

April 6, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Re: Request for Information Regarding Maternal and Infant Health in Rural Communities
Submitted electronically to ruralmaternalrfi@cms.hhs.gov

Dear Administrator Verma:

The American Nurses Association (ANA) is pleased to submit comments in response to the Request for Information Regarding Maternal and Infant Health in Rural Communities (RFI). We thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on opportunities to improve access, quality, and outcomes for women and their families in rural communities before, during, and after pregnancy.

At this moment when the nation is focused on the COVID-19 pandemic, we are all reminded that Medicaid plays a critical role in meeting the needs of our citizens when they are vulnerable. Time and again, states and communities rely on Medicaid's federal-state partnership to address the most challenging of health and health care issues facing low-income populations. The maternal health crisis is one such challenge, and the crisis has some of its deepest and most devastating impacts on Medicaid populations. Therefore, CMS has a critical role to play to address the crisis and deliver better outcomes for Medicaid enrollees.

Maternal morbidity and mortality rates are high in the U.S. overall, and the U.S. is the only developed country in the world with increases in maternal mortality (defined as death during pregnancy or within one year of the end of pregnancy, from a pregnancy-related cause).¹ To address the crisis, it is necessary to examine factors beneath the aggregate statistics, especially

¹ Centers for Disease Control and Prevention (CDC). Pregnancy Mortality Surveillance System. Trends in Pregnancy-Related Deaths. Accessed online at <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>;

Hispanic women. Similar disparities are found within Medicaid, the program that pays for 43 percent of the births in the country, and an even higher proportion in rural areas.² Medicaid beneficiaries are at 82 percent greater risk of severe maternal morbidity and mortality than privately insured people, with people of color and rural residents facing the highest risks.³

Against this backdrop, we respond in the comments below to each of the questions posed in the RFI:

1. What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?
2. What opportunities are there to improve the above areas (i.e., access, quality and outcomes)?
3. What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?
4. How can CMS/HHS support these efforts?

ANA urges CMS to:

- *Strengthen roles for nurses in Medicaid initiatives to improve maternal and infant health in rural areas.*
- *Build on innovative programs including nurse-led delivery models that coordinate care*
- *Incentivize states to expand practice authority for nurse practitioners (NPs) and Certified Nurse Midwives (CNMs).*
- *Conduct robust evaluation of demonstrations to determine the impact of workforce components and form strategies to diversify the maternity care workforce in rural areas.*

1. What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?

Women with low incomes, including many women with Medicaid, face unique challenges when it comes to their health and access to care in their reproductive years. These challenges must be addressed comprehensively to improve maternal health. Medicaid is an important source of coverage for women with low incomes, paying for more than 40 percent of births in the U.S. However, states vary considerably in their Medicaid coverage for adults, including prenatal,

² Centers for Medicare and Medicaid Services (CMS). Issue Brief: Improving Access to Maternal Health Care in Rural Communities. 2019. Accessible online at <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>

³ Kozhimannil, KB. Risk of Severe Maternal Morbidity and Mortality among Medicaid Beneficiaries. Presentation at the Medicaid and CHIP Payment and Access Commission (MACPAC). January 24, 2020. Accessed online at <https://www.macpac.gov/publication/maternal-morbidity-among-women-in-medicaid/>; Peiyin et al. Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14. Health Affairs (September 2017). Kozhimannil KB, et al. Rural-Urban Differences in Severe Maternal Morbidity And Mortality In the US, 2007–15. Health Affairs (December 2019).

pregnant and postpartum women. Postpartum women may lose access to coverage after 60 days from giving birth, even though their maternal health risks continue through 12 months postpartum.⁴ Gaps in maternal and reproductive health care, as well as primary care, may undermine the goal of providing appropriate care throughout the reproductive lifespan. In rural areas, maternal health risks are exacerbated, and the role of Medicaid is even more significant as Medicaid pays for 50-60 percent of births in rural areas. Health care delivery in rural areas is strained by closures of rural hospitals and physician shortages, including loss of labor and delivery capacity and absence of OB/GYNs.⁵ Women with low incomes often face social realities affecting their health, such as racism and sexism, and challenges with work flexibility, transportation, food, and housing. The prevalence of behavioral and psychological health conditions, particularly the opioid crisis, is also a significant factor affecting maternal health in rural areas.

