STATEMENT

of the

American Medical Association

to the

U.S. Senate

Committee on Health, Education, Labor and Pensions

Re: "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

May 2, 2024

Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) as part of the hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?" In order to support state and federal policy development and initiatives and make significant progress in this space, the AMA has worked collaboratively over the last year with a variety of members of the Federation of Medicine, including relevant specialty societies, key state medical societies, and physicians from rural parts of the U.S. As a result of these efforts, the AMA has cultivated the following recommendations and advocacy materials.

The AMA commends the Committee for focusing on this critically important issue, which disproportionately affects Black and American Indian/Alaska Native (AI/AN) pregnant and postpartum individuals. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to working with all interested parties, especially Members of Congress, to support efforts to reduce and prevent the rising rates of maternal mortality and serious or near-fatal maternal morbidity and believes that, with additional funding from Congress and the implementation of the recommendations discussed below, maternal health across the country can be significantly improved.

GROW AND RETAIN THE PHYSICIAN WORKFORCE TO PROVIDE COMPLEX CARE TO HIGHER-RISK PREGNANT, BIRTHING, AND POSTPARTUM PATIENTS

Recommendation 1a: Address physician workforce needs in maternity care.

Access to physician practices, clinics, and hospitals that provide maternal and infant care services is critical to providing high-quality care; yet, in 2023, only about 43,500 Obstetrician-Gynecologists (OBGYNs) were in practice across the entirety of the U.S. and its territories. According to the latest March of Dimes report, almost 7 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. As such, a greater emphasis is needed on increasing and retaining the number of physicians in the maternal and infant care space to decrease maternal care deserts and improve health outcomes. Therefore, in order to increase the number of maternal care providers and help with the retention of physicians who provide maternal care Congress should:

The Physician Residency Cap and Training

- Work to help remove the cap on physician residency slots. If this is not possible, Congress should work to increase the cap on physician residency slots and ensure that the cap is not stagnant—i.e., the cap is increased as needed. Moreover, the cap-building period for new residency programs should be increased.
- Expand maternal care education and training, especially to those physicians likely to have to administer care to pregnant or postpartum individuals but are not OBGYNs or maternal-fetal medicine specialists.

National Health Service Corps

- Increase funding for the National Health Service Corps (NHSC) and ensure that a higher percentage of physicians are accepted to the NHSC Loan Repayment Programs and Scholarship Programs.
- Ensure that further information about the Maternity Care Target Area (MCTA) addition to the NHSC is provided to the public and grant more funding for the MCTA addition so that an adequate number of maternity care physicians—including OBGYNs, family physicians with an emphasis on maternal care, emergency medicine physicians, and maternal-fetal medicine specialists—can be placed in Health Professional Shortage Areas (HPSAs) through the NHSC.

Indian Health Service

- The Indian Health Service (IHS) should establish an Office of Academic Affiliations responsible for coordinating partnerships with the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, accredited medical schools, and residency programs accredited by the Accreditation Council for Graduate Medical Education. Furthermore, to support these partnerships, funding streams should be developed to promote rotations and learning opportunities at IHS, Tribal, and Urban Indian Health Programs.
- The IHS loan repayment program should be strengthened. The payments received through the IHS loan repayment program are taxable. In order to align this loan repayment program with other similar programs the loan repayments received should be tax free.
- Compensation for IHS physicians should be increased to a level competitive with other Federal agencies and additional funding should be provided to the IHS loan repayment program to increase the number of physicians who can be supported, especially in the maternal care space.

- Additional funding should be provided for the IHS Maternal Child Health (MCH) program. The IHS MCH should ensure that the funds it receives are used to increase access to OBGYNs and maternal-fetal medicine specialists for AI/AN pregnant individuals.
- The Centers for Disease Control and Prevention should increase its engagement in the following ongoing initiatives (this list is not exhaustive): develop awards to fund support for MMRCs for AI Tribes, expand materials on the Hear Her Campaign website for AI Tribes, and continued support for the Healthy Native Babies Project (HNBP) to assist local programs in addressing safe infant sleep in AI/AN communities.

Teaching Health Center Graduate Medical Education

- Increase funding for Teaching Health Center Graduate Medical Education (THCGME) Programs. Since 2010 this program has helped 21 OBGYNs complete their residency and enter the workforce. Though this is an excellent start, additional funding, and support for this program, and in particular OGBYNs in the THCGME Program, is needed.

