STATEMENT

of the

American Medical Association

to the

U.S. Senate

Committee on Finance

Re: Rural Health Care: Supporting Lives and Improving Communities

May 16, 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 Finance as part of the hearing entitled, "Rural Health Care: Supporting Lives and Improving Communities." This hearing is critically important as it focuses on the ability of rural communities to access quality health care and highlights innovative solutions that these communities need to overcome persistent health care challenges.

The AMA commends the Committee for its consideration of this important issue aimed at, among other things, ensuring the continuation of certain programs and policy flexibilities granted as part of the response to the COVID-19 pandemic that help ensure patients retain access to at-home care. The COVID-19 pandemic made clear that rural and underserved areas that have historically lacked adequate access to health care services can greatly benefit from permanent legislative and regulatory flexibilities. As a result, we applaud the Committee for recognizing the importance of promoting health equity as it considers which COVID-19 policies to retain to facilitate continued access to home-based care. In addition, we urge Congress to consider how making many of these existing flexibilities permanent will provide the necessary assurances that physicians, health care organizations, and patients may need before investing additional resources into policies such as telehealth and the Hospital at Home program.

INNOVATION MODELS AND TECHNOLOGY

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services for Medicare patients by passing the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act" (S. 2016/H.R. 4189), and the "Telehealth Modernization Act" (S. 3967/H.R. 7623). Given that we are in the middle of a national physician workforce crisis, telehealth continues to provide critical access for patients across the country in various settings.

The AMA supports the CONNECT for Health Act and the Telehealth Modernization Act (S. 3967/H.R. 7623),

The CONNECT for Health Act is bipartisan legislation that would permanently extend many important COVID-19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID-19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services for the first time. The CONNECT for Health Act currently has 65

cosponsors, an overwhelming majority of supporters in the Senate and, as a result, should be passed expeditiously.

COVID-19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology. Therefore, passage of the Telehealth Modernization Act is crucial because, in addition to eliminating the geographic and originating site restrictions, thus allowing rural, urban, and suburban patients to receive telehealth services wherever they can access a telecommunications system, the legislation permanently continues the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated barriers that many patients in rural and underserved areas face when trying to obtain in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare. Also, in an effort to boost access to virtual mental health services, both the Connect for Health Act and the Telehealth Modernization Act repeal the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within six months of an initial telehealth visit for a mental health condition. Federal lawmakers have also introduced stand-alone bills, specifically S.3651/H.R. 3432, the "Telemental Health Care Access Act," to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within six months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously.

The AMA supports H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act

As an interim step, the AMA also recommends that Congress pass H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act." This important legislation will extend through 2026 many of the above telehealth provisions we strongly support including audio-only telehealth services, exemptions to geographic and originating site restrictions, and delaying the in-person requirements for telemental health services.

This bill also extends the Acute Hospital at Home Waiver Flexibilities through 2029. On March 11, 2023, the AMA along with other organizations, including medical groups participating in the Acute Hospital Care at Home (AHCaH) waiver program, submitted a request to Congress asking for at least a five-year extension of AHCaH before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to AHCaH programs that have demonstrated excellent clinical outcomes and lower the costs of care. With an expiration set for the end of this year, medical groups, and health systems nationwide need assurance that this waiver program will be extended if they are going to invest their resources into logistics, supply chain, and workforce for AHCaH.

Although our ultimate goal is that these flexibilities are made permanent to facilitate greater long-term investment in virtual care for the betterment of patients, we are glad Congress is prioritizing legislative action to extend the telehealth services currently scheduled to lapse at the end of the year and we urge that this extension be kept clean of guardrails that will serve to limit patient access to care.

The AMA opposes H.R. 1746, the Preventing Medicare Telefraud Act

The AMA strongly opposes any efforts to impose other types of antiquated "guardrails" pertaining to telehealth services. The AMA views telehealth as a method to deliver care, and creating significant burdens to access these services in the name of program integrity requires substantial justification. As a result, the AMA strongly opposes H.R. 1746, the "Preventing Medicare Telefraud Act," or any other legislation that promotes similar policies.

