



June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed Rule Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

The American Academy of Nursing (Academy) is pleased to offer the following comments in response to the May 10, 2022, proposed rule regarding opportunities to address health care disparities in hospital inpatient care and beyond and improving maternal health outcomes. The Academy serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis and dissemination of nursing knowledge. With more than 2,900 fellows, the Academy represents nursing's most accomplished leaders in policy, research, administration, practice and academia. They have been recognized for their extraordinary contributions to the promotion of the public's health through evidence and innovation.

Foundationally, the Academy is committed to advancing health equity and championing wellness. Our vision is *Healthy Lives for All People*. The Academy appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts to encourage hospitals to build health equity into their core functions and improve care delivered in and outside of the health care system as well as improve maternal health outcomes for vulnerable people, families, and communities. Our comments will be focused on two areas in the proposed rule

Advancing Health Equity

Improving Health Equity Measures

Over the past 20 years, an increasingly robust evidence base has documented that the physical, social, and economic circumstances in which people live, work, play, and learn affect their health and well-being.¹ The Academy believes that to truly improve health, policies must expand access to quality care across the lifespan through novel approaches, grounded in rigorous science and aimed at eliminating discrimination and racism while improving health equity. This requires a distinct focus on removing disparities and enhancing health care experiences. The three-health equity-focused measures for adoption in the Hospital Inpatient Quality Reporting (IQR) program could identify critical gaps and

¹ U.S. Department of Health and Human Services. (2018). *Secretary's Advisory Committee for Healthy People 2030: Issue Briefs to Inform Development and Implementation of Healthy People 2030*.

prioritize policies that include all communities.²

Vulnerable populations are often left behind by the rigid structures of inquiry that are used in measuring health care quality disparities. The first measure in the Hospital IQR program presents an opportunity to address the lack of data that is comprehensive, consistent, and accurate to improve access and include participants from vulnerable communities. A lack of comprehensive, consistent, and accurate data limits the ability to capture concrete activities across the five key domains³ (strategic planning, data collection, data analysis, quality improvement, and leadership engagement) and improve access, quality, and outcomes in healthy lives for all people. Having timely and accurate data will be key for what CMS has proposed in this rule. Moreover, there are cultural issues in some vulnerable communities related to the collection of data and the use of technology in health care settings, particularly around trust. Therefore, there is a need for a holistic view that considers individual preferences and capabilities, and a need for better understanding these preferences. The Academy recommends CMS consider the historic issues of racism in health care that have prevented the ability to build trust with federal programs as the agency finalizes the rule.

The second and third measures of the Hospital IQR program focus on screening for the social drivers of health and screening the positive rate for social drivers of health. These two measures could address the lack of or decreasing access to care in the local community. Numerous studies have documented that there are significant burdens related to food insecurities, housing instability, utility difficulties, and interpersonal safety in vulnerable communities. The Academy believes that through a transparent and non-biased screening for and the identification of unmet needs, hospitals that design, implement, and operationalize policies and programs to advance health equity can be in a better position to serve patients holistically by addressing and monitoring key contributors to health inequities. We recommend the agency consider these additional social burdens when finalizing these program measures.

Documenting the Social Determinants of Health

According to the U.S. Census Bureau the official poverty rate in 2020 was 11.4 percent, up 1.0 percentage point from 10.5 in 2019. This was the first increase in poverty after five consecutive declines.⁴ Homelessness and poverty are linked due to people whose needs are unmet such as being unable to pay for housing, food, childcare, health care and education.⁵ While the Medicaid program focuses solely on coordination and providing health care services, the program can assist states in building partnerships to facilitate the coordination of social services related to food insecurity, housing, and transportation in rural communities. Some states are already doing this with successful results.⁶ The Academy encourages CMS to support these efforts in various ways by streamlining reporting requirements, encouraging additional data sharing across programs, and sustained investment for states to better integrate eligibility and enrollment systems. We find that the Hospital IQR program CMS plans to propose can also play as a key supporter in this area as well, ensuring that the data is accurately and transparently collected to be reported out. The Academy also recommends that when documenting social determinants of health, CMS includes their Meaningful Measures 2.0 on building value-based care and promoting health equity. Meaningful Measures 2.0 was designed to address measurement gaps, reduce burden and increase efficiency through various aspects like prioritizing patient-reported and high

² Press release *CMS proposes policies to advance health equity and maternal health, Support Hospitals*. CMS. (2022, April 18). Retrieved from <https://www.cms.gov/newsroom/press-releases/cms-proposes-policies-advance-health-equity-and-maternal-health-support-hospitals>

³ Press release *CMS proposes policies to advance health equity and maternal health, Support Hospitals*. CMS. (2022, April 18). Retrieved from <https://www.cms.gov/newsroom/press-releases/cms-proposes-policies-advance-health-equity-and-maternal-health-support-hospitals>