Residency

Additional specific training tracks for maternal and infant care should be created and expanded. Rural track programs (RTP) already exist and are designed to encourage the training of residents in rural areas. Specifically, the Maternal Health and Obstetrics Pathway within the Rural Residency Planning and Development (RRPD) Program is available for both OBGYN rural residency programs and family medicine rural residency programs that have enhanced obstetrical training. The RRPD is a vital path that helps draw more physicians into rural practice. Therefore, **the AMA supports the Rural Residency Planning and Development Act of 2024 (H.R. 7855),** which would codify the RRPD program. This legislation is a great example of some of the permanent and meaningful fixes that Congress can make to help provide additional training pathways for physicians who want to provide much needed care in rural communities.

While the Maternal Health and Obstetrics Pathway within the RRPD is an important first step, it needs to be expanded so that additional maternal health pathways can be created. For example, additional training tracks should be created that allow for both rural and urban training for OBGYNs, maternal-fetal medicine specialists, family physicians, and other physicians who will likely have to provide maternal care. These training programs could be modeled off existing programs that are already accredited by ACGME such as the family medicine RTP programs which exist in the "1-2 format"—meaning the resident's first year is at a core family medicine program and the second and third years are at another site. Since there are already provisions of law and regulations that allow urban hospitals to create multiple RTPs and receive adjustments to their caps for newly established RTPs, it would be possible to create an educational format that allows for residents to train in urban and rural settings in maternal care thereby enabling physicians who will ultimately practice in rural areas to 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. As such, **more funding should be provided for the Maternal Health and Obstetrics Pathway and programs with similar goals should be**

created. Moreover, additional funding for rural clinics and hospitals should be provided to enable them to offer rotations for medical students and residents in rural obstetric care.

Recommendation 1b: Utilize new payment models to prevent maternal deaths.

More than one-third of the rural hospitals that still have labor and delivery services are losing money on patient services overall, putting their ability to continue delivering maternity care at risk. Moreover, the number of health care professionals who are needed to maintain labor and delivery units, such as physicians, nurses, and anesthesiologists, are costly. "As a result, payments per birth that are adequate at a large hospital are not enough to support maternity care at small rural hospitals with far fewer births." This lack of funding often results from the fact that the prenatal, perinatal, and postpartum care provided by physicians is paid for through a fixed "global" code, 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 individuals who have chronic conditions, undergo a high-risk pregnancy, or who experience health-related social needs. Therefore, it is imperative that additional payments are provided in the maternal health space.

FUND PATIENT-SAFETY BUNDLES, ACCESS TO SUBSTANCE USE DISORDER TREATMENT, AND MEDICAL-LEGAL PARTNERSHIPS TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 2a: Ensure feasibility and implementation of Core AIM Patient Safety Bundles and checklists.

The AMA strongly supports the Alliance for Innovation on Maternal Health (AIM) patient safety bundles, and we are encouraged that they are included in both the White House Blueprint and the new Transforming Maternal Health (TMaH) program. However, it is important for states and the federal government to recognize that the biggest barrier to implementing these bundles is a lack of resources and that additional funding, beyond what has already been invested, is needed to adequately implement the AIM bundles, especially in smaller institutions and institutions that do not have vast resources. **Therefore, the AMA strongly recommends that Congress provide the financial resources necessary for implementation of the Core AIM bundles and seek input from physicians providing obstetrical services about the barriers to implementing the AIM patient safety bundles.**

AIM: Simulation Training

Multiple AIM bundles include requirements to "[c]onduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients." The American College of Obstetricians and Gynecologists (ACOG Simulations Working Group) has already created multiple simulation resources including obstetric surgical skills, emergencies in clinical obstetrics, uterine atony, and cerclage. However, the cost of implementing simulations is always a concern, especially for smaller practices, practices located in historically minoritized areas, and rural practices. As such, it is vital that **funding be provided**

for consistent, up to date, holistic simulations that can improve maternal health. Moreover, these simulations should be available for every physician, and physician led team, who engages in maternal care, including OBGYNs, maternal-fetal medicine specialists, family physicians, and emergency medicine physicians.

Recommendation 2b: Expand evidence-based programs for pregnant and postpartum people with substance use disorder.

