the ambulatory care of women and newborns and emphasizes health promotion, education and disease prevention and sees the woman as central to the process of providing such care.

Care by CNMs and CMs includes preconception counseling, care during pregnancy and childbirth, provision of gynecologic and contraceptive services and care of the peri- and post-menopausal woman. With health education as a major focus, the focus is to assist women in developing and maintaining healthy habits so as to prevent health problems. CNMs and CMs are often the initial contact for providing health care to women, and they provide such care on a continuous and comprehensive basis by establishing a plan of management with the woman for her ongoing health care. Such care by CNMs and CMs is inclusive and integrated with the woman's cultural, socioeconomic and psychological factors that may influence her health status.

Patient Freedom of Choice

ACNM supports the proposed rule's provision that would prohibit the ACO from developing any policies that would restrict a beneficiary's freedom to seek care from providers and suppliers outside the ACO. This allows beneficiaries to continue to receive care from CNM/CMs who may not be part of a formal ACO. This is essential to promoting continuity of care, which is crucial to the goal of coordinating care and diminishing fragmentation.

Moreover**,** ACNM believes Congress failed to properly consider women's health when it neglected to include certified nurse-midwives as "ACO professionals" for the purpose of Section 3022 of the ACA. While we applaud the statute's recognition of the role of nurse practitioners and clinical nurse specialists, the omission of certified nurse-midwives as primary care providers for women is irrational and diminishes women's choices under the ACO model. We understand CNMs were left out of this definition because CNMs primarily provide care to women and not to the entire population. However, we assert that this determination was short-sighted. ACNM has met with CMS officials to discuss this matter and to request that the Secretary consider using her authority to ensure CNMs would not be excluded from the ACO professional definition.

ACNM is highly concerned that this modification is not reflected in the proposed rule and again urges the Secretary to reconsider the ACO professional definition and its impact on delivery of primary care services to women specifically. Failure to do so will discourage CNMs from participating in ACOs and construct an unnecessary barrier for women attempting to access the primary care health professional of their choice. Faced with a shortage of primary care providers in the U.S., it is imperative that we ensure that ACO regulations enable all qualified providers to fully participate in these care models.

Assignment of Beneficiaries to ACOs
Under the proposed rule, ACOs also may inadvertently separate some patients from their current preferred primary care provider by requiring that Medicare beneficiaries be assigned to utilize primary care services provided by physicians.

In addition to our recommendation that CMS modify the definition of an ACO professional, ACNM strongly recommends that the Secretary remedy the assignment of beneficiaries to include all professionals who provide primary care services, not merely physicians. Again, failure to make this adjustment will raise yet another barrier for beneficiaries to receive care from the health professional of their choice.

It should be noted that the Joint Commission's recently adopted Standards and Elements of Performance (EPs) for the Primary Care Medical Home Option (supplemental to its Ambulatory Care Accreditation Program) uses provider-neutral language throughout, by referring to "primary care clinicians." The EPs reflect a truly patient-centered care environment, where the organization allows each patient to designate his or her primary care clinician. To qualify, a primary care clinician must possess "the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflicting recommendations for care."

Maternity Care is a Prime Candidate for Quality Improvement at Reduced Cost
The development of ACOs will have implications for the delivery of health services to all women, not just those who are beneficiaries of the Medicare program. It is critical that CMS keep this in mind in crafting these regulations.

While maternity care is not a high-volume service area under Medicare, it currently accounts for nearly one in four hospital discharges and represents the most common and costly hospital condition paid for by either Medicaid or private insurers. There are approximately 4.2 million births in the U.S. each year, of which currently just less than 8% are attended by CNMs and CMs. Medicaid pays for more than 40% of all maternal childbirth-related hospital stays, and these account for the two most common conditions billed to Medicaid in 2007, comprising 53% of Medicaid discharges.

Unlike other health conditions in which we struggle to find an effective treatment or cure, we know how to provide high-quality, cost-effective maternity care. The U.S. maternity care system is currently characterized by a proliferation of expensive and intensive interventions that do not enhance quality, access to care, or patient satisfaction. Applying high-risk medical approaches to low-risk populations actually increases the short- and long-term health risks and cost for all. Midwifery care as practiced by CNMs and CMs is based on the principle of non-intervention in the absence of complications. This approach has been shown to result in outstanding birth outcomes and cost-containment. Nationally recognized performance measures in perinatal care support the

need to reduce unnecessary medical interventions and are already beginning to demonstrate improved outcomes of care.

