The American Association of Birth Centers: History, Membership, and Current Initiatives

Julia C. Phillippi, CNM, MSN, Jill Alliman, CNM, MSN, and Kate Bauer, MBA

The American Association of Birth Centers (AABC) is a multidisciplinary membership organization dedicated to the birth center model of care. This article reviews the history, membership, and current policy initiatives of the AABC. The history of AABC includes the promotion of research, education, and national and state policies that are supportive of birth center care. Current AABC priorities address three main pressures to birth center sustainability: high malpractice insurance rates, the lack of a federally mandated birth center facility fee, and low rates of certified nurse-midwife/certified midwife reimbursement. The AABC is addressing these concerns through lobbying, collaborating with other national organizations, and the promotion of birth research.
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INTRODUCTION

The American Association of Birth Centers (AABC) is a national multidisciplinary membership organization dedicated to the development and maintenance of the birth center model. It supports this innovation in the delivery of health care through policy initiatives, research, education, and professional services. This article discusses the history and current policy initiatives of AABC as it works to maintain the birth center model as a vibrant, sustainable part of the changing health care system.

HISTORY OF THE AMERICAN ASSOCIATION OF BIRTH CENTERS

Birth centers, also known as maternity centers, have existed in various forms since the early 20th century.[1,2] They were established primarily by midwives and physicians in underserved parts of the United States. One example was ''La Casita,'' which was operated in the 1940s by the nurse-midwives of the Medical Mission Sisters in Santa Fe, NM.[1,2] Another example was a birth center within a primary care center operated by nurse-midwives in Raymondsville, TX, during the 1970s (AABC archives).

The Childbearing Center, the first modern freestanding birth center demonstration project, was established at the Maternity Center Association (MCA) in New York City in 1975. The founding nurse-midwife and physician team was responding to consumer demand for a safe place for normal births that was part of a seamless system including transfer to acute care when indicated. The Childbearing Center obtained a Certificate of Need, licensure, liability insurance, and a contract for reimbursement of services from Blue Cross/Blue Shield of Greater New York. The contract included funds for evaluation of outcomes and cost of care.[3] The demonstration project was successful, with high rates of maternal satisfaction, excellent perinatal outcomes, and reduced cost when compared with hospital birth.[4] This success, coupled with the beginning of federal support for nurse-midwifery education from the Division of Nursing, led to a surge in interest in the replication of freestanding birth centers.[4]

In 1981, MCA organized birth centers into the Cooperative Birth Centers Network to continue to evaluate the safety, satisfaction, and financial savings of this service.[5] In 1982, the Institute of Medicine of the National Academy of Sciences, in response to concerns voiced about the safety of birth centers, commissioned a committee to review the research on birth settings.[6] The committee concluded that ''reliable information about the safety and efficacy of different birth settings, the psychological benefits of different practices, and the differences in economic costs of alternatives is lacking.''[6] Research on these topics was recommended. In 1982, The American Public Health Association adopted a policy supporting the birth center concept and published Guidelines for Licensure.[7] In 1983, MCA, with a grant from the John A. Hartford Foundation, restructured the Cooperative Birth Centers Network as the AABC (originally named the National Association of Childbearing Centers) to promote state licensure and regulations nationwide. When the Joint Commission for Accreditation of Healthcare Organizations and the Association for Accreditation of Ambulatory Health Care stated that the birth center did not fit their programs, a grant to MCA enabled a team from MCA and AABC to write Standards for Freestanding Birth Centers and establish the Commission for Accreditation of Birth Centers as an autonomous agency for the accreditation of birth centers.[8]

In 1985, at the height of a crisis in availability of liability insurance for all birth care providers, the AABC launched the National Study of Birth Centers, using a design recommended by the Institute of Medicine, support from the Kellogg Foundation, and data analysis by Columbia University School of Public Health. In 1989, the National Birth Center Study was

Address correspondence to Julia C. Phillippi, CNM, MSN, 345 Frist Hall, Vanderbilt University School of Nursing, 461 21st Ave. South, Nashville, TN 37240. E-mail: julia.c.phillippi@vanderbilt.edu

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published in the *New England Journal of Medicine*.[9] The study reported care and outcomes for more than 17,000 women enrolled for care in 84 birth centers and almost 12,000 women admitted to centers for labor and birth. This study further cemented the role of the birth center as a safe, satisfying, and cost-effective model of maternity care for low-risk childbearing women.[3]

That same year, after 6 years of planning and with support from the Pew Charitable Trusts, AABC collaborated with MCA, the Frontier School of Midwifery and Family Nursing, and the Frances Payne Bolton School of Nursing Case Western Reserve University to implement a pilot of the first entirely distance learning–based program for nurses in midwifery. It included preparation for starting or working in birth centers. This successful program was relocated to Frontier School of Midwifery and Family Nursing in Hyden, KY in 1991.[3,10]

In the past, birth centers have been hampered by a lack of research, inadequate numbers of collaborative physicians, malpractice insurance cancellations, and a need for more certified nurse-midwives (CNMs) prepared for out-of-hospital deliveries. AABC has met these challenges and continues to advocate for birth centers and the midwifery model of care through research, consumer education, workshops, and national lobbying.

