Department of Medical Assistance Services
Virginia Department of Health
Report to the Joint Commission on Health Care

Freestanding Birth Centers
Potential for Medicaid Facility Reimbursement

October 3, 2013

Report Mandate

The Joint Commission on Health Care (JCHC) requested, via a letter dated April 9, 2013, that the Virginia Department of Health (VDH) and the Department of Medical Assistance Services (DMAS) review the potential for licensure or recognition of freestanding birth centers for the purpose of Medicaid facility reimbursement.

Background

The request for this report was prompted by a recent JCHC study which concluded that reduced access to prenatal care, especially in rural areas, could be addressed, in part, by permitting freestanding birth centers (BCs) to be reimbursed by Medicaid.

The Commonwealth has expressed an interest in BCs for some time. In response to the closing of obstetrical services at many rural hospitals in 2005, the General Assembly authorized the Board of Health to approve BC pilots. The Family Maternity Center of the Northern Neck was the only pilot from that initiative that provided services; however, the Center stopped furnishing clinical services in August 2011.

There are six known freestanding birthing centers (not associated with an acute care hospital) operating in Virginia. There are three in northern Virginia, one in Charlottesville, one in Harrisonburg, and one in Rocky Mount. All six centers are proximate to an acute care hospital that offers obstetric (Ob) services. The average distance from each existing BC to an Ob-capable acute care hospital is 4.2 miles (range <0.1 mile – 13.2 miles). Each existing known BC is between 1 – 17 minutes drive time from an existing acute care hospital that offers Ob services. It is possible that BCs locate near acute care facilities, in order to assure their consumers of safety, in the event that hospital care is required during a BC delivery.

DMAS currently pays a practitioner fee to licensed nurse midwives who perform deliveries in BCs. The amount of the practitioner fee paid to nurse midwives is the same amount that Medicaid pays to physicians who perform deliveries in hospitals. DMAS pays a separate facility payment to the hospital for hospital deliveries; however, DMAS does not pay a separate facility payment to the BC.

The Affordable Care Act (ACA) requires Medicaid agencies to reimburse BCs if they are "licensed or otherwise approved by the State." In 2011, in order to comply with what was believed at the time to be a federal mandate to reimburse BCs, and given that Virginia does not license BCs, the Governor and the General Assembly passed budget language providing DMAS authority to "enroll and reimburse freestanding birth centers accredited by the Commission for the Accreditation of Birth Centers (CABC)[1]." However, subsequent guidance issued by the Centers for Medicare and Medicaid Services (CMS) indicated that the requirement to reimburse BCs did not apply to states that determined that BCs are not "licensed or otherwise approved by the state." The Virginia Office of the Attorney General (OAG) confirmed that the 2011 budget language provided the authority needed to reimburse BCs, but it did not require the Commonwealth to recognize and reimburse BCs.

Currently, there are two avenues which Virginia could use to recognize and reimburse BCs: 1) accreditation and 2) licensure. Each of these options is briefly defined below and the challenges that each of these options present to VDH and to DMAS are explained in the Discussion section.

Accreditation

Accreditation is a voluntary process by which health care providers contract with a third-party accreditation organization. The third party publishes a set of standards, which when met by a provider, results in accreditation and which, by their emphasis on defining a high quality organization, also serve to reduce risk to the public. Providers accredited by recognized accreditation organizations may enjoy certain privileges such as regional or national recognition, state exemption from licensure, or an improved payment environment. Two of the existing six BCs in Virginia are known to be accredited by the Commission for the Accreditation of Birth Centers (CABC).

Licensure

Regulation of a health care provider via the licensure process is a significant step. Licensure by its nature and function is a tool imposed when there is a substantial risk to the public, either from a type of facility or a classification of practitioner. When the risk or potential for risk to the public is determined to be so significant as to warrant State intervention, licensure and compliance with a set of regulations designed to minimize that risk is imposed. Once licensure is imposed, individual practice or provision of the regulated service is restricted to individual practitioners or facilities that are compliant with the regulations and possess a valid license.

