HERC Coverage Guidance: Planned Out-of-Hospital Birth
Disposition of Public Comments

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Discussion Table

IDs/#s	Summary of Issue	Draft Subcommittee Response
A1	Absence of neonatal consultation or transfer criteria.	*EbGS removed the neonatal consultation and transfer criteria (from the prior draft) because they are more appropriate as clinical guidance regarding care that would occur after the birth itself than as coverage criteria.*
B2, D2	Request for clarification or modification for history of postpartum hemorrhage requiring intervention (specifically around the scope of intervention).	*Consider changing to:* *History of postpartum hemorrhage requiring intervention* ***(e.g., blood transfusion or other advanced treatment such as ≥ 2 pharmacologic therapies)****.*
B3	Request to change a transfer condition to a consultation: 1. History of preeclampsia requiring preterm birth in the event it was a higher risk condition in the prior pregnancy (e.g., twins) that is not present in the current pregnancy.	*EbGS discussed the issue of preeclampsia requiring preterm birth and concluded that the risk associated with this condition requires a planned hospital birth.*
C2, F1	Request to change a transfer condition to a consultation:	*Prior cesarean delivery is a transfer criterion due to evidence of worse neonatal outcomes. This recommendation is aligns with*

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	2. History of prior cesarean delivery.	*recommendations from ACNM (2015), ACOG (2017), NICE (2017), and the WA Billing Guide (2017). It is also consistent with decisions to exclude women with prior cesarean sections from low-risk groups in multiple studies.* *EbGS previously discussed expert testimony indicating TOLAC is safe for women with a prior vaginal birth with a lower threshold for transfer. However, the subcommittee did not recommend coverage because TOLAC is not available at many rural hospitals due to a lack of availability of emergency delivery services (e.g., in-house anesthesia and/or in-house maternity provider) as well as the potential acuity of the need for transfer and potential for harm.*
C3	Request for removal for gestational Age > or = to 42 weeks 0 days.	*Studies report an increased mortality rate at ≥ 41 weeks gestation. There is also alignment with multiple sources for restrictions at ≥ 42 weeks gestation.* *However, for women who go into labor just before 42w0 but are in active labor progressing from 41w6 to 42w0, it may be appropriate to permit coverage?* *EbGS decision: Change to ≥ 42 weeks 0 days (unless already in active labor at 41w6d)*
E1	Scope of coverage guideline for organizations without practice guidelines.	*This coverage guidance is intended to aid in development of insurance coverage policy; it is not intended to be a clinical practice guideline.*

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E1	Request to readopt the 2015 Guidance for Planned Out-of-Hospital Birth.	*We are aware of the 2015 guidance and have produced the current guidance in light of additional evidence, extensive deliberation and public testimony.*

Commenters

Identification	Stakeholder
A	T. Allen Merritt, MD, MHA, FAAP, Samaritan Health Services [*Submitted February 16, 2020*]
B	Silke Akerson, CPM, LDM, Oregon Midwifery Council [*Submitted February 24, 2020*]
C	Catherine Akerson Bailey, CPM, LDM [*Submitted March 2, 2020*]
D	Celeste Kersey, CPM, LDM, Oregon Midwifery Council [*Submitted March 3, 2020*]
E	Sharron Fuchs, DC [*Submitted March 3, 2020*]
F	Desirée Ford [*Submitted March 3, 2020*]

Public Comments

ID/#	Comment	Disposition
A1	In the revision forwarded, I do not see any Neonatal guidelines for consultation or transfer of newborns. These are essential.	*See discussion table.*
B1	Thank you so much for the work that you put into the current draft of the Planned Out-of-Hospital Birth Coverage Guidance. It is clear that you took seriously the concerns about overreach of the previous draft expressed in the public comment period and that you put much thought into aligning the guidance with the available evidence. We support the current draft coverage guidance and think that it reflects the best evidence available on low-risk, planned, midwife-attended, out-of-hospital birth.	*Thank you for your comment.*
B2	We have two remaining small concerns. First, the consult requirement for "history of postpartum hemorrhage requiring intervention" remains vague. While we agree that consultation is appropriate in a case where a person has a history of hemorrhage requiring transfusion or other advanced treatment, we are	*Changed to "History of postpartum hemorrhage requiring transfusion or*

