AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to recommend several steps the Center for Medicare and Medicaid Innovation (CMMI) can take to ensure the new Transforming Maternal Health (TMaH) program will have a significant, positive impact on maternal health and birth outcomes for pregnant and postpartum women and their infants.

The AMA is deeply concerned about high rates of maternal and infant morbidity and mortality in our country. More women die from pregnancy-related complications in the United States than in any other developed country. According to the Centers for Disease Control and Prevention (CDC), approximately 1,205 pregnancy-related deaths occurred in the U.S. in 2021 and 80 percent of these deaths were preventable. Major disparities in maternal mortality exist, with Black women three to four times more likely than non-Hispanic White women to die due to pregnancy-related complications and American Indian or Alaska Native (AI/AN) women more than twice as likely than non-Hispanic White women to die due to pregnancy-related complications.

Birth inequities arise at the intersection of discrimination by race and gender for Black and AI/AN women. The AMA understands that there are a multitude of considerations necessary to address the maternal health crisis in this country, including lack of access to high-quality health care due to:

- Inadequate payments from Medicaid programs and commercial insurance plans for maternity care services, particularly services for individuals with complex needs and those who have difficulty accessing and utilizing traditional services;
- Burdensome reporting and regulatory requirements on physician practices that divert resources away from patient care and cause physician burnout that contributes to shortages of physicians in primary care, obstetrics and gynecology, and other specialties that are essential for delivering high-quality maternity care;
- Structural and societal barriers that contribute to inequities and disparities in maternal health outcomes; and
- Closures of labor and delivery units in many rural communities, and growing difficulties accessing maternity care for people in both rural and urban areas, both of which are due to a combination of inadequate payments and shortages of maternity care physicians.

These problems need to be addressed in order for the TMaH program to achieve significant improvements in maternity care. As CMMI works to finalize the details of the TMaH program, we recommend that the following components be included to ensure it is successful in addressing the underlying causes of the nation's maternal health crisis:

Recommendation 1: Expand the TMaH program to include all interested states.

We are very concerned that the TMaH announcement indicated that only 15 states would be able to participate, and that there would be no opportunity for additional states to participate for at least a decade. If the 15 states with the smallest number of Medicaid births are selected, only five percent of the nation's Medicaid pregnancies would be affected by the program. Even if the 15 states with the largest number of births were selected, the program would fail to reach one-third of the low-income pregnancies in the country.

Birthing people and babies are dying unnecessarily in every state in the country, and so we urge CMS to allow all interested states to participate. At a minimum, we urge that every state which has a high percentage of its population living in a maternity care desert or a high rate of maternal mortality be permitted to participate.

Recommendation 2: Expand the amount of funding provided to each state under TMaH.

We are also very concerned that at most $17 million would be provided to each state selected to participate in the TMaH program, and that this funding would be expected to support activities for a 10-year period. This means each state would only receive about $1.7 million per year. With an average of 30,000 Medicaid-funded births per state each year, this would represent only $57 per birth, and the funding would only represent about $25 per birth if the 15 states with the largest number of Medicaid births participate. It is difficult to imagine how this small amount of money could provide sufficient support for initiatives that would effectively address the serious problems of access and quality in maternity care that exist in every state.

CMMI has broad authority to implement models that will improve the quality of care or health outcomes for Medicaid patients along with sufficient resources to fulfill this directive from Congress, and we urge you to increase your investment in maternity care to ensure this model is a success.

Recommendation 3: Prioritize support for physicians, hospitals, and other providers that deliver obstetric care in underserved communities and to high-need populations.

We urge that the states participating in TMaH be required to prioritize funding and assistance to small, independent, and safety net physician practices and facilities that provide maternity care and obstetrical services in underserved rural and urban communities and to historically minoritized and marginalized patients. These physicians and facilities report that current Medicaid payments do not provide the resources necessary to support proactive care to pregnant and postpartum women or to fully address the needs of individuals with complex conditions, and these resource gaps must be filled if the nation is to achieve more equitable access and outcomes.