Discussion

[1] The CABC is an independent, not-for-profit organization that accredits developing and existing birth centers in the United States. It was founded by the American Association of Birth Centers which developed the first national standards for BCs.

Both DMAS and VDH recognize and support the importance of access to prenatal care and birth services for women, especially in rural areas. However, there are numerous constraints that may make it difficult to achieve this goal by providing Medicaid reimbursement to freestanding BCs. These constraints raise questions about the number of women who would gain access to services, the costs required to obtain licensure or accreditation, and the net impact on BCs. Both accreditation and licensure would allow BCs to receive Medicaid facility reimbursement, but each of these options presents a unique set of issues that must be fully considered.

Impact of Accreditation on the Medicaid Fee-For-Service Program

Item 297 EEEEE of the 2011 Appropriation Act gave DMAS the authority to recognize accreditation by the CABC as sufficient for DMAS reimbursement of BCs. Thus, DMAS could reimburse accredited BCs through the Medicaid fee-for-service (FFS) program, but doing so would require DMAS to depart from its current policy of only enrolling licensed providers. The Virginia Office of the Attorney General (OAG) indicated that recognizing accredited BCs might set a precedent affecting other provider types. DMAS is very hesitant to establish such a precedent.

Further, using an independent accreditation body rather than state licensing would shift responsibility from the State to the accreditation body, which is unprecedented and may impose a level of risk. Oversight would be delegated to and performed by the out-of-state accrediting body according to their scope, standards, policies, procedures and timeframes. If a mother or child dies or is seriously injured during birth, the state may be criticized for a lack of adequate oversight, as DMAS has neither the authority, the ability nor the resources to inspect and oversee BCs or to take any action in response to such occurrences.

Impact of Accreditation on the Medicaid Managed Care Program

The DMAS contract with the Medicaid MCOs (known as the Medallion II program) restricts MCOs from enrolling non-licensed providers into their networks and is silent regarding enrollment of and payment to accredited providers. Therefore, if DMAS were to allow enrollment of accredited BCs, DMAS would need to revise the Medallion II MCO contract to allow reimbursement to accredited BCs by Medicaid MCOs. DMAS has the ability to amend the Medallion II contract to include BCs as early as the July 2014 contract cycle, allowing the MCOs, at their discretion, to enroll and reimburse accredited BCs.

Medicaid MCOs are at full financial risk for the contracted benefits for their members. Due to this exposure to risk, each MCO is allowed to determine which provider types are needed and admitted into their networks, as well as the criteria (credentialing standards) used to select those providers. Medicaid MCOs make these decisions to ensure access, patient safety and high quality services. Further, inclusion of a provider in a network is a tacit endorsement of that provider. While accreditation and a contract change may allow the BCs to be considered for participation in the MCO networks, it would be contrary to current DMAS practice for DMAS to mandate that

the MCOs must accept an accredited BC into their network. Feedback received from the Medicaid MCOs reinforces the importance of their ability to select and screen their providers.

In the Medallion II contract, DMAS specifies network adequacy standards that must be met, and DMAS staff regularly monitors the MCO networks to verify that the MCOs maintain provider capacity to meet the expected needs of the enrolled population. The MCOs have been able to meet DMAS network adequacy standards for Ob services with their current provider contracts.

Impact of Licensure on Medicaid Fee-For-Service and Medicaid Managed Care

DMAS requires facilities to be licensed, in order to be eligible for Medicaid FFS reimbursement. And although Virginia does not license BCs, nurse midwives who perform deliveries in the BCs are licensed by the state. If Virginia pursues licensure of BCs, DMAS would be required, under the ACA, to reimburse BCs for deliveries for Medicaid FFS patients.

MCOs are also required to only contract with licensed providers, as stated above; however, MCOs have more flexibility than does DMAS in the types of providers they allow to participate in their networks and are not required to include in their networks all provider types that are enrolled in the Medicaid FFS program. MCOs usually base the decision on whether or not to include a provider type in their network on access needs and whether or not the provider type meets established quality standards, such as those required through the National Committee for Quality Assurance (NCQA).[2] MCOs are able to provide facility reimbursement to a BC indirectly, if the BC is affiliated with a licensed provider who is in the MCO network. Only one of the eight contracted Medicaid MCOs currently has such an arrangement.

