1999 SENATE HUMAN SERVICES

SB 2060

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2060

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 6, 1999

Tape Number	Side A	Side B	Meter #
1	X		
1/13 2	X		
2/1 2	X		5,400
Committee Clerk Signature Carol Koladzchuk			

Minutes:

Senator Thane called the Human Services Committee to order for the 1999 session. All senators were present. A short orientation to introduce new committee members, and procedures that Chairman Thane uses.

The hearing on SB 2109 was opened. SENATOR WATNE introduced the bill and recommended a due pass. Written testimony is attached.

TERRY BURRELL , instructor at the ND Medical Center and chairperson of the ND College of Midwives, spoke in favor of the bill and explained what the bill was intended to do. Written testimony is attached.

SENATOR DEMERS asked about the 1.22 figure used in the computation on page 2. Mr. Burrell explained that they paid of $97,513 in 1998 times the increase of 75% to 97% which is 1.22. That would total 118,000; so if they were paid $97,513 last year it would have been

$118,000 had it been at 97%. If there were no nurse midwives they would have had to pay 100% of the fee or 1.25. There is no difference between gynecologist and family practice physician. The reason for 97% is out of respect for the doctors who pay more for malpractice insurance.

SENATOR DEMERS asked where the certified nurse practitioners are located in the state. There are 2 in Minot; 1 in Williston; 3 at Fargo Dakota Clinic and 1 private practice in Fargo.

SENATOR KILZER asked about Hsaio report. The only resource that was different was the malpractice insurance. The education requirements are taken into consideration when the relative factor is computed. The fourth factor of the study was educational preparation; and Mr. Burrell was not familiar with why that piece was taken out other than the fact there didn't seem to be from a management standpoint a day in the actual practice that that was a fair relationship in a relative value based scale. The fact that all practitioners, as well as doctors, have to have a building, electricity, pay a staff, and pay malpractice insurance which was all factored in the that is why the three components were the three left in that formula.

SENATOR KILZER stated that the payment review commission is just for physicians, it is a follow-up of the Hsaio report originally to update not only the exact payment amount but also the relationship of one procedure to another whether it be carpal tunnel to a appendectomy between medical procedures. Mr. Burrell stated the importance of the relationship in the type of practice a certified midwife has and the type of practice a physician practices. There are different schooling, philosophies and ways of becoming licensed to practice. We will not be able to survive without some help from both insurance companies and from the state.

SENATOR THANE asked, concerning the rural nature of ND, how do you feel certified nurse midwives can best serve a state with smaller communities not having the best medical facilities.

Mr. Burrell answered that nurse midwives do not have to have a physician on site. There needs to be a process so that if the patient becomes a high risk or leaves the scope of the midwife's practice there is some place to send that patient. A nurse midwife could go in the rural area and open up a practice independently and see patients for annual exams, prenatal care, etc. They would have to have a surgeon for "C Section" capabilities and other kinds of specialties available. Without reimbursement for office and staff they would close the doors. BC/BS has ignored letters for the last four years. It is difficult to deal with. These people are certified by the American College of Nurse Midwives and licensed by ND Board of Nursing and keep in good standing.

PATTY RICHTER, certified nurse midwife from Minot, ND, addressed the rural ND question. In past two years, she has gone to New Town. Previous experience was that the women had as few as two prenatal visit and now they come to the clinic regularly and if you identify problems in a pregnancy early you will have less cost of prenatal care. They do a lot of education - nurses first, teaching patients. If a patient understands that will be more cooperative in their care and be an active participant in their care.

GLORIA BERG stated services are the same; why the difference in pay? The outcome is the same. States around us are paying 100%. What is wrong with our service. In 1996 there was 8 obgyn providers and 3 midwives that did 65% of the births.

SENATOR DEMERS asked if you are a salary employee and if you have privileges on your own or privileges are dependent on your physician. MS Berg stated that Patty and she were salaried. The Dakota Care are not; they are protection based only. They have independent privileges; we have guided privileges, we don't repair a 4th degree laceration; we call in a physician for that.

We have guidelines for that, but have the support of the physicians to get better reimbursement. They feel we are competent and follow the guidelines.

SENATOR DEMERS asked if that was the same if you are salaried or on the production basis. Yes. Guidelines come from hospital and also some from ACNM. Mr. Burrell offered that the state Board of Nursing looks at scope of practice and approve it. Practitioner submits for privileges and those admission privileges are given by hospital.

SENATOR LEE asked where the state Board of Nursing and Nurses Association stand on your request. How does this request fit in with other certified/licensed people. Ms. Berg stated that midwives do the low risk spectrum. Most of those technical procedures have very little diagnostic portion in this work. This person is responsible for looking at the results, telling the patient this is the diagnosis I'm giving you and this is how we need to treat it and taking responsibility for care and treatment of that patient.

PENNY WESTON, ND Nurses Assoc., supports this bill. We have not formally taken a position; however, our organization would support this. Anything that can increase access to the consumer and provide choice for those people is something that we would very much support.

SENATOR DEMERS talked to the executive director and she said it was important for the certified midwife to have this reimbursement to survive.

SENATOR THANE called for any opposition to the bill.

DAVID ZENTER, Director of Medical Services for the Dept of Human Services, presented opposition to the bill with attached written testimony.

SENATOR THANE asked why other states pay 100%. The answer was that each state decides how to reimburse for services and in this state we try to follow what Medicare and other provider

payers do and be consistent as much as we can. SENATOR THANE asked if the major concern is that it would have a ripple effect and others would come in and ask for the same. Yes, that is part of it.

SENATOR KILZER asked if it was difficult for Medicaid prenatal care to be obtained around the state? Are there people unable to find prenatal care? Answer was not to his knowledge. We are paying for almost 20% of the births in the state; individuals not having difficult time finding care. Risk has special program to make sure these patients get in to see physician on a regular basis.

SENATOR DEMERS What does BC/BS pay for normal birth and how does that compare to the $820 and $615 that quotes have been given. No information on that. We are about 50-60% of bill charges normally. SENATOR DEMERS asked what will happen if the nurse practitioners leave the state. They are saving you money now. Answered by equal with BC/BS and Medicare. Do they save us money? That is hard to quantify and I can't say yes or no.

SENATOR DEMERS asked how they could not save you money if you are paying them $615 compared to $820 for a delivery. Answer was when we build the budget we build it on the 75% so it does not save the program money. SENATOR DEMERS : but if it were not there it would cost the program dollars. Yes, that is correct.

The hearing was closed on SB2060.

Discussion was resumed on 1/13/99.

SENATOR DEMERS shared more information. She asked Dan Ulmer how much these positions get paid. $1800 for midwife is 75% of physicians for complete pregnancy care.

Physician probably gets about $2400. SENATOR KILZER had information from Dave Zentner. The $600 or $800 is just for the act of the delivery plus one postpartum visit. Mid Dakota thinks 97% is pretty high reimbursement. Malpractice insurance premium are $33,000 per year; after five years of working and then retire they still have a tail of around $40,000 to cover any potential claims after physician retires. SENATOR THANE asked why there are less 'cc' sections with women under their care? SENATOR KILZER thinks that statement is correct; the 'cc' rate is 20-25%; midwives about 10%. Mother chooses care giver - healthy choose midwives, the risk chooses physicians. SENATOR DEMERS stated one other factor that deals with issue of provider. Minot physicians refuse to deal with healthy women. They had to choose between the residents or midwives. Every doctor who works with them supports this bill.

The committee was recessed.

Discussion was resumed on January 26, 1999. There was some talk of withdrawing the bill so SENATOR LEE and SENATOR DEMERS will talk with the prime sponsor of the bill, SENATOR WATNE.

Discussion was resumed on 2/1/99.

SENATOR DEMERS moved amendment (90025.0101) of SENATOR WATNE. SENATOR FISCHER seconded it. Discussion brought forth several concerns - setting salaries, training differences, job responsibilities, malpractice policy. Roll call carried 4-0 with the vote left open for SENATOR LEE and SENATOR THANE, then the roll call carried at 6-0. SENATOR MUTZENBERGER will carry the bill.

FISCAL NOTE

(Return original and 14 copies)

Bill / Resolution No.: ______________ Amendment to: SB 2060

Requested by Legislative Council Date of Request: 02/04/99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

Narrative:

This bill as amended would require the Department to modify the state plan for the Medicaid Program to provide certified nurse midwives be paid at least eighty-five percent of the fee paid to physicians for the same service. We project the fiscal impact of direct billed certified nurse midwife services for the 1999-2001 biennium to be $14,681, of which $4,367 is general funds and is included in the budget request contained in SB 2012.

2. State fiscal effect in dollar amounts:

	1997-1999 Biennium		1999-2001 Biennium		2001-2003 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		4,367	10,314	4,565	10,712

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

a. For rest of 1997-99 biennium: -0-

b. For the 1999-01 biennium: 14,681

c. For the 2001-03 biennium: 15,277

4. County, City, and School District fiscal effect in dollar amounts:

1997-1999 Biennium			1999-2001 Biennium			2001-2003 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
-0-			-0-			-0-		

If additional space is needed, attach a supplemental sheet.

Signed: Brenda M Weisz

Typed Name: Brenda M. Weisz

Date Prepared: February 5, 1999

Department: Human Services

Phone No.: 328-2397

FISCAL NOTE

Revised

(Return original and 13 copies)

Bill / Resolution No.: SB 2060 Amendment to: ____________

Requested by Legislative Council Date of Request: 12/23/98

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

Narrative:

This bill would require the Department to modify the state plan for the Medicaid Program to provide certified nurse midwives be paid at least ninety-seven percent of the fee paid to physicians for the same service. A certified nurse midwife can become a medicaid provider and directly bill the Department or the physician supervising the midwife can bill for the services. Currently, nurse practitioners, physician assistants, or certified nurse midwives under the supervision of a physician are paid at seventy-five percent of the physician fee schedule.

We project the fiscal impact of direct billed certified nurse midwife services for the 1999-2001 biennium to be $59,623, of which $17,736 is general funds. However, we can not identify which provider types performed services under the supervision of a physician and therefore the total fiscal impact is unknown. If the payment method was increased from seventy-five to ninety-seven percent of the physician fee schedule for physician billed services the additional fiscal impact could be $92,256, of which $27,422 is general funds.

2. State fiscal effect in dollar amounts:

	1997-1999 Biennium		1999-2001 Biennium		2001-2003 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		17,736	41,887	18,536	43,495

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

a. For rest of 1997-99 biennium: -0-

b. For the 1999-01 biennium: 59,623

c. For the 2001-03 biennium: 62,031

4. County, City, and School District fiscal effect in dollar amounts:

1997-1999 Biennium			1999-2001 Biennium			2001-2003 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
-0-			-0-			-0-		

If additional space is needed, attach a supplemental sheet.

