

American Association of Birth Centers

America's Birth Center Resource



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April 30, 2014

Mr. Donald S. Clark, Secretary
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

RE: FTC Health Care Workshop, Project No. P131207

Dear Secretary Clark:

The American Association of Birth Centers (AABC), the national trade association for birth centers and the primary national resource for information regarding freestanding birth centers, submits the attached set of Comments in response to the February 24, 2014 *Federal Register* Notice entitled “Examining Health Care Competition.” These Comments supplement our initial Comments in this proceeding, which were filed on March 10, 2014.¹

AABC’s initial Comments provided information about the market for maternity care services in the United States and also focused on the role of freestanding birth centers (FSBCs) and the midwives who own and staff FSBCs. Birth centers are the actual and potential competitors of the dominant providers in that market – hospitals and obstetrician/gynecologist physicians. Our initial Comments generally discussed certain statutory and regulatory barriers to entry, as well as private restrictions that impede the ability of FSBCs and midwives to compete effectively. Depending upon state laws and rules, birth centers frequently operate in a needlessly restrictive regulatory environment which is often exacerbated by hostile or exclusionary practices on the part of dominant provider groups, health plans and other payers and professional liability insurers.

After filing our initial Comments, AABC sent its Senior Policy Analyst, Karen S. Fennell, MSN, RN, to attend both days of the Commission’s March 20 - 21 Health Care Competition Workshop. We also reviewed with great interest the Commission’s recently-published policy paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*², which has great relevance for our members.

¹A set of revised Comments was filed on March 19, 2014.

² Gilman, D., Koslov, T.I., *Policy Perspectives – Competition and the Regulation of Advanced Practice Nurses*. (March 2014) Federal Trade Commission. <http://www.ftc.gov/policy/reports/policy-reports/commission-and-staff-reports>

We developed and distributed an informal survey among our members to help determine in which states, and to what extent, state regulation impedes the development and growth of birth centers today. In this same survey, we asked our members to indicate whether they have been denied or excluded from beneficial business and professional relationships with physicians, hospitals, managed care organizations, other health plans, or other opportunities or benefits. We will summarize the survey responses in these Comments and provide copies of the completed surveys as an attachment. AABC has taken these steps because we believe that the FTC's advocacy program could help its members achieve needed legislative and regulatory changes at the state level. AABC works with its members on a state-by-state basis to advocate either for licensing of FSBCs in the nine states where such licensure is presently lacking or to amend restrictive provisions of existing laws or rules.

Restrictive State Statutes and Regulations

In most states, FSBCs, like other health care facilities, are required to be licensed under state law. At the present time, 41 states plus the District of Columbia provide some form of licensing for FSBCs. Birth centers are unregulated (but may operate without a license) in the following states: Idaho, Louisiana, Maine, Michigan, New Mexico, North Carolina, Virginia, and Wisconsin. They are not permitted in North Dakota. Since only licensed facilities are eligible for payment by Medicaid and most private health plans, most birth centers favor licensure, but have encountered varying degrees of resistance in state legislatures and/or regulatory agencies in these nine states. Most consumers, payers and professional liability insurance companies expect birth centers to be licensed. Thus, licensure is highly desirable for most birth centers. Many state licensing laws and rules, however, are overly restrictive, or better suited to hospitals, ambulatory surgical centers or other facilities that provide surgical or other invasive services.

As these Comments demonstrate, the regulatory restrictions featured in the APRN Policy Paper have direct counterparts in state regulation of birth centers. For example, FSBCs are required in many states to employ or contract with a medical director, to have a written collaboration/consultation/referral agreement with a physician and – in some states – to enter into a formal transport/transfer agreement with a local hospital. Although birth centers would prefer to have such relationships with hospitals and physicians, birth centers and midwives encounter the same difficulties as APRNs when such relationships are mandated, because physicians and hospitals, often direct competitors, frequently refuse. Such restrictions not only limit the number of providers but, as the Commission has recognized with APRNs, can limit the ability of those who do become licensed to compete effectively or even to remain in business. Furthermore, in at least five states at the present time, FSBCs are required to go through the same Certificate of Need process that state health planners use to limit the number of hospital beds. As the Commission noted regarding APRNs, restrictions on birth center operation are not related to “safety concerns” or quality, which has been the subject of numerous positive studies, “but to the political decisions in the state in which” the birth center is located.

Additionally, since the great majority of birth centers are owned and/or staffed by midwives, state restrictions on midwifery practice also limit birth center growth and sustainability. As might be expected, state regulation of Certified Nurse-Midwives (CNMs), in many states a category of APRNs,

exhibits the same restrictive limits on practice autonomy and scope of practice that restrict nurse practitioners. State laws that require physician collaboration or supervision limit the ability of a CNM to open or sustain a FSBC.