This legislation requires a patient to receive an in-person visit within six months of receiving "high-cost" durable medical equipment (DME) and laboratory tests ordered via telehealth. This provision makes little sense as it is impossible clinically for a physician to know if the patient will need high-cost DME or laboratory tests prior to receiving a telehealth visit. Under this legislation, "high cost" DME and laboratory tests would also be

defined by the Centers for Medicare & Medicaid Services (CMS) Administrator, which the AMA believes to be an excessive expansion of executive authority.

In addition, H.R. 1746 stipulates that, beginning six months after the effective date of the high-cost DME/lab clause, Medicare Administrative Contractors (MACs) shall conduct reviews on a schedule determined by the HHS Secretary of all claims of high cost DME/lab tests ordered over the preceding 12 months when at least 90 percent of these services are prescribed by a physician/provider via telehealth. Again, since telehealth is simply a modality, the AMA believes such audits are not appropriate or necessary because it provides no consideration of medical necessity.

In general, the AMA urges members of the Senate Finance Committee to reject any inclination to establish additional guardrails, including in-person visits or mandatory audits, in the name of rooting out fraud, waste, and abuse. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication of services are of particular concern for telehealth services.

The AMA believes existing HHS and OIG fraud capabilities and authorities are more than adequate to police telehealth services in the same way they oversee in-person Medicare services. A February 2024 HHS OIG report confirms this reality.[1] For 105 out of the 110 sampled Evaluation and Management (E/M) services provided via telehealth during the early parts of the pandemic, physicians appropriately complied with Medicare requirements. As a result, OIG did not provide any policy recommendations to CMS because, "…providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Medicare fraud is still Medicare fraud, irrespective of whether it involved telehealth services.

In February 2021, HHS's Principal Deputy Inspector General (OIG) released a statement dispelling any concerns with OIG's authority or ability to address concerns of fraud and abuse. Instead, HHS OIG's statement highlights that concerns stem from "telefraud" schemes, rather than "telehealth fraud," in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the telehealth visit but instead use the sham telehealth visit to induce a patient to agree to receive unneeded items and gather their info.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. CMS has also implemented Place of Service (POS) indicators for this purpose, including POS 02 when the originating site is someplace other than the patient's home and POS 10 when the patient is in their home. Additional indicators may be used for asynchronous services and home health services provided via telehealth. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via Modifier 95 and other CMS indicators.

The State of Health at Home Models: Key Considerations and Opportunities

Building on existing playbooks and resources supporting digitally enabled care, the AMA conducted research to explore the different ways health care is and can be provided in the home. The AMA report titled, "The State of Health at Home Models: Key Considerations and Opportunities" offers a comprehensive guide that outlines the concept and benefits of delivering care to patients in their home environments.[2] These include recommendations for physicians to: Determine whether your practice or organization should build your health at home program internally or partner with another organization; consider required training to strengthen your mobile workforce, which is a core component of health at home programs; ensure you understand the unique and varied circumstances of each home environment and plan for the patient and caregiver experience in detail; develop the

[1] https://oig.hhs.gov/oas/reports/region1/12100501.asp.
[2] https://www.ama-assn.org/system/files/health-at-home-models.pdf.

infrastructure up front that will provide the necessary tools to appropriately handle the flow of resources and information to provide patient care as required by your specific program.

Future of Health Case Study: Atrium Health

This case study highlights how this vision is being accomplished through a strategic partnership between a traditional brick-and-mortar health system and a technology company, with a common goal to build and scale a program that enables patients to continue their care and recovery at home. Each organization brings its expertise to the partnership, enabling thoughtful development and implementation of a complex, digitally enabled clinical initiative.

