June 10, 2024

Centers for Medicare & Medicaid Services,
United States Department of Health and Human Services
Attention: CMS-1808-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1808-P: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Brooks-LaSure,

On behalf of the undersigned groups representing nurse practitioners (NPs), we appreciate the opportunity to provide comments on this proposed rule. Our organizations are committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities. We appreciate CMS recognizing the important value of NPs in inpatient hospitals and long-term care hospitals in this proposed rule, and the continued focus of the Administration on addressing health inequity. We look forward to continuing to work with the agency on ensuring these policies continue to support health equity and improve quality of care for patients. Below are our specific comments on provisions of this proposed rule.

Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements Beginning With the FY 2028 LTCH QRP

We support the addition of the four new items (living situation, utilities, and two food items) as standardized patient assessment data elements. NPs are particularly skilled in whole-person, patient centered care which includes assessment of health-related social needs or social drivers of health (SDOH) in taking patient histories, assessing patient risk, and informing medical decision making, diagnosis, care and treatment. As such they recognize the importance of collecting these data elements and will be essential to ensure that the data is collected and utilized in a way that addresses these issues and assists patients in care transitions. It is critical that CMS continue to evaluate policies regarding care transitions to ensure that patients can be prepared to enter stable environments where their SDOH needs are met as they transition out of the hospital setting and back into the community.

Request for Information (RFI) on Obstetrical Services Standards for Hospitals, CAHs, and REHs

We appreciate CMS addressing the "ongoing concerns about the delivery of maternity care in Medicare and Medicaid certified hospitals, CAHs, and REHs"[1] and including this RFI within this proposed rule. We share those concerns and look forward to working with the agency on developing conditions of participation (COPs) that improve the standards of quality and access to maternity care across the country. In the RFI, we appreciate CMS recognizing nurse practitioners as clinicians qualified to provide supervision and oversight of an obstetrical unit. As CMS continues to develop these COPs, we stress the importance of ensuring that nurse practitioners are recognized throughout the COPs for their integral role in improving maternal health outcomes.

[1] 89 FR 35940.

Maternal mortality rates have steadily increased in the U.S. over the past three decades[2], with a parallel rise in maternal morbidity.[3] Pregnant and postpartum people of color are three times more likely to experience a pregnancy related death, and two to three times more likely to experience a life-threatening condition or life-saving procedure during childbirth as compared to white women,[10,4] and account for a greater proportion of deaths occurring from 43 days to one-year postpartum.[5] Those living in rural areas have a greater probability of experiencing severe maternal morbidity or mortality than urban residents.[6] Deaths related to pregnancy occur across the continuum, from pregnancy through one-year postpartum, with approximately 34% of deaths occurring on day of delivery through the first week following delivery and 42% of deaths occurring from one week to one year postpartum.[7] While the fraction of maternal deaths occurring in medical facilities is declining, the relative frequency of deaths in other settings is on the rise.[8]

Understanding Maternal Mortality

Leading causes of death vary by race/ethnicity, with cardiovascular disease and cardiomyopathy emerging as key drivers of mortality among black mothers, and mental health conditions as a leading contributor to deaths among white women.[15] Cardiovascular conditions collectively are the leading cause of maternal mortality, accounting for over one third of pregnancy related deaths, followed by infection and obstetric hemorrhage. Deaths due to obstetric emergencies, such as amniotic fluid embolism generally occur on day of delivery through the first week postpartum, whereas deaths due to cardiovascular disease occur throughout the prenatal, postpartum, and interconception continuum. Hypertensive disorders of pregnancy are more likely to be linked to deaths occurring during delivery or within one week postpartum, whereas deaths attributed to stroke are more likely within 42 days postpartum. Death due to cardiomyopathy remains a risk throughout the first year postpartum. Maternal deaths caused by cardiovascular disease occur more commonly during pregnancy and the early (up to 42 days) postpartum.[13] While deaths due to medical conditions tend to be more prevalent during pregnancy, delivery and early postpartum, deaths due to suicide, violence and overdose occur more frequently during the mid to late postpartum period, outpacing the top obstetric causes of death.[9,10]

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[2] Centers for Disease Control and Prevention (CDC). (2020, Feb. 24). *Pregnancy mortality suveillance system.* Retrieved from CDC Reproductive Health: https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[33] World Health Organization (WHO). (2019). Trends in Maternal Mortality 2000-2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Retrieved from https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/

[4] Howell, EA, Egorova, NN, Balbierz, A, Zeitlin, J, & Herbert, PL. (2016). Site of delivery contribution to black-white severe maternal morbidity disparity. American Journal of Obstetrics & Gynecology, 215(2), 143-152

[5] Petersen, EE, Davis, NL, Goodman, D, Cox, S, Mayes N, Johnston, E, Syverson, C, Seed, K, Shapiro-Mendoza, CK, Callaghan, WM, & Barfield, W. (2019). Vital Signs: Pregnancy-related deaths, United States, 2011-2015, and strategies for prevention, 13 states, 2013-2017. MMWR, 68(18), 423429.

