THE BIG PUSH FOR MIDWIVES CAMPAIGN
Healthy Pregnancy and Childbirth
List of Federal Policy Initiatives

This list of PREGNANCY AND BIRTH POLICY INITIATIVES has been put together by the **Big Push for Midwives Campaign** and represents ideas by state and national consumer organizations for federal policy initiatives.

1. Medicaid, Medicare, and Universal Health Care coverage for midwifery and birth center services.

At present, only Certified Nurse-Midwives ("CNMs") are included as eligible providers in the Medicare and Medicaid programs. We strongly endorse and urge **inclusion of Certified Professional Midwives ("CPMs, " who are direct entry midwives who have passed a national certifying exam) and birth centers as eligible—in fact, mandated—providers**. Aspects of the implementation of this agenda item can be accomplished through re-interpretation of existing laws [42 USC §1905(a)(28)] and/or regulations, while other aspects will require either new regulations or actual legislation (amendment of 42 USC § 1905(a) to include birth centers and CPMs as categories of eligible providers, and of 42 USC §1902(a)(10)(A), which would mandate the inclusion of these types of providers every state Medicaid plan).

Ultimately, midwifery, home birth, and birth centers must be included in whatever healthcare reform plan is enacted, but these interim steps to include all midwives and birth centers in Medicaid/Medicare are greatly needed. Approximately one-half of all women giving birth are eligible for Medicaid and, for many midwives and birth centers, the percentage of their clients who are Medicaid recipients is much higher, some as high as 80 to 95%. Midwives and birth centers provide high-quality, cost-effective, culturally competent care, which minimizes the use (or need) for expensive interventions, and their cesarean surgery rates are low. Medicare and Medicaid funding should also extend to midwifery "residency" training in all clinical settings—hospitals, birth centers and homes, similar to the funding presently available for physician residency programs.

2. Medicare payment levels should be increased for CNMs from present levels (65% of physician-fee levels) to 100%, and CPMs and birth centers should be added as Medicare-eligible providers.

This would have to be done by legislation, not regulation, but is essential, not only to provide greater access to CNMs for women with disabilities, but also because Medicare is being considered by some as a model or the basis for universal health care in this country. Legislation to increase rates for CNMs is presently pending in Congress (S. 507).

3. A new administration should require inclusion of CNMs, CPMs, and birth centers as mandated providers in the Federal Employees Health Benefit Plan (FEHBP) and the Tricare program.

This policy initiative is also important in its own right and as an interim step toward health care reform. The changes to FEHBP could be accomplished by Executive Order or internal policy change, but we are not sure if Tricare requires legislation or a change in DOD policy. Like Medicare, the FEHBP is offered as a model/the basis for health care reform by presidential candidates and health reform organizations, which makes it essential to include midwives and birth centers in these plans as eligible providers.

4. Funding for education of midwives, both CPMs and CNMs, and inclusion of CPMs and birth centers within the National Health Service Corps.

The NHSC, a scholarship and student loan repayment option for health professionals who agree to work for a period of time in health professional shortage areas in return for forgiveness for all or part of student loans). The NHSC already includes CNMs, but should add CPMs as eligible for scholarships and loan repayment, and should also recognize freestanding birth centers located in health-professional shortage areas as acceptable sites for such services to be provided. This is a strong workforce development initiative, as well as health-care initiative, and should include the development of midwifery education programs in community colleges. This could also be done in partnership with Native American health systems and rural or urban community health centers, in order to increase the development of community-based, culturally competent providers of women's health care and birthing services.

Another benefit to be realized is that these midwifery positions are like "green" jobs in that they are community-based, skilled jobs that did not exist before, that grow our economy, and that cannot be exported to other countries. These are also careers in which mostly, but not exclusively, female students will be trained. Midwifery education in community colleges will make such education more affordable for low income and minority women. Although funding of these programs will require legislative appropriations, these policies should be adopted by the new administration as part of its legislative agenda. Some of these policies (e.g., inclusion of CPMs and birth centers in the NHSC program) could be accomplished by policy prioritizing and, if necessary, new regulations.

5. Birth centers and midwifery education programs should be made eligible for coverage under the Federal Tort Claims Act.

Federally-qualified health centers are presently covered under this Act, protecting them from the skyrocketing costs and frequent unavailability of malpractice insurance. This protection should be extended to birth centers and midwifery education programs, many of which have been forced to close their doors in recent years as a result of insurance cost increases or unavailability. The rationale to support this move is that many midwives and birth centers are already located in rural or inner city health-provider shortage areas. Also, many hospitals in these areas *(e.g.*, Philadelphia) have closed their Labor and Delivery Units. In the event of a national, regional or local emergency (terrorism, epidemics, weather-related), hospitals will not have room or facilities for healthy women in labor (and may not be appropriate places for healthy women and babies), so triage to out-of-hospital birthing sites and a trained and experienced cadre of out-of-hospital birth providers will be necessary (see attached WISP study).

This could be done through adopting new DHHS policies or passing new regulations. The Homeland Security Agency should also be required to work with and include providers of birthing services within any and all disaster planning—local, regional, national. One CNM who has been active in this field came to her realization of this need after having personally attended five or six women who gave birth at the New Orleans airport during Katrina. In a flu pandemic, hospitals filled with highly-contagious patients are the last place anyone should give birth. The U.S. needs a network of birth centers and health professionals trained in safe out-of-hospital birthing practice who are also integrated into the public health and EMT systems and networks, who can be mobilized in the event of disasters. This is a major issue with respect to the health and potential survival of pregnant and laboring women and babies, which should be of the highest priority for disaster planning, yet it is often neglected or treated as an afterthought by the HSA and local disaster planners.