Signed: Brenda M. Weisz

Typed Name: Brenda M. Weisz

Department: Human Services

Phone No.: 328-2397

Date Prepared: January 5, 1999

FISCAL NOTE

(Return original and 10 copies)

Bill / Resolution No.: SB 2060 Amendment to: ______

Requested by Legislative Council Date of Request: 12/23/98

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   This bill would require the Department to modify the state plan for the Medicaid Program to provide certified nurse midwives be paid at least ninety-seven percent of the fee paid to physicians for the same service. A certified nurse midwife can become a medicaid provider and directly bill the Department or the physician supervising the midwife can bill for the services. Currently, nurse practitioners, physician assistants, or certified nurse midwives under the supervision of a physician are paid at seventy-five percent of the physician fee schedule. The Department's records do not identify which type of provider performs the services under the supervision of a physician.

   Since we can not identify which provider type performed the service, the fiscal impact of services specifically provided by a certified nurse midwife is unknown. However, if the payment method for the providers identified above was increased from seventy-five to ninety-seven percent of the physician fee schedule, the total fiscal impact for the 1999-2001 biennium would be $92,256, of which $27,442 is general funds.

2. State fiscal effect in dollar amounts:

	1997-1999 Biennium		1999-2001 Biennium		2001-2003 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		27,442	64,814	28,680	67,303

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

   a. For rest of 1997-99 biennium: -0-

   b. For the 1999-01 biennium: 92,256

   c. For the 2001-03 biennium: 95,983

4. County, City, and School District fiscal effect in dollar amounts:

1997-1999 Biennium			1999-2001 Biennium			2001-2003 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
-0-			-0-			-0-		

If additional space is needed, attach a supplemental sheet.

Signed: Brenda M. Weisz

Typed Name: Brenda M. Weisz

Date Prepared: January 5, 1999

Department: Human Services

Phone No. 328-2397

Date: 2/1/99
Roll Call Vote # : 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2060

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on ______
or
☐ Conference Committee

Legislative Council Amendment Number ______

Action Taken Amendment

Motion Made By Sen DeMers Seconded By Sen Fischer

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Sen Watne's amendment

Date: 2/1/99
Roll Call Vote #: 2

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2060

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on ______
or
☐ Conference Committee

Legislative Council Amendment Number ______

Action Taken Do Pass as Amended

Motion Made By ______ Seconded By ______

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer		✓			
Senator Fischer	✓				
Senator Lee		✓			
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 4 (yes) 2 (no)

Absent 0

Floor Assignment Sen Mutzenberger

If the vote is on an amendment, briefly indicate intent:

Sen Watne's amendment

REPORT OF STANDING COMMITTEE

SB 2060: Human Services Committee (Sen. Thane, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2060 was placed on the Sixth order on the calendar.

Page 1, line 16, replace "ninety-seven" with "eighty-five"

Renumber accordingly

1999 SENATE APPROPRIATIONS

SB 2060

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2060

Senate Appropriations Committee

❑ Conference Committee

Hearing Date February 8, 1999

Tape Number	Side A	Side B	Meter #
1	X		2140-4900
2-11-99 1		X	1396-1480
Committee Clerk Signature	Kathy C. Kottenbrock		

Minutes:

SENATOR NETHING: Opened the hearing on SB2060; A BILL FOR AN ACT TO AMEND AND REENACT SECTION 50-24.1-01.1 OF THE NORTH DAKOTA CENTURY CODE, RELATING TO MEDICAID PAYMENT OF NURSE MIDWIFE FEES.

DAVID ZENTNER: Appeared to provide information regarding SB2060 (testimony attached) (tape 2231-2590).

DARLENE WATNE: State Senator from District 5 to testify in support of SB2060 (tape 2800-3230). There are only six Midwife's in the State. The majority work for clinics and the clinics are concerned about the 65% that they have been paid. In fact, even at 85%, some of them are going to lose their jobs. A baby is delivered by a Doctor or Midwife. A Midwife is saving money. Studies on a national level show the Midwife's should be paid at 97%. A lot of this is based on the Malpractice Insurance costs, theirs is much less. Because of the Malpractice Insurance, many Doctors have given up delivering babies. The Midwife's have continued on in school and received a very high degree, a special C & M degree. The Midwife's came to me and asked if I could help because the Human Service Department was not working with them in trying to get the 97%. Human Services had a number of objections to the bill. First, they didn't feel it should be in the law. Mr. Zentner worked with them and agreed to 85%. You are looking at the appropriation. We feel it's a saving and there should be no cost to it. In lei of a Doctor, your having a Midwife at a lower cost. The Midwife's do more than delivery babies, it's a total package.

SENATOR ST. AUBYN: I'm confused on the cost. If the deliveries are made by a Doctor, wouldn't the department be paying more anyway?

DAVID ZENTNER: If there were no Midwifes' performing these services, yes the cost would go up. To keep them operating, that's why we went to the 85% level. When you get up to 97%, then there really isn't a difference.

SENATOR LINDAAS: Are the Midwife's employees of a clinic and does the clinic provide the malpractice insurance?

SENATOR WATNE: I'm not exactly sure.

RALPH KILZER: State Senator from District 47 to testify in opposition of SB2060 (testimony attached (tape 3731-4275).

SENATOR LINDAAS: The malpractice insurance premium of $5,000 for Midwife's, $33,000 for Obstetricians, wouldn't that be based on the number of deliveries and cesarean births?

RALPH KILZER: Yes, those are true. However, actuarially when the insurance companies designate the premium is on a regional bases and it doesn't matter on the number of deliveries.

SENATOR ANDRIST: Did you present your testimony at the other committee?

RALPH KILZER: I did not present formal testimony, I was involved with the discussion.

SENATOR NETHING: I presume you brought up the same concerns that you've shared with us?

RALPH KILZER: Yes I have but, I've done a little bit more research. I didn't know the $33,000 figure for Obstetricians.

SENATOR SOLBERG: That $33,000, is that just for OB insurance or the combination of OBGYN?

RALPH KILZER: This is OBGYN.

SENATOR NETHING: Closed the hearing on SB2060.

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2/11/99

SENATOR NETHING: Reopened the hearing on SB2060.

SENATOR ST. AUBYN: Explained that SB2060 is incorporated into SB2012, section 22.

SENATOR NETHING: Called for the motion on SB2060.
SENATOR ST. AUBYN: Moved a Do Not Pass on SB2060.
SENATOR ROBINSON: Seconded the motion.
ROLL CALL: 14 YEAS; 0 NAYS; 0 ABSENT & NOT VOTING.

CARRIER: SENATOR KRAUTER

SENATOR NETHING: Closed the hearing on SB2060.

Date: 2-11-99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2060

Senate APPROPRIATIONS Committee

☐ Subcommittee on
or
☐ Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Senator St. Aubyn Seconded By Senator Robinson

Senators	Yes	No	Senators	Yes	No
Senator Nething, Chairman	✓				
Senator Naaden, Vice Chairman	✓				
Senator Solberg	✓				
Senator Lindaas	✓				
Senator Tallackson	✓				
Senator Tomac	✓				
Senator Robinson	✓				
Senator Krauter	✓				
Senator St. Aubyn	✓				
Senator Grindberg	✓				
Senator Holmberg	✓				
Senator Kringstad	✓				
Senator Bowman	✓				
Senator Andrist	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Senator Krauter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2060, as engrossed: Appropriations Committee (Sen. Nething, Chairman) recommends **DO NOT PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2060 was placed on the Eleventh order on the calendar.

1999 TESTIMONY

SB 2060

400 E. Burdick Expy.
Post Office Box 1489
Minot, ND 58702-1489

Medical Arts Clinic, P.C.

Switchboard (701) 857-7000
Toll Free 1-800-598-1205
Fax (701) 857-7342

January 4, 1999

Human Services Committee
Legislative Council
Attn: Russell Thane, Chairman
600 East Boulevard
Bismarck, ND 58505

RE: SB 2060

Dear Mr. Thane:

This is a letter of support of Certified Nurse-Midwives. I feel that their reimbursement should be increased to a level commensurate with their skills and capabilities.

It is my feeling that the Certified Nurse Midwives fill a need and a gap. Frequently, their patients refuse to see physicians whether they be males or females, and thus the service they provide is something that is complimentary to the service provided by physicians. They work hard, they are diligent, they are competent. They deserve a better reimbursement scale than they are now receiving.

I thank you very much for your attention to this letter.

Sincerely,

A. Fischbach, M.D.

Arie Fischbach, M.D., FACOG
Department of Obstetrics and Gynecology

AF/slb

cc: Administrator Medical Arts Clinic
Ralph Kilzer, Vice-Chair
Judy Lee
Judy DeMers
Tom Fisher

AMERICAN COLLEGE OF NURSE-MIDWIVES

A SUMMARY

This comprehensive study used birth certificate data to examine the differences in outcomes and survival for infants whose births were attended by nurse-midwives compared with those attended by physicians.

All singleton vaginal births between 35-43 weeks gestation attended by physicians and nurse-midwives in 1991 were included.

After controlling for medical and sociodemographic risk factors the main findings were[1]:

1. The risk for neonatal mortality (death which occurs in the first 28 days of life) was 33% less for births attended by nurse-midwives.
2. The risk of delivering a low birth weight infant was 31% lower for the nurse-midwife attended births.
3. The mean birth weight was 37grams higher for the nurse-midwife attended births.
4. The infant mortality rate (death during the first year of life) was 19% lower for the nurse midwife attended births.

This well-designed study was done at the National Center for Health Statistics (a part of the Centers for Disease Control and Prevention) and was published in the peer reviewed Journal of Epidemiology and Community Health. The authors discussed how practice differences between nurse-midwives and physicians might help explain the differences in birth outcomes. These include spending more time with mothers during prenatal visits, providing more education and emotional support and a more personalized and one on one presence during labor and birth. They conclude that "...national data do support the findings of other local studies that certified nurse-midwives have excellent birth outcomes, and provide a safe and viable alternative to maternity care in the United States, particularly for low and moderate risk women."

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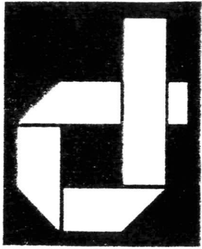
[1] JOURNAL OF EPIDEMIOLOGY & COMMUNITY HEALTH, May 1998, Vol 52, No 5, p 310-317)

818 CONNECTICUT AVENUE, NW • SUITE 900 • WASHINGTON, DC 20006 • 202/728-9860 • FAX 202/728-9897



DAKOTA CLINIC, LTD.