Payment and Delivery in Rural Hospitals

In this issue brief, the AMA reports on background, challenges, costs, and strategies related to the delivery of care in rural hospitals. Additionally, this includes strategies to improve rural health and hospital viability.

ASPE Report - Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019-2021

This report by the Assistant Secretary for Planning and Evaluation (ASPE) reveals sustained above-pre-pandemic levels of telehealth utilization among Medicare beneficiaries, notably for behavioral health and primary care visits. This sustained utilization highlights the importance of telehealth in bridging access gaps, particularly for vulnerable populations due to the severity and complexity of their illnesses. The findings from ASPE highlight the critical role of telehealth in maintaining continuity of care and suggest a pressing need for policies that support the permanent integration of telehealth services within the Medicare program.

AHRQ Study - The Impact of Expanded Telehealth Availability on Primary Caree Utilization

An Agency for Health Care Research and Quality (AHRQ) funded study analyzing over four million primary care encounters highlights telehealth's role in maintaining health care utilization levels without contributing to overutilization. This study's results challenge concerns about potential increased health care utilization due to telehealth expansion, reinforcing telehealth's value as a viable alternative to in-person encounters when deemed appropriate. Given these insights, it is important for legislation like the CONNECT for Health Act and the Telehealth Modernization Act to pass, ensuring telehealth's role as a cornerstone of accessible, efficient health care delivery.

Change Healthcare and Cybersecurity

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians, hospitals and pharmacies, and delays in patient care.

In fact, on March 19, Representatives Mariannette Miller-Meeks (R-IA) and Robin Kelly (D-IL), along with 96 bipartisan members of the House of Representatives, sent a letter to HHS Secretary Becerra alerting the administration of the ongoing challenges physicians and patients are continuing to experience as part of the Change Healthcare cyberattack. In addition to highlighting the inability of physician practices to file claims and receive prompt payment, the letter urges CMS to clarify why they issued such stringent repayment terms as part of their March 9 announcement permitting advance payments for Part B physicians and other providers. The letter also highlights how individuals are being forced to pay out-of-pocket for pharmaceuticals and health care services due to the cyberattack, as well as pressed the Department for answers as to how it proposes to safeguard patients from the negative impact of their private health care information being inappropriately disclosed to malicious actors.

Overall, the attack demonstrates the vulnerability of our health care sector's infrastructure to cyber threats and the cascading effects these breaches can have on patient safety, privacy, and the overall delivery of care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

This incident is especially concerning for rural, remote, and underserved communities, where access to health care services is already limited. The reliance on digital platforms for telehealth and at-home care programs has been a lifeline for these communities, offering a measure of parity in access to essential health care services. However, the cybersecurity vulnerabilities exposed by the attack on Change Healthcare reveal a potential gap in our efforts to extend health care equity through digital means. As noted in the March 21 letter led by Vice Chairman Vern Buchanan and 19 Ways and Means members, a 2022 AMA study found that nearly 75 percent of patients expressed concern about protecting their personal health data.

The technical and financial burden of implementing cybersecurity should not be placed solely on physicians or the hospitals. Congress must provide important financial resources to assist physician practices with the challenge of protecting health care data. Ensuring the security of digital health care services is not merely about protecting data but about safeguarding the continuity of care for the most vulnerable populations in our society.

ELECTRONIC FUND TRANSFER (EFT) FEES AND REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE

The AMA recognizes the critical need to address financial and administrative inefficiencies that detract from our health care system's ability to serve rural and underserved communities effectively. A pressing issue in this context is the undue financial strain imposed on physicians and health care providers by unnecessary fees for Electronic Fund Transfers (EFTs).