To reiterate, if Virginia licenses BCs, DMAS would be required to enroll BCs in the Medicaid FFS program, but the Medicaid MCOs would retain discretion regarding inclusion of licensed BCs in their provider networks. This is significant because the majority of pregnant women enrolled in Medicaid in Virginia who are appropriate candidates for BC births are served by the DMAS-contracted MCOs, and it is expected that this percentage will increase over time. Most of the births that are paid through DMAS FFS are by women who have enrolled in Medicaid late in their pregnancies and have therefore not had time to be enrolled in a Medicaid MCO before delivery, and they have had little or no prenatal care, making them poor candidates for BC deliveries, as BCs only accept women with low-risk pregnancies. Thus, if Virginia licenses BCs, the number of deliveries performed in BCs eligible for Medicaid reimbursement would be limited.

Impacts of Licensure on DMAS and VDH

VDH has the authority to license hospitals (Va Code § 32.1-125). The authority to issue a license to a hospital rests with the State Health Commissioner (Va Code § 32.1-126). The functional definition of hospital is broadly stated in the Code of Virginia. There is no specific

[2] DMAS requires that all its contracted MCOs obtain NCQA accreditation within two years of the beginning of operation in Virginia and maintain an acceptable accreditation status throughout their engagement with the state.

authority to license "birthing centers"; however, in citing specific types of hospitals as examples, the definition refers to an outpatient maternity hospital.[3] Outpatient refers to services in which the patient/client's facility stay does not exceed 24 hours. While no definition of outpatient maternity hospital is made in the Code of Virginia, it is reasonable to equate birthing centers, (e.g., an outpatient facility in which obstetric or birthing services are provided) to an outpatient maternity hospital.

All hospital licensure regulation must include the requirement that the facility be compliant with the standards of the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" issued by the American Institute of Architects (Guidelines). The Guidelines include building standards for the minimum size of a birthing room, minimum corridor width, the minimum number of air exchanges in the required housekeeping room, and the type of lighting in the birthing rooms, to list a few. Consistent with prior State practice, existing providers of a service which are subsequently required to obtain licensure are required to become fully compliant with the Guidelines in their current locations, or else relocate to a facility that is compliant with the Guidelines. This requirement would apply to all existing BCs, if Virginia requires them to become licensed.

Further, in addition to the policy considerations and the impact of licensing requirements, in order to operationalize reimbursement to licensed BCs, DMAS would be required to implement a number of technical and programmatic changes including: establishment of a payment rate; development of a provider enrollment processes (including any applicable ACA provider screening requirements); and development of billing and claims processing procedures - all of which will require changes to the Medicaid Management Information System (MMIS). In addition, DMAS would need to establish documentation requirements and audit protocols, update provider manuals, and communicate the new policy to Medicaid providers. (all of these changes would also be required if Virginia decides to recognize accredited BCs.) New regulations would also be required to implement BC reimbursement. Performing all of these administrative tasks could require up to two years and significant resources, in order to accommodate a limited number of Medicaid FFS births.

And as no regulations specific to the licensing of BCs exist in VDH, new regulations would need to be drafted and promulgated. VDH estimates that the promulgation of licensure regulations specific to BCs would take approximately two years to become effective, in order to accommodate a small number of births or facilities. This is particularly relevant considering that there has been no indication that a significant public risk exists from the un-regulated operation of BCs.

Requirement for Certificate of Public Need

Licensure of BCs as hospitals would require certificate of public need (COPN) authorization per § 32.1-102.3 which states that all *projects* (as defined) require advance COPN authorization. One of the definitions of *project,* as it relates to COPN, is the "establishment of a medical care

[3] Va Code § 32.1-123. Definitions

facility."[4] A medical care facility, as it relates to COPN, is defined as, among other facility types, "any facility licensed as a hospital."[5]

Similar to licensure, COPN is seen as a barrier to entry into the marketplace and is a tool intended to limit the number of specific services in a given geographic region. Applicants seeking to establish a new BC would have to demonstrate, through a plan for compliance with a yet-to-be developed set of criteria, that a public need exists for a BC of the intended size at the proposed location. COPN application fees range from $1,000 to $20,000 depending upon the expected capital cost of the project. An application for COPN authorization typically takes approximately eight months from initial notice to decision, but has taken as long as one year. Denied COPN requests often are appealed to circuit court.