January 4, 1999

Honorable Men and Women of the
Human Resources Committee
North Dakota Senate
Bismarck, ND 58505

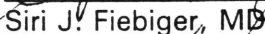
Dear Senator/Representative:

We are writing to request your support for Bill 2060 concerning fair reimbursement of certified nurse-midwives (CNM's) serving Medicaid beneficiaries. Currently, CNM's are reimbursed for services they provide to Medicaid recipients at a rate that is 75 percent of the amount physicians are paid for the same services. The American College of Certified Nurse-Midwives (ACNM) has studied the Medicare Resource Based Relative Value Scale (RBRVS) which uses a formula incorporating work expense, overhead expense and malpractice expense to determine a relative value for Medicaid services. Based on this scale, ACNM has determined that nurse mid-wives should be reimbursed at 97 percent of physician reimbursement rates primarily because of CNM's malpractice liability expenses.

Numerous studies support the cost-effectiveness of using nurse-midwives to care for vulnerable populations. Unfortunately, at the current reimbursement rates, the treatment of Medicaid patients by Certified Nurse-Midwives in North Dakota cannot be accomplished without a financial loss. Our CNM's are compensated at a percentage of net professional billings without salary. Therefore, I urge you to introduce legislation in this session of Congress that would set reimbursement rates for CNM services provided to Medicaid patients at 97 percent of what physicians are paid for similar services.

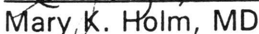
We would be pleased to discuss this issue or supply you with additional information. We can be reached at 701-280-3418 or at the address above. You may also feel free to contact Karen Fennel, Senior Policy Analyst at ACNM 202-728-9860, or Terry Burrell, MS, CNM at the address above or 701-280-3396.

Sincerely,

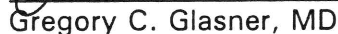


Siri J. Fiebiger, MD

Orvis M. Wells, MD



Mary K. Holm, MD



Gregory C. Glasner, MD

ORIGINAL

1702 South University Drive • P.O. Box 6001 • Fargo, ND 58108-6001
(701) 280-3300 • Fax (701) 280-3229

Elizabeth Jones, MD
Obstetrics & Gynecology
1213 15th Avenue West
PO Box 636
Williston, ND 58802-0636
(701) 572-8857

January 5, 1999

To: Human Resources Committee
Re: Bill 2080

We respectfully request that you support Bill 2080 and a policy of increased reimbursement for the Certified Nurse Midwife. A Certified Nurse Midwife (CNM) is a unique practitioner. The scope of practice, the educational preparation, the clinical preparation and the practice setting of the CNM are significantly different than other Advanced Registered Nurse Practitioners practicing in North Dakota, and in fact is more similar to the physicians practice setting than that of the typical Advanced Registered Nurse Practitioner.

Medicaid pays 100% of physician fee schedule in more than 50% of states. The Federal Government has put CNM's at 97% of OB/Gyn's on the relative value scale based on work effort, overhead, and malpractice cost. The 3% difference comes strictly from the cost differential of malpractice insurance. The Robert Wood Johnson Foundation and the Pew Organization studied outcomes of patients who utilized CNM's (both for obstetrics and for gynecology) and found that they were actually somewhat better. This increase in patient outcomes could very well have had to do with the increased time spent with patients by CNM's resulting in lower cost to the client as well as to the third party payor.

"The use of midwives is a natural solution to the problem of improving access to skilled perinatal services while lowering costs... mothers and babies have distinctly better than average outcomes when births are attended by midwives, either in or out of hospitals." American Journal of Public Health

Studies have shown the C/S rate in the care of low risk women to be lower for CNM's than for family physicians and OB/Gyn's. The midwifery style of care for ob patients leads to patients who are much less likely to require a variety of technological tools to monitor or modify the course of labor, continuous electronic fetal monitoring during labor, oxytocin to induce or augment labor, and epidural anesthesia to cope with the pain of labor. The result is lower cost for the patient and the third party payor.

Thank you very much for your consideration in this matter.

Sincerely,

Elizabeth Jones, MD

Kerry Raghib, CNM, MSN

OB/GYN Associates, Ltd.

2701 9th Avenue SW
Suite 100
Fargo, ND 58103
701-234-9234 • 1-800-932-5590
Fax 701-234-9020
www.fargocity.com/obgyn

Alan R. Lindemann, M.D.
Carol Lennon, M.D.
Gregory Joslin, M.D., Ph.D.
Susan K. Nelson, M.D.

Gail Stafford, CNM
JoAnn Jorgenson, CNP
Sharon Ries, PA-C

January 5, 1999

Honorable Men and Women of the
Human Resources Committee
North Dakota Senate
Bismarck, ND 58505

Dear Senator/Representative:

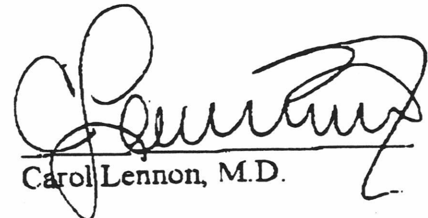
We are writing to request your support for Bill 2060 concerning fair reimbursement of certified nurse-midwives (CNM's) serving Medicaid beneficiaries. Currently, CNM's are reimbursed for services they provide to Medicaid recipients at a rate that is 75 percent of the amount physicians are paid for the same services. The American College of Certified Nurse-Midwives (ACNM) has studied the Medicare Resource Based Relative Value Scale (RBRVS) which uses a formula incorporating work expense, overhead expense and malpractice expense to determine a relative value for Medicaid services. Based on this scale, ACNM has determined that nurse mid-wives should be reimbursed at 97 percent of physician reimbursement rates primarily because of CNM's malpractice liability expenses.

Numerous studies support the cost-effectiveness of using nurse-midwives to care for vulnerable populations. Unfortunately, at the current reimbursement rates, the treatment of Medicaid patients by Certified Nurse Midwives in North Dakota cannot be accomplished without a financial loss. Our CNM's are compensated at a percentage of net professional billings without salary. Therefore, I urge you to introduce legislation in this session of Congress that would set reimbursement rates for CNM services provided to Medicaid patients at 97 percent of what physicians are paid for similar services.

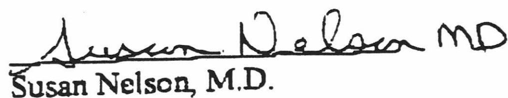
We would be pleased to discuss this issue or supply you with additional information. We can be reached at 701-234-9234 or at the address above. You may also feel free to contact Karen Fennel, Senior Policy Analyst at ACNM 202-728-9860, or Gail Stafford, CNM at the address above.

Sincerely,

Alan Lindemann, M.D.



Carol Lennon, M.D.



Susan Nelson, M.D.

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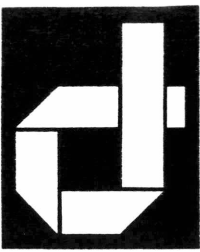


DAKOTA CLINIC

Managing Your Healthcare Today & Tomorrow

January 5, 1999

To Whom It May Concern:

Malpractice insurance premiums for nurse midwives at Dakota Clinic are about 22% higher than premiums for a Dakota Clinic family practitioner who does obstetrics.

Sincerely,

Sonja Taves
Risk Manager

Dakota Clinic, Ltd. • 1702 South University Drive • Fargo ND 58103 • 1-701-280-3300 • 1-800-437-4054

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE
REGARDING SENATE BILL 2060
January 6, 1999

Chairman Thane, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information and oppose this bill requiring the Department to pay certified nurse midwives at least ninety-seven percent of fees paid to physicians for the same service.

The Department pays all allied providers 75 percent of the fees paid to physicians for the same service. Payment is made to physicians based on the relative value unit process. A relative value is assigned to each procedure code based on the amount of resources that the physician utilized to provide the service. That value is then multiplied by the base rate to arrive at the payment amount. Currently, physicians receive $818.90 for a delivery. Nurse midwives would be paid 75% of that amount or $614.17. The Department paid for 1,987 births for the year ending June 30, 1998. Due to the manner in which providers bill the department it is not possible to identify the number of deliveries that were provided by nurse midwifes.

The Department opposes this bill because:

1. We currently pay certified nurse midwives at 75% of the fee paid to physicians, the same method used by other payers in the state such as Blue Cross/Blue Shield and Medicare.

2. The estimated fiscal impact of this bill on the Department's budget will increase the appropriation by $59,623, of which $17,736 are general funds for services that are directly billed by certified

nurse midwives. Also, Medicaid is billed directly by physicians who directly supervise physician assistants, nurse midwives, and nurse practitioners. The Department's records do not identify who provided the service under the supervision of the physician. The additional cost to pay for these services at the 97% level would be $92,256, of which $27,442 are general funds.

3. If this change is passed, it would cause preferential treatment for one class of allied provider. We anticipate that, once passed, other providers that are paid in this manner will also request equal treatment. We estimate the fiscal impact of changing all payments, including certified nurse midwives, from 75% to 97% would total $199,749, of which $59,416 are general funds.

4. The Department believes that given the training and education differences, the current payment deferential between physician payments and allied providers is appropriate.

I would be happy to answer any questions you may have.

Testimony
Senate Bill # 2060
Representative Sally Sandvig
January6,l999

Chairman Thane and members of the Senate Human Services Committee:

For the record my name is Representative Sally M. Sandvig from District 21 in Fargo and I am here to testify in behalf of SB 2060 because I feel that certified nurse midwives are not being adequately compensated for their services when serving Medicaid patients. This issue was brought to my attention by my own certified nurse midwife, Dr. Terry Burrell , who works at Dakota Clinic in Fargo.

Nurse midwives provide the same services as Doctors and nurse practitioners, yet their reimbursement rates vary. In most cases they provide better care because they have more time to spend with their patients listening to their concerns and therefore do a more thorough exam. They perform very valuable services in their communities.

Please vote in favor of this bill.

Thank you for your time.

THANE

Terry Burrell MSCNM
Chairman, North Dakota District
American College of Nurse-Midwives
1702 University Drive So
Fargo, North Dakota 58107

January 6, 1999

Honorable Men and women of the
Human Services Committee
North Dakota Senate
State Capitol
600 East Blvd Ave.
Bismark, ND 58505

Dear Senator/Representative

We are requesting your support for Bill 2060, legislation concerning access to care and reimbursement for CNMs.

President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry released a Consumer Bill of Rights and Responsibilities in November 1997. This report states that "women should be able to choose a qualified provider... such as gynecologists, certified nurse-midwives... for the provision of covered care necessary to provide routine and preventive women's health care services."