[6] Kohzimannil, KB, Interrante, JD, Henning-Smith, C, & Admon, LK. (2019). Rural-Urban Differences in Severe Maternal Morbidity and Mortality in the US, 2007-2015. Health Affairs, 38(12), 2007-2085.

[7] Davis NL, Smoots AN, Goodman, DA. (2019). Pregnancy-related deaths: Data from 14 US Maternal Mortality Review Committees, 2008-2017. Retrieved April 22, 2020 from https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf

[8] Burgess, A.P.H., Dongawar, D., Spigel, Z., Salihu, H.M., Moaddab, A., Clark, S.L., & Fox, K. (2020) Pregnancy-related mortality in the United States, 2003-2016: Age, race, and place of death. American Journal of Obstetrics & Gynecology, pii: S0002-9378(20)30208-8. doi: 10.1016/j.ajog.2020.02.020

[9] Metz, T.D., Rovner, P., Hoffman, M.C., Allshouse, A. A., Beckwith, K. M., & Binswanger, I. A. (2016). Maternal deaths from suicide and overdose in Colorado, 2004-2012. Obstetrics & Gynecology, 128(6):1233-1240.

[10] Koch, A, Rosenberg, D, & Geller, S. (2016). Higher Risk of Homicide Among Pregnant and Postpartum Females Aged 10-29 Years in Illinois, 2002-2011. Obstetrics & Gynecology, 128(3):440-446, September 2016. DOI: 10.1097/AOG.00000000000015590

Nurse Practitioners as A Solution in Addressing Maternal Mortality

In short, pregnancy-related deaths are not confined to one timeframe in the perinatal continuum. They occur in acute care, non-acute care and community settings, affecting women across geographic areas. Further, chronic health conditions, such as obesity, diabetes, hypertension and substance use are recognized contributors to increasing maternal mortality and morbidity rates.[11] In order to improve maternal outcomes, attention must focus not only on the time and providers centered on the delivery but must encompass the entirety of the pregnancy and first year postpartum, as well as the time before and between pregnancies. Nurse practitioners are essential to the solution.

Nurse practitioners provide a substantial portion of the high-quality[12], cost-effective[13] care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[14] Approximately 42% of Medicare patients receive billable services from a nurse practitioner[15], and approximately 80% of NPs are seeing Medicare and Medicaid patients.[16] NPs have a particularly large impact on primary care as approximately 70% of all NP graduates deliver primary care.[17] According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[18] NPs are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[19]

Board certified NPs generally, and in each of the population foci, strengthen women's health care in efforts to optimize maternal health and decrease maternal mortality and morbidity. Both Adult Gerontology Nurse Practitioners (AGPCNP) and Family Nurse Practitioners (FNP -BC) provide primary care for women, including chronic disease management. Women's Health Nurse Practitioners (WHNP-BCs) provide uncomplicated and high risk prenatal and postpartum care, and complex prepregnancy and interpregnancy care.[20] Pediatric Nurse Practitioners (CPNP-PC) provide care for adolescents, laying the foundation for reproductive health. Finally, Psychiatric Mental Health Nurse Practitioners (PMHNP) provide essential mental health services to address maternal mental and behavioral health concerns.

Summary

Collectively and within each population focus, NPs provide access to important components of health care at critical touchpoints in women's lives. As such, they are a vital element of the health care workforce in addressing maternal mortality. Within the clinical settings included in this RFI, inclusion of NPs with expertise in addressing at risk maternal conditions in planning and implementing maternal mortality prevention strategies, and overseeing care delivery is essential to meeting the challenge of maternal mortality and morbidity.[21]

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[11] Barfield, WD, & Warner, L. (2012). Preventing chronic disease in women of reproductive age: Opportunities for health promotion and preventive services. Preventing Chronic Disease, 9, E34.
[12] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[13] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[14] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021
[15] Ibid.
[16] NP Fact Sheet (aanp.org)
[17] Ibid
[18] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[19] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[20] NPWH. (2020). *Women's Health Nurse Practitioner: Guidelines for Practice and Education (8th Ed).* Washington, DC: Author.
[21] NPWH. (2019). Eliminating Preventable Maternal Deaths. Available at: https://www.npwh.org/lms/filebrowser/file?fileName=Eliminating%20Preventable%20Maternal%20Deaths%20Position%20Statement%20Final.pdf

Conclusion

We appreciate the focus of CMS on improving maternal care, improving data collection on SDOH, and improving care transitions within this proposed rule. We look forward to continued partnership to address these critical issues. Should you have comments or questions, please contact MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

American Association of Nurse Practitioners

Gerontological Advanced Practice Nurses Association

National Association of Nurse Practitioners in Women's Health

National Association of Pediatric Nurse Practitioners

National Organization of Nurse Practitioner Faculties