INSTITUTE FOR MEDICAID INNOVATION

Improving Maternal Health Access, Coverage, and Outcomes in Medicaid

A Resource for State Medicaid Agencies and Medicaid Managed Care Organizations

Preface

Shortly after this project was completed, the first cases of COVID-19 in the United States were reported. As we go to press, the pandemic is bringing to the forefront the very issues this project was designed to address; never could we have anticipated such a need for attention to maternal health policy in Medicaid, particularly midwifery-led care at freestanding birth centers. COVID-19 is laying bare existing health inequities, the consequences of lack of health insurance coverage, as well as the limited capacity of existing birth centers, regulatory barriers and restrictive requirements for midwives. This moment presents an opportunity to address these inequities and barriers and fully incorporate the midwifery-led model of care into the Medicaid program.

Acknowledgments

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In addition, we thank the organizations and individuals who responded to the national request for information to identify exemplars in the maternal model of care for Medicaid and who participated in extensive phone and in-person interviews. They included Birth Detroit, Boston Medical Center, Buffalo Prenatal-Perinatal Network, Community of Hope, Dasher Inc., El Rio Birth Center, HealthConnect One, HealthNet Community Doula Program, Mamatoto Village, Mountain Area Health Education Center, Penn Center for Community Health Workers, Roots Community Birth Center, San Francisco Support Sisters, and Uzazi Village.

Their dedication to improving maternal and child health outcomes in the Medicaid population has resulted in the development of innovative programs and critical lessons learned that have the potential to assist other Medicaid stakeholders.

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Statement on Gender

The Institute for Medicaid Innovation (IMI) recognizes that there are individuals who become pregnant and give birth who might not identify as women. Individuals who identify as women might also depend on a diverse set of health care needs. The following report frequently uses the words "woman," "women," and "maternal." This includes transgender, gender non-conforming, and non-binary individuals who might need the suite of care services related to pregnancy, birth, and postpartum care. Also, "maternal care" in this document includes all individuals who require such services.

The document uses the pronouns "they/them/theirs" whenever possible in recognition of the gender-diverse population who may be included in maternal care. IMI has attempted to create a resource that is gender-neutral, limiting gendered language and only using such terms when necessary to conform with language specified in Medicaid requirements, statutes/policy language, and cited research and data. IMI hopes to create a resource that is inclusive of all individuals in the Medicaid community and their diverse health care needs.

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Executive Summary

Under-utilization of high-value, evidence-based care, such as the midwifery-led model of care, and over-utilization of unnecessary care, such as cesarean deliveries without indication, are gaining attention in the U.S. as the nation attempts to address growing concerns about maternal health.

These concerns include rising rates of maternal mortality and morbidity, increased costs of care, poor or even traumatic patient experiences, workforce shortages, and decreases in access to care in some regions of the country.

The alarming trends of racial/ethnic, geographic, and socioeconomic disparities are necessitating local, state, and national conversations. These concerns are compounded by increased awareness of the role that unmet social needs, implicit bias, and structural racism have on maternal and infant outcomes.

The factors contributing to poor maternal and infant outcomes in the U.S. are extensive and complex. There will not be only one intervention that will address all of these factors. As the nation considers the combination of potential interventions, it is important to fully consider opportunities to implement a high-value, evidence-based maternal model of care such as the midwifery-led model, both in hospitals and in freestanding birth centers.

Midwifery-led care might be a means to improve health equity and ultimately, maternal and infant outcomes for pregnant individuals enrolled in Medicaid.

> *Midwife-led continuity of care has been defined as care where* ***"the midwife is the lead professional in the planning, organization, and delivery of care given to a woman from initial booking to the postnatal period."***[1]

This report reflects the Institute for Medicaid Innovation's ambitious national project to answer critical questions that are needed to advance maternal health, specific to the midwifery-led model of care, for the Medicaid population:

1. **What is the current evidence on the midwifery-led maternity model of care and freestanding birth centers? Are there differences between Medicaid and commercially insured populations?**
2. **What are the state variations in access and coverage for the Medicaid population specific to midwifery services and freestanding birth centers? What are the policy barriers by state?**
3. **What are the innovative initiatives and best practices specific to the Medicaid population for midwifery-led models of care and freestanding birth centers?**
4. **What are the billing codes and quality measures for midwifery services and freestanding birth centers?**
5. **What emerging payment and contracting approaches align Medicaid and managed care resources?**
6. **What is the business case and return on investment (ROI) to support the financial models of the midwifery-led model of care?**

This resource is intended for Medicaid stakeholders, including state Medicaid agencies and Medicaid managed care organizations that are dedicated to improving maternal health outcomes for Medicaid recipients, their families, and communities. The report highlights the decades-long evidence base demonstrating that the midwifery-led model of care has comparable or improved outcomes when compared to care by physicians. For instance, a landmark systematic review showed lower rates of cesarean deliveries, preterm births, and interventions such as labor induction and regional anesthesia, and higher rates of breastfeeding.[2-3]

Moreover, there is substantial evidence that patient experience is improved in a midwifery-led model of care.[3-4] In response to the body of evidence and to increase awareness and utilization of midwives globally, the World Health Organization has declared 2020 as the year of the nurse and midwife.[5]

Within this report are sections that focus on critical information necessary for Medicaid stakeholders who are considering improving access and coverage for the midwifery-led model of care, including accreditation, licensure and certification, and state variation in Medicaid reimbursement. The report also provides information to support the development of a business case for the midwifery-led model of care in Medicaid, including a checklist of essential items to consider. In addition, the report discusses the realities and challenges of the midwifery-led model of care and highlights case studies with lessons learned. A glossary of terms used throughout the report can be found in Appendix A.

While the report offers information and resources to support efforts by Medicaid stakeholders, it also identifies the following areas that require immediate attention and ongoing work to support these efforts.

Clinical Opportunities

- Consider creating care team models that increase access to midwifery care for prenatal, intrapartum, and postpartum care.
- Explore ways to increase professional and public awareness of the benefits of the midwifery-led model of care and increase access for those enrolled in Medicaid.
- Consider designing a system of maternity care, based on acuity and unique need(s), that drives the right care, at the right place, at the right time, for the right person and allows maternity care providers to practice at the top of their training and license.
- Consider financially sustainable models that link the midwifery-led model to the Medicaid population, such as freestanding birth centers within federally qualitifed health centers (FQHCs).

Research Opportunities

- Explore ways to conduct studies that identify the return on investment for the midwifery-led model of care in Medicaid.
- Explore the relationships between state variation in Medicaid policies relative to midwifery practice integration, access, and birth outcomes.
- Continue the development of evidence for the midwifery-led model of care in Medicaid.
- Consider investigating individual views of midwifery services and freestanding birth centers, including perceptions, needs, and values derived from receiving such services.
- Explore the development of public reporting metrics describing appropriate utilization of the midwifery model, including the percentage of hospital-based, midwife-attended births.

Policy Opportunities

- Consider convening a statewide, multidisciplinary, maternity-led model of care commission.
- Explore removing barriers to support equitable reimbursement of midwifery services.
- Consider a statewide requirement for direct billing for all services provided by midwives.
- Explore developing supportive statewide policies that increase access to and support the sustainability of freestanding birth centers that are led by and serve people of color.

Coverage of Pregnancy Services in Medicaid

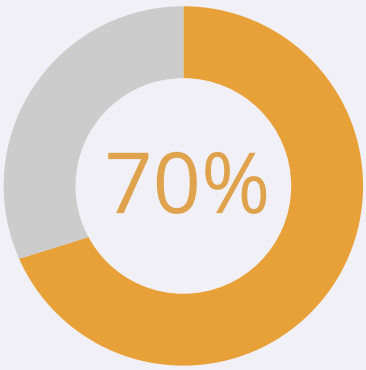
Medicaid financed approximately 43 percent of births in 2018 in the United States.[6] By federal law, all states must cover pregnant women with incomes up to 133 percent of the federal poverty level (FPL), with most states setting more generous eligibility criteria, called "pregnancy-only eligibility."[7-8] The 2019 FPL for a family of three was $21,330. The median income eligibility limit for pregnant women was 200 percent of the FPL in 2018, with four states setting levels above 300 percent and four states with levels at 138 percent.[9]

Medicaid-covered pregnancy services varies across the country. States that expanded Medicaid under the Affordable Care Act are required to pay for all preventive services, as recommended by the United States Preventive Services Task Force with a Grade of A or B.[10] These essential benefits include services such as well-women visits, interpersonal violence screening, and lactation support. Medicaid coverage of maternity services from nonphysician providers such as midwives and out-of-hospital births such as freestanding birth centers varies by state and is dependent on licensure and credentialing laws within each state.[8] The state variations are detailed in later sections of this report. However, the Public Health Services Act Section 2706, within the Affordable Care Act (ACA), states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." Essentially, the ACA mandated that all insurance plans must cover pregnancy services as an essential health benefit, and that health plans cannot discriminate against any licensed or certified provider, such as a midwife. The ACA also included provisions related to freestanding birth centers under Section 2301 requiring all states with licensed or otherwise state-approved birth centers to cover birth center services under Medicaid.

Pregnant individuals with Medicaid insurance coverage typically receive care in private solo or group provider practices, federally qualified health centers, and hospital outpatient department clinics under capitated managed care arrangements or fee-for-service, depending on the state. In the past two decades, the trend among state Medicaid agencies has been to contract with managed care organizations with the rationale of presumed cost savings, improved access, coordination of services and supports, and continuity of care. In 2016, 68 percent of all individuals enrolled in Medicaid were members of a Medicaid Managed Care Organization (MCO).[11] MCOs are responsible for assuring that enrollees have access to high-value, evidence-based services.

Medicaid plays a critical role in the health of low-income women:

Nearly 50 percent of all births are covered by Medicaid.



70 percent of women enrolled in Medicaid are of reproductive age, 15-49 years.

Timeline of Federal Medicaid Pregnancy Coverage

1965 — Medicaid was signed into law by President Johnson as Title XIX of the Social Security Act.

1984 — Children and pregnant women become mandatory Medicaid eligibility groups.

1985 — The Institute of Medicine issues *Preventing Low Birthweight*; calling for increased access to prenatal care and specifically more investment in Medicaid.

1981- 1989 — Multiple states expand eligibility for pregnant women; ultimately, all states are required to cover pregnant women in families with incomes of <133% FPL.

1989 — Children up to age six and pregnant women up to 133% of the FPL become eligible. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are expanded.

1996 — The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) replaces the Aid to Families with Dependent Children (AFDC) program with Temporary Assistance for Needy Families (TANF), ending formal linkage between cash assistance and Medicaid eligibility.

1997 — The Balanced Budget Act of 1997 allows Medicaid to be delivered through managed care organizations (MCOs). The State Children's Health Insurance Program (CHIP) was created, and states had the option to provide coverage for uninsured children in low-income families above the FPL.

2010 — The Patient Protection and Affordable Care Act (ACA) is passed, allowing states to expand Medicaid eligibility to all eligible individuals with incomes at or below 138 percent of the FPL. The ACA mandated that all insurers cover pregnancy services as an essential health benefit, and that plans cannot discriminate against any licensed or certified provider, such as a midwife. Section 2301 states that all states with licensed or otherwise state-approved birth centers must cover birth center services under Medicaid.

2012 — The U.S. Supreme Court rules in the *National Federation of Independent Business v. Sebelius* to make Medicaid expansion optional for states.

2012 — CMS embarked on two major activities to improve perinatal health outcomes:

- **Strong Start** A public-private partnership to pilot potential best practices for reducing the rate of early elective deliveries across all payers and a four-year grant opportunity piloting three models of enhanced prenatal care for reducing preterm births for women covered by Medicaid and/or CHIP.
- **Expert Panel for Improving Maternal and Infant Health Outcomes** to identify opportunities and strategies that could be adopted in the short term to provide better care while reducing the cost of care for mothers and infants covered by Medicaid and/or CHIP.

2013 — **The Strong Start for Mothers and Newborns** initiative, funded under Section 3021 of the ACA, supported enhanced services through three evidence-based models (i.e., group prenatal care, maternity care homes, and birth centers) and supported the delivery of these services.

2014 — ACA implementation begins including (1) incentives for health systems, insurance companies, and providers to develop and expand models of care that improve coordination and continuity of care; (2) the launch of funding for demonstration projects in Medicaid, and (3) coverage of midwifery care.

2014 — CMS launches the Maternal and Infant Health Initiative in collaboration with states to increase the number of postpartum visits and the use of effective methods of contraception.

2018 — Strong Start findings are published. Of the three evidenced-based models studied, women served by birth centers had the lowest risk of preterm birth and the lowest cesarean delivery rates, regardless of whether they delivered in the birth center or in the hospital. Costs were lowest through the birth and the year following the birth in this model, as well.

2020 — Thirty-six states and the District of Columbia (D.C.) expanded Medicaid since the passage of the ACA; fourteen states have not adopted the expansion.

Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid*.

Disparities among Maternal Health Outcomes

Disparities in maternal health outcomes are related to race, age, and socioeconomic status. The maternal mortality rate in the U.S. in 2018 was 17.4 deaths per 100,000 live births.[12] Within this measure, there are disparities related to race and ethnicity, particularly in non-Hispanic black women, who experienced 37.1 deaths per 100,000 live births, compared to 14.1 for non-Hispanic white women and 11.8 for Hispanic women.[13]

Similar to maternal health, there are disparities in outcomes related to infant health. The 2017 infant mortality rate (IMR) was 5.8 deaths per 1,000 live births.[13] The rate varies by race and ethnicity and is more than twice as high (11.1 deaths per 1,000 live births) for non-Hispanic blacks than for white individuals.[14]

Nearly 20%

of infant deaths are closely linked to preterm delivery and low birthweight with persistent disparities.[14]

In 2017, the overall preterm birth rate was 9.9 percent but was 1.6 times higher for non-Hispanic black women than for white women.[14-16] The incidence of low birthweight is 8.0 percent for all infants but 13.1 percent for non-Hispanic black infants.[14] These higher rates of preterm birth and low birthweight are the primary drivers of the differences between IMR in white and non-Hispanic black infants and important contributors to long-term health consequences throughout the lifespan.

> For every maternal death, more than 100 women – an estimated **52,000 women per year** – experience severe maternal morbidity.[17]

Maternal morbidities include conditions such as hemorrhage, infection, embolism, acute renal failure, stroke, and acute myocardial infarction.[17] Severe morbidity contributes to extended lengths of hospital stay, higher direct medical costs, and the need for long-term rehabilitation. It also inflicts immeasurable trauma on women and their families with potential long-term psychiatric morbidity.[18-19] Not surprisingly, there are racial and socioeconomic disparities in severe morbidity related to childbirth as well. Women with severe maternal morbidity were more likely to be poor, older, delivered by cesarean, black, and enrolled in Medicaid.[17,19-20]

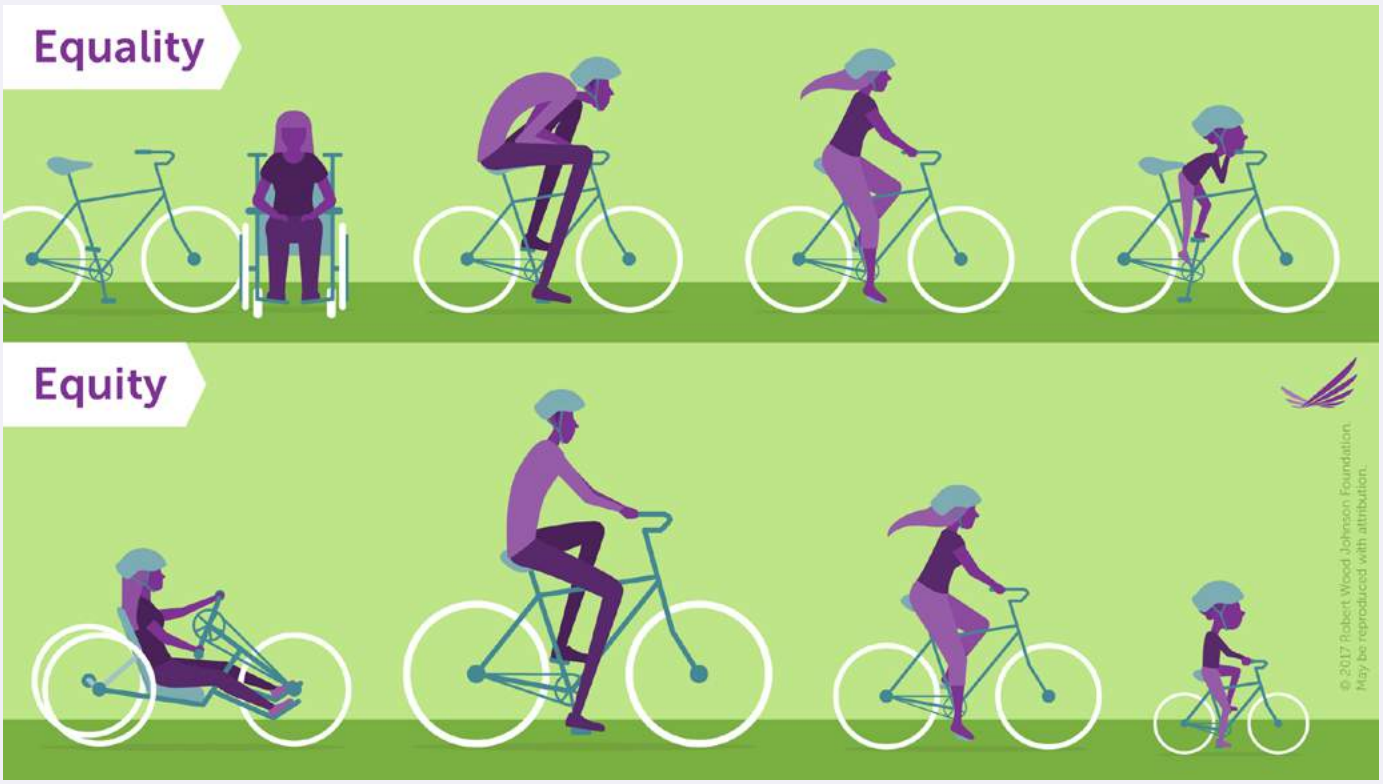
In addition to contributing to inequitable health outcomes, disparities increase health care costs. In one analysis of 14 states, an estimated $114-$214 million of savings to Medicaid would be realized if racial and ethnic disparities in maternal outcomes, such as rates of preterm birth, preeclampsia, and gestational diabetes, were reduced to the benchmark lowest race/ethnic group.[21] Over-utilization of unnecessary interventions is also expensive. Shifting to a high-value, evidence-based model of maternity care may also reduce unnecessary care and help address the underlying causes of health disparities.

Challenges in Accessing Pregnancy Services in Medicaid

Despite relatively comprehensive covered services, pregnant individuals enrolled in Medicaid face barriers accessing high-quality care early in pregnancy and in the postpartum period because of a variety of factors, including eligibility and coverage gaps, unmet social needs, and issues related to implicit bias and racism. These barriers create an inequitable health system that ultimately affects health outcomes. "Health equity" or "equity in health" implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Figure 1 depicts the differences between equality and equity.

Access to the same resources, such as a standard bicycle, might not be enough to ensure that everyone has access to the same outcomes, such as riding a bicycle. From a health perspective, it is necessary to provide resources that are accessible and appropriate for achieving equity in outcomes. Developing interventions and programming that are robust and equity-promoting for vulnerable populations, including individuals enrolled in Medicaid, is critical to improving the health of all individuals.

Figure 1. Equality versus Equity



Source: Robert Wood Johnson Foundation. 2017. Visualizing health equity: One size does not fit all infographic. Retrieved from: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download

Eligibility and Coverage Gaps

Churn, defined as a pattern of disruption in insurance coverage, has a direct impact on pregnant individuals enrolled in Medicaid.[22] Many individuals first become eligible for Medicaid during pregnancy and can lose coverage 60 days postpartum.

> In an analysis of nationally representative survey data from 2005-2013, **half of women** who were uninsured nine months before the month of delivery had acquired Medicaid or CHIP coverage by the month of delivery.[23]

However, 55 percent of women with Medicaid coverage at delivery experienced a coverage gap in the following six months.[23] Gaps in care limit access to postpartum services, including mental health screening and treatment and family planning. As a result, individuals experiencing churn may have an increased risk of postpartum complications and missed opportunities for care that could affect future pregnancies.

Medicaid coverage is important during the postpartum period. A recent Centers for Disease Control and Prevention (CDC) report of pregnancy-related maternal mortality reviews from 2008 to 2017 in 14 states found that more than two-thirds of the deaths were preventable.[24] Preventability was defined as at least some chance of a death being averted by one or more reasonable changes to the patient, community, provider, facility, and/or systems factors. Nearly half of the documented maternal deaths occurred after the usual time of release from the hospital. A quarter of the deaths occurred after six weeks postpartum, which is the typical time when many women enrolled in Medicaid lose coverage.[24]

Unmet Social Needs

Unmet social needs, including environmental, political, socioeconomic, and behavioral barriers, affect a pregnant individual's ability to access maternity care. A recent study examining experiences of pregnant black women found that three categories of factors were barriers to accessing care. [25] These included structural, psychosocial stress, and attitudes and perceptions.

The structural category included challenges with getting and maintaining Medicaid insurance, finding providers who accept Medicaid insurance, finding transportation to and from medical appointments, and being turned away if late for a medical appointment. The psychosocial category included exhaustion, relationship or legal difficulties, lack of social support, and experiences of discrimination. The attitudinal category included ambivalence about the pregnancy and the perception that the visits were of low quality and not worth the trouble to get to. The authors of the study concluded that prenatal care should be improved to include a more caring environment that offers flexibility, education, and social supports as well as community resources, engagement, and mitigation of barriers.[26]

Group prenatal care models might be an appropriate model to address some of these needs.[27] Several models are designed to improve patient education and opportunities for social support, including CenteringPregnancy (trademark) and Supportive Pregnancy Care.[28-30] At least two reports conclude that these models are particularly effective in reducing preterm births among low-income black women.[31-32]

Implicit Bias and Racism

Implicit bias and racism might also affect access to high-value, evidence-based care. Implicit bias is defined as unconscious and automatic attribution of particular qualities to a member of a racial, cultural, or social group that might have an effect on clinical care.[33] Implicit bias might not reflect one's belief system and therefore might not be consciously apparent. However, such biases might unconsciously influence treatment plans and recommendations. For example, a review of implicit bias in clinical decision making suggests that clinicians have unconscious preferences for certain types of patients, (e.g. white, thin) and implicit biases against racial and ethnic groups, particularly people of color

and obese individuals.[34] A systematic review of research articles examining implicit racial/ethnic bias scores using the Implicit Association Test (IAT) found that health care providers' implicit bias against black, Hispanic/Latino/Latina and dark-skinned individuals was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patients' health outcomes.[35]

Furthermore, there is growing recognition that chronic exposure to racism can have an independent negative effect on maternity outcomes.[36] The cumulative effect of life stressors—often referred to as allostatic load* — is a contributor. The Black Mamas Matter Alliance report, *Setting the Standard for Holistic Care of and for Black Women*, identifies and amplifies the maternity care knowledge, legacy, and work of black women. The report includes recommendations for increasing and improving holistic maternal care, including listening to black women, recognizing the historical experiences and expertise of black women and families, providing care through a reproductive justice framework, and disentangling care practices from the racist beliefs in modern medicine.[37]

Understanding the interplay between health equity, churn, unmet social needs, bias, and racism on outcomes, especially in the Medicaid population, is developing.[38] Medicaid plays a unique role in providing care services for a large population of the United States' low-income, reproductive-age population. While the majority of births in the U.S. are low- to medium-risk and appropriate for midwifery-led, low-intervention, evidence-based care, the majority of women do not have access to this model of maternity care.[39-40] Increasing access to high-value, evidence-based models of maternal care should be a priority for Medicaid stakeholders.

*Allostatic load defined as the cost of chronic exposure to elevated or fluctuating endocrine or neural responses resulting from chronic or repeated challenges that the individual experiences as stressful.

Featured Case Studies

Throughout this report, we include case studies, compiled from an extensive, nationwide environmental scan and in-depth interviews to identify best practices, innovative initiatives, and lessons learned for the midwifery-led model of care.

Initiative/Organization	Unique Features	Page Number
BMC Birth Center *Boston Medical Center* Boston, Massachusetts URL: bmc.org/obstetrics/labor-delivery	An **alongside birth center** model with two rooms within the birthing unit of a hospital that primarily serves a low-income population. Births in this midwifery-led model are in low risk women who desire physiologic birth.	28
Birth Detroit *Birth Detroit* Detroit, Michigan URL: birthdetroit.com	An early-phase, **community-supported birth center**. Ongoing and active community engagement to co-design the birth center will include an emphasis on culturally concordant care and a focus on serving the Medicaid population.	31
Baby and Company *Baby and Company* Nashville, Tennessee URL: babyandcompany.com	Originally developed as a network of private equity- backed, **freestanding birth centers**, the model encountered financial and regulatory barriers that forced the company to close all but one birth center. Lessons learned from their experience are provided.	45
Community of Hope *Community of Hope* Washington, D.C. URL: communityofhopedc.org/healthcare/family-health-and-birth-center	A nationally accredited birth center that is linked to a large **Federally Qualified Health Center** (FQHC) with three sites which provides a range of healthcare services for the entire family, with a special focus on serving pregnant mothers and their babies. Launched in 1980, the nonprofit organization continues to grow by leveraging unique community partnerships and resources.	49

What is the Midwifery-Led Model of Care?

The practices of midwifery and medical obstetrics are separate but complementary disciplines. Historically, the medical practice of obstetrics has focused on uncovering maternal and fetal pathology and treating abnormal conditions that preexist or arise in the course of pregnancy, delivery, or postpartum. Traditional obstetrical care is provided in a hospital typically involving intensive monitoring for complications and facilitation of delivery, often in an operating room-type setting, by a medical doctor. Although occasionally necessary for high-risk women, low- to medium-risk women might experience unnecessary interventions that can spiral into a cascade of additional interventions and complications that were necessitated by the unnecessary first intervention. The potential result is higher costs and no improvement or a worsening of outcomes.[41-43]

A recent ACOG Committee Opinion acknowledged that many common obstetrical practices are of "limited or uncertain benefit for low-risk women in spontaneous and normally progressing labor and with no evidence of fetal compromise."[44] Two such unnecessary practices that are associated with increased cesarean delivery are artificial rupture of membranes (amniotomy) and continuous fetal monitoring. The latter, a routine practice, has not been shown to improve outcomes such as perinatal death and cerebral palsy.

> In contrast, midwifery views **reproduction as a natural process** and directs the management of normal pregnancy, physiologic birth, and postpartum care through a lens that incorporates the pregnant individual, their social structure, and their personal needs in the transition to parenthood.[45]

As noted in the philosophy of midwifery by the American College of Nurse-Midwives (ACNM), midwives "practice watchful waiting and nonintervention in normal processes" with the "appropriate use of interventions and technology" and "consultation, collaboration, and referral with other members of the health team to provide optimal care."[46] This process is relationship building-intensive and requires more time than is typically allotted to physicians in the outpatient and labor and delivery setting.

A midwife is a trained, typically certified birth attendant who provides a comprehensive range of services. These services include primary care; gynecologic and family planning services; preconception care; care during pregnancy, childbirth, and the postpartum period; care of the normal newborn during the first 28 days of life; and more.[41]

There are several types of midwives, including:

1. **Certified Nurse-Midwife (CNM)** *(the most common)*
2. **Certified Midwife (CM)**
3. **Certified Professional Midwife (CPM)**
4. **Licensed Midwife (LM)**

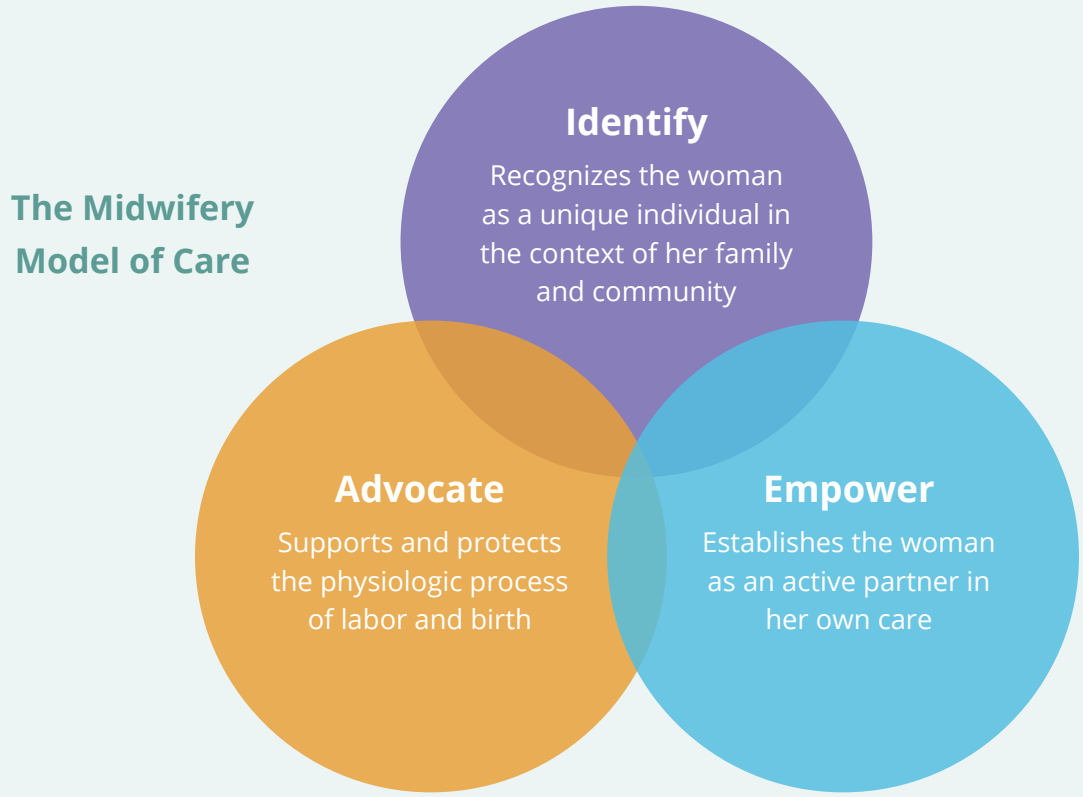
A summary of the differences between CNMs, CMs, and CPMs, including their education, training, licensure, credentialing, and practice settings can be found in Appendix B. In addition, a detailed state-by-state table highlighting the specific statutes related to state licensure (e.g. whether states recognize LMs, etc.), regulation, and Medicaid reimbursement policies can be found in Appendix C.

The midwifery-led model of care promotes physiologic birth or, in other words, understanding, facilitating, and avoiding interference with the body's natural, physiologic birth process. It is reliant on shared decision making and respect for an individual's cultural needs, comfort, and privacy. Emphasizing the normalcy of birth, those practicing a midwifery model generally avoid practices that might lead to further interventions such as continuous fetal monitoring in lieu of intermittent fetal auscultation and the use of nonpharmacologic pain management techniques when safe and desired.[47] The midwife provides care during the prenatal, intrapartum, and postpartum periods. Figure 2 highlights three interconnected concepts that are characteristic of this model, including identification, empowerment, and advocacy.

Finally, it should be acknowledged that many of the components of the midwifery-led model of care are not exclusively practiced by midwives and have been incorporated by practicing physicians into the care they provide. In fact, there is a critical role for family practice physicians working in rural areas to have expertise in both the midwifery-led model of care and obstetrics to ensure optimal outcomes.

Increasingly, physicians are trained in interprofessional learning environments that foster increased awareness and understanding of the midwifery-led model of care while also building trusting, collaborative relationships. Physicians who learn and work alongside midwives recognize the importance of the options and preferences of women they serve and value the midwifery model. As such, a growing number of physicians, including obstetricians and family practice physicians, are incorporating these high-value, evidence-based midwifery principles into their practices.

Figure 2. Three Characteristics of the Midwifery Model of Care



Source: Pacific Business Group on Health (year), "How to successfully integrate midwives into your practice: A guide for physician practices and hospitals." Retrieved from: http://www.pbgh.org/midwifery

What Is the Evidence on the Midwifery-Led Model of Care?

The safety, quality, and high value of midwifery care has been well documented by research studies over the past three decades.[48-56] In 2014, Lancet published a series of papers developed collaboratively by leading experts from multidisciplinary groups on the worldwide contributions of midwifery to maternal and infant health outcomes. The series acknowledged the vital and cost-effective contribution of midwives to high-quality care and projected that scaling up the model worldwide would improve many maternal and newborn outcomes, including mortality and morbidity.[57]

> The *Lancet's* series concluded that "midwifery is a **vital solution** to the challenges of providing **high-quality maternity and newborn care** for all women and newborn infants, in all countries."[58]

The series highlighted that childbearing women need more than access to care; they need a combination of skills and relationship-based care. Recognizing the extensive evidence on the value of the midwifery-led model of care, the World Health Organization has launched a global campaign to raise awareness and encourage adoption of the model.[5]

A large continuously updated systematic Cochrane review of relatively small-scale research studies in midwifery-led care has shown favorable birth outcomes for women with low-risk pregnancies.[59] Women who experienced the midwife-led continuity model of care were less likely to have regional anesthesia for pain management, or experience operative vaginal deliveries, episiotomies, or preterm births before 37 weeks. The majority of the studies within this review reported a higher rate of maternal satisfaction with their care.[59] Another large systematic review had similar findings to the Cochrane review but also added lower rates of cesarean deliveries, lower rates of third- and fourth-degree lacerations, and higher rates of initiation of breastfeeding among women delivered by CNMs.[60] In response to the strong scientific evidence on midwifery-led models of care and outcomes, it was recommended that all women be offered midwife-led models of care.[59-60]

Larger studies have recently emerged that also demonstrate the benefit of the midwifery-led model of care. A 2018 retrospective study of 8,779 low-risk women found that women who initiated care with a midwife had a significantly lower risk of cesarean ($p < .001$) and preterm delivery ($p < .001$) than did those who initiated care with a physician.[61] A 2019 study of 23,100 planned hospital births across eleven hospitals in a multi-center quality improvement collaborative between 2014 and 2018 (3,816 births attended by CNMs and 19,284 births attended by obstetricians) found that the CNMs had significantly lower use of intervention compared to obstetricians, including induction of labor, episiotomy, admission at less than three centimeters, epidural use, artificial rupture of membranes, oxytocin use, and cesarean delivery.[62] CNM patients were significantly more likely to experience "physiologic birth," defined as "a spontaneous vaginal delivery with spontaneous onset of labor without the use of oxytocin, epidural, or episiotomy."

In CNM patients...

The risk of cesarean delivery in individuals who have *never before given birth* was reduced by **30 percent**

...and a nearly **40 percent** lower risk of cesarean delivery in individuals who *have already given birth.*[62]

There was a significantly higher risk of shoulder dystocia in multiparous women receiving midwifery care. Total hospital stays for mothers and newborns were similar or slightly shorter in the midwifery group. The authors concluded that greater integration of midwifery care into maternity services in the United States might reduce intervention labor and cesarean delivery in low-risk pregnancies.[61-62]

The mere presence of CNMs as members of interdisciplinary teams with physicians has also been shown to improve birth outcomes in hospitals. A recent large retrospective multicenter cohort study comparing low-risk nulliparous women delivering in hospitals that incorporate midwives to women delivering in hospitals staffed only by physicians found a 74 percent lower rate of labor induction, a 75 percent lower rate of augmentation of labor, and a 12 percent lower rate of cesarean deliveries in hospitals with midwives.

Hospitals with midwives had a...

↓ 74%

lower rate of labor induction.

↓ 75%

lower rate of augmentation of labor.

↓ 12%

lower rate of cesarean deliveries in hospitals with midwives.[63]

The authors were not able to discern whether the delivering provider was a midwife or a physician but surmise that the presence of midwives within a hospital system is associated with a culture that fosters less intervention in labor. It should be noted that the majority of the studies evaluating the impact of midwives were exclusively focused on certified nurse-midwives, both in-hospital and freestanding birth centers. The international studies may have a mix of majority CNM-focused studies and other midwives.

Evidence for the quality of care provided by the midwifery-led model of care consistently indicates positive outcomes for women or their infants. The value of midwives, including quality of care and patient satisfaction, has been demonstrated in extensive research studies. Increasing access and coverage to the midwifery-led model of care for low-risk women enrolled in Medicaid might improve outcomes in this population.

The Value of Midwives

Quality

In addition to high rates of spontaneous vaginal births, better integration of midwifery increases the rates of vaginal birth after C-section and breastfeeding while lowering rates of intervention, preterm birth, and adverse neonatal health outcomes.

Patient satisfaction

Midwives develop a supportive relationship with patients that increases a patient's sense of control during labor and birth, improves readiness for labor and birth, and increases a sense of respect, compassion, and attentiveness.

Spend

With low rates of C-sections, obstetric intervention, and NICU admissions, midwives can help lower costs.

Clinician burnout and retention

Practices that consciously approached the integration of midwives to help reduce workload burden on physicians found physician workplace satisfaction improved.

Source: Pacific Business Group on Health (year) "How to successfully integrate midwives into your practice: A guide for physician practices and hospitals."
Retrieved from: http://www.pbgh.org/midwifery

Practice Settings

The National Academies of Science, Engineering, and Medicine recently convened a special committee and began to unpack some of the common barriers and opportunities in various birth settings, including home, birth center, and hospital. The report concluded that all the settings had risks and benefits for either the pregnant individual or the newborn.[64] Midwives work in a variety of settings, such as hospitals, alongside birth centers, freestanding birth centers, and home births, in partnership with physicians and health systems.

Currently, about 9 percent of all births in the U.S. are attended by CNMs.[16]

However, that number is likely higher because of underreporting as a result of various state and facility policies (e.g., incident to billing) that do not capture the services of CNMs in total birth reports.[65-67]

Since 1989, when U.S. birth certificates were revised to include a checkbox for midwife-attended deliveries, there has been a steady increase in reported midwife-led births. The overwhelming majority (98.5%) occur in-hospitals.[66] Although home births in the United States increased by 71 percent from 2004 to 2014, the increase has been relatively small, from 0.56 percent of all births in 2004 (n=23,027 births) to 0.96 percent in 2014 (n= 37, 351 births).[68] And, although home birth is an important setting for midwifery-led care, the population of individuals who have home births and are covered by Medicaid is small.

For the purposes of this report, the focus is on the midwifery-led model of care in the hospital and in freestanding birth centers.

Hospital Births

An increasing number of childbearing women are cared for by midwives in-hospital for some, if not all, aspects of their birth. In the hospital setting, physicians and midwives might work together in parallel practices with separate panels of patients; they might share some patients with a form of collaboration or consultation, or they might function as members of an integrated interdisciplinary team with shared responsibility for one population.[54] If a patient requires care beyond the scope of practice of the midwife, several options are available, including the following:

Consultation with a physician:

where the midwife continues to be primarily responsible for care of the patient but seeks the advice of a physician for management decisions.

Co-management:

where the physician and midwife jointly manage the patient.

Transfer to medical management:

where the physician assumes primary responsibility for the patient. The midwife might continue to be involved, but her role is more supportive. An example would be for a patient requiring a cesarean section.

In 2014, an expert panel was convened to develop a shared mental model of the ways in which midwives function as part of an interprofessional team. This “Clarity of Collaboration” work product demonstrated the wide range and scope of practice of midwives. The definitions developed by this expert

panel were helpful in both understanding and quantifying the amount of midwifery care provided in collaborative models.[69] This range encompassed midwife-directed care to collaborative care with physicians as members of the care team. Regardless of the approach, effective collaborative practice teams were found to be based on professional competence, mutual and shared values, awareness of different roles and skills, and acknowledgment of interdependence and equality in power between individuals.[70]

Collaborative arrangements are often determined by local regulatory factors such as whether midwives within a state are considered licensed independent practitioners (LIPs) or are required to practice under the supervision of an LIP, a physician.[†] The Joint Commission allows only LIPs to have hospital admitting privileges. In states where midwives must practice under the supervision of an LIP, they can admit, manage, and care for a laboring woman, but there is a signatory burden on the attending physician.[69]

For groups that integrate physician and midwives into one practice, there are several types of staffing models for covering birth within the hospital. As noted below, they include shared caseload, midwifery laborist, midwifery first call, and obstetric hospitalist.[42]

Midwifery-led care in the hospital setting depends on more than just the presence of midwives; it relies on the collaborative practice of the clinical team. Although there are a variety of approaches, a team-based approach to care is important to increase utilization of this high-value model, particularly for the Medicaid population. The case study on page 28 from Boston Medical Center (BMC) demonstrates how an alongside birth center that is part of the hospital can foster innovation and collaboration among maternity care providers. In this midwifery-led setting, with a dedicated space and a culture promoting physiologic birth, CNMs teach midwifery students, medical students, and residents about the midwifery model of care. The key implementation lesson noted by the BMC Birth Center is the need for systemwide recognition of the value of this model, interdisciplinary clinical support, and community engagement from the beginning.

Integrated Hospital Staffing Models for Physicians and Midwives

Shared Caseload

In this model, patients might be followed antenatally by both midwives and physicians and **delivered by whichever provider is on call in the hospital at the time of delivery,** with physician back-up as detailed in the midwifery-led model.

Midwifery Laborist Model

Midwives in this model provide **24/7 labor and delivery care for any patient** followed by the practice and attend deliveries for patients who are within their scope of practice. The delivering midwife might or might not have been involved in the patient's prenatal care.

Midwifery First Call Model

In an integrative practice model, **both physicians and midwives see the same patients in the outpatient setting**. The midwife sees all patients as they present to the hospital, admits them to the birthing unit, and determines their risk and appropriateness for midwife-led care for delivery. If outside the scope of practice for midwifery care, the remainder of care is assumed by the physician on-call.

Obstetric Hospitalist Model

In some larger practices, there might be complete separation of outpatient and inpatient responsibilities for both midwives and physicians, and **patients are cared for by an interdisciplinary team of physicians and midwives** as they present to the hospital. The midwives would assume responsibility for patients within their scope of practice.

[†]LIP, a term coined by the Joint Commission, is defined as "Any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner's license and consistent with individually assigned clinical responsibilities."

Source: Pacific Business Group on Health (year) "How to successfully integrate midwives into your practice: A guide for physician practices and hospitals." Retrieved from: http://www.pbgh.org/midwifery

Collaboration and Innovation: Implementing an In-Hospital, Midwifery-Led Birth Center

Initiative Name: BMC Birth Center
Type of Initiative: Alongside (Hospital-Based) Birth Center
Organization: Boston Medical Center
Location: Boston, Massachusetts
Phase of Implementation: Early Stage

Since 1977, the midwives at Boston Medical Center (BMC) have been serving low-income communities. Currently 20+ midwives provide half of the hospital practice's prenatal care in neighborhood health centers and the hospital clinic, as well as care during labor and birth. To address the need for a culture and setting that promote physiologic birth, BMC is planning to launch an alongside, in-hospital, midwifery-led birth center for people with uncomplicated labor and a preference for natural childbirth. Planning includes focus groups with current or recently pregnant mothers in their practice, as well as with midwives who serve the neighborhood health centers and BMC-affiliated community doulas. Interdisciplinary clinical committees and guidance from the American Association of Birth Centers are contributing to strategic planning.