Similarly, Certified Professional Midwives (CPMs) and other Licensed Midwives, who own and/or staff a significant percentage of birth centers,³ also face state regulatory challenges. At the present time, only 28 states license or grant legal status for CPMs; in the remaining states and the District of Columbia, CPMs risk arrest or civil cease and desist proceedings. Thus, they tend to practice in an underground economy that precludes owning or staffing a state-licensed health facility. Few if any FSBCs exist in these states. In contrast, states that license CPMs tend to have a greater number of FSBCs, such as Texas (60+), Florida (20+) and California (20+). Although licensed CPMs enjoy greater practice autonomy than CNMs, some states mandate physician involvement in their practice or limit CPM scope of practice below nationally-recognized standards.⁴

Potential – and Actual – Procompetitive Effects of FSBCs

Despite the restrictions they encounter, FSBCs and the midwives who own and/or staff FSBCs are already participating in the maternity care market as essentially autonomous entities. As such, they have established a track record as not merely potential but, in fact, actual competitors of hospitals and physicians, in terms of quality, cost and patient satisfaction. As the studies and articles in Appendix B indicate, fees charged by birth centers and midwives and payments made to these providers by both government and private payers, are significantly lower (30% - 50% on average) than payments made to hospitals and hospital based physicians. Although birth centers are still too few in number to exert a significant downward effect on the overall cost of maternity care, policymakers are beginning to realize this might be possible and already use birth center payment data in comparison to the cost of hospital-based maternity care. Furthermore, birth centers' low cesarean section rates, excellent outcomes, high quality of services and high rates of patient satisfaction have become maternity care benchmarks of the type to which policymakers and third party payers are beginning to hold hospitals. Observationally, hospitals have already adopted many of the patient-desired characteristics of FSBCs - home-like atmosphere, water birth, doula and midwives -- and have sought to capture consumers' growing interest in out-of-hospital birth by labeling their labor and delivery units as "birthing centers." Their actual and potential benefits to competition strongly indicate that it would be good policy to support the development and sustainability of birth centers.

³ In 2010, AABC determined that CPMs or other direct-entry midwives staffed 61% of all birth centers and owned 47% of birth centers (see Attachment "Characteristics of Birth Centers"). About one-half of AABC members are staffed either entirely by CPMs or by CNMs and CPMs working together.

⁴ *NACPM Standards for Practice*. National Association of Certified Professional Midwives. 2004.
<http://www.nacpm.org/nacpm-documents.html>

Private Restrictions on Birth Center Competition

Regulatory restrictions, while serious, paint only part of the picture. As demonstrated over thirty years ago by the Lewin study⁵, which was published by the Commission in 1982, physician opposition to one of the first birth centers, the New York City Maternity Center, created serious problems for the birth center as it attempted to secure relationships with consultants and hospitals. FSBCs and midwives today struggle against the same hostility, opposition and restrictions on the part of hospitals and physicians, which is still a daily fact of life for most FSBCs. Midwives and birth centers, as a general matter, prefer to have collegial and amicable professional relationships with local obstetricians and hospitals.

As the National Birth Center Study II⁶ indicates, most women have uneventful and uncomplicated pregnancies and births. Not everyone, however, is an appropriate candidate for birth center delivery. Birth center delivery is safe because midwives are very good at determining whether a woman has developed complications that require consultation with or referral to physician care. Women who develop complications that would make birth center delivery inappropriate, or who require care beyond a midwife's scope of practice, are appropriately referred for physician care and, if indicated, inpatient delivery in a hospital. Likewise, if complications develop during labor, or if the woman becomes tired or decides she wants pain medication, she is appropriately transferred to a hospital for delivery. In the National Birth Center Study II approximately 12% of women who were admitted to a FSBC in labor are transferred to the hospital, although fewer than 2% of these transfers were considered emergencies.⁶ The attached Best Practices transport guidelines recently published by the multi-disciplinary Home Birth Summit concluded its recommendations for all parties involved in transfers from home or birth center to hospital care concludes: "The best available evidence shows that the highest quality of care occurs with seamless coordination across care settings."⁷ At the present time, many hospitals refuse to enter into formal transfer relationships or develop mutual transfer protocols with birth centers and may actively try to discourage birth center and midwives from transferring clients to their facilities. Midwives and clients are harassed and treated with hostility at many hospitals, whose staffs often refuse to accept the transferred clients' medical records. Many birth centers report that local hospital administrators and staff members have repeatedly filed baseless complaints against the midwife and/or birth center with the professional board or licensing agency. Local hospitals have also denied clinical privileges to midwives who work in or own birth centers. Similarly, birth centers often find it difficult, if not impossible, to find an obstetrician or OB group practice willing serve as a consultant or accept client referrals. One member reported contacting 16 different OB practices in her community without finding a single one willing to consult with or accept referrals from her birth center.