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	concerned that, as currently worded, we may be required to consult for every person who had any intervention for hemorrhage even if it resolved with one minor intervention, such as Pitocin, and without complication.	*other advanced treatment (e.g. Bakri balloon)"*
B3	Second, in the very rare instance that a person had a history of preeclampsia requiring preterm birth in a previous twin pregnancy, we are concerned that the transfer requirement might exclude someone who may not actually be high risk in a current, singleton pregnancy.	*See discussion table.*
B4	We are grateful for the care you have taken in creating this draft guidance. Thank you.	*Thank you for your comment.*
C1	Wow! Thank you so much for listening to the feedback I (and many others) sent in for the last round of public comment. You have made so many positive changes to this document and I am really grateful! You have condensed this list in a way that seems much more in line with its intent. Thank you.	*Thank you for your comment.*
C2	There are a few remaining items that I am concerned about. They include: Medical History or OB History: 1. Cesarean Section - Move to consult requirement. Clients should be able to choose their place of birth whether or not they've had a previous cesarean birth, even though it is more high risk, as long as they have been given adequate informed consent and have had a consult with a hospital provider. Please consider changing this requirement.	*See discussion table.*
C3	Conditions of Current Pregnancy: 2. Gestational Age > or = to 42 weeks 0 days - Remove. So many clients, when given the opportunity to not be induced, ride this line of 42 weeks. Perhaps it could change to 42 weeks 3 days, or, include 'without family history of post-dates delivery' or allow primips to go a few days past 42 weeks, since it's so much more common for them to go late. I have many clients with family history of going post-dates and also many primips, with or without family history, go post-dates themselves with no issue. Of course I understand that the risk of stillbirth increases after 42 weeks, but I do believe that it should be an option for clients to decline induction with informed consent.	*See discussion table.*
C4	Thank you for taking the time to consider my feedback.	*Thank you for your comment.*

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D1	I'm so grateful for the work that you put into the current draft of the Planned Out-of-Hospital Birth Coverage Guidance and your openness to considering many of the concerns raised at the December meeting. Thank you for looking closely at what evidence is available and applicable to our rules. We at the Oregon Midwifery Council and myself, as an independent midwife, support the current draft coverage guidance and believe that it does reflect the best evidence available and pertinent to out-of-hospital birth.	*Thank you for your comment.*
D2	While most all the draft is appropriate I want to suggest that the consult requirement for "history of postpartum hemorrhage requiring intervention" be given more clarity. I can see the wisdom in having a consultation for a case where a person has a history of hemorrhage requiring transfusion or other advanced treatment, I am worried that this could mean that we are required to consult when a client has had any intervention for hemorrhage even if it easily resolved.	*See discussion table.*
D3	Again, thank you for the care you have taken in creating this draft guidance and for considering my comments.	*Thank for your comment.*
E1	The draft Coverage Guidance for Planned Out-of-Hospital Birth is wholly inadequate as Guidance or Guidelines for professions that have no written scope of practice or standards of care, including the Chiropractic profession. I ask you to readopt the 2015 Guidance for Planned Out-of-Hospital Birth.	*See discussion table.*
F1	When I was 21 I experienced the birth of my first son. I decided to go with a certified nurse midwife in hospital after researching different birth options and what I thought would be best for my baby. I wanted to have a natural birth with the least amount of interventions as possible. On the day of my estimated due date I was told I needed to have my labor induced, but not really given a reason why. This induction created a snow ball effect of expensive interventions that lead to an unnecessary C-section and the reason why I have had two VBACS since. At the hospital I was induced with cervical gel, my labour was not progressing as fast as the nurse midwife liked so they administered pitocin. My labor came on very fast and was extremely painful after this was administered. I have labored twice since then, and the contractions brought on by pitocin were far more painful in comparison. I was then given pain medication which didn't do much for the pain and made me feel like I was on drugs. At this point I was told an epidural would be helpful, so through the guidance of my midwife, I was told that it was needed. I got the epidural and my labour slowed. I was exhausted, frustrated, confused, overwhelmed and wanting to do what was best for my baby. I was told due to failure to progress	*Thank you for your comment.* *EbGS does not weigh in on individual cases, rather, creates recommendations to HERC for coverage policy.* *The provided citation, Hochler et al. (2019) is a poster abstract investigating in-hospital outcomes for women with 1 one prior cesarean delivery and grandmultiparity (≥ 6 deliveries) undergoing induction or augmentation for trial of labor after*