In order to issue COPNs for birth centers, VDH would need to develop and promulgate amendments to the State Medical Facilities Plan, 12 VAC5-230 (SMFP.) As with licensure regulations, VDH estimates that it will take at least two years to develop and promulgate these regulatory amendments.

There is no mechanism to exempt existing BCs from the requirement to obtain COPN authorization. Absent legislative relief for existing BCs from COPN, existing BCs would have to stop operations until such time as a COPN is authorized and a license is issued, presuming that existing BCs would meet the public need criteria developed in the SMFP and qualify for a COPN. Given the proximity of the existing BCs to acute care hospitals with Ob programs, meeting these criteria may be difficult. With the exception of one BC in northern Virginia (located in the Town of Marshall), existing BCs offer no improvement in geographic access to Ob services over that afforded by existing acute care hospitals based on the SMFP standard for the availability of Ob services of 30 minutes driving time (12VAC5-230-900).

Summary

Through Appropriation Act language, DMAS has authority to initiate payment to BCs that are accredited by the Commission for the Accreditation of Birth Centers. Non-accredited BCs would still be allowed to operate but would be prohibited from receiving payment from Medicaid or from the Medicaid MCOs directly. VDH currently has the authority to license hospitals, including outpatient maternity hospitals/birthing centers. All BCs would be required to obtain a COPN and become licensed in order to operate, and all BCs would be eligible to receive payment from DMAS and the Medicaid MCOs.

Accreditation of BCs is not considered an appropriate solution given that accreditation would set a precedent that might then apply to other provider types. Additionally, there is concern that allowing a non-state body, the accreditation organization, to assume oversight of the quality and compliance functions of BCs in Virginia would leave the State subject to criticism should an untoward medical event occur at a BC.

[4] ("§ 32.1-102.1. Definitions. "Project"1).
[5] (§ 32.1-102.1. Definitions. "Medical Care Facility.11").

Absent a clearly defined and demonstrated risk to the public, licensing BCs is too substantial a step to undertake solely for the purpose of facilitating payment. Additional regulation without an existing clear threat to public health and safety would be counter to the principles and direction set forth in Executive Order 14 to undertake regulatory action "with the least possible intrusion." Licensure would create several layers of barriers to operating current and developing new BCs through the requirement to obtain certificate of public need authorization and then licensure for all BCs, not only those seeking payment from Medicaid reimbursement.

Both accreditation and licensure would be potentially expensive undertakings for BCs, which are typically small businesses. The minimum cost to BCs to become licensed, not inclusive of any cost to bring the physical plant into compliance with the Guidelines and other expenses incurred to comply with the regulations, would be $1,075 (minimum COPN application fee plus license fee), then $75 annually thereafter and could be as much as $20,075 initially. The cost to BCs to become accredited, also not inclusive of any cost to comply with the accreditation standards, would be $3,300 and an average of $1,567 annually thereafter.

Due to the need to develop and promulgate regulations for the licensure track, and the need to make technical and programmatic changes for the both the licensure and the accreditation track, implementation of either track would require at least two years. And because of the need for COPN authorization, the licensure track would require an additional eight to twelve months before a BC could be licensed.

Conclusion

Providing Medicaid facility reimbursement to BCs would cover a relatively small number of births. The cost to the Commonwealth and to BCs would be relatively high. The lack of an identified public risk associated with care provided in BCs makes licensure an inappropriate vehicle to facilitate additional payments to BCs, and accreditation creates precedents that may have significant unintended consequences. Neither licensure nor accreditation of BCs is in keeping with the principles and direction set forth in Executive Order 14. For these reasons, VDH and DMAS believe that pursuit of Medicaid facility reimbursement for BCs would not substantially increase access to prenatal care and delivery services in Virginia.