Currently, there are only four alongside birth center units that are accredited by the Commission for the Accreditation of Birth Centers (CABC). The BMC birth center will be integrated into a collaborative practice, with plans for midwives to teach midwifery students, medical students, and residents in the birth center setting. The learning model will require continuity of care for the residents and students, from prenatal care through labor and the postpartum visit.

In addition to incorporating input from neighborhood health centers into the development and planning of the birth center, community supports such as local breastfeeding cafés, parenting education programs, and other wrap-around services will be integrated into the Center's resources and referrals. The Center plans to conduct an evaluation using historical controls to assess costs and outcomes. They hope to engage payers in the design of this evaluation.

The hospital has given initial approval for financing this initiative. They aim to include the construction of the center in capital budgets and will also seek philanthropy contributions to support the implementation.

The team at BMC Birth Center identified the following recommendations for state Medicaid agencies and managed care organizations to consider:

- Reimburse non-clinical supports, including doulas and community health workers, in addition to the global maternity care payment.
- Reimburse midwives at 100% of the physician rate for the same work.
- Finance and expand coverage during the postpartum period from 6 weeks to 12 months to increase access to contraception, conduct depression screenings, and improve inter-conception care.
- Fund low-intervention birthing facilities at a rate that incentivizes their use.

Freestanding Birth Centers

Freestanding birth centers represent another setting for the midwifery-led model of care. This clinical setting includes freestanding birth centers that are physically separate from a hospital, compared to the alongside birth centers, which are housed within the same campus or even on a separate floor or block of rooms within a hospital; as noted in the BMC Birth Center case study. The American Association of Birth Centers (AABC) defines a freestanding birth center as a "home-like facility within a health care system with a program of care designed in the wellness model of pregnancy and birth" and maintains an evidence-based, quality and safety guidance document, *Standards for Birth Centers.*[71] In 2020, there were 384 birth centers in the United States, having grown 97% since 2010.[72]

Licensure and accreditation of birth centers vary by state. Licensure is mandatory for Medicaid reimbursement and dependent on adherence to regulations within a state. Section 2301 of the Affordable Care Act mandates that all states with licensed or otherwise state-approved birth centers must cover services under Medicaid. Accreditation is voluntary and a choice that a birth center makes to show their "accountability and dedication to best practices." [73] The accreditation process occurs through the Commission for the Accreditation of Birth Centers (CABC) and/or the Joint Commission. While the Joint Commission focuses on a wide array of healthcare organizations, the focus of CABC is solely on birth centers. However, not all birth centers are accredited through the CABC. As of April 2020, 118 freestanding birth centers were accredited through CABC.

> In 2017, approximately 0.5 percent of births in the U.S. occurred in birth centers.[113]

The concept is that low-risk individuals arrive in active labor, receive limited use of medical interventions and support for normal, physiologic birth, and are then discharged home several hours postpartum. This birth setting is used successfully in other high-income countries and in 2014 was recommended by the National Institute for Health and Care Excellence (NICE) in the United Kingdom as a valuable option for healthy individuals with normal pregnancies.[40] Midwifery-led birth centers are designed for the lowest-risk pregnancies and are reliant on trained birth attendants working in collaborative relationships with clinicians in an integrated health system with capacity for timely transport to the local hospital.[74]

In contrast to European nations where freestanding birth centers are well integrated into the healthcare system, there is a lack of consistent integration into higher levels of care in the U.S. Recognizing this need for the "growth and maturation of systems for the provision of risk-appropriate care," ACOG, in a 2019 consensus paper, acknowledged that birth centers are a part of the healthcare system in the U.S for low-risk women who are expected to have an uncomplicated birth.[75] However, they recommended adherence to AABC standards that require birth centers to have an established consultation, collaboration, or referral system in place to meet the needs of the woman or infant.

Freestanding Birth Center Outcomes in Medicaid

The Strong Start for Mothers and Newborns Initiative, commonly referred to simply as Strong Start, was authorized by the ACA and is managed by the Centers for Medicare and Medicaid Innovation. The initiative sought to address the underuse of evidence-based non-medical enhancements in care, such as counseling in nutrition and parenting, and childbirth and breastfeeding preparation and support through midwifery-led models of care (with a focus on CNM/CM care) including in the hospital and certified freestanding birth centers.[76] The evaluation of the five-year program found significantly better outcomes for women receiving care in midwifery-led birth centers compared with matched population controls, including a decrease in the cesarean birth rate (17.5% vs. 29%, $p<0.01$), preterm birth rate (6.3% vs. 8.5%, $p<0/01$), and low-birthweight rate (5.9% vs. 7.4% $p<0.01$).[77] Importantly, costs for births decreased by 21

percent for infants in the first year of life and were 16 percent lower for women enrolled in birth center care. Mothers and babies receiving care at freestanding birth centers averaged a cost savings of $2,010 per dyad in the first year of life. Focus groups with participants found that they were more likely to report being "very satisfied" with their care experience compared to women in traditional clinical settings.

Studies have shown that freestanding birth centers successfully support women in avoiding interventions such as cesarean delivery.[39,54,78] Transfer rates were variable across studies, but the majority were considered non-emergent.[39,54,78] There were racial disparities in utilization of the birth center, with underutilization among black women.[54,78] Using data from a large, prospective cohort from the AABC Uniform data set, it was found that one of every four individuals in the sample population were insured by Medicaid.[78] Freestanding birth centers provide high-value care to individuals, especially those who have low medical risk with high social risk.[77] However, it should be noted that the majority of the studies evaluating the impact of midwifery-led care in freestanding birth centers were focused on certified nurse-midwives, one type of midwife, but included a mix of midwifery professionals, including CMs. In addition, the studies evaluated a mix of accredited and non-accredited freestanding birth centers.

Increasing access to freestanding birth centers to increase utilization among Medicaid recipients requires regulatory/accreditation, interprofessional education, and AABC guidance to organizations, communities, states, and federal systems. As the case study on page 31 describes, increasing access to freestanding birth centers also requires authentic community engagement. Birth Detroit is in the early stages of implementing an innovative, empowerment-focused, and community-driven movement to start a freestanding birth center in Detroit, Michigan. Among their key lessons learned during the early phase of implementation are the importance of community dialogue, sustainable and diverse funding sources, and design with the Medicaid population in mind. Birth Detroit also identified challenges with state licensure and accreditation, topics that will be explored further in this report.

Building a Community-Led Birth Center: Early Lessons

Initiative Name: Birth Detroit
Type of Initiative: Freestanding Birth Center
Organization: Birth Detroit
Location: Detroit, Michigan
Phase of Implementation: Early Stage

Despite increasing evidence that birth centers improve outcomes, enhance patient satisfaction, and lower costs, there are no freestanding birth centers in Detroit. Birth Detroit is working to open a perinatal clinic in 2020 and a birth center in 2021.

Birth Detroit is asking and answering the question: What does it take to cultivate a protective environment for black maternal health that centers black women as leaders in their own care? Birth Detroit embraces a community organizing approach to birth center development, rooted in deep equity and meaningful partnerships. To date, Birth Detroit has conducted an online community survey, shared results in a community event referred to as a "launch and learn," and initiated Birth Talk kitchen table conversations.

More than 40 percent of Detroit births are to persons with Medicaid. Birth Detroit's financial model is constructed to provide services to 50 percent Medicaid; 30 percent employer-sponsored, commercial pay; and 20 percent self-pay. Building upon financial models provided by the American Association of Birth Centers, Birth Detroit is working to develop a sustainable financial infrastructure by year three of its operation.

Helpful advice from the Birth Detroit team includes:

- Ask the community who you will serve, what they need.
- Conduct an environmental scan and know what resources, strengths, and potential partners are present in your community.
- Diversify the funding opportunities you pursue.
- Get consultation from individuals and organizations who/that have done this before.
- Build equity into your planning and development processes.

The team at Birth Detroit identified the following recommendations for state Medicaid agencies and managed care organizations to consider:

- Reimburse birth centers, doulas, and lactation consultants at a fair rate comparable to hospital-based uncomplicated deliveries that will sustain the services.
- Support behavioral health services as a part of postpartum care.

Licensure & Scope of Practice

State and federal regulations regarding the provision of pregnancy services in the Medicaid program currently favor physicians and Certified Nurse Midwives (CNMs) and, in some states, Certified Midwives (CMs); excluding other types of midwives. Appendix C offers a state-by-state comparison of state statutues affecting the practice of midwifery. This section of the report is specific to the current state and federal regulations regarding the provision of pregnancy services provided by CNM/CMs in hospitals and freestanding birth centers for the Medicaid population.

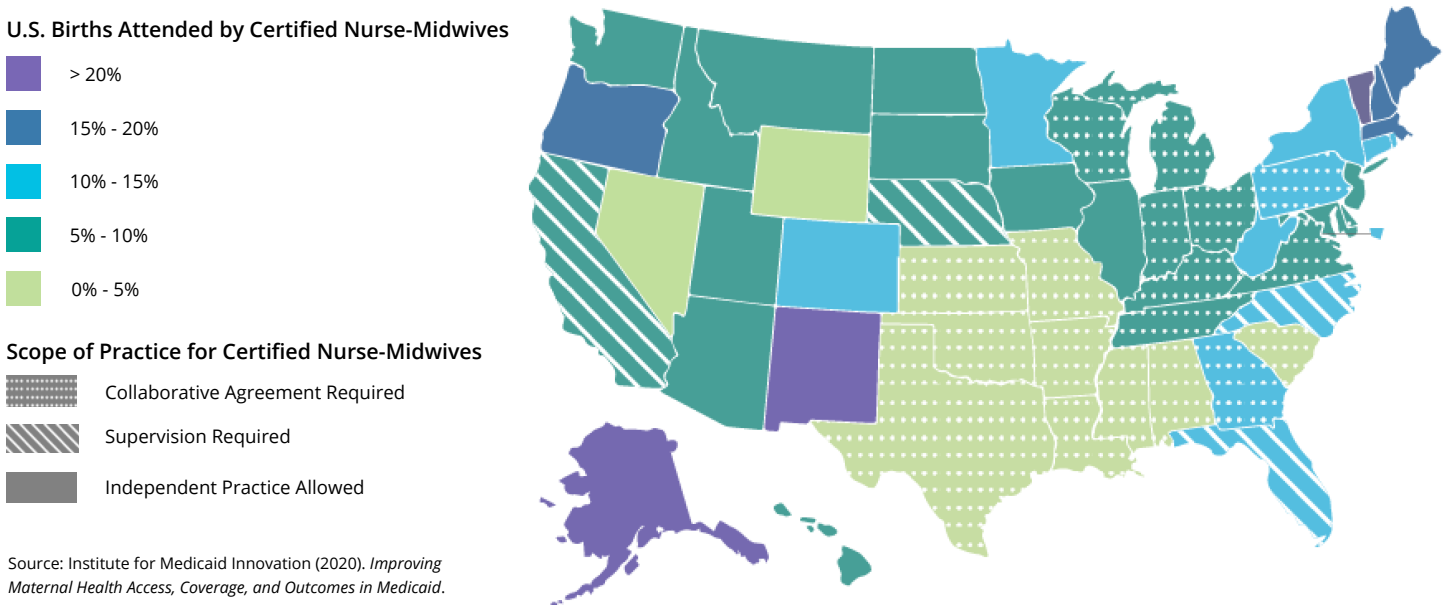
The Certified Nurse Midwife role requires regulatory recognition beyond the registered nurse license with each state adopting its own licensing requirements, role title, and scope of practice. State practice environments are continually evolving and moving closer to full practice authority in all states. Currently, twenty six states plus the District of Columbia allow CNMs to practice independent of physicians.‡ Four states require physician supervision and twenty require collaborative practice agreements.[79] In contrast, six states recognize the role of Certified Midwives.[80] (see Appendix C)

‡States that allow CNM independent practice: AK, HI, AZ, CT, DC, WA, OR, ID, MT, ND, SD, MN, IA, IL, CO, NV, UT, NM, WV, NY VT, NH, MA, RI, NJ, MD. States that require physician supervision: CA, FL, NE, NC. States that require collaborative practice agreements: TX, OK, KS, MO, AR, LA, MS, AL, GA, SC, TN, VA, KY, IN, MI, WI, OH, PA, VA, DE.

States that support autonomous midwifery practice have been found to have a larger nurse-midwifery workforce and a greater proportion of CNM-attended births.[81] These states also have overall better birth outcomes such as lower odds of a cesarean delivery, preterm birth, and low birthweight compared to states with more restrictive regulations.[78] One study created a scoring system for midwifery integration within each state based on several factors including scope of practice, autonomy, and prescriptive authority. States identified as having the highest level of integration of midwives across all settings also have higher rates of spontaneous vaginal delivery, vaginal delivery after cesarean section, and breastfeeding. They also have lower rates of cesarean and preterm birth, low birth weight infants, and neonatal deaths.[82]

Figure 3 illustrates the relationship between scope of practice and midwife-attended births. Some of the variation is regional, as in the northeast where full independent practice authority is associated with higher midwifery deliveries, and the requirement for collaborative agreements with physicians is associated with lower midwifery birth numbers, as in much of the southern part of the U.S. The Birth Place Lab offers additional information through an interactive map and state-by-state report card evaluating the level of midwifery integration in relation to outcomes. The resources can be accessed at https://www.birthplacelab.org/.

Figure 3. U.S. Births Attended by Nurse-Midwives and State Variation of Scope of Practice for CNM Care, 2018

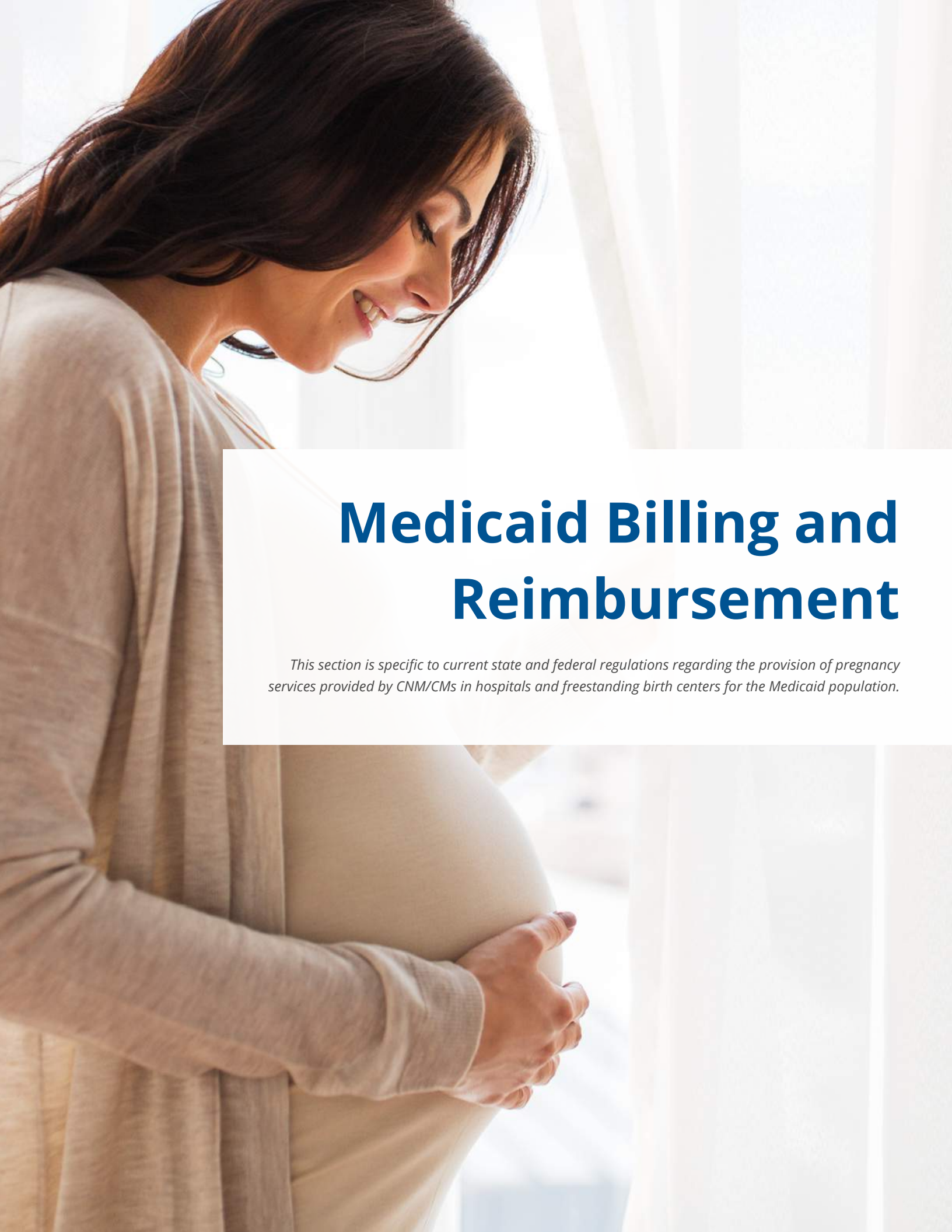


Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid*.

Given the variation in licensure and scope of practice, the National Council of State Boards of Nursing (NCSBN) has led an effort to provide standardization for licensure and promote independent practice for advanced practice registered nurses (APRN); including Certified Nurse Midwives. In July of 2008, NCSBN's Advanced Practice Registered Nurse Advisory Committee and the Advanced Practice Registered Nurse Consensus Workgroup published "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education."

The model was endorsed by multiple national nursing organizations and focused on four advanced practice categories, including certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners.[83]

States now have guidance to align their nurse practitioner regulations with the major elements of The Consensus Model, including independent practice and prescription authority.



Medicaid Billing and Reimbursement

This section is specific to current state and federal regulations regarding the provision of pregnancy services provided by CNM/CMs in hospitals and freestanding birth centers for the Medicaid population.

To facilitate the billing process for all health care providers, standardized claim forms with mutually agreed-upon data elements are used by all clinicians who wish to be reimbursed through Medicaid fee-for-service or an MCO. The two forms, developed by CMS in collaboration with the National Uniform Billing Committee (NUBC), are reviewed and revised multiple times throughout the year.

CMS Standardized Billing Forms

1 Professional Services:

The **CMS 1500** claim **form**, used by physicians, nurse practitioners, and other health care providers and suppliers of durable medical equipment, was developed by **CMS** and is the standard **form** used by all insurance carriers.

Facility Services: 2

The **CMS-1450**, more commonly referred to as the **UB-04** claim form, is used by institutional facilities such as hospitals or outpatient facilities to include surgery, radiology, laboratory, or other facility services.

For hospital-based deliveries, facility charges are billed separately from providers' professional services. For example, prenatal and postpartum care and the provider's time to attend the delivery are billed separately from the birth center facility fee or the hospital's charges.

Billing and Service Codes

Clinical documentation of services and accurate coding assists in avoiding errors that result in fraud, waste, and abuse but also captures the revenue data necessary to support a birthing center's mission. Coding for medical services is very complex, with constant rule and code changes that are best managed by certified professional coders (CPC).[84]

Table 1 presents a basic overview of coding requirements that clinicians either in a hospital or birth center setting must navigate.

Table 1. Basic Medical Billing Code Terminology

Billing Code	Code Use and Description
International Classification of Diseases, Tenth Revision, Clinical Modification **(ICD-10-CM)**	• The code indicates the diagnosis • All providers, including physicians, use this code set in health care settings • Centers for Disease Control and Prevention (CDC) developed and maintains the code set • There are more than 68,000 diagnosis codes • IDCD-10 Codes specific to pregnancy are in the chapter: Pregnancy, childbirth and the puerperium • The Z34 series "Encounter for supervision of normal pregnancy" is the diagnosis code set used to report an uncomplicated pregnancy

International Classification of Diseases, Tenth Revision, Procedure Coding System **(ICD-10-PCS)**	• The code set providers use to report procedures performed only in a hospital inpatient health care setting
	  • Centers for Disease Control and Prevention (CDC) developed and maintains the code set
	  • There are >75,000 individual ICD 10-PSC codes, all with 7 alpha-numeric characters
	  • The ICD-10 PCS code used to report a delivery in a hospital facility is: 10E0 Products of Conception

Current Procedural Terminology **(CPT)** (Centers for Medicare and Medicaid Services, 2019)	• The code set providers use to report medical procedures and professional services furnished in ambulatory/ outpatient settings, including physician visits to inpatients
	  • The American Medical Association (AMA) developed, copyrighted, and maintains the code set
	  • When a single provider or provider group provides all prenatal, delivery, and postpartum care a Global billing code is used
	  • 59400 Vaginal Delivery
	  • 59510 Cesarean delivery
	  • 59610 Vaginal Birth After Cesarean Delivery (VBAC)
	  • 59618 Cesarean Section After Failed Trial of Labor (prior Cesarean)
	  • When multiple providers or groups are engaged in pregnancy care (mother changes provider groups or a covering physician performs the delivery), individual CPT codes are used.
	  • 59425 (antepartum **care** only; 4 to 6 visits) or
	  • 59426 (antepartum **care** only; 7 or more visits)
	  • 59409 Vaginal Delivery Only
	  • 59430 Postpartum Care Only
	  • 59410 Vaginal Delivery Only Including Postpartum Care
	  • 59514 Cesarean Section Delivery Only

Healthcare Common Procedure Coding System **(HCPCS)**	• Level I codes and modifiers are the CPT codes (as described above) • Level II codes and modifiers primarily identify products, supplies, and services not included or described by any CPT codes • CMS maintains the code set, except for the code set for dental services (D-codes). The American Dental Association (ADA) developed, copyrighted, and maintains the D-codes.

Facility Revenue **(RV)** and Place of Service Codes **(POS)**	• The unique three-digit code affects reimbursement and represent the services provided by the facility
	  • The RV code set is only reported on a UB-04 from and used by facilities to report the type of service to be reimbursed (Intensive care, medical surgical unit, Pediatrics, Obstetrics, etc.)
	  • The RV code for a Birthing Center is "0724 for labor room or delivery at a Birthing Center with a "Place of Service Code" added to the RV code to indicate if the facility is a birthing center (25) or a hospital (11)

Source: Centers for Medicare and Medicaid Services (2019). ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets. *Medicare Learning Network* (July), 1–5.

Incident to Billing

Medicaid reimbursement for covered CNM services is allowed in all states and the District of Columbia.[85] CMs are reimbursed by Medicaid in two of the six states where they practice (see Appendix C for more details). To process reimbursement, CNM/CM services may be billed directly using the midwife's National Provider Identification (NPI) number, or the midwife may bill under a supervising physician's NPI number as "incident to" billing. "Incident to" is defined as services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.[86]

When the requirements for "incident to" billing are met, the (SA) modifier, a Healthcare Common Procedure Coding System (HCPCS) code, indicating that the midwife has rendered service in collaboration with a physician, is applied to the billed service code. Reimbursement is based on 100 percent of the physician's contracted fee schedule amount. When services are not shared or split between a physician and a CNM/CM, the midwife-covered service is reported under the midwife's NPI number, and Medicaid payment may be reduced.

There are 22 states where CNMs receive less than 100 percent of the fee as compared to physicians, which creates a disincentive for CNMs to bill their services separately.[85] Although a midwife may be licensed to function independently, accepting the oversight of a physician colleague will maximize the CNM's reimbursement rate. This might create a disincentive for physician practices to employ midwives. In addition, as many clinical outcome studies are dependent on claims data, to evaluate the midwife's impact on reducing health care costs, improving outcomes, and satisfaction, "incident to" billing presents a barrier to understanding the degree to which the midwife contributes to improved outcomes.

Establishing Reimbursement Rates for Midwifery-Led Care

In addition to the services required under the ACA Women's Health Preventive Service Guidelines, each state Medicaid agency, in collaboration with CMS guidance, determines the service codes that will be covered/reimbursable benefits for those enrolled in Medicaid.[87] The actual dollar amount to be reimbursed for each service is often derived from the Medicare fee schedule. For example, a state may determine a Medicaid service code will be reimbursed significantly more (120%) than the Medicare Fee Schedule or significantly less (60%).

To arrive at the baseline cost and subsequent reimbursement allowed for each service code, a complex formula is used. The calculation includes the following:[84]

1. Time, effort, and expense of a service or procedure, called **Relative Value Units (RVU).**
2. Adjustments for geographic economic variation, called the **Geographic Cost Indices (GCI).**
3. Multiple conversion factors and modifications related to **incentives and value-based payments.**

The Influence of Medical Loss Ratios on Reimbursement

A state Medicaid agency's or managed care organication's decision to alter reimbursement for a service is often predicated on the medical loss ratio (MLR), the proportion of premium revenues spent on clinical services and quality

improvement. For example, if an insurer uses 85 cents of every premium dollar to pay its enrollee's medical claims and activities that improve quality of care, the company has an MLR of 85 percent, which also indicates that the insurer is using the remaining 15 cents of each premium dollar to pay overhead expenses. Therefore, should medical claims decrease because of improvements in care that lower medical costs, MCOs have more-available premium funds to increase provider reimbursement or quality improvement strategies.

To promote consistency among state Medicaid MLR requirements, CMS issued a final Medicaid managed care rule on April 25, 2016, establishing a federal MLR standard for Medicaid of at least 85 percent. Although some states do require MCOs to reimburse premium dollars in excess of the applicable MLR threshold, this is not a requirement of the final rule. The MCO's MLR will fluctuate during the year and from year to year based on the clinical acuity of its membership--for example, a difficult flu season and changes in premium rates offered by the state agency.

Managing this balance is a complex process as states strive to improve the overall health of the population at a sustainable expense with MCOs who present a strong fiscally responsible value proposition. Service providers who demonstrate their value by partnering with MCOs to achieve optimal clinical outcomes at a low cost are essential to maintaining this balance.

Figure 4. Medical Loss Ratio Formulas: Traditional and Affordable Care Act

Medical Loss Ratio (MLR) Formulas: Traditional and Affordable Care Act (ACA)

$$\text{Traditional MLR} = \frac{\text{Health Care Claims}}{\text{Premiums}}$$

$$\text{ACA MLR} = \frac{\text{Health Care Claims + Quality Improvement Expenses}}{\text{Premiums - Taxes, Licensing \& Regulatory Fees}}$$

Source: Kaiser Family Foundation. (2012). Explaining health care reform: Medical loss ratio (MLR). Retrieved from: https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/

Equitable Compensation

In an effort to address challenges with reimbursement for midwifery-led services, the ACNM position statement on equitable compensation defines midwifery independent practice as well as the mutual benefits of a collaborative physician/midwife relationship.[88]

Among their principles for equitable compensation, three are specifically related to compensation rate reductions that state Medicaid agencies and Medicaid managed care organizations are in a position to address.

Payers should reimburse CNMs at the same rate as other providers for the same service.

Reimbursement methodologies should determine the relative value of the payment made for those services based on the resources required to provide the service, not the type of provider rendering the care. To reimburse at a reduced rate relative to what is paid to physicians does not recognize the underlying reality of the fee schedule methodology used by Medicare (and almost every other payer), and it therefore inappropriately disadvantages midwives relative to their colleagues and discourages their participation in the provider networks of such payers.[88]

Physicians and midwives need to adhere to state and federal reimbursement statutes and regulations.

Midwives may submit bills for the services they perform that are within their legal scope of practice as defined by state and federal law.[88]

Consultation and the financial relationship between physicians and midwives should mirror the consultation and financial relationship between physician generalists and specialists.

Perinatologists do not charge obstetricians, family practice physicians, or midwives a fee to be available for consultation and collaboration. Cardiologists, neurologists, and other specialty physicians do not charge internists, family practice physicians, or midwives to be available for consultation. Obstetricians should not expect midwives to pay them to be available either.[88]

Medicaid Contract Considerations

This section is specific to the current state and federal regulations regarding the provision of pregnancy services provided by CNM/CMs in hospitals and freestanding birth centers for the Medicaid population.

If a CNM/CM is not employed by the hospital, they must apply for hospital admitting privileges, which includes a detailed review of the midwife's credentials and work history. This process helps to ensure that high-quality care is delivered by qualified practitioners but can also be used to limit or prohibit midwifery practice within a hospital. All states but one (Maryland) have laws or regulations that explicitly or implicitly allow CNMs to admit patients to a hospital and to be included on a hospital's medical staff.[89] All six states where CMs practice have similar laws.[89] However, although state laws allow these actions, individual hospitals may not. For example, they may allow privileging only with physician supervision or place limitations on participation in medical staff voting.[89]

A Certified Nurse-Midwife or Certified Midwife must also obtain a National Provider Identifier (**NPI**) number to facilitate reimbursement for services provided. This is a unique 10-digit identification number issued by CMS. It is used for billing on all claim forms, remittance notices used by payers, and claims processing clearinghouses. To be reimbursed by Medicaid, the CNM/CM must also be credentialed as a Medicaid provider by the state as well as all managed care organizations (MCOs) contracted to provide coverage in the regions where the CNM/CM will be providing services.

Contracted affiliation with a MCO includes, among many provisions, an agreement to accept a defined payment for services. It also allows the CNM to be an "in-network" provider and to be listed in the MCOs' provider directory. Ideally, Medicaid enrollees wishing to obtain services from a CNM/CM may then identify a CNM/CM in their area by calling their MCO's customer service line or by using an on-line provider look-up tool. Although a signed Medicaid MCO contract is an essential step in being listed as an in-network provider, directories might not be regularly updated and some midwives might find, if they are not practicing independently, that they are not listed in the directory.

Contracting with Freestanding Birth Centers

Although some states are very specific and uniform in their requirements for safe operation of freestanding birth centers, others might be nonspecific or vary in their requirements and regulations.

Nine states (ME, VT, VA, NC, AL, MI, WI, ND, and ID) have no regulations for licensing birth centers. However, birth centers may still operate without licenses in some states.[39, 90]

To address the issues with inconsistency and to assure the public and commercial/government-based health insurers of the safety and quality of care administered in birth centers, the AABC developed practice and operating standards for birth centers. To facilitate center accreditation, in 1985, the Commission for Accreditation of Birth Centers (CABC) was founded by the AABC. They are now two distinct organizations that play different roles regarding national standards and accreditation of birth centers. The CABC uses the "AABC Standards for Birth Centers" found at https://www.birthcenters.org/page/Standards as the basis for its accreditation process, although it has no mandate to do so. In addition to AABC standards and CABC accreditation, the *Guidelines for Perinatal Care*, 8th edition, also recognizes alternative pathways to accreditation for birth centers, including the Accreditation Association for Ambulatory Health Care and The Joint Commission.[91]

CNM/CMs who practice in freestanding birth centers are typically employed by the birth center and are not routinely credentialed individually by Medicaid MCOs or other health insurance companies if their practice is limited to the birth

center. They receive a salary from the birth center, and their services are billed by the birth center. When state licensure is available, the birth center seeks state licensure to operate and then accreditation with the CABC. Should the birth center wish to accept health insurance payments, the birth center must apply for credentials as a service provider with commercial and government-based health insurance providers (e.g., a Medicaid MCO). A license to operate a birth center is required for this process; therefore, those states without licensure requirements are not eligible for Medicaid reimbursement.

Contracting Challenges with Freestanding Birth Centers

Once a freestanding birth center is credentialed with a health insurer, a network provider contract is executed. Elements of the contract include language related to the center's license to operate, reimbursement fee schedules, and accreditation and transfer agreements. Because the process of becoming a network provider and operating under the requirements of health insurers may be burdensome, especially for a low-volume operation, birth centers may choose to focus their practice only on self-pay clients. Common contracting challenges include limits on the physical distance from an acute care facility, transfer agreement clauses, and unsustainable compensation for services.

Freestanding birth centers have found that acute care facilities and physician groups are reluctant to enter into these agreements. In a March 2014 letter from the AABC to the Federal Trade Commission, members' experience with transfer agreements was described as being "very difficult or often impossible to find a physician who is willing to sign [an] consulting or referral acceptance agreement."[92] The letter also adds, "hospitals, which are often direct competitors of birth centers, are likewise typically unwilling to enter into transfer or transport agreements, even [though] such agreements improve patient care by providing a more seamless transfer when necessary."[92]

Transfer agreements are supported by detailed policies and remain an important measure of quality. Freestanding birth centers may also obtain support from Ambulatory Surgical Centers (ASC). Although not considered an ASC, there may be similarities for birth centers regarding transfer agreement requirements and barriers. For instance, hospitals may be resistant to enter into transfer agreements, and ASC administrators have cited tactics by hospitals that include seeking to control the ACS, limit competition, and stifle access to care.[93] Subsequently, a new CMS rule, issued September 25, 2019, eliminated hospital transfer agreements for Ambulatory Surgical Centers. It is unknown if CMS is considering similar rules for birth centers.

Common Contracting Challenges

Limits on physical distance from an acute care facility

A frequent addition to state licensure, accreditation, and Medicaid MCO contracting is limits on the physical distance to an acute care facility. Although intended to support a swift and safe transfer to a higher level of care for the mother and baby, this requirement may limit options for rural or frontier birth centers that were intended to operate in underserved, critical-access locations.

Transfer agreement clause

This is a written agreement between the birth center and an acute care facility, outlining a plan for patient transfer. These agreements are procedural and memorialize the protocols necessary in an emergent situation. The intent for this agreement is to facilitate a swift and safe transfer in addition to meeting the important need for continuity of care between the birthing center and the accepting acute care provider and facility. It is important to emphasize that hospitals are not refusing patients in transfer or turning away patients from emergency rooms as mandated through the Emergency Medical Treatment & Labor Act (EMTALA)); however, the agreement is frequently seen as a requirement to operate.

Since Medicaid payment for obstetric services can be as low as 30 percent of commercial payment rates, the economics for low-volume centers with high personnel costs, malpractice insurance, and other operating and facility costs have driven freestanding birth centers to concentrate only on self-pay clients, or, if they do take health insurance payments, only employer-sponsored commercial payers, to remain solvent. Furthermore, given the reduced reimbursement offered in comparison to the reimbursement offered to physicians and acute care facilities for CNM/CMs practicing at freestanding birth centers, which are often more time-intensive even for low-risk pregnancies, low-volume centers may find themselves unable to sustain themselves on Medicaid payment rates.

The case study on page 45 highlights Baby and Company, a for-profit midwifery-led freestanding birth center in Nashville, Tennessee. As Baby and Company began to grow, it faced challenges when scaling-up their model in new markets. These challenges included low reimbursement and high transfer rates along with regulatory issues, including efforts in their state to restructure the Medicaid program.

Among their lessons learned, the organization emphasized the need for seamless transition management between the freestanding birth center, emergency services, and hospitals; and tracking quality outcomes and measures. Understanding how different organizations learn from and adapt to common challenges is critical for increasing utilization of midwifery and birth center services.

Challenges & Lessons Learned from a For-Profit Birth Center

Initiative Name: Baby and Company
Type of Initiative: Freestanding Birth Center
Organization: Baby and Company
Location: Nashville, Tennessee
Phase of Implementation: Established Initiative

Baby and Company was a network of midwife-led birth centers integrated with regional health systems designed to be highly engaging, education-intensive, prevention-oriented, and family-centered. The for-profit company, funded by private equity investment, was recently restructured, and all but one of the network sites were closed due to underperformance and regulatory challenges. The remaining center is close to profitability with the recent integration of a physician practice and additional fee-for-service service lines (e.g. gyn surgery, ultrasound).

Challenges the Baby and Company Team encourage others to consider:

Baby and Company has not demonstrated a return on investment. The main challenge has been low reimbursement, especially when the birth does not occur in the birth center because of medical eligibility or client preference. In addition, antepartum transfer rates have been substantially higher than originally forecasted. They did not engage with Medicaid health plans for the first several years of growth because of the restructuring of the state Medicaid program and because of the low reimbursement from Medicaid programs compared with employer-sponsored commercial health plans. Other challenges included the high cost of upfront investment and delays in payment, inadequate data and IT systems to support the care model and track outcomes/value, and the regulatory environment with respect to midwife scope of practice and birth center licensure.

The team at Baby and Company identified the following recommendations for state Medicaid agencies and managed care organizngations to consider:

- Be diligent about tracking and reporting outcomes and value.
- Work closely with EMS services and conduct practice drills with emergency transports.
- Gain and maintain CABC accreditation.
- Engage in rigorous, continuous quality improvement, including reporting and responding to sentinel events and measuring and managing client/family experience.

Baby and Company recommended that state Medicaid agencies and Medicaid managed care organizations could offer support by:

- Increasing reimbursement for midwives and birth centers and ensuring parity with equivalent services provided by physicians and hospitals.
- Shifting payment from the intrapartum to the prenatal and postpartum phases of care.
- Requiring CABC accreditation for payment.
- Providing or reimbursing complementary services such as language interpretation, behavioral and mental health, social services, and lactation support.

Alternative Payment Models

Alternative payment models (APM) are value-based payment (VBP) methodologies that incentivize providers to provide high-value care. Rather than reimburse for the volume and intensity of services, as in a fee-for-service model, APMs link payment for services to high-quality, evidence-based, and high-value care. They are intended to drive improvements in the care process and health outcomes while decreasing the overall cost of care. One APM that is gaining traction within the Medicaid program is bundled payments.

Bundled Payment Arrangements

Rather than reimbursing for each service, bundled payment, or episodic payment models, establish a single, lump-sum payment (based on historical experience) for all care needed to support a specific condition over a specified amount of time. The episode includes care provided by multiple providers such as office visits, diagnostic testing, medications, hospitalization, rehabilitation, durable medical equipment, home visits, and so forth. One provider organization, identified as the coordinator of care or "convener," is responsible for implementing individualized care pathways for each patient that will yield high-value care with the best possible outcome, satisfaction, and cost.

With a full financial risk bundled agreement, payment is based on a predetermined target price, which is set to include all maternity care, from prenatal through the postpartum period, with or without complications. In addition to the financial target, MCOs incorporate quality improvement measures and goals to ensure that quality is maintained or improved. Participating providers share in any loss or savings that result between the target price and the actual cost. The payment may be prospective, offered as care is initiated, which eliminates the need for actual fee-for-service claims to be filed, or retrospective, by assessing the total amount paid for each case and later reconciling with the targeted amount.

Of primary consideration in implementing bundled payments is that health care systems will be incentivized to engage in high-value, evidence-based models of care that are underutilized. Examples include the midwifery-led model of care, as well as other essential support services such as home visiting programs, lactation consultation, doulas, and community health workers. Initiatives with demonstrated success in improving outcomes that bring down the overall cost of care through reduction in morbidity, mortality, and cesarean-section rates, as well as improvements in birthweight and breastfeeding rates, have the potential to see increases in utilization under alternative payment models such as bundled payments.

> "Maternity care is considered an **ideal candidate for the bundled payment option** because the condition is common and high volume, with defined start and stop times; it is covered by Medicaid in all states; and there is considerable variation in cost, care practices, and outcomes."

Although the cost associated with an individual pregnancy and delivery can be considered comparatively low when considering the episodic costs of other clinical services, a pregnancy that results in a poor outcome, with NICU care for the newborn, is among the highest cost category covered by MCOs. NICU care consistently ranks among the top-three most expensive conditions treated in U.S. hospitals.[94]

Currently, bundled payments are being piloted in partnership with state Medicaid agencies in OH, TN, WA, ID, and AR. Some of these pilots also include partnerships with Medicaid MCOs.[95] Other stakeholders, including freestanding birth centers, are exploring ways to ensure fiscal sustainability while serving the Medicaid population by bundling services and payment. The Minnesota Birth Center has developed a proposed pilot program, BirthBundle®, to test a bundled payment approach. As part of the initiative, the Medicaid MCO would receive monthly prepaid medical assistance payments from the state department of health, specifically designated for mother and newborn care. These payments would add up to at least $19,000 per pregnancy, in contrast with a current Medicaid payment for all-in birth center

services of ~$4,000 for mother and baby. At the time of publication of this report, the proposed pilot had not been implemented.

In addition to bundled payment models, there have also been publicly funded collaborations and initiatives between private and public payers to co-develop models to streamline the administrative processes, align outcome measures with evidenced-based practices, and reduce the reporting burden for providers. An example is the Health Care Payment Learning and Action Network (LAN), sponsored by the CMS Alliance to Modernize Healthcare (CAMH). The LAN Maternity Care Episode model incentivizes payment for value with the aim of reducing unnecessary care, particularly non-indicated cesarean deliveries, and providing better-coordinated, high-value care across the prenatal, delivery, and postpartum spectrum. The focus is to improve birth outcomes and lower costs.[96]

Although much work has been done to develop and support alternative payment models in maternity care, it is still in an early stage of adoption. Providers and payers must address significant obstacles before this payment approach can be implemented broadly in Medicaid for maternity care. Provider acceptance of the model, data systems that offer providers real-time reporting on results, and verifiable quality measures that assure that clinical quality and satisfaction are improving as cost are reducing will continue to require investment.

Federally Qualified Health Centers

Another potential strategy to mitigate costs, increase access for Medicaid enrollees, and support a financially sustainable model that is less dependent on payer mix to cover costs is to offer the the freestanding birth center model as part of a federally qualified health center (FQHC). FQHCs provide a physical space, organizational structure, and relief from other fixed costs such as utilities and malpractice insurance. They also have the added bonus of establishing and maintaining trusting relationships with the communities they serve. An in-depth analysis of several freestanding birth centers found that integration into existing health systems such as FQHCs may contribute to broader expansion of the freestanding birth center model and equitable access for those enrolled in Medicaid.[97]

Since FQHCs are multi-service units, they have the ability to shift costs during the early years of the freestanding birth center's operation until it reaches financial viability. This helps maintain sustainability and allows the FQHC to serve a diverse payer-mix population.[97] An FQHC freestanding birth center can also provide more than maternity care services. The co-location of ancillary services and facilitated coordination with more-complex health needs, or the ability for families to be seen at the same clinic, may make it more accessible for individuals to access the midwifery-led model of care, where they might otherwise be "risked out" in order to address more-complex health needs.[97]

FQHC freestanding birth centers might also help with clinician recruitment and reimbursement. Clinicians interested in participating in the National Health Service Corps program might serve at an FQHC and become eligible for school-related loan repayment.[97] In addition, FQHC birth centers are eligible for enhanced reimbursement rates through the Medicaid Prospective Payment System. Although this is still generally a reduced reimbursement rate compared to commercial insurance, it is still higher than what a non-FQHC freestanding birth center would receive.[97]

As an example, **Community of Hope (COH)** is an FQHC in Washington, D.C., that merged with a freestanding birth center. For more than 20 years, the birth center has provided high-value, sustainable care to a majority low-income population. COH has active community engagement and diverse financing, including its position as an FQHC. Although the majority of pregnant persons receiving prenatal care at COH deliver at hospitals, families continue to visit the clinic for their ongoing health needs after birth. The full case study can be found on page 49.

