EMPLOYMENT GUIDE

Information on Certified Nurse Midwives

A collaborative project of the WisTREC Utilization Committee initiated by the Wisconsin AHEC System and funded by The Robert Wood Johnson Foundation.
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INTRODUCTION

This booklet was developed by the Wisconsin Program for Training Regionally Employed Care providers (“WisTREC”) utilization committee. WisTREC is a project of the Wisconsin Area Health Education Center System, is funded by the Robert Wood Johnson Foundation-Partnerships for Training program, and is administered through the University of Wisconsin-Madison School of Nursing.

WisTREC is focused on increasing access to primary care in underserved areas and for underserved populations by increasing the training and use of physician assistants, nurse practitioners, and nurse midwives in these areas and populations.

WisTREC and its collaborating partners are committed to sharing the information in these guides with all interested parties. These guides may be copied and distributed or excerpts used if the WisTREC project is credited.
CREDITS

Consultant:
Jeff Bramschreiber, CPA
Wipfli Ullrich Bertelson LLP
414 S. Jefferson St.
Green Bay, WI  54305-1957
ph: (920) 430-3322
fax: (920) 432-4009

Primary Authors:
Kathryn S. Harrod, DNSc, CNM
WI Chapter Am. College of Nurse Midwives
Aurora Medical Group and Marquette University College of Nursing

Contributing Authors:
Suzanne Bottum-Jones
Wisconsin Office of Rural Health
Anne Dopp, MS, PNP
Wisconsin Division of Public Health-Primary Care Office
Lou Falligant, BS, PAC
Wisconsin Academy of Physician Assistants and Dean Medical Center
Laurie Hartjes, MS, CPNP
Wisconsin Association of Pediatric Nurse Practitioners
UW-Madison School of Nursing
Jeannette McDonald, DVM, PhD
WisTREC Director
Jeff Nicholson, MEd, PAC
WisTREC Utilization Committee Chair
University of Wisconsin-Madison Physician Assistant Program
Wisconsin Academy of Physician Assistants
Peggy Ore, MS, RN
Wisconsin Primary Health Care Association
Rebecca Richards, MS, APNP-FNP
Wisconsin Nurses Association-Nurse Practitioner Forum
Susan Riesch, DNSc, RN, FAAN
University of Wisconsin-Madison School of Nursing
**FACTS ABOUT CERTIFIED NURSE MIDWIVES**

**General Description**

Certified Nurse-Midwives (CNMs) are registered nurses with advanced preparation in both nursing and midwifery. Most CNMs work in clinic settings, hospitals, and/or birthing centers. CNMs attend women during labor and birth and are trained and experienced in prenatal, postpartum, normal newborn care, and routine gynecological care. Thus, they carry on a centuries-old tradition of assisting women in the safe birth of babies, using their professional skills, while incorporating the advances of modern medicine.

The word midwife means “with woman”. The term refers to a care provider prepared in the discipline of midwifery who has specialized in women’s health. It is an ancient word, reflecting the historic tendency for women to attend to each other and offer close and attentive support during labor, birth, and the adjustment period afterwards. However, the evolution and expansion of nurse-midwifery practice has resulted in the current identification of CNMs as primary care providers who also incorporate gynecologic services for women throughout the life span.

CNMs are educated to assess, counsel, diagnose, prescribe, and manage many of the primary care needs of their clients. Nurse-midwifery care focuses on wellness and consumer choice. They work in collaboration with other health care professionals such as physicians, pharmacists, and physician assistants. CNMs are eligible for reimbursement from private and public third party payers. CNMs are licensed to practice by the State in which they practice and are certified upon national examination.

- Ninety percent of visits to CNMs are for primary, preventive care including care outside of the maternity cycle. Examples of this kind of care include annual exams and reproductive health visits. (Readership and Practice Profile of the ACNM, Journal of Nurse-Midwifery, 39).

- Currently, 70 percent of the women seen by nurse-midwives are considered at additional risk by virtue of their age, socioeconomic status, education, ethnicity, or location of residence (Scupholme et al. 1992).

- Certified nurse-midwives offer prenatal care, support in labor, added comfort measures, and woman-centered birth, resulting in a cesarean section rate that is half the national average in comparable patient populations (Gabay and Wolfe, 1997).

- The care provided by certified nurse-midwives has been shown to reduce the incidence of low birth weight especially among socioeconomically high-risk women, thus lessening the primary reason for the persistently high rate of infant mortality in the United States when compared to other developed countries (Rooks, 1997).
CNMs possess comprehensive assessment, interviewing, counseling, communication, and case management skills. CNMs, like NPs, exercise a high degree of independent judgement, complex clinical decision making, and skill in managing health care environments (American Nurses Association, 1996). As advanced practice nurses, CNMs practice evolves in response to developments in nursing research, advances in medical therapeutics, and changes in the health care delivery system.