Moreover, we urge that small physician practices, small hospitals, and safety net providers be able to access any grants provided through TMaH without burdensome application, matching, or reporting requirements. Too often, new funding fails to reach those who need it most because the physician practices and facilities do not have adequate time or staff to apply for it or to fulfill the administrative

requirements that accompany the funding. CMS and states should provide guidance and support for those applicants in high need areas that are less resourced than health care institutions.

Recommendation 4: Address the chronic and acute conditions that cause maternal mortality and morbidity by ensuring physicians and facilities have the resources and support necessary to adopt evidence-based patient safety bundles.

The AMA supports the Alliance for Innovation on Maternal Health (AIM) patient safety bundles, and we are encouraged that they are included in the TMaH model. It is important for CMMI and states to recognize that the biggest barriers to implementing these bundles are not only, in some cases, a lack of awareness or willingness to do so, but also a lack of resources. In most cases, all of the prenatal, perinatal, and postpartum care provided by physicians is paid for through a fixed "global" fee, regardless of the complexity of the patient receiving the care. This fixed fee fails to support the additional services that are necessary to provide high-quality care for pregnant women who have a chronic condition or health-related social needs.

The utilization of safety bundles and checklists can facilitate adherence to evidence-based guidelines. Specifically, we support the Core AIM Patient Safety Bundles that physician-led teams can implement to address the most common causes of maternal mortality. These primary bundles, which are supported by specific quality metrics and measures through the AIM Data Center, are the core building blocks of the AIM program's efforts to address the leading known causes of preventable severe maternal morbidity and mortality in the United States. The Core AIM Patient Safety Bundles were developed as part of the AIM Program and funded by the Health Resources & Services Administration (HRSA). The AMA strongly encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the AIM program and state perinatal quality collaboratives. Enrollment in the AIM program occurs at the state-level; hospitals have the ability to engage in AIM initiatives through their state-based entities, often perinatal quality collaboratives (PQCs) or departments of health. Participants in the AIM program collaborate with experts in perinatal quality improvement to implement patient safety bundles and learn from other organizations that have successfully improved maternal health outcomes.

The six most frequent underlying causes of pregnancy-related death were hemorrhage, cardiac and coronary conditions, infection, thrombotic embolism, cardiomyopathy, and mental health conditions (including deaths of suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the Maternal Mortality Review Committees to be related to a mental health condition, including substance use disorder)—which accounted for over 75 percent of pregnancy-related deaths. Although the leading underlying cause of death varied by race and ethnicity, the CDC data indicates that cardiac and coronary conditions were the leading underlying cause of pregnancy-related deaths among non-Hispanic Black persons. Based on a review of pregnancy-related deaths among AI/AN people, mental health conditions and hemorrhage were the most common underlying causes of death, accounting for 50 percent of deaths with a known underlying cause. Most pregnancy-related deaths of AI/AN people (93 percent) were determined to be preventable. About 64 percent of deaths occurred between seven days to one year after pregnancy.[1,2] The patient safety bundles utilized by the AIM program are designed to reduce variations in care and improve outcomes related to common complications, such as severe hypertension in pregnancy, cardiac conditions in obstetric care, and obstetric hemorrhage. As part of their participation in AIM, hospitals submit structure, process, and outcome data to their state-based entities. This data is used to understand progress towards program goals and can be used for peer comparison and

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[1] https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.
[2] https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html.

learning. This rapid cycle quality improvement methodology has been used by PQCs to improve maternal health outcomes. The AMA believes that to truly further the national goal of improving maternal health outcomes across the U.S., the TMaH should aim its work towards elevating and expanding these CORE bundles in states.

We strongly recommend that TMaH provide the financial resources necessary for implementation of the AIM bundles. As part of the pre-implementation period of this model, CMMI and states should seek input from physicians providing obstetrical services about the barriers to implementing the AIM patient safety bundles. The AMA would welcome the opportunity to facilitate discussions between CMMI, the states, and physicians. Then, CMMI and states should provide sufficient funding, assistance, and waivers in order to overcome those barriers during the implementation phase of TMaH.

Recommendation 5: Partner with the Health Resources & Services Administration and other agencies to address workforce shortages in maternity care.