⁵ Lazarus, Wendy. *Competition Among Health Practitioners: The Influence of the Medical Profession on the Health Manpower Market*. Vol. 1. US Federal Trade Commission, 1981.

⁶ Stapleton, Susan Rutledge, Cara Osborne, and Jessica Illuzzi. "Outcomes of care in birth centers: demonstration of a durable model." *Journal of Midwifery & Women's Health* 58.1 (2013): 3-14.

⁷ Home Birth Summit, "Best Practice Guidelines: Transfer from Planned Home Birth to Hospital, available at http://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf (the Guidelines note that they are equally appropriate for birth center-to-hospital transfers).

In an attempt to quantify this information to some degree, the AABC Member Survey provides information on a percentage basis, as well as some empirical examples, regarding the types of government and private restrictions that impede birth centers as competitors in the maternity care market. Members were asked ten questions about each subject area, government or private restrictions that have impeded their ability to compete effectively. Thirty members responded, although only one response was received too late for the Summary. A copy of the Summary, which uses bar graphs to indicate percentages, is provided, as are the actual member responses, which contain comments and explanations related to many of the responses.

Survey Results: Government-Imposed Restrictions

The first question was “Does your state have any requirement that makes it difficult for birth centers to qualify for a license?” Four options were offered: Certificate of Need (CON), Medical Director Required, Written Agreement with a Physician and Hospital Transfer Agreement.

Certificate of Need: Five members (20.83% of responses) indicated that CON requirements made it difficult to qualify for a license. Members answering yes are located in Florida, Georgia, Iowa and New York. The application for CON, filed by our Developing Birth Center member in Iowa, was rejected earlier this year. AABC is also aware that a Developing Birth Center member from Kentucky was denied a CON within the past year. As the Commission is aware, the principles underlying Certificate of Need statutes are based upon a health planning rather than a competitive model. In this model, the extent to which a birth center might compete against a local hospital counts against the applicant. Local hospitals are often the opponents of granting CON, even though most birth centers typically have no more than three beds. Three out of five members who went through CON stated that the local hospital had opposed their application. The Kentucky member also experienced strong hospital opposition to her application. Certificate of Need laws are obsolete and irrelevant in today’s health care market.⁸ While complete repeal of all CON is unlikely in those states that still have these laws in place, AABC believes that reasonable arguments can be made for exempting FSBCs, due to their small size and the essentially outpatient nature of birth center services. Most women who give birth at a birth center spend fewer than twenty-four hours there. With respect to prenatal and postpartum services, birth centers function more like a physician’s or midwife’s office than a health care facility. Furthermore, local levels of high demand will typically exist for a proposed birth center, because women who are opposed to hospital birth or who might otherwise prefer a home birth to hospital birth or who would be willing to travel for a birth center birth, will strongly support adding a birth center in the local community. Birth centers are also likely to attract women from outside the community who would never have traveled from their own community to give birth in the local hospital. In the experience of AABC and its members, CON Boards, which often exhibit high degrees of regulatory capture, tend to reject the birth center’s arguments out of hand and rule against granting CON. Some birth centers have had to go through multiple rounds of CON before approval was finally granted. These expensive proceedings constitute a significant barrier to entry for most would-be birth center entrepreneurs, most of whom would be considered small businesses and many of which, like the birth center applicant in Iowa, which is a

⁸ The Federal Trade Commission, Department of Justice, [Improving Health Care: A Dose of Competition](#) (Washington D.C.: FTC, DOJ, 2004) 361 pages PDF

Federally-Qualified Health Center (FQHC), are owned by non-profit organizations.

Medical Director: Most types of health care facilities are required to have a Medical Director, but it is neither necessary nor appropriate to require this of an FSBC. Since the midwifery model of care, rather than a medical model of care,⁹ is provided by midwives in a birth center, it is not only acceptable practice, but deemed clinically safe and appropriate under AABC's Standards for Birth Centers, for birth centers to have a midwife as clinical director. However, 58.33% of responding members indicated that the state where they were located (Florida, Georgia, Maryland, Missouri, Nebraska, New York, and Pennsylvania) required them to name a physician Medical Director. As is the case with physician supervision, a mandated medical director is unnecessary. Many obstetricians are hostile to birth centers and unwilling to cooperate with them. Furthermore, even birth center friendly physicians might not wish to take on the potential liability implied by the role of medical director of a facility where they do not practice. Some birth centers have to pay a physician to fill the position of Medical Director to satisfy state requirements, even though actual work is minimal in some cases. Comments made by members in the "private restrictions" section of the survey (questions 11 through 20) indicate the difficulties birth centers have had and the extents to which they must often go to satisfy state law requirements like these.