**Education and Certification**

To become a CNM in the United States, one must complete an accredited educational program, demonstrate that the core competencies in practice areas have been met, and pass a credentialing examination to receive national certification. In Wisconsin, CNMs must first obtain certification to become licensed to practice. Graduate nurse-midwifery programs include advanced level course work in health promotion and disease prevention, health assessment, pathophysiology, diagnostic assessment, clinical decision-making, pharmacology and therapeutics, research, human diversity, health policy, and advanced ethics. Content in the specialty addresses the unique needs of the patient in the context of human development, health and illness, and family. The US Department of Education has recognized the American College of Nurse-Midwives, Division of Accreditation (DOA) as the accrediting agency for nurse-midwifery education programs since 1982.

The American College of Nurse-Midwives (ACNM) Certification Council, Inc. administers the national certification examination to all graduate nurse-midwives. The certification for individuals who passed the ACNM Certification Council, Inc. national exam after 1996 will expire after 8 years, and will require re-certification to maintain the professional designation. In addition to certification, a CNM must receive necessary licensure(s) for practice and maintain these by meeting renewal requirements. Each CNM may enroll in a certification maintenance program and/or continuing competency assessment to demonstrate lifelong accrual of current knowledge, thereby maintaining active certification through meeting re-certifying requirements. In addition, CNMs are committed to quality assurance. Wisconsin CNMs voluntarily participate in peer review through a Wisconsin Chapter ACNM committee and are active in other continuous quality improvement measures.

A CNM with a master's degree, national certification, and preparation in pharmacotherapeutics can become Advanced Practice Nurse Prescribers (APNP). A nurse who uses the initials APNP is legally certified to prescribe medications for the treatment of illness and the prevention of disease. In Wisconsin, eighty-six percent of Wisconsin CNMs hold either a masters degree or a doctorate.
Characteristics of Practitioners

Practitioner Demographics

The American College of Nurse-Midwives currently has more than 7,000 members. Of those, approximately 5,700 are in clinical practice. The rest are students, faculty members, retired, or outside of clinical practice for a variety of reasons. According to a report prepared by the U.S. Department of Health and Human Services in 1996, roughly 82 percent were employed in clinical practice.

A survey conducted in 1998 for the WisTREC Partnership for Training program compiled information on 60 Certified Nurse-Midwives in the state of Wisconsin. This study found that nearly all of the CNMs (98%) were female and white (98%), over seventy percent were married, and all were certified by the national organization.

Number of Practitioners

In its 1996 report, the U.S. Department of Health & Human Services (HHS) estimated there were approximately 5,337 CNMs employed in clinical practice nationwide. Similar data published by the Journal of the American Medical Association (JAMA) showed that the national supply of CNMs increased from 3,000 in 1990 to approximately 6,000 in 1997.

The 1998 WisTREC Survey concluded that approximately 80 CNMs reside and practice in the state of Wisconsin. This survey was distributed to all CNMs identified as currently practicing in the state.

Enrolled Candidates

Nationally the growth in the midwifery workforce has been steady but modest in terms of total numbers. For example, although the production of new CNMs more than doubled between 1992 and 1997, the total number of nurse-midwives newly certified in 1997 was less than 600. Each year, approximately 400 nurse-midwives pass the national certification exam. The number of nurse-midwives who are certified each year has increased by 25 percent since 1991.

In Wisconsin, a total of 20 candidates, both full- and part-time, were enrolled in nurse-midwife programs for the 2000-2001 academic year. Marquette University in Milwaukee had 15 candidates enrolled in its program during the 2000-2001 academic year. The remaining students are enrolled in various out-of-state distance-learning programs.

Practice Settings

CNMs practice in communities spanning the most densely urban to the most remote and rural. Nationally, nearly one quarter of CNMs practice in rural (non-metropolitan statistical) areas.
The 1998 WisTREC survey data indicated that 61 percent of CNMs worked in medical practice sites; 17 percent in various types of community health centers; 10 percent in hospital departments; 5 percent in governmental agencies; and the remaining 7 percent in various other settings. Data also revealed that nearly 88 percent of Wisconsin CNMs were employed in urban settings, as defined by the Census Bureau.

According to the recent data compiled by the WisTREC program, most of the Certified Nurse-Midwives in Wisconsin provide a full scope of nurse-midwifery services, which includes antepartum, intrapartum, postpartum, gynecological, well-woman and minor acute illness care. Only 10% of Wisconsin CNMs do not provide full scope care.

**Scope of Practice**

A Certified Nurse-Midwife is licensed by the Wisconsin Board of Nursing both as a Registered Nurse and as a CNM. Wisconsin licensure for CNMs requires national certification and recognizes the ACNM Certification Council Inc., as the credentialing body. CNMs are licensed to provide:

“the overall management of care of a woman in normal childbirth and the provision of prenatal, intrapartal, postpartal and nonsurgical contraceptive methods and care for the mother and the newborn.” CNMs can collaborate in but not independently manage the care of patients with complications and patients requiring Cesarean section or mechanical assistance with delivery. Management of these patients must be referred to the physician providing general supervision and who has training in obstetrics (Wisconsin Board of Nursing, Administrative Code Chapter 4).