A Community-Focused & Financially Sustainable FQHC Birth Center

Initiative Name: Community of Hope Birth Center
Type of Initiative: Freestanding Birth Center
Organization: Community of Hope
Location: Washington, D.C.
Phase of Implementation: Established Initiative

Community of Hope (COH) is one of five FQHCs in the United States that houses a freestanding birth center. The birth center follows a midwifery-led model of care and the CenteringPregnancy® approach to prenatal care. This includes group care classes (shared medical appointments) during pregnancy and the early postpartum period. In addition to monthly prenatal check-ups, these sessions focus on strategies for a healthy pregnancy, childbirth, infant care education, and empowerment activities for participants. Patients also have the option of receiving a volunteer doula to support their labor at no cost. Most women receiving prenatal care give birth in the hospital with the COH midwife. Often, the entire family continues to visit the clinic for their health care needs long after the birth. COH is proud that many of the members of the midwifery care team are also residents of the community that they serve.

Challenges the Community of Hope team encourages others to consider:

Many of COH's clients are covered by Medicaid managed care organizations (MMCOs). Interactions are client-focused, such as helping individuals better understand their coverage. It is difficult to keep up with the various MMCOs that cover COH clients, particularly because the organizations frequently change their covered services and associated hospitals. For example, individuals may be able to deliver at any hospital and be covered by their insurance; however prenatal testing or advanced care with a specialist prior to delivery may not be included under their MMCO plan. This makes it difficult to update individuals on the most current information and provide the highest-quality care to patients.

Helpful advice from the Community of Hope team includes:

- Buy-in from leadership is essential.
- Promote continuity and a team-based approach, while simultaneously maintaining the integrity of each individual facet of care.
- Establish a streamlined communication workflow between care coordinators and clinicians.
- Community partnerships are a necessary component to this model of care.
- Hospitals need to contract with every MCO, not just one or two, which limits services and accessibility for the patients whom the FQHC serves.

The team at Community of Hope identified the following recommendations for state Medicaid agencies and Medicaid managed care organizations to consider:

- Increase transparency around covered services and institutions.
- Increase covered services.
- Improve reimbursement rates for innovative models of care.

Monitoring & Evaluation

Central to the process of monitoring and evaluating the midwifery-led model of care in Medicaid is access to timely and accurate demographic, outcome, and patient-reported data that can be used to measure the relationship between the intervention and its impact. Currently, there are a limited number of valid and reliable measures for monitoring and evaluating the quality of maternity care. The most commonly used measures are the National Committee for Quality Assurance (NCQA)-developed Healthcare Effectiveness Data and Information Set (HEDIS). CMS has identified a core measure set of maternal and perinatal health measures for Medicaid and CHIP. This core set consists of eight measures from CMS's child core set and four measures from the adult core set. Table 2 provides an overview of the core set. CMS uses these measures to evaluate progress toward improvement of maternal and perinatal health in Medicaid and CHIP. They can be used to calculate performance and/or reporting at the individual practitioner, group, or system level. Furthermore, consumers of healthcare services can use these measures to support informed decisions about their care and treatment options, such as types of providers, birth setting options, and procedures and interventions.

Table 2. 2020 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set)

NQF #	CMS Core Set	Measure Steward	Measure Name	Data Collection Method
0469/ 0469e	Adult	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
0471	Child	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	Child	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	Child	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1392	Child	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1517*	Child	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
1517*	Adult	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	Child	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2902	Adult	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/ 2904	Child	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
2903/ 2904	Adult	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative

* This measure is no longer endorsed by NQF.

Source: Centers for Medicare and Medicaid Services. (2020). 2020 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set). Retrieved from: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-maternity-core-set.pdf

Challenges in Quality Measurement

Medicaid managed care organizations may experience unique challenges in measuring quality for maternity care services, regardless of the type of clinician or birth setting. Commonly used global service codes do not identify the frequency of or specific dates of service for prenatal or postpartum visits, and non-reimbursable provided services necessitate time-consuming and costly manual chart reviews or self-reporting with associated audits. In addition, unique to the evaluation of maternal health services is the lag in time between a preconception or prenatal intervention and the multiple years or, minimally, nine months to assess an outcome. Further, linking the mother's data with newborn data can be difficult for Medicaid enrollees, particularly in states where enrollment numbers are not matched. The astute analyst, using claims data, must first develop a matching algorithm to link mother and baby and, even under the best of circumstances, might achieve only an 80 percent match.

In recent years, a revolution in data science has paved the way to produce valuable health and health system insights. However, access to health care data can be met by multiple barriers, including necessary regulations such as the need to maintain confidentiality as defined by the Health Insurance Portability and Accountability Act (HIPAA) and other burdensome limitations such as variations in electronic health record systems and inadequacies of claims data (a system designed to pay claims) to describe a clinical outcome.

Measurement Development & Reporting

State Medicaid agencies and Medicaid managed care organizations might consider engaging in efforts to develop measures that better assess quality, safety, and outcomes in maternity care. Current quality gaps emphasize the need to develop valid and reliable measures that improve specific processes that have been demonstrated to improve outcomes, including ending preventable maternal morbidity and mortality, reducing maternal infections, reducing unnecessary procedures that may cause harm or risk to mother and baby, balancing quality measures for maternal and infant health, and increasing screening and treatment for depression, substance use disorders, and domestic violence during and after pregnancy.

Quality measure development alone requires a lengthy evaluation and endorsement process before adoption as a reporting standard by national organizations such as The Joint Commission, Healthcare Effectiveness Data and Information Set (HEDIS), or state Medicaid agencies. Even then, an endorsed measure may require a costly hybrid approach to reporting using electronic medical records, medical claims, insurance enrollment files, and manual access to a paper medical record to satisfy complex numerator and denominator requirements. Furthermore, it has been noted that there is an absence of good quality measures to track and reduce racial and ethnic disparities in maternity care. Such measures might require an alternative approach of tracking self-identified race and ethnicity.[98]

To accelerate the adoption of best practices for quality, safety, and performance-based payment models, such as bundled payments, multiple public and private organizations are collaborating to streamline measure development and data access.

Among the first of these collaborations is the **California Maternal Quality Care Collaborative**, a multi-stakeholder organization partnering state agencies, professional groups, consumer organizations, healthcare systems, purchasers and payers, hospitals and clinicians, policymakers and researchers to drive quality improvement and measure development in California.[99]

Their evidence-based approach has garnered national attention, and other state and regional collaboratives are applying the framework to their own population.

Although for the most part these organizations are engaged in annual, aggregate reporting (not at the individual patient or enrollee level), with up to a six-month report development period, the endorsed measures and their numerator and denominator definitions can serve as guideposts to those engaged in maternity models evaluation. A list of organization and resources that can be used by state Medicaid agencies, providers, and Medicaid MCOs to inform conversations about data collection and quality measurement are highlighted below.

Organizations Supporting Measure Development, Quality Improvement & Reporting
Agency for Healthcare Research and Quality (AHRQ) An agency of the U.S. Department of Health and Human Services (HHS) that generates measures and data used by providers and policymakers. Among AHRQ's notable projects relative to the assessment of midwifery care is The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys used to assess patients' experience of care in hospitals. URL: https://www.ahrq.gov/
American Association of Birthing Centers (AABC) - Perinatal Data Registry AABC maintains an online data registry for ongoing collection of perinatal data in all settings and by all providers. The registry is designed to collect comprehensive data, including 185 variables, on the process and outcomes of the midwifery model of care. Access to the database is offered as a free benefit for AABC birthing centers and institutional members, with a subscription fee for others. URL: https://www.birthcenters.org/page/PDR
American College of Nurse Midwives (ACNM) Data Collection Project ACNM is developing a patient-level data collection process to support quality improvement initiatives. The vendor chosen for this project is Maternity Neighborhood. The goal is to allow data to flow between both data sets, and to develop data standards that enable research studies across birth settings and practice models. ACNM is partnering with the **American College of Obstetricians and Gynecologists (ACOG) Women's Health Registry Alliance**, to improve women's health outcomes through collaboration in use and development of multiple databases and registries. They are also involved in the **Society of Maternal-Fetal Medicine** Obstetric Health Information Initiative to identify common standards for data and clinical content in electronic health records (EHRs). URL: https://www.midwife.org/Data-Collection-FAQs URL:https://www.acog.org/About-ACOG/ACOG-Departments/Health-Information-Technology/Womens-Health-Registry-Alliance?IsMobileSet=false
National Committee for Quality Assurance (NCQA) NCQA maintains the **Healthcare Effectiveness Data and Information Set (HEDIS)**, a widely used set of accreditation performance measures also deployed by state Medicaid agencies to hold MCOs accountable to value-based purchasing contract agreements. The measure set is developed and maintained by the National Committee for Quality Assurance (NCQA), the organization providing health plan accreditation services. URL: https://www.ncqa.org/hedis/
Centers for Disease Control (CDC) CDC maintains the **Pregnancy Risk Assessment Monitoring System (PRAMS)** - a surveillance project with state health departments designed to report maternal attitudes and experiences before, during, and shortly after pregnancy. Forty-seven states currently participate in PRAMS, representing approximately 83 percent of all U.S. live births. Multiple risk factors such as pre-pregnancy weight, smoking, intimate partner violence, depression, oral health, and health care coverage are reported at the aggregate level. URL: https://www.cdc.gov/prams/index.htm
National Quality Forum (NQF) NQF deploys a consensus process with expert committees, made up of multi-stakeholders to thoroughly review and endorse new and maintenance measures. Endorsed measures are considered the gold standard for healthcare measurement. Convened under NQF is the Perinatal and Women's Health standing committee. The committee oversees of portfolio of perinatal and women's health measures, including reproductive health, pregnancy, labor and delivery, high-risk pregnancy, newborns, postpartum care, and premature or low-birthweight neonates. URL: https://www.qualityforum.org/Home.aspx

Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid.*

The Joint Commission (JC), the nation's oldest and largest standards-setting and accrediting body in health care, operates as an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.[100]

Organizations that seek accreditation must comply with performance measure standards defined by their proprietary ORYX® initiative. The measures selected are aligned as closely as possible with CMS. The 2020 ORYX® reporting requirements for hospitals providing obstetrical services include perinatal care measures related to early elective delivery, cesarean sections, breastfeeding, and unexpected newborn complications. Alternative payment models such as bundled payment and pay-for-performance may leverage the JC perinatal core measures to generate quality benchmarks and targets. Table 3 provides additional details for these measures.

Table 3. 2020 Joint Commission Reporting Requirements for Hospitals Providing Obstetric Services*

ID/Name	Developer	Description
PC-01 Elective Delivery	Hospital Corporation of America	Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.
PC-02 Cesarean Birth	California Maternal Quality Care Collaborative	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.
PC-05 Exclusive Breast Milk Feeding	California Maternal Quality Care Collaborative	Exclusive breast milk feeding during the newborn's entire hospitalization.
PC-06 Unexpected Complications in Term Newborns	California Maternal Quality Care Collaborative	Unexpected complications among full-term newborns with no preexisting conditions. PC-06.0 Unexpected Complications in Term Newborns - Overall Rate PC-06.1 Unexpected Complications in Term Newborns - Severe Rate PC-06.2 Unexpected Complications in Term Newborns - Moderate Rate

**All hospitals providing obstetrical services are required to report perinatal care (PC) measure PC-01; those with at least 300 live births per year must report on all active PC measures*

Source: The Joint Commission. (2019). Specifications Manual for Joint Commission National Quality Measures (v2020A1). Retrieved from https://manual.jointcommission.org/releases/TJC2020A1/PerinatalCare.html

Finally, state Medicaid agencies and Medicaid MCOs may want to utilize the data from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). The statistics are the nation's official source for vital events data on births, deaths, marriages, divorces, and fetal deaths. Vital statistics data briefs derived from birth and death certificates include information for all births and deaths occurring in the United States. Rates are reported in aggregate without identifiable data by the Federal Government; however, the actual certificate data are maintained at the state level. In generating benchmarks for service outcomes using claims or EMR data, it is reasonable for MCOs to use these NCHS data as a guidepost when measuring quality outcomes; however, given that the source of the data is markedly different, direct comparisons are not appropriate.[§] An overview of key birth certificate data available by state/U.S. territory can be found on this page.

§ "The NCHS revised its policy on the release of and access to vital statistics micro-data effective with the 2005 data year. This revised policy is consistent with CDC and NCHS goals to make data available as widely as possible while protecting respondent confidentiality, assuring data quality, and conforming to state laws and regulations around vital statistics data. Micro-data refers to records for individual cases. Micro-data files released by DVS may include a single record for each birth or death (National Center for Health Statistics, n.d.).
Public use Birth, Period Linked Birth – Infant Death, Birth Cohort Linked Birth – Infant Death, Mortality Multiple Cause, and Fetal Death micro-data files can be downloaded from the NCHS website.
*Researchers who require exact dates or geographic information that is not available in the public-use files or through CDC WONDER may request access to **restricted-use files** from NCHS through the process outlined on the restricted-use vital statistics data page or request access to the data through the NCHS Research Data Center.*

Sample of Birth Certificate Data Available by State/U.S. Territory

General fertility rate: Number of births per 1,000 women ages 15–44.

Teen birth rate: Number of births per 1,000 females ages 15–19.

Vaginal birth after cesarean delivery rate (VBAC): Number of births to women having a vaginal delivery per 100 births to women with a previous cesarean delivery.

Repeat cesarean rate: Number of births to women having a cesarean delivery per 100 births to women with a previous cesarean delivery.

Preterm birth rate: Births delivered prior to 37 completed weeks of gestation per 100 births. Gestational age is based on the obstetric estimate of gestation.

Early-term birth rate: Births delivered at 37–38 completed weeks of gestation per 100 births.

Full-term birth rate: Births delivered at 39–40 completed weeks of gestation per 100 births.

Late- and post-term birth rate: Births delivered at 41 or more completed weeks of gestation per 100 births.

Pregnancy-related deaths: Death while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration, or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Infant mortality rate: Death of an infant before the first birthday, expressed as the number of infant deaths/1,000 live births.

Source: National Center for Health Statistics (n.d.). Data Release Policy for Vital Statistics Micro-Data Files.

Developing the Business Case

An essential component of the decision-making process to adopt emerging healthcare innovation is the business case. As state Medicaid agencies and Medicaid MCOs consider the midwifery-led model of care as a covered benefit, it is important to note that midwives may work in multiple settings under various employment arrangements. Therefore, each novel initiative or program enhancement would require a unique analysis of the new service volume, income, and expense to arrive at the return on investment (ROI) assumption. In addition, the ROI calculation might be unique to the investor, such as state Medicaid agencies, Medicaid health plans, or health systems. For instance, one may wonder, should an MCO make a modest investment in increasing reimbursement for the CNM/CMs services in a state? In doing so, this investment might attract more CNM/CMs and yield a significant reduction in MCO medical expenses for both the mother and newborn. The operational expenses would be minimal (i.e., physical space, supplies, and information technology), but risks for success would predicate on assumptions outside of the MCO's control such as access to education and consumer interest in engaging a midwife. All of these factors would be outlined in the business case. Likewise, a proposal related to expanding a physician practice with the addition of a CNM/CM would include unique factors such as offsetting salary savings of not hiring a higher-cost obstetrician, the difference in practice volume to be generated by the CNM/CM and net income to the practice. Finally, the business case to support the creation or expansion of a freestanding birth center would be more complex with detailed demand assumptions related to the targeted population's clinical needs and preferences, one-time capital requirements, operating expenses, licensure, accreditation and MCO reimbursement.

What is a reasonable ROI?

When we consider the current state of U.S. maternal health outcomes, including increasing preterm birth rates, maternal and infant mortality, and their persistent racial disparities in comparison to other developed nations, it is difficult to accept that the path to adoption of innovative improvements must be derived from a financial model alone. One could also make the argument that improving maternal and infant outcomes in the U.S is the "right thing to do" and, given the time between intervening in prenatal care and at least one year postpartum, investors should not expect a quick turnaround on their investment.

However, investors and Medicaid organizations must continue to balance limited resources with multiple competing priorities. Regardless of the ROI threshold, unless an initiative is self-funded through real-time improvements to medical costs, the state's budget will ultimately be charged for any initiative implemented; this requires a careful balance of costs, savings, health outcomes, and societal impact with other critical initiatives. As all Medicaid leaders consider initiatives designed to improve the overall health and well-being of the population, investing in an integrated system that incorporates skilled midwives could provide the seed to reduce not only short-term expenses associated with unnecessary medical interventions and poor birth outcomes, but also to avoid longer-term, lifelong disabilities and their associated societal impacts.

Business Case Scenarios to Consider

In addition to describing the characteristics that predict success and challenges to implementation, a business case will include a five-year ROI planning horizon, with a detailed cashflow statement showing an ideal net present value income of 3:1 ($3 earned for every $1 spent), breaking even in the first year of operation. With the exception of labor management initiatives that target reductions in cesarean section rates, the approach to investing in maternal outcome improvement innovations, such as the midwifery-led model of care, may require tolerance for investments that show an ROI that grows slowly over a longer time period.

Developing a business case and creating an ROI model for a maternal health initiative is a complex task and requires at least a month of dedicated work by a diverse team of stakeholders, including clinicians, healthcare analysts, and financial experts. It involves nuanced information and data specific to individual Medicaid markets. However, state

Medicaid agencies and Medicaid managed care organizations have an opportunity to leverage their access to data and their understanding of specific markets to identify the potential benefit of implementing a maternal health initiative based on the midwifery-led model of care.

There are multiple potential maternal health improvement opportunities outlined in this report for state Medicaid agencies, Medicaid MCOs, midwives, and other investors to consider. A list of potential midwifery-led model case scenarios for the Medicaid population are provided on this page.

Potential Scenarios for Business Case Development

Should a physician practice hire a CNM?

Should a hospital hire CNMs?

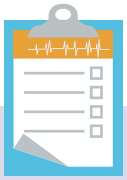
Should a CNM open their own practice?

Should a hospital invest in opening an alongside birth center?

Should the state health department offer independent CNM practice license?

Should a state health department offer birth center license opportunities?

Should a state eliminate “incident to billing?”



Should you invest in opening a freestanding birth center?

Should a birth center expand its services to include Medicaid?

Should a birth center seek accreditation?

Should a state Medicaid agency increase reimbursement for CNMs and/or birth centers?

Should an MCO increase reimbursement for CNMs to 100% of the Medicaid fee schedule for an MD for a similar service?

Should an MCO increase reimbursement to birth centers to 100% of the Medicaid fee schedule for a similar low risk hospital facility delivery?

Should an MCO actively contract with and promote (to members) the freestanding birth center option?

Essential Elements for a Maternal Health Initiative Business Case

As noted earlier, developing a maternal health initiative business case in Medicaid is a complex but achievable task. In an effort to learn from Medicaid MCOs that have successfully contracted with CNMs practicing in hospitals and freestanding birth centers, the Institute for Medicaid Innovation conducted in-depth interviews to glean the lessons learned, challenges, and tips for success. The culmination of information obtained from the interviews resulted in the identification of essential elements for developing a business case specific to the midwifery-led model of care. A checklist for developing a business case that includes these essential elements begins on this page. This resource can also be downloaded as a standalone, editable, pdf document on the Institute for Medicaid Innovation website.

Essential Elements for Developing a Business Case for Midwifery-Led Care

Description of the Initiative	In Place	Actively Planning *(Implementation Target Date)*	Future Priority *(Target Date to Begin Planning)*
Include a description of the initiative and target population.			
Include quantitative analysis of people of childbearing years' population and fertility rates.			
Identify the clinical needs.			
Identify opportunities for improvement.			
Demand Analysis	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Complete a competitive analysis.			
Identify market share trends.			
Identify consumer preferences.			
Marketing	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify opportunities to overcome current role confusion.			
Assess ability to attract patients to the new service.			

Personnel Resource Allocation	In Place	Actively Planning *(Implementation Target Date)*	Future Priority *(Target Date to Begin Planning)*
Include direct care requirements.			
Identify CNM travel time between inpatient and outpatient care settings as well as other non-direct care requirements.			
If applicable, identify the time of nonclinical administrative support and management such as supervising physicians.			
If applicable, identify the proportion of time allocated between the CNM and physician.			
Include vacation coverage.			
Medicaid Market Enrollment Eligibility	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify the estimated covered population for expansion vs. non-expansion states.			
Identify potential coverage for fourth trimester care (i.e., 12 months postpartum).			
Regulatory, Professional Organization, and Community Support	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify the CNM scope of practice in each state that the initiative is being considered.			
Identify the licensing requirements for freestanding births centers in each state that the initiative is being considered.			
Identify Medicaid provider requirements in each state that the initiative is being considered.			
Assess hospital support and admitting privileges for CNMs.			
Assess community alignment and support.			
Assess professional organization alignment and support.			
Payer Mix	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify and compare available reimbursement rates offered by Medicaid, MCO and commercial payers.			
Identify the optimal ratio of Medicaid members to employer-sponsored commercial insurance.			
Identify opportunities to enhance reimbursement through participation in emerging value-based payment models; such as bundled maternity payments.			

Financial Analysis - Implementation and 5-year Projection	In Place	Actively Planning *(Implementation Target Date)*	Future Priority *(Target Date to Begin Planning)*
Income			
Identify volume in units.			
Identify income for each unit.			
Identify other income (e.g., grants and potential for quality-based bonus payments).			
Identify any off-setting savings from medical expenses (e.g., reduction in non-delivery hospital admissions, cesarean section rates, NICU admissions, outpatient visits associated with complications).			
Expenses			
Identify one-time implementation expenses, including: • Capital equipment, IT, marketing, legal, consultation services, etc.			
Salary, including: • Annual hours multiplied by mean range for each position. • Fringe benefits and vacation coverage. • Expected salary increases over the 5-year period.			
Operating expenses, including: • Services - marketing, IT, licenses, legal, and communication. • Supplies - medical and office. • Space - lease and other maintenance.			
Implementation Plan	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify key milestones leading to the launch date.			
Identify expected dates to reach each milestone.			
Identify the goal launch date.			
Identify the tracking measures to assess success.			
Risk Assessment	**In Place**	**Actively Planning** *(Implementation Target Date)*	**Future Priority** *(Target Date to Begin Planning)*
Identify risks to reaching the stated goals.			
Identify plans to mitigate each risk.			

Program Evaluation	In Place	Actively Planning *(Implementation Target Date)*	Future Priority *(Target Date to Begin Planning)*
Identify financial and quality improvement tracking measures to confirm a successful launch.			
Develop plans for publication and dissemination of the results.			

NEED ASSISTANCE?

Would your state Medicaid agency, health plan, or provider group benefit from expert assistance and consultation in developing a maternal health initiative and business case that is based on the midwifery-led model of care? The Institute for Medicaid Innovation offers a range of in-depth, confidential consultation and technical assistance to support your efforts. Please contact Dr. Jennifer Moore at **JMoore@MedicaidInnovation.org.**

ADDITIONAL RESOURCES FOR CREATING A BUSINESS CASE

In addition to the information presented in this section of the report and the checklist resource, state Medicaid agencies and Medicaid MCOs might find the following additional resources useful:

The Advisory Board's Business Planning Template

https://www.advisory.com/research/market-innovation-center/tools/2014/business-innovation-toolkit/business-plan-template

PBGH Midwifery Initiatives Resources

http://www.pbgh.org/midwifery

http://www.pbgh.org/midwifery-resources

Opportunities

This report has outlined the decades-long evidence in support of the midwifery-led model of care and also noted the persistent barriers such as variable and, at times, limiting scope of practice regulations, low Medicaid reimbursement rates for midwifery services, confusing and/or complicated credentialing practices for midwives and freestanding birth centers, and state variation for MCOs operating in multiple states. Opportunities to address these barriers range from legislative (i.e. state-specific mandates) to changes in individual practice (i.e. effective collaborative relationships between physicians and midwives). Eliminating reimbursement rate reductions for midwifery care might encourage expansion and adoption of the model. Also, requiring direct billing for all services provided by the midwife and eliminating "incident to" billing will allow for accurate reimbursement and evaluation of the cost and quality of care delivered by midwives. Bundled payments that include provider and facility fees for freestanding birth centers at sustainable rates might also improve access to birth centers for Medicaid enrollees. To that end, there are a range of potential opportunities to address the barriers and fully incorporate the midwifery-led model of care into the Medicaid program.

Engagement in the State Medicaid RFP and Procurement Process

The state Medicaid agency's Request for Proposal (RFP) process is the basis of future contracts that will be executed between the state and Medicaid managed care organizations. Therefore, it serves as the single most important opportunity to incorporate the midwifery-led model of care into the payment and health care system for the Medicaid population.

In a capitated payment procurement process, state Medicaid agencies determine the actuarial sound premium rates they will pay per enrollee to Medicaid MCOs. Health plans then review the requirements of the contract, including quality thresholds that must be met and the anticipated medical needs (medical spending) of the population to be covered. Considering many variables, including the anticipated cost and premium offered by the state, the MCO will decide whether to reject the opportunity to bid on the state's business or accept the state's proposed premium, move forward with the bidding process, and highlight the competitive and innovative services that the Medicaid MCO will provide to the state, its enrollees, and providers in the RFP response.[101]

With a competitive rate-bidding process, MCOs evaluate the state Medicaid agency's proposal requirements and then put forward a detailed plan to meet the requirements, subsequently telling the state the capitation rate they believe is necessary to cover services they will offer. Typically, an MCO's ability to harness its own operational efficiencies, with a demonstrated history of providing high-quality care and operational services, a well-conceived proposal to reduce the state's Medicaid costs, and innovative solutions to address the state's priorities will fare well in the bidding process.[100]

Contracts are awarded for multi-year segments. However, not long after bids are awarded and the contracting process has ended, states will begin strategic procurement planning for the following bid cycle. Each bidding cycle provides the state with an opportunity to establish or reestablish the state's expectations for quality improvement.

For this reason, subject matter experts in population health management and maternal models of care, both within the state Medicaid agency and those external to the agency, wishing to influence a state's next Medicaid procurement cycle, should always be prepared to consider how they might become engaged in setting the state's priorities. Engaging early in the process while the state is still developing its RFP will provide advocates with the best opportunity to influence the process toward the inclusion of maternal models of care interventions.

The four Medicaid managed care life-cycle phases described in Figure 4 on page 65 highlight the procurement life cycle phases and opportunities for potential collaboration.

Figure 5. Life Cycle of Managed Care Programs and the Contracting Process

Source: ASTHO (2019). Leveraging public health assets in Medicaid managed care. Retrieved from https://www.astho.org/ASTHOReports/Leveraging-Public-Health-Assets-in-Medicaid-Managed-Care/05-29-19/

Once priorities are set, the state's improvement goals are identified and value-based purchasing (VBP) requirements are developed and added to the state's RFP requirements. VBP requirements include monitoring clinical quality performance with defined performance measures and specific performance target expectations, along with consequences or rewards relative to a health plans performance.[101]

Table 4 on page 66 provides speculative examples of RFP goals and measures that might be deployed to influence improvements in birth outcomes and the adoption of maternal models of care.

Table 4. Examples of Opportunity Goals and VBP Measures Associated with a State's Priority to Improve Birth Outcomes

Goal	Measure
Increase access to Certified Nurse Midwife models of care	Critical access standards are met in all active operating regions. MCO credentialed CNMs are reimbursed at 100% of the Medicaid fee schedule. CNMs are listed as an OB provider in the provider directory.
Increase access to Birth Center models of care	MCO has a unique and clearly defined credentialing and contracting process to add licensed and certified Birth Centers to their provider network. Freestanding Birth Centers are listed in the provider directory. Reimbursement is set at 100% of the Medicaid fee schedule for professional and facility services.
Decrease Preterm Birth Rate	MCO demonstrates a consistent year-over-year reduction in the PTBR (real-time claims-based measure).
Increase Postpartum Visit Rates	MCO meets the HEDIS Quality Compass 75th percentile for the Postpartum Care measure: "the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery."
Decreased Low-Risk C-section Rate	Term, singleton baby in a vertex position delivered by cesarean birth.
Early Elective Delivery Rate	Elective vaginal or cesarean births at >= 37 and < 39 weeks of completed gestation without evidence of medical necessity.

Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid.*

Clinical, Research, and Policy Opportunities

Overall, it is important to increase the public, professional, legislative, and community-based organization awareness of the benefits of midwives and freestanding birth centers and their potential impact on improving birth outcomes, health equity, and the cost of health care. Medicaid stakeholders may consider the following clinical, research, and policy opportunities as next steps to reduce those barriers.

Clinical Opportunities

- **Consider creating care team models that increase access to midwifery care for prenatal, intrapartum, postpartum care.**
  Research has shown that the midwifery-led model provides high-value, evidence-based care to improve clinical outcomes and patient experience. Examples of integration models anchored in midwifery care include a) CNM/CMs acting within a team-based approach with a physician group practice, b) a laborist role, or c) as a leader of a birth center.

- **Explore ways to increase professional and public awareness of the benefits of the midwifery-led model of care and increase access for those enrolled in Medicaid.**
  Increasing awareness of the benefits of the midwifery-led model may improve uptake of these high-value, evidence-based models. Examples would include leveraging public reporting of CNM/CM practice settings and clinical outcomes and framing the midwifery model as one that embodies person-centered, relationship-based, and respectful care that honors an individual's needs and preferences.

- **Consider designing a system of maternity care, based on acuity and unique need(s), that drives the right care, at the right place, at the right time, for the right person and allows maternity providers to practice at the top of their training and license.**
  When a pregnancy is determined to be low- or medium-risk, and normal, physiologic birth is desired, midwifery-led care in a hospital or freestanding birth center might be the best option. This approach has the potential to improve birth outcomes and patient satisfaction while also reducing costs.

- **Consider financially sustainable models that link the midwifery-led model to the Medicaid population such as freestanding birth centers within federally qualitifed health centers (FQHCs).**
  Early research indicates that integrating freestanding birth centers within FQHCs might be the most financially sustainable option, especially for birth centers that serve the Medicaid population. This approach has the potential, for women enrolled in Medicaid, to increase their access to the midwifery-led model of care.

Research Opportunities

- **Explore ways to conduct studies that identify the return on investment (ROI) for the midwifery-led model of care in Medicaid.**
  Considering each state's Medicaid program, investigations exploring payment models that support an acceptable ROI for the midwifery-led model of care can inform its implementation by health systems and payers. Analysis should consider both in-hospital and freestanding birth centers as options, in a variety of settings (e.g. rural v. urban).

- **Explore the relationships between state variation in Medicaid policies relative to midwifery practice integration, access, and birth outcomes.**
  Understanding how different Medicaid policies (i.e. Medicaid expansion, maternal health covered benefits, reimbursement) affect midwifery integration, access to care, and birth outcomes, will help identify best practices and challenges. The information will support better understanding of the gaps in care and the approaches that yield positive results.

- **Continue the development of evidence for the midwifery-led model of care in Medicaid.**
  Currently, most research on the value of midwifery-led care does not stratify by payer type, which limits understanding the value of this model for the Medicaid population. All studies on midwifery-led care would benefit from analyzing and reporting the data by payer type. Additionally, analysis should consider both hospital and freestanding birth center settings. Finally, because studies on outcomes of midwives who are not CNMs are limited, this is an area that needs further exploration.

- **Consider investigating individual views of midwifery services and freestanding birth centers, including perceptions, needs, and values derived from receiving such services.**
  It is important to have a qualitative understanding of the perceived value, including acceptability and access to various birth settings, for those who are or would be eligible to receive these services. Understanding the nuances of public perception (i.e. is midwifery care more acceptable when it is associated with a hospitalist model? Are freestanding birth centers perceived by some as providing "lesser" care?) is the first step toward shifting cultural understanding toward greater acceptance of midwifery-led care.

- **Explore the development of public reporting metrics that describe appropriate utilization of the midwifery model, including the percentage of hospital-based, midwife-attended births.**
  Developing metrics that help establish a benchmark and recommended target for the percentage of deliveries that should be attended by midwives in the hospital and freestanding birth centers might help to reduce barriers to implementing midwifery-led care. It could also support public awareness of the value of the midwifery-led model of care.

Policy Opportunities

- **Consider convening a statewide, multidisciplinary, maternity-led model of care commission.** This commission might be established as part of a state's Perinatal Quality Collaborative or Maternal Mortality Review Board. It could potentially be charged with the task of eliminating confusion and barriers to the adoption of the midwifery-led model of care, including freestanding birth center licensure and certification, CNM/CM independent practice, hospital and MCO credentialing, Medicaid reimbursement rates, and facility-level public reporting of birth outcomes.

- **Explore removing barriers to support equitable reimbursement of midwifery services.** States could consider eliminating reimbursement rate reductions for CNM/CMs and equalize reimbursement rates for midwives and physicians for the same services. Equitable reimbursement rates could reduce confusion and improve the sustainability of the evidence-based, midwifery-led model of care including freestanding birth centers.

- **Consider a statewide requirement for direct billing for all services provided by midwives.** States might want to explore ways to improve accurate evaluation of the cost and quality of care delivered by CNM/CMs. One approach might be eliminating "incident to" billing under a physician's NPI number.

- **Explore developing supportive statewide policies that increase access to and support the sustainability of freestanding birth centers that are led by and serve people of color.** As the case studies in this report demonstrate, access to culturally concordant, community-rooted care is an important focus for midwifery-led care, including freestanding birth centers. Creating policies that eliminate systemic barriers for those who seek care and increase educational resources for individuals of color who want careers in midwifery might help to improve maternal health equity.

Appendix A

Glossary

Maternal Mortality

The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.[102]

Maternal mortality ratio is the number of maternal deaths per 100,000 live births.

Pregnancy-Related Mortality

The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.[103]

Pregnancy mortality ratio is the number of pregnancy related deaths per 100,000 live births.

Severe Maternal Morbidity

Unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[104]

Health Equity

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.[105]

Midwife

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy, labor, and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, the promotion of physiologic birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and

preparation for parenthood and may extend to women's health, sexual or reproductive health, and childcare. A midwife may practice in any setting, including the home, community, hospitals, clinics, or health units.[106]

Certified Nurse Midwives (CNMs) are advanced practice nurses with either a university-based master's or doctoral degree. CNMs are trained in education programs that are accredited by the Accreditation Commission for Midwifery Education (ACME).[107]

Certified Midwives graduate from a masters-level midwifery education program that is also accredited by the Accreditation Commission for Midwifery Education (ACME). The training is similar to that of a CNM, but they do not have a nursing degree.[107]

Certified Professional Midwives have varying educational and/or training experiences that might include work as an apprentice.

Physiologic Care

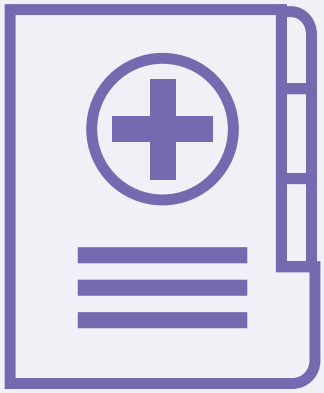
Understanding, facilitating, and avoiding interference with the body's natural birth process.[107]

Low-risk Laboring Individuals/NTSV

Nulliparous (has never given birth) individual with a term (37 weeks 0 days to 41 weeks 6 days) singleton pregnancy fetus in vertex (head down) position; also referred to as NTSV.

Birth Center

Freestanding: A freestanding birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. The birth center is not a hospital but rather, an integrated part of the health care system. It is guided by principles of prevention, sensitivity, safety, appropriate medical intervention, and cost-effectiveness.[108]



Alongside: An Alongside Maternity Center is a midwifery-led, homelike unit that is located within a hospital but is separate from the Labor & Delivery unit. It is designed for use by women who have a low-risk pregnancy and are anticipating a normal labor and birth. Care in an Alongside Maternity Center consists of evidence-based practices that support physiologic labor and birth, and optimal breastfeeding and maternal-newborn attachment.[109]

Structural Quality Measures

Structural measures describe the context in which care is delivered and focus on the capacity of an organization such as the physical facility, human resources, and equipment.

Examples of structural measures include the patient-to-staff ratio or the capacity of a hospital to perform a vaginal birth after cesarean delivery.[110-111]

Glossary

Outcome Quality Measures

Outcome measures are considered the gold standard as they are most directly linked to care provided and are meant to measure changes in health or quality of life.

Examples include changes in health status such as readmission rates, morbidity, or mortality.[110-111]

Process Quality Measures

Process measures are the technical measures of how care is delivered and include measures of steps known to improve health such as immunizations, or screening for certain conditions such as depression or sexually transmitted infections.

Because of the difficulty of measuring the effects of care on health and the rare nature of many of these events, process measures are used as proxies for outcomes measures.[110-111]

Ideally, they are backed by evidence that directly links the process measure with improved or desired outcomes.

Patient Experience Quality Measures

Patient experience encompasses the range of interactions that patients have with the health care system, including their care from health plans and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities.[90-91]

They measure whether something that should happen in a health care setting (such as clear communication with a provider) actually happened or how often it happened, and increasingly are seen by payers and reporting agencies as trusted measures of the quality of care.[110-111]

Patient Satisfaction Quality Measures

Patient satisfaction measures consider whether a patient's expectations about a health encounter were met.[110-111]

Two people who receive the exact same care, but who have different expectations for how that care is supposed to be delivered, can give different satisfaction ratings because of their different expectations.

Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid.*

Appendix B

Overview of CNM, CM, and CPM Education, Credentialing, and Licensure

Title	Education	Degree	Credentialing Organization	Credential	Licensure	Practice Setting(s)
Certified Nurse Midwife	Completion of an accredited program of the Accreditation Commission for Midwifery Education (ACME). Bachelor's degree and licensure as a registered nurse are required for consideration for admission.	Master's degree in nursing (MSN) or doctorate of nursing practice (DNP)	American Midwifery Certification Board	American Midwifery Certification Board	All states provide licensure.[85]	Hospital, Birthing Centers and/or Home
Certified Midwife	Completion of an accredited program of the Accreditation Commission for Midwifery Education (ACME). Bachelor's degree in a related health care field.	Master's Degree	American Midwifery Certification Board.	American Midwifery Certification Board.	Five states authorize practice: DE, MO, NJ, NY, RI.[85]	Hospital, Birth Center, and/ or Home
Certified Professional Midwife	Graduate from an approved midwifery education accreditation council (MEAC) program or school.	Not required.	North American Registry of Midwives (NARM)	Certified Professional Midwife (CPM)	34 states authorize practice by license.[112]	Birth Center and/or Home

Source: Institute for Medicaid Innovation (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid.*

Appendix C

State Regulations of Midwifery Practice & Medicaid Reimbursement

Alabama	
Medicaid State Plan Amendment: Covered Services	No state plan amendments regarding covered services relevant to midwives were located. Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). Medicaid covers nurse midwife services. Code of Ala. § 34-19-11(2)-(3) (2017). Alabama provides that midwifery is the "provision of primary maternity care during the antepartum, intrapartum, and postpartum periods." Code of Ala. § 34-21-81(4)(b) (2001). Alabama defines midwives in the context of advance practice nursing, or the "delivery of health care services by registered nurses who have gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles." "Practice as a certified nurse midwife (CNM) means the performance of nursing skills by a registered nurse who has demonstrated by certification that he or she has advanced knowledge and skills relative to the management of women's health care focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning, and gynecological needs of women, within a health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Nurse Midwives manage the care for normal healthy women and their babies in the areas of prenatal; labor and delivery; postpartum care; well-woman gynecology, including family planning services; and normal newborn care.
Licensing or Credentialing Requirements	**Only CNM services are covered.** Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). Alabama Medicaid "enrolls nurse midwives and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual. *See also* Code of Ala. § 34-19-17 (2017). Alabama requires a midwife to be licensed to practice midwifery unless the individual is a certified nurse midwife, in training under a licensed midwife or assisting the licensed midwife, or if the individual is providing gratuitous assistance at childbirth. Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). Alabama Medicaid requires nurse midwives submit a copy of the current licensure or licensure renewal card, the American Midwifery Certification Board (AMCB) certificate, the Certified Nurse Midwifery Protocol signed by a collaborating physician, and a letter from the hospital granting admitting privileges for deliveries. If the application is approved, Medicaid offers the applicant a one-year renewable contract. "Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service." **Alabama offers a midwifery license, but services are not covered by Medicaid.** Code of Ala. § 34-19-12 (2017). Code of Ala. § 34-19-15(a) (2017). Code of Ala. § 34-19-15(b) (2017). Code of Ala. § 34-19-15(c)-(d) (2017). Code of Ala. § 34-21-90 (1995).
Other Coverage Requirements (site of service, etc.)	Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations. Alabama law provides rules under which properly trained nurses can be licensed to practice Nurse Midwifery. Federal law requires that Medicaid include the services of nurse midwives."

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	Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "The practice of Nurse Midwifery must be performed under appropriate physician supervision." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). Alabama imposes written record requirements, including a plan of care to accomplish the delivery in a licensed hospital (in non-emergency cases) under appropriate physician supervision with a collaborative agreement. Code of Ala. § 34-21-81(5), (11) (2001). Alabama details specific requirements for midwife-physician collaboration. Code of Ala. § 34-21-86 (1995). Alabama permits "certified nurse midwives, engaged in collaborative practice with physicians practicing under protocols approved in the manner prescribed by this article may prescribe legend drugs to their patients, subject to both of the following conditions: (1) The drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating physician; and (2) The drug shall be on the formulary recommended by the joint committee and adopted by the State Board of Medical Examiners and the Board of Nursing." Alabama prohibits certified nursing midwives from initiating a call-in prescription. Code of Ala. § 34-21-93.1(a) (2018). Alabama grants midwives signature authority for physicians in certain circumstances.
Coverage Limitations	Code of Ala. § 34-19-18(b) (2017). Alabama does not permit midwives to practice medicine or prescribe drugs.
Reimbursement Rate	Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for nurse midwife providers." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions."
Reimbursement Methodology	Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nurse midwifery-related claims." "Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "When a nurse midwife provides total obstetrical care, the claim form should reflect the procedure code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "When a nurse midwife provides eight or more prenatal visits, performs the delivery, and provides postpartum care, the midwife uses a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "In order to bill for Antepartum Care Only services, nurse midwife providers must use the appropriate procedure codes when billing for the services. Antepartum Care Only services filed in this manner do not count against the recipient's annual office visit benefit limits. Nurse midwives who provide fewer than four visits for antepartum care must use office visit procedure codes when billing for the services. The office visit procedure codes count against the recipient's annual benefit limits for office visits." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Delivery includes vaginal delivery (with or without episiotomy) and postpartum care or Vaginal Delivery Only services. Do not bill more than one delivery fee for a multiple birth (i.e., twins, triplets). Delivery fees include all professional services related to the hospitalization and delivery services provided by the nurse midwife. Additional claims for the nurse midwife's services in the hospital (e.g., admission) may not be filed. EXCEPTION: When a nurse midwife's first and only encounter with the recipient occurs at delivery ("walk-in" patient), the midwife may bill for a hospital admission (history and physical) in addition to delivery charges."