Congressman Towns (D-NY) will be introducing the Medicare bill increasing reimbursement to CNMs/CMs to 95%.

More private payers and Medicaid programs are converting their allowable schedules to a variation of the Medicare Resource Based Relative Value Schedule (RBRVS).

The RBRVS methodology of payment was created from a study performed by William Hsiao, Ph.D. and his colleague at Harvard University. This study was commissioned by the Health Care Financing Administration in 1990. The methodology for paying physicians was implemented in the Medicare program in January 1992. The implementation process blends the new RBRVS rate with the historical reasonable charge rates from 1992 to 1996.

This payment system differs from other systems in that the study was resource-based instead of historical fee-based. Relative values were defined in their categorical areas: practice expense content, work component and malpractice component.

Each of these three components is then adjusted geographically, using three separate geographic practices cost indexes. The related value was multiplied by a single conversion factor to arrive at the geographic specific fee schedule allowable for a given area. Very few payers in the private sector use the single conversion factor.

The current Medicare law, which was passed by Congress in 1987, only pays for CNM services at 65 percent of the physician fee schedule.

When the Physician Payment Review Commission studied this issue, they never made specific recommendations to Congress on how to pay for CNM services.

The ACNM replicated the Hsiao study, conducted for obstetricians. Our findings propose that the relative value of practice costs and work effort were the same as physicians. The only relative value differences were observed nationally in the area of malpractice costs. In this region malpractice rates are similar for physicians and CNM's.

Based on these studies, and recognizing that the ACNM is seeking federal legislation to change the CHAMPUS and Medicare payment systems to pay CNMs at 95 percent of physician fee schedules, we are requesting an increase in state Medicaid payments to CNM's at 97% of the physicians fee schedules.

The 97% figure is higher than the national request, based on the malpractice costs in this region.

Why should Certified Nurse-Midwives be paid more than Physician Assistants and Nurse Practitioners?

A) Malpractice premiums for CNM's range from $4,600.00 to $26,000.00. An OB/GYN nurse practitioner's highest premium is $850.00 on an occurrence basis.

B) CNM premiums in this area are 22% higher than family practice physicians who do obstetrics.

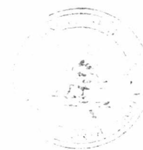
C) CNM's accumulate a higher educational loan debt; the average is over $70,000.00.

Sincerely,

Terry Burrell MSCNM
Chairman, North Dakota ACNM

THANE

NORTH DAKOTA SENATE



STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator Darlene Watne
District 5
520 28th Avenue SW
Minot, ND 58701

COMMITTEES:
Judiciary, Vice Chairman
Political Subdivisions

Chairman Thane and members of the Senate Human Services Committee:

Senate Bill 2060 does only one thing, it provides that certified nurse midwives (CMNs) in our state be paid at least 97% of the fee paid to physicians for the same service - - and that service is primary health care to women. Their services emphasize health promotion, education, and disease prevention. Care-giving by CNMs includes preconception counseling, care during pregnancy and childbirth, normal gynecological services, and care of the peri- and post-menopausal woman. Currently CNMs are reimbursed for services they provide to Medicare recipients at a rate that is 65% of the amount physicians are paid for the exact same services.

First I feel you must know what a certified nurse midwife is because we only have six of them in our state and they are professionals I have deeply come to admire. CNMs are trained in both disciplines of nursing and midwifery. They have graduated from an accredited midwifery program and are certified under the American College of Nurse-Midwives. They focus on wellness and patient choice; there are more than 4,000 in practice today. CNMs can independently prescribe medications in more than half of the 50 states, including North Dakota. Their training enables them to provide a compassionate and total approach to all aspects of women's health care; and the personal touch, this more natural approach to health - - and especially with childbirth - - makes them especially attractive in our society of often-rushed doctor appointments.

The ***Minot Daily News*** this year carried an article about CNMs that I'd like to pass around.

Second is the issue of the percentage that should be paid for the services of a CNM. Attached is a letter draft from Terry Burrell, a MS CNM from Fargo, to the president of the North Dakota Blue Cross/Blue Shield which he is copying to all legislators. Please read it carefully because it gives you the background of federal legislation that impacts this bill and the reasoning for our request. He outlines this much better than I can.

And this request is not to put money in the pockets of the CNMs in our state because most of them are salaried positions affiliated with clinics. This is an issue of fairness and a recognition of a very specialized profession. And, by the way, passage of this bill will get more midwives working, will give better patient outcomes, and eventually be a savings to third party payers. In most cases it comes down to a 24-hour stay versus a doctor delivery that is 48 hours or more in a hospital for a childbirth.

NORTH DAKOTA SENATE

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator Darlene Watne
District 5
520 28th Avenue SW
Minot, ND 58701

COMMITTEES:
Judiciary, Vice Chairman
Political Subdivisions

A study by the American College of Nurse-Midwives (ACNM) looked at the Medicare Resource Based Relative Value Scale (RBRVS), which uses a formula incorporating work expense, overhead expense, and malpractice expense to determine a relative value for Medicare services and determined this figure of 97%, primarily because of lower malpractice liability expenses.

I have with me here today some of our CNMs who will answer your questions and give you further background on this important issue.

Thank you most sincerely for your time and attention and I urge a DO PASS recommendation.

Respectfully,

Darlene Watne

Darlene Watne
Senator, Fifth District

Friday, December 04, 1998

Michael Unhjem, President Blue
Cross/Blue Shield of North Dakota 4510 13th
Ave. SW Fargo, North
Dakota 58102

Dear Senator Watne:

Below is rough draft of the letter we propose to send to each senator and representative in North Dakota. The letter faxed yesterday was an earlier draft that I sent inadvertently.

Dear Senator/Representative: (Individuals name will be substituted here)

I am writing to request your support for legislation concerning access to care and reimbursement for CNMs/CMs.

President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry released a Consumer Bill of Rights and Responsibilities in November 1997. This report states that "women should be able to choose a qualified provider... such as gynecologists, certified nurse-midwives... for the provision of covered care necessary to provide routine and preventive women's health care services."

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This payment system differs from other systems in that the study was resource-based instead of historical fee-based. Relative values were defined in their categorical areas: practice expense content, work component and malpractice component.

Each of these three components is then adjusted geographically, using three separate geographic practices cost indexes. The related value was multiplied by a single conversion factor to arrive at the geographic specific fee schedule allowable for a given area. Very few payers in the private sector use the single conversion factor.

Movement in the private sector and in the Medicaid program toward using this formula, without a change in the Medicare law for payment of certified nurse-midwifery services, will have a great impact on financial resources. The current Medicare law, which was passed by Congress in 1987, only pays for CNM services at 65 percent of the physician fee schedule.

When the Physician Payment Review Commission studied this issue, they never made specific recommendations to Congress on how to pay for CNM services.

The ACNM replicated the Hsiao study, conducted for obstetricians. Our findings propose that the relative value of practice costs and work effort were the same as physicians. The only relative value differences were observed in the area of malpractice costs.

Based on these studies, and recognizing that the ACNM is seeking federal legislation to change the CHAMPUS and Medicare payment systems to pay CNM's at 95 percent of physician fee schedules, we are requesting an increase in state Medicaid payments to CNM's at 97% of the physicians fee schedules.

Why should Certified Nurse Midwives be paid more than Physician Assistants and Nurse Practitioners ?

A) Malpractice premiums for CNM's range from $4,600.00 to $26,000.00. An OB/GYN nurse practitioner's highest premium is $850.00 on an occurrence basis.

B) CNM premiums are comparable to family practice doctors who do obstetrical care.

C) CNM's accumulate a higher educational loan debt; the average is over $70,000.00.

Sincerely,

Terry J. Burrell, MS CNM

Testimony for Human Services Committee concerning Senate Bill # 2060

Standardized Reimbursement for equal services

letter from CNM's

letters from Dakota Clinic physicians

letter from Arie Fischbach

letter from OB/GYN Associates

Malpractice Rates letter

table 7

Cost effectiveness

ACNM Summary

Evidence Based Health Care (page 6)

Analysis of CNM "C Section" rate in ND 1997

"C Sections" CNM total: 32	*Deliveries CNM total: 343*
"C Sections" total: 1897	*Deliveries total: 9642*
CNM "C Section" Rate: 9%	*Total "C Section" rate: 19.6%*
Additional C Sections if no CNM's: 32	*Extra Cost of "C Section" Vs Vaginal Delivery": $4,000.00 X 32= $128,000.00*

Total paid to CNM's 1998: $97,513 X 1.22 = $118,965.86 (21,452.86)

If no CNM's $97,513 X 1.25 = $121,891.25 (24,378.25)

Total Health Care Budget 1997-99 $486,671,000.00 or about $162,223,666.00 per year.

CNM's increased reimbursement less than 1/100th percent

Cesarean Section Cooperative Project

Cesarean Section Cooperative Project

For the past year, North Dakota Health Care Review, Inc. (NDHCRI), the North Dakota Department of Health (NDDH), and nine North Dakota hospitals have been collaborating on the Cesarean Section (C-section) Cooperative Project.

Project Objectives

- To evaluate the variation in C-section rates among North Dakota hospitals.
- To decrease the variation in C-section rates through process evaluation and improvement activities.
- To build a risk model for use by the NDDH for the future evaluation of North Dakota's C-section rates.

Project Participants

The nine participating hospitals range in size from small to large, and have C-section rates that vary from low to high.

Strategies For Improvement

During the course of the project, participating hospitals were asked to evaluate individual processes surrounding C-sections and develop strategies for improvement. Factors influencing process change decision making included awareness of the *Healthy People 2000** goal of 15 percent (overall C-section rate), peer comparisons, American College of Obstetrics and Gynecology (ACOG) guidelines, etc. A sampling of the areas selected for improvement by the various participants include:

- Instituting comprehensive prenatal classes
- Instituting comprehensive VBAC (vaginal birth after C-section) education
- Attempting VBACs for all patients with a previous C-section unless contraindicated
- Using trained labor companions during the labor and delivery process
- Incorporating active management of labor into labor and delivery philosophies
- Developing comprehensive in-house peer review programs
- Enhancing staff education programs
- Developing algorithms and clinical pathways for labor and delivery, fetal monitoring, etc.
- Developing a more aggressive approach to pain management
- Taking a more aggressive approach to dystocia management
- Developing preadmission access programs
- Incorporating Certified Nurse Midwives into existing obstetric services

Time Frames

Project Start Date
June 1, 1996
Initial Analysis
Mailed to participants August 16, 1997
Improvement Strategies
Development and implementation dates of improvement strategies varied among individual participants
Baseline Measurement
All live births in North Dakota from January 1, 1994 through May 31, 1996
Remeasurement
All live births in North Dakota from June 1, 1996 through April 1, 1997

*U.S. Department of Health and Human Services. Healthy People 2000. Washington, DC: Department of Health and Human Services Publications 1990:328.