Certified Nurse-Midwives with additional education, training, or experience can apply for additional certification from the State Board of Nursing to be Advanced Practice Nurse Prescribers (APNP). The APNP independently issues prescriptions for laboratory testing, radiographs or electrocardiograms appropriate to her or his area of competency. APNPs are required to practice within a collaborative relationship defined as:
"Collaboration" means a process which involves 2 or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer. N8.02 (5)

The certified nurse-midwife’s scope of practice may include, but is not limited to, the following nursing, nurse midwifery, and medically delegated services:

- Advanced physical assessment (patient histories and physical exams);
- Selection and performance of appropriate diagnostic and therapeutic procedures;
- Ordering and interpreting lab tests;
- Diagnosis, treatment and monitoring of common acute and chronic clinical conditions;
- Prescription and administration of drugs, treatments and therapies; and
- Patient case management and referral to physicians and other specialists.

Certified nurse-midwives do not require on-site physician supervision. Delegated medical care can be provided by CNMs who are competent based on their education, training and experience, and under the “general supervision” of a physician with training in obstetrics. The supervising physician must be available for consultation and emergencies with deviations from normal (including Cesarean sections and mechanical assistance with deliveries), and must enter into a formal written agreement with the CNM. The written agreement must be annually reviewed and approved and must outline collaborative practice protocols, conditions of referral, and identification of health care facilities to be used (including home deliveries when appropriate).

Nursing and nurse-midwifery care are provided by CNMs as an independent function, ranging from comprehensive patient assessment and care management to population health assessment and intervention. Because of the increasing complexity of health care and an increasing commitment to providing more comprehensive care, many licensed health care professionals provide care in collaborative, team practice settings.

**Spectrum of Practice Settings**

CNMs contribute to meeting the needs for women’s health, and childbirth related care, for many Americans who would otherwise lack access to ongoing health care services. CNMs practice in public, private, university, and military hospitals. Many work in health maintenance organizations, in private practices, public health clinics, and in birth centers. CNMs are also active in international health programs working worldwide to improve the health of mothers and their babies.

The broad range of practice settings can help to explain the strong demand for certified nurse-midwives and the steady growth in the number of practicing CNMs.

- Nurse-midwifery practice is legal in all 50 states and the District of Columbia.
• Over half of all CNMs work primarily in an office/clinic environment. Most list a hospital or physician practice as their place of employment.

• Most CNM attended births occur in hospitals. In 1997, 96 percent of CNM attended deliveries occurred in hospitals, 2.4 percent in freestanding birth centers and 1 percent in the home.

• The typical nurse-midwife sees up to 140 clients a month and attends 10 births a month.

• The 1991 infant mortality rate for nurse-midwives was 4.1 per 1,000 live births, the national average for that year was 8.6 per 1,000.

A collaborative relationship between physicians and CNMs offers services which can enhance the medical practice.

• Clients can be offered the option of seeing the CNM for routine and/or urgent care visits. The reduced waiting time and the CNM’s emphasis on education can improve patient satisfaction.

• CNMs can provide outreach, care coordination and case management of underserved and special need populations. In fact, many Wisconsin CNMs are working with those at additional risk based on age, socioeconomic status, ethnicity, or location of residence.

• A collaborative practice between CNMs and physicians allows the physicians to focus on those patients with more complex medical problems.

• The addition of CNM care brings both expertise in midwifery and nursing into a practice. CNMs are skilled in providing education and care through collaborative relationships with the health care team, including physicians, physician assistants, nurse practitioners, nurses, pharmacists, and other providers.

Prescriptive Authority

Current state regulations under Chapter N 8 of the Wisconsin Board of Nursing Administrative Code permit a certified nurse midwife to independently prepare prescription orders. To qualify for certification to be an advanced practice nurse prescriber (APNP), a nurse midwife must comply with the following:

1) Have a current license to practice as a professional nurse in the state.

2) Be currently certified by a national certifying body approved by the Board of Nursing as a certified nurse midwife.
3) Applicants who receive national certification as a CNM after July 1, 1998, must hold a master’s degree in nursing or a related health field granted by a college or university approved by the Board of Nursing.

4) Have completed at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application.

5) Have passed a jurisprudence examination for advanced practice nurse prescribers.

Chapter N 8.06 describes limitations to the prescribing authority of the CNM. The CNM may only issue those prescription orders appropriate to the prescriber’s areas of competence, as established by his or her education, training, or experience. The prescribing CNM may not issue a prescription order for any schedule I controlled substances. Prescription orders for schedule II controlled substances can only be issued in specific instances.

Prescription orders prepared by the CNM must contain the name, address, and telephone number of the CNM prescriber. Prescription orders for Schedule III, IV, and V controlled substances require the APNPs’ DEA registration number. APNPs must maintain malpractice insurance as specified in Chapter N 8.08.
Compensation Arrangements

Salary and Benefit Structure

Arrangements for the compensation of Certified Nurse Midwives vary by organization; however, the direct compensation for most CNMs is typically based on a straight salary or a salary plus bonus incentive payment. A 1997 survey of 537 group practices conducted by the Medical Group Management Association revealed that of 39 employed CNMs, 51 percent were compensated on a straight salary basis, whereas 44 percent had a salary plus a bonus or incentive payment. The remaining 5 percent were compensated on a production basis, computed by gross charges, net charges, or on a relative value unit formula.