Written Consultant Agreement: Some states require, in lieu of a Medical Director, a Consulting or Collaborating Physician to sign an agreement with the birth center or to approve the center's protocols or practice guidelines. Our member survey indicates that two-thirds of responding members are required by state law to have of these agreements. States indicated as having this requirement include Alaska, Colorado, Georgia, Maryland, Missouri, Pennsylvania and South Carolina. Please note that many of these states also require a Medical Director in addition to a Consulting Physician Agreement, which increases the burden on birth centers to obtain the agreement of not one but as many as three physicians since, in some states, agreements are required with both an obstetrical physician and a pediatrician. Several members have commented that they have been required to pay a premium, unrelated to any clinical or administrative services provided, to secure the necessary signature. These payments can be significant, in some cases as much as \$60,000 per year or more. South Carolina has recently begun interpreting its consulting physician law as requiring the physician be available to travel to the birth center to examine the woman in labor if the midwife requests a consult and to approve a midwife's decision to transfer a women from birth center to hospital. This interpretation not only increases costs unnecessarily, because a midwife is perfectly capable of determining when a women should be transferred to a hospital, but increases the risk for consumers, since it delays the transfer of a patient until the physician consultant has traveled to the birth center to examine her. Requirements such as these not only constitute serious barriers to entry into the maternity care market, but also impose burdensome ongoing costs for the birth center and midwife who seeks to compete in that market.

⁹ The midwifery model of care and the medical model of care are two distinct approaches to the care of childbearing women that was first defined by sociologist Barbara Katz-Rothman in 1979. Rooks J. *Midwifery and childbirth in America*. Philadelphia: Temple University Press, pp. 1–3, 125–132, 1997.

Hospital Transfer Agreements Birth centers are required to have formal transfer agreements or arrangements with a hospital in the states where 54.13% of responding members are located: California, Georgia, Kansas, Missouri, Montana, Nebraska, New York and Pennsylvania. AABC is aware that this requirement is also imposed in Mississippi, although the Developing Member from that state did not respond to the survey. Like physician collaboration or consultation agreements, mandated hospital transfer agreements force the birth center to seek a benefit from an often hostile competitor. To be clear, this is not a question of birth centers not wanting a reliable relationship with a local hospital. Every member of AABC that would be delighted to find a hospital willing to cooperate. However, as with mandated physician collaboration for APRNs, it is the other party – the hospital – that refuses the relationship. Such requirements, like the medical director and consulting physician rules, are anticompetitive in their effects because they give a relatively powerful market player effective veto power over a new market entrant that is already perceived as a potential if not actual competitive threat.

Interestingly, hospital associations and physician organizations always lobby vociferously in favor of restrictions such as these to be placed on birth centers, midwives (and APRNs, for that matter), insisting that these agreements are essential for patient safety. Most individual hospitals and physician members of these groups, however, refuse to enter into such agreements, citing fear of liability or loss of insurance coverage, disapproval of the care model or fear of retaliation from other physicians. AABC members report having had a good relationship with a particular physician or group practice until the practice is acquired by the local hospital, at which point the physician is forced to terminate the relationship with the birth center. Other birth centers report that their consulting physicians or physicians who accept their referrals are harassed by hospital administration or their medical staff colleagues to terminate the relationship and are subjected to such tactics as baseless peer review, loss or suspension of their privileges, exclusion from call coverage groups, harassment of transferred patients and similar tactics.

At some point in the near future, AABC believes, hospitals will come to recognize that birth center patients, as citizens in the community, are entitled to safe, respectful, care no matter what stage they enter into care at the hospital and will voluntarily enter into transfer arrangements such as those described in the Home Birth Summit Guidelines document. Until that time, however, it constitutes a significant barrier to entry into the maternity services market to require a birth center proprietor to secure permission to enter that market from the dominant provider in the community. In the meantime, legislators require education regarding the power structure of local health care markets so that they can resist the lobbying tactics of corporate medicine and the state hospital association.