C-section Project Concludes

For the past year, NDHCRI, the North Dakota Department of Health, and several North Dakota hospitals have been collaborating on the Cesarean Section Cooperative Project. The impetus for the project was the Health Department's observation of a wide variation in C-section rates among the state's hospitals, and their interest in gaining an understanding of the variation through process evaluation and quality improvement activities. At the time the project began, North Dakota's mean C-section rate was 19 percent. However, C-section rates in individual North Dakota hospitals ranged from less than 10 percent to greater than 45 percent.

Process Improvement Activities

The nine hospitals invited to participate in the C-section Project ranged in size from small to large, and had C-section rates that varied from low to high. Because a cross-section of hospitals were represented in the project, participants were able to learn from each other about effective improvement strategies and common barriers to change. As each of the hospitals discovered, C-section is a procedure that is strongly influenced by the diversity of the processes that surround delivery, such as prenatal education and prenatal care, understanding of "active" labor, the definition of dystocia and cephalopelvic disproportion, and interpretation of fetal monitoring.

The areas for improvement targeted by the participants were:

- Instituting comprehensive prenatal classes
- Instituting comprehensive VBAC (vaginal birth after C-section) education
- Attempting VBACs for all patients with a previous C-section, unless contraindicated
- Using trained labor companions during the labor and delivery process
- Incorporating active management of labor into labor and delivery philosophies
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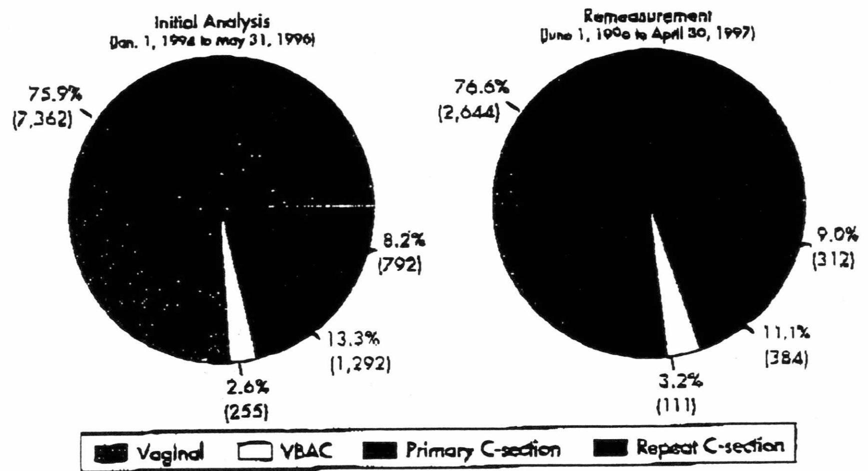


- The pie charts reflect the rates of Vaginal Births, VBACs, Primary C-section, and Repeat C-section during the baseline and remeasurement periods.
- The baseline measurement captures all births over a 29 month period, from January 1, 1994 through May 31, 1996. Remeasurement captures all births for an 11 month period, from June 1, 1996 through April 30, 1997

Conclusion

During this project, several facilities were able to significantly decrease their average C-section rates. Although it is important for hospitals to better understand processes and reduce the variation in rates, it is equally important to recognize that a hospital's C-section rate is not the sole quality indicator of delivery processes. Other significant indicators include prenatal and postnatal morbidity and mortality, maternal morbidity and mortality, neonatal transfers, etc.

continued on page 6

C-Section Project Concludes

continued from page 2

As always, the final decision for proceeding with process change rests with individual facilities and what health care providers within a facility feel is acceptable. The facilities and providers that participated in the C-section Cooperative Project demonstrated an understanding of the complexity of the issues involved and a true commitment to improvement and to continued excellence in health care. Although NDHCRI's involvement with the C-section Cooperative Project has concluded, the individual participating facilities plan to continue to monitor and evaluate the processes that surround C-section deliveries.

The Risk Model

At the request of the North Dakota Department of Health, NDHCRI constructed a risk model which will be used by them to evaluate North Dakota's C-section rates in the future. The model identifies the factors that contribute to the decision for C-section, calculates the influence of each factor, and predicts C-section rates.

Using data including all live births from January, 1994, to April, 1997, the risk model reveals that currently the four strongest predictors for C-section are:

- Cephalopelvic disproportion
- Breech/malpresentation
- Fetal distress
- Previous C-section

In the future, changes in delivery processes or technological advancements could alter the impact of each of these predictors. For example, the influence of "previous C-section" as a predictor for C-section will diminish if VBACs become more prevalent. The risk model is constructed to reflect the fluctuations that occur in practice patterns and processes.

Taking Diabetes Personally

continued from page 4

in North Dakota, and obesity is another risk factor. Lastly, we know diabetes affects a large number of elderly people in North Dakota."

With about 75 percent of her patients being diabetics, Dr. Blehm sees firsthand how diabetes affects North Dakota's diabetic population. Dr. Blehm says having diabetes has allowed her to be empathetic to patients' needs. "I think having been a patient before becoming a doctor has helped. A lot of physicians hadn't been on the other side of the fence by the time they were in med school. Well, I had, and so I had strong feelings about how patients were treated and the information that was given to them."

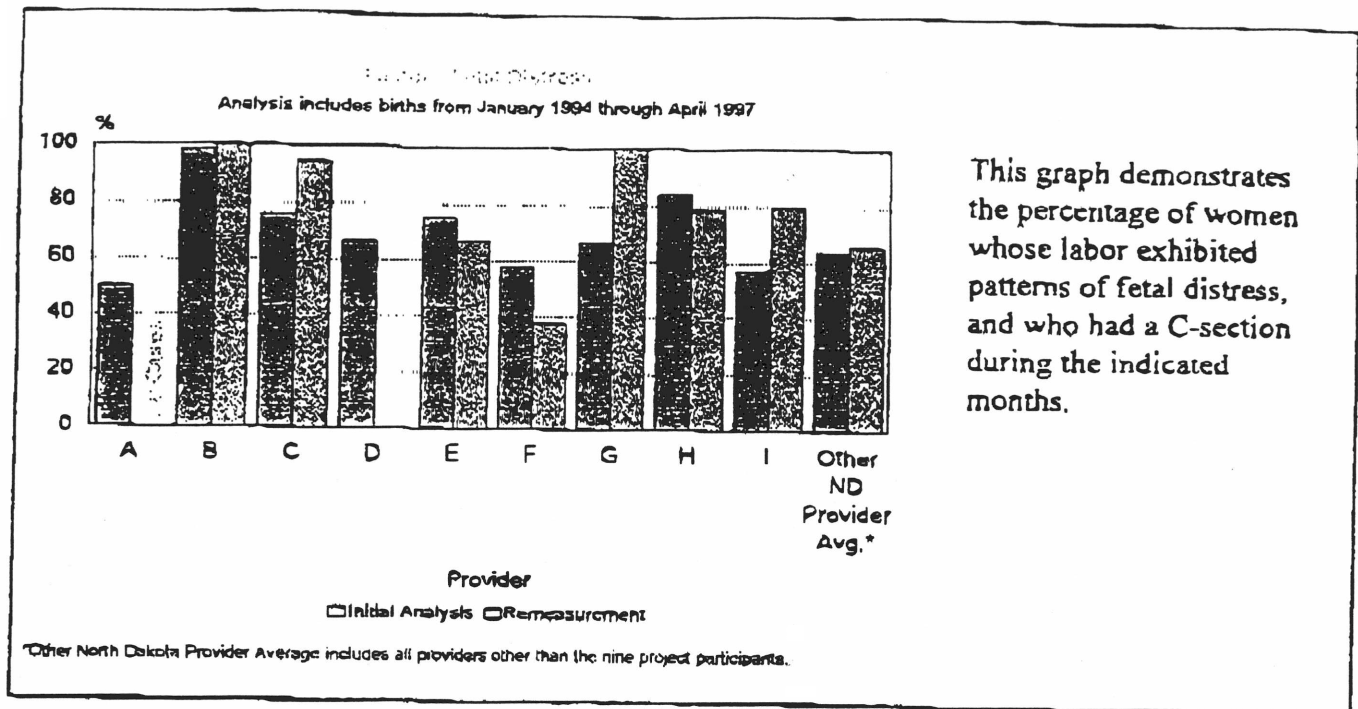
Dr. Blehm is confident the future will bring positive information for her to give to her patients. In 1993 the Diabetes Control and Complication Trial results were released, indicating that if diabetics control diabetes well and if they keep their sugars as close to normal as possible, they can delay or prevent the onset and/or progression of complications.

"The study gave us ammunition to encourage physicians to attempt to improve blood sugar control in people with diabetes. This, in turn, will decrease both the complications and health costs, thus improving the quality of life for people with diabetes," she says. "Twenty years ago there was no way we could've kept patients in good control."

And what about a cure?

"I have become very cautious about forecasting a cure in the next 20 years, because every time we hear that, it doesn't happen," she says. "I think researchers will find a prevention for Type I diabetes; they may or may not find one for Type II. I think we could have an artificial pancreas, or a way to figure out how to transplant islet cells alone, so you wouldn't have to take a person's whole pancreas."

Dr. Blehm confesses her "strong interest" in diabetes could be defined as something else. "I put a lot of time and effort into diabetes...I guess you could call it a passion."



This graph demonstrates the percentage of women whose labor exhibited patterns of fetal distress, and who had a C-section during the indicated months.

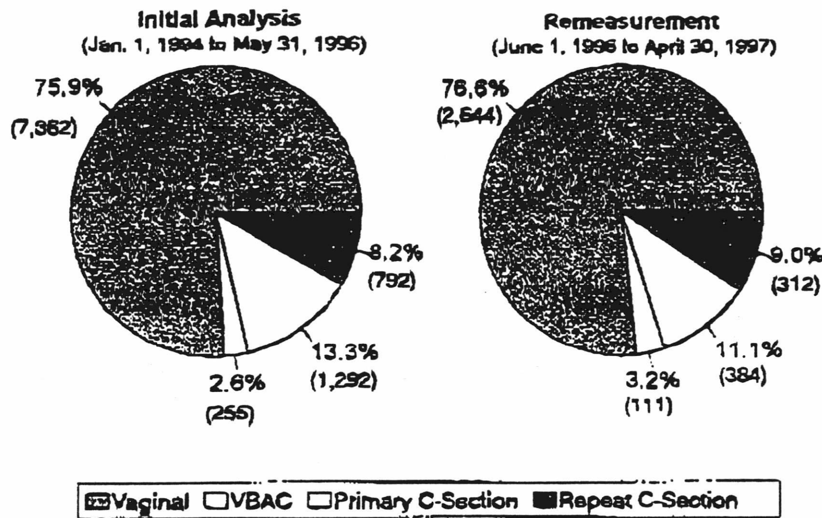
Cesarean section is a procedure strongly influenced by the processes that surround it, such as prenatal education and care, understanding of "active" labor, varying definitions of dystocia and cephalopelvic disproportion, interpretation of fetal monitoring, etc. Developing a better understanding of those processes could help facilities better manage and reduce the variation in C-section rates. It is important to recognize that a hospital's average C-section rate is not the sole indicator of the quality of health care processes for deliveries. Other information that would be important to understand when evaluating delivery care processes and C-section rates include pre- and postnatal morbidity and mortality, maternal morbidity and mortality, neonatal transfers, etc. Ultimately, the final decision for proceeding with a process change rests with the individual facility and what the health care providers within that facility feel is acceptable.

