August 13, 2024

The Hon. Ron Wyden, Chair
Senate Committee on Finance
United States Senate
219 Senate Dirksen Office Building
Washington, DC 20510

Subject: ANA Recommendations on Strengthening the *Keeping Obstetrics Local Act*

Dear Chairman Wyden:

The American Nurses Association (ANA) appreciates this opportunity to provide feedback on your discussion draft of the *Keeping Obstetrics Local Act*. ANA shares your desire to guarantee that expectant and postpartum mothers have access to labor and delivery units in rural and medically underserved urban communities across the country. We applaud the thoughtful approaches detailed in the proposed legislation. ANA respectfully offers the following recommendations that we deem essential to adequately address these challenges and the need to ensure access to critical nursing services within obstetrics units.

ANA is the premier organization representing the interests of the nation's 5 million registered nurses (RNs), through its constituent and state nurses associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include those practicing in the four advanced registered nurse (APRN) roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). ANA is dedicated to partnering with healthcare consumers to improve practices, policies, delivery models, outcomes, and access across the healthcare continuum.

This legislation aims to stem the number of hospital maternity unit closures around the country, happening at alarming rates—with closures especially prevalent in rural and medically underserved urban communities. The unfortunate shuttering of Saint Alphonsus Medical Center's Obstetrics and Birth Center last year was just one of many maternity unit closures in these communities over the past decade.[1] Between 2011 and 2021, 267 rural hospitals – approximately a quarter of rural hospitals – ceased providing obstetric services.[2]

[1] Baker City maternity ward's looming closure has expectant parents fearing the worst - OPB
[2] rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf (chartis.com)

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

This troubling trend is fueling the continued expansion of maternity care deserts where expectant and new mothers have little to no access to maternity care services. These mothers confront the need to travel long distances for critical prenatal, perinatal, and postpartum care, and quite often experience suboptimal health outcomes with many of these outcomes contributing to our nation's growing maternal mortality rate.[3] This trend is more pronounced among Black, Native American, and Alaskan Native women who face mortality rates that are twice that of Caucasian women.[4]

ANA knows the importance of addressing the underlying factors leading to maternity unit closures, including the recruitment and retention of obstetrics-trained nurses. APRNs and RNs play a key role in maternity care, and we urge you to keep them central as you pursue solutions to this crisis. ANA would appreciate thoughtful consideration of the recommendations detailed below as this legislation continues to be refined.

Eliminate Regulatory Barriers to Nurse Clinicians

With workforce shortages being a key driver of hospital maternity unit closures, ANA believes that a bedrock element of solving this crisis is removing barriers to care preventing CNMs and other APRNS from practicing to the top of their education and clinical training. Unfortunately, access to CNMs and other APRN providers of choice within hospital settings is restricted by federal and state regulations and then often further restricted by individual hospital policies. These regulatory barriers that restrict nurses' ability to practice to the fullest extent of their education and clinical training must be removed so that these hospitals have the workforce necessary to function and ensure patient access to high-quality maternal health care services.

First, ANA strongly recommends that this draft legislation include incentives for hospitals to consider these clinicians as hospital staff with voting, admitting, and clinical privileges. For example, CNMs receive specialized education in women's health care and midwifery and are trained to offer comprehensive care to women through every phase of their lives. During a typical hospital labor and birth, a CNM can admit a pregnant person to the hospital, write medical orders, prescribe medications, manage labor and birth, deliver the baby, and provide postpartum care independently within the scope of CNM education and training. In fact, a 2019 brief from the Centers for Medicare & Medicaid Services found that while midwives may only attend 10 percent of all births nationally, they attend over 30 percent in rural hospitals.[5] These providers are also vital to the provision of quality maternal health care services. As the American College of Nurse-Midwives notes, patients of CNMs have lower rates of c-sections,

[3] 2022_Maternity_Care_Report.pdf (marchofdimes.org)
[4] www.cdc.gov/hearher/aian/disparities.html
[5] https://www.cms.gov/about-cms/agency-information/omh/downloads/improving-access-to-maternal-health-care-in-rural-communities-an-issue-brief.pdf

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

fewer episiotomies and higher rates of breastfeeding when they have access to these clinicians for their labor and delivery care.[6] These facts underscore the critical role that CNMs play in ensuring patient access to obstetric care in the very communities that the draft legislation targets.