The Case for Quality Improvement

While most Americans believe that the outcomes of childbirth continue to improve in this country, in the past 20 years, maternal mortality has increased and the nation's preterm birth and low birthweight rates have increased. At the same time, the use of surgical and medical interventions without indication has increased, and costs have skyrocketed. There are significant variations in clinical practices, cost, and outcomes, with little or no relationship to clinical status.

For up-to-date statistics on maternity care in the U.S, , please see Childbirth Connection's "United States Maternity Care Facts and Figures, December 2010," and Amnesty International's "Deadly Delivery: The Maternal Health Care Crisis in the USA (Summary)." In particular, we highlight the following:

- **Maternal mortality** doubled from 1987 to 2006. U.S. women have a higher risk of dying of pregnancy-related complications than in 40 other countries. Reporting changes account for some of this increase, but do not provide a complete picture.

- The 2009 **cesarean rate** of 32.9% was the 13th consecutive year of increase and an all-time US record high. In 2008 the rate varied across states from 22%-38%. Cesarean section is now the most common operating room procedure in the US. In some hospitals, c-section rates as high as 75% have been reported.

  While a cesarean delivery clearly can be a lifesaving procedure, cesarean birth poses greater short-term and long-term risk to both the mother and infant and the outcome of future pregnancies compared to vaginal birth. The World Health Organization has recommended an optimal cesarean rate of 10-15%. In other words, according to that recommendation, for every woman who receives a necessary cesarean delivery in the U.S. today, two to three others receive one unnecessarily. Intermountain Healthcare, a leading health system with a 21% cesarean rate, recently estimated that health care costs would be reduced by $3.5 billion annually if the national rate came down to their level. Using data from the AHRQ-HCUP, Intermountain estimates that "every one percent decrease in the nation's C-section rate could save more than $300 million in maternal charges."

  - *CNMs and CMs participating in ACNM's 2009 benchmarking project reported c-section rates of between 11.5-14.1%.*

- The nation's rate of **preterm birth** rose from 10.6% in 1990 to 12.8% in 2006. It has declined modesty to 12.2% in 2009. Across states, the 2009 preterm birth

rate ranged from 9.3% in Vermont to 18.0% in Mississippi. Much of the increase in preterm birth has occurred among late preterms (34-36 weeks) and has been attributed to elective inductions of labor.

  - *CNMs and CMs participating in ACNM's 2009 benchmarking project reported preterm birth rates ranging from 2.9-5.0%, depending on the size of the midwifery practice.*

- The use of **labor induction** doubled from 9.5% in 1990 to 22.5% in 2006. A 16-hospital study of more than 31,000 births found that 21% of births were induced—25% for no apparent reason. Hospital induction rates varied fourfold and provider rates varied sevenfold. The proportion with no apparent medical rationale varied across hospitals (from 12-55%) and across providers in hospitals (3-76%).

  - *CNMs and CMs participating in ACNM's 2009 benchmarking project reported induction rates of 12.2-18.3%, depending on the size of the midwifery practice.*

- The rate of **low birthweight** has also risen over a quarter century, from 6.7% to 8.2% in 2008. State rates range from 5.7% to 12.3%. Non-Hispanic black infants experience much higher rates of both preterm birth and low birthweight compared to other ethnicities.

  - *CNMs and CMs participating in ACNM's 2009 benchmarking project an incidence of low birthweight of 1.9-3.5%, depending on the size of the midwifery practice.*

Conclusion

The Institute of Medicine (IOM) recently released a landmark study, "The Future of Nursing: Leading Change, Advancing Health," recommends that "nurses should be full partners, with physicians and other healthcare professionals, in redesigning healthcare in the United States." ACNM calls on CMS to fully recognize the integral role of midwives, nurses, and other licensed and qualified health care providers, in the ACO model. Indeed, the financial structure and care coordination of the ACO must recognize the contributions of *all qualified health professionals*. To ensure that the ACO model attains the transformational objectives it seeks for our healthcare system, it is critical that final regulations for the implementation of ACOs include language fully integrating midwives, RNs and APRNs as leaders and team members in each ACO.

Efficient, high quality care is the hallmark of services provided by CNMs/CMs, and CNMs and CMs seek to be part of the solution that ACOs are designed to address. ACNM urges the Secretary to make every effort to ensure that all qualified primary care providers,

including those who are expert in addressing the needs of women, are able to participate in a meaningful way as ACO professionals in the final rule.

Thank you for your consideration of these comments. To discuss these issues further, please contact Patrick Cooney at (202) 347-0034 or via email at patrick@federalgrp.com.

Sincerely,

Lorrie Kline Kaplan, CAE
Executive Director