6. A serious study—either within DHHS, by the GSA, or the Congressional research service and/or through Congressional hearings—is needed to investigate the frightening increase in cesarean surgery rates and hospital bans on vbac.

The cesarean surgery rate nationally is now at least 30%, but these rates are even higher—as much as 50 to 60%—in many localities around the country (*e.g.,* some hospitals in Miami). Since 84% of all women will be pregnant and carry a child to term at some point in their lives, this means that nearly one-third or more of these women—a huge number of women—are at risk for having unnecessary major and debilitating surgery, which carries with it a significantly higher risk of maternal and infant mortality and morbidity.

The March of Dimes has just released research showing that the increase in cesarean surgeries has had a direct causal relationship to the increase in pre-term births over the past 10 years.

Similar studies and/or investigations are needed to examine the rapidly-rising rates of induction of labor, a phenomenon which is linked to both increased cesarean surgery rates and increasing numbers of "late pre-term" babies (that is, babies born from induced labor or cesarean surgery prior to 40 weeks gestation). All such studies should include a range of health professionals and researchers, not only physicians. The financial costs for medical and hospital care related to cesarean surgery are double to triple the fees and costs of a normal vaginal birth, and this surgery also imposes serious risks of medical complications in the short-term and long-term—which also carry a high price tag in both financial and human terms.[1]

7. Amendment by DHHS of the EMTALA rules and the Medicare Conditions of Participation to provide more explicit protection for pregnant and laboring women with respect to hospital vbac bans, informed refusal for cesarean surgery, and better informed consent regarding childbirth interventions.

EMTALA is the Emergency Medical Treatment and Active Labor Act, which prohibits hospitals from denying care to women in active labor. In general, there is a need for amendment of these regulations and, longer term, for new legislation to require hospitals and healthcare professionals to provide genuine evidence-based informed consent for pregnant and laboring women, and to curb abuses in this area, such as incomplete or inaccurate informed consent or outright denial of the patient's right of informed refusal of unwanted interventions, including cesarean surgery. This issue is more fully developed in the policy initiatives suggested by Citizens for Midwifery and International Cesarean Awareness Network, which are attached.

8. DHHS should revise its policies and rules to foster greater transparency and accountability in the area of pregnancy and birthing services.

At the present time, consumers can find out more information about an automobile they want to buy than they can find out about their local hospitals. Transparency has readily increased in other areas of health care, but not maternity care. This would include publication of hospital cesarean surgery rates and rates for interventions such as epidurals, inductions, and breastfeeding at discharge, as well as vbac rates. This information is collected on birth certificates and aggregated by State Departments of Health but not generally made public. The publication of aggregate facility-level data does not conflict with HIPPA regulations since no personally identifying information is included in those statistics. Only two states (MA and NY) have state laws requiring any such transparency.

[1]But, you may ask, aren't women asking for these surgeries? Well, no, they're not. The data just doesn't support that conclusion. The best data we have (the Listening to Mothers II Survey conducted by the Childbirth Connection) shows that only a tiny fraction of women are choosing cesarean as a "lifestyle choice." The data demonstrate that clear that those women who do elect cesareans are being misled by their doctors to believe it is a safe practice – that is, they are not receiving accurate informed consent.

A national Maternity Information Act (similar to NY) requiring hospitals individually to make public their intervention rates or a DHHS policy initiative encouraging states to post *facility-level* maternity intervention rates DOHs collect would go far to remedying this lack of transparency in maternity care. Additionally, birth care providers, particularly hospitals, are not held accountable for birth outcomes (one reason cesarean surgeries have risen beyond 30% and more in some areas).

A good starting point would be for DHHS to promote implementation of the steps for the Mother Friendly Childbirth Initiative developed by the Coalition for Improving Maternity Services (see attachment). Increasing transparency in maternity care is consistent with current recommendations by the Institute of Medicine and current DHHS policies. Accountability and transparency are major consumer issues that could be implemented through federal policies, since states have not acted in this area.

9. Stronger antitrust enforcement by the Department of Justice Antitrust Division and the Federal Trade Commission against restraints of trade within the health care market.

Anticompetitive practices on the part of organized medicine or powerful medical groups, such as the Scope of Practice Partnership ("SOPP," which has been developed by the AMA together with several physician specialty groups and state medical societies), have been directed against midwives and other non-MD health care professionals. This would be a strong consumer-oriented policy change, but would not require any new laws or regulations or even an executive order but, rather, a policy re-focus within DOJ and the FTC.

10. Stronger support for breastfeeding within DHHS (and any other federal agencies—such as the EEOC—that might have an impact on discrimination against breastfeeding women).

This could be accomplished through new policy initiatives and emphasis, without requiring new rules or legislation, but there could well be a need for federal regulations prohibiting discrimination against breastfeeding women in public accommodations, workplaces, etc. (this isn't exactly a pregnancy or birthing issue, per se, but U.S. hospitals are notorious for various birthing-related practices (taking babies away from the woman immediately after birth, giving formula "samples" in new-Mom gift bags) that explicitly or subtly discourage breastfeeding and encourage formula-feeding of newborns.

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