The benefit structure for employed CNMs also varies by organization. Typical benefits of practicing CNMs include three to four weeks paid vacation (including six to ten paid holidays), paid sick and continuing medical education leave, pension/retirement fund, malpractice insurance, health insurance, group term life insurance, group long-term disability insurance, annual dues/licensures, and a continuing education allowance.

National Salary Data

Several organizations accumulate and report annual salary data for Certified Nurse Midwives. According to data collected in 1996 by HHS, the mean annual income for CNMs nationwide was $54,182. The Medical Group Management Association’s Physician Compensation and Production Survey: 2000 Report Based on 1999 Data reported that the median compensation of CNMs was $67,250; the mean was $68,857.

National survey data has revealed wide variations in the earnings among CNMs due to factors such as years of experience, population of the geographic area, whether the CNM takes call, and whether the CNM has administrative and/or supervisory responsibilities for other CNMs.

Wisconsin Salary Data

In 1998, the WisTREC survey reported salary data on Certified Nurse Midwives. Based on the survey respondents residing in Wisconsin, the majority of CNMs (59%) reported an annual income between $50,000 and $70,000. The survey also identified that 10.3% of the CNMs were paid less than $50,000, whereas 66.6% were paid in excess of $65,000 annually.
**Contribution to Practice Revenue**

**Pricing of Services**

In most medical practices, the amounts charged for services rendered by the CNM are identical to the amounts charged for comparable services performed by a physician. Therefore a patient may be charged the same amount for the same service, whether a CNM or a physician performs it. However, the average complexity of patient health care needs and services rendered by the CNM may be less than the typical physician. A difference in the mix of services delivered will result in lower average charges per patient cared for by the CNM (for example, CNMs have been shown to use less technology, have lower cesarean section rates, and fewer low birthweight babies) in comparison to the physician, thus reducing overall expenses.

**Volume Indicators**

Patient visit statistics can be an effective barometer of the financial performance of a health care provider, particularly in a primary care practice setting. A patient visit is typically defined as an identifiable contact between the patient and a health care provider where advice, a procedure, service, or treatment is provided.

The 1998 WisTREC research indicates that of those CNMs working full-time, the average number of outpatient visits per week is 38 and the average number of inpatient visits is six per week. The Medical Group Management Association reports the number of ambulatory (outpatient) encounters for CNMs in primary care practices. The 2000 MGMA Survey reported the average number of annual ambulatory encounters for CNMs as 1,716. Assuming the average CNM works approximately 48 weeks per year (allowing for vacation and CME), the MGMA data would translate into approximately 36 ambulatory patient visits per week.

In addition to outpatient visits, CNMs either share call or are on call continuously supporting pregnant clients and their families during labor and birth. CNM practices thus generate outpatient clinic charges as well as intrapartum charges.

**Production Data**

Production (revenue) generation by Certified Nurse Midwives is not widely reported in trade journals or medical surveys, but patient charges can be another key indicator of the financial performance of the CNM. The role of the CNM within the medical practice can have a direct impact on the amount of patient charges resulting from services provided by the practitioner. For instance, the role of a CNM could be primarily limited to prenatal visits; services that are usually bundled in a physician’s charge for a global service and not separately billed. Therefore, revenue generation may not be a proper indicator of financial performance since the work of the CNM is intended to relieve the physician of these functions and allow him or her to focus more attention on performing billable services.

*The average annual gross professional charges for CNMs: $291,241.00 (MGMA, 2000)*
In most situations, however, gross charges generated by the CNM are tracked separately by practice managers to evaluate the financial contribution of the CNM to the employing organization. The 2000 Medical Group Management Association *Physician Compensation and Production Survey* reports the average annual gross professional charges for CNMs as $291,241. It should be noted that these amounts exclude the technical component of all ancillary services such as laboratory and radiology.

**Third-Party Coverage and Payment**

**Medicare Coverage and Payment**

The first Medicare coverage of physician services provided by Certified Nurse Midwives was authorized by the Rural Health Clinic Services Act in 1977. In the following two decades, Congress incrementally expanded Medicare Part B payment for services provided by CNMs in collaboration with a physician in rural hospitals, nursing facilities, physicians’ office or clinic, and in a rural independent practice setting.

As of January 1, 1998, Medicare pays for medical services provided by CNMs in most settings at 65 percent of the physician’s fee schedule using the Resource-Based Relative Value Scale (RBRVS) system. This includes hospitals (inpatient, outpatient, and emergency departments), nursing facilities, physician offices and clinics. Medicare assignment is mandatory and state law determines supervision and scope of practice. However, urban hospitals that employ Certified Nurse Midwives may choose not to separately bill Part B for services provided by CNMs in an urban hospital setting. These services can be bundled with other facility services of the hospital and would be covered by the intermediary payment to the facility.

Outpatient services provided in offices and clinics may still be billed under Medicare’s “incident-to” provisions if Medicare’s restrictive billing guidelines are met. This allows payment at 100 percent of the physician’s fee schedule if: (1) the physician is physically on-site when the CNM provides care; (2) the physician treats all new Medicare patients (CNMs may provide the subsequent care); and (3) established Medicare patients with new medical problems are personally treated by the physician (CNMs may provide the subsequent care).