From 2018 to 2021, the mortality ratio more than tripled among pregnant and postpartum women aged 35 to 44 years. Increasing access to holistic care for pregnant and postpartum women with substance use disorder (SUD) is vitally important, and one of the issues addressed in the core AIM bundles. As such, **we recommend that the AIM bundles be built out to cover additional care concerns connected with SUD and maternal health and to incorporate some additional best care practices.**

Increase access to evidence-based treatment to help patients access medications for opioid use disorder

The AMA commends the HELP Committee for advancing the Modernizing Opioid Treatment Access Act (M-OTAA)—policy that would greatly expand access to care for methadone in the community rather than limiting it to only federally authorized opioid treatment programs. This legislation would increase access to methadone if prescribed by board-certified addiction medicine physicians or addiction psychiatrists—among the highest trained specialists to treat substance use disorders in the nation. As such, **the AMA and more than 70 local, state and national organizations, support this important piece of legislation and urge Congress for its passage.**

Provide the Department of Labor with the authority to levy civil monetary penalties for violations of the Mental Health Parity and Addiction Equity Act (MHPAEA)

Congress should provide the U.S. Department of Labor (DOL) with the authority to assess civil monetary penalties for parity violations. After 15 years of health plans consistently failing to comply with MHPAEA—as detailed in the 2022 and 2023 Reports to Congress from the DOL, Department of Health and Human Services and Department of the Treasury—the AMA urges Congress to provide the DOL the necessary resources and authority to finally hold health plans accountable for their failures. Insurers' actions have made clear for nearly 15 years that they will not comply with MHPAEA unless forced to do so.

Increase the addiction medicine, addiction psychiatry, and pain medicine workforce

Congress should pass the Substance Use Disorder Workforce Act of 2024 (H.R. 7050). Only 102 Accreditation Council for Graduate Medical Education (ACGME) -accredited addiction medicine fellowship programs exist nationwide, falling short of the goal of 125 fellowships by 2022 set by the President's Commission on Combating Drug Abuse and the Opioid Epidemic in 2017. These fellowships, available to a wide range of physicians, including those in family medicine, internal medicine, psychiatry, pediatrics, and emergency medicine, offer vital training

in evidence-based SUD care. If enacted, H.R. 7050 would provide Medicare support for an additional 1,000 new graduate medical education positions over five years in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine and their prerequisite programs. More physicians in these specialties must be trained to meet the needs of patients with a mental illness or an SUD.

Require states to comply with federal law protecting access to medications for opioid use disorder as a condition of their prison systems receiving federal dollars

Despite positive efforts from some states and the U.S. Department of Justice to ensure access to medications for opioid use disorder (MOUD) in jails and prisons for individuals, denial of MOUD in jails and prisons continues, including for individuals who are pregnant and postpartum. Denying access to MOUD violates the Americans with Disabilities Act, and federal court decisions protecting the right to receive MOUD in carceral settings, jails, and prisons. **The AMA encourages the federal government to help ensure pregnant people in jails and prisons have access to their rights under the law, including access to MOUD during pregnancy and postpartum periods, per federal law.**

Urge the U.S. Food and Drug Administration (FDA) to take steps to revise the outdated buprenorphine drug label limiting access to this life saving drug in the era of illicit fentanyl

There is widespread evidence that supports buprenorphine as an evidence-based medication to treat opioid use disorder (OUD). In the age of illicit fentanyl killing tens of thousands of Americans, buprenorphine doses greater than 24mg are showing effective in some cases. The current FDA label is based on old studies that did not include fentanyl—and that label is used by health insurance companies and other payers to deny access to higher dose buprenorphine. **AMA advocacy has for years called for removing all barriers to buprenorphine for the treatment of OUD—including prior authorization reforms, the x-waiver, telehealth restrictions, and dosage caps.** Congress has taken several of these steps. Removing the outdated 24mg threshold is the next important step to save lives from illicit fentanyl.

Recommendation 2c: Address Social Determinants of Health within the pregnant and postpartum population by enhancing medical-legal partnerships.

"Perinatal medical–legal partnerships share responsibility across a diverse team, integrate legal care as needed, and leverage law and policies to help manage vulnerabilities that are exacerbated by an advancing pregnancy…. Encouraging the use of medical–legal partnership in more perinatal settings is warranted as obstetric visits offer an advantageous moment for the types of interventions offered." Moreover, some very successful medical-legal partnerships (MLPs) have been established across the country such as the Georgetown University Health Justice Alliance's Perinatal Legal Assistance and Well-being (LAW) Project – one of the first MLPs to focus specifically on perinatal needs. These MLPs show a reproduceable pathway to helping patients navigate the health care system. As such, **the AMA urges Congress to work together to provide funding to expand MLPs across the U.S. so that every birthing person can have access to the benefits they are entitled to ensure a healthy pregnancy.**

LEVERAGE DIGITAL HEALTH TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 3a: Promote telehealth and home monitoring during pregnancy and the postpartum period and address barriers to providing remote patient care.