⁴ Bureau, U. S. C. (2022, March 1). *Income and poverty in the United States: 2020*. Census.gov. Retrieved from <https://www.census.gov/library/publications/2021/demo/p60-273.html>

⁵ *Homelessness in America*. National Coalition for the Homeless. (2017, September 21). Retrieved from <https://nationalhomeless.org/about-homelessness/>

⁶ Katch, H. (2020, January 27). *Medicaid Can Partner With Housing Providers and Others to Address*. *Center on Budget and Policy Priorities*. Retrieved from <https://www.cbpp.org>

value quality measures.⁷ Through the use of Meaning Measures 2.0, CMS would be able to leverage and improve quality measures that would promote health equity and close gaps.

Improving Maternal Health Outcomes

Advancing Maternal Health Equity and Improving Care

To truly improve outcomes, the Academy applauds CMS for focusing on the social, economic, and environmental factors that affect maternal health. This is especially important in vulnerable communities across the country. One community-based example that looks at these social determinants of health to improve maternal health outcomes is the Academy's Edge Runner model regarding maternity care at the Family Health and Birth Center (FHBC) now integrated with the Developing Families Center (DFC) in Washington, DC.⁸ This center provides a midwifery/nurse practitioner model for alternative, cost effective maternal/child care for low-income women. With an emphasis on social supports, early childhood education, and providing perinatal care through the child's second year, the program has made a tremendous impact on maternal as well as infant health. Most notably, 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 FHBC found that their program leads to fewer interventions, lower costs, and equivalent or better outcomes for the women receiving prenatal care at the center, most of whom are low-income. The FHBC estimates that the application of the FHBC model to all Medicaid births could yield a savings of almost \$2 billion.⁹ The Academy believes efforts such as the FHBC model will have a positive impact on addressing barriers in maternal health in vulnerable communities. A study found that if this model were expanded nationwide, it could have substantial savings for this type of care in the Medicaid program.¹⁰ Specifically, this birth center model could be expanded nationwide and could potentially reduce costs for all pregnancies by an average of 16 percent, which translates to about \$11.64 million for every 10,000 Medicaid deliveries.¹¹ We recommend CMS support expansion of the number of birth centers generally and incorporate the FHBC model in birth centers across the nation to further evaluate the potential impact for optimizing maternal and newborn health outcomes especially in communities of color experiencing the highest rates of health disparities.

Limited or no expansion of Medicaid in some states is another barrier to improving access, quality, and outcomes in maternal health. A 2019 report found states that expanded their Medicaid program under the Affordable Care Act improved maternal health.¹² This report further found that expansion of Medicaid is key to addressing health disparities in this area. Numerous evidence-based studies have found a lack of access to care ultimately leads to not only higher healthcare costs overall, but also lower health outcomes. Increasing access to maternity care lowers the risk of pregnancy-related complications for mothers before, during, and after giving birth.¹³ Healthier mothers and babies equal better health

⁷ U.S. Centers for Medicare and Medicaid Services. (2022, May 20). *Meaningful measures 2.0: Moving from measure reduction to modernization*. CMS. Retrieved from <https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization>

⁸ *Family Health and Birth Center in the Developing Families Center*. (n.d.). American Academy of Nursing. <https://www.aanet.org/initiatives/edge-runners/profiles/edge-runners--family-health-and-birth-center-in-the-developing-families-center>

⁹ American Academy of Nursing Edge Runners: Family Health and Birth Center in the Developing Families Center. (n.d.). Retrieved April 9, 2020, from <https://www.aanet.org/initiatives/edge-runners/profiles/edge-runners--family-health-and-birth-center-in-the-developing-families-center>

¹⁰ Howell, E., Palmer, A., Benatar, B., & Garrett, B. (2014a). Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center. *Medicare & Medicaid Research Review*, 4(3), E1–E13. Retrieved from https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a06.pdf

¹¹ Howell, Palmer, Benatar, & Garrett, 2014b.

¹² Searing, A., & Ross, D. C. (2019). *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*. Retrieved from <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>

¹³ Recommendations to Improve Preconception Health and Health Care --- United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. (2006). *Morbidity and Mortality Weekly Report*, 1–23. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

outcomes and lower healthcare costs. We appreciate efforts to extend Medicaid coverage for mothers up to one-year post-birth and encourage CMS to consider incentives for more states to provide this coverage post birth.