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	Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "Postpartum care includes office visits following vaginal delivery for routine postpartum care within 60 days after delivery. Additional claims for routine visits during this time should not be filed. Family planning services performed by the delivering provider on the day of the postpartum exam or within five days of the postpartum exam are noncovered as they are included in the postpartum exam. The only exception to this is Extended Contraceptive Counseling visits, which are performed at the same time as the postpartum exam. If the provider does not perform the delivery but does provide the postpartum care, family planning services rendered within five days of the postpartum exam are noncovered, as they are included in the postpartum exam." Ala. Medicaid, Provider Billing Manual, Ch 25 (Oct. 2019). "The nurse midwife may be reimbursed for well-woman gynecological services including the evaluation and management of common medical or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease)."
Notes [managed care, private plans, related services]	Code of Ala. § 34-19-21 (2017). Alabama does not require any health benefit plan, group insurance plan, policy, or contract for health care services to cover midwife services. Alabama also provides: "No health benefit plan subject to the provisions of this chapter shall terminate the services, reduce capitation payment, or otherwise penalize an attending physician, certified nurse midwife, or other health care provider who orders medical care consistent with this chapter. No health benefit plan shall provide, directly or indirectly, any financial incentive or disincentive or grant or deny any special favor or advantage of any kind or nature to any person to encourage or cause early discharge of a hospital patient from postpartum care, excluding capitation or global fee arrangements. Provided nothing contained in this chapter is intended to expand the list or designation of covered providers as specified in any health benefit plan or to modify the scope of practice of a certified nurse midwife as provided by law." Code of Ala. § 27-48-3 (1996).
Alaska	
Medicaid State Plan Amendment: Covered Services	AK-SPA-14-010 (Nov. 3, 2014). Updated the payment fee schedules for—among others—direct entry midwife services and nurse-midwife services. The SPA also stabled rates for midwife services provided in a birthing center. Additionally, CMS required additional information regarding Alaksa's Midwife Birth Center Services, Nurse Midwife Services, and Birthing Centers section of the plan to be included in a new state plan. No follow up state plan was located, but Alaska has since established Midwife Birthing Center Services. Alaska Medicaid, Alaska Provider Billing Manuals (2019). Medicaid, Provider Billing Manual Ch 25 (Oct. 2019). "The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care." Alaska Stat. § 08.65.190(3) (2014). Alaska defines the practice of midwifery as "providing necessary supervision, health care, preventative measures, and education to women during pregnancy, labor, and the postpartum period; conducting deliveries on the midwife's own responsibility; providing immediate postpartum care of the newborn infant, well-baby care for the infant through the age of four weeks, and preventative measures for the infant; identifying physical, social, and emotional needs of the newborn and the woman; arranging for consultation, referral, and continued involvement of the midwife on a collaborative basis when the care required extends beyond the scope of practice of the midwife; providing direct supervision of student and apprentice midwives; and executing emergency measures in the absence of medical assistance, as specified in regulations adopted by the board."
Licensing or Credentialing Requirements	**1) CNM** CNMs are licensed by the Board of Nursing. **2) Direct Entry Midwife** Alaska Stat. § 08.65.050 (1992). Alaska requires the Board of Certified Direct-Entry Midwives to issue a certificate to practice direct-entry midwifery to a person who "(1) applies on a form provided by the

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	board; (2) pays the fees required under AS 08.65.100; (3) furnishes evidence satisfactory to the board that the person has not engaged in conduct that is a ground for imposing disciplinary sanctions under AS 08.65.110; (4) furnishes evidence satisfactory to the board that the person has completed a course of study and supervised clinical experience; the study and experience must be of at least one year's duration; (5) successfully completes the examination required by the board." Alaska Stat. § 08.65.160 (1992). Alaska permits apprentice direct-entry midwives to practice under certain circumstances.
Other Coverage Requirements (site of service, etc.)	**1) CNM** Physician Provider Manual Alaska Medicaid covers services for a normal vaginal delivery performed by an advanced nurse practitioner certified as a nurse midwife. **2) Direct Entry Midwife** Alaska Stat. § 08.65.140 (2016). Alaska required the Board of Certified Direct-Entry Midwives to adopt regulations requiring certified direct-entry midwives to comply with certain examination, informed consent, and blood sampling requirements. *See also* Alaska Stat. § 08.65.140 (2016). Alaska Stat. § 08.65.180 (1992). Alaska stipulates the following responsibilities for care for direct entry midwives: "If a certified direct-entry midwife seeks to consult with or refer a patient to a licensed physician, the responsibility of the physician for the patient does not begin until the patient is physically within the physician's care." Alaska Stat. § 25.20.055(b) (2016). Alaska requires midwives comply with the early acknowledgement of paternity program.
Coverage Limitations	**2) Direct Entry Midwife** Medicaid, Provider Billing Manual Ch 25 (Oct. 2019). "Alaska Medicaid covers direct-entry midwife services related to managing prenatal, intrapartum and postpartum care* and will reimburse only those services which direct-entry midwives are certified under 12 AAC 14 to provide. Direct-entry midwives in training or in apprentice programs do not qualify for reimbursement from the State of Alaska for direct-entry midwife services. A direct-entry midwife preceptor or other supervising individual is prohibited from billing for services performed by a direct-entry midwife apprentice or direct-entry midwife in training. "
Reimbursement Rate	**1) CNM** Fee Schedule, link unavailable. **2) Direct Entry Midwife** Medicaid Alaska Direct Entry Midwives Fee Schedule (2019). All covered services are listed in the Direct-Entry Midwives Fee Schedule.

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Reimbursement Methodology	**1) CNM** Link unavailable. **2) Direct Entry Midwife** Medicaid, Provider Billing Manual Ch 25 (Oct. 2019). "A direct-entry midwife may submit a global, all-inclusive claim for midwife services only if the recipient has third-party health insurance that pays a global rate. If the recipient does not have other insurance, antepartum care must be billed with the appropriate evaluation and management procedure code. [...] A provider who performs only the delivery must bill for vaginal delivery only. If, during the recipient's postpartum period, the provider sees the recipient or provides any postpartum service, whether in the hospital or the office, the provider must bill for vaginal delivery only, including postpartum care. [...] Billing for postpartum care only may be used only once per delivery to report all services provided to the recipient during the postpartum period. This restriction also applies to multiple providers in the same group practice."
Notes [managed care, private plans, related services]	Alaska Stat. § 21.42.355 (2016). Alaska imposes the following insurance coverage requirements for costs of services provided by certified nurse midwives: "(a) If a health care insurance plan or an excepted benefits policy or contract provides indemnity for the cost of services of a physician provided to women during pregnancy, childbirth, and the period after childbirth, indemnity in a reasonable amount shall also be provided for the cost of an advanced practice registered nurse who provides the same services. Indemnity may be provided under this subsection only if the advanced practice registered nurse is practicing as a certified nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice of that certification. (b) If a health care insurance plan or an excepted benefits policy or contract provides for furnishing those services required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth, the contract shall also provide that an advanced practice registered nurse may furnish those same services instead of a physician. Services may be provided under this subsection only if the advanced practice registered nurse is practicing as a certified nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice of that certification."
Arizona	
Medicaid State Plan Amendment: Covered Services	2018-2019 Provider Operations Manual Members may elect to receive labor and delivery services in their home from their maternity provider and may also elect to receive prenatal care, labor and delivery, and postpartum care by certified nurse midwives or licensed midwives. Ariz. Rev. Stat. § 32-1601 "Certified nurse midwife" means a registered nurse who: (a) Is certified by the board. (b) Has completed a nurse midwife education program approved or recognized by the board and educational requirements prescribed by the board by rule. (c) Holds a national certification as a certified nurse midwife from a national certifying body recognized by the board. (d) Has an expanded scope of practice in the provision of health care services for women from adolescence to beyond menopause, including antepartum, intrapartum, postpartum, reproductive, gynecologic and primary care, for normal newborns during the first twenty-eight days of life and for men for the treatment of sexually transmitted diseases. The expanded scope of practice under this subdivision includes: (i) Assessing patients, synthesizing and analyzing data and understanding and applying principles of health care at an advanced level. (ii) Managing the physical and psychosocial health care of patients. (iii) Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health

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	care problem and selecting, implementing and evaluating appropriate treatment. (iv) Making independent decisions in solving complex patient care problems. (v) Diagnosing, performing diagnostic and therapeutic procedures and prescribing, administering and dispensing therapeutic measures, including legend drugs, medical devices and controlled substances, within the scope of the certified nurse midwife practice after meeting requirements established by the board. (vi) Recognizing the limits of the nurse's knowledge and experience by consulting with or referring patients to other appropriate health care professionals if a situation or condition occurs that is beyond the knowledge and experience of the nurse or if the referral will protect the health and welfare of the patient. (vii) Delegating to a medical assistant pursuant to section 32-1456. (viii) Performing additional acts that require education and training as prescribed by the board and that are recognized by the nursing profession as proper to be performed by a certified nurse midwife. See also: R9-16-108. Responsibilities of a Midwife; Scope of Practice.
Licensing or Credentialing Requirements	**1) CNM** Ariz. Rev. Stat. § 36-752 Except as provided below, no person may act as a midwife without being licensed pursuant to this article. The following persons are exempt from the licensure requirements of this section: 2. A registered nurse certified by the state board of nursing as a qualified nurse-midwife. **2) Licensed Midwife** License Application is available here. Ariz. Rev. Stat. § 36-752 Except as provided below, no person may act as a midwife without being licensed pursuant to this article. The following persons are exempt from the licensure requirements of this section: 3. A person acting under the direction and supervision of a physician licensed pursuant to title 32 who is permitted within his scope of practice to deliver infants. 4. A student of midwifery in the course of taking an internship, preceptorship or clinical training program, who is under the direction and supervision of a midwife licensed pursuant to this article. 5. A person who has no prearranged agreement to provide delivery assistance, but who delivers a baby as a result of an emergency situation. 6. A mother or father delivering their own infant.
Other Coverage Requirements (site of service, etc.)	**1) CNM** 2018-2019 Provider Operations Manual For Members receiving maternity services from a certified nurse midwife or a licensed midwife, The Health Plan will assign a Primary Care Provider (PCP) to provide other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the Member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all of their primary care from the assigned PCP. All physicians and certified nurse midwives who perform deliveries are required to have OB hospital privileges or a documented hospital coverage agreement for those practitioners performing deliveries in alternate settings. Physicians, certified nurse practitioners, and certified nurse midwives within the scope of their practice may provide labor and delivery services in the Member's home.

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	2) Licensed Midwife Fee for Service Provider Billing Manual Labor and delivery services provided by licensed midwives generally are provided in the member's home. Licensed midwife services cannot be provided to AHCCCS members in a hospital, free-standing birthing center, or other licensed health care institution. 2018-2019 Provider Operations Manual Licensed midwives perform deliveries only in the Member's home.
Coverage Limitations	**1) CNM** None found, other than within limits of scope of practice. **2) Licensed Midwife** Fee for Service Provider Billing Manual Licensed midwives must obtain prior authorization from AHCCCS CMSU. Documentation certifying risk status of the member's pregnancy must be submitted prior to providing licensed midwife services. Licensed midwife services may be provided only to pregnant AHCCCS members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. 2018-2019 Provider Operations Manual Licensed midwives may not provide any additional medical services as primary care that are not within their scope of practice. Licensed midwife services may only be provided to members for whom an uncomplicated prenatal course and a low-risk labor and delivery is anticipated. The age of the member must be included as a consideration in the risk status evaluation; Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution.
Reimbursement Rate	**1) CNM** Depends on the service/number of visits – see next column. **2) Licensed Midwife** Fee for Service Provider Billing Manual Reimbursement is the lesser of billed charges or the AHCCCS capped fee.
Reimbursement Methodology	Fee for Service or Global. **1) CNM** Fee for Service Provider Billing Manual The AHCCCS global obstetrical (OB) package includes all OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital for delivery. Providers must bill the global OB code if the member is seen five or more times prior to delivery. Physicians, practitioners and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the member has been seen for less than 5 visits prior to delivery. If a CNM refers a member to a non-affiliated physician for on-going OB care, that physician may bill for the visits plus the delivery, unless the requirements for billing the global OB code are met. The CNM

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	who referred the member may bill for the visits that occurred prior to referring the patient to the non-affiliated physician for on-going OB care. The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider. **2) Licensed Midwife** Fee for Service Provider Billing Manual Licensed midwives must bill for delivery using CPT-4 code 59400 - Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Reimbursement is the lesser of billed charges or the AHCCCS capped fee. If complications arise during the pregnancy and the woman must be referred to a physician, the licensed midwife may bill for prenatal care only using CPT code 99212 - Office or other outpatient visit for the evaluation and management of an established patient. Each visit date should be billed on a separate line of the CMS 1500 claim form
Arkansas	
Medicaid State Plan Amendment: Covered Services	Certified Nurse-Midwife Section II 212.000 Nurse-Midwifery means the performance of nursing skills relevant to the management of women's health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning and gynecological needs of women, within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. AR Medicaid Covered Services Page A certified nurse-midwife is trained to deliver babies in a hospital, birthing center or clinic, or in a patient's home, and to care for a woman while she is pregnant and just after she has a baby. Medicaid and ARKids First pay for certified nurse-midwife services. Provider Manual Page Section 103.100, Federally Mandated Services, requires coverage of CNM for all ages. Not Covered: Non-CNM Services Coverage for services provided by lay midwives (non-CNM) are not included on the list of covered providers for Arkansas Medicaid. Provider Manual Page The scope of services permitted for a CNM depends on the area of practice (e.g., home health, routine service, etc.).
Licensing or Credentialing Requirements	**Only services by CNM are covered.** A.C.A. § 17-87-302 To qualify as a CNM, an applicant shall: Hold current certification by a national certifying body recognized by the board in the advanced practice registered nurse role and population foci appropriate to educational preparation; and Have an agreement with a consulting physician if providing intrapartum care. A.C.A. § 17-85-105 It is unlawful for any person not licensed as a lay midwife by the Board, excluding licensed nurse midwives and physicians licensed by the State Medical Board, to: (1) Receive compensation for attending birth as a lay midwife; or

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	(2) Indicate by any means that the person is licensed to practice lay midwifery in Arkansas. The law does not prohibit the attendance at birth of the mother's choice of family, friends, or other uncompensated labor support attendants. **Note:** While Arkansas does issue a state license for lay midwifes (e.g., non-nurse), it does not appear that Medicaid covers services provided by lay midwives. A.C.A. § 17-85-102 The state board of health has the authority to license lay midwives. A.C.A. § 17-85-103 A lay midwife is any person other than a physician, a nurse midwife, or a licensed nurse practicing within the scope of the Arkansas Nurse Practice Act, § 17-87-101 et seq. who performs for compensation those skills relevant to the management of women in the antepartum, intrapartum, and postpartum period of the maternity cycle.
Other Coverage Requirements (site of service, etc.)	Certified Nurse-Midwife Section II 213.600 Beneficiaries 21 and older are limited to 12 visits per state fiscal year (July 1 through June 30) for services provided by a CNM, physician's services, rural health clinic services, medical services furnished by a dentist, office medical services by an optometrist, services provided by an advanced nurse practitioner, or a combination.
Coverage Limitations	Certified Nurse-Midwife Section II 213.700-215.322 Specific procedures (i.e. fetal monitoring, fetal non-stress test, external fetal monitoring, fetal echography etc.) have specific coverage limitations Certified Nurse-Midwife Section II 202.000 CNMs providing intrapartum care must have a consulting agreement with a Medicaid-enrolled physician and must furnish the name of the consulting physician with the provider application and the Medicaid contract. 1. The consulting physician must be available within 30 minutes of the hospital admitting the CNM's laboring patients or within 30 minutes of the alternative birth site if the patient is not transported to the hospital. 2. A licensed CNM will not be deemed an agent or employee of the physician solely on the basis of a collaborative or consulting physician agreement and will be enrolled as an independent provider with the Arkansas Medicaid Program in the category of CNM Certified Nurse-Midwife Section II 272.462 A CNM with prescriptive authority may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules. For patients with joint Medicare/Medicaid coverage, services that are denied by Medicare for lack of medical necessity are not payable by Medicaid.
Reimbursement Rate	Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located here under the provider manual section. The fees represent the fee-for-service reimbursement methodology. Certified Nurse-Midwife Section II 251.010

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Reimbursement Methodology	FFS Certified Nurse-Midwife Section II 251.000 Licensed CNMs may be reimbursed for their services to Medicaid beneficiaries. Services may be provided in a variety of settings, including an office, a birthing center or clinic, a beneficiary's home or a hospital. Certified Nurse-Midwife Section II 212.000
Notes [managed care, private plans, related services]	Co-pay of $10. Provider Manual Page
California	
Medicaid State Plan Amendment: Covered Services	CA-15-018 Incorporates changes to state law from AB 1308 (Bonilla, 2013) which removes the physician supervision requirement for licensed midwives and allows licensed midwives to bill independently for services provided within the scope of their license, including those provided in Alternative Birth Centers as birth attendants. See also the 2015 All Plan Letter (APL; issued before the approval of the SPA above).
Licensing or Credentialing Requirements	**1) Certified Nurse Midwives** Licensed as a registered nurse and certified as a nurse midwife by the California Board of Registered Nursing (APL). **2) Licensed Midwife (LM)** Licenses to practice midwifery are issued by the Medical Board of California. **Note** that services rendered by a Certified Nurse Midwife are covered as services rendered by a non-physician medical practitioner. (Medi-Cal Manual). Licensed Midwives use the same application (the Non-Physician Medical Practitioner and Licensed Midwife Application) to enroll in Medi-Cal. There are two distinct options to enroll as either a CNM or as an LM on the application.
Coverage Limitations	Medi-Cal Manual Any primary care services provided outside the scope of midwife services must be performed under the general supervision of a physician. Update: In September of 2020 Governor Newsom signed SB1237 into law, removing "physician supervision" from California's Certified Nurse Midwives. Midwifery Education Program: CCR Title 16 Article 5 Chapter 4 Section 1379.30 Describes the midwife practice. **LM** Medi-Cal Manual LMs may not prescribe contraceptive medications and/or prescription drugs; insert intrauterine contraceptive devices; insert subdermal contraceptive implants or prescribe contraceptive hormonal patches.

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Reimbursement Rate	Not available
Reimbursement Methodology	Fee-for-service. Medi-Cal Manual LMs can bill for services only within their scope of practice as non-physician licensed practitioners with established protocols, procedures, and treatments authorized by law. LMs are permitted to bill directly for services rendered, excluding Comprehensive Perinatal Services Program services where LMs can only be employed as contract service providers.
Notes [managed care, private plans, related services]	Licensed or otherwise state-approved Alternative Birth Centers exist in CA – must be a certified NM or a licensed MW in the state.
Colorado	
Medicaid State Plan Amendment: Covered Services	**Certified Nurse-Midwives ("CNMs")** CO-10-002: Earliest SPA in the database grants approval to reimburse for "[s]ervices provided by non-physician practitioners consisting of certified nurse midwives . . ." CO-13-044: This SPA adds Licensed Freestanding Birth Centers and identifies certified nurse midwives as approved for providing services in freestanding birth centers. CO-10-027: Earliest SPA in database grants approval to revise the methods and standards for establishing payment rates for extended services for pregnant women (Prenatal Plus Program). Certified-nurse midwives are approved providers are under this program (*see* 10 CCR 2505-10, 8.748.4). **Note:** No SPAs denote coverage of **"direct entry" midwives.**
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** **1) CNMs** • The State Board of Nursing licenses CNMs as advanced practice registered nurses ("APRNs") in Colorado • Completion of an "appropriate graduate degree as determined by the board" • Obtain national certification from a nationally recognized accrediting agency for nurse midwives (*See* Nurse Practice Act (C.R.S. 12-38-103(10)) **2) Direct-Entry Midwives** • Register with the Division of Professions and Occupations of the CO Department of Regulatory Agencies • Graduate from a midwifery program accredited by the Midwifery Education Accreditation Council ("MEAC") • Obtain credentialing as a Certified Professional Midwife ("CPM"), in good standing, as established by the North American Registry of Midwives ("NARM"). Direct-Entry Midwives Practice Act, C.R.S. 12-37-103).

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Other Coverage Requirements (site of service, etc.)	**CNMs** • Required to utilize Place of Service ("POS") Codes for obstetrical care claims; Health First Colorado (CO Medicaid program) accepts 36 CMS POS codes (*see* Obstetrical & Reproductive Health Care Provider Manual, p. 20). • Health First Colorado ordering or referring physicians or other professionals providing services be enrolled as providers. **Note:** Services provided by "Direct-Entry Midwives" do not appear to be covered under Health First Colorado.
Coverage Limitations	**CNMs** • "Health First Colorado eligible pregnant women have continuous eligibility . . . throughout her pregnancy and until the end of the month in which the 60th day following the end of her pregnancy occurs . . . the infant has continuous eligibility until his or her first birthday." • "Within the definitions of the Nurse Practice Act, services do not require physician order or on-premise physician supervision" (*See* Health First Colorado: General Provider Information Manual) **Note:** A licensed CNM cannot also be registered as a direct-entry midwife (*See* Direct-Entry Midwives Practice Act, C.R.S. 12-37-101(b)(I)).
Reimbursement Rate	**CNMs** "Services provided by non-physician practitioners consisting of certified nurse midwives . . . shall be reimbursed by the lower of the following: 1. Submitted charges or 2. Fee schedule as determined by the Department of Health Care Policy and Financing" (*See* 10 CCR 2505-10 8.200.8.C; *see also* CO State Plan, Attachment 4.19-B: Methods and Standards for Establishing Payment Rates, 6.d).
Reimbursement Methodology	**CNMs** Fee-for-Service • CNMs receive direct reimbursement • CNMs may be reimbursed as "supervisors of lesser licensed practitioners" (*See* Health First Colorado: General Provider Information Manual)
Notes [managed care, private plans, related services]	APRN-CNM Practice Scope: "includes prescribing medications" as authorized and "the practice of professional nursing," which is defined in the Colorado Nurse Practice Act (C.R.S. 12-38-103(10)). Direct-entry midwifery means "the advising, attending, or assisting of a woman during pregnancy, labor and natural childbirth at home, and during the postpartum period in accordance with this article [six weeks after birth]." Direct-Entry Midwives Practice Act, C.R.S. 12-37-102). These practitioners are very limited in the scope of services they can provide (C.R.S. 12-37-105). Colorado Managed Care Organizations ("MCOs") members are "entitled to the same Health First Colorado benefits as members who are not enrolled in managed care." While MCOs provide most of these benefits, those not available through MCOs are "provided through Fee-for-Service reimbursement." Health First Colorado Managed Care Programs

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Connecticut	
Medicaid State Plan Amendment: Covered Services	CT-SPA-11-018 (June 21, 2012. Amended the nurse-midwife fee schedule to add an obstetrical fee for delivery after previous cesarean delivery services for specified procedure codes and aligned the obstetrical reimbursement for all vaginal and cesarean deliveries to 1505 of Medicare. CT-SPA-14-102 (Apr. 26, 2017). Increased increases fees for injectable codes to allow mid-level practitioners, including certified nurse-midwives, to be paid 100% of the applicable physician rates for injectable codes (J codes and certain A, S, and Q codes). Conn. Gen. Stat. § 20-86a (2016). Connecticut provides the following definitions relevant to midwives: "(1) "Nurse-midwifery" means the management of women's health care needs, focusing particularly on family planning and gynecological needs of women, pregnancy, childbirth, the postpartum period and the care of newborns, occurring within a health care team and in collaboration with qualified obstetrician-gynecologists. Conn. Gen. Stat. § 20-86b (2016). Connecticut generally provides the following scope of practice provisions for midwives: "Nurse-midwives shall practice within a health care system and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. Nurse-midwifery care shall be consistent with the standards of care established by the Accreditation Commission for Midwifery Education. Each nurse-midwife shall provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the midwife's scope of practice. Each nurse-midwife shall sign the birth certificate of each infant delivered by the nurse-midwife. If an infant is born alive and then dies within the twenty-four-hour period after birth, the nurse-midwife may make the actual determination and pronouncement of death provided: (1) The death is an anticipated death; (2) the nurse-midwife attests to such pronouncement on the certificate of death; and (3) the nurse-midwife or a physician licensed pursuant to chapter 370 certifies the certificate of death not later than twenty-four hours after such pronouncement. In a case of fetal death, as described in section 7-60, the nurse-midwife who delivered the fetus may make the actual determination of fetal death and certify the date of delivery and that the fetus was born dead."
Licensing or Credentialing Requirements	**Only CNM services are covered.** Conn. Gen. Stat. § 20-86a (2016). (2) "Nurse-midwife" means a person who has demonstrated competence to practice nurse-midwifery through successful completion of an educational program accredited by the Accreditation Commission for Midwifery Education and who is certified by the American Midwifery Certification Board, and is licensed under the provisions of this chapter." Conn. Gen. Stat. § 20-86e (1989). Connecticut specifies nurse-midwives licensed under the Midwifery chapter shall be known as a "licensed nurse-midwife." Conn. Gen. Stat. § 20-86c (2016). Connecticut specifies additional fee and licensure requirements Conn. Gen. Stat. § 20-86i (2016). Connecticut temporarily exempts graduates of nurse midwifery programs meeting specific circumstances from licensing requirements.
Other Coverage Requirements (site of service, etc.)	Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). "In order to enroll in the Medical Assistance Program and receive payment from the department, a nurse-midwife shall: (a) meet all applicable licensing, accreditation, and certification requirements; (b) meet and maintain all departmental enrollment requirements; and (c) have a valid provider agreement

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	on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program." Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). Connecticut Medicaid covers the following: "the professional services of a licensed and certified nurse-midwife which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history. (a) The department shall pay for the following: (1) services provided in the provider's office, client's home, hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or -operated institution, or home for the aged; (2) family planning services as described in the Regulations of Connecticut State Agencies; and (3) HealthTrack Services and HealthTrack Special Services. (b) Limitations on covered services shall be as follows: (1) services concerned with the care and management of the care of essentially normal mothers and newborns, only throughout the maternity cycle, and well-woman gynecological care, including family planning services; and (2) services covered shall be limited to these listed in the department's applicable fee schedule." Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). Connecticut Medicaid requires prior authorizations in certain circumstances.
Coverage Limitations	Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). Connecticut Medicaid does not cover the following services: "(a) nurse-midwifery services to newborns occurring beyond the maternity cycle; (b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge; (c) information or services provided to a client by a provider over the telephone; (d) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined; and (e) cancelled office visits and appointments not kept." Conn. Gen. Stat. § 20-101c (1999). Connecticut provides the following prescribing provisions for midwives: "A nurse-midwife licensed under chapter 377, in good faith and in the course of the nurse-midwife's professional practice only, may prescribe, dispense, and administer controlled substances in schedules II, III, IV and V, or may cause the same to be administered by a registered nurse or licensed practical nurse under the nurse-midwife's direction and supervision, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws." See also Conn. Gen. Stat. § 20-14c(3).
Reimbursement Rate	Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). Sec. 17b-262-583 Payment Rate (a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes. (b) Payment rates shall be the same for in-state and out-of- state providers. (c) Nurse-midwifery rates for each procedure shall be set at 90% of the department's fee for physician procedure codes. Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). "The department shall pay for medically necessary and appropriate nurse-midwifery services for Medical Assistance Program eligible clients: (a) requiring care during an essentially normal maternity cycle or requiring well-woman gynecological care; (b) of child-bearing age who indicate a need for family planning services and are free from coercion or mental pressure and are free to choose the method of family planning to be used; (c) provided by a licensed and certified nurse-midwife within the scope of the nurse-midwife's practice; and if the services are made part of the client's medical record."

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Reimbursement Methodology	Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). Connecticut Medicaid imposes a number of billing procedures specific to midwives, including: (d) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day. (e) The following routine laboratory tests shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination, and urine glucose. Payment for these tests is included in the fee for a routine workup. (f) Laboratory services performed in the nurse-midwife's office are payable to the nurse-midwife. Nurse-midwife's shall bill for these services as separate line items. When a nurse-midwife refers a client to a private laboratory for services, the laboratory shall bill directly. No laboratory charge shall then be paid to the nurse-midwife. . . . (h) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care and routine care for the same child." Connecticut InterChange MMIS Provider Manual, Ch. 7 – Nurse Practitioner/Midwife (Jan. 1, 2008). The Connecticut Medicaid provider billing manual provides the following payment procedures specific to midwives: "Sec. 17b-262-582 Payment shall be made at the lowest of: (a) the provider's usual and customary charge to the general public; (b) the lowest Medicare rate; (c)the amount in the applicable fee schedule as published by the department; (d) the amount billed by the provider; or (e) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity." Sec. 17b-262-584 Describes the Numerous Payment Limitations
Notes [managed care, private plans, related services]	Conn. Gen. Stat. § 38a-499(b) (2019). Connecticut includes the following individual health insurance policy provisions relevant to midwives: "Each individual health insurance policy providing coverage of the type specified in subdivisions [of Individual Health Insurance Coverage] delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the services of [...] certified nurse-midwives [...]." Conn. Gen. Stat. § 38a-526(b) (2011). Connecticut includes the following group health insurance policy provisions relevant to midwives: "Each group health insurance policy providing coverage of the type specified in subdivisions [of the Group Health Insurance provisions] delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the services of [...] certified nurse-midwives [...]."
Delaware	
Medicaid State Plan Amendment: Covered Services	DE-17-00 (Apr. 1, 2017). Covers certified nurse midwives. Also lists certified nurse midwives, lay midwives, certified professional midwives, and other types of licensed midwives as able to deliver care within respective scopes of practice **at freestanding birth centers**. 24 Del. C. § 1799FF(9) (2016). Delaware defines "midwifery" as "the practice of providing supervision,

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	care, and advice to a client during prepartum, pregnancy, labor, and the postpartum periods, and conducting deliveries on the midwife's own responsibility or in collaboration with a licensed physician, or licensed Delaware health-care delivery system. The licensed practice of midwifery includes taking certain safety measures and identifying the physical, social and emotional needs of the client.
Licensing or Credentialing Requirements	24 Del. C. § 1799FF(9) (2016). The practice of midwifery requires that level of education, experience, knowledge, and skill ordinarily expected of an individual who meets the requirements for licensure pursuant to this chapter. In order to practice midwifery in the State, a midwife must be licensed pursuant to this chapter." The statutes distinguishes that "'midwifery' does not include the practice of certified nurse midwives." **1) CNMs** 24 Del. C. § 1799FF(2)-(3) (2016). Delaware provides the following definitions and licensing requirements for a certified professional midwife: "a practitioner who has received certification by the North American Registry of Midwives (NARM) or its equivalent or successor." 24 Del. C. § 1799II (2016). Delaware requires a certified professional midwife to be licensed by the Board and meet certain requirements including possessing a valid CPM credential or other valid credential, among other requirements. 24 Del. C. § 1799II(c) (2016). Delaware waives some midwife licensure requirements based on the Midwifery Education and Accreditation Council's findings in certain circumstances. **2) Certified Midwives** 24 Del. C. § 1799FF(2)-(3) (2016). Delaware provides the following definitions and licensing requirements for certified midwives: "a practitioner who has received certification by the American Midwifery Certification Board or its equivalent or successor."
Other Coverage Requirements (site of service, etc.)	16 Del. C. § 804 (2019)**.** Delaware imposes reporting requirements for the inflammation of eyes of newborns for midwives and other providers. 24 Del. C. § 1799JJ (2015). Delaware imposes client screening requirements for homebirth delivery services. 24 Del. C. § 1799LL (2015). Delaware imposes specific requirements when a midwife treats or examines minors. 24 Del. C. § 1799MM (2015). Delaware imposes recordkeeping requirements on midwives that discontinue practice or move states.
Coverage Limitations	None identified beyond those described above.
Reimbursement Rate	**1) CNMs** Fee Schedule Nurse midwives have the same fee schedule as nurse practitioners. **2) Freestanding Birth Centers** Reimbursement of freestanding birthing centers is based on a fee-for-service basis. The payment for freestanding birthing center services is limited to the lower of the billed or allowed amount. Established procedure code and revenue code rates govern the birthing center payments. The Medicaid procedure codes are set at a percentage of the Medicare rates for HCPC and CPT codes and a percentage of Medicare rates for lab and x-ray codes. The HCPC and CPT code fee schedules are available on the Delaware Medical Assistance Program (DMAP) website, at: http://www.dmap.state.de.us/home/index.html.

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Reimbursement Methodology	18 Del. C. § 3336 (2016). Delaware enacted the following midwife services reimbursement provisions: "(c)This section shall apply to all private and public programs for health services and facilities reimbursement, including but not limited to any such reimbursement programs operated by the State. (d) Whenever an insurance policy, contract or certificate or health services reimbursement program provides for reimbursement for any health-care service which is within those areas of practice for which a midwife may be licensed pursuant to § 122 of Title 16 or pursuant to statute in the state where the service is delivered, or for the cost of birthing facilities, the insured or any other person covered by the policy, contract or certificate, or health services or facilities reimbursement program shall be entitled to reimbursement for such service or use of the facilities performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. Whenever such service is performed by a licensed certified nurse midwife and reimbursed by a professional health services plan corporation, the licensed certified nurse midwife shall be granted such rights of participation, plan admission and registration as may be granted by the professional health services plan corporation, to a physician or osteopath performing such a service. When payment is made for health-care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the services performed by the licensed certified nurse midwife."
Notes [managed care, private plans, related services]	18 Del. C. § 3336 (2016). Delaware enacted the following provisions also applicable to private health insurance policies: "Whenever an insurance policy, contract or certificate or health services reimbursement program provides for reimbursement for any health-care service which is within those areas of practice for which a midwife may be licensed pursuant to § 122 of Title 16 or pursuant to statute in the state where the service is delivered, or for the cost of birthing facilities, the insured or any other person covered by the policy, contract or certificate, or health services or facilities reimbursement program shall be entitled to reimbursement for such service or use of the facilities performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. Whenever such service is performed by a licensed certified nurse midwife and reimbursed by a professional health services plan corporation, the licensed certified nurse midwife shall be granted such rights of participation, plan admission and registration as may be granted by the professional health services plan corporation, to a physician or osteopath performing such a service. When payment is made for health-care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the services performed by the licensed certified nurse midwife."
Florida	
Medicaid State Plan Amendment: Covered Services	Fla. Medicaid's Covered Services and HCBS Waivers, Birth Center and Midwife Services. Medicaid reimburses licensed birth centers and midwives that provide obstetrical services for pregnant women with **low-medical risk pregnancie**s. This service is one of the minimum covered services for all Managed Medical Assistance plans serving Medicaid enrollees.
Licensing or Credentialing Requirements	**A person may practice midwifery in Florida so long as they are either licensed as a CNM or as a midwife.** **1) CNMs** Fla. Stat. 467.003: "Certified nurse midwife" means a person who is licensed as an advanced practice registered nurse under part I of chapter 464 and who is certified to practice midwifery by the American College of Nurse Midwives.

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	"Midwife" means any person not less than 21 years of age, other than a licensed physician or certified nurse midwife, who is licensed under this chapter to supervise the birth of a child. **2) Licensed Midwives** Fla. Stat. 467.006: (1) Any person who seeks to practice midwifery in this state must be at least 21 years of age and must be licensed pursuant to s. 464.012 [licensure of an advanced practice registered nurse] or this chapter. (2) A midwife who on October 1, 1992, holds a valid license to practice midwifery in this state may continue to practice midwifery pursuant to the provisions of this chapter except for the provisions relating to collaborative care and to administration of medicinal drugs in s. 467.015(2) and (3). Upon successful completion of additional training requirements, as determined by the council and department, the midwife may practice midwifery in accordance with all provisions of this chapter.
Other Coverage Requirements (site of service, etc.)	Fla. Medicaid's Covered Services and HCBS Waivers, Birth Center and Midwife Services. All Medicaid recipients who meet the **following criteria** may receive birth center and midwife services: Pregnant women whose pregnancies are determined to be **low medical risk.** Fla. Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook Florida Medicaid reimburses **birth centers** for providing Medicaid-covered services appropriate to the care of Medicaid recipients including low-risk pregnancies, antepartum, deliveries, and the postpartum period. Florida Medicaid reimburses **licensed midwives** for providing Medicaid-covered services appropriate to the care of Medicaid recipients including low-risk pregnancies, antepartum, deliveries, and the post-partum period. During the period of presumptive eligibility, Medicaid will reimburse for services provided in the birth center or home prior to delivery. Medicaid does not reimburse inpatient hospital services for presumptively eligible pregnant women. **Medicaid will reimburse practitioners including licensed midwives, licensed physicians, and certified nurse midwives separately** for professional services provided in a licensed birth center or in the recipient's place of residence. **Certified nurse midwives and physicians must follow the requirements in the Florida Medicaid Practitioner Services Coverage and Limitations Handbook.** Medicaid will not reimburse the birth center and the treating practitioner for the same service provided to the same recipient on the same date, as this would constitute duplicate payment. Fla. Stat. 467.017 (1) Every licensed midwife shall develop a written plan for the appropriate delivery of emergency care. A copy of the plan shall accompany any application for license issuance or renewal. The plan shall address the following: (a) Consultation with other health care providers. (b) Emergency transfer. (c) Access to neonatal intensive care units and obstetrical units or other patient care areas.
Coverage Limitations	Fla. Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook. Medicaid **does not reimburse family planning services provided by licensed midwives**. Fla. Stat. 467.015 (1) A midwife shall accept and provide care for **only those mothers who are expected to have a normal pregnancy, labor, and delivery** and shall ensure that the following conditions are met: (a) The patient has signed an informed consent form approved by the department pursuant to s. 467.016. (b) If the patient is delivering at home, the home is safe and hygienic and meets standards set forth by the department. (2) A midwife may provide collaborative prenatal and postpartal care to pregnant women not at low risk in their pregnancy, labor, and delivery, **within a written protocol of a physician currently**

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	licensed under chapter 458 or chapter 459, which physician shall maintain supervision for directing the specific course of medical treatment. The department shall by rule develop guidelines for the identification of high-risk pregnancies. (3) A midwife licensed under this chapter **may administer** prophylactic ophthalmic medication, oxygen, postpartum oxytocin, vitamin K, rho immune globulin (human), and local anesthetic pursuant to a prescription issued by a practitioner licensed under chapter 458 or chapter 459, and **may administer such other medicinal drugs as prescribed by such practitioner.** (4) The care of mothers and infants throughout the prenatal, intrapartal, and postpartal periods shall be in conformity with rules adopted by the department pursuant to this chapter and the public health laws of this state. (5) **The midwife shall**: (a) Prepare a written plan of action with the family to ensure continuity of medical care throughout labor and delivery and to provide for immediate medical care if an emergency arises. The family should have specific plans for medical care throughout the prenatal, intrapartal, and postpartal periods. (b) Instruct the patient and family regarding the preparation of the environment and ensure availability of equipment and supplies needed for delivery and infant care, if a home birth is planned. (c) Instruct the patient in the hygiene of pregnancy and nutrition as it relates to prenatal care. (d) Maintain equipment and supplies in conformity with the rules adopted pursuant to this chapter.
Reimbursement Rate	Fee Schedule-based **1) CNM** Advanced Registered Nurse Practitioner FFS schedule **2) Licensed Midwife** Licensed midwife services FFS schedule
Reimbursement Methodology	Fla. Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook. A Medicaid enrolled **licensed midwife** may be employed by or under contract with a birth center and will be **reimbursed by Medicaid directly** according to the Licensed Midwife Fee Schedule. In accordance with Title 42, Code of Federal Regulations, section 447.10(g), the practitioner's fee may be reimbursed by Medicaid to the center on behalf of the practitioner, if the center requires that as a condition of the contract or employment. Medicaid licensed midwife covered services are limited to procedures listed on the Licensed Midwife Fee Schedule. Medicaid will reimburse the birth center a facility fee for deliveries provided within the birth center. The facility fee is intended to reimburse the birth center for costs related to equipment, staff, and general operational expenses incurred during a birth center delivery.
Notes [managed care, private plans, related services]	Fla. Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook. For **home births**, the licensed midwife in attendance is responsible for the coordination and referral of the newborn to an authorized conductor of newborn hearing screenings. The licensed midwife must refer the baby for an appointment within 30 days after the birth. When a home birth is not attended by the licensed midwife, the licensed midwife must refer the baby for a hearing screening within the first three months after the baby's birth.
Georgia	
Medicaid State Plan Amendment: Covered Services	In a state plan amendment approved by CMS on December 20, 2018 (GA 16-0010), certified nurse midwives ("CNMs") are deemed eligible for supplemental payments if provided "at a physician practice affiliated with a governmental teaching hospital enrolled in Georgia Medicaid." This amendment expands the physician upper payment limit ("UPL") to include CNMs.

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Licensing or Credentialing Requirements	**Only services by CNMs are covered.** The Georgia Board of Nursing requires **certified nurse-midwives** to obtain an authorization in order to practice in Georgia. Requirements for authorization: • Submit a completed written application and fee; • Current RN license from GA • Certified by recognized national certifying body • Graduated from accredited APRN program See also O.C.G.A. § 43-26-3(1), (1.1). "No person shall practice midwifery . . . unless that person has a current certification from the Georgia Board of Nursing to practice as a Certified Nurse-Midwife" Ga. Admin. R. 511-5-1-.02 *See also* O.C.G.A. 31-26-2.
Other Coverage Requirements (site of service, etc.)	Georgia Medicaid Nurse Midwifery Services Provider Manual, Sec. 601.2 "The nurse-midwife must be immediately available on the site at the time the services are delivered" "Services performed by **non-enrolled nurse-midwives in a group practice** are not covered" "A nurse-midwife covering for another will not be construed as a violation of this section when the covering nurse-midwife is on call and provides emergency or unscheduled services for a period of time not to exceed fourteen continuous days. The covering nurse-midwife must also be a Georgia Medicaid enrolled nurse-midwife."
Coverage Limitations	Ga. Admin. R. 511-5-1-.02 Practice by direct entry midwives is *unlawful* • Required certification authorized by the state of Georgia is only available to CNMs O.C.G.A. 43-34-25(b) "A physician may delegate to an advanced practice registered nurse in accordance with a *nurse protocol agreement* the authority to order drugs, medical devices, medical treatments, diagnostic studies, or, in life-threatening situations, radiographic imaging tests." Georgia Medicaid Nurse Midwifery Services Provider Manual **Non-covered midwifery services** include: (1) assisting physicians during delivery (905.2), (2) Diagnostic ultra-sound in obstetrical care (905.4), and (3) several enumerate procedures under 905.7
Reimbursement Rate	GA State Plan: Provider Reimbursement, Attachment 4.19-B, p. 6.1 Georgia Medicaid covers and reimburses for "services rendered by providers administering prenatal labor and delivery or postpartum care ***in freestanding birth care centers*** such as . . . nurse midwives." Georgia Medicaid Nurse Midwifery Services Provider Manual, Sec. 1001 "The Division [of Georgia Medicaid] will pay the lower of the nurse midwife's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, the lowest price charged to other third party payers, or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered."