As with all areas of health care, the evaluation of C-section has not only uncovered opportunities for growth and improvement, but has also led to the realization that there are additional areas to consider when looking at C-sections; for example, risk management education, standardized definitions for cephalopelvic disproportion and dystocia, continued emphasis on patient and staff education. The possibilities are numerous. Facilities are encouraged to continue their efforts in this area, keeping in mind that quality involves continuous learning and evaluation.

The activities of the participants in this project demonstrate a true commitment to continued excellence in health care.

(If you would like more information about the C-section Cooperative Project, please contact Karen Zimmerman, RN, Health Information Coordinator, North Dakota Health Care Review, Inc., at (701) 852-4231.)

ANALYSIS



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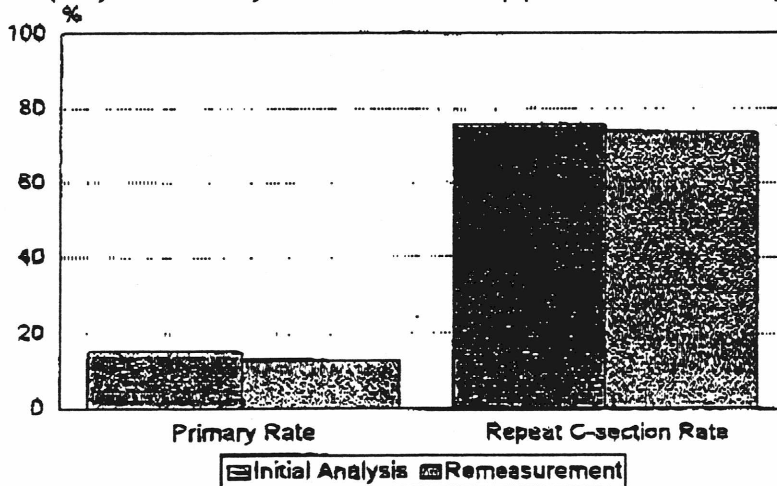
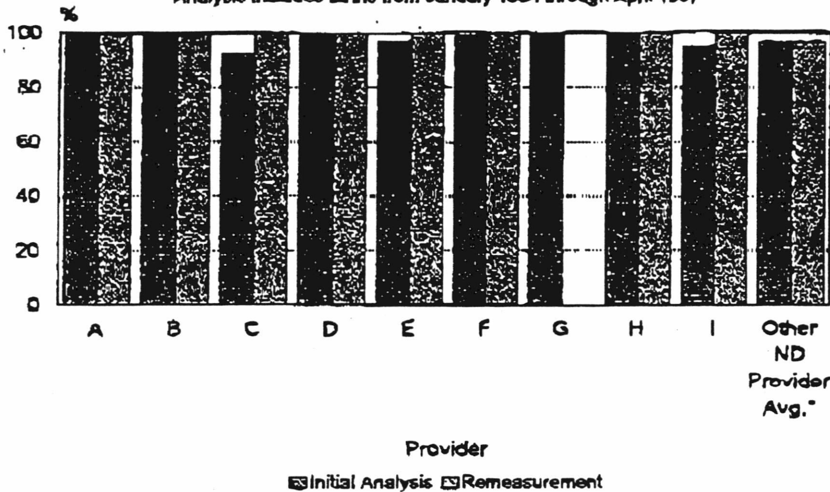
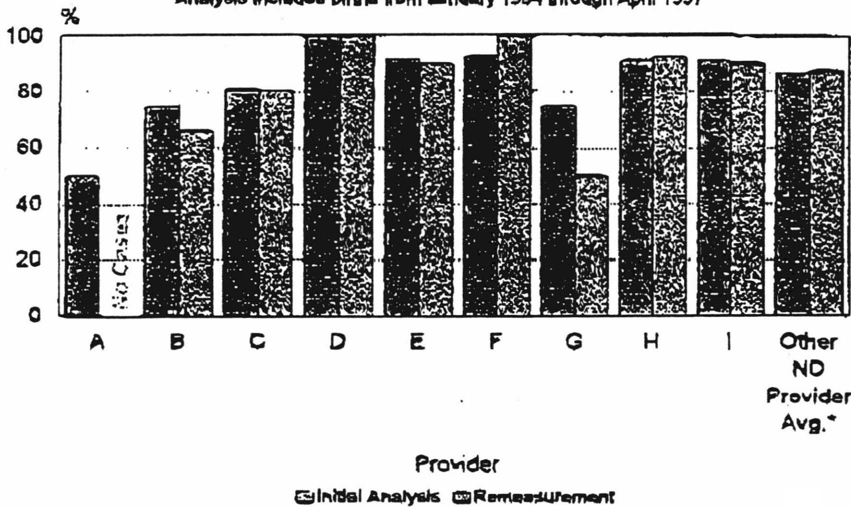


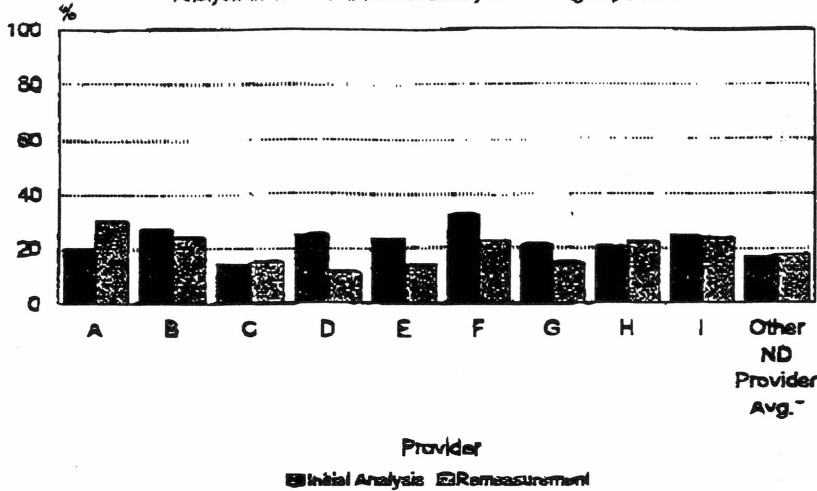
- The primary C-section rate, which includes only those who did not have a previous C- section, has decreased significantly ($p<.05$) from 14.9 percent to 12.7 percent.
- The repeat C-section rate has fallen only slightly, from 75.6 percent to 73.8 percent.



This graph demonstrates the percentage of women with cephalopelvic disproportion who had a C-section during the indicated months.

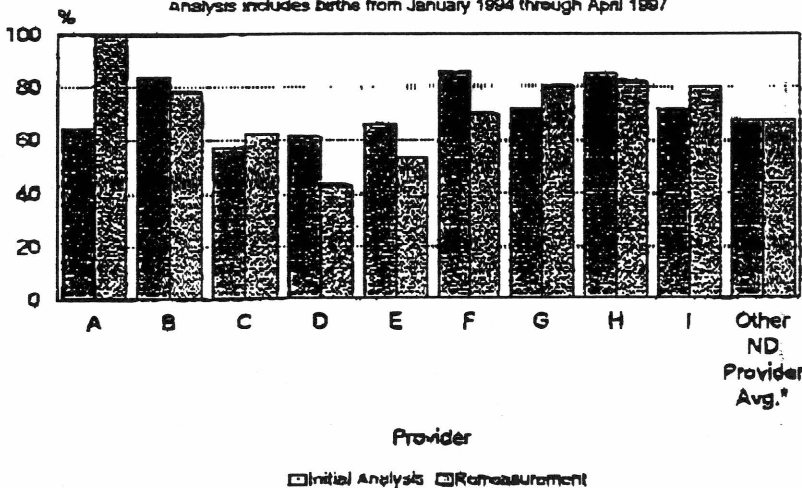


This graph demonstrates the percentage of women with breech/malpresentation who had a C-section during the indicated months.