AABC also notes that, in most states, health care facility services are integrated, formally or informally, into a system for reasonably seamless transfers of care from less intensive to more intensive, from community hospitals to Level 3 NICUs, trauma centers and teaching hospitals. As licensed health care facilities, FSBCs belong within that integrated system and FSBC patients, as citizens of that state, are entitled to the benefit of seamless integration when they must transfer from FSBC to hospital. These goals will not be achieved by placing the legal mandate on the weaker party, the market entrant, but by requiring hospitals to accept such proposals on the same basis as other inter-facility transfer

arrangements in that state. Such laws will provide a more level playing field for hospital-birth center business and professional relationships.

Structural Issues: Many state birth center laws contain provisions for structural facility elements, such as room, hallway and door dimensions, electrical, plumbing or fire code standards that are stricter than necessary for safe birth center operation. Approximately half of responding members indicated that some structural requirements in state laws were an impediment to obtaining a license. Strict or stringent structural requirements that are perhaps appropriate for the medical model, are almost always unnecessary in a birth center. No surgery takes place at birth centers, no anesthesia is provided, and clients are awake and ambulatory. If evacuation in the event of fire became necessary, patients could walk out, with some assistance, rather than needing a gurney. Childbirth is not an illness or medical event but, rather, a natural function that in most cases does not require medical intervention. The birth center model is a maxi-home rather than a mini-hospital. Ideally, a renovated house or small office building is an optimum site. Renovation requirements should be consistent with the care model.

Yet, some state laws and regulations categorize birth centers as if they were hospitals or ambulatory surgical centers, while other states simply impose the more stringent standards applicable to these other facilities, rather than developing regulations specific to the birth center experience and AABC's National Standards. AABC's Standards have been endorsed by the American Public Health Association and adopted by a number of states that regulate birth centers more appropriately than those described in these Comments. The more stringent state rules often require extremely wide halls and doorways for stretchers and gurneys, much larger birthing rooms than needed, *en suite* baths and sinks like a hospital room, and other detailed structural requirements. These requirements are not needed for safety or quality control, but rather serve to impose unnecessary costs on birth center owners before they can enter the maternity services market.

Other Regulatory Issues: To gain more information about these state regulations, AABC asked its members whether their respective states have different standards for larger birth center than for those with fewer rooms. This is particularly significant because two states, Utah and Missouri, impose extremely stringent rules on birth centers with more than a minimal number of rooms, but permit birth centers with fewer birthing rooms to remain unlicensed if they choose. This presents a difficult choice because unlicensed FSBCs are ineligible for Medicaid provider status or participation in most private health plans, including the new ACA Insurance Exchanges, but the cost of renovating a building to comply with the requirements sets too high a bar. As a result, no birth centers are licensed in Utah and only one in Missouri. We also asked whether the state in which the member was located licensed birth centers as a different type of facility. Two members responded that their birth centers were licensed as ambulatory care centers (Missouri), while others indicated that they were variously licensed as a diagnostic and treatment center (New York), an outpatient clinic (Florida, Montana), or a health clinic (Nebraska). Members indicated that having to license their birth centers as a different type of facility increased their costs and burdens of obtaining a license and maintaining licensed status. A member from New York described an extremely unreasonable process for obtaining a license, which included a requirement to lease the building where the center would be located prior to beginning the CON

process, which cost her over one year's rent for an unused building.

AABC and its members intend to seek significant policy changes in the laws that govern birth centers and midwife practice in the states whose laws are most restrictive of birth center growth. At present, there are only about 300 birth centers in the entire United States. Demand for freestanding birth centers and midwives is growing rapidly, however, as we demonstrated in our initial Comments (see Chart 32 from the *New Mothers Speak Out* report). If birth centers are going to be able to meet that demand, the antiquated and anticompetitive laws and rules that restrict birth center growth and development must be amended. With these Comments as a starting point, AABC wishes to reach out to the FTC to ask that the agency consider addressing these statutory and regulatory restrictions on birth centers and midwives in the same manner as you have for APRNs. Mindful of the analytical framework used to evaluate the evidence of "benefits of competition and the potential adverse competitive impact of regulations, along with other legitimate policy goals," we have provided in Appendix B several links to important studies which should help the Commission staff evaluate the net procompetitive benefit that will result if birth centers can break free from existing regulatory restraints. These studies examine the safety and quality of birth center care, the potential for birth centers and midwives to lower health care costs, improve outcomes and increase patient satisfaction and the interests of consumers in gaining access to better maternity care services.

We have also provided, in Exhibit A, links to the websites, social media pages and blogs of a number of national and state consumer organizations that are presently engaged in advocacy for improved maternity care and access to midwives and birth centers. The maternity services market is one where vocal consumer groups have begun to take a leading role in developing health care policy for the near and long-term future. These consumers are already aware of the benefits of greater competition in the maternity health care market and can be expected to support the legislative changes for which AABC and its members will advocate. Midwives and birth centers are fortunate in that we enjoy the support of a vocal and knowledgeable set of consumer advocates.