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Reimbursement Methodology	Fee for Service Georgia Medicaid Family Planning Services Provider Manual, 901.5 [M]idwives . . . will be reimbursed for the insertion and removal of intrauterine devices only after their training requirements have been completed . . . *Providers should use the codes below* when billing for this service"
Hawaii	
Medicaid State Plan Amendment: Covered Services	HI-SPA-08-007. Allows PPS reimbursement of nurse midwives in federally qualified health centers and rural health centers. Hawaii Dep't of Human Servs. Provider Manual, ch. 21 (Mar. 2016). Hawaii's Medicaid program states "maternity services are to be provided by licensed physicians and/or Certified Nurse Midwives": "Pregnancy and Delivery are covered as a global service that includes ante-partum visits meeting the periodicity and standards currently recommended by the American College of Obstetricians and Gynecologists (ACOG), delivery (either vaginal or Cesarean section),postpartum care, and treatment of routine gynecological conditions. Health education concerning such topics as fetal development, nutrition, prenatal vitamins, exercise, smoking and substance abuse, family violence, breastfeeding, choosing a pediatrician, labor and delivery and screening for conditions which could make a pregnancy "high risk" are important components of ante-partum care and not separately reimbursable." H.B. 2184, 29th Leg., Gen. Sess. (Haw. 2018) (to be codified at HRS § __-(1)-(2) (2019). Hawaii's new midwife provisions define terms relevant to midwives and made the following legislative findings: "The legislature finds that: (1) Midwives offer maternity and newborn care from the antepartum period through the intrapartum period to the postpartum period
Licensing or Credentialing Requirements	**Only CNM services are covered** Hawaii Dep't of Human Servs. Provider Manual, ch. 21 (Mar. 2016),; HRS § 346-53.64(a). In Hawaii's Medicaid program, certified nurse midwives may provide PPS eligible services when licensed and a resident of Hawaii for services furnished in a federally qualified health center or rural health clinic that are: "(1) Within the legal authority of a federally qualified health center to deliver, as defined in section 1905 of the Social Security Act; (2) Actually provided by the federally qualified health center, either directly or under arrangements; (3) Covered benefits under the Medicaid program, as defined in section 4231 of the State Medicaid Manual and the Hawaii Medicaid state plan; (4) Provided to a recipient eligible for Medicaid benefits; (5) Delivered exclusively by health care professionals, including physicians, physician's assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and other persons acting within the lawful scope of their license or certificate to provide services; (6) Provided at the federally qualified health center's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of residence, including long term care facilities, or at another medical facility; and (7) Within the scope of services provided by the State under its fee-for-service Medicaid program and its Medicaid managed care program, on and after August 1994, and as amended from time to time. [...]" H.B. 2184, 29th Leg., Gen. Sess. (Haw. 2018) (to be codified at HRS § __-6 (2019). Hawaii grants the midwife licensing exemptions for certified nurse-midwives, performing work within one's scope of practice, student midwives currently enrolled and under direct supervision, a person rendering aid in emergency and the following which includes an exemption for "traditional Hawaiian healers."

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Other Coverage Requirements (site of service, etc.)	Hawaii Dep't of Human Servs. Provider Manual, ch. 21 (Mar. 2016). Prior Authorization is not required for prenatal care or delivery.
Coverage Limitations	None identified.
Reimbursement Rate	Payments for nurse midwife are limited to 75% of the Medicaid reimbursement rate for OBGYNs.
Reimbursement Methodology	Hawaii Dep't of Human Servs. Provider Manual, ch. 21 (Mar. 2016). In Hawaii's Medicaid program, Nurse-Midwife services are listed under "Basic Medical Services covered by all Medicaid Programs" and specifies certain reimbursement procedures for providers. Hawaii Dep't of Human Servs. Provider Manual, ch. 21 (Mar. 2016). Hawaii's Medicaid program lists the scope of conditions and specifies certain reimbursement provisions for maternity care.
Notes [managed care, private plans, related services]	HRS 20 § 346-53.64(c). "A federally qualified health center or rural health clinic that provides prenatal services, delivery services, and post natal services may elect to bill the managed care organization for all such services on a global payment basis. Alternatively, it may bill for prenatal and post natal services separately from delivery services and be paid the per visit prospective payment system reimbursement for prenatal and post natal visits. In this case, it may bill the managed care organization separately for inpatient delivery services that are not eligible for prospective payment system reimbursement."
Idaho	
Medicaid State Plan Amendment: Covered Services	**1) Licensed Midwife (LM)** ID-12-003 This SPA provides Medicaid reimbursement for midwifes licensed by the Idaho Board of Midwifery Idaho Medicaid Standard State Plan: "Licensed Midwife (LM) Licensed Midwife services include maternal and newborn care provided by LM providers **within the scope of their practice**. Medicaid will reimburse LM providers for **antepartum, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care."** Form CMS-179 **2) Nurse Midwife** Idaho MMIS Provider Handbook Nurse midwives were added to the list of covered providers as of August 2018.

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Licensing or Credentialing Requirements	**1) LM: Licensure by the Idaho Board of Midwifery** Idaho MMIS Provider Handbook, (LM) Section for Licensed Midwife (current through June 2017) IDAPA 16.03.09, Medicaid Basic Plan Benefits LMs are distinct from nurse midwives, per Section 2.1.1 of the Handbook. Eligible LMs must submit an enrollment application to Idaho Medicaid prior to providing services. **2) Nurse Midwife (Physician and Non-Physician Practitioner)** Idaho MMIS Provider Handbook Nurse midwives must be licensed in the state where services are performed and enroll as an Idaho Medicaid provider prior to submitting claims for services. 2010 Idaho Board of Nursing Statement One of the four roles of advanced practice nursing is nurse midwifery. A licensed RN who has graduated from a nurse midwifery education program accredited by the ACME, passin a qualifying exam, and holds a current BON certificate is recognized as a Certified Nurse Midwife. **Note** that Idaho Medicaid provides coverage for both "licensed midwives" and for "nurse midwives."
Other Coverage Requirements (site of service, etc.)	**1) LM:** Must be within scope of services (see Coverage Limitations)
Coverage Limitations	**1) LM: Limited Covered Services** Idaho MMIS Provider Handbook Participant Eligibility (LM) • A participant is eligible to receive maternity and newborn services from a licensed midwife if the participant is any of the following: • Pregnant • In the six-week postpartum period • A newborn up to the age of six weeks No primary care services are covered when provided by an LM (considered outside the scope of practice, which can be found at IDAPA 24.26.01, Rules of the Idaho Board of Midwifery)
Reimbursement Rate	**1) LM** Idaho MMIS Provider Handbook Section 2.1.9 The lower of (1) Provider's actual charge for the service (2) Medicaid's established maximum allowable reimbursement from its pricing file for the service. Most mid-level reimbursement is 85% of the physician fee schedule as posted at idmedicaid.com. **2) Nurse Midwife (Physician and Non-Physician Practitioner)** Idaho MMIS Provider Handbook Up to the Medicaid maximum allowance (typically up to 85% of the allowed physician max), except for services provided in a RHC, FQHC, or Indian Health Services.
Reimbursement Methodology	**1) LM** Idaho MMIS Provider Handbook Section 2.1.9 Fee-for-service up to the Medicaid maximum allowance **2) Nurse Midwife (Physician and Non-Physician Practitioner)** Idaho MMIS Provider Handbook Fee-for-service up to the Medicaid maximum allowance (typically up to 85% of the allowed physician max), except for services provided in a RHC, FQHC, or Indian Health Services.

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Notes [managed care, private plans, related services]	Idaho Managed Care Program Features as of 2016: covered under **Primary Care Case Management for Healthy Connections and Healthy Homes** **PCCM Provider FAQ:** Participation is limited to individual primary care providers or organizations enrolled as Idaho Medicaid billing providers. *Specialists participating in Medicaid are not required to submit additional information unless they want to be designated a PCP.* **NOTE:** Certified nurse midwives can be designated as PCPs. Idaho Managed Care Presentation from 2011.
Illinois	
Medicaid State Plan Amendment: Covered Services	Practitioner Handbook **Covered services include:** • Antepartum care for the initial visit to determine pregnancy • Initial prenatal visit • Subsequent prenatal office visits • Emergency room or inpatient hospital visits for complications of pregnancy or other diagnosis/ conditions related to pregnancy • Treatment to prevent premature delivery, including injection of alpha hydroxygrogesterone and home uterine monitoring • Medical office visits that occur during the prenatal period for conditions other than pregnancy • Delivery, including admission to the hospital, the admission history and physical, management of labor, vaginal or cesarean delivery and post-partum hospital care • Multiple births • Initiation and/or supervision of internal fetal monitoring during labor only when performed by a consulting practitioner • One six-week postpartum visit • Postoperative wound checks or visits outside the six-week postpartum period must be billed with the appropriate E&M CPT code Preconception risk assessment Postpartum visits and perinatal care transitions APNs may enroll as a primary care provider ("PCP") under the Maternal and Child Health ("MCH") program
Licensing or Credentialing Requirements	Only services by CNMs are covered. 89 Ill. Admin. Code §140.435 Certified Nurse Midwife ("CNM") is an advanced practice nurse ("APN") who is licensed as a "registered professional nurse" A written collaborative agreement is required for all APNs engaged in clinical practice with a physician, podiatrist or dentist, except for APNs practicing in a hospital, hospital affiliate or ambulatory surgical treatment center 225 ILCS 65/65-40 A collaborating physician may, but is not required to, delegate prescriptive authority to an APN as part of a written collaborative agreement. The collaborating physician must have a valid current Illinois controlled substance license and federal registration to delegate authority to prescribe delegated controlled substances. To prescribe controlled substances under this Section, an APN must obtain a mid-level practitioner controlled substance license. Medication orders shall be reviewed periodically by the collaborating physician.

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	225 ILCS 65/65-43 An **APN certified as a nurse midwife** who files with the State a notarized attestation of completion of at least 250 hours of continuing education or training and at least 4,000 hours of clinical experience after first attaining national certification does not require a written collaborative agreement. Sample collaborative agreement form The state of Illinois **does not yet recognize the Certified Professional Midwife ("CPM") credential.** 225 ILCS 65/65-30 The scope of practice of an APN includes, but is not limited to, each of the following: • Advanced nursing patient assessment and diagnosis. • Ordering diagnostic and therapeutic tests and procedures, performing those tests and procedures when using health care equipment, and interpreting and using the results of diagnostic and therapeutic tests and procedures ordered by the advanced practice registered nurse or another health care professional. • Ordering treatments, ordering or applying appropriate medical devices, and using nursing medical, therapeutic, and corrective measures to treat illness and improve health status. • Providing palliative and end-of-life care. • Providing advanced counseling, patient education, health education, and patient advocacy. • Prescriptive authority. • Delegating selected nursing interventions to a licensed practical nurse, a registered professional nurse, or other personnel.
Other Coverage Requirements (site of service, etc.)	**Covered sites of service include:** Practitioner Handbook Hospital: Payment for delivery includes admission to the hospital, the admission history and physical, management of labor, vaginal or cesarean delivery and post-partum hospital care. Home: Payment may be made for a vaginal delivery that the practitioner performs in the participant's home. The appropriate vaginal delivery CPT code is to be used and Place of Service (POS) must be home. Birth Center Handbook Birth Center: birth centers are reimbursed for medically necessary services that are provided to eligible participants covered under the State's medical programs These services must be provided in compliance with birth center licensing standards 89 Ill. Admin. Code §146.830 Payment may be made for the following types of care: • Delivery Services • Observation Services • Transfer Fee Encounter Clinic Handbook Encounter Clinics (FQHCs, Rural Health Clinics, Encounter Rate Clinics): Core services of the clinic/center include covered services of nurse practitioners, ***nurse midwives***, and physician-supervised physician assistants
Coverage Limitations	Practitioner Handbook A practitioner billing for prenatal services must have ***hospital delivery privileges*** or, if the practitioner does not have such privileges, then the practitioner must have a ***written agreement with a practitioner or a group of practitioners who do have such privileges*** and who agree to accept referred participants for delivery and hospital care The agreement must attest that the referring practitioner will provide participant's medical records to the admitting practitioner on their mutually agreed upon date of transfer of the participant from the care of the referring practitioner to the care of the admitting practitioner, but no later than thirty-six (36) weeks of the gestational period

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Reimbursement Rate	Practitioner Handbook Payment made for allowable services will be made at the lower of the provider's usual and customary charge or the State's maximum reimbursement rate Healthcare and Family Services All services rendered by an APN are reimbursed at 100% of the physician's rate **Applicable Fee Schedules:** Birth Center Rates for birth center services, including delivery services, observation services, and transfer fee Practitioner Practitioner fee schedule, including charges submitted by Advanced Practice Nurses Add Ons Maternal and Child Health/PCP Provider add-ons
Reimbursement Methodology	**Fee-for-service:** Maternity Care Services All maternity care services must be billed with separate codes, dates, and charges An all-inclusive "global" care package will not be reimbursed PCP CNMs who provide services with an affiliated physician may serve as a PCP in the Illinois Health Connect program PCPs enrolled in the program receive a monthly care management fee for each enrollee whose care they are responsible to manage PCPs are to bill their usual and customary rate for services rendered and will be reimbursed for covered services at the lesser of the provider's usual and customary rate or the State's maximum reimbursement rate MCH The MCH is a primary health care program coupled with case management services for children under age 21 and pregnant women enrolled in one of the State's Medical Programs The program includes increased payment rates for selected services and expedited payment Illinois Health Connect PCPs automatically receive the enhanced MCH rates Providers outside of the Illinois Health Connect Program may be eligible for these enhanced rates as well but must meet the following participation requirements: • Maintain hospital admitting privileges • Provide periodic health screening and primary pediatric care as needed • Provide obstetrical care and delivery services as appropriate to the provider's specialty • Perform risk assessment for pregnant women and children • Maintain 24-hour telephone coverage for consultation including ensuring that "sick" children and "at-risk" pregnant women are treated as needed, based on a triage of need • Schedule diagnostic consultation and specialty visits as appropriate • Provide adequate equal access to medical care for participants • Communicate with the case management entity

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Notes [managed care, private plans, related services]	MCO Charges for services and items provided to participants enrolled in a Managed Care Organization ("MCO") must be billed to the MCO according to the contractual agreement with the MCO Managed Care Covered Services Covered services by managed care plans include nurse midwife services MCO Manual (Certified Nurse Midwife) A CNM is an APN that provides medical and preventive services, is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the State and contracted with the Health Plan.
Indiana	
Medicaid State Plan Amendment: Covered Services	SPA-IN-17-0000-001. Included nurse midwife services under nursing services for home and community-based health services. Medicaid Medical Assistance Program Medical Policy Manual. The Indiana Medicaid program does not appear to distinguish between the two types of midwives. "A nurse-midwife is another type of advanced practice nurse. Medicaid reimbursement is available for services rendered by a certified nurse-midwife under the same criteria as advanced practice nurses as provided in 848 IAC 4-1-3. 848 IAC 3-1-2 states that the practice of nurse-midwifery means the practice of nursing and the extension of that practice, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post - delivery. For further details on the scope of practice for nurse-midwives, see 848 IAC 3- 3-1." *See also* Burns Ind. Code Ann. § 34-18-6.5 (2013); Burns Ind. Code Ann. § 25-0.5-6-20 (2014).
Licensing or Credentialing Requirements	**Only CNM Services are Covered** Burns Ind. Code Ann. § 25-23.4-1-4(a)-(b) (2013). Distinguishes between CDEMs and certified nurse midwives "engaged only in the practice of midwifery under IC 25-23. Burns Ind. Code Ann. § 25-23-1-13.1(a)-(b) (2013). Describes application requirements for certified nurse midwives. Burns Ind. Code Ann. § 25-23.4-3-1(a)-(d) (2017). Lists licensing exemptions for nursing midwife students meeting certain requirements. Burns Ind. Code Ann. § 25-23.4-2-6(a)-(c) (2013). Indiana's State Board of Nursing establishes certification requirements for certified direct entry midwives and issues certifications. *See also* Burns Ind. Code Ann. § 25-23.4-3-3 (2013). Certified direct entry midwives must provide an annual report to the board regarding each birth form the previous year. Burns Ind. Code Ann. § 25-23.4-4-4 (2013).
Other Coverage Requirements (site of service, etc.)	Indiana details midwife-physician collaboration agreement requirements at Burns Ind. Code Ann. § 25-23.4-5-1(a)-(b) (2014) and Burns Ind. Code Ann. § 25-23.4-5-4 (2013)." Indiana details midwives' informed disclosure and consent requirements at Burns Ind. Code Ann. § 25-23.4-4-3 (2015) and Burns Ind. Code Ann. § 25-23.4-4-2(a)-(b) (2013). Indiana details collaborative plan of treatment requirements at Burns Ind. Code Ann. § 25-23.4-6-2(a)-(b) (2013). Burns Ind. Code Ann. § 16-38-4-9(a)-(c) (2019). Indiana imposes reporting requirements for birth problems.

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Coverage Limitations	Burns Ind. Code Ann. § 25-23.4-4-5 (a)-(c) (2013). Indiana does not permit midwife administration of prescription drugs.
Reimbursement Rate	Indiana Medicaid Medical Assistance Program Medical Policy Manual (Jan. 2007). Indiana's Medicaid program permits certified nurse midwives to render services at birthing centers using certain following billing procedures. Providers should refer to the *IHCP Provider Type and Specialty Matrix* at in.gov/medicaid/providers for other enrollment criteria. Facility charges are billed on an institutional claim (*UB-04* claim form or electronic equivalent). Birthing center claims must report billing provider taxonomy code 261QB0400X (birthing) on the claim. Birthing centers are paid at an all-inclusive rate. The services are billed using revenue code 724 – *Birthing center*. Only vaginal deliveries should be billed with this revenue code. Reimbursement rates are based on the revenue code 724 when the member delivers. When labor occurs but does not result in delivery, providers should bill revenue code 724 along with HCPCS code S4005 – *Interim labor facility global (labor occurring but not resulting in delivery)*.
Reimbursement Methodology	Indiana Medicaid Medical Assistance Program Medical Policy Manual. The most recently found Indiana Medicaid policy describing midwife billing requirements states: "The Provider Manual Chapter 8, Section 3 lists the IHCP instructions for proper billing of nurse practitioner procedures as follows. The term nurse practitioner, as indicated in the billing section of the provider manual, refers to all advanced practice nurses [including nurse midwives]." Billing instructions provide: • Independently practicing nurse practitioners are reimbursed at 75 percent of the rate on file. The nurse practitioner provider number is included in Locators 24K and 33 of the CMS-1500 Claim Form. • Nurse practitioners, not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians, in a physician directed group or clinic, bill services with the SA modifier and the physician number in locators 24K and 33 and are reimbursed at 100 percent of the Medicaid allowed amount. • Nurse practitioners, with an individual provider number, and employed by a physician(s) should bill using their own provider number in locator 24K and the billing group number in locator 33 and are reimbursed at 100 percent of the Medicaid allowed amount. • Nurse practitioner services in outpatient hospital settings are not separately billable and are included in the hospital outpatient reimbursement rate. Further information for billing nurse practitioner services are found in the IHCP Provider Manual, Chapter 8, Section 3."
Iowa	
Medicaid State Plan Amendment: Covered Services	https://dhs.iowa.gov/sites/default/files/ARNP.pdf?070920191303 The Medicaid program covers all types of ARNPs, in compliance with Iowa Code section 249A.4(7). These include: Certified nurse-midwife, an ARNP educated in the disciplines of nursing and midwifery who is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically. 655 IAC 6.1(152) "Certified nurse-midwife" is an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current advanced level certification by a national professional nursing certifying body approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically"

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Licensing or Credentialing Requirements	**Only services by a CNM covered.** 655 IAC 7.2 7.2(1) Qualifications. An applicant for an ARNP license shall meet the following qualifications: a. Hold an active unrestricted license as a registered nurse in accordance with 655--Chapter 3. b. Graduation from an accredited graduate or postgraduate advanced practice educational program in one of the following roles, except as provided by subrule 7.2(2): (1) Certified nurse-midwife. (2) Certified registered nurse anesthetist. (3) Certified nurse practitioner. (4) Clinical nurse specialist. c. Current certification issued by a national professional certification organization as a certified nurse-midwife or certified registered nurse anesthetist, or as a certified nurse practitioner or clinical nurse specialist in at least one of the following population foci: (1) Women's health/gender-related. (2) Family (individual across the lifespan). (3) Psychiatric mental health. (4) Adult/gerontology. (5) Pediatrics. (6) Neonatal.
Other Coverage Requirements (site of service, etc.)	https://dhs.iowa.gov/sites/default/files/ARNP.pdf?070920191303 The Medicaid program covers all types of ARNPs, in compliance with Iowa Code section 249A.4(7). These include: Certified nurse-midwife, an ARNP educated in the disciplines of nursing and midwifery who is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically. https://dhs.iowa.gov/sites/default/files/Birthctr.pdf?070220191345 Birth Centers are eligible to participate • Payment will be made for prenatal care, delivery, and postpartum care provided by certified nurse-midwife • Must have prenatal risk assessment; if high risk, must refer to enhanced services • Enhanced services may not be provided by a nurse-midwife Public Health Department 641-96.7(144) Non-institution birth In case of a non-institution Iowa live birth, the official non-institution birth worksheet shall be completed and filed with the state registrar by one of the following in the indicated order of priority: **a.** The physician in attendance at or immediately after the live birth. **b.** Any other person, including a certified nurse midwife or doula, in attendance at or immediately after the live birth. **c.** The mother or her legal spouse. **d.** The person in charge of the premises where the live birth occurred
Coverage Limitations	https://dhs.iowa.gov/sites/default/files/ARNP.pdf?070920191303 Payment will be approved through the Medicaid program for services provided by ARNPs within their licensure and scope of practice, pursuant to Board of Nursing rules and definitions, including medically delegated functions under a collaborative practice agreement. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth in the following sections. No payment will be made for services of a private-duty nurse. https://dhs.iowa.gov/sites/default/files/Section_3_as_of_102417.pdf?070220191344 Nurse-midwives are eligible to practice to the extent they are authorized to do so under state law and "without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle." Nurse-midwives are permitted to enter into independent contract agreements with the Medicaid agency without regard to whether they are under the supervision of a physician.

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Reimbursement Rate	https://dhs.iowa.gov/sites/default/files/Section_3_as_of_102417.pdf?070220191344 Medicaid pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State Plan.
Reimbursement Methodology	https://dhs.iowa.gov/sites/default/files/ARNP.pdf?070920191303 The basis of payment is a fixed fee. The lower of the billed charges or the fixed fee is paid. The basis of payment for CRNA services is a fee schedule based on the HCPCS codes, with base units as established by the Centers for Medicare and Medicaid Services for the Medicare program.
Notes [managed care, private plans, related services]	Some of these links must be copied into the search bar.
Kansas	
Medicaid State Plan Amendment: Covered Services	No State Plan Amendment. Kansas Medical Assistance Program Fee-for-Service Provider Manual Kansas Medicaid only covers CNM services.
Licensing or Credentialing Requirements	**1) CNM** Kan. Stat. Ann. § 65-28b02 (b): "Certified nurse-midwife" means an individual who is educated in the two disciplines of nursing and midwifery, currently certified by a certifying board approved by the state board of nursing, and is currently licensed under the Kansas nurse practice act. Kan. Stat. Ann. § 65-28b02(c): "Independent practice of midwifery" means the provision of clinical services by a certified nurse-midwife without the requirement of a collaborative practice agreement with a person licensed to practice medicine and surgery when such clinical services are limited to those associated with a normal, uncomplicated pregnancy and delivery, including: (1) The prescription of drugs and diagnostic tests; (2) the performance of episiotomy or repair or a minor vaginal laceration; (3) the initial care of the normal newborn; and (4) family planning services, including treatment or referral of male partners for sexually-transmitted infections.
Other Coverage Requirements (site of service, etc.)	Kansas Medical Assistance Program Fee-for-Service Provider Manual: Labor and delivery in a maternity center setting is covered for Medicaid for certified nurse-midwives providing care within the scope of their license.

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Coverage Limitations	Kan. Stat. Ann. § 65-28b06: It is unlawful for a person to engage in the independent practice of midwifery without a collaborative practice agreement with a person licensed to practice medicine and surgery, unless such certified nurse-midwife holds a license from the state board of nursing and the board.
Reimbursement Rate	According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Kansas for services provided by certified nurse midwives relative to physician reimbursement rates is 100%. See also, Kansas Medical Assistance Program Fee-for-Service Provider Manual: Certified nurse midwives are reimbursed at 75% of the Medicaid allowed amount for services provided.
Reimbursement Methodology	Fee-for-service or managed care model.
Notes [managed care, private plans, related services]	KanCare Managed Care Organizations.
Kentucky	
Medicaid State Plan Amendment: Covered Services	No State Plan Amendment. Kentucky Department for Medicaid Services ; Provider Billing Instructions KY Medicaid only covers CNM services. Ky. Rev. Stat. Ann. § 314.011(8) Kentucky follows the Standards for the Practice of Midwifery with respect to scope of practice.

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Licensing or Credentialing Requirements	**1) CNM** Ky. Rev. Stat. Ann. § 314.011(8) A certified nurse midwife means an advanced practice registered nurse who is certified by the American Nurses' Association or other nationally established organizations or agencies recognized by the board to certify registered nurses as a certified nurse midwife, and, who is licensed to engage in advance practice registered nursing pursuant to KRS 314.042 and certified in at least one (1) population focus. **2) Lay-Midwifery (NOTE: not covered by Medicaid, and the permit is no longer offered in Kentucky post-1975)** 902 Ky. Admin. Reg. 04:010 The practice of lay-midwifery means the assistance, or offer of assistance, rendered by a person, other than a physician or nurse-midwife, to a woman in normal childbirth, without using any instrument or artificial, forcible or mechanical means and without performing or attempting to perform any version or removing or attempting to remove adherent placenta and without prescribing, using or advising the use of any drug except silver nitrate for the eyes of the newborn. Section 2: Practice of Lay-midwifery without Permit Prohibited. Section 3: Lay-midwife Permits. New applications to practice lay-midwifery in the State of Kentucky shall not be accepted after April 9, 1975. Provided, however, that persons who have actively engaged in the practice of lay-midwifery in this state for a period of one (1) year prior to April 9, 1975, and who hold a valid and effective permit issued by the former Department of Health may, upon furnishing proof thereof, be entitled to renewal of their existing permit upon recommendation of the local board of health certifying a need for such services.
Other Coverage Requirements (site of service, etc.)	The Kentucky Department for Medicaid Services defines covered services of APRNs as medically necessary services that are furnished by certified nurse midwives through a face-to-face interaction with the patient.
Coverage Limitations	The Kentucky Department for Medicaid Services identifies procedures not covered to include: procedures not considered medically necessary. The certified nurse midwife must also perform procedures within his/her scope of practice.
Reimbursement Rate	907 Ky. Admin. Reg. 1:104 Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
Reimbursement Methodology	Fee-for-service.
Notes [managed care, private plans, related services]	The Department for Medicaid Services (DMS) contracts with five Managed Care Organizations to provide coverage for most of Kentucky's Medicaid recipients.

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Louisiana	
Medicaid State Plan Amendment: Covered Services	Louisiana State Plan (2005) Method of payment for nurse-midwife services shall be 80 percent of the rate of the professional services fee schedule for covered services and 100 percent of the rate for a designated group of procedure as determined by the Medicaid Program. Louisiana Medicaid Professional Services Fee Schedule 2019 Louisiana Medicaid offers coverage for CNMs and Licensed Midwives. **1) CNM** La. Admin. Code Prof. & Occup. Stand. 46, § 4503 Authorized to manage the nurse midwifery care of newborns and women in the antepartum, intrapartum, and postpartum periods as well as primary care for women across their lifespan and treatment of their male partners for sexually transmitted infections (STI). **2) Licensed Midwife** La. Rev. Stat. 37 § 3241 "Licensed midwifery" means the provision of health services in pregnancy and childbirth by a person not licensed as a physician or a certified nurse midwife.
Licensing or Credentialing Requirements	**1) CNM** La. Admin. Code Prof. & Occup. Stand. 46, § 4503 Defines "Certified Nurse Midwife" as a nurse authorized by the Louisiana State Board of Nursing to practice as a certified nurse midwife in the state. The Louisiana Board of Nursing defines a Certified Nurse Midwife as an advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the board. **2) Licensed Midwife** La. Rev. Stat. 37 § 3241: "License midwife" means a person who has completed all requirements of R.S. 37:3247, 3253, and 3255, and has successfully completed the examination process, and is **certified as a midwife by the North American Registry of Midwives** along with being in good standing on the registry of licensed midwives maintained by the board. **3) Certified Professional Midwife (similar to Licensed Midwife)** La. Rev. Stat. 37 § 3241: "Certified professional midwife" means a person **certified by the North American Registry of Midwives**.
Other Coverage Requirements (site of service, etc.)	Louisiana Dept. of Health Medicaid Services Chart 2019: CNMs may provide services at free standing birth centers, rural health clinics, and Federal Qualified Health Centers (FQHC). Licensed midwives may provide services at free standing birth centers.

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Coverage Limitations	Louisiana Dept. of Health Medicaid Services Chart 2019: Covered Services for Free Standing Birthing Centers: Vaginal delivery services for females who have had a **low risk**, normal pregnancy, prenatal care and that are expected to have an uncomplicated labor and normal vaginal delivery. Louisiana Free-Standing Birthing Centers Provider Manual 2016: Non-covered services for Free-standing birthing centers: (i) neither general nor epidural anesthesia (ii) assessment for active labor that do not result in admission to the birthing center. FSBC services do not include items and services for which payment may be made under other provisions. FSBC services do not include: physician services; lab and x-ray not directly related to the delivery; diagnostic procedures (other than those directly related to performance of the delivery); ambulance services; or durable medical equipment for use in the recipient's home. La. Admin. Code Prof. & Occup. Stand. 46, § 4505 defines Collaborative Practice Agreement: The joint management of the health care of a patient by a certified nurse midwife performing midwifery services and one or more consulting physicians.
Reimbursement Rate	Louisiana Medicaid Professional Services Fee Schedule 2019: Certified nurse midwives are reimbursed at 80% of the full fee service. Licensed midwives are paid at 75% of the full service fee.
Reimbursement Methodology	Fee for service.
Maine	
Medicaid State Plan Amendment: Covered Services	No State Plan Amendment. MaineCare Benefits Manual, Physician Services (2019) Only CNMs are listed under Other Providers.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Maine Board of Nursing defines a "certified nurse-midwife" as a registered professional nurse who has received post-graduate education designed to prepare the nurse for advanced practice registered nursing in a specialty area in nursing that has a defined scope of practice and has been certified in the clinical specialty by a national certifying organization acceptable to the Board. **Maine offers licensure for Certified Professional Midwives** (Me. Rev. Stat. Ann. 32 § 12533) **and Certified Midwives, but these are not covered by Medicaid.**

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	Certified Professional Midwife Me. Rev. Stat. Ann. 32 § 12533: An applicant for a license to practice midwifery as a certified professional midwife shall submit to the board the following: (1) Fee; (2) Certification. Proof of a current and valid national certification as a certified professional midwife from the national registry of midwives; and (3) Education. Proof of successful completion of a formal midwifery education and training program as follows: (A) An educational program or institution accredited by the midwifery education accreditation council; (B) For an applicant certified as a certified professional midwife who is certified before January 1, 2020 and who has completed a midwifery education and training program from an educational program or institution that is not accredited by the midwifery education accreditation council, a midwifery bridge certificate; or (C) For an applicant who has maintained an authorization to practice midwifery as a licensed certified professional midwife in a state that does not require completion of midwifery education and training program from an educational program or institution that is accredited by the midwifery education accreditation council, regardless of the date of that authorization, a midwifery bridge certificate. **Certified Midwife** Me. Rev. Stat. Ann. 32 § 12534: A person qualifies for a license to practice midwifery as a certified midwife shall submit to the board: (1) Fee; (2) Certification. Proof of a current and valid national certification as a certified midwife from the national midwifery certification board; and (3) Education. Proof of successful completion of a graduate-level education program in midwifery that is accredited by the accreditation commission for midwifery education. Me. Rev. Stat. 32 § 12532: Persons and practices exempt: Nothing in this subchapter may be construed as preventing: (3) Religious or cultural traditions. A traditional birth attendant from practicing midwifery without a license if the traditional birth attendant has cultural or religious traditions that have historically included the attendance of traditional birth attendants at births and that birth attendant serves only the women and families in that distinct cultural or religious group.
Other Coverage Requirements (site of service, etc.)	MaineCare Benefits Manual, Physician Services (2019): Provider Qualifications: MaineCare reimburses for obstetric services provided to a woman who is pregnant only when provided by a provider appropriately licensed or certified in the state in which he or she practices, practicing within their scope of that licensure or certification, and qualified to deliver services under this Section. Providers are expected to engage in collaborative management of individual members with appropriate consultation, referrals, and transfers of care including, but not limited to, transfer of care for the purpose of specialized treatment and admission to an approved MaineCare hospital, with such treatment including maternity services.
Coverage Limitations	MaineCare Benefits Manual, Advanced Practice Registered Nursing Services 2015: Covered services are those reasonably necessary medical, nursing, and remedial services that: are provided in an appropriate setting; reflect coordination and appropriate communication with the prescribing licensed physician or dentist where required by the licensing authority; are within the scope of practice for the advanced practice registered nurse providing the service; and are recognized as standard medical/nursing care authorized by the state or province in which services are provided.
Reimbursement Rate	According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Maine for services provided by certified nurse midwives relative to physician reimbursement rates is 100%. MaineCare Benefits Manual, Advanced Practice Registered Nursing Services 2015: Reimbursement for independent practitioners billing for services not billed through hospitals or physicians, shall be the amount listed for services as described in "Physician Services."

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Reimbursement Methodology	MaineCare Benefits Manual, Physician Services (2019): Reimbursement for Obstetrical Care: MaineCare provides two methods for maternity care billing, global charge basis or per service charge basis. Providers may choose only one (1) of the two (2) methods for each delivery as set forth below: i. Global charge basis. Several procedure codes are all-inclusive of delivery, antepartum, and postpartum care and can be used to bill one all-inclusive charge following the member's delivery. Providers may not bill a global charge for patients who were not MaineCare eligible during the entire pregnancy. Providers may bill total maternity care codes (global charge basis) only in those instances where the provider performs each of the components of maternity care, and only if eight (8) or more visits over a period of at least four (4) months are provided during the antepartum phase of maternity care. Providers may bill maternity related office visits in excess of eleven (11) visits in addition to the global code. ii. Per service charge basis. Providers may bill on per service basis for maternity care.
Maryland	
Medicaid State Plan Amendment: Covered Services	Maryland State Plan Amendment 2017: Medicaid covered services for certified nurse midwives includes medically necessary services that are within the certified nurse midwife's scope of practice as described in State Law and authorized in the state in which the services are rendered.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Md. Code. Regs. 10.27.05.02: "Certified Nurse Midwife" means a person who: (1) holds a current Maryland license in good standing to practice registered nursing or a multistate privilege to practice registered nursing; (2) has graduated from a Board-approved graduate level program for nurse midwives at the Masters' level or higher that is accredited by The National League for Nursing Accreditation Commission (NLNAC); The Commission on Nursing Education (CCE); ACME; or any other accrediting body recognized by the Board; (3) holds a current national certification as a nurse midwife from the AMCB or any other national certifying body recognized by the Board. If a person's nurse midwifery program was completed before July 1, 2014, and was not at a Master's degree or higher level, but the applicant otherwise qualifies for certification, the applicant shall provide the Board with: (1) verification of completion of a nurse midwifery program recognized by AMCB; and (2) Current national certification by AMCB or any other national certifying body recognized by the Board. **Maryland offers licensure for Direct Entry Midwives, but these are not covered by Medicaid.** **Direct Entry Midwife** Md. Code. Ann., Health Occ. § 8-6C-01: A "Licensed Direct-Entry Midwife" means an individual who has been granted a license under Health Occupations Article, Title 8, Annotated Code of Maryland. Licensed direct-entry does not include a licensed registered nurse certified as a nurse-midwife.
Other Coverage Requirements (site of service, etc.)	Maryland Medical Assistance Program Professional Services Provider Manual (2019): Medically necessary services in provider's office, participant's home, hospital, free-standing clinic or other locations applicable to certified nurse-midwives.
Coverage Limitations	Maryland Medical Assistance Program Professional Services Provider Manual (2019): Services not covered include services that are not considered medically necessary. (Certified nurse midwives only)

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Reimbursement Rate	According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Maryland for services provided by certified nurse midwives relative to physician reimbursement rates is 100%.
Reimbursement Methodology	Fee-for-service.
Notes [managed care, private plans, related services]	Maryland Medicaid Program OB/GYN Services Factsheet: Most pregnant women enrolled in Medicaid must enroll in HealthChoice, Medicaid's managed care program. HealthChoice beneficiaries who do not select an MCO are auto-assigned to an MCO.
Massachusetts	
Medicaid State Plan Amendment: Covered Services	No State Plan Amendment guidance for midwife reimbursement. 130 CMR 450.105(A)(1): "Certified nurse midwife services" are a standard covered benefit under MassHealth.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** 130 CMR 433.419(C): To participate in MassHealth, a certified nurse midwife ("CNM") must be licensed by the state or by the licensing agency of another state in which the certified nurse midwife services are provided. **Note** that Massachusetts does not provide for licensure of any other types of midwife professionals. Additionally, MassHealth does not cover services provided from non-CNM midwives.
Other Coverage Requirements (site of service, etc.)	CNM services are likely to only be covered when performed in a facility setting.
Coverage Limitations	130 CMR 433.419: Services paid are limited to scope of practice authorized by the Board or of state licensing agency of another state; CNM must not be employee of the hospital or other facility in which the CNM services are performed; MassHealth does not pay for consultation between a CNM and a physician as a separate service. 244 CMR 4.06(2)(b): The scope of practice for CNMs include provision of primary health care to women throughout the lifespan including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, care of the newborn and treatment of the partner of their clients for sexually transmitted disease and reproductive health.

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Reimbursement Rate	130 CMR 433.421: Masshealth pays a single inclusive fee for all prenatal and postpartum visits, and the delivery. Must perform a minimum of 6 prenatal visits, the delivery, and at least 1 postpartum visit. 130 CMR 433.424: Obstetric services can be billed as fee-for-service, as an alternative to the global fee basis referenced above.
Reimbursement Methodology	Two methods of payment for services: either Global Fee or Fee for Service, see left column for detail.
Notes [managed care, private plans, related services]	Mass. Gen. Laws ch. 175 § 47E: Insurance policies must provide benefits for CNM services, provided that reimbursement for such services are at parity when performed by other licensed practitioners, and are within the lawful scope of practice for a CNM. H4655: Legislation to establish a separate Certified Midwife Board.
Michigan	
Medicaid State Plan Amendment: Covered Services	Provider Manual **Covered services include:** The management of low risk and uncomplicated pregnancies and services to essentially normal women and newborns Coverage for ***antepartum care*** includes all usual antepartum services provided prior to delivery and referral to MIHP given the presence of psychosocial or nutritional factors that could adversely affect the pregnancy • If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered • If the beneficiary is seen by several CNMs within a group or multiple CNMs supervised by the same physician or physician group, the antepartum care package is covered. CNMs may perform and bill Medicaid for non-stress tests when this service is determined medically necessary, is part of routine care provided for uncomplicated pregnancies, and is completed within the CNM scope of practice guidelines Coverage of the ***delivery*** includes monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary Medicaid covers ***post-partum office visits*** following the delivery • Routine post-partum hospital care for the mother is covered as a part of the delivery • Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether he performed the delivery Visits not directly related to antepartum care or follow-up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code A CNM can provide family planning services, defined as any Medicaid covered contraceptive service, including diagnostic evaluation, drugs, and supplies, for voluntarily preventing or delaying pregnancy CNMs may receive direct reimbursement for gynecologic care when completed within the CNM scope of practice guidelines Medicaid will reimburse for evidence-based lactation support services provided to Medicaid eligible postpartum women in the outpatient setting up to and through 60 days post-delivery • Services must be rendered by a licensed, qualified health professional • A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy One visit is reimbursable per date of service

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Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Michigan Dept of Health a Human Services **CNMs** are allowed to enroll in the Medicaid program They must comply with all licensing laws and regulations applicable to their practice in Michigan, and not be excluded from participating in Medicaid by state or federal sanction Medicaid Provider Manual CNMs are authorized health professionals who may order, prescribe or refer services to Medicaid beneficiaries CNMs can be considered hospital-based providers; hospital-based providers must be enrolled separately as Medicaid providers and bill MDHHS directly using their own provider NPI number for any covered professional service(s) that they provide Lactation support and counseling services must be rendered by an Internationally Board Certified Lactation Consultant ("IBCLC") credentialed by the International Board of Lactation Consultant Examiners ("IBLCE") with possession of a valid and current IBCLC certification • Rendering IBCLC providers must be Medicaid-enrolled physicians, nurse practitioners, physician assistants or ***nurse midwives*** When a Medicaid-enrolled practitioner provides delegation and supervision, within the confines of his/her scope of practice, to an individual with possession of a valid and current IBCLC certification, that Medicaid-enrolled health professional may bill for comprehensive lactation support services
Other Coverage Requirements (site of service, etc.)	Provider Manual Deliveries performed by a CNM are covered in a ***licensed setting only*** • ***Home deliveries*** and services associated with these deliveries are ***not covered*** Plan Amendment Licensed or otherwise State-recognized covered professionals providing services in ***freestanding birth centers are not covered*** • There are no licensed or State approved freestanding birth centers Provider Manual CNMs may order specified pregnancy-related laboratory tests (enumerated in the Medicaid Provider Manual) • The ordering practitioner must document the medical necessity of laboratory tests in the beneficiary's medical record, regardless of where the test(s) is performed • Hospitals are not reimbursed for tests ordered by a CNM that are not enumerated in the Medicaid Provider Manual CNMs may also perform certain laboratory tests (enumerated in the Medicaid Provider Manual) • These tests are not covered for the CNM if rendered by an outside laboratory MDHHS covers Medicaid enrolled hospitals for medically-necessary radiology services, including diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultrasound, and other imaging procedures necessitated by injury or disease, including benign or malignant conditions; needed to diagnose a specific condition, illness, or injury; and ordered by physicians (MD or DO), podiatrists, dentists, nurse practitioners, or ***nurse-midwives***

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Coverage Limitations	Provider Manual Medically complicated pregnancies and services to beneficiaries with high-risk conditions must be referred to a physician • Services provided to high-risk women and women with medical complications are only covered under the delegation and supervision of a physician Pharmaceuticals, including oral contraceptives, can only be ordered by a CNM under the delegation of a physician • Pharmaceuticals must be provided by an enrolled pharmacy or, if appropriate, by an enrolled Family Planning Clinic ("FPC") Family planning services must be furnished under the supervision of a physician or dispensed by a pharmacy
Reimbursement Rate	**CNM** Fee Schedule: Provider Manual MDHHS provides an enhanced payment for each Medicaid delivery performed • The additional reimbursement is added to the fee reimbursed under FFS for the global maternity and delivery procedure codes • The maternity case rate paid to MHPs is also enhanced • Inpatient and outpatient services provided by CNMs, when not included in facility payments to public entities are included State Plan Amendment Reimbursement for neonatal critical care and intensive care services is 75% of the annual Medicare rates published January of each year • Reimbursement is made in accordance with Medicaid's fee screens or the usual and customary charge for these services, whichever amount is less.
Reimbursement Methodology	Fee for Service
Minnesota	
Medicaid State Plan Amendment: Covered Services	Minn. Stat. Ann. § 147D.01 "Traditional midwifery services" means the assessment and care of a woman and newborn during pregnancy, labor, birth, and the postpartum period outside a hospital. Minn. Stat. Ann. § 256B.0625 Professional services provided by licensed traditional midwives are covered Minn. R. 9505.0280 The following providers are eligible for medical assistance payment for a family planning service or family planning supply: physicians, nurse practitioners, certified nurse midwives, physician-directed clinics, community health clinics, rural health clinics, outpatient hospital departments, pharmacies,

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	public health clinics, and family planning agencies. Minn. R. 9505.0320 "Nurse midwife" means a registered nurse who is certified as a nurse midwife by the American College of Nurse Midwives. "Nurse midwife service" means a health service provided by a nurse midwife for the care of the mother and newborn throughout the maternity period. Minn. Stat. Ann. § 148.171 APRN, means an individual licensed as an advanced practice registered nurse by the board and certified by a national nurse certification organization acceptable to the board to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner. Minn. R. 4605.7000 CNMs are considered "health care practitioners" Minn. Stat. Ann. § 147D.03 Within the meaning of sections 147D.01 to 147D.27, a person who shall publicly profess to be a traditional midwife and who, for a fee, shall assist or attend to a woman in pregnancy, childbirth outside a hospital, and postpartum, shall be regarded as practicing traditional midwifery. The practice of traditional midwifery includes, but is not limited to: (1) initial and ongoing assessment for suitability of traditional midwifery care; (2) providing prenatal education and coordinating with a licensed health care provider as necessary to provide comprehensive prenatal care, including the routine monitoring of vital signs, indicators of fetal developments, and laboratory tests, as needed, with attention to the physical, nutritional, and emotional needs of the woman and her family; (3) attending and supporting the natural process of labor and birth; (4) postpartum care of the mother and an initial assessment of the newborn; and (5) providing information and referrals to community resources on childbirth preparation, breastfeeding, exercise, nutrition, parenting, and care of the newborn.
Licensing or Credentialing Requirements	**1) Traditional Midwives** Minn. Stat. Ann. § 147D.17 To be eligible for licensure, an applicant, with the exception of those seeking licensure by reciprocity must follow certain steps as outline by statute. Minn. Stat. Ann. § 147D.17 There is also licensure by reciprocity and there are temporary permits that the board can issue Minn. Stat. Ann. § 147D.11 To be eligible for licensure as a traditional midwife, an applicant must develop a medical consultation plan, including an emergency plan. The plan must describe guidelines and under what conditions the plan is to be implemented. Specifics can be found in the statute. **2) CNMs** Minn. Stat. Ann. § 148.171 APRN, means an individual licensed as an advanced practice registered nurse by the board and certified by a national nurse certification organization acceptable to the board to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner.
Other Coverage Requirements (site of service, etc.)	None identified.