It is impossible for women to receive high-quality maternal and infant health care if they do not have access to physician practices, clinics, and hospitals that provide maternal and infant care services and medications needed. According to the latest March of Dimes report, almost seven million women live in maternal care deserts. Moreover, 36 percent of counties nationwide, largely in the South and Midwest, have no obstetric hospitals, birth centers, or physicians who provide obstetric care. According to a new Center for Healthcare Quality and Payment Reform report, more than half of the rural hospitals in the U.S. no longer offer labor and delivery services, and in 10 states, more than two-thirds of rural hospitals do not have these vital services. This unsustainable lack of access to care forces women to arrange transportation, childcare, or time off from work to travel long distances for maternity care services, making it more likely they will forego or delay essential prenatal or postpartum care. As a result, mothers and babies in maternal care deserts face a higher risk of poor health outcomes, including death.

We do not believe that TMaH can be successful in improving maternal outcomes unless it includes resources to expand the availability of physicians who provide obstetrical services. Since HRSA operates multiple programs that are intended to address workforce shortages in maternity care, we urge that CMMI work closely with HRSA to attract more physicians with maternity care skills to undeserved areas and to ensure clinicians in those areas receive the support needed to deliver high-quality care. We believe that particular attention is needed in these areas:

- Increase the cap placed on residency slots.
- Increase funding and slots in programs such as the Maternal Health and Obstetrics Pathway.
- Expand rural track programs so that obstetrician-gynecologists (ob-gyns), maternal-fetal medicine specialists, family physicians, and emergency physicians that will likely have to provide maternal and infant care can do rotations in hospitals with a high volume of deliveries so they can receive ongoing training and experience with cesarean sections and pregnancy-related complications.
- Provide funding for rural clinics and hospitals to enable them to offer rotations for medical students and residents in rural obstetric care.
- Provide additional funding and support for the Teaching Health Center Graduate Medical Education (THCGME) Program, and in particular ob-gyns, family physicians that will provide maternal and infant care, and emergency medicine physicians that are likely to deal with obstetric emergencies in the THCGME Program.
- Increase funding for, and placement of, maternity care physicians in the National Health Service Corps through the Maternity Care Target Area program.

- Increase funding for the Indian Health Service (IHS) loan repayment program so that compensation for physicians can be higher, loan repayments are tax free, and additional holistic support for physicians can be provided. This increased funding should also be used to recruit ob-gyns, maternal-fetal medicine specialists, family physicians, and emergency physicians with experience in maternal and infant care to participate in the IHS loan repayment program.
- Increase support systems for physicians working in rural areas and historically marginalized and minoritized communities so that they have adequate assistance, peers to consult with, and do not feel isolated.

Recommendation 6: Promote home monitoring of hypertension during the postpartum period and address barriers to providing this level of care.

The AMA, through its AMA MAP™ hypertension program, supports physicians and care teams in the implementation of evidence-based strategies to improve blood pressure control. The AMA is currently exploring how to expand their quality improvement solutions to birthing people in the postpartum period.

In particular, the weeks immediately following birth are marked by substantial physiological and lifestyle changes. According to the CDC, more than 50 percent of maternal deaths occur seven days to one year postpartum.[3] Therefore, the importance of timely monitoring and intervention cannot be overstated. Additionally, the postpartum period is unique in that it involves a number of care transitions, most notably from inpatient to outpatient care, which too often result in gaps in care. The traditional postpartum care model involves one visit roughly two to six weeks after childbirth; however, many birthing people are unable to attend this visit for various reasons. This means that women who need blood pressure (BP) monitoring may not receive needed care postpartum, which can lead to increased morbidity and mortality. **Therefore, we recommend that CMMI and the states utilize home BP monitoring, also called self-measured blood pressure (SMBP), to close the gaps in hypertension care in the postpartum period.** We believe this would complement the agency's ongoing work following release of the *Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP* toolkit late last year and help improve health outcomes for postpartum people.