Using that analytical framework as a reference, we think we have established that these regulations do "significantly impede competition." First, they make the process for licensing birth centers much more costly and difficult for midwives and others to wish to enter into competition in the maternity services market as a FSBC. These restrictions also limit the availability of birth center services, at a time when consumer demand is increasing.

The consumer health and safety needs that birth center licensure and regulation are supposed to meet can be satisfied with far less restrictive requirements. This has been demonstrated in states that have adopted less restrictive regulatory schemes based upon AABC Standards. AABC believes it can be demonstrated that the restrictive state regulations do not actually provide intended benefits and are not necessary to achieve safety or quality. These regulations do not provide information to consumers or make it easier for consumers to choose between birth centers or hospitals. Rather, they burden the process by imposing what may be unwanted physician services and hospital costs on consumers who would prefer to choose a non-hospital, non-physician option. By requiring physician supervision or

mandatory hospital transport or CON requirements, these regulations simply make it more expensive for consumers to choose among service providers and access their preferred choice.

Furthermore, since empirical evidence indicates that physicians and hospitals are largely unwilling to enter into the relationships that have been mandated for birth centers and midwives, the regulations are unlikely to result in their intended goals such as providing supervision.

Finally, these regulations are heavy-handed, broad and oppressive, far from being narrowly tailored to address genuine concerns. The chief result of these restrictive laws and regulations appears to be that they allow hospitals and physicians to control the entry into the market and the day-to-day operation of cost-effective, quality competitors.

For these reasons, AABC requests that the Commission work with us to develop advocacy presentations tailored to birth centers and midwives in the maternity health care market and to an analysis of the restrictions that impede birth centers from becoming more effective competitors in that market. Please let us know if there is any other information we can provide, including published studies or access to experts in this field, including researchers from Childbirth Connection and the Centers for Disease Control. We look forward to scheduling a meeting with Bureau of Competition staff members in the near future to discuss whether this is an area of advocacy the Commission is interested in exploring.

Private Restrictions: Mindful of the considerable overlap between governmentally-imposed restrictions and private restraints, AABC concluded its member survey with a series of questions designed to elicit information about various privately-imposed restraints on birth center market entry or operation. One example is the overlap between state laws that mandate physician direction or consultation and the apparent refusal of all obstetricians in a single community, or on a single medical staff, to provide such direction. Whether or not such private restraints on competition can ever be proven as an unfair method of competition is not our question for today. Rather, we simply sought to catalog some of the impediments to competition that birth centers face and, in many instances, have overcome.

Therefore, in addition to state-imposed restrictions and impediments to competition, AABC asked its members whether their birth center had experienced any of the following competitive problems:

- Required to pay a physician or physician group to induce them to sign a consulting agreement or serve as medical director (37% said yes)
- Staff midwives unable to obtain clinical privileges at local hospital(s) (50% of CNM members said yes)
- Problems dealing with hospital or its medical staff (59% said yes; see discussion for specifics)
- Denied participation in managed care health plans (56% said yes)
- Excluded from physician-dominated or hospital-controlled provider networks (54% said yes)
- Malpractice insurance coverage for cooperating physicians (4 members indicated this was a problem in their states)

- General hostility (this question was added to solicit information about hostility to birth centers that did not fit neatly in any category (68% said yes regarding local hospital hostility, while 86% perceived hostility to the birth center from local physician groups).

We will consider each of these areas separately, including selected comments from the survey instrument.

Payment to a physician or physician group: Members were asked if their birth center provided any payment to a physician or physician group to serve as medical director or sign a consulting agreement, or otherwise collaborate with the birth center, without regard to any services the physician might perform. That is, we wanted to know if our members were paying physicians simply for availability or simply to get a signature on the line. Of those that responded “yes,” only two members indicated the amount they were paying. The first indicated that their birth center utilized as consultants members of the faculty at the teaching hospital where its nurse-midwives hold privileges. These faculty members are on call and if a midwife needs a consultation or a referral, the consulting physician will be able to bill for the service. Nevertheless, the hospital is charging the birth center over \$200,000 per year simply to permit its faculty members to be on call. Another member reported that her “collaborating MD owns 24% of the birth center and is paid at 24% despite doing NO WORK.” Two other members explained that their birth centers were paying the collaborating/consulting physician basically for availability, not for services. Five members simply said “yes” in response to this question, without providing details. One member said that her birth center paid about \$2000 for her consultant’s additional malpractice insurance premium to consult with the birth center. Please note that payments such as these to physicians are not reimbursable on any basis by government or private payers because no patient service is being provided. Rather, these are basically payments from one provider to another that amount to “rent” for being able to remain in business. Such payments – which have been imposed on midwifery practices for years, as reported by the American College of Nurse-Midwives in the FTC/DOJ 2003 health care competition hearings, add to the cost of doing business and make competition more difficult for FSBCs and midwives.