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Coverage Limitations	**1) Traditional Midwives** Minn. Stat. Ann. § 256B.0625 Services are not covered if provided by an unlicensed traditional midwife. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Minn. Stat. Ann. § 147D.03 The practice of traditional midwifery does not include: (1) the use of any surgical instrument at a childbirth, except as necessary to sever the umbilical cord or repair a first- or second-degree perineal laceration; (2) the assisting of childbirth by artificial or mechanical means; or (3) the removal of a placenta accreta. Minn. Stat. Ann. § 147D.09 A licensed traditional midwife shall not prescribe, dispense, or administer prescription drugs, with the enumerated exceptions below A licensed traditional midwife may administer vitamin K either orally or through intramuscular injection, maternal RhoGAM treatment, postpartum antihemorrhagic drugs under emergency situations, local anesthetic, oxygen, and a prophylactic eye agent to the newborn infant. A licensed traditional midwife shall not perform any operative or surgical procedures except for suture repair of first- or second-degree perineal lacerations. **2) CNM** Minn. R. 9505.0322 Medical assistance payment for nurse midwife service is limited to services necessary to provide the care of the mother and newborn throughout the maternity period and provided within the scope of practice of the nurse midwife.
Reimbursement Rate	Minn. Stat. Ann. § 256B.0625 Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100% of the rate paid to a physician performing the same services.
Reimbursement Methodology	Fee for service
Notes [managed care, private plans, related services]	Managed care organization

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Mississippi	
Medicaid State Plan Amendment: Covered Services	Mississippi State Plan Amendment: Discusses reimbursement for certified nurse midwifery services. Mississippi Division of Medicaid for Maternity Services. The Division of Medicaid covers maternity services which include: (1) Antepartum services defined by the Division of Medicaid as the care of a pregnant woman during the time in the maternity cycle that begins with conception and ends with labor; (2) Delivery services defined by the Division of Medicaid as the care involved in labor and delivery.; (3) Postpartum services defined by the Division of Medicaid as the care of the mother.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Miss. Code Ann § 73-15-20: Certified Nurse Midwives are advanced practice registered nurses governed by the Mississippi Board of Nursing. Mississippi does not license direct-entry midwives, and the practice of medicine is defined so that it does not include "females engaged solely in the practice of midwifery". Miss. Code Ann. § 73-25-33
Other Coverage Requirements (site of service, etc.)	Mississippi Division of Medicaid for Maternity Services. The Division of Medicaid covers maternity services . . . . inclusive of both hospital and office visits following delivery for sixty (60) days including any remaining days in the month in which the sixtieth (60th) day occurs. Miss. Code Ann. § 73-15-20: A certified nurse midwife shall perform authorized functions within a collaborative/consultative relationship with a physician.
Coverage Limitations	Mississippi Division of Medicaid for Maternity Services. The Division of Medicaid does not cover non-medically early elective deliveries, prior to the expected due date including, but not limited to, the following: (1) maternal request, (2) convenience of the beneficiary or family, (3) maternal exhaustion or discomforts, (4) availability of effective pain management, (5) provider convenience (6) facility scheduling, (7) suspected macrosomia with documented pulmonary maturity with no other medical indication, (8) well-controlled diabetes, (9) history of rapid deliveries, (10) long distance between beneficiary and treating facility, or (11) adoption.
Reimbursement Rate	According to Mississippi Division of Medicaid Physician Services, the reimbursement rate in Mississippi for services provided by certified nurse midwives relative to physician reimbursement rates is 90%. Mississippi State Plan Amendment Reimbursement for certified nurse midwifery services shall not exceed 90% of the reimbursement rate for comparable services rendered by a physician.
Reimbursement Methodology	Fee for Service. See Mississippi Division of Medicaid Physician Services

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Missouri	
Medicaid State Plan Amendment: Covered Services	Missouri HealthNet Nurse Midwife Manual: Section 13.9, Covered Services Medicaid covered nurse midwife services are services provided to any individual including, but not limited to, the care, management and monitoring of a woman, in the absence of medical complications, and her unborn/newborn infant throughout the course of the normal cycle of gestation including pregnancy, labor and delivery and the initial post-delivery/postpartum period not to exceed six weeks. Covered services may also include services outside the maternity cycle such as family planning and services to individuals other than mothers and newborns. **A nurse midwife may provide the following services:** Antepartum care, risk appraisal, delivery, postpartum care, preventative healthcare (Healthy Children and Youth Program), newborn care, case management services, family planning services, and laboratory services. Missouri HealthNet Nurse Midwife Manual: Section 13.1 Services furnished by a nurse midwife must be within the scope of practice authorized by federal and state laws or regulations and, in the case of inpatient or outpatient hospital services or clinic services, furnished by or under the direction of a nurse midwife only to the extent permitted by the facility.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Mo. Rev. Stat § 335.016 (6): A certified nurse midwife is a registered nurse who is currently certified as a nurse midwife by the American College of Nurse Midwives, or other nationally recognized certifying body approved by the board of nursing. Mo. Rev. Stat § 335.016 (2): In Missouri, certified nurse midwives are licensed as advanced practice registered nurses. Missouri does not license direct-entry midwives. However, pursuant to Mo. Rev. Stat. § 376.1753, any person who holds current ministerial or tocological certification by an organization accredited by the National Organization for Competency Assurance (NOCA) may provide services as defined in 42 U.S.C. 1396 r-6(b)(4)(E)(ii)(I) ("services related to pregnancy (including prenatal, delivery, and postpartum services)".
Other Coverage Requirements (site of service, etc.)	Missouri HealthNet Nurse Midwife Manual: Section 13, Benefits and Limitations **Provider Participation**: To participate in the MO HealthNet Nurse Midwife Program, the nurse midwife provider must have: (1) a current Missouri Registered Nurse (RN) License (2) evidence of certification by the American College of Nurse Midwives (3) a signed and accepted "MO HealthNet Division" Title XIX Participation Agreement for Nurse Midwife Services" and "MO HealthNet" Provider Questionnaire" in effect with the Missouri Department of Social Services, MO HealthNet Division. **Place of Service:** A nurse midwife may provide care in the following places of service: • Office • Home (delivery and newborn care only) • Inpatient Hospital • Outpatient Hospital • Birthing Center

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Coverage Limitations	Missouri HealthNet Nurse Midwife Manual: Section 13, Benefits and Limitations **Non-covered Services:** • Laboratory tests that were ordered which were provided by another provider. These services must be billed by the provider performing the service. • Night visits—no additional payment is made for night (after hours) visits or for visits on Sundays or holidays. • A nurse midwife may not order or perform an amniocentesis. If there is any indication the maternity care is not for a normal, uncomplicated pregnancy and delivery, the nurse midwife must refer the case to a physician. **Non-allowable Services:** The following services are included in the procedure/delivery and are not separately allowable, billable to the participant or to the MO HealthNet agency as office/outpatient visits, or in any other manner: • Administration of medication/injection (if the patient is examined/treated the service is included in the office/outpatient visit or other procedure performed); • Canceled or "no show" practitioner appointments; • Claim filing; • Courtesy calls; • Drawing fees; • Handling charges for specimens referred to an independent laboratory for interpretation; • Hospital visits. If nurse midwives are in the hospital for delivery, they are the "attending" and sole providers of maternity care. Thirty days postpartum care is included in the reimbursement for the delivery. Separate payment for hospital visits for the mother is non-allowed. • Local anesthetic administered in the office; • Medical care or advice provided by mail or telephone; • Mileage in connection with home deliveries; • Office visits to obtain a prescription, the need of which had already been ascertained; • Prenatal classes; • Routine postpartum care following delivery; • Services or supplies furnished free of charge by any government body (e.g., injectable material, etc.); • Venipuncture for the purpose of obtaining a blood specimen.
Reimbursement Rate	Licensed nurse midwife services operate on a FFS schedule. According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Missouri for services provided by certified nurse midwives relative to physician reimbursement rates is 100%.
Reimbursement Methodology	Missouri HealthNet Nurse Midwife Manual: Section 12, Reimbursement Methodology Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

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	Participant Cost Sharing Services of the Nurse Midwife Program described in this manual are subject to a cost sharing or copay amount. The provider must accept in full the amounts paid by the state agency plus any cost sharing or copay amount required of the participant. Refer to Section 13 of the Nurse Midwife Provider Manual for program specific information.
Notes [managed care, private plans, related services]	Missouri HealthNet Nurse Midwife Manual **Section 12.6 – Managed Care** A basic package of services is offered to the participant by the MO HealthNet Managed health care plan; however, some services are not included and are covered by MO HealthNet on a FFS basis. Nurse midwife services are included as a plan benefit in the MO HealthNet managed care program. **Section 1.5.C(1) Home Birth Services for Managed Care Program** If a managed care health plan member elects a home birth, the member may be disenrolled from the managed care program at the request of the managed care health plan. The disenrolled member then receives all services through the FFS program. The member remains disenrolled from the managed care health plan if eligible under the MO HealthNet for Pregnant Women category of assistance. If the member is not in the MO HealthNet for Pregnant Women category and is disenrolled for the home birth, she is enrolled/re-enrolled in a managed care health plan six weeks post-partum or after a hospital discharge, whichever is later. The baby is enrolled in a managed care health plan once a managed care health plan number is assigned or after a hospital discharge, whichever is later.
Montana	
Medicaid State Plan Amendment: Covered Services	Medicaid Member Guide CNMs are considered mid-level providers by Montana Medicaid. SPA MT-17-0016: Montana Medicaid covers direct entry midwives for reimbursement. The SPA clarified that doulas and lactation consultants are not covered birth attendants. Birth attendant means a person that is licensed as a direct entry midwife as defined in Title 37, chapter 27, Montana Codes Annotated (MCA) and Administrative Rules of Montana (ARM) Title 24, chapter 111, subchapter 6.

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Licensing or Credentialing Requirements	**1) CNM** Mont. Admin. R. 24.159.1413 CNMs are licensed as advanced practice registered nurses. Mont. Admin. R. 24.159.1475 Certified Nurse Midwifery practice means the independent and/or collaborative management of care of women throughout the lifespan. The CNM is certified in the population focus of women's/ gender-related health and provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and the care of the newborn in diverse settings. The practice includes treating the male partner of their female clients for sexually transmitted diseases and for reproductive health. Mont. Code Ann. § 37-8-405 An applicant seeking to obtain their license must have completed a 4-year high school degree and basic professional curriculum in an approved school of nursing and holds a diploma from that school. **2) Direct-Entry Midwives** Mont. Code Ann. § 37-27-201 To be eligible for a license as a direct-entry midwife, an applicant: (1) must possess a high school diploma or its equivalent; (2) must be of good moral character and be at least 21 years of age; (3) shall satisfactorily complete educational requirements in pregnancy and natural childbirth, approved by the board, which must include but are not limited to the following: • provision of care during the antepartum, intrapartum, postpartum, and newborn period; • parenting education for prepared childbirth; • observation skills; • aseptic techniques; • management of birth and immediate care of the mother and the newborn; • recognition of early signs of possible abnormalities; • recognition and management of emergency situations; • special requirements for home birth; • intramuscular and subcutaneous injections; • suturing necessary for episiotomy repair; • recognition of communicable diseases affecting the pregnancy, birth, newborn, and postpartum periods; • assessment skills; and • the use and administration of drugs authorized in 37-27-302; (4) shall acquire practical experience, which may be attained in a home, clinic, or hospital setting. Practical experience must include the following types and numbers of experiences: • provision of 100 prenatal examinations; • observation of 40 births; and • participation as the primary birth attendant at 25 births, 15 of which included continuous care (5) shall file documentation with the board that the applicant has been certified by the American heart association or American red cross to perform adult and infant cardiopulmonary resuscitation. (6) shall file documentation with the board that the applicant has been certified by the American academy of pediatrics or the American heart association to perform neonatal resuscitation.

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Other Coverage Requirements (site of service, etc.)	**CNM – Site of Service** Mont Admin. R. 37.85.207(l) Delivery services are not covered by Medicaid if they are not provided in a licensed health care facility or nationally accredited birthing center unless as an emergency service. **CNM – Required Modifier** Mont. Admin. R. 37.86.205(8) Claims for child delivery must have one of the following line procedure code modifiers or the line will be denied (see codes in link) [See also Mont. Admin R. 37.86.205(10) which states that gestational age must be determined and documented in medical records for reimbursement.] **Direct Entry Midwives – Site of Service** Mont. Admin. R. 37.86.1201 (2) Direct-entry midwives may only provide prenatal labor and delivery or postpartum care in a birthing center. Mont. Admin. R. 37.86.3001(3) "Birthing center" means a facility that provides comprehensive obstetrical care for women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy and is either: (a) a licensed outpatient center for primary care with medical resources as defined at 50-5-101, MCA; or (b) a private office of a physician or certified nurse midwife that is accredited by a national organization as an alternative to a homebirth or a hospital birth **Reporting Requirements – Direct-Entry Midwives** Mont. Code. Ann § 37-27-320 A licensed direct-entry midwife shall submit semiannually to the board, on forms supplied by the board, a summary report on each patient who was given care. The report must include vital statistics on each patient and information on the procedures and scope of care administered, including transport of the patient to a hospital and physician referrals, but may not include information disclosing the identity of the patient. (2) A licensed direct-entry midwife shall report within 72 hours to the board and to the department of public health and human services any maternal, fetal, or neonatal mortality or morbidity in patients for whom care has been given. [See also Mont. Admin. R. 24.111.613.]
Coverage Limitations	**Direct Entry Midwives –Administration of prescription drugs prohibited (exceptions)** Mont. Code Ann. § 37-27-302 A licensed direct-entry midwife may not dispense or administer prescription drugs other than newborn vitamin K (oral or intramuscular preparations), pitocin (intramuscular) postpartum, xylocaine (subcutaneous), and, in accordance with administrative rules adopted by the department of public health and human services, prophylactic eye agents to newborn infants. These drugs may be administered only if prescribed by a physician. **Direct Entry Midwives –Operative and surgical procedures prohibited (exception)** Mont. Code Ann. § 37-27-303 A licensed direct-entry midwife may not perform any operative or surgical procedures except for an episiotomy and simple surgical repair of an episiotomy or simple second-degree lacerations. **Direct Entry Midwives –Physician consultation advised.** Mont. Code Ann § 37-27-315 A licensed direct-entry midwife shall advise all women accepted for midwifery care to consult with a physician or certified nurse-midwife at least twice during the pregnancy. **Direct Entry Midwives – High-risk pregnancies** Mont. Admin. R. 24.111.610 Direct-entry midwives are not permitted to accept a woman as a client who has a high-risk pregnancy. See also Mont. Admin. R. 24.111.611, which details instances in which direct-entry midwives are

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	required to consult a physician. **Direct Entry Midwives – Vaginal Birth After Cesarean (Vbac) Deliveries** Mont. Admin. R. 24.111.612 A licensed direct-entry midwife shall not assume primary responsibility for prenatal care and/or birth attendance for women who have had a previous cesarean section, unless certain conditions are met.
Reimbursement Rate	**Certified Nurse Midwives** Mont. Admin. R. 37.86.205 CNMs are reimbursed at the same rates as all mid-level practitioner services. According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Montana for services provided by certified nurse midwives relative to physician reimbursement rates is 90%. **Direct-entry midwife** services operate on a Fee Schedule.
Reimbursement Methodology	**CNMs** Mont. Admin. R. 37.86.205 Reimbursement for services, except as otherwise provided in this rule, is the lower of: (a) usual and customary charges; or (b) a provider rate of reimbursement which is a percentage of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105. **Direct Entry Midwives** Mont. Admin. R. 37.85.212 Direct-entry midwives are reimbursed pursuant to a resource based relative value scale.
Nebraska	
Medicaid State Plan Amendment: Covered Services	Nebraska Medicaid Program: Medicaid Services Medicaid pays for the following nurse midwife activities: 1. Attending cases of normal childbirth; 2. Providing prenatal, intrapartum, and postpartum care; 3. Providing normal obstetrical and gynecological services for women; and 4. Providing care for the newborn immediately following birth *See also* Neb. Rev. Stat. 38-611 NE Medicaid State Plan, 3.1(a)(1)(ii((Rev'd Feb. 2018) Nurse-midwife services listed in section 1905(a)(17) [services furnished by a nurse-midwife], are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider

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Licensing or Credentialing Requirements	**Only services by Nurse Midwives are covered.** Neb. Rev. Stat. 38-604 Must successfully complete an approved certified nurse midwifery education program 471 NAC 18-004.42 Nebraska Medical Assistance Program ("NMAP") [NE Medicaid] • Nurse-midwife must be certified by the Nebraska Department of Health and Human Services Regulation and Licensure • There must be a ***"practice agreement"*** between the nurse-midwife and the physician must be on file with the Department of Health and Human Services Regulation and Licensure. • The nurse-midwife is approved for enrollment in NMAP under a group provider agreement with the physician with whom s/he has a practice agreement.
Other Coverage Requirements (site of service, etc.)	None identified.
Coverage Limitations	NE Medicaid State Plan, 3.1(a)(1)(iii) "Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends)" 471 NAC 18-004.42 NMAP covers nurse-midwife services that are medically necessary in accordance with his/her scope of practice as defined by law NMAP ***does not cover routine office visits*** to a physician when a nurse-midwife is providing complete obstetrical care, unless documentation of medical necessity for the physician's office visit is submitted
Reimbursement Rate	471 NAC 18-004.42 "Payment for nurse-midwife services is made at the lower of – 1. The provider's submitted charge; or 2. The Medicaid allowable amount for the procedure code billed." 471 NAC 18-004.42 "NMAP covers prenatal care, delivery, and post-partum care as a 'package' service" "Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items."
Reimbursement Methodology	471 NAC 18-004.42 "Payment for nurse-midwife services is made to the group with whom the nurse-midwife has a practice agreement; the group is then responsible for payment to the nurse-midwife."

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Notes [managed care, private plans, related services]	Neb. Rev. Stat. 38-609 **"Practice agreement"** is defined under the Certified Nurse Midwifery Practice Act as "the written agreement authored and signed by the certified nurse midwife and the licensed practitioner with whom he or she is associated which: (1) Identifies the settings within which the certified nurse midwife is authorized to practice; (2) Names the collaborating licensed practitioner or, if more than one licensed practitioner is a party to such practice agreement, names all of the collaborating licensed practitioners; (3) Defines or describes the medical functions to be performed by the certified nurse midwife, which are not inconsistent with the Certified Nurse Midwifery Practice Act, as agreed to by the nurse midwife and the collaborating licensed practitioner; and (4) Contains such other information as required by the board." Title 172 Ch 104 Nebraska Medicaid Managed Care: "Services included in the Basic Benefits Package: . . . Physician services, including . . . certified nurse midwife services." 482 NAC 4-004.01. "The Department [of Health and Human Services in Nebraska] pays a monthly capitation fee to the Managed Care Organization's (MCO's) physical health plan (health plan) for each enrolled client for each month of Managed Care coverage (per member per month). The monthly capitation fee includes payment for all services in the Basic Benefits Package." 482 NAC 4-005. Nursing Home NMAP covers nurse-midwife services that are medically necessary and are concerned with the management of the care of mothers and newborns throughout the maternity cycle. The maternity cycle includes pregnancy, labor, birth, and the immediate postpartum period (up to six weeks), including care of the newborn. To be covered, the services must be provided by a certified nurse- midwife according the terms of the practice agreement between the nurse-midwife and the physician (Medicaid, p. 344).
Nevada	
Medicaid State Plan Amendment: Covered Services	Billing Guide "Certified nurse midwives (CNMs) are registered nurses (RNs) who have advanced education and midwifery training and certification. Nurse midwives work with women, before and after pregnancy, deliver babies in hospitals and in homes, provide family planning and birth control counseling and may provide gynecological exams." Billing Guide **Covered Services:** "Medicaid provides reimbursement to nurse midwives for pregnancy related services such as office visits, maternity care, and prenatal and family planning services only. Some lab services are also covered Medicaid benefits."and family planning agencies.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Provider Enrollment Checklist **Required Documents for Provider Enrollment as a Midwife:** 1. State Board of Nursing license for Advanced Practitioner of Nursing (APN) 2. American College of Nurse Mid-wifes license

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Other Coverage Requirements (site of service, etc.)	Medicaid Services Manual p. 21 Rural Health Clinics (RHCs): Medicaid covered outpatient services provided in RHCs are reimbursed at an all inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day. This all-inclusive rate includes any one or more of the following services and medical professionals: Certified Nurse Midwife Medicaid Brochure "Some certified midwives can deliver babies in a birthing center or the hospital in case of an emergency during delivery."
Coverage Limitations	Medicaid Services Manual p. 9 Maternity Care is a program benefit which includes antepartum care, delivery, and postpartum care provided by a physician and/or a nurse midwife. For women who are eligible for pregnancy related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21, and eligible for pregnancy only, are not entitled to EPSDT services.
Reimbursement Rate	Medicaid State Plan Amendment Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below in the linked Plan Amendment above.
Reimbursement Methodology	**Nurse Midwives bill as Fee-for-Service.** Linked here is the Reimbursement Schedule for Nurse Midwives: Reimbursement Schedule
Notes [managed care, private plans, related services]	Medicaid Services Manual p. 11 The MCO must make certified nurse midwife services available to enrollees, if such services are available in the MCO's service area. If the MCO does not have a contract for said services, the MCO must pay the certified nurse midwife provider according to the Medicaid FFS schedule for services rendered to the recipient.
New Hampshire	
Medicaid State Plan Amendment: Covered Services	NH Healthy Families Provider Manual Nurse midwives are covered as APRNs. Certified Midwife Provider Manual **Covered Services:** 1. Providing supervision and advice during pregnancy, labor and the postpartum period 2. Providing care during the member's: a) Pregnancy, including: • Preventive care

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	• The detection of abnormal conditions of the mother and fetus • The execution of emergency measures in the absence of medical help b) Labor, including: • The conduction of vaginal deliveries on their own responsibility • The execution of emergency measures in the absence of medical help c) Postpartum period, including: • Preventive care for the mother and newborn; • The detection of abnormal conditions of the mother and newborn • The execution of emergency measures for the mother and newborn in the absence of medical help 3. Administering medications in accordance with RSA 326-D:12. See also N.H. Admin. R. Mid 502.01 – 502.02 detailing the scope of practice of a certified midwife and appropriate related procedures. See also NH Medicaid Program Webpage, list of covered services
Licensing or Credentialing Requirements	**1) CNMs** New Hampshire Board of Nursing Certified Nurse Midwives are licensed as advanced registered nurse practitioners. **2) Certified Midwives** N.H. Rev. Stat. Ann. § 326-D:7 Direct-entry midwives are certified as New Hampshire certified midwives by the New Hampshire Midwifery Council. To become certified a person shall: • have completed high school • complete one college-level course in human anatomy and physiology, or pass a college-level equivalency program or credit by exam • Meet practical experience requirements prescribed by the council See also N.H. Admin. R. Mid. 303.01 Certified Midwives must hold a current certificate in in adult, child and infant cardiopulmonary resuscitation.
Other Coverage Requirements (site of service, etc.)	Home Birth N.H. Admin. R. Mid. 502.03(k)(6) A client preparing for home birth must keep information readily available for ambulance services, nearby hospitals, and the newborn's health care provider. N.H. Admin. R. Mid. 502.09 If certain health conditions are present, a certified midwife must consult with a CNM or obstetrician to evaluate whether an out-of-hospital birth is appropriate. **Documentation** Certified Midwife Provider Manual Midwifery services can be submitted on either a CMS1500 paper form or the UB04 depending on whether the center is free standing or hospital based. **Consultation** N.H. Admin. R. Mid. 502.05 – 502.06 A certified midwife is required to consult a physician or CNM to determine whether the care for a client or newborn should be transferred to the hospital setting if certain complications occur.

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Coverage Limitations	**Ineligibility for Midwife Care** N.H. Admin. R. Mid. 502.08 A certified midwife cannot accept a client if they appear or report certain health conditions (e.g. insulin dependent diabetes, blood diseases, chronic hypertension, etc.). N.H. Rev. Stat. Ann. § 326-D:12 **Certified Midwives** must administer medications under the conditions listed: (a) Rh immune globin (Rhogam), if indicated. (b) Eye prophylaxis in accordance with RSA 132:6. (c) Oxygen for fetal distress and infant resuscitation. (d) Lidocaine Hydrochloride by infiltration and suture material, but only for the purpose of postpartum repair of tears, lacerations, or episiotomy. (e) Vitamin K by injection or oral vitamin K for control and prevention of acute and late onset hemorrhagic disease in the newborn. (f) Oxytocins such as pitocin, ergotrate, and methergine, by injection or orally, only for postpartum control of maternal hemorrhage. (g) Intravenous fluids such as Ringer's Lactate with or without D5W and Normosol-R with or without D5W, with no additional medications unless specifically ordered by physician. (h) Other drugs or medications as prescribed by a physician, consistent with the scope of midwifery practice as defined by the council. Certified Midwife Provider Manual **Non-Covered Services** Non-covered certified midwife services are those services which a NHCM is not legally recognized to perform, including: • Operative obstetrics • Cesarean sections • General and conductive anesthesia • Contraction stress tests • Treatment to enhance fertility or procreation • Any artificial, forcible, or mechanical means to assist the delivery • Induced abortions **Prior Cesarean Section** N.H. Admi. R. Mid. 503.02 A midwife can accept a client if she has had a previous birth by cesarean section if certain conditions are met.
Reimbursement Rate	**1) CNM** According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in New Hampshire for services provided by certified nurse midwives relative to physician reimbursement rates is 100%. **2) Certified Midwife** Midwives are reimbursed on a fee-for-service basis.
Reimbursement Methodology	**1) CNM** Fee schedule **2) Certified Midwife** Certified Midwife Provider Manual Payment for services to NHCMs shall be made in accordance with fee schedules established by the Department pursuant to RSA 161:4, VI(a). Payment is made for the administering of injections when provided as part of an examination and/or treatment in accordance with the following guidelines: HCPCS Codes J2000–J7120, include the cost of the drug. In addition, use 90782 for the cost of administering the medication. Injections may be billed separately or in conjunction with an office visit. The cost of administering the RhoGam vaccine may be billed using HCPCS code 90471.

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New Jersey	
Medicaid State Plan Amendment: Covered Services	No State Plan Amendment guidance for midwife reimbursement.
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** N.J. Admin. Code § 10:58-1.4(a): Nurse midwives must be licensed by the New Jersey State Board of Nursing and certified by the American College of Nurse Midwives. **Note** that New Jersey provides for licensure of **"certified midwives" or "certified professional midwives"** as regulated by the Midwifery Liaison Committee under the Board of Medical Examiners. Certified midwives and certified professional midwives are a distinct category from certified nurse midwives. **New Jersey Medicaid does not cover services provided by certified midwives or certified professional midwives.**
Other Coverage Requirements (site of service, etc.)	N.J. Admin. Code § 10:54-2.4(a): A Certified Nurse Midwife shall work with a physician under the collaborative arrangement. N.J. Admin.Code § 10:58-1.2: Reimbursement may be made for services provided by a CNM employed by a physician (or group), by an independent clinic, or by a hospital.
Coverage Limitations	N.J. Admin. Code § 10:58-1.3: Nurse midwifery services means services provided by a CNM to manage the care of essentially normal women during the maternity cycle; to provide care to essentially normal newboards at time of delivery; and to provide well-woman health care. Nurse midwifery services are provided within the scope of practice of nurse midwifery and by the rules of Board of Medical Examiners.
Reimbursement Rate	N.J. Admin.Code § 10:58-1.7(a): Reimbursement for CNM services shall be based upon the provider's usual and customary charge or the allowance determined by the Commissioner of the Department of Human Services and contained in NJAC 10:58-3, whichever is less.
Reimbursement Methodology	N.J. Admin.Code § 10:58-1.7(b): A CNM that is independent and not part of a physician group may be directly reimbursed by the FFS programs. N.J. Admin.Code § 10:58-1.7(d): A CNM shall not bill FFS if salaried and whose services are reimbursed as part of the hospital's costs.
Notes [managed care, private plans, related services]	N.J.Stat. §§ 17:48A-7ee, 17:48E-35.32, 17B:26-2.1bb, 17B:27-46.1hh: 17B:27A-7.15, 26:2J-4.33: NJ: Statutes require insurance policies that provide benefits for maternity services to provide for reimbursement of obstetrical providers, including a certified midwife or a certified nurse midwife.

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New Mexico	
Medicaid State Plan Amendment: Covered Services	N.J.Stat. §§ 17:48A-7ee, 17:48E-35.32, 17B:26-2.1bb, 17B:27-46.1hh: 17B:27A-7.15, 26:2J-4.33: NJ: Statutes require insurance policies that provide benefits for maternity services to provide for reimbursement of obstetrical providers, including a certified midwife or a certified nurse midwife.
Licensing or Credentialing Requirements	**1) CNM** 16.11.2.9 Licensure requirements: A CNM shall hold a license that meets the New Mexico board of nursing requirement to practice as a registered nurse in New Mexico and shall hold current certification by AMCB or its designee. The department may deny licensure, including renewal or reinstatement of licensure, to a CNM whose midwifery or nursing license has been subject to disciplinary action in any jurisdiction. If denied, re-application will only be considered after a minimum of one year from date of initial denial, and the re-application must be accompanied by full disclosure and complete record of previous actions. A CNM license is not transferable. 16.11.2.9 An initial CNM license may be issued at any time upon submission and verification of the materials required of this subsection and shall expire on the expiration date of the registered nurse license issued by the New Mexico board of nursing. A CNM license shall be valid for a maximum of two years. **2) Licensed Midwives** 16.11.3.8 An apprentice midwife may provide any care or services allowed by these regulations as set out in 16.11.3.12.1 only under the supervision of a midwifery instructor. The midwifery instructor reviews and evaluates all care provided by and attends every labor and delivery managed by the apprentice. The midwifery instructor retains the responsibility for clients seen by apprentices The Division requires full disclosure of past midwifery licensure, suspensions, and revocations which will be considered before granting any license or permit
Other Coverage Requirements (site of service, etc.)	1) CNM No additional information was found for CNMs. **2) Licensed Midwife** 6.11.3.12 Scope of Practice: The licensed midwife may provide care to women without general health or obstetrical complications as defined by the Standards and Core Competencies of Practice for Licensed Midwives in New Mexico and the New Mexico Midwives Association: Policies and Procedures, or equivalent approved by the NMMA and the Division. Such care includes: (1) Prenatal care and counseling (2) Intrapartum care and support (3) Postpartum care and counseling (4) Well-woman care (5) Immediate newborn care (6) Administration of specific drugs and medications as outlined in the New Mexico Midwives Association Policies and Procedures Each woman accepted for care must be referred at least once to a duly licensed physician within 4 weeks of her initial midwifery visit. The referral must be documented in the chart

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	It shall be the responsibility of the midwife to develop a means for consultation with or referral/transfer to a physician or hospital if there are significant deviations from the normal in the health status of either mothers or infants as set out in the Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico Any consultative relationship with a physician shall not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife.
Coverage Limitations	8.310.2.12 Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife: (i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient; (ii) services furnished by an apprentice; unless billed by the supervising midwife; (iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim. **CNM-Specific** Section 26-1 NMSA 1978, New Mexico Drug, Device and Cosmetic Act A CNM who prescribes, distributes, or administers a dangerous drug or device shall do so in accordance with Section 26-1 NMSA 1978, New Mexico Drug, Device and Cosmetic Act. Section 26-1 1978 NMSA, Controlled Substances Act CNMs cannot prescribe nor distribute controlled substances in Schedule I of Section 26-1 1978 NMSA, Controlled Substances Act. 16.11.2.10(c) CNM cannot prescribe, distribute, or administer controlled substances in Schedules II-V of the Controlled Substances Act unless the CNM is registered with the New Mexico board of pharmacy and the United States drug enforcement administration to prescribe, distribute, and administer controlled substances.
Reimbursement Rate	8.310.3.11 CNMs are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at 77% of the rate paid to physicians for furnishing the global services and at 100% of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule. If partial services are furnished by a midwife, such as prenatal care only, 1 or 2 trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code. If the services furnished include a combination of services performed by a midwife and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the CNM or licensed midwife MAD covers postnatal care by a midwife as a separate service only when the midwife does not perform the delivery. Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.
Reimbursement Methodology	8.310.3.11 Reimbursement for midwife maternity services is based on one global fee, which includes prenatal care, delivery and postnatal care. Services related to false labor are included as part of the global fee.

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New York	
Medicaid State Plan Amendment: Covered Services	Section II New York Medicaid Program Midwife Manual Policy Guidelines Under the New York State Medicaid Program, midwife services may be provided as medically indicated to eligible recipients. Midwife services are services concerned with the management of the care of mothers and newborns throughout the maternity cycle as well as services provided for primary preventive reproductive health care of essentially healthy women as set forth in State Education Law and newborn evaluation, resuscitation and referral for infants. The maternity cycle includes pregnancy, labor, birth and the immediate postpartum period. The immediate postpartum period extends a maximum of six weeks from the date of delivery. Pre and post-natal visits may include counseling about family planning services to the extent that such counseling is within the midwife's scope of practice.
Licensing or Credentialing Requirements	**It appears that only services provided by a nurse midwife are covered, but that the state may consider "equivalent" licensure or certification for coverage.** Title 8 Article 140 Section 6955. Requirements for a professional license Midwifery To qualify for a license as a midwife an applicant must (a) complete educational preparation (degree or diploma granting) for the **practice of nursing**, followed by or concurrently with educational preparation for the practice of midwifery in accordance with the commissioner's regulations, **or** (b) submit evidence of license or certification, the educational preparation for which is determined by the department to be **equivalent to the foregoing**, from any state or country, satisfactory to the department and in accordance with the commissioner's regulations, or (c) complete a program determined by the department to be equivalent to the foregoing and in accordance with the commissioner's regulations.
Other Coverage Requirements (site of service, etc.)	New York Medicaid Program Midwife Manual Policy Guidelines Midwife services may be provided in a hospital on an inpatient or outpatient basis, in a treatment and diagnostic center, in an office, or in the recipient's home. The midwife must maintain and submit to the DOH, on request, a copy of the written practice agreement(s) with a licensed and currently registered physician(s) defining protocols for referral and consultation in the event of medical complications.
Coverage Limitations	Section II New York Medicaid Program Midwife Manual Policy Guidelines The maternity cycle includes pregnancy, labor, birth and the immediate postpartum period. The immediate postpartum period extends a maximum of six weeks from the date of delivery. Pre and post-natal visits may include counseling about family planning services to the extent that such counseling is within the midwife's scope of practice.
Reimbursement Rate	Fee for Service
Reimbursement Methodology	Fee for Service

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North Carolina	
Medicaid State Plan Amendment: Covered Services	N.C. Dept of Health and Human Services – Medicaid Eligibility Manual – Medicaid Covered Services (MA-2905-XXXVI) Medicaid covers nurse midwives who are licensed and approved by the Board of Nursing and who practice under the supervision of a physician who is licensed by the Board of Medicine to practice and who is actively engaged in the practice of obstetrics. "Core services" as they pertain to midwives--Nurse midwife services and services and supplies incident to such services Obstetrics Pregnancy Medical Home (PMH) services Physician services & physician-directed services (includes certified nurse midwives) in Rural Health Clinics (covers family planning services, antepartum care, and postpartum care) Nurse midwives may bill Medicaid for telemedicine professional services Nurse midwives can be reimbursed for Regular Medicaid Family Planning services, including consultation, examination, and treatment Nurse midwives who employ certified childbirth educators are eligible to bill for this service See FAQs from the Board of Nursing
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** 10A 90-178.3 Need approval under Nurse Licensure Compact (to obtain approval, complete an application on a form furnished by joint subcommittee, submit evidence of certification by American College of Nurse-Midwives, submit evidence of arrangements for physician supervision, and pay the application fee) Persons approved under Nurse Licensure Compact may practice midwifery in a hospital or non-hospital setting under the supervision of a licensed physician actively engaged in the practice of obstetrics Graduate nurse midwife applicant status may also be granted by the joint subcommittee **Midwifery:** the act of providing prenatal, intrapartum, postpartum, newborn, and interconceptional care. N.C. Gen. Stat. § 90-178.2 **Midwife:** A certified nurse midwife appear to be the only acceptable level of "midwife" in NC. Such midwives must have a primary supervising physician and at least one back-up primary supervising physician. 21 NCAC 33 .0101 **Advanced Practice Registered Nurse (APRN):** nurse-midwives can be APRNs, and must meet the same continuing education program requirements for their advanced degrees. 21 NCAC 36.0120; 21 NCAC 36.0223
Other Coverage Requirements (site of service, etc.)	Obstetrics: Covered services may be provided at an inpatient hospital, outpatient hospital, physician office. For federally qualified health center (FQHC) and rural health center (RHC) "core services," Medicaid covers when furnished at the clinic, SNF, adult care home, other medical facility, or the beneficiary's place of residence by a staff member employed by FQHC or RHC

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Coverage Limitations	No prior approval. Delivery procedures are limited to 1 per 225 days unless separate pregnancies and deliveries.
Reimbursement Rate	**N.C. Hospital Service Provider Manual, Appendix C Medicaid Services and Programs** Certified nurse midwives are "registered professional nurse[s] providing services to essentially healthy pregnant women and newborns throughout the maternity cycle that includes labor, birth and the postpartum period. Nurse midwives practicing in accordance with state law are reimbursed at the same rate as physicians for those services they are authorized to perform."
Reimbursement Methodology	Fee for service
Notes [managed care, private plans, related services]	**N.C. Medicaid Manual 6.1**: Nurse midwives may provide telemedicine professional services and bill Medicaid or NCHC.
North Dakota	
Medicaid State Plan Amendment: Covered Services	Provider Manual p. 145 Certified nurse midwife services covered under Medicaid. Nurse Practices Act 43-12.01-02(1) "Advanced practice registered nurse" means an individual who holds a current license to practice in this state as an advanced practice registered nurse within one of the roles of certified nurse practitioner, certified registered nurse anesthetist, **certified nurse midwife**, or certified clinical nurse specialist, and who functions in one of the population foci as approved by the board." Nurse Practices Act 43-12.1-03. An advanced practice registered nurse shall use the abbreviation "APRN" and may use the applicable role designation of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist inclusive of population foci
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** Nurse Practices Act 43-12.1-03. Direct entry midwives are not regulated by North Dakota; there is no licensure available. Certified Nurse-Midwives are licensed as Advanced practice registered nurses (APRN).

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Other Coverage Requirements (site of service, etc.)	None identified.
Coverage Limitations	Provider Manual p. 20 No age restrictions, service authorization not required, no limitations, and no referral required from primary care for nurse midwife services.
Reimbursement Rate	No fee schedule available.
Reimbursement Methodology	**Fee-for-service** Provider Manual p. 145
Ohio	
Medicaid State Plan Amendment: Covered Services	Provider Manual p. 95 A certified nurse midwife approved under section 4723.42 of the Revised Code is eligible to become an Ohio Medicaid provider as an individual nurse midwife. Ohio Admin 3701-83-56. (A) "Apprentice midwife" means an individual who is currently serving an apprenticeship under a practicing midwife. (B)"Certified professional midwife" means an independent practitioner who has met the standards for certification set by the North American registry of midwives. (C)"Certified nurse-midwife" or "CNM" has the same meaning as in paragraph (A) of rule 3701-83-33 of the Administrative Code. (G) "Lay midwife" or "traditional midwife" means an individual who has entered the profession as an apprentice to a practicing midwife rather than a formal school or certification program. (K) "Midwife" means a certified professional midwife, a lay midwife, or a traditional midwife. OAR 4723-8-01(A). (A) "Advanced practice registered nurse" means an individual who holds a current, valid license issued under Chapter 4723. of the Revised Code that authorizes the practice of nursing as an advanced practice registered nurse and is designated as any of the following: (1) A certified registered nurse anesthetist; (2) A clinical nurse specialist; (3) A certified nurse-midwife; (4) A certified nurse practitioner. Provider Manual p. 94 "Advanced practice nurse" shall be defined for the purpose of rules 5101:3-8-21 to 5101:3-8-23 of the Administrative Code as: is a registered nurse who holds a certificate of authority issued by the board of nursing to practice as a certified nurse practitioner, clinical nurse specialist, or **certified nurse midwife** in accordance with section 4723.42 of the Revised Code and meets the criteria set forth in rule 5101:3-8-21 of the Administrative Code.