Medicare-certified rural health clinics (RHCs) and federally qualified health centers (FQHCs) receive cost-based reimbursement for covered services to Medicare beneficiaries regardless of the provider of care, physician or CNM. In general, RHCs and FQHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. The 2000 maximum payment limit per encounter for RHCs was $61.85, rural FQHCs was $82.55, and urban FQHCs was $96.02. These payment limits apply to all covered services furnished during the patient visit including all physician services, CNM services, incidentals, and diagnostic laboratory tests. As of January 1, 1998, the all-inclusive payment limitation for RHCs is waived only for those clinics in rural hospitals with fewer than 50 beds.
Medicaid Coverage and Payment

All state Medicaid programs cover medical services provided by Certified Nurse Midwives. To be certified by Wisconsin Medicaid, CNMs must be licensed by the Board of Nursing in Wisconsin as registered nurses and as certified nurse midwives (e.g., including national professional certification as a CNM). All CNMs providing services to Wisconsin Medicaid recipients must be individually certified by the Wisconsin Medical Assistance Program (WMAP) in order to be reimbursed. CNM reimbursement by Wisconsin Medicaid is 90% of the maximum allowable fee established for physician services. Medicaid-certified CNMs can bill independently for covered services using their Medicaid provider number.

CNMs may also meet Wisconsin Medicaid criteria to be certified as a Medicaid Nurse Practitioner billing provider, if the CNM has completed a master’s degree program for advanced clinical practice nursing. CNMs who are certified as Medicaid NP providers are reimbursed at 100% of the maximum allowable fee established for physician services, and can bill independently for the covered NP services using this Medicaid provider number. Employers and billing offices need to review and follow Medicaid billing policies as detailed in the various Medicaid provider manuals.

Wisconsin Medicaid also provides incentive payments to primary care and emergency medicine providers, including CNMs, who either serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs) or practice within a designated HPSA zip code. The incentive payment for HPSA-eligible primary care and emergency medicine procedures is 20 percent of the physician maximum allowable fee. HPSA-eligible obstetrical procedures receive the HPSA bonus and an additional 25 percent incentive payment.

Medicaid-certified rural health clinics (RHCs) and federally qualified health centers receive cost-based reimbursement for covered services to Medicaid recipients regardless of the provider of care, physician or CNM. In Wisconsin, all RHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicaid maximum payment limit. An additional 10 percent incentive payment is made to RHCs who serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs). The Wisconsin Medicaid maximum payment limit per encounter for RHCs in 2000 was $68.04, including the HPSA incentive payment. Wisconsin Medicaid cost-based reimbursement for FQHCs is not limited by the maximum payment rates.

Commercial Insurance Coverage and Payment

Most commercial insurance companies allow for the coverage of CNM-provided medical services. However, insurance companies often differ in how medical services provided by CNMs are covered and how insurance claim forms should be submitted. Typically, commercial insurance companies will extend coverage for medical services provided by a CNM if those services are included as part of the physician’s bill. Many insurers require that the bill for medical services provided by CNMs be filed under the physician’s name and provider number. Since some insurers prefer the claim to be filed under the CNMs name, billing personnel should check with the individual insurance company to determine the particular policy on coverage for medical services provided by CNMs.

Managed Care Coverage and Payment

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Historically, the financial health of a medical practice depended on its ability to provide an expanding array of services to an increasing number of patients. The traditional model of health care delivery was fueled by the absence of price competition for health services as well as a seemingly endless demand for patient services. However, the emergence of managed care organizations (MCOs) has changed the financial incentives among health care providers. Instead of focusing on increased patient utilization of costly services, medical practices with managed care contracts are focusing on how to manage patient care more efficiently and reduce utilization.

Payment arrangements vary from one MCO to the next, but a common reimbursement strategy is to pay health care providers a fixed amount for the care of a covered population. The fixed payment may represent the total amount for all care delivered (i.e., a global capitation payment) or the amount for primary care professional services only. Nevertheless, an emphasis in most managed care arrangements is placed on shifting the financial risk for the provision of health care services from an employer or insurance carrier to the health care provider.

Health care providers have responded to the demands of the managed care market by developing strategies to lower operating costs, improve patient satisfaction, and enhance the overall health of the patient population. Certified Nurse Midwives can make significant contributions in each of these areas through their involvement in patient education, wellness programs, patient recalls, telephone triage, utilization review, and quality assurance programs, as well as their efficient treatment of those individuals requiring medical attention.

**Cost/Benefit Analysis**

The following tables provide two compelling illustrations of the financial benefits of a physician/CNM practice model. Revenues for this analysis are from all professional services, excluding diagnostic services such as laboratory tests and radiology procedures. Only certain variable expenses are presented, including salaries and fringe benefits for a physician, a CNM, and a medical assistant. Malpractice insurance premiums are also included. This analysis has been simplified to clearly show the variability in contribution to overhead expenses under both a traditional fee-for-service operating environment and under a 100 percent capitated payment arrangement.

Financial data for this analysis was drawn from the Medical Group Management Association 2000 *Cost Survey*, the 2000 *Physician Compensation and Production Survey*, and actual data from various medical practices.
Fee-for-Service Model

Table I below illustrates the traditional fee-for-service model. Column 1 with a single physician staff results in a contribution margin of $185,250. Table I, column 2 presents the same traditional fee-for-service arrangement but includes a CNM provider in addition to the original physician.