Infrastructure for Remote Patient Care

While the Centers for Medicare & Medicaid Services (CMS) created the State Medicaid & Children's Health Insurance Program (CHIP) Telehealth Toolkit as well as a Supplement to facilitate state implementation of telehealth policies and promote greater provision of telehealth services in the maternal health space, in order to guarantee that remote maternal care can be offered, it is vital to first ensure that the infrastructure for remote care services is in place. Accordingly, **it is imperative that there are reliable broadband connections at both the site of the physician and the patient to ensure that consistent, reliable, maternal care can be provided virtually. Thus, the federal government should build out, and make permanent, initiatives like the Connected Care Pilot Program** which provides funding for "eligible costs of broadband connectivity, network equipment, and information services...." Moreover, it is exceptionally important that these initiatives focus on rural areas that tend to have the worst broadband access. Consequently, **programs like the Rural Health Care Program and the Rural Telehealth Initiative Task Force should be provided with additional support**, potentially through the Internet for All Initiative, so that broadband access can be provided to these communities as quickly as possible. Moreover, it is important to ensure that programs that increase access to the internet so patients can receive remote care (e.g., the Affordable Connectivity Program) are provided with the funding needed to continue.

Coverage of Telehealth

While maternity care is covered without cost-sharing by private plans and Medicaid expansion program under the Affordable Care Act, there are no federal requirements for coverage or reimbursement of telehealth care provided during or after pregnancy. However, due to the increased reliance on telemedicine over the past few years, Medicaid programs have begun to permanently expand coverage of telemedicine as a modality to provide health care services, although maternal and postpartum virtual care is not always included in these policies. **The AMA believes that telehealth and remote patient monitoring are a critical part of the future of effective, efficient, and equitable delivery of health care in the United States and encourages the federal government to help ensure comprehensive Medicaid coverage of virtual maternal health care services.**

Monitoring of Hypertension During Pregnancy and Postpartum

Over the last decade, the AMA has developed and disseminated an evidence-based quality improvement program, AMA MAP™ hypertension (HTN), that has demonstrated improvement in blood pressure (BP) control for adult patients with hypertension in primary care settings. In addition the AMA has collaborated with other interested groups to increase access to tools, resources and services to improve the clinical management of hypertension, including clinical

services and home devices for self-measured blood pressure (SMBP), specifically increasing Medicaid coverage. SMBP is an evidence-based strategy for BP control that is incorporated into AMA MAP HTN and other AMA solutions.

The AMA is convening clinical subject matter experts to identify effective strategies and best practices to improve care of patients with Hypertensive Disorders of Pregnancy (HDP). Expected deliverables include clinical resources, issue briefs/commentaries, and peer-reviewed publications for national dissemination. The AMA collaborates regularly with organizations and leaders in maternal health who are national experts on HDP to build upon the AMA work to develop an SMBP postpartum strategy.

Improving Care for Patients with Hypertensive Disorders of Pregnancy

HDPs are one of the leading causes of pregnancy-related deaths that occur in the first six weeks postpartum. The rate of patients entering pregnancy with chronic HTN and the overall rate of HDPs have risen considerably in recent years. The use of SMBP has been shown to increase compliance with ACOG recommendations for BP monitoring, increase patient satisfaction, and decrease readmissions for HDPs. SMBP has also shown promise in reducing inequities in the monitoring and treatment of BP in postpartum patients. Multiple barriers prevent the widespread adoption and use of SMBP for which there are potential solutions. These include coverage and access, clinical infrastructure, clinical quality improvement, federal legislation related to remote patient monitoring, and teleconsultation which are discussed below.