Unfortunately, existing federal and state laws and regulations, as well as individual hospital bylaws and policies, create barriers that prevent patients from accessing CNMs as their provider of choice. While at times dictated by state regulations, most often the privileges of hospitals and medical systems are determined by their own rules dictating the types of providers who are allowed to admit patients and what services these providers may perform. Several states maintain that hospitals should not discriminate against nurse midwives seeking hospital privileges, while several others expressly limit admitting privileges to physicians only. In most states, there is no regulation concerning who may admit patients. Medicare regulations allow CNMs to secure medical staff membership if permitted by state law, but do not mandate CNM membership. Amending Medicare statute to include nurse midwives as members of "medical staff" under Medicare's Hospital Conditions of Participation (CoP) would improve continuity of care, expand consumer choice and access to care, and increase cost-effectiveness within the Medicare program. Medicare is viewed as the "gold standard" and it sets precedents that are often followed by states and other insurers. As such, the committee should consider including language in the legislation directing CMS to make this critical change to the CoP to increase access to CNMs relied on by patients in rural and underserved communities.

Moreover, ANA strongly encourages the incorporation of provisions from the bipartisan *Improving Care and Access to Nurses (*ICAN Act; H.R. 2713 / S. 2418) to address other outdated barriers facing APRNs. This legislation includes language that would allow CNMs to issue a prescription or written order for durable medical equipment, prosthetics, orthotics and supplies to Medicare beneficiaries as well as provide face-to-face care without being subject to physician supervision. Similarly, the measure would require CNMs to be included alongside NPs, CNSs, and PAs as Part B Medicare providers eligible to certify and recertify a Medicare beneficiary for home health services without being subject to physician supervision. Finally, the ICAN Act also contains a section that would allow CNMs to bill Medicare for training and supervision of medical interns and residents in the field of obstetrics—which is currently often unreimbursed. Addressing these barriers in the legislation is a commonsense solution that is crucial to supporting obstetric units in rural and underserved urban areas while safeguarding access to many patients' providers of choice for maternal health services. We strongly

6 https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007463/Removing%20Barriers%20to%20Midwifery%20Care%20Hospital%20Privileges%20FINAL.pdf#:~:text=The%20American%20College%20of%20Nurse,voting%2C%20admitting%20and%20clinical%20privileges.

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

recommend inserting Sections 301, 302 and 303 from S. 2418 into the *Keeping Obstetrics Local Act.*

Encourage Nurse-led Health Homes

ANA appreciates the draft legislation's inclusion of support for states choosing to create maternal health homes, where a designated provider leads a care team to provide comprehensive, patient-centric, and culturally competent care to pregnant and postpartum patients. The proliferation of these health homes would increase patient access to a wide variety of healthcare services, including primary care, acute care, behavioral health care, health-related social needs services, and long-term services within their communities. However, Section 202 needs to be further revised in recognition of the reality that healthcare professionals, representing disciplines beyond the physician community, can and do provide this high-quality, culturally competent care to patients. Specifically, ANA strongly urges the definition of a "designated provider" be strengthened to authorize and encourage APRNs specializing in maternal, labor, and delivery services to lead health homes. Additionally, the definition of the "team of health care professionals" needs to be modified to explicitly include RNs and the full range of APRN providers. These modifications would ensure that health homes reflect the full spectrum of healthcare providers delivering high-quality care to their communities.