<table>
<thead>
<tr>
<th></th>
<th>(1) Physician Only</th>
<th>(2) Physician/ CNM Team</th>
<th>(3) Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross charges – OB/GYN Phys.</td>
<td>$785,000</td>
<td>$785,000</td>
<td>$-0-</td>
</tr>
<tr>
<td>Gross charges – CNM</td>
<td>-0-</td>
<td>290,000</td>
<td>290,000</td>
</tr>
<tr>
<td>Adjustments – Physician (35%)</td>
<td>(274,750)</td>
<td>(274,750)</td>
<td>-0-</td>
</tr>
<tr>
<td>Adjustments – CNM (35%)</td>
<td>-0-</td>
<td>(101,500)</td>
<td>(101,500)</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>510,250</td>
<td>698,750</td>
<td>188,500</td>
</tr>
<tr>
<td><strong>VARIABLE EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salary &amp; Fringes – OB/GYN Phys.</td>
<td>275,000</td>
<td>275,000</td>
<td>-0-</td>
</tr>
<tr>
<td>Salary &amp; Fringes – CNM</td>
<td>-0-</td>
<td>80,000</td>
<td>80,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
<td>-0-</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>-0-</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance – Physician</td>
<td>25,000</td>
<td>25,000</td>
<td>-0-</td>
</tr>
<tr>
<td>Malpractice Insurance – CNM</td>
<td>-0-</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Total Variable Expenses</td>
<td>325,000</td>
<td>437,000</td>
<td>112,000</td>
</tr>
</tbody>
</table>

Based on the data presented in Table I, the CNM can add $188,500 in net revenue, $80,000 in salary and fringe benefit cost, a medical assistant of $25,000 in annual cost, and roughly $7,000 in malpractice insurance premiums. The computed net increase in contribution margin as a result of adding the CNM is $76,500. The new contribution to overhead for the two providers combined has increased to $261,750.
The results in Table II indicate that a 50% increase in panel size can result in a greater contribution margin than an individual physician may be able to achieve on his or her own.

### Managed Care Model

Table II illustrates a much different environment consisting of a prepaid (capitated) HMO patient population. Revenue is depicted as fixed payments of $15 per member per month for the patient panel. In Table II, column 1, with a panel of 2400 health plan members, total net capitated revenue for the year is estimated at $432,000. Associated variable expenses are $325,000 leaving a net contribution of $107,000. In column 2, there is an addition of a CNM, but together both providers are still managing the same panel size. Obviously the contribution will drop commensurate with the additional costs of the CNM and support staff. In columns 3 and 4, the panel is shown to increase by 600 members each, resulting in increased capitated payments and a higher contribution margin. In column 4, representing a panel size of 3600, the contribution has grown to $211,000, or nearly 33 percent of the net revenue.

**TABLE II**

<table>
<thead>
<tr>
<th>Sample Analysis</th>
<th>(1) Physician (2400 Panel)</th>
<th>(2) Phys./CNM (2400 Panel)</th>
<th>(3) Phys./CNM (3000 Panel)</th>
<th>(4) Phys./CNM (3600 Panel)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitated Payments</td>
<td>$432,000</td>
<td>$432,000</td>
<td>$540,000</td>
<td>$648,000</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>432,000</td>
<td>432,000</td>
<td>540,000</td>
<td>648,000</td>
</tr>
<tr>
<td><strong>VARIABLE EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salary &amp; Fringes – Physician</td>
<td>275,000</td>
<td>275,000</td>
<td>275,000</td>
<td>275,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – CNM</td>
<td>-0-</td>
<td>80,000</td>
<td>80,000</td>
<td>80,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>-0-</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance - Physician</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance – CNM</td>
<td>-0-</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Total Variable Expenses</td>
<td>325,000</td>
<td>437,000</td>
<td>437,000</td>
<td>437,000</td>
</tr>
<tr>
<td><strong>Contribution to Overhead</strong></td>
<td>$107,000</td>
<td>($5,000)</td>
<td>$103,000</td>
<td>$211,000</td>
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</table>
EMPLOYMENT INFORMATION

Employment Contracts and Agreements

In most instances, a written agreement is presented to the employed CNM outlining the key terms of his or her employment status. This agreement may be in the form of an employment contract or it may be less formally drafted into a letter of employment. However written, several key areas are commonly addressed within the employment document. These areas include:

- **Job Description**
  - Scope of practice
  - Physician supervision
  - Administrative responsibilities
  - Office location(s)
  - Hours of operation
  - Expected hours per week
  - Call schedule
  - Holidays/weekends

- **Insurance**
  - Malpractice insurance
  - Health/dental insurance
  - Life/disability insurance

- **Compensation Package**
  - Base salary
  - Bonus arrangement
  - Annual salary adjustments
  - Pension/retirement benefits
  - Profit sharing
  - Paid time off

- **Professional expenses**
  - CME program and travel costs
  - CME paid time off
  - Certification expenses
  - Membership dues

- **Contractual provisions**
  - Effective date
  - Probationary period
  - Renewal
  - Termination provisions
  - Notifications

The above items represent basic areas of employment that should be clarified when the CNM, employer, and consulting physician discuss the terms of employment. It is advisable to have a written contract or practice agreement that clearly spells out the terms of employment.