Clinical Privileges: Approximately one-half of the CNM-staffed birth centers responded that they had not been able to obtain clinical privileges at local hospitals. Other members’ answers were not applicable, either because they are physicians who are able to get privileges, or CPMs, who do not provide hospital-based midwifery services. Thirteen members provided comments in response to this question. A small-town Pennsylvania FSBC reported that the local hospital was “interested in CNMs,” but CNMs in that state are required to have a written collaboration agreement with an obstetrician. All obstetricians in town belong to a single group practice which refuses to work with CNMs, and will not “allow” the family practice physicians for whom they provide surgical backup to work with CNMs either. Another Pennsylvania birth center CNM stated that she had been “unable to get full privileges.” One Virginia birth center midwife reported that she “hadn’t even tried,” because it would be impossible for a birth center CNM to get privileges. Another Virginia CNM at a different birth center explained that she did not apply because “all physicians are owned by two hospital groups who will not let them sign agreements or cover calls for those who do.” These physician groups are “not willing to be ‘responsible’

for CNMs”, or even to hire CNMs for the obstetric clinic. CNMs at all three California birth centers who responded stated that they had been denied privileges at the local hospitals where they applied. One commented that “I have my suspicions, but cannot prove it.” One member in New York reported that the CNMs at her center were able to get privileges eventually, but the ‘credentialing process takes longer for CNMs because MDs get higher priority.” A Georgia birth center midwife reported that she had been denied privileges because the hospital required CNMs to “have an MD ‘sponsor’ or employer.” She couldn’t find a “sponsor” so she couldn’t work at that hospital.

The two birth center owners in Colorado each had interesting reports. One stated that: “All hospitals in Colorado require MD supervision for CNMs in hospital, but MDs cannot get malpractice insurance to cover out-of-hospital birth,” which precludes them from working with birth center CNMs. This is particularly interesting because the medical malpractice insurance company in question is COPIC, which was founded by physicians, has a physician-controlled board of directors and has the exclusive endorsement of the Colorado Medical Society. COPIC has frequently either prohibited its insured physicians from working with CNMs or Certified Registered Nurse Anesthetists (CRNAs) or has attempted to enforce a surcharge to those who do. The other Colorado birth center owner reported that she did not try to apply for privileges because she was aware that “the other midwife group had to pay the physician group a percentage of fees whether or not they provided services in order to get access to the hospital.” The last two comments concern refusals to amend medical staff bylaws to include CNMs as a type of provider eligible for privileges. Our Missouri birth center member reported that “every local hospital we approached, we were told that the mechanisms do not exist to grant privileges to CNMs,” even though these hospitals have other categories of APRNs on staff. In Wisconsin, our member was told that the medical staff was “hostile to out-of-hospital” birth. There were no provisions for midwives in the bylaws and they were unwilling to rewrite them. This same hospital also refused to enter into a transport agreement.

Problems with Local Hospital and/or Medical Staff: We asked our members to describe any problems they have experienced interacting with the local hospitals and the medical staff members at that hospital. The types of problems we heard of include refusals to enter into transfer or collaboration arrangements, hostility on the part of the medical or nursing staff to midwives when they transport or hostility to the clients and baseless complaints filed by hospital officials, staff or medical staff against the birth center or midwives with government agencies, as well as negative talk about the birth center or midwives within the medical community. Members were instructed to identify all categories that applied.

A majority of members who responded to the survey indicated they had experienced some kind of difficulty with the local hospital or medical staff. Fifty-nine percent stated that the local hospital had refused to enter into a transfer agreement or protocols for transfer with the birth center. Approximately 76% indicated that they had experienced hostility to the birth center and midwives, while 53% reported hostility to clients when they were transferred to the local hospital. Baseless complaints were filed by hospital personnel or medical staff to the birth center licensing agency regarding 18% of members who responded, while 24% of them reported baseless complaints had been filed against them with the

disciplinary board for midwives in that state. Over 40% reported that baseless complaints about the birth center or midwives had been made to another midwife or physician in the community.

