March 24, 2020

The Honorable Chuck Grassley
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Information: Solutions to Improve Maternal Health

Dear Chairman Grassley and Ranking Member Wyden:

The American Nurses Association (ANA) is pleased to submit comments in response to the Committee's request for information on improving maternal health. 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, the Committee has a critical role to play to improve maternal health 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 race, income and geography. The fact is that maternal mortality rates are 3-4 times higher for Black women and 2-3 times higher for Native American women, compared to white non-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]

[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;

[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

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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. However, states vary considerably in their Medicaid coverage for adults, including prenatal, pregnant and postpartum women. In some states, postpartum women 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 those 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, especially in rural areas.

Against this backdrop, we respond in the comments below to the following topics raised by the Committee:

1. Use of non-physician clinicians and continuity, coordination of care
2. Coverage and standards of care to improve maternal health.
3. Addressing disparities and disparate outcomes.
4. Data collection and effective evaluation to improve outcomes and quality.

ANA urges the Committee to:

- *Support strong roles for nurses in Medicaid initiatives to improve maternal health, especially in underserved areas.*
- *Build on innovative Medicaid 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 evaluations of Medicaid demonstrations to determine the impact of workforce components.*

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).

[4]See 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.

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Use of non-physician clinicians and continuity, coordination of care

In light of the access barriers identified above, there is a significant opportunity to address maternal health, particularly in underserved 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.

Unfortunately, many states have laws and regulations that restrict the scope of CNM and NP practice. For instance, only about half of states allow CNMs to practice independently to full extent of their training, without supervision or burdensome collaborative agreements with physicians.[9] Such restrictions can create barriers to maternity care access.[10] We urge the Committee to consider innovative federal strategies through legislation or administrative oversight to reduce these barriers. Precedent for federal action in this area is found in CMS' Healthy Adult Opportunity (HAO) initiative, which 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."[11] In crafting new Medicaid policy to address maternal health, Congress should consider similar approaches to incentivize states to remove practice barriers that reduce access to maternity care.

Coverage and standards of care to improve maternal health

As noted above, variations in state coverage rules mean that some women may lose access to Medicaid coverage 60 days after giving birth, even though health risks continue beyond that time.[12] Congress should expand Medicaid access to care for 12 months after birth in all states, and ensure states pay adequately for postpartum care, including care provided by NPs and CNMs. ANA supports the IMPACT to Save Moms Act (H.R. 6137) in the House of Representatives, as a step toward this critical reform.

Congress should additionally strengthen Medicaid waiver and plan amendment authorities specifically to improve maternal health care delivery. For instance, CMS should have resources and authority to expand and scale innovative maternity and reproductive health care models in Medicaid. Such models

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[6] See Vedam Saraswati et al. Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes. PLoS One. February 2018.

[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

[9] Midwifeschooling.com. States that Allow CNMs to Practice and Prescribe Independently vs those that Require a Collaborative Agreement. Accessible online at https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states/

[10] Vedam, Saraswati et al. Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes. February 2018.

[11] CMS. State Medicaid Director Letter No. 20-001. January 30, 2020.

[12] CMS. Improving Access to Maternal Health Care in Rural Communities. 2019.

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include home visiting, birth centers, and telehealth delivery for primary care, family planning, prenatal care, and behavioral health care.

In addition, CMS' Center for Medicare and Medicaid Innovation should be directed to develop payment models that account for and reward the value of RNs, NPs, and CNMs providing maternity care, especially in rural and underserved areas. These efforts could draw upon promising and proven nurse-led programs and incentivize culturally appropriate care coordination that meets the needs of diverse communities. Edge Runner programs profiled by the American Academy of Nursing (AAN) are promising models. 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.[13] These models provide templates to strengthen and incentivize quality transitions of care and recognize the important role that RNs play in primary care and care coordination. An Appendix to this letter summarizes a selection of Edge Runner programs for maternal and infant care.

Addressing disparities and disparate outcomes

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 midwives from maternity care systems, and noted the resulting lack of culturally congruent care.[14] The Committee should consider ways to increase the number and availability of women of color in the pool of Medicaid providers. One approach would be to develop models of care for Medicaid specifically designed to meet the needs of diverse communities of women. State Medicaid programs should be supported in designing and implementing models unique to their enrollee and workforce needs.

Data collection and effective evaluation to improve outcomes and quality

As the health care system transforms, it is critical to have data and evaluation findings documenting the impact of workforce policy on women's health and maternity care. Congress should invest in appropriate Medicaid research, and ensure that CMS rigorously evaluates workforce components of maternal health delivery models and programs. CMS should be required and resourced to report detailed data analysis on participating provider types, including demographic information, to inform further model design and development. Similarly, states and Medicaid plans should be held 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.

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

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

[14] 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

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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 Ingrid Lusis, Vice President, Government Affairs and Advocacy, at 301-628- 5081 or Ingrid.lusis@ana.org.

Sincerely,

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer/EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, ANA 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.

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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

10 Steps to Promote and Protect Human Milk and Breastfeeding in Vulnerable Infants	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)
11th Street Family Health Services, Drexel University	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. • 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).
Family Health and Birth Center in the Developing Families Center, Washington DC	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

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	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. • 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. *Application of the FHBC model to all Medicaid births could yield a savings of almost $2 billion.*
Creating Opportunities for Parent Empowerment (COPE)	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. • 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	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

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	toddler stage. Nurse home visitor caseloads do not exceed 25 families. • 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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