**Credentialing**

Hospital Privileges

Certified Nurse Midwives practice nurse-midwifery with physician collaboration. Within the hospital setting, CNMs may be granted privileges to conduct rounds; perform histories and physicals; evaluate changes in a patient’s condition; issue orders for such things as medications, treatments, and laboratory tests; record progress notes; write discharge summaries; manage labor and births; perform circumcisions; and assist in surgery.

Hospitals that grant privileges to CNMs to practice in their facilities should verify that the CNMs are properly certified, licensed both as RNs and CNMs, and have adequate professional liability insurance. On demonstration of satisfactory training and experience, and after approval by the hospital board or designated individual, a CNM may be granted privileges with general supervision of a physician who has appropriate privileges. The criteria and process for granting
clinical privileges to CNMs should be outlined in the medical staff bylaws. It is recommended that the actual CNM privileges be stated, not in the bylaws but in the medical staff rules and regulations, where amendments can be made more easily and efficiently. Preferably, this may be done in a category specifically for Certified Nurse Midwives as medical staff members.

Hospitals typically have a system for granting physicians provisional approval on particular privileges until competence is shown. A similar system may be established for CNMs. Likewise, many hospitals use virtually the same form for physicians and Certified Nurse Midwives that are applying for privileges.

**Patient Satisfaction**

Early studies of patient acceptance and satisfaction on Certified Nurse Midwives showed that, compared with physicians, CNMs function at comparable levels, use no more health care services, and are accepted by patients at a comparable level. A more recent study conducted in 1995-96 by Kaiser Permanente of the Northwest (KPNW), a health maintenance organization, explored differences in patient satisfaction with physician and nonphysician providers. An analysis of this study confirmed earlier findings that patients are satisfied with their care regardless of the type of practitioner delivering the care. This study further suggests that patient satisfaction appears to depend on the communication skills and style of the provider, and not on the type of provider. Safriet (1992) also demonstrated patient satisfaction with CNM care. She found CNM care is cost-effective especially given the diversity of the populations they serve. In addition, she found CNM care results in at least equivalent and sometimes better outcomes, perhaps more quickly, given their patients' enhanced adherence to care regimes; the substantially lower cost of their training; and the collateral benefits of increased consumer choice and satisfaction. Therefore, the incorporation of Certified Nurse Midwives in the health care delivery system can result in greater patient satisfaction, along with the economic benefits commonly associated with nonphysician providers.

**Liability Insurance**

**Employer Coverage and Individual Policies**

Professional liability insurance for the CNM can be obtained through the employing clinic, personally by the CNM, or by a combination of both parties. Most CNMs currently in practice are insured by their employers.

Costs for professional liability insurance policies vary depending on the CNM's scope of practice, the type of coverage, and the policy limits. Annual premium costs range from $900 to over $7,500 depending on the location of the practitioner, length of practice, the CNM's scope of practice, and the policy limits.

**Patient Compensation Fund**

Professional liability insurance in Wisconsin is a two-tiered structure whereby commercial insurance is obtained for coverage up to a mandated limit. Coverage beyond the mandated limits is provided through a statewide fund entitled the Patient Compensation Fund. Beginning in 1997,
the mandated coverage limits were $1,000,000 per occurrence and $3,000,000 aggregate. The extended coverage through the Patient Compensation Fund would cost approximately $7,500.

**Recruitment and Retention**

There are a number of federal and state loan repayment and scholarship programs that can assist primary care clinics, in rural and urban shortage areas, in the recruitment and retention of Certified Nurse Midwives. There are also federal and state reimbursement incentives to retain CNMs who provide primary care in designated rural and urban shortage areas.

**Loan Repayment and Scholarship Programs**

The National Health Service Corps (NHSC), a federal program, offers loan repayment or scholarship assistance to Certified Nurse Midwives who agree to provide primary care for at least two years in a rural or urban federally designated Health Professional Shortage Area (HPSA). A NHSC scholarship can cover full tuition, or NHSC loan repayment can provide up to $50,000 for a two-year obligation. The Wisconsin Division of Public Health – Primary Care Section helps clinics and Certified Nurse Midwives by providing information and applications for these programs.

The Wisconsin Health Professions Loan Assistance program can provide up to $25,000 for a three-year obligation for Certified Nurse Midwives who agree to provide primary care in federally designated rural and urban HPSAs in Wisconsin. The Wisconsin Office of Rural Health helps clinics and Certified Nurse Midwives by providing information and applications for this program.

**Recruitment Strategies**

Educational institutions and professional associations provide several means of assisting potential employers of CNMs in finding the right candidate for their organization.

- **Clinical Preceptorship**
  A large percentage of annual CNM graduates are hired by one of their clinical preceptor sites. By mentoring students as preceptors, CNMs and physicians can assess the applicants whose level of health care experience, clinical capabilities, and personality best fit their practice environment.