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	at eight centimeters I needed a C-section. Before I knew it I was being prepped for surgery and getting ready to do the thing I wanted to avoid. There was no safety risk, I was just taking to long according to the hospital. Before I had the surgery I was laboring for 20 hours. This is not uncommon and is in fact quite an average amount of time for first time births. Fast forward 6 years. I found out I was pregnant again. I started researching my options for my up coming birth. I heard about a VBAC and saw there was a lot of success. I weighed the pro's and con's and felt the pro's far out weighed the cons. I decided this was the direction I was going to go. I had two options I wanted to look into. Hospital VBAC or out of hospital VBAC. First I toured a couple hospitals and asked if they allow VBACs. Some nurses would say they do, but most would say they are required to do a C-section. This was super discouraging, but I just moved a long my search and looked into the birth center. At the birth centers I loved the set up as well as the community that was supportive of natural birth. Unfortunately, my insurance didn't cover the birth center, so my search continued. This is when I met the midwife that would be there for my first vaginal delivery, and completely change my life. The appointments were wonderful, she had so much information about VBACs, nursing, postpartum depression and how to have a successful natural birth. Her support was so amazing during the pregnancy. I felt so empowered and confident about my choices. Quickly the due date came and we were ready to go. I started having the contractions on my own and they were not as bad as the ones brought on by the pitocin. They progressed and got heavier. They were very intense, but it was okay. When my midwife arrived she checked my cervix and I was at nine centimeters. Nine centimeters! In the hospital they claimed I was failure to progress at eight. At this point I knew I could do it. Emotionally, I was elated. Two hours later I delivered a 10lb 21inch healthy baby. I felt so proud of myself and I can say to this day that it was the most empowering experience in my life. I was able to have a successful nursing relationship, produce plenty of milk and bond with my baby in a way I did not experience previously. I had excellent aftercare, physically healed quicker and did not experience postpartum depression symptoms. Over all I felt like I had a fantastically comprehensive foundation for taking care of my new born.	*cesarean, compared to women with 2-5 prior deliveries (including 1 prior cesarean) undergoing TOLAC induction or in spontaneous labor. This study would not meet inclusion criteria for our evidence review (i.e., abstract, in-hospital setting).* *See discussion table.*

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	What I would like for you to consider after reading this letter is just how much of a positive impact this birth experience had on my family and myself. Not only was I able to birth my child with no interventions what so ever, I also know that having two vaginal births has reduced the danger of my risk status. Even DMAP has seen this in their studies and is quoted in saying ”DMAP also argues that petitioner's case is not justiciable because certain relevant circumstances may change in the future. For one, DMAP argues that, due to petitioner's successful VBAC at the birth center, she may no longer be considered “high risk” for a future VBAC and therefore would not necessarily be denied prior authorization for an out-of-hospital birth”. If this is DMAPS opinion on this case, then why not for mine? Vaginal birth is so much more affordable, it just does not make economic sense to cover a much more expensive procedure that is unnecessary .The issue I am facing with a hospital birth is many have protocol in place that require me to have a C-section just because I have had a C-section in the past. The data attached will show that I no longer qualify as “high risk” I had a successful VBAC back twice and it was covered by Oregon Health Plan before. I feel like it should continue to be covered now and in the future as well. Thank you for taking the time to consider my letter.	

References Provided by Commenters

ID	References
F1	Blevins v. Division of Medical Assistance Programs, Court of Appeals of Oregon (decided 2018). https://caselaw.findlaw.com/or-court-of-appeals/1895602.html Hochler, H., et al. (2019). Uterine rupture risk in a trial of labor after cesarean section with previous vaginal birth. *American Journal of Obstetrics & Gynecology, 220*(1), S508-S509. https://www.ajog.org/article/S0002-9378(18)31822-2/fulltext Margulis, J. (2016, February 27). "Denied: Vaginal birth after Cesarean." *Jefferson Public Radio.* https://www.ijpr.org/post/denied-vaginal-birth-after-cesarean#stream/0