The Medicaid program can also pose unintended burdens on patients who have to travel a long distance to receive health care. For example, the Texas Medicaid Medical Transportation Program provides non-emergency medical transportation services for Medicaid recipients who do not have transportation to get to scheduled healthcare services.¹⁴ However, the program does not permit pregnant women or new mothers to travel with their children to medical appointments.¹⁵ Less than one half of women living in rural areas live within a 30-minute drive to a hospital that offers perinatal services.¹⁶ Women who do not have their own means of transportation to access care may not have access to child care. The Academy encourages CMS to use opportunities like the Texas example to partner with entities in vulnerable communities to address their unique needs in order to lessen barriers in place for pregnant and postpartum individuals seeking care.

Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

“Birthing Friendly Hospitals” designations could advance health care quality, safety, and equity for pregnant and postpartum patients for various aspects of maternal and infant health including low-risk Cesarean deliveries and severe obstetric complications. However, given that the designations would be awarded to hospitals based on their attestation to the Hospital IQR program’s *Maternal Morbidity Structure Measure*,¹⁷ this could create an unintended barrier to improving maternal health outcomes for vulnerable communities with high rate adverse birth outcomes as well as those communities that have low rates of obstetric health care professionals. Since 2005, 172 hospitals in rural areas have closed of which 130 have closed in the last decade alone.¹⁸ Additionally, the National Rural Health Association notes that many rural areas have shortages of healthcare providers specializing in maternity care.¹⁹ Rural hospital closures combined with a lack of local healthcare providers specializing in this type of care creates an access challenge as women and infants must travel longer distances for prenatal, postnatal and infant care. As CMS considers future notice-and-comment rulemaking in this area, the Academy recommends the agency include measures such as whether these hospitals have health care professionals such as nurse midwives and women’s health nurse practitioners on staff. This will be especially important in areas of the country where there are shortages of this type of health care professional. We also urge CMS to include all well documented models of care that can improve maternal-child health outcomes as part of the assessment for a “Birth Friendly Hospital” designation. This includes the practice of nurse midwives and interdisciplinary models with nurse midwives and nurse practitioners.

Maternal mortality reporting has improved through the use of computerized collection of information, sharing of data, as well as coding and death certificate information updates. However, there is a strong possibility of errors related to this data. A 2012 study found an overestimation in maternal mortality

¹⁴ Texas Health and Human Services Commission. (n.d.) Medical Transportation Program. Available: <https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-transportation-program>

¹⁵ Katch, H. (2020, January 27). Medicaid Can Partner With Housing Providers and Others to Address. *Center on Budget and Policy Priorities*. Retrieved from <https://www.cbpp.org>

¹⁶ Rayburn WF, Richards ME, Elwell EC. Drive times to hospitals with perinatal care in the United States. *Obstet Gynecol* 2012; 119:611–6.

¹⁷ *Maternal Morbidity Structural Measure*. (n.d.). Centers for Medicare and Medicaid. <https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf>

¹⁸ 172 Rural Hospital Closures: January 2005 - Present (130 since 2010). (2020, May 8). Retrieved from <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

¹⁹ Anderson, B., Gingery, A., McClellan, M., Rose, R., Schmitz, D., & Schou, P. (n.d.). *NRHA Policy Paper: Access to Rural Maternity Care*. Retrieved from https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2019-NRHA-Policy-Documents/Access-to-Rural-Maternity-Care.pdf

rates because of the reliance on obstetric coding only in Texas.²⁰ This research concluded that maternal death reporting data would be better understood as well as more accurate with data matching and review of relevant medical and death investigation information. The 2020 National Academies of Sciences, Engineering, and Medicine report, *Birth Settings in America: Outcomes Quality, Access, and Choice*, found that vital statistics and birth registry data have limitations for evaluating birth outcomes by setting, provider types, and intentionality.²¹ The lack of comprehensive, consistent, and accurate data limits the ability to capture concrete activities that would improve access, quality, and outcomes in health for maternal care. We encourage CMS to include additional measures that consider maternal mortality data reporting requirements that are comprehensive and accurate in the designation of a “Birthing Friendly Hospital.”

In summary, the Academy appreciates your efforts to address the significant health inequities and quality measures to improve health care access and maternal and infant health in disadvantaged/underrepresented communities. We are eager to work with you to identify and implement policies that close this gap. Thank you again for the opportunity to provide our comments and recommendations, and I hope you will contact us for assistance in any efforts to address these issues or policies. The Academy’s Senior Director of Policy, Christine Murphy, is available at cmurphy@aannet.org or 202-777-1174 if you have any questions or need additional information.

Sincerely,



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President

²⁰ Baeva, S., Saxton, D. L., Ruggiero, K., Kormondy, M. L., Hollier, L. M., Hellerstedt, J., ... Archer, N. P. (2018). Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012. *Obstetrics & Gynecology*, 131(5), 762–769. <https://doi.org/10.1097/aog.0000000000002565>

²¹ National Academies of Sciences, Engineering, and Medicine (NASEM). 2020. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25636>.