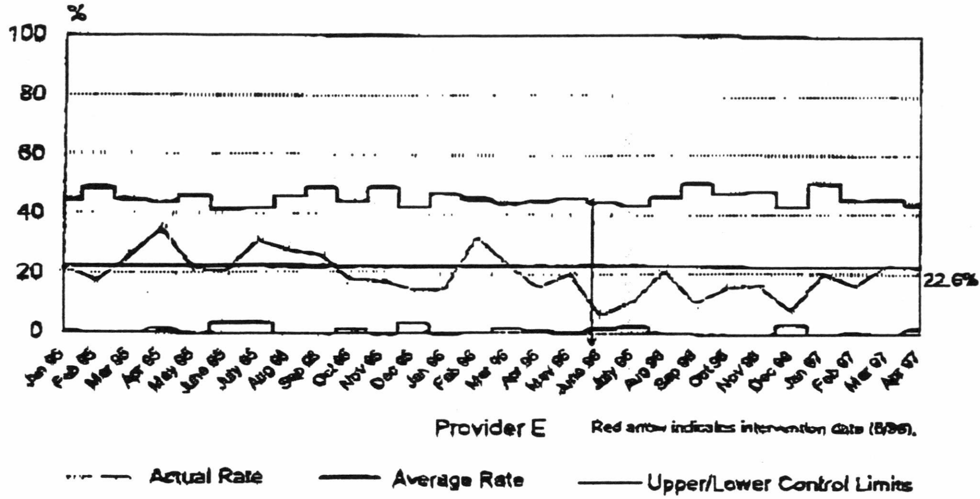


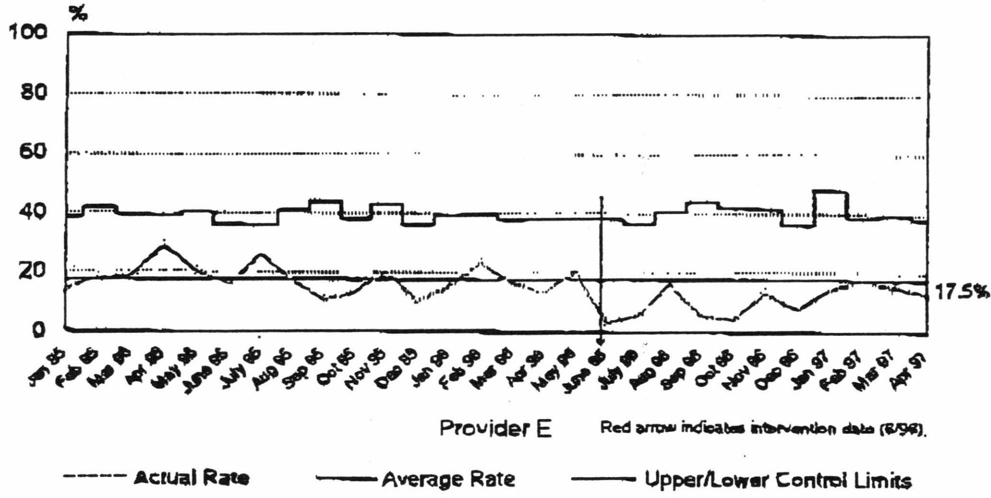
- This graph demonstrates the baseline and remeasurement C-section rates for the nine participating hospitals, and an aggregate rate for all nonparticipating hospitals.
- The nine hospital aggregate C-section rate decreased significantly ($p<.053$) from 21.5 percent to 20.2 percent.
- Several of the individual hospitals saw significant decreases, namely D, E, and F. Provider G also saw a noticeable decrease, though not statistically significant due to the small number of cases.

- The following four factors (previous C-section, cephalopelvic disproportion (CPD), breech/malpresentation and fetal distress) represent the factors that weigh the heaviest in the decision-making process associated with C-section. These factors may occur independently or together. These graphs illustrate the percentage of C-sections associated with each risk factor before and after intervention based on the risk model analysis. No statistically significant differences were noted from baseline to remeasurement for CPD, breech/malpresentation or fetal distress.
- The graphs will also show where there was improvement or where there is room for improvement. For example, Provider F had a significant decrease in its repeat C-section rate (see graph below), which contributed to its significant overall decrease. Providers D and E also exhibited a large decrease in their repeat C-section rate, although the decrease was not significant.



This graph demonstrates the percentage of women with a previous C-section who had a C-section during the indicated months.


Graph A1
Overall Cesarean Section Rates
January 1995 - April 1997
Control Chart
%
100
80
60
40
20
0
22.6%
Provider E
Actual Rate
Average Rate
Upper/Lower Control Limits


Graph B1
Primary Cesarean Section Rates
January 1995 - April 1997
Control Chart
%
100
80
60
40
20
0
17.5%
Provider E
Red arrow indicates intervention date (6/96).
Actual Rate
Average Rate
Upper/Lower Control Limits

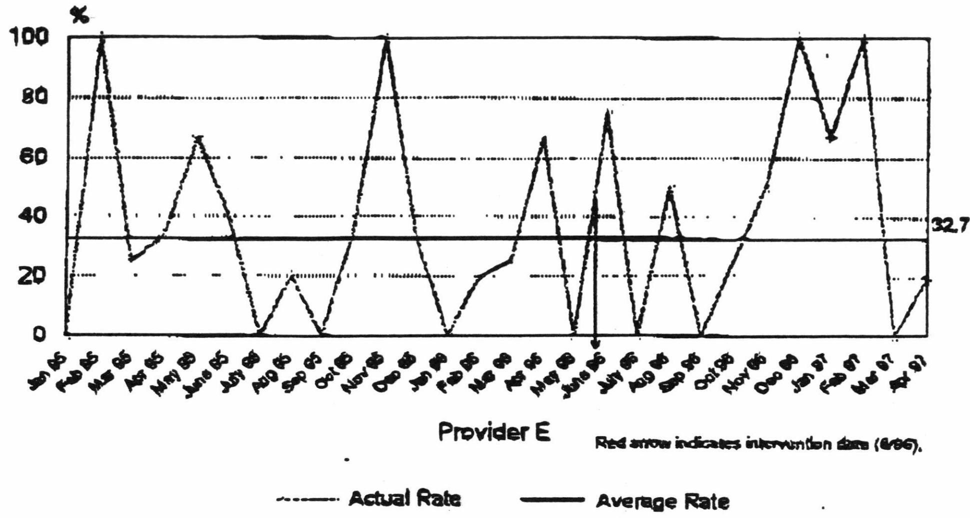

Graph C1
Vaginal Birth After Cesarean (VBAC) Rates
January 1995 - April 1997
%
100
80
60
40
20
0
32.7
Provider E
Red arrow indicates intervention date (6/96).
Actual Rate
Average Rate

TABLE 7
Medicaid Reimbursement - Percentage of Physician Fee Schedule*

Jurisdiction	Percentage	Jurisdiction	Percentage	Jurisdiction	Percentage
Alabama	80%	Louisiana	100%	Oklahoma	100%
Alaska	100%	Maine	100%	Oregon	100%
Arizona	capitated	Maryland	70-100%	Pennsylvania	100%
Arkansas	80%	Massachusetts	100%	Puerto Rico	N/A
California	100%	Michigan	100%	Rhode Island	rate unclear
Colorado	100%	Minnesota	100%	South Carolina	80 - 100%
Connecticut	90%	Mississippi	90%	South Dakota	100%
Delaware	100%	Missouri	100%	Tennessee	capitated
D.C.	rate unclear	Montana	80%	Texas	85%
Florida	80%	Nebraska	100%	Utah	CNM schedule
Georgia	100%	Nevada	not specified	Vermont	100%
Hawaii	75%	New Hampshire	100%	Virginia	100%
Idaho	100%	New Jersey	70%	Virgin Islands	N/A
Illinois	70%	New Mexico	100%	Washington	100%
Indiana	75%	New York	100%	West Virginia	100%
Iowa	80%	North Carolina	100%	Wisconsin	80 - 100%
Kansas	75%	North Dakota	75%	Wyoming	100%
Kentucky	75%	Ohio	100%		

*In the context of Medicaid Managed Care, much of this data may not be applicable.

Revised June 1997

TABLE 8
Jurisdictions That Regulate Birth Centers

Alabama	Georgia	New Hampshire[1]	South Carolina
Alaska	Hawaii	New Jersey	Tennessee[4]
Arizona	Iowa	New Mexico[2]	Texas
Arkansas	Kansas	New York[3]	Utah
California	Kentucky	North Carolina[4]	Vermont
Colorado	Maryland	Ohio	Washington
Connecticut[2]	Massachusetts	Oklahoma	West Virginia
Delaware	Mississippi	Oregon	Wyoming
District of Columbia	Missouri	Pennsylvania	
Florida	Nevada	Rhode Island	

According to the National Association of Childbearing Centers (NACC), regulations are in the pending/exploratory/draft stages in:

Illinois	Maine	Virginia
Indiana	Michigan	Wisconsin

Revised January 1998

[1] As "health facilities."
[2] Under same statutes as "maternity homes."
[3] As "diagnostic" or "treatment centers."
[4] As "ambulatory centers."

Note: Other states may not regulate birth centers but nevertheless do not prohibit them.

© America College of Nurse-Midwives 1998

Quality of care: Certified Nurse-Midwives (CNMs) caring for low risk women improve the infant mortality rate while lowering the cesarean section rate, both in hospitals and birth centers, compared to physicians caring for equally low risk women.

❖Birth certificate data from 1991 was examined for all singleton vaginal deliveries between 35 and 43 weeks. After adjusting for socio-demographic and medical risk factors including fetal distress, breech/malpresentation,hydramnios/oligohydramnios and abruptio placenta, the outcomes for physicians and nurse-midwives were compared:

- The risk for neonatal mortality was 33 percent lower for births attended by CNMs;
- The risk of delivering a low birth weight infant was 31 percent lower for CNM attended births;
- The mean birth weight was 37 grams higher for CNM attended births;
- The infant mortality rate was 19 percent lower for CNM attended births.

[Source: MacDorman M. et al. Midwifery care, social and medical risk factors, and birth outcomes in the US. J Epidemiology and Public Health, May 1998 Vol.52:5; 310-317]

❖All medical and obstetrical procedures are accessible to CNM clients, but their use is based on the condition of the woman and her baby. The clients of certified nurse-midwives are much less likely to need:

- A variety of technological tools to monitor or modify the course of labor;
- Continuous electronic fetal monitoring *during* labor; intermittent monitoring of low risk mothers is done allowing greater mobility, comfort, and better outcomes.
- Oxytocin to induce or augment labor;
- Epidural anesthesia to cope with the pain of labor

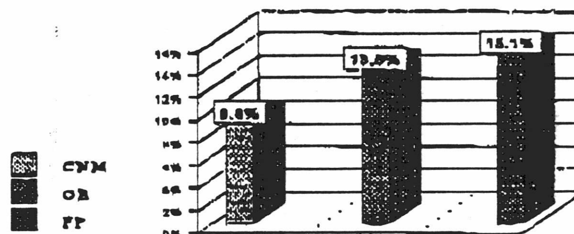
This results in care that is less invasive, less expensive and less likely to result in misdiagnosis of fetal distress. As a consequence, unnecessary cesarean sections, forceps and vacuums are avoided.

[Source: Rosenblatt, R. A., MD MPH, et. al. Interspeciality Differences in the Obstetric Care of Low-Risk Women, American J of Public Health 387:3; 344-351, 1997]

❖Examining the differences in the practices of family physicians, obstetricians and certified nurse-midwives in the care of low risk women, the authors found the following in comparable practices in the state of Washington:

- The cesarean section rate was 8.8 percent for certified nurse-midwives;
- The cesarean section rate was 13.6 percent for obstetricians;
- The cesarean section rate was 15.1 percent for family physicians;

CESAREAN SECTION RATE



- The certified nurse-midwives used 12.2 percent fewer resources than either group of physicians.

[Source: Rosenblatt, R. A., MD MPH, et. al. Interspecialty Differences in the Obstetric Care of Low-Risk Women, American J of Public Health 387:3; 344-351, 1997]

❖The National Birth Center Study reported on the outcomes of care for 11,814 women who were admitted in labor to 84 birth centers throughout the country. The results:

- No maternal mortality;
- Neonatal mortality of 1.3 births/1000, or 0.7/1000 if lethal anomalies were excluded (these rates are comparable to studies of low risk in-hospital births);
- Cesarean section rate of 4.4 percent (approximately one half that in studies of low risk in hospital births).