A Virginia member reports that her local hospital personnel and medical staff “are often rude and unprofessional,” and “say critical things to both the clients and the midwives. They have filed complaints with the Board of Medicine because they didn’t think we should be able to have our birth center.” This same member also reported that baseless complaints had been made to the facility licensing agency, the disciplinary board and midwife and physician colleagues, as well as hostility from members of the disciplinary board, who are opposed to midwifery and do not understand it. Another Virginia member states that “no OB [in her area] is willing to enter into a collaborative practice agreement or is able to due to the hospital system that employs them.” Most cite non-compete clauses or professional liability issues. “We are operating due to one family practice physician who has been willing to sign for prescriptive privileges and be our ‘team leader.’ If anything happens to her, we are probably out of business.”

A New York member reports that the local hospital “has instructed its house/faculty staff not to care for our patients in the event of a transfer,” which seems like a violation of the federal EMTALA law. A California member said that a baseless complaint had been filed against her with the nursing board alleging that she had “dumped” a patient in the ER of one local hospital. She points out that she had tried for fourteen years to convince that hospital to enter into a transfer agreement with her but had refused. A Georgia member reports that there has been “almost continuous review and audit of our practice by obstetricians who do not work with CNMs.” There is no true peer review and no opportunity to respond to criticisms. Our Colorado member describes a terrible situation with its local hospitals, one of which denied a birth certificates to a transferred client, refused to allow another transfer to receive care from her preferred physician. At some local hospitals, nurses and pediatricians act unprofessionally and have falsely claimed that the birth center “kills babies.” A Missouri member states that her local hospital “ordered a physician to stop cooperating with us and instead forced our patients to transfer to the ER call physician,” which is “not ideal for smooth transfer or collaboration.”

Exclusion from Health Plans, Physician Networks and IPAs: In many states, FSBCs are being excluded from managed care plans, including Medicaid managed care organizations (MCOs) and from provider networks, on the basis that they are staffed by midwives without a physician in the practice group. The situation is serious in several states. Two members in California report that birth centers are being excluded from the provider networks for Blue Cross/Blue Shield, United Health Care, Kaiser, Anthem, Health Net and Molina. Some of these plans, however, include midwives and birth centers in other states. Most troubling in California is the exclusion of birth centers and midwives from physician-controlled IPAs. For example, all three IPAs in Sacramento County – River City Medical Group, Hill Physicians and EHS – which, among them, “have all the managed care contracts, do not allow non-MDs to contract with the [managed care] plans.” In Colorado, birth centers and midwives are being excluded from the state health insurance exchange, Rocky Mountain Health Plans. According to our members, “multiple plans on the exchange, including CIGNA, Blue Cross/Blue Shield and Aetna,” refuse to include birth centers or midwives in their networks. In Nebraska, Tricare, United Health Care, Coventry, Aetna and CIGNA all exclude birth centers and midwives. In Florida, Humana and Coventry will only contract

with birth centers or midwives if there is a physician in the group. In New York, BC/BS won't even contract with a physician-owned birth center member. In Georgia, the same names crop up for excluding midwives and birth centers – Blue Cross/Blue Shield, CIGNA, Aetna, Humana and Coventry. United, CIGNA, and Aetna are also cited in Kansas for excluding birth centers and midwives, while Anthem Blue Cross/Blue Shield is a problem for birth centers in Missouri and Virginia. A plan called Optima also excludes Virginia birth centers and midwives.

Finally, our Wisconsin member reports that “every plan that we have tried, including United and Blue Cross/Blue Shield,” refuses to permit midwives or birth centers onto its provider network.

Professional Liability Insurance As the Commission is aware, many professional liability insurance companies for physicians are also owned or controlled by physician groups and some are affiliated with the state medical society, not unlike State Volunteer Mutual Insurance Company, which was one of the defendants in the *Nurse-Midwifery Associates v. Hibbett* decision.¹⁰ Our members' responses to these questions indicate that many physicians fear they will lose insurance coverage if they consult with midwives or birth centers and some professional liability insurance companies have threatened loss of coverage or raised rates. One California birth center has had difficulty obtaining a medical consultant because liability insurance rates go up dramatically when a physician signs on as a birth center collaborating physician. We are not aware of any actuarial basis for such an increase in rates.

Conclusions AABC appreciates the opportunity to bring these matters to the attention of the Federal Trade Commission and its staff members. We look forward to the opportunity to schedule a meeting at your offices in Washington, DC and perhaps to arrange a tour of one of our member facilities in the DC area. We hope that you will agree with us that the types of restrictions imposed on birth centers and midwives are similar in nature and effect to those imposed on APRNs and that the Commission will assist us, as you assisted the advanced practice nurses, through your Competition Advocacy program.

Respectfully submitted,



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American Association of Birth Centers

¹⁰ *Nurse-Midwifery Associates v. Hibbett*, 918 F. 2d 605 (6th Cir. 1990).