Enhance Financial Support to Nurses

Title I of the discussion draft increases Medicaid and CHIP payment rates to certain rural and safety net hospitals that provide obstetric services to remedy inadequate reimbursement for labor and delivery services and offset high fixed operating costs. Hospitals that experience a low volume of births would also receive "anchor payments" through Medicaid, requiring recipients to enter into contractual agreements with their state and commit to investing the add on payments toward maternity, labor, and delivery services. Hospitals that renege on this contractual obligation would be responsible for repaying the state the full amount of any received add on payments. These conditional provisions appropriately serve to ensure that hospitals utilize these payments for their intended purpose. ANA supports the inclusion of these stipulations and recommends its broad application to Title I to ensure that the other enhanced Medicaid and CHIP payments go toward the provision of maternity, labor, and delivery services as intended.

At the same time, we encourage incentives that better target payments for these services to lead to more equitable payments for APRN providers. ANA knows these nurses are critical to labor and delivery care teams and continues to call on policymakers to reflect that in reimbursement approaches. While we are encouraged by the discussion draft's inclusion of

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Section 203, which directs the U.S. Department of Health and Human Services (HHS) to issue guidance to support and improve patient access to CNMs, doulas, and other maternal health professionals through coverage under the Medicaid program, ANA is concerned that more concrete steps must be taken to bolster access to nurses. We encourage consideration of incorporating other incentives within the add on payments proposed in the legislation that would support and drive towards payment parity for key maternal health services provided by nurses. Such policies would not only be reflective of the value nurses provide to expectant and postpartum mothers, but would also provide meaningful incentives for APRNs to practice in these settings where they are desperately needed.

Increase Nurse Faculty, Clinical Preceptors and Accelerated Nursing Programs

Many rural and underserved urban maternity units struggle with having adequate resources that allow them to attract and retain needed obstetric-trained clinical staff. A diverse, well-prepared, and fully supported nursing workforce is critical to ensure that expectant and postpartum mothers have access to needed services. Further complicating these challenges is the ongoing shortages of nurse faculty in nursing schools and nurse preceptors in clinical settings. In fact, nursing programs turned away more than 80,000 applications due to insufficient faculty and supervisors, clinical and classroom training sites, and financial resources.[7] Two-thirds of nursing programs specifically cite the lack of faculty and clinical preceptors as reasons for admitting fewer qualified applications.

ANA recommends that the legislation include provisions that complement existing efforts on Capitol Hill and within the Administration to attract nurse faculty and clinical preceptors who can educate and train the next generation of maternal health nurses. Strong examples of policy solutions include narrowing the pay disparity between nurse faculty and nurses in clinical settings as proposed in the Nurse Faculty Shortage Reduction Act (H.R. 7002 /S. 2815). Additionally, ANA recommends consideration of providing a tax credit for nurses to serve as clinical preceptors to nursing students specializing in obstetrics care, similar to what has been proposed in the Providing Real-World Education and Clinical Experience by Precepting Tomorrow's (PRECEPT) Nurses Act (S. 1627). Finally, the bipartisan Stop Nurse Shortages Act (H.R. 8330) provides a template that can be incorporated into this draft legislation to invest in accelerated nursing programs. These are just a few examples of how Congress can address some underlying factors that make it difficult for hospitals to recruit and retain nurses specializing in obstetric care.

ANA recognizes and applauds efforts to ensure that expectant and postpartum mothers in rural and medically underserved urban communities have access to critical maternal health

[7] Nursing Shortage Fact Sheet (aacnnursing.org)

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

care in the draft legislation. We know that nurses play a key role in maternity care and we encourage further recognition of this fact as you finalize provisions aimed at addressing obstetric care. We look forward to continued collaboration with your office and we stand ready to serve as a resource. Please contact Tim Nanof, Vice President of Policy and Government Affairs at (301) 628-5081 or Tim.Nanof@ana.org with any questions.

Sincerely,

Debbie Hatmaker

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

cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, Chief Executive Officer

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org