MEMBERSHIP IN THE AMERICAN ASSOCIATION OF BIRTH CENTERS

AABC, as an organization, is centered on the birth center model of care rather than a provider-based model of care. AABC membership does not require specific professional credentials and is open to those who desire to support and advocate for the birth center model. Membership categories include individual, institutional, and birth center members. The majority of members are midwives and birth center owners. However, individual members also include nurses, physicians, childbirth educators, doulas, and consumers. Institutional members, such as educational programs and health care practices, also support AABC's mission through membership.

Birth center members receive professional services to assist in establishing and maintaining centers. Birth centers are structured and owned under different organizational models, including both non- and for-profit models. Community boards, federally qualified health centers, and other groups own or administer nonprofit centers. Midwives are the most common owners of for-profit centers. Others are owned by hospitals or physicians.

AABC acknowledges that many providers are capable of skilled care at a birth center delivery, including CNMs, certified midwives (CMs), midwives unassociated with the American Midwifery Certification Board (AMCB), and physicians.[11] The Standards for Birth Centers require that providers be licensed according to state guidelines.[8] CNMs are legal providers in all states.[12] CMs currently have legal status in 3 states: New York, New Jersey, and Rhode Island.[12] Midwives who are not certified by the AMCB but who have legal status or licensure within their states, such as certified professional midwives (CPMs), certified direct-entry midwives (CDMs), and licensed midwives (LMs), are also providers within accredited birth centers.[8] Physicians also practice in birth centers, but attend a small percentage of birth center deliveries as compared with midwives (AABC Survey of Birth Center Experiences, 2007).

CURRENT AMERICAN ASSOCIATION OF BIRTH CENTERS PRESSURES AND INITIATIVES

As a national organization, AABC is proactive in addressing potential threats to birth center practice and advocates independently and in concert with similar organizations to effect change. AABC has identified 3 main pressures on birth center financial sustainability: the current malpractice insurance crisis, the need for a federally mandated birth center facility fee, and reimbursement issues, such as the rate for CNM/CM reimbursement.

Malpractice Insurance

Several factors have combined to create a crisis in the malpractice insurance industry, and the multifaceted nature of the problem has made resolution difficult.[13,14] Insurance companies invest premiums to generate income to cover future losses.[13] In the 1990s, the stock market produced sufficient income to support payments from lawsuits. Even though the frequency and payouts from lawsuits increased dramatically in the 1990s, the industry was able to use investment income to cover costs without raising premiums. In many cases, the companies kept premium rates below the levels of losses and even below the level of inflation.[13,14] After September 11, 2001, the insurance industry faced large investment losses in the stock market and was no longer able to use investment income to support claims payment, so they increased premiums dramatically to remain financially stable.[14,15]

It is difficult to estimate overall increases in malpractice insurance rates because insurance rates vary with many

Julia C. Phillippi, CNM, MSN, is a lecturer at Vanderbilt University School of Nursing in Nashville, TN, and a PhD student at the University of Tennessee, Knoxville, TN. She practices on a locum tenens basis with the Women's Wellness & Maternity Center and Lisa Ross Birth & Women's Center in Knoxville, TN.

Jill Alliman, CNM, MSN, is the Center Director for Women's Wellness & Maternity Center, an accredited nonprofit birth center in Madisonville, TN, where she has provided full scope care for more than 22 years. She is Chair of the Legislative Committee and former President of the American Association of Birth Centers.