There are currently several barriers to engaging birthing people in SMBP. There are coverage gaps resulting in limited or no access to SMBP devices or clinical services. Another associated barrier is lack of payment to support the team and technology infrastructure. We believe TMaH is well positioned to address this barrier and others, however, it will require greater creativity and a whole-of-government approach. For instance, there is a lack of reliable Wi-Fi and internet connectivity in parts of the country, and a dearth of policies, such as paid parental leave and support for childcare, that contribute to the complexities of delivering care postpartum. While the AMA is in the early learning phase of creating an SMBP solution to meet the needs of birthing people and their physicians and care teams, we believe SMBP and coordination of care has the potential to drive significant improvements in maternal morbidity and mortality related to hypertensive disorders of pregnancy and cardiovascular conditions. We would be happy to share the early findings of our work in this space.

Recommendation 7: Equip states to prevent maternal deaths caused by opioid-use disorder (OUD).

In recent years, opioid-related overdoses also have become a leading cause of death associated with pregnancy and the postpartum period, with mortality rates rising more than 80 percent between 2017 and

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[3] https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.

2020.[4,5,6] Left untreated, OUD during pregnancy can have severe medical and social consequences. It can destabilize a pregnancy and contribute to adverse outcomes such as low birth weight, preterm labor, fetal distress, and demise. It can also increase the likelihood of newborns being separated from their families at birth, raising the risk of trauma to the mother and harms to the newborn.[7]

The Biden Administration's efforts to extend Medicaid coverage during the postpartum period are an extremely important tool for preventing birthing people from losing access to medications for opioid use disorder (MOUD) during the postpartum period, which we know can lead to drug overdose deaths. Building on this, TMaH can equip states to prevent morbidity and mortality related to OUD by providing guidance to states on removing policies that punish women for being treated with MOUD, ensuring the availability of MOUD if and while incorporated or under judicial supervision; and ensuring continuity of care upon release from a jail or prison, including enrolling an individual in Medicaid prior to release.

Recommendation 8: Ensure that any alternative payment models (APMs) are developed in collaboration with physicians who provide maternity care and that the models provide adequate resources to support high-value care.

As we have indicated in previous correspondence, we believe that APMs will only be successful if they are developed in collaboration with physicians, if the models provide the resources physicians need to deliver high-quality care, and if the models hold physicians accountable for aspects of costs and outcomes that the physicians can control. If APMs are developed as part of the TMaH program, we urge CMMI to:

- Actively engage with physicians throughout all model development and implementation stages.
- Ensure that new payment models place physicians at the center of decision making about care delivery, give them the resources and flexibility they need to deliver services that can achieve good outcomes for all types of patients, and avoid placing the physicians at financial risk for outcomes or costs they cannot control.
- Provide prospective payments designed to support the costs of high-quality care, rather than merely providing bonuses and penalties based on estimates of Medicaid savings. Moreover, payments must be adequate to ensure access to high-quality care for patients with higher levels of need.
- Provide start-up funding to APM participants so they can invest in the capabilities, training, and practice changes that are needed to improve care delivery. This is particularly important to enable successful participation by small, independent, rural, and safety net practices.
- Increase payments annually to ensure they continue to be adequate to cover the costs of high-quality care. Payment increases should cover cost increases that are due to inflation, to changes in technology, and to changes in evidence about the effectiveness of services.

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[4] Harter K. Opioid use disorder in pregnancy. *Ment Health Clin*. 2019 Nov 27;9(6):359-372. doi: 10.9740/mhc.2019.11.359. PMID: 31857932; PMCID: PMC6881108.

[5] When Reimagining Systems Of Safety, Take A Closer Look At The Child Welfare System, Health Affairs Blog, October 7, 2020. DOI: 10.1377/hblog20201002.72121.

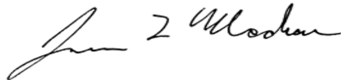
[6] Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022.

[7] Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence. *J Womens Health (Larchmt)*. 2021 Feb;30(2):236-244. doi: 10.1089/jwh.2020.8875. Epub 2020 Dec 8. PMID: 33295844; PMCID: PMC8020563.

- Commit to continuing payments for a long enough period of time to allow practices to make significant changes in care delivery and provide assurance that payment models will not be terminated or changed abruptly.

Thank you for your consideration of our recommendations to strengthen the TMaH. If you have any questions regarding our recommendations or if we can be of assistance to you in implementing the recommendations, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: Elizabeth Fowler, PhD, JD