[Source: Rooks, J.P.,et.al. Outcomes of care in birth centers: the national birth center study. New England Journal of Medicine

312:1804-1811, 1989]

❖The reported outcomes of intended home births in nurse-midwifery practice demonstrate safe, high-quality care. Reports on the outcomes of 1,404 women enrolled for care showed:

- Only 9.1 percent of women were transferred to the hospital during labor or postpartum;
- No maternal mortality;
- For women *delivering at home*, the neonatal mortality rate was 1.8/1000;
- Just 1.1 percent of infants were transferred to the hospital.

[Source: Murphy, Patricia A and Fullerton, J. Outcomes of Intended Home Births in Nurse-Midwifery Practice; A Prospective Descriptive Study, Obstetrics & Gynecology 1998 92:3; 461-470]

Cost of care: Health care payers benefit because nurse-midwifery care is cost-effective.

❖The lower costs associated with nurse-midwifery care are due to:

- Lower rates of technological intervention;
- Shorter lengths of stay in hospitals;
- Lower payroll costs for staff model HMOs.

Use of a birth center instead of a hospital lowers costs even further, while planned home births eliminate the hospital costs entirely.

[Source: Gabay M and Wolfe SM. Encouraging the use of nurse-midwives: a report for policy makers. Public Citizen's Health Research Group, 1995]

❖This prospective cohort study, with a concurrent comparison group evaluated the Birth Place model of care (CNMs in a birth center in collaboration with obstetricians) with traditional perinatal care (obstetricians in a hospital). The cost analysis section from the payor perspective concluded "the midwife/birth center collaborative model cost the payor 21% or $1,122/birth less ($4,342 vs $5,464) for pregnancy related services".

[Source: Fullerton E.J., et. al. Outcomes from the San Diego Birth Center Study; Presented at the Association for Health Services Research 15th Annual Meeting Washington, DC, June 22, 1998]

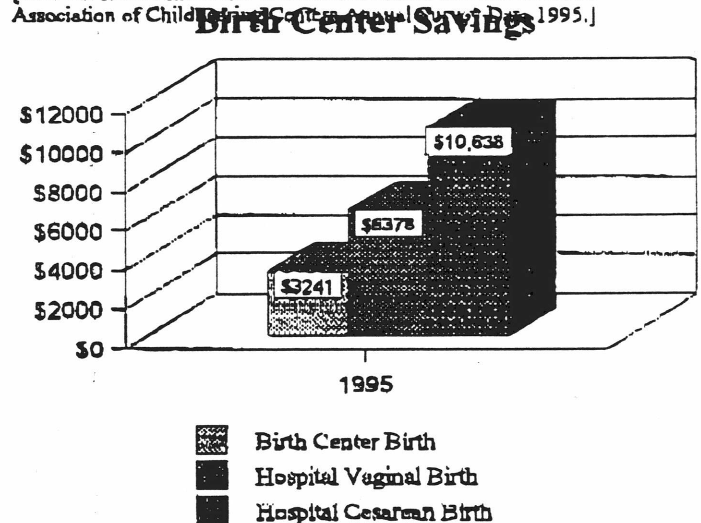
❖In a comparison of birth center costs with hospital costs, it is estimated that:

- If only 100,000 births were attended in birth centers, not only would access to care be greatly improved, but annual savings would total almost $314 million;

This research is based on the following assumptions:

- All charges include professional and facility fees.
- Birth center charges are based on an average stay of nine hours postpartum and include a comprehensive educational program for early discharge and careful and continuous home follow-up.
- Hospital charges for vaginal birth are based on a stay of 48 hours postpartum and include ancillary charges.
- Hospital charges for cesarean birth are based on a stay of 72 hours postpartum and include ancillary charges.

[Sources: Health Insurance Association of America and National Association of Childbearing Centers Annual Survey Data 1995.]



- For every 1,000 women that birth centers prevent from having a cesarean birth, savings could equal $7.4 million

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Haire, D. and Elsberry, C. Maternity care and outcomes in a high-risk service: the North Central Bronx Hospital experience. Birth 18:33-37, 1991

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NORTH DAKOTA SENATE

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COMMITTEES:
Judiciary,
Vice Chairman
Political Subdivisions

January 22, 1999

Members of the Senate Human Services Committee:

Regarding Senate Bill 2060, the CNM bill, the CNMs have been in contact with Mr. Zentor of the Human Services Department negotiating their percentage. I have been informed that the Human Services agrees to 85% at this time.

At this 85%, I am also informed that the CNMs at the clinic in Minot will not be treating the Medicare patients any longer because the clinic will not serve these clients at that percentage. That is really sad.

However, to protect the CNMs at this time so at least the 85% is not lost, I propose the following amendment:

> Page 1, Line 16, replace "ninety-seven" with "a minimum of eighty-five"
> Page 1, Line 17, remove the final period and add the following: ", as agreed by Human Services."

I am still firmly convinced, based on the national studies, that the 97% was, and is, a very fair request.

Please reconsider this bill and add the suggested amendment or reinstate the original bill. Your consideration is deeply appreciated.

Respectfully

Darlene

Darlene Watne
Senator, Fifth District

TESTIMONY BEFORE THE SENATE APPROPRIATIONS COMMITTEE

REGARDING SENATE BILL 2060

FEBRUARY 8, 1999

Chairman Nething, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you today to provide information regarding this bill.

The bill originally required the department to pay nurse midwives 97% of the current fee paid to physicians for deliveries and other services provided to Medicaid eligible recipients. The bill was a surprise to the department as no one had contacted me directly regarding this payment issue to determine if our current fee structure was adequate.

The Medicaid Program paid Nurse Midwives at 75% of the fee paid to physicians, the same as other allied providers such as nurse practitioners. Testimony from the nurse midwives during the committee hearing noted that costs such as malpractice insurance for nurse midwives is higher than that of the other allied providers and that they provide the same services in routine deliveries as that of a physician. They also noted that if payment did not increase, the services for nurse midwives could be reduced in some areas thus reducing access for Medicaid recipients or requiring them to seek physician care at a higher cost.

In response to these concerns, I had several conversations with the nurse-midwives in an effort to negotiate a solution to this problem. Currently, Blue Cross/Blue Shield pays its allied providers 75% of the fee paid to physicians, the same as Medicaid. Medicare does allow payment up to 85% of the physician fee for allied providers. It has been our policy to try and maintain similar payment policies with other third party payers in order to reduce the administrative burden to providers. In an effort to attempt to assure that our recipients continue to receive needed

prenatal, delivery and postnatal care that is essential to healthy babies, the Department agreed to increase the percentage of the physician fee paid to nurse midwives to 85%. The Department also agreed to review the payment process again if Congress changes the payment rate for Medicare in the future to determine if the Medicaid rate should also be increased.

The Department paid for 1,987 births for the year ending June 30, 1998. Of those about 86 or about 4.3% were delivered by nurse midwives. The current physician fee for a Medicaid delivery is $818.90. At the 75% amount, nurse midwives received $614.17 and at 85%, they will receive $696.06. The cost to the Department for this increase totals about $14,681, of which $4,367 is general funds. The cost impact is minimal and therefore we intend to incorporate the increase within the current proposed appropriated funding level for the Medicaid Program.

Based on the negotiation, the Senate Human Services Committee amended the bill to require the Department to pay nurse midwives at least 85% of the fees paid to physicians.

We hope that this compromise will continue to allow nurse midwives to provide quality services to our recipients at a reasonable cost. Also, since we are now meeting the intent of the proposed legislation, the Department questions the need to pass this bill. I am not aware of any other legislation that mandates a particular payment process for the Medicaid Program other than nursing facility care. This legislation could set a precedent for other provider groups to emulate in order to guarantee a certain level of payment that would require state general fund support on an ongoing basis and reduce the flexibility of the Department to manage and control costs.

I would be happy to answer any questions you may have.

TESTIMONY ON SB 2060

PRESENTED BY SENATOR RALPH KILZER

FEBRUARY 8, 1999

Chairman Nething and members of the Senate Appropriations Committee. For the record, my name is Ralph Kilzer, Senator from District 47, which is the northwest part of Bismarck.

I speak in opposition to Senate Bill 2060. I was concerned that I might be violating the decor of the hearing process by appearing in front of your committee, but my mentor assured me it is OK to do this. SB 2060 was submitted at the request of the 6 nurse/mid-wives practicing in North Dakota, to mandate the Department of Human Services to pay them 97% of the fee Obstetricians receive for a vaginal birth. The DHS has a medical services division that determines the fee schedule by which the department sets the amount that each medical service is worth. Formally, the prevailing fee was based on bill charges which were to be "usual, customary, and reasonable." In the early 1980's, after Dr. Hsaio, a Harvard Economist, developed a resource-based relative value scale (RBRBS) at the request of the HCFA, this is now the guide used by nearly all third party payors. The relative value scale assigns a number to each procedure, such as removing a gall bladder, diagnosing a psychiatric patient, interpreting an Xray, treating a heart attack, or delivering a baby. The resource part is taken into account. Resources include the amount of training required of the provider to do the service, in addition to the overhead expenses. One of the big items is the malpractice premium. I testified that the resources required of a nurse/mid-wife is considerably less than that of an obstetrician. The training beyond college of a nurse/mid-wife is 2 years while that of an Obstetrician is at least nine years. The malpractice premium for a nurse/mid-wife is about $5,000 per year at the most while the obstetrician in Bismarck pays $33,000 per year.

This bill was put in before any negotiating between the nurse/mid-wives and the DHS had taken place. I understand that the 85% amendment is a compromise that has occurred between the parties. It is my opinion that nurse/mid-wifes do a good job, but let's not destroy the RBRBS system.

Fees for medical services by DHS are a touchy subject. As you know, they are quite low by comparison to other third party payors. They are low, but at least they are fair to all providers. Providers loose money on Medicaid patients. Mr. Zentner told the committee there was no shortage of baby-delivery services in this State. He opposed the bill when it was heard before our Senate Human Service Committee.

This one bill is not a budget buster - with only six providers involved. The Medicaid delivery fee for a nurse/mid-wife is a little over $600 and for an Obstetrician a little over $800. Presently nurse/mid-wives are paid at the 75% rate, just like the other non-physician providers, such as nurse practitioners, anesthetists, physician assistants. Blue Cross/Blue Shield has a similar fee schedule. To pass this legislation and to micro-manage the fee schedule - disregarding the accepted RBRBS - would invite a parade of medical providers all asking mandated increases in their particular area of expertise. This would eventually bust the Human Services budget. I would be happy to take your questions.