Kate Bauer, MBA, is the Executive Director of the American Association of Birth Centers, located in Perkiomenville, PA, and the Project Administrator of the AABC Uniform Data Set.

factors, including region, practitioner type, experience, and previous claim history.[13] A 30% increase in premiums to match premium prices to the rate of inflation was expected in 2001 as the stock market fell.[13] However, most practitioners had premiums increase by 30% or more not once but each year since 2001. AABC's national survey of birth centers revealed that, on average, birth centers saw a 189% rise in their premiums between 2006 and 2007 alone (AABC Liability Insurance Survey, 2007). Increasing medical malpractice insurance rates are of concern for all practitioners, but they are especially hard for CNMs/CMs because they are paid less than physicians for the same procedures.[16] The cost of increased malpractice insurance rates may be especially difficult for practices that predominately care for Medicaid or self-pay clients, because payment amounts can be lower from these sources.[13]

The Federal Tort Claims Act A is a federal policy that is being explored by some birth centers in an effort to decrease malpractice insurance costs. Under this act, employees of centers or clinics supported by the US Department of Health and Humans Services, Health Resources and Services Administration (HRSA) are covered by a federal program that provides an alternative mechanism for malpractice claims.[17] This federal protection is available at no cost, but only to Federally Qualified Health Centers (FQHC) receiving Section 330 funding. To receive this designation, birth centers must become or formally partner with a FQHC, which can result in a loss of some operating independence and autonomy. As of July 2008, 4 AABC birth centers have taken this step, and others are considering this change (AABC internal data).

Decreasing malpractice premiums is one way birth centers are hoping to increase their financial stability; the other is to increase revenues. Two key areas that are being targeted for change are the creation of a federal Medicaid facility fee for birth centers by the Center for Medicare and Medicaid Services (CMS) and the reimbursement rate for CNMs under Medicare Part B.

Facility Fee for Birth Center Care

While birth center care has been shown to be a safe,[9] high quality,[9,18-21] and cost-effective[22,23] alternative for the delivery of low-risk women,[24] it is difficult to quantify absolute cost differences between women who choose to birth in hospitals and women who deliver in birth centers because of self-selected bias, crossover between groups, and differences among providers.[23] However, the birth center model of care results in fewer operative births and medical procedures without sacrificing neonatal or maternal outcomes.[22,23,25] Despite this research, insurers do not uniformly reimburse birth centers for delivery services.

A birth center generates revenue predominately by billing for midwifery and delivery services. Providers can bill insurance for prenatal, delivery, newborn, and postpartum services; these are known as professional fees. As discussed previously, all states reimburse CNMs for these services to Medicaid clients. Non–nurse midwives, such as CMs and CDMs, are reimbursed through individual contracts with states and insurance providers.

The birth center can also bill for the facility costs during a delivery, which is similar to hospital fees for delivery. These facility fees cover the costs of operating the birth center, including additional employees, rent, supplies, and other overhead costs. According to internal AABC data, the average charge for a birth center facility fee was $1872 in 2007, which is substantially less than the average hospital facility charge of $6973.[26]

Currently, 22 states reimburse a birth center facility fee billed to Medicaid. In these states, Medicaid facility fees are paid half with state money and half with federal funds. However, the CMS, which oversees the Medicaid program,[27] has begun to deny some states' ability to pay birth center facility fees with federal money because of a discrepancy in interpretation of the federal statute. Four states have had their entire Medicaid plan denied federal matching dollars because they included funding for birth center facility fees: Alaska, South Carolina, Texas, and Washington (AABC internal data). Three of these states have found temporary workable solutions and one is in litigation. AABC is working with states experiencing problems with birth center reimbursement, but a national solution is needed. AABC is asking the US Congress to add the birth center facility to Medicaid as a mandated service. Getting this legislation passed will take the support of birth center midwives and other midwives, physicians, policy makers, and clients to let legislators know of the need for mandating this coverage. However, AABC believes this is vital to sustainability of birth centers. If the federal government mandates payment of birth centers by Medicaid, all states are required to comply.[28]

The Medicaid facility fee issue intersects with the regulation of midwives and the battle over direct-entry midwifery in the United States. A federal mandate on birth center reimbursement would be beneficial to birth centers but may be difficult to get passed because of AABC's inclusion of direct-entry midwives as qualified providers of birth center care. In October 2006, the American College of Obstetricians and Gynecologists (ACOG) released a statement that opposed all out-of-hospital births.[29] AABC, American College of Nurse-Midwives (ACNM), and other national organizations were able to cite a large body of research supporting the safety of birth in an accredited birth center. ACOG rescinded their initial statement and issued a second statement opposed to home birth and direct-entry midwifery but in support of accredited birth centers and midwives certified by the AMCB.[30] The facility fee for birth centers intersects with the larger national debate on routes to midwifery

practice. It is not clear how this larger national debate on midwifery practice affects the CMS interpretation on reimbursement of birth center facility charges.