2. What opportunities are there to improve the above areas (i.e., access, quality and outcomes)?

In light of the barriers identified above, there is a significant opportunity to address maternal and infant health in rural areas by engaging nurses to expand provider capacity. Certified Nurse Midwives (CNMs) are a high-quality, high-value source of pregnancy care.⁶ The midwifery model of care was successfully tested in Medicaid's Strong Start demonstration.⁷ Nurse Practitioners (NPs) may also be trained in women's health, providing primary care, preconception care, and interconception care, all of which contribute to healthy women, healthy mothers, and healthy babies.⁸ Additionally, Registered Nurses (RNs) can serve on care teams, providing care coordination, ensuring pregnant and postpartum women are connected to behavioral health and social services as needed to optimize maternal and infant outcomes. Promising nurse models are discussed more below.

In order to effectively address racial and geographic disparities in maternal outcomes, there is a specific opportunity to improve the cultural appropriateness of women's health care. In recent Congressional testimony, a leading maternal health expert pointed to historic exclusion of Black

⁴ American College of Obstetricians and Gynecologists. Medicaid and Medicare. Accessible at <https://www.acog.org/advocacy/policy-priorities/medicaid-and-medicare>; Gordon, Sarah et al. Effects Of Medicaid Expansion On Postpartum Coverage and Outpatient Utilization. Health Affairs (December 2019).

⁵ CMS. Improving Access to Maternal Health Care in Rural Communities. 2019.

⁶ See Vedam S, Stoll K, MacDorman M, et al. Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes. PLoS One 2018;13(2):e0192523.

⁷ See CMS Center for Medicare and Medicaid Innovation. Strong Start Evaluations. Accessible online at <https://innovation.cms.gov/initiatives/strong-start/>

⁸ Nurse Practitioners in Womens Health. Nurse Practitioner & Women's Health Nurse Practitioner Practice Facts. Accessible online at <https://www.npwh.org/pages/about/NPfacts>

midwives from maternity care systems, and noted the resulting lack of culturally congruent care.⁹ One strategy would be to increase the number and availability of women of color in women's health professions through grants, scholarships, and loan forgiveness programs, and likewise expand the number of health professionals in rural communities who are from those communities. Another approach would be to develop models of care specifically designed to meet the needs of diverse communities of women.

3. What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?

Nursing care is a central component in key programs and strategies to promote maternal and infant outcomes. Example are evidence-based home-visiting programs, such as Nurse Family Partnership (NFP) which deploys RNs to visit first-time mothers in their homes for prenatal and postnatal care. NFP in particular has been found to have positive impacts on families, as well as positive cost outcomes.¹⁰ Home-visiting models have demonstrated positive health outcomes such as “few preterm and low-birthweight babies, more children adequately immunized and completing well-child visits, greater achievement of developmental milestones, fewer child emergency department visits, and better maternal physical and mental health.”¹¹

Other innovative nurse-led maternity care models have been profiled by the American Academy of Nursing (AAN)'s Edge Runner program. Through Edge Runner, AAN recognizes a wide range of nurse-designed models of care and interventions designed to manage costs, improve health care quality and enhance consumer satisfaction.¹² These models provide templates to strengthen and incentivize care coordination and recognize the important role that RNs play in primary care and care coordination.

Edge Runner models of delivery of maternal and infant health are summarized in the Appendix to this letter. For instance, the Family Health and Birth Center (FHBC) in the Developing Families Center of Washington DC is an Edge Runner model. The FHBC is a midwifery/nurse practitioner model with an added focus on social supports and extended care through the children's second year of life. Reported outcomes after six years included reduced preterm births and cesarean section rates, decreased costs, and high breastfeeding rates.

⁹ Crear-Perry, Joia. Testimony. U.S. House of Representatives, Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions and Subcommittee on Workforce. January 28, 2020. Accessible online at <https://edlabor.house.gov/hearings/expecting-more-addressing-americas-maternal-and-infant-health-crisis>

¹⁰ See Miller, Ted. Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996-2013. Prevention Science. August 2016; Social Programs That Work: Evidence Summary for the Nurse Family Partnership. Updated January 2020. Accessible online at <https://evidencebasedprograms.org/document/nurse-family-partnership-nfp-evidence-summary/>

¹¹ Sandstrom, H. Early Childhood Visiting Programs and Health. Health Affairs Health Policy Brief, April 2019.