The burden of EFT fees, as outlined in our support for S. 3805, the "No Fees for EFTs Act" in the Senate, and support for H.R. 6487, the corresponding House bill, highlights a significant barrier to the efficient operation of health care practices. These fees, which can range from two percent to five percent of the claim payment, are levied by some health plans and their vendors without explicit agreement from practices, thereby exacerbating the financial and administrative burdens on physicians. This issue is especially significant for health care providers in rural and underserved areas, where financial resources are already stretched thin, and administrative burdens can significantly impact the quality and accessibility of patient care.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

Need for an Inflation Based Update to Physician Payment

The physician payment system is on an unsustainable path that threatens patients' access to physician services. This year, physicians faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed Medicare budget neutrality rules. Congress acted last March to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts completely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates fell 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2023 annual report, the Medicare Trustees "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the system. The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The current Medicare physician payment system—with its lack of an adequate annual physician payment update—is particularly destabilizing as physicians, many of whom are small business owners, contend with a

wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent this year.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, this pattern of last-minute stop gap measures must end. As the Committee looks to provide adequate payments to physicians, particularly those in rural and underserved areas, annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation. Specifically, we ask Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care.

Improvements to Budget Neutrality

Another way to help ensure physicians have ample resources to provide more care in the home is via reforms to statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The AMA urges Congress to pass H.R. 6371, the "Provider Reimbursement Stability Act." In fact, the Energy and Commerce Committee already took action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023.

The reality is that physician payments are further eroded by frequent and large payment redistributions caused by these budget neutrality adjustments. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these misestimates are not adjusted in a timely way, it results in permanent removal of billions of dollars from the payment pool. Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for misestimates and adjust the conversion factor to reflect actual claims data.
In addition, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $53 million to best account for past inflation.

Merit-based Incentive Payment System (MIPS)

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. In particular, the 2022 Quality Payment Program Experience Report shows that 27 percent of small practices, nearly 50 percent of solo practitioners, and 18 percent of rural practices received a MIPS penalty. Yet, a 2022 study found MIPS scores were inconsistently related to performance, "which suggests that the MIPS program is approximately as effective as chance at identifying high vs low performance." This program is driving up burden, penalizing physician practices with fewer resources, and devoid of meaning for patients.

Last year, the AMA responded to a Congressional RFI request from the House Committee on Ways and Means' on ways to improve health care in rural and underserved areas. In our comments, we highlight the difficulties experienced by health care providers, particularly small, rural, independent, and safety net practices, in adapting to

the MIPS framework, especially in the context of the disruptions caused by the COVID-19 pandemic. We also proposed three key legislative changes aimed at mitigating the negative impacts of MIPS penalties, improving the timeliness and relevance of performance feedback and claims data provided by CMS, and making the program more clinically relevant while reducing the administrative burden on practices. We urge the Senate Finance Committee and Congress, in general, to continue considering these same recommendations and look forward to collaborating closely on these critical issues to ensure that health care providers, especially those in rural and underserved areas, are supported effectively through the MIPS framework.

Private Equity and Health Care

The increasing presence of private equity in the health care sector raises important considerations for the sustainability and accessibility of health care services. With a notable shift in physician practice ownership from independent practices to those owned by hospitals, health systems, and private equity groups, there is an urgent need to examine the implications of these changes, especially in rural and underserved areas where health care options are already limited. Rural and underserved communities stand to be significantly impacted by the growing influence of private equity in health care. These areas, already grappling with a shortage of health care providers and limited access to medical services, may find themselves further marginalized by health care consolidation and the business-driven approaches of private equity-owned practices. The AMA's observation of a decline in the percentage of physicians working in private practices highlights the potential for decreased health care autonomy and personalized patient care, aspects crucial for addressing the unique health challenges of these rural communities. The AMA supports legislation which creates a more equitable and transparent health care system that prioritizes patient care over profit. H.R. 2474 is one such proposal that seeks to ensure sustainable Medicare physician payment rates, a crucial factor in maintaining the viability of independent practices and, by extension, preserving access to high-quality health care in rural and underserved areas.