Practitioner Reimbursement

Medicaid reimbursement for nurse-midwifery services is required in all US states, and 33 states mandate that private insurance cover nurse-midwifery care.[31] CNMs are reimbursed by Medicare Part B at 65% of a physician's fee for the same services.[32] This is lower than for most nurse practitioners who receive 85% of a physician's fee, and much less than for certified registered nurse anesthetists who are reimbursed at the same rate as physician anesthesiologists.[32] CMs are reimbursed by Medicaid and private insurers on a case-by-case basis.

Increasing the rate of reimbursement is a priority for AABC. Currently, ACNM is lobbying for 100% reimbursement for CNMs/CMs,[32] and AABC is supportive of their efforts. ACNM has introduced several bills to Congress regarding CNM/CM reimbursement. ACNM has stated that they will continue to lobby for an increase in CNM/CM Medicare fees, because Medicare is a standard for the industry and often influences other insurers' reimbursement patterns.[32,33]

While Medicare provides a standard, private insurance companies are not required to follow Medicare's reimbursement patterns. Private insurers negotiate reimbursement rates individually with practitioners or clinics, often paying different amounts to same-level providers for the same services.[34] Insurers often use data, including cost-effectiveness data from their claims database and current literature, in determining provider rates. This practice is sometimes called ''pay for performance.''[34] AABC supports increased practitioner reimbursement rates and is collecting research to validate the cost effectiveness of birth center and midwifery models of care to assist in negotiations with insurers.

Research

Reliance on data in reimbursement decisions underscores the need to collect consistent and reliable use and outcomes data and to consolidate and analyze these data as efficiently as possible. This information is critical in negotiations with managed care organizations and hospitals and in explaining birth center and midwifery services to consumers. Research and the facilitation of research have been priorities since AABC's inception.

In 1996, the AABC Research Committee designed the Uniform Data Set tool to collect data on births in all settings (i.e., home, birth center, and hospital) with all types of providers. After several years in development, AABC launched a Web-based version of the Uniform Data Set tool in 2007. Data on a wide range of interventions and outcomes are collected beginning at the initial visit and ending after the 6-week postpartum examination.

This online data registry provides prospective and retrospective data on midwifery and birth center care. This comprehensive data set can be accessed for studies on childbirth and women's health. Data includes detailed maternal demographic and behavioral characteristics, models of prenatal care and interventions, intrapartum location and care, practitioner type, and wide-ranging postpartum and newborn details. All midwives, regardless of their birth setting, are encouraged to participate in data collection, because a larger data set will enable more powerful statistical analysis in a variety of potential studies. Information on contributing data can be found on the AABC Web site.

In 2008, AABC, using the Uniform Data Set, launched the AABC National Study of Optimal Birth.[35] This prospective, descriptive study will examine the process and outcomes of midwifery care in all practice settings to augment the evidence on midwifery outcomes and cost-effectiveness.[35]

Additional American Association of Birth Centers Activities

AABC has designed many programs to increase the sustainability of existing birth centers and to promote the formation of new centers. Three times a year, AABC hosts a ''How to Start a Birth Center Workshop,'' and actively supports developing birth centers through its national office. AABC's annual conference, the AABC Birth Institute, provides educational, networking, and risk management opportunities. AABC and its Web site (*www.birthcenters.org*) provide resources for potential birth center clients. AABC is also working to promote birth centers as access points into prenatal care for all women. Many birth centers provide care in underserved areas, such as inner cities and rural locations, and work within regional health care networks to ensure that women can enter and maintain prenatal care close to home and give birth in a facility appropriate to their needs. Programming, policies, and outreach activities are designed to meet the diverse needs of birth centers across the country, advancing the birth center model of care.

CONCLUSION

AABC is committed to the birth center model of care. It promotes birth centers through national standards, initiatives, lobbying, research, and education. Several forces are greatly affecting birth center financial sustainability, including the malpractice crisis, low rates of professional reimbursement, and the lack of a federally mandated birth center facility fee. Despite these challenges, the number of birth centers has increased by 44% since 1994 to a current total of 195. AABC actively seeks to alleviate some of the financial pressures through lobbying and midwifery

research. As a national professional organization, AABC collaborates with other organizations to promote the health of women, infants, and families and to open sites for midwifery practice. Through promotion of research, collaboration with other organizations, and affecting national policy, AABC safeguards the birth center as a safe, evidence-based location for normal birth and the care of women.

We would like to acknowledge the midwives who have worked, watched, and waited with mothers and birth centers. Without all those midwives, birth centers would not be possible.

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