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Licensing or Credentialing Requirements	Only services by CNM are covered. OAC 4723-8-03. Only a person who holds a current valid advanced practice registered nurse license issued in accordance with sections 4723.41, 4723.42 and 4723.482 of the Revised Code and this chapter to practice as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist shall: (1) Practice in accordance with section 4723.43 of the Revised Code and this chapter as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist; (2) Hold themselves out as being a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, clinical nurse specialist, or advanced practice registered nurse; (3) Use any title or initials implying that the person is a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, clinical nurse specialist, or advanced practice registered nurse authorized to practice in accordance with section 4723.03 of the Revised Code and paragraph (A) of this rule Medicaid Provider Manual Rule 5101:3-8-21 A **certified nurse midwife** can become an eligible Medicaid provider by receiving a certificate of authority to practice as a certified nurse midwife from the Ohio Board of Nursing. In order to receive this certificate, a certified nurse midwife must have completed an accredited course of study and be certified by either the American College of Nurse Midwives, the American Midwifery Certification Board, or the American College of Nurse Midwives Certification Council. Provider Manual p. 95 A certified nurse midwife approved under section 4723.42 of the Revised Code is eligible to become an Ohio Medicaid provider as an individual nurse midwife upon execution of an Ohio Medicaid provider agreement if all of the following are met: (1) The certified nurse midwife holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code. (2) The certified nurse midwife has completed an accredited course of study. (3) The certified nurse midwife is certified by the American college of nurse-midwives, the American midwifery certification board, or the American college of nurse midwives certification council.
Other Coverage Requirements (site of service, etc.)	Ohio does not license or otherwise regulate direct-entry midwives, but it does expressly allow direct-entry midwives to practice in "freestanding birthing centers." Ohio Admin 3701-83-56.
Coverage Limitations	Covered Services- Medicaid Manual 5160-8-23(c)(6). "Covered nurse midwifery services" are defined as those services which that constitute the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically. Only advanced practice nurses who are certified nurse midwives may perform and bill for deliveries. In addition, the following services are noncovered when performed by nurse midwives, except in unavoidable, emergency situations: (a) Management of an acute obstetric emergency;, including any obstetric operation; (b) Version or delivery of breech or face presentation; and (c) Use of forceps.
Reimbursement Rate	Unable to locate public fee schedule.
Reimbursement Methodology	Fee-for-service
Notes [managed care, private plans, related services]	Medicaid Managed Care Program Managed Care reimbursement available for providers that have contracted with a managed care plan.

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Oklahoma	
Medicaid State Plan Amendment: Covered Services	Oklahoma Healthcare Authority Medicaid covers nurse midwife services. Okla. Stat. tit. 59, § 567.3a 8. "Nurse-Midwife" is a nurse who has received an Advanced Practice Registered Nurse license from the Oklahoma Board of Nursing who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. A Certified Nurse-Midwife in accordance with the scope of practice of such Certified Nurse-Midwife shall be eligible to obtain recognition as authorized by the Board to prescribe, as defined by the rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician. This authorization shall not include the dispensing of drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients. The Certified Nurse-Midwife accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice registered nursing standards and functions as defined by the scope of practice/role definition statements for the Certified Nurse-Midwife; 9. "Nurse-midwifery practice" means providing management of care of normal newborns and women, antepartally, intrapartally, postpartally and gynecologically, occurring within a health care system which provides for medical consultation, medical management or referral, and is in accord with the standards for nurse-midwifery practice as defined by the American College of Nurse-Midwives;
Licensing or Credentialing Requirements	**Only services by CNM are covered.** Okla. Admin. Code § 485:10-15-8 (a) Educational preparation. An applicant for licensure as a Certified Nurse-Midwife must provide evidence of Successful completion of a nurse midwifery program accredited by the Accreditation Commission for Midwifery Education. Effective January 1, 2016, an applicant for initial licensure or licensure by endorsement as a Certified Nurse-Midwife must hold a graduate level degree from an advanced practice education program accredited by the Accreditation Commission for Midwifery Education. (b) Certification. The applicant for licensure as a Certified Nurse-Midwife must hold current certification for the practice of nurse-midwifery from the American Midwifery Certification Board (AMCB).
Other Coverage Requirements (site of service, etc.)	Okla. Stat. tit. 59, § 567.3a A Certified Nurse-Midwife in accordance with the scope of practice of such Certified Nurse-Midwife shall be eligible to obtain recognition as authorized by the Board to prescribe, as defined by the rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician.
Coverage Limitations	Okla. Stat. tit. 59, § 567.3a A Certified Nurse-Midwife in accordance with the scope of practice of such Certified Nurse-Midwife shall be eligible to obtain recognition as authorized by the Board to prescribe, as defined by the rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician. This authorization shall not include the dispensing of drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients.
Reimbursement Rate	Fee Schedule
Reimbursement Methodology	Fee for service

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Oregon	
Medicaid State Plan Amendment: Covered Services	Oregon's Out-of-Hospital Reimbursement Guide **LDMs, CNMs, DCs, NDs, DOs, NPs, and MDs** enrolled with OHA may seek authorization and reimbursement for planned out-of-hospital birth services to OHP members. ORS 687.405 Direct Entry Midwifery means providing the following services for compensation: 1. Supervision of the conduct of labor and childbirth; 2. Providing advice to a parent as to the progress of childbirth; 3. Rendering prenatal, intrapartum and postpartum care; and 4. Making newborn assessments. Board of Direct Entry Midwifery - Practitioner Information LDMs are legally authorized to administer certain legend drugs and devices under ORS 687.493 and Oregon Administrative Rules (OAR) 332-025-0030, 0040 and 0050, including anti-hemorrhagics, oxygen, I.V. drip sets and catheters, and sutures.
Licensing or Credentialing Requirements	**Services provided by CNMs and LDMs are eligible for coverage.** Oregon's Out-of-Hospital Reimbursement Guide All providers seeking authorization/reimbursement for an out of hospital birth must: -Have a current license to practice in Oregon; -Be in good standing with their respective licensing boards; and -Have no patient safety-related disciplinary investigation or action pending or in process. (OHA will consider providers with past investigations or actions for enrollment on a case-by-case basis.) ORS 687.415 Persons performing midwifery duties are required to be licensed by the State unless already licensed as a health care professional with midwifery duties within the scope of the license; or the person is a traditional midwife. Board of Direct Entry Midwifery - License Information Qualifications for Licensure include satisfactory evidence of current CPM credential from the North American Registry of Midwives and certain clinical experience requirements.
Other Coverage Requirements (site of service, etc.)	Oregon's Out-of-Hospital Reimbursement Guide Licensed providers must personally perform all of the care provided, with the exception allowed for direct supervision of a student in the provider's area of licensure. Direct supervision means the licensed provider is present and actually able to intervene for the student if necessary. ORS 687.405 Licensed direct entry midwives provide care in the home, in birthing centers, clinics, and as teachers at midwifery schools. They are educated through self-study, apprenticeship, a midwifery school or college-based program distinct from the discipline of nursing.
Coverage Limitations	Oregon's Out-of-Hospital Reimbursement Guide OHP will reimburse licensed out-of-hospital birth providers practicing within the scope of their license for prenatal, labor and delivery, and postpartum care that is: - Medically appropriate for pregnancies that meet OHP's low-risk pregnancy criteria, and Authorized prior to billing OHP.

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Reimbursement Rate	Fee Schedule-based
Reimbursement Methodology	Oregon's Out-of-Hospital Reimbursement Guide OHP will reimburse licensed out-of-hospital birth providers practicing within the scope of their license for prenatal, labor and delivery, and postpartum care that is: - Medically appropriate for pregnancies that meet OHP's low-risk pregnancy criteria, and - Authorized prior to billing OHP. LDMs, CNMs, DCs, NDs, DOs, NPs, and MDs enrolled with OHA may seek authorization and reimbursement for planned out-of-hospital birth services to OHP members.
Notes [managed care, private plans, related services]	Reciprocity: Under ORS 687.430, a person licensed to practice direct entry midwifery under the laws of another state who demonstrates to HLO's satisfaction that the person has passed a written examination at least equal to the written examination required of persons eligible for licensure in Oregon may have the written examination waived pursuant to standards of the Board of Direct Entry Midwifery.
Pennysylvania	
Medicaid State Plan Amendment: Covered Services	49 Pa. Code §18.6 The nurse-midwife is authorized or required, or both, to do the following: • Maintain a midwife protocol and collaborative agreements • Prescribe medical, therapeutic and diagnostic measures for essentially normal women and their normal neonates in accordance with the midwife protocol or a collaborative agreement, or both. • A nurse-midwife may, in accordance with a collaborative agreement with a physician, prescribe, dispense, order and administer medical devices, immunizing agents, laboratory tests and therapeutic, diagnostic and preventative measures. A nurse-midwife who possesses a master's degree or its substantial equivalent, and National certification, and applies to the Board, is eligible to receive a certificate from the Board which will authorize the nurse-midwife to prescribe, dispense, order, and administer drugs, including legend drugs and Schedule II through Schedule V controlled substances
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** 49 Pa. Code §18.2 Certified nurse midwives must: • Be licensed as a registered nurse • Have successfully completed a midwife program • A passing grade on a midwife examination or certification as a midwife by the American College of Nurse-Midwives (ACNM) before the ACNM certification examination was first administered in 1971 49 Pa. Code §18.3 A nurse-midwife license must be registered biennially.

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Other Coverage Requirements (site of service, etc.)	CNM services are likely to only be covered when performed in a facility setting. 55 Pa. Code § 1150.55 **Obstetrical services** The fee for a delivery includes: • Antepartum care provided on an inpatient basis. • Inpatient and outpatient office or home visits provided by the practitioner who performed the delivery, for a purpose related to delivery, during the number of postpartum days specified in the Medical Assistance Program Fee Schedule for each obstetrical procedure. During this specified period, the practitioner who performed the delivery is eligible to receive payment for treatment of a medical or surgical condition if the diagnosis necessitating the treatment is different and unrelated to the delivery. • The practitioner performing the delivery may also bill for visits for care of the newborn if that practitioner is the responsible attending physician for the newborn. • In addition to the practitioner performing the delivery, another practitioner may bill for stand-by services but only in the case of Cesarean sections or high risk deliveries. This is in lieu of billing for an initial visit. **Birth Centers** 55 Pa. Code § 1127.51 Payment is made for services provided for participating birth centers subject to the conditions and limitations established in this chapter, Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule. 55 Pa. Code § 1127.52(b) Total payment to a birth center will be made at 70% of the overall Statewide average hospital prospective payment rate in effect on July 1, 1986, plus a component to cover midwife prenatal visits and the delivery fee. The total prenatal visit amount will be based on 12 visits.
Coverage Limitations	**Collaborative Agreements** 49 Pa. Code §18.5 A nurse-midwife may not engage in midwifery practice without having entered into a collaborative agreement and having filed the collaborative agreement with the Board. Expansions and modifications of the midwife practice guidelines agreed to by the nurse-midwife and the collaborating physician shall be set forth, in detail, in the collaborative agreement. If the collaborating physician intends to authorize the nurse-midwife to relay to other health care providers medical regimens prescribed by that physician, including drug regimens, that authority, as well as the prescribed regimens, shall be set forth in the collaborative agreement. 49 Pa. Code §18.6 A CNM can perform medical services that may go beyond the scope of midwifery, if the authority to perform those services is delegated by the collaborating physician in the collaborative agreement, and the delegation is consistent with standards of practice embraced by the nurse-midwife and the relevant physician communities in this Commonwealth, as set forth in § § 18.401—18.402 (relating to medical doctor delegation of medical services). Otherwise, the CNM must transfer the client's care to a physician. **Noncompensable Services** 55 Pa. Code § 1142.55 Payment will not be made for: (1) Procedures not listed in the fee schedule in the MA Program fee schedule. (2) More than 12 midwife visits per recipient per 365 days (this includes prenatal and postpartum visits). One postpartum visit is included in the delivery fee and is not considered when computing the maximum of 12 visits. (3) Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. (4) Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).

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Reimbursement Rate	Based on a fee schedule. According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Pennsylvania for services provided by certified nurse midwives relative to physician reimbursement rates is 100%.
Reimbursement Methodology	55 Pa. Code § 1142.1 The Medicaid Program provides payment for specific medically necessary midwives' services rendered to eligible recipients by midwives enrolled as providers under the program. 55 Pa. Code § 1142.52 **Payment Conditions** Payment will be made to a midwife for services furnished if: (1) The midwife does not have a financial arrangement to provide the services with a hospital, independent medical clinic, rural health clinic or physician. (2) The services billed to the Department are furnished by the midwife. 55 Pa. Code § 1142.54 **Payment Limitations** Payment for a delivery includes the delivery and at least one outpatient postpartum visit. For an inpatient delivery, payment also includes inpatient care provided during the antepartum and postpartum period.
Notes [managed care, private plans, related services]	Pennsylvania PROMISe Provider Handbook, Section 4.12 **Procedures for Birth Centers and Nurse Midwives to Expedite Newborn Eligibility** Birth Centers and nurse midwives must immediately notify the County Assistance Office (CAO) of a child's birth when the mother is eligible for MA at the time of delivery. This contact must be done by telephone or fax to the appropriate CAO. Providers that have a high volume of MA births may wish to make arrangements with the local CAO to expedite this process. In addition, within three working days of the baby's birth, birth centers and midwives must submit a Newborn Eligibility Form (MA 112) to the appropriate CAO. The CAO authorizes eligibility for the newborn under the mother's record, enters the newborn's identifying information on the MA 112 and returns it to the birth center or nurse midwife.
Rhode Island	
Medicaid State Plan Amendment: Covered Services	5/29/2018 Public Notice of Proposed Amendment to Rhode Island Medicaid State Plan Nursing services may include...nurse midwife services, . . . in a home, school or other setting. 216-RICR-40-05-23 A CM is a person who successfully completed an accredited educational program in midwifery, holds a current certification as a midwife by the AMCB, and is licensed to practice midwifery in Rhode Island. A CNM is a person who has successfully completed an accredited educational program in midwifery, holds a current certification as a nurse- midwife by the AMCB, and is licensed to practice midwifery in Rhode Island. A certified professional midwife or "CPM" is a person who has successfully completed an accredited educational program in midwifery, holds a current certification as a certified professional midwife by the North American Registry of Midwives and is licensed to practice midwifery in Rhode Island.

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	A midwife means a person who has successfully completed an accredited educational program in midwifery, holds a current certification as a CNM, CM, or certified professional midwife and is licensed to practice midwifery in Rhode Island - Midwifery means the independent management of cases of childbirth, including prenatal, intrapartum, postpartum, and normal newborn care, and well woman care including the management of common health problems.
Licensing or Credentialing Requirements	**Only services by CNM are covered.** § 23-13-9 The state director of health makes regulations for midwifery and licensure 216-RICR-40-05-23 Midwives shall be required to submit evidence that they are qualified and are licensed Midwives must be licensed to use any title, abbreviation, sign, card or device to indicate that such a person is practicing midwifery 3. CNMs must hold a current Rhode Island license as a registered nurse or privilege to practice and shall not hold an encumbered license or privilege to practice as a registered nurse in any state or territory. 23.7 Licensing of Midwives By Education and Examination By Endorsement The license to practice midwifery authorizes the holder to practice the independent management of cases of childbirth, including prenatal, intrapartum, postpartum, and normal newborn care, and well woman care including the management of common health problems that provides for consultation, collaborative management, or referral as indicated by the health status of the client in accordance with standards established by the American College of Nurse-Midwives and Midwives Alliance of North America Licensed midwives shall conform to all state laws pertaining to the conduct of childbirth and management of the newborn, including, but not limited to, the provisions of R.I. Gen. Laws § 23-13-4, "Ophthalmia Neonatorum"; R.I. Gen. Laws § 23-13-19 «HIV»; R.I. Gen. Laws § 23-13-13 «Testing for Hearing Impairments»; R.I. Gen. Laws § 23-13-14 "Newborn Screening"; and R.I. Gen. Laws § 23-3-10, "Birth Registration".
Other Coverage Requirements (site of service, etc.)	5/29/2018 Public Notice of Proposed Amendment to Rhode Island Medicaid State Plan Nursing services may include . . . , nurse midwife services, . . . in a home, school or other setting.
Coverage Limitations	Explanation of Benefits Codes Postpartum care is limited to 1 per 6 months for nurse midwives Prenatal visits limited to 15 per year for nurse midwives

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Reimbursement Rate	6/28/2019 Public Notice of Proposed Amendment to Rhode Island Medicaid State Plan Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of nurse mid-wife services. The agency's fee schedule rate was set as of 2000 and is effective for services provided on or after that date. All rates are published here.
Reimbursement Methodology	Coverage Guidelines Providers must bill the Medicaid Program at the same usual and customary rate as charged to the general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to the Medicaid Program. Payments to providers will not exceed the maximum reimbursement rate of the Medicaid Program.
South Carolina	
Medicaid State Plan Amendment: Covered Services	SPA SC-11-016 – Established care provided in free-standing birth centers as a mandatory Medical Service. Limited coverage for licensed/state-approved freestanding birth centers. Limited coverage of covered services provided in a free-standing birth center (physicians and certified midwives; lay midwives; certified professional midwives; licensed midwives).
Licensing or Credentialing Requirements	**1) CNM** S.C. Code 44-89-30 (3) "Certified Nurse-Midwife (CNM)" means a person educated in the discipline of nursing and midwifery, certified by examination by the American College of Nurse-Midwives, and licensed by the State Board of Nursing as a Registered Nurse. **2) Licensed/Lay Midwife** S.C. Code 44-89-30 Defines the following: (1) "Birthing center" means a facility or other place where human births are planned to occur. This does not include the usual residence of the mother or any facility which is licensed as a hospital. (5) "Lay midwife" means an individual so licensed by the department. (9) "Physician" means a doctor of medicine or osteopathy with training in obstetrics or midwifery and licensed by the South Carolina State Board of Medical Examiners to practice medicine. See also S.C. Code 40-33-20 S.C. Reg. 61-24 (Licensed Midwives) Provides additional definitions. **B. 1. License**. It shall be unlawful to conduct midwifery services within South Carolina without possessing a valid license issued by the Department.

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	B.8. Exceptions to Licensing Standards. The Department may make exceptions to these standards where it is determined that the health and welfare of the community require the services of the licensee and that the exception, as granted, will have no significant impact on the safety, security or welfare of the licensee's patients. C. Requirements for Licensure. No person may provide midwifery services or represent that s/he is a midwife without first possessing a license issued by the Department in accordance with the provisions of these regulations. Licensure as a midwife shall be by **certification by NARM or other Department approved organization(s).** **EXCEPTION:** Individuals licensed by the Department prior to the publication date of this regulation will not be required to obtain certification by NARM or other Department approved organization(s). However, if a midwife is delinquent in submitting her/his license renewal application and the delinquency period exceeds 30 days the midwife must obtain certification by NARM or other similar Department approved organization(s) and also meet the requirements outlined in this section. D**. Scope of Practice**. The licensed midwife may provide care to low-risk women and neonates determined by medical evaluation to be prospectively normal for pregnancy and childbirth (see Sections J., K. and L.), and may deliver only women who have completed between 37 to 42 weeks of gestation, except under emergency circumstances. Care includes: 1. Prenatal supervision and counseling; 2. Preparation for childbirth; 3. Supervision and care during labor and delivery and care of the mother and newborn in the immediate postpartum, so long as progress meets criteria generally accepted as normal. See also S.C. Medicaid Program, Physician Provider Manual (updated 12/1/2018)
Other Coverage Requirements (site of service, etc.)	S.C. Medicaid Program, Physician Provider Manual (updated 12/1/2018) The following **documentation** must be maintained for all services provided by **a licensed midwife**: • The midwife's initial claim for prenatal services for each beneficiary must be accompanied by signed documentation from a physician credentialed in obstetrics who agrees to provide medical backup in the event of a complication or emergency. •Documentation of the physician's hospital privileges must be provided to SCDHHS. • Any changes in the physician backup must be reported in writing to the Division of Physician Services. • The physician who agrees to provide backup must be enrolled as a Medicaid provider. The following **additional documentation** regarding the **Licensed Midwife** must be kept in the patient's medical record: • A signed consent form that documents the beneficiary's awareness that her choice of provider can be made or changed at any point in the pregnancy • A certification statement provided to the physician by the midwife that the particular home is an acceptable environment for a birth • A copy of the plan for accessing emergency care with a confirmed source of transportation to the hospital provided to the beneficiary • Documentation that the beneficiary has been advised of Family Support Services available through the SCDHEC. **Required Modifier** for Licensed Midwives – When filing claims for services rendered by licensed midwives, all procedure codes must be filed with an SB modifier. Initial OB Exam by the Licensed Midwife – The initial obstetrical exam by the licensed midwife must be billed using the appropriate level of evaluation and management CPT procedure code for the complexity of the exam. An initial OB exam may be billed one time only during the term of pregnancy. An exam billed using this procedure code must meet the following requirements:

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	• Must be a comprehensive medical exam • Must establish the patient's medical history • Must provide health education materials • Must include a WIC referral to the local county health department (This referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.) **Physician Backup Coding** – Each of the two obstetrical examinations by the backup physician must be billed using the appropriate level of complexity evaluation and management CPT procedure code. **Delivery Supply Code** (S8415) – An additional code has been developed to reimburse for supplies used for delivery in the home setting. Procedure code S8415 may be billed by the licensed midwife in addition to the vaginal delivery code. Newborn Care (99461) – The newborn examination should be billed with CPT code 99461 using the SB modifier. **Newborn Metabolic Screening** (S3620) – In compliance with DHEC Newborn Screening regulations, if there is no attending physician, then the licensed midwife is responsible for the collection of specimens. Procedure code S3620 may be billed by the licensed midwife when an invoice has been sent to them from DHEC for the service. The invoice must be maintained in the medical records.
Coverage Limitations	S.C. Code 44-89-40 No person may establish, conduct, or maintain a birthing center without first obtaining a **license** from the department. The license is effective for a twelve-month period following the date of issue. A license issued under this chapter is not assignable or transferable and is subject to suspension or revocation at any time for failure to comply with this chapter or the regulations promulgated thereunder.
Reimbursement Rate	Licensed nurse midwife services operate on a FFS schedule
Reimbursement Methodology	**1) CNM** S.C. Medicaid Program, Physicians Provider Manual (updated 12/1/2018) A **certified nurse midwife** (CNM) must be licensed to practice as a registered nurse and as a certified nurse midwife in the state in which he or she is rendering services. Services are provided under the supervision of a physician preceptor according to a mutually agreed-upon protocol. **Reimbursement is 100% of the physician rate.** If a physician or certified nurse midwife is preparing to deliver a baby and it is decided that the baby must be delivered by an emergency C-section and an obstetrician must be called in, then the following applies: The physician or certified midwife may receive payment from Medicaid for his or her involvement in the case by billing the C-section code with an 80 modifier, assistant surgeon. Technically, the physician or certified nurse midwife would be billing as an assistant surgeon on the C-section. Reimbursement for this procedure is 20% of the C-section rate **2) Licensed/Lay Midwife** S.C. Medicaid Program, Physicians Provider Manual (updated 12/1/2018) A **licensed midwife** is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Health and Environmental Control (SCDHEC), for the purpose of providing specifically defined prenatal, delivery, and postpartum services to low-risk women. **Reimbursement is 65% of the physician rate.**

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South Dakota	
Medicaid State Plan Amendment: Covered Services	Professional Services Billing Manual; Recipient Handbook CNM services are required to be covered. S.D. Codified Laws § 36-9C-13: Scope of practice of a certified professional midwife, but not covered by Medicaid.
Licensing or Credentialing Requirements	**Only services by CNM covered.** Certified Nurse Midwife Licensure and Practice Application and details available at the link. SDCL 36-9A-13 Scope of Practice of a CNM (1) Conduct an advanced assessment; (2) Order and interpret diagnostic procedures; (3) Manage the provision of women's health care throughout the lifespan, from adolescence through post menopause, including: (a) Establishing primary and differential diagnoses; (b) Managing prenatal care; (c) Managing intrapartum care; and (d) Managing postpartum care of the mother-baby unit; (4) Manage sexually transmitted infections in males; (5) Prescribe, order, administer, and furnish therapeutic measures as follows: (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources; (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter 34-20B; and (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services including home health care, physical and occupational therapy; (6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and (7) Delegate and assign therapeutic measures to assistive personnel.
Other Coverage Requirements (site of service, etc.)	SDCL 36-9A-19 If a certified nurse practitioner or certified nurse midwife renders services in a hospital or a related institution licensed pursuant to chapter 34-12, the certified nurse practitioner or certified nurse midwife is subject to the rules and regulations of that hospital or related institution
Coverage Limitations	SDCL 36-9A-13.1 The certified nurse practitioner or certified nurse midwife shall collaborate with other health care providers and refer or transfer patients as appropriate SDCL 36-9A-14 Nothing in this chapter shall authorize a certified nurse practitioner or certified nurse midwife to practice pharmacy
Reimbursement Rate	Unable to find publicly available information.
Reimbursement Methodology	Fee for Service

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Tennessee	
Medicaid State Plan Amendment: Covered Services	2011 state plan amendment to require coverage of services provided in freestanding birth centers (to comply with ACA) Tenn. Code 56-7-2407 mandates coverage of any service provided by a midwife that is within the lawful scope of practice of a **licensed nurse midwife** (applies to "any contract, plan, or policy of insurance issued in this state" that "provides for reimbursement of any service that is within the lawful scope of practice of a [licensed] nurse midwife."
Licensing or Credentialing Requirements	**Only services by CNMs are covered.** 62 Tenn Code Ann § 29 et seq. **Midwife** is defined as a person who is trained to give the necessary care and advice to women during pregnancy, labor, and the post-birth period, to conduct normal deliveries on the midwife's own responsibility and to care for the newly born infant. A **Certified Nurse Midwife** is defined as a registered nurse currently licensed by TN Board of Nursing and certified by American College of Nurse-Midwives and qualified to deliver midwifery services **Certified Professional Midwife** is defined as a North American Registry of Midwives certified midwife, who must have midwifery skills and experience evaluated and pass written and skills examinations (1200-8-24-.01) The Council of Certified Professional Midwifery oversees the practice of midwifery in TN Midwife certified under 63-29-108 may use initials CPM-TN; initial certificate available for no more than 2 year period; certificate is renewable; need to comply with continuing education requirement; current CPR certification; remain in good standing.
Other Coverage Requirements (site of service, etc.)	**Certified nurse midwives** are considered covered professionals when providing services at a licensed or otherwise state-approved freestanding birth center
Coverage Limitations	None identified beyond requirements already identified
Reimbursement Rate	According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in TN for services provided by certified nurse midwives relative to physician reimbursement rates is 90% (no support from Manual or state plan)
Reimbursement Methodology	Per the 2011 state plan amendment, reimbursement for services provided in licensed or otherwise state-approved freestanding birth centers is based on the rates negotiated between the managed care organizations and the freestanding birth centers

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Texas	
Medicaid State Plan Amendment: Covered Services	2013 SPA: Adds licensed direct entry midwives as a payable provider type in birthing center setting. Amends 6.d (10) of Appendix 1 to Attachment 3.1-A: "Birthing services provided in a Medicaid certified freestanding birthing center by a licensed direct-entry midwife are covered services. Services provided by a licensed direct-entry midwife are available to Medicaid beneficiaries. Services provided by a licensed direct-entry midwife must be reasonable and medically necessary as determined by the single state agency or its designee. To be considered for Medicaid reimbursement, licensed direct-entry midwives must be licensed by the Texas Midwifery Board . . . in accordance with the Texas Midwifery Act. . . . Participating licensed direct-entry midwives must be enrolled in the Texas Medical Assistance Program and comply with the terms of the provider agreement and all the regulatory provisions." 2009 SPA: Updates the reimbursement rates for Certified Nurse Midwife (CNM) services within the Physician Services fee schedule (single payment that reimburses both birthing center facility cost and cost associated with professional services), and removes the state plan pages for birthing centers because they will no longer received Medicaid payments per CMS compliance action. This is "uniform to governmental and private providers."
Licensing or Credentialing Requirements	1) CNMs Services provided by CNMs are covered by Medicaid under Physician Services 2) Licensed direct-entry midwives SPA 2013: To be considered for Medicaid reimbursement, licensed direct-entry midwives must be licensed by the Texas Midwifery Board at the Department of State Health Services. Participating licensed direct-entry midwives must be enrolled in the Texas Medical Assistance Program
Other Coverage Requirements (site of service, etc.)	SPA 2013: Must be conducted at birthing center Facility Services (freestanding birthing center) licensed in the state of Texas or other legally authorized licensing authority under applicable state laws to provide a level of service commensurate with the professional skills of physician, certified nurse-midwife (CNM) or licensed midwife who acts at the birth attendant.
Coverage Limitations	SPA 2013: Unless approved by the State Agency or its designee, the birthing center may not bill for services provided by another type of provider.
Reimbursement Rate	Based on Fee Schedule
Reimbursement Methodology	SPA 2013: The fee establishment by HHSC is based upon: (1) survey of costs to provide the services; (2) review of Medicaid feed paid by others states; (3) Medicaid fees for similar services (4) Medicare Fees; and/or (5) some combination or percentage thereof.

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Utah

Medicaid State Plan Amendment: Covered Services	Utah Medicaid State Plan Nurse midwives will be reimbursed under Medicaid as long as they are authorized/licensed under state law. Utah Code Ann 58-44a-102(7) **(7)** "Nurse midwife means a person licensed under this chapter to engage in practice as a certified nurse midwife" Utah Code Ann 58-44a-102 **(9)** "Practice as a certified nurse midwife" means: **(a)** practice as a registered nurse as defined in Section 58-31b-102, and as consistent with the education, training, experience, and current competency of the licensee; **(b)** practice of nursing within the generally recognized scope and standards of nurse midwifery as defined by rule and consistent with professionally recognized preparations and educational standards of a certified nurse midwife by a person licensed under this chapter, which practice includes: **(i)** having a safe mechanism for obtaining medical consultation, collaboration, and referral with one or more consulting physicians who have agreed to consult, collaborate, and receive referrals, but who are not required to sign a written document regarding the agreement; **(ii)** providing a patient with information regarding other health care providers and health care services and referral to other health care providers and health care services when requested or when care is not within the scope of practice of a certified nurse midwife ; and **(iii)** maintaining written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed; and **(c)** the authority to: **(i)** elicit and record a patient's complete health information, including physical examination, history, and laboratory findings commonly used in providing obstetrical, gynecological, and well infant services to a patient; **(ii)** assess findings and upon abnormal findings from the history, physical examination, or laboratory findings, manage the treatment of the patient, collaborate with the consulting physician or another qualified physician, or refer the patient to the consulting physician or to another qualified physician as appropriate; **(iii)** diagnose, plan, and implement appropriate patient care, including the administration and prescribing of: **(A)** prescription drugs; **(B)** schedule IV-V controlled substances; and (C) schedule II-III controlled substances in accordance with a consultation and referral plan; (iv) evaluate the results of patient care; (v) consult as is appropriate regarding patient care and the results of patient care; (vi) manage the intrapartum period according to accepted standards of nurse midwifery practice and a written intrapartum referral plan, including performance of routine episiotomy and repairs, and administration of anesthesia, including local, pudendal, or paracervical block anesthesia, but not including general anesthesia and major conduction anesthesia; (vii) manage the postpartum period; (viii) provide gynecological services; (ix) provide noncomplicated newborn and infant care to the age of one year; and **(x)** represent or hold oneself out as a certified nurse midwife, or nurse midwife, or use the title certified nurse midwife, nurse midwife, or the initials C.N.M., N.M., or R.N. Utah Code Ann 58-77-300 Definition for "direct-entry midwife" (4) "Direct-entry midwife" means an individual who is engaging in the practice of direct-entry midwifery. (8) "Practice of direct-entry midwifery" means the practice of providing the necessary supervision, care, and advice to a client during essentially normal pregnancy, labor, delivery, postpartum, and newborn periods that is consistent with national professional midwifery standards and that is based upon the acquisition of clinical skills necessary for the care of a pregnant woman and a newborn baby, including antepartum, intrapartum, postpartum, newborn, and limited interconceptual care, and includes a number of requirements as specified in the act.

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Licensing or Credentialing Requirements	**Only services by CNM are covered by FFS Medicaid.** **1) CNM** Utah Code Ann 58-44a-301 (1)A license is required to engage in practice as a certified nurse midwife, except as provided in Section 58-1-307. **2)Direct Entry Midwife*** Utah Ann Code 58-77-201. Utah direct-entry midwives must be licensed by the state by the Entry Midwife Board. Utah Code Ann 58-77-302 Qualifications for Direct-Entry Midwives are included under this provision. **Note:** Coverage of direct entry midwife services not required. However, some managed care plans may allow for coverage of a licensed direct entry midwife. Utah Code Ann 58-77-601 Standards of Practice **(6)** This chapter does not mandate health insurance coverage for midwifery services.
Other Coverage Requirements (site of service, etc.)	**1) CNM** Physician Services Manual p. 11 Home visits can be included in the management plan of pregnant members when there is a need to assess the home environment and its implications for the management of prenatal and postnatal care; to provide direct care; to encourage regular visits for prenatal care; to provide emotional support; and to determine educational needs. **Covers certified nurse midwife Physician Services Manual p. 12 Group prenatal and postnatal education is classroom learning experience for improving the knowledge of pregnancy, labor, childbirth, parenting and infant care. The objective of this planned educational service is to promote informed self-care, to prevent development of conditions which may complicate pregnancy, and to enhance early parenting and child care skills. **Certified nurse midwife
Coverage Limitations	**1) CNM** Physician Services Manual Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psychosocial, nutritional, educational and other services for the pregnant woman. Perinatal Care Coordination Service Providers must be a licensed provider in Utah and one of the following qualified providers: Certified nurse midwife Utah Medicaid State Plan Nurse midwives do not need to be an independent provider agreements with physician to receive Medicaid coverage. Physician Services Manual p. 13 Risk assessment is the systematic review of relevant member data to identify potential problems and determine a plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contributes significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. A care plan for high risk members, in addition to standard care, includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the risk factor(s) involved. A care plan for low risk members includes primary care services and additional services specific to the needs of the individual.
Reimbursement Rate	Unable to locate public fee schedule.
Reimbursement Methodology	Fee-for-service

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Vermont	
Medicaid State Plan Amendment: Covered Services	Vermont Medicaid Provider Manual, Section 10.3.41 Vermont Medicaid recognizes and reimburses CNMs and licensed lay midwives. Department of Vermont Health Access, Medicaid Covered Services Rules **Scope of Practice – CNMs** Coverage is limited to enrolled nurse practitioners in either independent practice or affiliated with a physician when certified as: a Nurse-Midwife or, a Family Nurse Practitioner or, a Pediatric Nurse Practitioner and is limited to Medicaid covered services contained in protocols reviewed and accepted by the Vermont State Board of Nursing and the Vermont State Board of Medical Practice. Administrative Rules for Midwives, 3.13 **Scope of Practice – Lay Midwives** The midwife is a person who provides well-woman care, support and education to healthy women during the childbearing cycle, including normal pregnancy, labor, childbirth and the postpartum period. Midwifery care emphasizes education, health promotion, shared responsibility, and mutual participation in decision making. The midwife works with each client and the client's family to identify their unique physical, social, cultural, and emotional needs. When the care required extends beyond the midwife's abilities, the midwife continues involvement and arranges for consultation, referral, and collaboration with appropriate health care providers.
Licensing or Credentialing Requirements	**1) CNM** CNMs are licensed as advanced practice registered nurses. Vt. Stat. Ann. tit. 26, § 28-1611 To be eligible for an APRN license, an applicant shall: Have a degree or certificate from a Vermont graduate nursing program approved by the Board or a U.S. graduate program approved by a state or a national accrediting agency that includes a curriculum substantially equivalent to Vermont programs approved by the Board. Programs shall include a supervised clinical component in the role and population focus of the applicant's certification. The program shall prepare nurses to practice advanced nursing in a role as a nurse practitioner, certified nurse midwife, certified nurse anesthetist, or clinical nurse specialist in psychiatric or mental health nursing and shall include, at a minimum, graduate level courses in: • advanced pharmacotherapeutics; • advanced patient assessment; and • advanced pathophysiology. **2) Licensed Midwives** Vt. Stat. Ann. tit. 26, § 85-4183 A person shall be eligible to be licensed as a midwife, if the person has: (1) certification as a certified professional midwife (CPM) by the North American Registry of Midwives; (2) earned a high school degree or its equivalent as a basis for entry into the study of midwifery; and (3) agreed to practice according to the scope and standards of practice as required by rules adopted pursuant to section 4185 of this title.
Other Coverage Requirements (site of service, etc.)	**Home births are covered under Medicaid.** **Required Written Plan for Consultation and Emergency Transfer** Vt. Stat. Ann. tit. 26, § 85-4190 Every licensed midwife shall develop a written plan for consultation with physicians licensed under chapter 23 of this title and other health care providers for emergency transfer, for transport of an infant to a newborn nursery or neonatal intensive care nursery, and for transport of a woman to an appropriate obstetrical department or patient care area **CPR Certification** Administrative Rules for Midwives, 3.10 A midwife licensed in this state must show proof of current cardiopulmonary resuscitation certification for adults and newborns and for neonatal resuscitation as a condition of initial issuance of license and of license renewal.

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	Written Informed Consent Vt. Stat. Ann. tit. 26, § 85-4191 Before accepting a client for care, a licensed midwife must first obtain written informed consent.
Coverage Limitations	**1) Limitations for all midwives (CNMs and licensed professional midwives)** Vermont Medicaid Provider Manual, Section 10.3.41 Important Billing Information for Licensed Midwives (Nurse and Professional): Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability) Licensed Midwives (Nurse and Professional) will not be reimbursed for surgery of assistant-at-surgery charges Vermont Medicaid Provider Manual, Section 10.3.40 The DVHA will reimburse prolonged services only when a planned home delivery results in a hospital admission and the delivery is done by a different Medical Doctor/Medical Doctor group (these services are included in regular OB billing when the providers are of the same billing group). **2) Limitations for Licensed Midwives** Administrative Rules for Midwives, 3.14.1 **Limitations on Clients Midwives May Care For** If a history of certain specified disorders or situations is found to be present at the initial interview or if any of the following disorders or situations becomes apparent through history, examination, or laboratory report as prenatal care proceeds, the midwife must not assume or continue to take responsibility for the client's pregnancy and birth care. (See rule for complete list of conditions) Administrative Rules for Midwives 3.14.2 **Conditions Requiring Consultation** If certain enumerated situations or conditions are present or become apparent during prenatal care, the midwife must consult with a licensed M.D. or D.O, must document such consultation and the consultant's recommendations, and must document discussion of the consultation with the client. (See rule for complete list of conditions) See also in Administrative Rules for Midwives for further limitations: • Section 3.14.2.1 Previous Cesarean Delivery • 3.15 Record Keeping 3.16 Protocol for Drug and Equipment Use
Reimbursement Rate	Based on a fee schedule. According to a 2013 report by the American College of Nurse-Midwives, the reimbursement rate in Vermont for services provided by certified nurse midwives relative to physician reimbursement rates is 100%.
Reimbursement Methodology	Vermont Medicaid Provider Manual, Section 10.1 **Certified Nurse-Midwife** Reimbursement basis is 100% of the Vermont Medicaid rate on file. **Licensed Professional Midwife** Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. Reimbursement is limited to certain procedure codes.
Notes [managed care, private plans, related services]	Vermont Medicaid Provider Manual, Section 9.1 Vermont Medicaid does reimburse for abortions performed by Certified Nurse Midwives.

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Virginia	
Medicaid State Plan Amendment: Covered Services	Va. Code Ann. § 54.1-2957.7 (West) Midwife: any person who provides primary maternity care during, and subsequent to childbirth, and who is not a doctor or certified nurse midwife. Practicing midwifery: providing primary maternity care that is consistent with a midwife's training, education, and experience to women and their newborns throughout the childbearing cycle, and identifying and referring women or their newborns who require medical care to an appropriate practitioner." Baby Care Manual, Ch. 2 Covered Services Nurse midwife services are provided, with limitations by the Virginia Medicaid Program. Risk Screens Maternal and Infant Risk Screens (DMAS 16-P) must be completed by a licensed physician, certified nurse midwife, nurse practitioner or physician assistant. The licensed practitioner does not have to be an enrolled Medicaid provider to complete the risk screens. However, to receive reimbursement, the licensed practitioner will need to be enrolled as a Medicaid provider.
Licensing or Credentialing Requirements	**Only nurse midwife services are covered.** Va. Code Ann. § 54.1-2957.8 (West) Midwives must be licensed by the Board of Medicine. The applicant must submit evidence that she has obtained the Certified Professional Midwife credential. Va. Code Ann. § 54.1-2957 (West) Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a nurse practitioner. Regulations Governing the Practice of Licensed Midwives: 18VAC85-130-45. Practical experience under supervision. A person may perform tasks related to the practice of midwifery under the direct and immediate supervision of a licensed doctor of medicine or osteopathic medicine, a certified nurse midwife, or a licensed midwife while enrolled in an accredited midwifery education program or during completion of the North American Registry of Midwives' Portfolio Evaluation Process Program without obtaining a license issued by the board until such person has taken and received the results of any examination required for CPM certification or for a period of 10 years, whichever occurs sooner.
Other Coverage Requirements (site of service, etc.)	Va. Code Ann. § 54.1-2957.13 (West) Other laws shall not prevent or prohibit: 1. A licensed midwife from delegating to an apprentice or personnel in his personal employ and supervised by him such activities or functions that are nondiscretionary and that do not require the exercise of professional judgment for their performance, if such activities or functions are authorized by and performed for the licensed midwife and responsibility for such activities or functions is assumed by the licensed midwife; or 2. Any person from performing tasks related to midwifery under the direct and immediate supervision of a licensed doctor, a certified nurse midwife, or a licensed midwife during completion of the North American Registry of Midwives' Portfolio Evaluation Process Program within a time period specified in regulations adopted by the Board or while enrolled in an accredited midwifery education program. Va. Code Ann. § 32.1-134.2 (West) The grant or denial of clinical privileges to certified nurse midwives licensed as nurse practitioners pursuant to § 54.1-2957 by any licensed VA hospital, and the determination by the hospital of the scope of such privileges, shall be based upon such practitioner's professional license, experience, competence, ability, and judgment, and the reasonable objectives and regulations of the hospital in which such privileges are sought.