¹²American Academy of Nursing. Edge Runners: Transforming America's Health System Through Nursing Solutions. <https://www.aannet.org/initiatives/edge-runners>

4. How can CMS/Health and Human Services (HHS) support these efforts?

Two out of three adult women enrolled in Medicaid are in their reproductive years (ages 19 to 49).¹³ As the federal driver of Medicaid policy, CMS and other HHS agencies have an enormous role and responsibility to uplift proven strategies and support innovation to significantly improve maternal and infant outcomes. ANA specifically recommends approaches that strengthen and uplift the contributions of nurses and the nursing profession.

- CMS should use its waiver and plan amendment authorities to expand and scale innovative maternity and reproductive health care models in Medicaid, including home visiting, birth centers, and telehealth delivery for primary care, family planning, prenatal care, and behavioral health care. CMS' Center for Medicare and Medicaid Innovation should develop payment models that account for and reward the value of RNs, NPs, and CNMs providing maternity care in rural and underserved areas. These efforts should draw upon promising and proven Edge Runner programs and incentivize care coordination that meets the needs of diverse communities in rural areas. An Appendix to this letter summarizes a selection of Edge Runner programs.
- When evaluating innovative pilots in maternity and infant care delivery, CMS should rigorously evaluate and analyze workforce components and report detailed data on participating provider types, to inform further model design and development. Similarly, CMS should hold states and Medicaid plans accountable for measuring and reporting meaningful data, such as maternity care workforce capacity, care provided by NPs, CNMs, and doulas, and impacts of improvement programs on racial and geographic disparities.
- In using its waiver and demonstration authorities to improve maternal and infant health, CMS should incentivize states to allow NPs and CNMs to practice at the full extent of their education and training. Precedent for federal leadership in this area is found in CMS' Healthy Adult Opportunity (HAO) initiative. HAO explicitly calls for state applicants to address "laws that inhibit choice and competition in their health care system – such as certificate of need laws and laws limiting providers' scope of practice or imposing unnecessarily restrictive supervisory requirements – which undermine efforts to generate greater efficiencies in the delivery of quality care."¹⁴

CMS should support legislation to expand access to postpartum care for 12 months after birth, and ensure states pay adequately for postpartum care, including care provided by NPs and CNMs.

¹³ Kaiser Family Foundation. Fact Sheet. Medicaid's Role for Women. March 2019. Accessible online at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>

¹⁴ CMS. State Medicaid Director Letter No. 20-001. January 30, 2020.

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ANA is the premier organization representing the interests of the nation's 4 million RNs, through its state and constituent member associations, organizational affiliates, and individual members. ANA members also include the four advanced practice registered nurse roles (APRNs): Nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).¹⁵ ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

If you have questions, please contact Brooke Trainum, JD, Assistant Director of Policy and Regulatory Advocacy, at (301) 628-5027 or brooke.trainum@ana.org.

Sincerely,

A handwritten signature in black ink that reads "Ingrida Lusia". The signature is written in a cursive style with a large initial "I" and a long, sweeping underline.

Ingrida Lusia
Vice President, Policy and Government Affairs

cc: Debbie Hatmaker, PhD, RN, FAAN
Acting Chief Executive Officer

¹⁵ The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Appendix*
Edge Runner Profiles of Nurse-Led Maternal/Infant Care Models

The Edge Runner initiative of the American Academy of Nursing “recognizes nurse-designed models of care and interventions that impact cost, improve healthcare quality and enhance consumer satisfaction. Through its Edge Runner program, the Academy is mobilizing its fellows, health leaders and partner organizations to recognize nurses who are leading the way with new ideas to transform the health system.” <https://www.aannet.org/initiatives/edge-runners>

*Summary prepared by the American Nurses Association, based on Edge Runner profiles available online at <https://www.aannet.org/initiatives/edge-runners/initiativesedge-runnersprofiles-by-focus>