- **Bulletin Boards**
  Most CNM programs keep a bulletin board of job announcements or notify CNMs of open positions for both new graduates and practicing Certified Nurse Midwives. In addition, the ACNM maintains a list of job openings on their web site (www.midwife.org).

- **Newsletters** such as the ACNM publication, *Quickening*

- **Employment Exchange Program**
  The Wisconsin Office of Rural Health provides this practice opportunity listing service free of charge to both the health professional and the employer/community. Positions listed are available via a monthly bulletin provided to all inquiring health professionals on request. The monthly bulletin includes the basic elements of a position vacancy and
potential practitioners can contact the prospective employer directly for further information.

Retention Assistance

The WisTREC project, Wisconsin AHEC System and academic training programs are partnering on a variety of programs to help rural and urban underserved areas recruit and retain primary care providers. These programs include: recruiting more students from rural and underserved populations, developing more student experiences in rural and urban shortage areas, and developing more distance education to help students live and work closer to home. It is believed that CNM students who are able to work and/or reside in rural and underserved areas while enrolled in the educational program are much more likely to remain in these communities after completion of the nurse-midwifery educational program. These students are likely candidates for employer recruitment efforts in rural and urban health professional shortage areas.

The Wisconsin Medicaid Program offers a primary care Health Professional Shortage Area (HPSA) bonus payment to encourage primary care providers, including CNMs, to practice in HPSAs or to provide services to Medicaid recipients who live in designated shortage areas. Wisconsin Medicaid provides a 20 percent HPSA bonus payment for certified providers who render selected primary care services for covered Medicaid recipients. Also, providers of obstetrical services may be eligible for an additional 25 percent obstetric HPSA bonus payment for covered recipients.

The federal Rural Health Clinic Services Act authorizes favorable Medicare and Medicaid cost-based reimbursement to certified rural health clinics (RHCs) for services provided by Certified Nurse Midwives and other non-physician providers. As a condition of participation in the RHC program, certified clinics are required to employ a nurse practitioner, or other qualified nonphysician provider, to serve patients at least 50 percent of the time the clinic is open. Once certified, the RHC is required to retain the nurse practitioner or lose the favorable cost-based reimbursement for Medicare- and Medicaid-covered patients.
Facts About Certified Nurse Midwives

General Description

ACNM membership department figures, 1999


Education and Certification

American College of Nurse-Midwives  
Web site – http://www.midwife.org

Marquette University College of Nursing  
Dr. Leona VandeVusse, Program Director  
(414) 288-3842 for information  
Web site – http://www.mu.edu.dept.nursing

Wisconsin Program for Training Regionally Employed Care Providers (WisTREC), UW Madison School of Nursing, CSC K6/254, 600 Highland Avenue, Madison, WI  53792-2455; phone (608) 263-5170; fax (608) 263-5170.  
Web site - http://academic.son.wisc.edu/wistrec/

Characteristics of Practitioners


Scope of Practice

American College of Nurse-Midwives  
Web site - http://www.midwife.org

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison, WI  53708; phone (608) 266-2811; fax (608) 261-7083.  
Wisconsin Administrative Code, Chapters N 6-8.  
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Web site - http://www.wisconsinnurses.com/

Spectrum of Practice Settings

American College of Nurse-Midwives  
Web site - http://www.midwife.org

Prescriptive Authority

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison WI  53708; phone (608) 266-2811; fax (608) 261-7083.

Wisconsin Administrative Code, Chapter N 8.

Web site - http://badger.state.wi.us/agencies/drl/Regulation

Reimbursement And Financial Analysis

Compensation Arrangements

American College of Nurse-Midwives

Web site - http://www.midwife.org


Web site - http://www.mgma.org


Contribution to Practice Revenue


**Third-Party Coverage and Payment**


WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.

WPS-Medicare Part B, 1717 West Broadway, P.O. Box 1787, Madison, WI 53701; phone (608) 221-4711.


*EDS Provider Maintenance; phone (608) 221-9883.*

WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.

**Cost/Benefit Analysis**


Employment Information

Employment Contracts and Agreements


Credentialing

American College of Nurse-Midwives
Web site - http://www.midwife.org


Web site: http://www.jcaho.org


Patient Satisfaction

American College of Nurse-Midwives
Web site - http://www.midwife.org


**Liability Insurance**

American College of Nurse-Midwives
Web site - [http://www.midwife.org](http://www.midwife.org)


Wisconsin Department of Regulation and Licensing, Board of Nursing. (1999, April). APNP malpractice insurance coverage. *Regulatory Digest*. Madison, WI: Author. [P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811; fax (608) 261-7083].
Web site - [http://badger.state.wi.us/agencies/drl/Regulation](http://badger.state.wi.us/agencies/drl/Regulation)

**Recruitment and Retention**

American College of Nurse-Midwives
Web site - [http://www.midwife.org](http://www.midwife.org)


Wisconsin Division of Public Health, Primary Care Section. (1999, April). *Primary Care Recruitment and Retention Resources Available to Shortage Areas in Wisconsin*. Madison, WI: Author. [phone (608) 264-6528, See appendix].

*Primary Providers for Wisconsin: Employment Exchange*; phone (800) 488-9512.