HEALTH CARE WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

Rural hospitals play a very important role within communities. For example, in "2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as $220 billion in economic activity in rural communities." However, between 2010 and 2021, 136 rural hospitals closed. These closures only compound the problems experienced by the current Health Workforce Shortage Areas (HPSAs). According to the Health Resources and Services Administration over 19,000 providers are currently needed just to eliminated our primary care and mental HPSAs. Moreover, these closures have contributed to unequal access and distribution of providers since about 20 percent of the U.S. population lives in rural communities, but only 10 percent of physicians practice in such areas. On top of this, with our aging physician workforce, it is projected that there will be about a quarter fewer rural physicians practicing by 2030.

In order to increase providers in rural areas, and to combat the projected shortage of 86,000 physicians by 2036, **more residency positions should be created**. Additionally, "Cap-Flexibility," which would allow new and current GME teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), would begin to help to remedy the physician shortage we are currently experiencing. "Giving these [rural] hospitals more time to establish their caps will help them start more programs and attract more residents to their communities before the Medicare-funded resident caps are set."

In order to encourage more individuals to become physicians and to practice in areas that are most in need we recommend that:

- Congress should act to allow the cap on GME slots to be increased as needed to meet the nation's changing needs rather than remain stagnant. Also, the cap building period should be increased.
- The immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government. Moreover, the Teaching Health Center Graduate Medical Education, Rural Residency Planning and Development Programs, the National Health Service Corps, and the Indian Health Service should have their funding increased to bolster scholarships, loan forgiveness, and expand these programs.
- Support should be provided so that more institutions are incentivized to create rural training track programs.

- Holistic changes to how physicians are recruited need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound diverse clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural or underserved areas, support systems are needed.

Specific bills we support include: H.R. 2389/ S. 1302 the "Resident Physician Shortage Reduction Act;" H.R. 4942/ S. 665, the "Conrad State 30 and Physician Access Reauthorization Act;"; H.R. 6205/S. 3211 the "Healthcare Workforce Resilience Act,"; H.R. 6980/ S. 2719, the "Directing Our Country's Transfer Of Residency Slots" or the " DOCTORS Act;"; H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act;"; H.R. 2761/ S. 705, the "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act,"; S. 1403/ H.R. 3046, the "Medical Student Education Authorization Act,"; S. 3022, the "IHS Workforce Parity Act;" H.R. 7050, the "Substance Use Disorder Workforce Act;"; H.R. 7258/ S. 3968, the "Community Training, Education, and Access for Medical Students (Community TEAMS) Act;"; H.R. 7855, the "Rural Residency Planning and Development Act of 2024,"; legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities; and Physician Shortage GME Cap Flex legislation.

OBSTETRICS CARE IN RURAL COMMUNITIES

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. In order to increase the number of maternal care providers and help with the retention of physicians who provide maternal care Congress should:

- National Health Service Corps: 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 HPSAs through the NHSC.
- Indian Health Service: 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; and 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.**

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.

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 American College of Obstetricians and Gynecologists 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. Unfortunately, coverage varies by state, which means that the acquisition of an extra appropriately size cuff, often needed to ensure clinical accuracy, is not always covered. 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; and 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; and 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.**

Federal Legislation Related to Remote Patient Monitoring

It is vital to begin 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.

For additional information about the AMA maternal health recommendations please see these resources:

- What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?
- AMA Recommendations on Maternal Health.
- Maternal health: Expanding on the AMA's recommendations to reduce deaths and improve outcomes.
- AMA advocacy to improve maternal health.

CONCLUSION

The AMA is committed to working with the Senate Finance Committee and Congress to find permanent solutions that ensure that Medicare beneficiaries have uninterrupted continued access to high quality, affordable health care. This will require a multi-pronged approach including continued investment and stability for access to telehealth, addressing the lack of an inflationary update in the Medicare physician payment system, working to eliminate administrative burdens that make practicing medicine difficult and drive physicians out of private practice, and policies to facilitate a larger and stronger health care workforce. We must build on the gains achieved during the pandemic so that all patients have access to the care they need.