Coverage and access

Medicaid covers 42 percent of all births in the U.S. Coverage varies by states including the inclusion of an extra appropriately size cuff, often needed to ensure clinical accuracy. This variation and others are barriers to scaling SMBP. Even when coverage exists there are still access issues. Some states prohibit shipping a covered device directly to the patients or require patients to go to a specific durable medical equipment supplier rather than a more convenient location. For SMBP coverage to be clinically impactful it necessitates that patients have coverage and access to devices that are appropriately sized and clinically validated. **Therefore, we recommend policies that support increased coverage and access to SMBP devices clinically validated for pregnancy and appropriate cuff sizing options.**

Clinical infrastructure

SMBP requires investments in clinical personnel and technology integration into clinical practice. Therefore, we recommend policies that support:

- **Improved interoperability of apps/platforms to support the transfer of BP measurement data from patients to clinical teams.**
- **Increased reimbursement for physician-led team-based care in order to increase patient access to programs that improve care for patients with HDP.**

Clinical quality improvement

Clinical teams require access to data to drive and measure quality improvement programs as well as research efforts. Dedicated funding to scale promising interventions nationally and measure the impact on outcomes is also needed to identify the most effective solutions and strategies. Therefore, we recommend policies that support:

- **Increased availability of standardized clinical and billing data for use in quality improvement.**
- **Increased funding for clinical, dissemination and implementation research on HTN and cardiovascular diseases during pregnancy and postpartum in order to identify and measure effective interventions to improve quality of care and health outcomes.**

Additional factors that may impact the use of SMBP are the availability of maternity care, the status of policies related to caregiving (e.g., parental leave) and the status of health insurance coverage availability (e.g., Medicaid expansion).

Federal Legislation Related to Remote Patient Monitoring

Improving maternal and infant health outcomes for pregnant and postpartum women with the support of telehealth and remote patient monitoring solutions. Telehealth and technology enabled devices have proven to be key assets in the physician's toolbox for prevention and improved health outcomes for a number of conditions. The AMA recognizes the same technology is critical to addressing maternal mortality and morbidity by helping screen new mothers for high blood pressure and related treatable and preventable conditions, such as preeclampsia, that lead to unnecessary and avoidable maternal deaths and adverse health outcomes.

To help improve maternal health outcomes, **the AMA strongly supports S. 712, the "Connected Maternal Online Monitoring (Connected MOM) Act."** This bill would require CMS to send a report to Congress identifying barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.

Teleconsultation

In many rural and underserved areas that lack regular and reliable access to physician specialists and subspecialists, such as maternal-fetal medicine physicians and fetal cardiologists, primary care physicians routinely manage pregnancy care. These primary care physicians need access to specialist consultations to help address complex clinical challenges that may arise over the course of pregnancy or delivery. One way to support multidisciplinary peer collaboration is through a telehealth hub-and-spoke model in which one large "hub" hospital provides additional support and training for smaller "spoke" facilities. This model, introduced through Project ECHO, enables physicians in rural areas to connect with specialists in facilities with capacity to

provide higher levels of maternal care via telehealth. **These models should continue to be supported, and provided with additional funding, to enable patients to access higher levels and more specialized care without having to leave their communities.**

Recommendation 3b: Ensure the acquisition of the right type of data.

Advancing Interoperability for Maternal Health

Standardization is the first step in forming robust research datasets and is especially important for studies on maternal health. One of the first improvements that must be made in the collection and usage of maternal health data is ensuring that the data are complete. For example, maternal health and child health are inextricably linked, but relevant data are often held in separate, unconnected health records. In order to address this issue, models are being developed to support data exchange for predictive analysis, risk assessment, and retrospective maternal health research. One such project is HL7's Longitudinal Maternal & Infant Health Information for Research. **This project, and projects like it, should be supported and provided with additional funding so that the necessary data linkage between individuals and their infant's health can be made and a holistic picture of the maternal mortality crisis can be achieved.**

To further aid in creating this holistic picture of maternal and infant health, Medicaid eligibility and claims data should be used, in conjunction with vital statistics and data from the Pregnancy Risk Assessment Monitoring System (PRAMS), to help review maternal and infant health data points that could indicate trends in care across Medicaid and CHIP. Moreover, **federal policies should support the expansion of the Pregnancy Mortality Surveillance System (PMSS)**. To aid in this, standards are needed to support physician collection of patient-identified race and ethnicity information to better detect inequities because better electronic health record (EHR) data in clinical settings and standardization across health systems is essential for meaningful and unbiased research.

Conclusion

The issues surrounding maternal health are deep-seated, multicultural, and systemically ingrained. The AMA believes it will require a holistic approach to ensure that birthing individuals and their children receive the care they need and deserve. While our recommendations, if implemented, will have a significant positive impact on maternal health across the nation, we remain committed to seeking solutions to broader SDOH issues that impact maternal health.

The AMA thanks the Committee for this hearing and for the careful consideration of solutions to improve maternal health outcomes across this country. We look forward to working with the Committee and Congress to help ensure that birthing individuals experience healthy pregnancies.