<p>10 Steps to Promote and Protect Human Milk and Breastfeeding in Vulnerable Infants</p>	<p>In 2000, prior to the implementation of Dr. Spatz’s* program, the percentage of NICU infants at Children’s Hospital of Philadelphia (CHOP) receiving human milk at discharge was approximately 30%. Since implementation in 2008, over 99% of mothers who deliver in the hospital’s Special Delivery Unit initiate pumping for their critically ill infants. In 2014, of infants born at CHOP and discharged from the NICU, over 86% were discharged on human milk. *(Diane L. Spatz, PhD, RN-BC, FAAN; University of Pennsylvania School of Nursing)</p>
<p>11th Street Family Health Services, Drexel University</p>	<p>Provides comprehensive, trans-disciplinary care to residents of public housing communities and other vulnerable populations including 26,676 clinical service visits and 1,676 home visits to pregnant or new mothers and 6,827 patient encounters in health education and wellness programs.</p> <ul style="list-style-type: none"> • Reduced pre-term births to 2.5% in African American women seen at 11th Street compared to 15.6% in Philadelphia (2011). • Improved Quality of Life for patients participating in the fitness program, as measured by the SF 36, with a significant increase in perceived health status at 3, 6 and 12 month follow ups (2011). • Decreased unnecessary medical specialty workups for children whose issues are family/behaviorally based, such as enuresis, through the integration of a pediatric behavioral health consultant in primary care. • Increased the use of self-care plans for patients with chronic illness to 100% and increased patients’ self-efficacy through the Living with Chronic Illness Program (2010-2011).

<p>Family Health and Birth Center in the Developing Families Center, Washington DC</p>	<p>The Family Health and Birth Center (FHBC) now integrated with the Developing Families Center provides a midwifery/nurse practitioner model for alternative, cost effective maternal/child care for low-income women. With the intent to replicate a birth center but with an expanded emphasis on social supports and early childhood education and redefining “perinatal” to include the time from preconception through the children’s 2nd year of life. The founder, a midwifery/nurse practitioner, established the FHBC in a low-income community in Washington, DC in 1994. The vision of the birth center was broadened in 2000 to include comprehensive social supports, case management, and early childhood education.</p> <ul style="list-style-type: none"> • After six years of operation, there was a substantial lowering of African American preterm birth (5 percent at the center, vs. 15.6 percent of African Americans in DC), low birth weight (3 percent at the center, compared with 14.5 of African Americans in DC) and cesarean section rates (10 percent vs. 31.5 percent of African Americans in DC). • The center’s successes in 2006 alone reduced costs for the District of Columbia’s health care system by more than \$1.6 million – more than the total of the center’s annual operating budget. • Breast feeding rates were also high at 88.4% at discharge and 56.8% at 6 weeks. • Of 4 million U.S. births annually, 1.75 million are Medicaid-supported. <i>Application of the FHBC model to all Medicaid births could yield a savings of almost \$2 billion.</i>
<p>Creating Opportunities for Parent Empowerment (COPE)</p>	<p>Provides education and skills building activities to parents of preterm infants, in an effort to reduce hospital stays, enhance parent-infant interaction, and reduce parental depression and anxiety.</p> <ul style="list-style-type: none"> • Infants in the COPE program had a 3.8-day shorter hospital length of stay (mean of 35.2 days) than infants in the attention control group (mean of 39.2 days); an 8 day shorter length of stay for infants less than 32 weeks gestation. • Overall, the program achieved cost savings of at least \$4,864 per infant. For infants weighing less than 1,500 grams, net cost savings were \$9,864 per infant. Translated to a national level, this means that delivering the COPE program in NICUs across the United States could save the health care system a minimum of more than \$2 billion per year in addition to improving parent and child outcomes. • Insurers and neonatal intensive care units across the U.S. and globe are adopting and implementing COPE and achieving even shorter hospital stays for their premature infants than was demonstrated in the original full-scale clinical trial.

Nurse Family Partnership	<p>Evidence-based nurse home visitation program for first-time parents and their children. Nurse home visitors and their clients make a 2 ½ year commitment to the program, with 14 visits planned during pregnancy, 28 during infancy and 22 during the toddler stage. Nurse home visitor caseloads do not exceed 25 families.</p> <ul style="list-style-type: none">• 79% reduction in preterm delivery for women who smoke; 35% fewer hypertensive disorders of pregnancy; and a decrease in smoking.• 39% fewer injuries among children, including a 56% reduction in emergency visits for accidents and poisonings from birth to age 2, and a 32% reduction in emergency visits in the second year of life.• For the higher-risk families now served by the program, a 2005 RAND Corporation analysis found a net benefit to society of \$34,148 (in 2003 dollars) per family served, with the bulk of the savings accruing to government, which equates to a \$5.70 return per dollar invested in NFP.
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