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Coverage Limitations	Various manuals (I.e., Babycare, physician/provider, nursing facilities) are available discussing coverage limitations. Va. Code Ann. § 38.2-4221 (West) Nonstock corporations shall not refuse to pay for services rendered by any nurse midwives *so long as the services are provided for in the subscription contract* and the midwife is *licensed* to render the services.
Reimbursement Rate	State Agency Fee Schedule for Resource Based Relative Value Scale (RBRVS) 12 VAC 30-80-190 The Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers [which includes midwives] using a fee schedule that is based on a RBRVS
Reimbursement Methodology	Fee for service 12VAC30-80-30 Virginia Premier's Provider Manual 2018 If a nurse practitioner (pediatric, family or nurse midwife) wants to bill directly for services, they must submit a Virginia Premier provider application, complete the credentialing process and be a participating practitioner with Medicaid.
Washington	
Medicaid State Plan Amendment: Covered Services	RCW 18.50.010 Practicing midwifery defined—Gratuitous services—Duty to consult with physician Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her newborn up to two weeks of age or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the newborn. SPA: **Nurse-midwife services provided with limitations**. (6)(d)(1) All other practitioners covered by the Medicaid agency include . . . licensed non-nurse midwives, limited to services within the scope of specialty. (d)(5) Licensed non-nurse midwives: To participate in home births and in birthing centers, midwives must be an agency-approved provider. (29)(b) Covered practitioners providing services in the freestanding birth center . . . must be licensed in the State of Washington as a Physician or a Nurse Midwife (18.79 RCW) or Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birthing center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 – Midwife under chapter 18.50 RCW.

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Licensing or Credentialing Requirements	**1) Licensed Midwife** Washington State Department of Health – Midwife License Requirements Low-risk pregnancies only. **2) Certified Nurse Midwife** Holds a nursing degree and certified with the College of Nurse-Midwives **Note** that Washington State Medicaid covers services provided by licensed midwives and certified nurse midwives. The Department of Health developed a helpful brochure that defines the differences in what services each are permitted to provide.
Other Coverage Requirements (site of service, etc.)	WAC 182-533-0600 The Medicaid agency covers **planned home births and births in birthing centers** for clients who choose to give birth at home or in an agency-approved birthing center and: (a) Are eligible for the alternative benefit package under WAC 182-501-0060, categorically needy or medically needy scope of care under WAC 182-533-0400(2); (b) Have an agency-approved medical provider who has accepted responsibility for the planned home birth or birth in birthing center under this section; (c) Are expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and (d) Pass the agency's risk screening criteria. The agency provides these risk-screening criteria to qualified medical services providers. (2) Qualified providers. Only the following provider types may be reimbursed for planned home births and births in birthing centers: (a) Physicians licensed under chapters 18.57 or 18.71 RCW; (b) Nurse midwives licensed under chapter 18.79 RCW; and (c) Midwives licensed under chapter 18.50 RCW.
Coverage Limitations	WAC 182-533-0600 (6) Limitations. The agency does not cover planned home births or births in birthing centers for women identified with any of the following conditions: (a) Previous cesarean section; (b) Current alcohol or drug addiction or abuse; (c) Significant hematological disorders or coagulopathies; (d) History of deep venous thrombosis or pulmonary embolism; (e) Cardiovascular disease causing functional impairment; (f) Chronic hypertension; (g) Significant endocrine disorders including preexisting diabetes (type I or type II); (h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy or abnormal liver function tests; (i) Isoimmunization, including evidence of Rh sensitization or platelet sensitization; (j) Neurologic disorders or active seizure disorders; (k) Pulmonary disease; (l) Renal disease; (m) Collagen-vascular diseases; (n) Current severe psychiatric illness; (o) Cancer affecting the female reproductive system; (p) Multiple gestation; (q) Breech presentation in labor with delivery not imminent; or (r) Other significant deviations from normal as assessed by the provider.
Reimbursement Rate	Not available
Reimbursement Methodology	Fee-for-service
Notes [managed care, private plans, related services]	Planned Home Births & Births in Birthing Centers Billing Guide

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West Virginia	
Medicaid State Plan Amendment: Covered Services	SPA WV-12-007 This SPA establishes a fee schedule for freestanding birth center services provided on or after April 1, 2012. . . Additionally, this SPA indicates that physicians, midwives, and other licensed practitioners are paid a separate fee for services performed in the freestanding birth center based on a procedure code. WV Provider Manual, 519.19 A wide range of women's health services are covered for West Virginia Medicaid members when provided by enrolled Physicians, Physician assistants (PAs), or Advanced Practice Registered Nurses (APRNs) acting within the scope of his/her license. Services include, but are not limited to, preventive, pregnancy related, and disease related services. This section lays out the conditions under which these women's health services are provided under Medicaid.
Licensing or Credentialing Requirements	**Only CNM services are covered.** Direct entry midwives are not regulated by the state of West Virginia; there is no licensure available. W. Va. Code § 30-7-1 et seq. **Certified Nurse Midwives** CNMs are licensed as advanced practice registered nurses. See also W. VA. CODE § 30-7-6 for more information on licensure. WV Medicaid Provider Manual, Ch.200 An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advanced practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner. An advanced practice registered nurse may also have comparable licensure from the state in which he or she practices and meets all national certification requirements.
Other Coverage Requirements (site of service, etc.)	WV Provider Manual, 519.19.2.2 **Home births are covered.** Delivery services include delivery in the home or admission to a hospital or birthing center; an admission history and physical examination; management of labor; vaginal delivery with or without episiotomy and with or without forceps; and postpartum care. WV Medicaid Provider Manual, Ch. 533 **Birthing Centers** The WV Medicaid Program covers newborn deliveries that may be safely performed in the birthing center setting, and that do not require the level of support and medical service available only in the inpatient hospital setting. WV Provider Manual, 519.19 In addition, covered services within the CNM's scope of practice may be provided in an office, outpatient, inpatient, free-standing birthing centers, and the member's home setting. CNMs are eligible for reimbursement for newborn assessments, hospital observation care related to pregnancy and postpartum visits. CNMs are approved for billing the appropriate CPT codes in the Emergency Department.
Coverage Limitations	WV Medicaid Provider Manual, Ch. 533 **Birthing Centers** Non-covered services for Birthing Centers include, but are not limited to: • Deliveries that cannot be safely performed in an outpatient setting or without support of the full array of hospital diagnostic and treatment services and equipment. • Procedures not covered by Medicaid. • Medical equipment or supplies dispensed for use in the patient's home. Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

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Reimbursement Rate	Based on a fee schedule.
Reimbursement Methodology	SPA WV-12-007 The payment for services provided by a freestanding birth center is limited to the lower of the encounter rate base vor on a fee for the services provided in the clinic. WV Medicaid Provider Manual, Ch. 533 Birthing Centers are reimbursed a one-time per case facility fee that covers the facility's cost, nursing services, other facility support staff, anesthetic and usual supplies related to the uncomplicated newborn delivery procedure. Supplies and other items incidental to the delivery are not covered for separate reimbursement. The cost of such items is included in the case payment to the facility. Physician or nurse midwife professional charges are reimbursable by the Medicaid Program participating professional practitioner at RBRVS rates in effect for that particular procedure as of the date of service. If the member is enrolled in a Medicaid Managed Care Organization (MCO), reimbursement will be made by the MCO based upon the agreement between the Birthing Center and the MCO. WV Provider Manual, 519.19 An independent enrolled Certified Nurse Midwife (CNM) may bill for vaginal deliveries in a hospital when the hospital has approved these services through the credentialing and delineation of privileges process and the CNM has a collaborative agreement with an enrolled Obstetrician/Gynecologist. The CNM's delineation of privileges and collaborative agreement must be on file with BMS Provider Enrollment Unit.
Wisconsin	
Medicaid State Plan Amendment: Covered Services	**State Plan Amendment** WI-16-0003 Certified professional midwife services are a covered service when provided by a qualified provider who has been granted a license under section 440.982 of the Wisconsin Statutes to engage in the practice of midwifery. "Practice of midwifery" means providing maternity care during the antepartum, intrapartum, and postpartum periods.
Licensing or Credentialing Requirements	**1) CNMs** Wis. Stat. § 441.15 The board shall grant a license to engage in the practice of nurse-midwifery to any registered nurse who is licensed under this subchapter or who holds a multistate license, who does all of the following: 1. Submits evidence satisfactory to the board that he or she meets the educational and training prerequisites established by the board for the practice of nurse-midwifery. 2. Pays the initial credential fee determined by the department under s. 440.03 (9) (a). 3. If applicable, submits evidence satisfactory to the board that he or she has in effect the malpractice liability insurance required under the rules promulgated under sub. (5) (bm). See also Wis. Admin. Code N. § 4.01 et seq. **2) Licensed Midwives** Wis. Stat. § 440.982 No person may engage in the practice of midwifery unless the person is granted a license under this subchapter, is granted a temporary permit pursuant to a rule promulgated under s. 440.984 (2m), or is licensed as a nurse-midwife.

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	Licensure requirements: The applicant must submit evidence satisfactory to the department of one of the following: • The person holds a valid certified professional midwife credential granted by the North American Registry of Midwives or a successor organization. • The person holds a valid certified nurse-midwife credential granted by the American College of Nurse Midwives or a successor organization. See also Wis. Admin. Code S.P.S. § 181.01 et seq.
Other Coverage Requirements (site of service, etc.)	Wisconsin Forward Health Provider Information, 2016 **Home delivery** ForwardHealth will reimburse all supplies and materials used for home delivery under Healthcare Common Procedure Coding System (HCPCS) procedure code S8415 (Supplies for home delivery of infant). See also 2019 Wisconsin Medicaid Provider Manual p.51 Wisconsin Forward Health Covered Services Medically necessary nurse practitioner and nurse midwife services are covered when they are also considered covered physician services. Medicaid-enrolled nurse midwives are limited to providing the following categories of covered services: Family planning services Laboratory services Obstetric services Office and outpatient visits TB (Tuberculosis)-related services The practice of nurse midwifery means the management of women's health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse Midwives and the education, training, and experience of the nurse midwife (Board of Nursing Wis. Stats. § 441.15). Only antepartum and postpartum visits and outpatient treatment of complications are eligible for cost-based reimbursement.
Coverage Limitations	Wisconsin Forward Health Provider Information, 2016 The following services will be included in the reimbursement for maternity and newborn care and will not be separately reimbursable by Wisconsin Medicaid: • Individual charges for supplies and materials (e.g., disposable gloves and injection supplies) used in conjunction with a home delivery •Office visit codes for maternity care • Initial newborn hearing screen •Pulse oximetry • Venipuncture • Family planning counseling • Time spent travelling by the licensed midwife • Initial hearing and cardiovascular screening **1) CNMs** Wis. Admin. Code N. § 4.07 • (1) The nurse-midwife shall not independently manage those complications that require referral pursuant to the written agreement. • (2) The nurse-midwife may not perform deliveries by forceps or Caesarean section. The nurse-midwife may use vacuum extractors only in emergency delivery situations. • (3) The nurse-midwife may not assume responsibilities, either by physician-delegation or otherwise, which he or she is not competent to perform by education, training or experience.

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	• (4) Following notification of a physician as required by s. 441.15 (4), Stats., a nurse-midwife may continue to manage the delivery when complications occur if emergency measures are required and the physician has not yet arrived. **2) Licensed Midwives** Prohibited Practices See administrative code for a detailed list of prohibited practices for licensed midwives. Wis. Admin Code. S.P.S. § 182.03(6) Informed Consent Wis. Admin Code. S.P.S. § 182.02 A licensed midwife shall, at an initial consultation with a client, provide a copy of the rules promulgated by the department under sub ch. XII of ch. 440, Stats., and disclose to the client orally and in writing on a form provided by the department all of the required informed consent elements. Consultation and Referral Wis. Admin Code. S.P.S. § 182.03(4) A licensed midwife shall consult with a licensed physician or a licensed certified nurse-midwife providing obstetrical care, whenever there are significant deviations, including abnormal laboratory results, relative to a client's pregnancy or to a neonate. If a referral to a physician is needed, the licensed midwife shall refer the client to a physician and, if possible, remain in consultation with the physician until resolution of the concern.
Reimbursement Rate	**1) CNMs** Based on maximum allowable fee schedule **2) Licensed Midwife** Based on a fee schedule
Reimbursement Methodology	**1) CNMs** Based on a maximum allowable fee schedule **2) Licensed Midwife** WI-16-0003 Payments for certified professional midwife services are equal to the lower of the submitted charge or the appropriate maximum fee from the Wisconsin Department of Health Services Fee Schedule.
Wyoming	
Medicaid State Plan Amendment: Covered Services	SPA-WY-16-0004 Acknowledges coverage of nurse midwife services. Updated reimbursement rates for nurse midwife services to be the lessor of charges of a percentage of the physician fee schedule amount. The SPA established a maximum allowable fee by procedure code regardless of location. Wyo. Dep't of Health, CMS 1500 ICD-10 Provider Manual (Oct. 1, 2019) Wyoming Medicaid permits Licensed Midwives to: "perform services under the scope of their license that are also a covered service under Wyoming Medicaid. Maternity services include "antepartum, delivery & postpartum care of a pregnant woman, according to guidelines set forth in the current edition of the CPT-4 book" under procedure codes ranged 59000-59898.

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Licensing or Credentialing Requirements	**Only CNM Services are Covered** H.B. 0043, 65th Leg., Gen Sess. (Wyo., 2019). Wyoming passed a law in February 15, 2019, allowing Medicaid coverage for midwives certified by the Board of Nursing and the Board of Midwifery, which went into effect July 1, 2019. Wyo. Stat. § 42-4-103 (a)(ix) (2019) further distinguishes between certified nurse midwives licensed by the board of nursing and midwives licensed by the board of midwifery. Wyo. Stat. § 33-46-102 (a) (2010). "**Midwife**" means any person who provides primary prenatal, intrapartum and postpartum care by affirmative act or conduct to women and newborns during the childbearing cycle; "**Midwifery**" or "**practice of midwifery**" means providing primary maternity care that is consistent with a midwife's training, education and experience to women and their newborn children throughout the childbearing cycle, and includes identifying and referring women or their newborn children who require medical care to an appropriate health professional. Wyo. Stat. § 33-46-103 (2010). Created the Board of Midwifery to regulate the practice of midwifery in the state and permitted the board to license midwives. Wyo. Stat. § 7-19-201 (a)(xix) (2019). Requires midwives to submit to fingerprinting to obtain state and national criminal history record information when applying for licensure to the Wyoming board of midwifery. Wyo. Stat. § 7-19-106 (a)(xxiv) (2019). Requires midwives to undergo a criminal background check to obtain state and national criminal history record information when applying for licensure to the Wyoming board of midwifery.
Other Coverage Requirements (site of service, etc.)	Wyo. Stat. § 42-4-103 (a) (2019). Specifies services authorized for medical assistance.
Coverage Limitations	None identified beyond those in the row above.
Reimbursement Rate	Wyo. Dep't of Health, CMS 1500 ICD-10 Provider Manual (Oct. 1, 2019) See the fee schedule for covered services by taxonomy as well as percent of physician charges. Medicaid Fee Schedule The most recent 2019 physician fee schedule permits nursing midwives to receive 90% of physician charges for many procedure codes ranged 59000-59898.
Reimbursement Methodology	Wyo. Dep't of Health, CMS 1500 ICD-10 Provider Manual (Oct. 1, 2019). All claims are subject to both pre-payment and post-payment review for medical necessity by Medicaid. Should a review determine that services do not meet all the criteria listed above, payment will be denied or, if the claim has already been paid, action will be taken to recoup the payment for those services. Wyo. Stat. § 42-4-103 (b)-(c) (2016). In Wyoming, Medicaid covers face-to-face encounters between clients and nurse midwives in rural health clinics using the all-inclusive encounter rate established by Medicaid. The encounter in rural health clinics must be billed with the 0521 revenue code paired with a procedure code T1015 for a general encounter, a procedure code in the range of 99381-99385 or 99391-99395 for a health check encounter using a 32 modifier to indicate a referral to a specialist, and mist bill the total usual and customary charges for the visit. Any appropriate outpatient revenue code must be paired with any appropriate procedure code."

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References

[1] Royal College of Obstetricians and Gynaecologists. (2001). *The national sentinel caesarean section audit report*. London: RCOG Clinical Effectiveness Support Unit. Retrieved from: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/nscs_audit.pdf

[2] Newhouse, R. P., Stanik-hutt, J., White, K. M., Bass, E. B., Wilson, R. F., & Weiner, J. P. (2011). Advanced practice nurse outcomes 1990-2008 : A systematic review. *Nursing Economics* 29(5). Retrieved from: https://pubmed.ncbi.nlm.nih.gov/22372080/

[3] Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane database of systematic reviews, 4*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

[4] Perriman, N. Davis, D.L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery*, 62(February), 220–229. https://doi.org/10.1016/j.midw.2018.04.011

[5] World Health Organization. (n.d.). *The year of the nurse and the midwife.* Retrieved from: https://www.who.int/campaigns/year- of-the-nurse-and-the-midwife-2020

[6] Medicaid and CHIP Payment and Access Commission. (2020). *Medicaid's role in financing maternity care*. Retrieved from: https://www.macpac.gov/wp-content/ uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf

[7] Adams, E. K., Gavin, N. I., Handler, A., Manning, W., & Raskind-Hood, C. (2003). Transitions in insurance coverage from before pregnancy through delivery in nine states, 1996-1999. *Health Affairs*, 22(1), 219–229. https://doi.org/10.1377/hlthaff.22.1.219

[8] Gifford, K., Walls, J., Associates, H. M., Ranji, U., Salganicoff, A., & Gomez, I. (2017, April*). Medicaid coverage of pregnancy and perinatal benefits: Results from a state survey*. Kaiser Family Foundation. Retrieved from http://files.kff.org/attachment/Report-Medicaid-Coverage-of- Pregnancy-and-Perinatal-Benefits

[9] Kaiser Family Foundation. (2019). *Medicaid and CHIP income eligibility limits for pregnant women as a percent of the federal poverty level*. Retrieved from: https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/

[10] Stolp, H., & Fox, J. (2015). Increasing receipt of women's preventive services*. Journal of Women's Health*, 24(11), 875–881. https://doi.org/10.1089/jwh.2015.5552

[11] Ahn. J, Fleming C., Jadun, C., Kirk, S., Lester, R., Libersky, J., Lipson, D., O'Malley, C., & Williams, S. (2018). *Medicaid managed care enrollment and program characteristics*, 2016. Mathematica. Retrieved from https://www.mathematica-mpr.com/our-publications-and-findings/publications/ medicaid-managed-care-enrollment-and-program-characteristics-2016

[12] Hoyert, D.L. & Miniño, A.M. (2020, January) *Maternal mortality in the United States: Changes in coding, publication, and data release, 2018.* National Vital Statistics Report. 69(2). Retrieved from: https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_02-508.pdf?deliveryName=USCDC_171-DM18268

[13] Murphy, S. L., Xu, J., Kochanek, K. D., & Arias, E. (2018). *Mortality in the United States, 2017: Key findings data from the national vital statistics system*. National Center for Health Statistics (328), 1–8. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db328.htm

[14] Mathews, T. J., Macdorman, M. F., & Thoma, M. E. (2015). *Infant mortality statistics from the 2013 period linked birth / infant death data set*. National Vital Statistics Reports, 64(9), 2000–2013.https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf

[15] Frey, H. A., & Klebanoff, M. A. (2016). The epidemiology, etiology, and costs of preterm birth. *Seminars in fetal and neonatal medicine*, 21(2), 68–73. https://doi.org/10.1016/j.siny.2015.12.011

[16] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2017). *National Vital Statistics Reports*, *Volume 67, Number 8, November 7, 2018*. National Vital Statistics Reports, 67(8), 1–50. Retrieved from https://www.cdc.gov/nchs/data_ access/Vitalstatsonline.htm

[17] Callaghan, W. M., Creanga, A. A., & Kuklina, E. V. (2012). Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. *Obstetrics & Gynecology*, 120(5), 1029–1036. https://doi.org/10.1097/ AOG.0b013e31826d60c5

[18] Fingar, K. R., Megan, M., Heslin, K. C., & Moore, J. E. (2018). *Trends and disparities in delivery hospitalizations involving severe maternal morbidity, 2006-2015.* Statistical brief, 66(1), 1–21. https://europepmc.org/books/n/hcupsb/sb243/?extid=30475561&src=med

[19] Lewkowitz, A., Rosenbloom, J., JD, L., Macones, G., Olsen, M., & Cahill, A. (2019). Association between severe maternal morbidity and psychiatric illness within 1 year of hospital discharge after delivery. *Obstetrics & Gynecology*, 134(4), 695–707. https://doi.org/10.1097/AOG.0000000000003434.

[20] Creanga, A. A., Berg, C. J., Ko, J. Y., Farr, S. L., Tong, V. T., Bruce, F. C., & Callaghan, W. M. (2014). Maternal mortality and morbidity in the United States: Where are we now? *Journal of Women's Health*, 23(1), 3–9. https://doi.org/10.1089/jwh.2013.4617

[21] Zhang, S., Cardarelli, K., Shim, R., Ye, J., Booker, K. L., & Rust, G. (2013). Racial disparities in economic and clinical outcomes of pregnancy among medicaid recipients. *Maternal and Child Health Journal*, 17(8), 1518–1525. https://doi.org/10.1007/s10995- 012-1162-0

[22] Sommers, B.D.,Gourevitch, R., Maylone, B., Blendon, R. J., & Epstein, A. M. (2016). Insurance churning rates for low-income adults under health reform: Lower than expected but still harmful for many. *Health Affairs*, 35(10), 1816–1824. https://doi. org/10.1377/hlthaff.2016.0455

[23] Daw, J. R., Hatfield, L. A., Swartz, K., & Sommers, B. D. (2017). Women in the United States experience high rates of coverage 'churn' in months before and after childbirth. *Health Affairs*, 36(4). doi: 10.1377/hlthaff.2016.1241

[24] Davis, N. L., Smoots, A. N., & Goodman, D. A. (2019). *Pregnancy-related deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017*. Maternal Mortality Review Committee, 13, 2–5. Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf

[25] Mazul, M., Ward, T. C. S., & Emmanuel, N. M. (2017). Anatomy of good prenatal care: Perspectives of low income African- American women on barriers and facilitators to prenatal care. *Journal of Racial and Ethnic Health Disparities*, 4, 79–86. doi: 10.1007/s40615-015-0204-x.

[26] Gadson, A., Akpovi, E., & Mehta, P. K. (2017). Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Seminars in Perinatology,* 41(5), 308–317. https://doi.org/10.1053/j.semperi.2017.04.008

[27] American College of Obstetricians and Gynecologists. (2018*). Committee Opinion Number 781: Group Prenatal Care*. Retrieved from: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co731.pdf?dmc=1&ts=20200207T1616466287

[28] Cunningham SD, Lewis JB, Thomas JL, Grilo SA, & Ickovics JR. (2017). Expect with me: Development and evaluation design for an innovative model of group prenatal care to improve perinatal outcomes. *BMC Pregnancy Childbirth*, 17(147). https://doi.org/10.1186/s12884-017-1327-3

[29] Craswell A, Kearney L, Reed R. (2016). 'Expecting and Connecting' group pregnancy care: Evaluation of a collaborative clinic. *Women Birth; 29,* 416–22. DOI: 10.1016/j.wombi.2016.03.002

[30] Rising SS. (1998). Centering pregnancy. An interdisciplinary model of empowerment. *Journal of Nurse Midwifery*; 43,46–54. doi: 10.1016/s0091-2182(97)00117-1.

[31] Carter, E. B., Temming, L. A., Akin, J., Fowler, S., Macones, G. A., Colditz, G. A., & Tuuli, M. G. (2016). Group prenatal care compared with traditional prenatal care. *Obstetrics & Gynecology*, 128(3), 551–561. https://doi.org/10.1097/AOG.0000000000001560

[32] Ickovics, J. R., Kershaw, T. S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H., & Rising, S. S. (2007). Group prenatal care and perinatal outcomes. *Obstetrics & Gynecology*, 110(2, Part 1), 330–339. https://doi.org/10.1097/01.aog.0000275284.24298.23

[33] Byrne, A., & Tanesini, A. (2015). Instilling new habits: Addressing implicit bias in healthcare professionals. *Advances in Health Sciences Education*, 20(5), 1255–1262. https://doi.org/10.1007/s10459-015-9600-6

[34] Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine*, 28(11), 1504–1510. https://doi.org/10.1007/s11606-013-2441-1

[35] Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., ... Coyne-Beasley, T. (2015). Implicit racial/ ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health*, 105(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

[36] Dominguez, T. P. (2008). Race, racism, and racial disparities in adverse birth outcomes. *Clinical Obstetrics & Gynecology*, 51(2), 360–370. https://doi.org/10.1097/GRF.0b013e31816f28de

[37] Black Mamas Matter Alliance. (2018). *Setting the standard for holistic care of and for black women*. Retrieved from: http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf

[38] Institute for Medicaid Innovation. (2019). *Innovations and opportunities to address social determinants of health in Medicaid managed care*. Retrieved from: https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf

[39] Alliman, J., & Phillippi, J. C. (2016). Maternal outcomes in birth centers: An integrative review of the literature. *Journal of Midwifery and Women's Health*, 61(1), 21–51. https://doi.org/10.1111/jmwh.12356

[40] National Institute for Health and Care Excellence. (2015). *Intrapartum care Quality Standard* [QS105]. Retrieved from https://www.nice.org.uk/guidance/qs105

[41] American College of Nurse-Midwives. (2011). *Definition of midwifery and scope of practice of certified nurse-midwives and certified midwives*. Retrieved from http://www.midwife.org/ACNM/files/ ACNMLibraryData/UPLOADFILENAME/000000000266/Definition of midwifery and scope of practice of CNMs and CMs Dec 2011. Pdf

[42] Hughes, B., Rubinstein, B., & Dau, K. Q. (n.d.). *How to successfully integrate midwives into your practice: A guide for physician practices and hospitals.* Pacific Business Group on Health. Retrieved from: https://www.pbgh.org/midwifery

[43] Shaw, D., Guise, J. M., Shah, N., Gemzell-Danielsson, K., Joseph, K. S., Levy, B., ... Main, E. K. (2016). Drivers of maternity care in high-income countries: Can health systems support woman-centred care? *The Lancet*, 388(10057), 2282–2295. https://doi. org/10.1016/S0140-6736(16)31527-6

[44] Committee on Obstetric Practice. (2019).ACOG Committee Opinion No. 766: Approaches to Limit Intervention During Labor and Birth. *Obstetrics and Gynecology, 133(2),* e164–e173. https://doi.org/10.1097/AOG.0000000000003074

[45] Rooks, J. P. (1999). The midwifery model of care. *Journal of Nurse-Midwifery*, 44(4), 370–374. https://doi.org/10.1016/S0091-2182(99)00060-9

[46] American College of Nurse Midwives. (n.d.-b). *Our philosophy of care*. Retrieved from https://www.midwife.org/Our- Philosophy-of-Care

[47] American College of Nurse Midwives, Midwives Alliance of North America, & National Association of Certified Professional Midwives. (2013). Supporting healthy and normal physiologic childbirth: A consensus statement by ACNM, MANA, and NACPM. *The Journal of Perinatal Education*, 22(1), 14–18. https://doi.org/10.1891/1058-1243.22.1.14

[48] Heins, H. C., Nance, N. W., McCarthy, B. J., & Efird, C. M. (1990). A Randomized Trial of Nurse-Midwifery Prenatal Care to Reduce Low Birth Weight. *Obstetrics & Gynecology*, 75(3), 341–345.

[49] Johantgen, M., Fountain, L., Zangaro, G., Newhouse, R., Stanik-Hutt, J., & White, K. (2012). Comparison of labor and delivery care provided by certified nurse-midwives and physicians: A systematic review, 1990 to 2008. *Women's Health Issues*, 22(1), e73–e81. https://doi.org/10.1016/j.whi.2011.06.005

[50] Nijagal, M. A., Kuppermann, M., Nakagawa, S., & Cheng, Y. (2015). Two practice models in one labor and delivery unit: Association with cesarean delivery rates. *American Journal of Obstetrics & Gynecology*, 212(4), 491.e1-491.e8. https://doi. org/10.1016/j.ajog.2014.11.014

[51] Oakley, D., Murray, E., Murtland, T., Hayashi, R., Anderson, F., Mayes, F., & Rooks, J. P. (1996). Comparisons of outcomes of maternity care by obstetricians and certified nurse-midwives. *Obstetrics & Gynecology*, 88(5), 82309. DOġ:10.1016/0029-7844(96)00278-5

[52] Shaw-Battista, J., Fineberg, A., Boehler, B., Skubic, B., Woolley, D., & Tilton, Z. (2011). Obstetrician and nurse-midwife collaboration: Successful public health and private practice partnership. *Obstetrics & Gynecology*, 118(3), 663–672. https://doi. org/10.1097/AOG.0b013e31822ac86f

[53] Weisband, Y. L., Gallo, M. F., Klebanoff, M., Shoben, A., & Norris, A. H. (2018). Who uses a midwife for prenatal care and for birth in the United States? A secondary analysis of listening to mothers III. *Women's Health Issues*, 28(1), 89–96. https://doi. org/10.1016/j.whi.2017.07.004

[54] Jolles, D. R., Langford, R., Stapleton, S., Cesario, S., Koci, A., & Alliman, J. (2017). Outcomes of childbearing Medicaid beneficiaries engaged in care at Strong Start birth center sites between 2012 and 2014. *Birth*, 44(4), 298–305. https://doi.org/10.1111/ birt.12302

[55] Attanasio, L., & Kozhimannil, K. B. (2018). Relationship between hospital-level percentage of midwife-attended births and obstetric procedure utilization. *Journal of Midwifery and Women's Health*, 63(1), 14–22. https://doi.org/10.1111/jmwh.12702

[56] Altman, M. R., Murphy, S. M., Fitzgerald, C. E., Andersen, H. F., & Daratha, K. B. (2017). The cost of nurse-midwifery care: Use of interventions, resources, and associated costs in the hospital setting. *Women's Health Issues*, 27(4), 434–440. https://doi. org/10.1016/j.whi.2017.01.002

[57] Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., ... Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*, 384(9948), 1129– 1145. https://doi.org/10.1016/S0140-6736(14)60789-3

[58] Renfrew, M. J., Homer, C. S. E., Downe, S., McFadden, A., Muir, N., Prentice, T., & ten Hoope-Bender, P. (2014). An executive summary for the Lancet's series "Midwifery." *Lancet*, 1–8. Retrieved from http://download.thelancet.com/flatcontentassets/ series/midwifery/midwifery_exec_summ.pdf

[59] Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane database of systematic reviews,* 4, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

[60] Newhouse, R. P., Stanik-hutt, J., White, K. M., Bass, E. B., Wilson, R. F., & Weiner, J. P. (2011). Advanced practice nurse outcomes 1990-2008 : A systematic review. *Nursing economics* 29(5). Retrieved from: https://pubmed.ncbi.nlm.nih.gov/22372080/

[61] Loewenberg Weisband, Y., Klebanoff, M., Gallo, M. F., Shoben, A., & Norris, A. H. (2018). Birth outcomes of women using a midwife versus women using a physician for prenatal care. *Journal of Midwifery and Women's Health*, 63(4), 399–409. https://doi. org/10.1111/jmwh.12750

[62] Souter, V., Nethery, E., Kopas, M. Lou, Wurz, H., Sitcov, K., & Caughey, A. (2019). Comparison of midwifery and obstetric care in low-risk hospital births. *Obstetrics & Gynecology*. 134(5) doi: 10.1097/AOG.0000000000003521.

[63] Neal, J. L., Carlson, N.S., Phillippi, J. C., Tilden, E. L., Smith, D. C., Breman, R. B., … Lowe, N. K. (2018). Midwifery presence in United States medical centers and labor care and birth outcomes among low-risk nulliparous women: A consortium on safe labor study. *Birth*, 1–12. https://doi.org/10.1111/birt.12407

[64] National Academies of Sciences, Engineering, and Medicine. (2020). *Birth settings in America: Outcomes, quality, access, and choice* . Washington, DC: The National Academies Press. https://doiorg/10.17226/25636.

[65] Freytsis, M., Phillippi, J. C., Cox, K. J., Romano, A., & Cragin, L. (2017). The American College of Nurse-Midwives Clarity in Collaboration Project: Describing midwifery care in interprofessional collaborative care models. *Journal of Midwifery and Women's Health*, 62(1), 101–108. https://doi.org/10.1111/jmwh.12521

[66] Declercq, E. (2015). Midwife-attended births in the United States, 1990-2012: Results from revised birth certificate data. *Journal of Midwifery and Women's Health*, 60(1), 10–15. https://doi.org/10.1111/jmwh.1228

[67] Walker, D. S., Schmnuk, S. B., & Summers, L. (2004). Do birth certificate data accurately reflect the number of CNM- attended births? An exploratory study. *Journal of Midwifery and Women's Health*, 49(5), 443–448. https://doi.org/10.1016/j. jmwh.2004.03.010

[68] MacDorman, M. F., & Declercq, E. (2016). Trends and characteristics of United States out-of-hospital births 2004-2014: New information on risk status and access to care. *Birth*, 43(2), 116–124. https://doi.org/10.1111/birt.12228

[69] King, T. L., Laros, R. K., & Parer, J. T. (2012). Interprofessional collaborative practice in obstetrics and midwifery. *Obstetrics & Gynecology Clinics of North America*, 39(3), 411–422. https://doi.org/10.1016/j.ogc.2012.05.009

[70] Waldman, R., Kennedy, H. P., & Kendig, S. (2012). Collaboration in maternity care: Possibilities and challenges. *Obstetrics & Gynecology Clinics of North America*, 39(3), 435–444. https://doi.org/10.1016/j.ogc.2012.05.011

[71] American Association of Birth Centers. (2017). *Standards for birth centers*. Retrieved from http://www.ghbook.ir/index.php?name=&option=com_dbook&task=readonline&book_id=13650&page=73&chkhashk=ED9C9491B4&Itemid=218&lang=fa&t-mpl=component

[72] American Association of Birth Centers. (2020). *AABC Press Kit*. Retrieved from: https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/about_aabc_-_documents/AABC-Press-Kit.pdf

[73] Commission for the Accreditation of Birth Centers (n.d.). *Accreditation and regulation*. Retrieved from: https://www.birthcenteraccreditation.org/accreditation-and-regulation/

[74] Bovbjerg, M. L., Cheyney, M., Brown, J., Cox, K. J., & Leeman, L. (2017). Perspectives on risk: Assessment of risk profiles and outcomes among women planning community birth in the United States. *Birth*, 44(3), 209–221. https://doi.org/10.1111/ birt.12288

[75] The American College of Obstetricians and Gynecologists. (2019). *OCC #9: Levels of Maternal Care*. 134(9), 41–55. Retrieved from: https://www.smfm.org/publications/277-acog-smfm-occ-9-levels-of-maternal-care#:~:text=To%20standardize%20a%20complete%20and,perinatal%20health%20care%20centers%20(level

[76] Krans, E. E., & Davis, M. M. (2014). Strong start for mothers and newborns. *Current Opinion in Obstetrics & Gynecology*, 26(6), 511–515. https://doi.org/10.1097/gco.0000000000000118

[77] Hill, I., Dubay, L., Courtot, B., Benatar, S., Garrett, B., Blavin, F., … Rouse, M. (2018). *Strong start for mothers and newborns evaluation: Year 5 project synthesis Volume 1: Cross-Cutting Findings*. Retrieved from: https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf

[78] Stapleton, S. R., Osborne, C., & Illuzzi, J. (2013). Outcomes of care in birth centers: Demonstration of a durable model. *Journal of Midwifery and Women's Health*, 58(1), 3–14. https://doi.org/10.1111/jmwh.12003

[79] Nursing@Georgetown (2019). *How does the role of nurse-midwives change from state to state?* Nursing@Georgetown Blog. Retrieved from:https://online.nursing.georgetown.edu/blog/scope-of-practice-for-midwives/

[80] American College of Nurse Midwives. (2019). *Essential Facts about Midwives*. Retrieved from: https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007531/EssentialFactsAboutMidwives-UPDATED.pdf

[81] Yang, Y. T., Attanasio, L. B., & Kozhimannil, K. B. (2016). State scope of practice laws, nurse-midwifery workforce, and childbirth procedures and outcomes. *Women's Health Issues*, 26(3), 262–267. https://doi.org/10.1016/j.whi.2016.02.003

[82] Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., Fisher, T., Butt, E., Yang, Y. T., & Kennedy, H. P. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PLoS ONE*, 13(2), 1–20. https://doi.org/10.1371/journal.pone.0192523

[83] APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee. (2008). *Consensus model for APRN regulation: Licensure , accreditation, certification & education.* APRN Joint Dialogue Group Report, 1–41. https:// doi.org/10.1056/NEJMoa1315817

[84] AAPC: Advancing the Business of Healthcare. (n.d.). *Medical coding training & education.* AAPC. Retrieved from: website: https://www.aapc.com/training/medical-coding-training.aspx

[85] Kinzelman, C., & Bushman, J. (n.d.). Understanding your practice environment: *Making an informed decision about where to work.* American College of Nurse-Midwives. Retrieved from: http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000004315/Understanding-Practice-Environment.pdf

[86] Centers for Medicare and Medicaid Services. (2016). *"Incident to" services*. Medicare Learning Network. Retrieved from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

[87] Health Resources & Services Administration. (2016). *Women's Preventive Service Guidelines*. Retrieved from: https://www.hrsa. gov/womens-guidelines-2016/index.html

[88] American College of Nurse Midwives. (n.d.-c). *Position statement: Principles for equitable compensation agreements between CM/CNMs and Physicians.* Retrieved from: https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000083/Principles-for-Equitable-Compensation-PS-9-12-16.pdf

[89] American College of Nurse Midwives. (n.d.-a). *Hospital credentialing and privileging*. Retrieved from https://www.midwife.org/ Hospital-Credentialing-and-Privileging

[90] American Association of Birth Centers. (2019). *Birth Center Regulations*. Retrieved from: https://www.birthcenters.org/ page/bc_regulations.

[91] American College of Nurse Midwives, & The American College of Obstetricians and Gynecologists. (2018). *College Statement of Policy*. Retrieved from: https://www.midwife.org/ACNM-and-ACOG-annouce-new-joint-statement

[92] Rathbun, L., Bauer, K. E., Fennell, K. S., & Jenkins, S. M. (2014). *Preliminary comments of the American Association of Birth Centers*. American Association of Birth Centers. Retrieved from: https://www.ftc.gov/system/files/documents/public_comments/2014/03/00069-89017.pdf

[93] Dickson, V. (2018). *Hospitals urge CMS to continue requiring ASC patient transfer agreements*. ModernHealthcare.com. Retrieved from Modern Healthcare.com website: https://www.modernhealthcare.com/article/20181121/NEWS/181129976/hospitals-urge-cms-to-continue-requiring-asc-patient-transfer-agreements

[94] Torio C. & Moore B. (2016). *National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2013. HCUP Statistical Brief #204.* Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb204- Most-Expensive-Hospital-Conditions.pdf.

[95] Health Care Transformation Task Force. (2019). *Expanding access to outcomes-driven maternity care through value-based payment.* Retrieved from: https://hcttf.org/wp-content/uploads/2019/07/Expanding-Access-to-Outcomes-Driven-Maternity-Care- through-Value-Based-Payment.pdf

[96] Health Care Payment Learning & Action Network. (n.d.). *Maternity episode payment model online resource bank.* Retrieved from https://hcp-lan.org/maternity-resource-bank/

[97] Frost, J. (2018) *Equitable access to maternity care practices that promote high-value family-centered intrapartum care* [Doctoral dissertation, Boston University]. OpenBU. https://open.bu.edu/handle/2144/32699

[98] Howell, E. A., & Zeitlin, J. (2017). Quality of care and disparities in obstetrics. *Obstetrics & Gynecology Clinics of North America*, 44(1), 13–25. https://doi.org/10.1016/j.ogc.2016.10.002

[99] California Maternal Quality Care Collaborative. (n.d.). *Partner Organizations*. Retrieved from:https://www.cmqcc.org/about-cmqcc/partner-organizations

[100] The Joint Commission. (2019). *Specifications Manual for Joint Commission National Quality Measures (v2020A1).* Retrieved from https://manual.jointcommission.org/releases/TJC2020A1/PerinatalCare.html

[101] Bailit Health Purchasing LLC. (n.d.). *Value-based Purchasing for Managed Care Procurements: A Toolkit for State Medicaid Agencies.* Retrieved from https://www.shvs.org/wp-content/uploads/2018/01/SHVS_Medicaid-Toolkit_Final.pdf

[102] World Health Organization. (n.d.b). *Maternal mortality ratio (per 100,000 live births).* Retrieved from: https://www.who.int/healthinfo/statistics/indmaternalmortality/en/

[103] Centers for Disease Control and Prevention. (2019). *Preventing Pregnancy-Related Deaths*. Retrieved from: https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths.html

[104] Centers for Disease Control and Prevention (2017). *Severe maternal morbidity in the United States*. Retrieved from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

[105] World Health Organization. (n.d.a). *Health equity*. Retrieved from https://www.who.int/topics/health_equity/en/

[106] American College of Nurse Midwives (2019). *Comparison of certified nurse midwives, certified midwives, and certified professional midwives: Clarifying the distinctions among professional midwifery credentials in the U.S*. Retrieved from: https://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000268/Comparison.Chart.Update.July2019.pdf

[107] American College of Nurse Midwives. (n.d.-b). *Our philosophy of care*. Retrieved from: https://www.midwife.org/Our- Philosophy-of-Care

[108] American Association of Birth Centers (n.d.). *What is a birth center?* Retrieved from: https://www.birthcenters.org/page/whatisbirthcenter?&hhsearchterms=%22free+and+standing%22

[109] Commission for the Accreditation of Birth Centers. (n.d). *Benefits of AMC Accreditation*. Retrieved from: https://www.birthcenteraccreditation.org/benefits-of-amc-accreditation/

[110] Main, E. (2009). New perinatal quality measures form the National Quality Forum, the Joint Commission, and the Leapfrog Group. *Current Opinion in Obstetrics & Gynecology*, 21, 532–540. doi: 10.1097/GCO.0b013e328332d1b0.

[111] Skochelak, S., Hawkins, R., Lawson, L., Starr, S., Borkari, J., & Gonzalo, J. (2017). *Health Systems Science (1st ed.).* Philadelphia.

[112] Midwives Alliance of North America (n.d.b). *About midwives: Legal status of U.S. midwives*. Retrieved from: https://mana.org/ about-midwives/legal-status-of-us-midwives

[113] MacDorman, M. F., & Declercq, E. (2019). Trends and state variations in out-of-hospital births in the United States, 2004-2017. *Birth*, 46(2), 279–288. https://doi.org/10.1111/birt.12411

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