AMA AMERICAN MEDICAL ASSOCIATION

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The Honorable Chuck Grassley
Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden:

On behalf of our physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to submit comments to the Senate Committee on Finance's request for information regarding, "Solutions to Improve Maternal Health." The AMA commends the Committee for focusing on this critically important issue, which disproportionately affects Black women and Native American/Alaska Native women. 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 other stakeholders to support efforts to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity.

1. Proposals Within the Jurisdiction of the Senate Finance Committee

   a) Extending Medicaid and CHIP coverage for individuals during the postpartum period;

The AMA believes it is critical that Congress works in a bipartisan manner to ensure Medicaid and CHIP coverage for women for one-year postpartum. Almost half of all U.S. births are to women with public insurance.[1] Public insurance has large coverage gaps for the low-income women who require it: in many states this coverage is not available prior to pregnancy, when women with medical conditions require it.[2] Insurance also terminates in the months following pregnancy when the vast majority of maternal deaths occur.[3] Medicaid coverage has improved maternal outcomes for low-income women.[4] In addition, research has shown Medicaid expansion has made progress in increasing pre-pregnancy coverage rates.[5] **We strongly urge Congress to safeguard Medicaid funding so as to not exacerbate the problem of maternal mortality and morbidity in the U.S.** Maternity care and childbirth are covered by Medicaid and Children's Health Insurance Program (CHIP). These state-based programs cover pregnant women and their children below certain income levels.[6] Maternal mortality (pregnancy-related death) is defined as the death of a woman while pregnant or within one year of the end of a pregnancy—regardless of the outcome, duration, or site of the pregnancy—from any cause related to or

[1] https://www.cdc.gov/nchs/products/databriefs/db318.htm
[2] https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf
[3] Id.
[4] https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/
[5] https://www.ncbi.nlm.nih.gov/pubmed/30156498
[6] Eligibility and benefits are different in each state. Income levels to qualify are different for Medicaid and CHIP.

aggravated by the pregnancy or its management, but not from accidental or incidental causes.[7] The Centers for Disease Control and Prevention (CDC) has found that about one-third or 33 percent of maternal deaths happened one week to one-year postpartum.[8] In order to assure optimal health care for the women at risk for medical or mental health conditions leading to maternal death, we believe additional insurance coverage is required.

b) Ensuring the full range of comprehensive benefits for pregnant and postpartum women;

The AMA supports ensuring the full range of comprehensive benefits, including mental health services, throughout the pregnancy spectrum. The CDC reports higher rates of depression in women of color, and lower rates of treatment.[9] Depression in pregnancy is associated with poor maternal outcomes including maternal death. With regards to postpartum depression, it is a mood disorder that can affect women after childbirth. Mothers with postpartum depression experience feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for them to complete daily care activities for themselves or for others. Postpartum depression occurs in nearly 15 percent of births. It is important to note that postpartum depression does not have a single cause, but likely results from a combination of physical and emotional factors. Postpartum depression does not occur because of something a mother does or does not do. Without treatment, postpartum depression can last for months or years. In addition to affecting the mother's health, it can interfere with her ability to connect with and care for her baby and may cause the baby to have problems with sleeping, eating, and behavior as he or she grows.[10] The AMA believes that ongoing surveillance and activities to promote appropriate screening, referral, and treatment are needed to reduce depression and suicide among women before, during, and after pregnancy.

c) Advancing evidence-based maternity care models;

The AMA recommends that the Center for Medicare and Medicaid Innovation (CMMI) be allowed to finish developing its maternal mortality model before an additional model from Congress is released. The AMA believes that having a limited Medicaid model that states can apply to, and participate in, will help to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes during pregnancy.

To provide physician practices the flexibility to address women's social needs, the AMA recommends that any alternative payment model for maternity care support obstetric care practices financially and does not require additional payments to be included in the global payment, such as facility fees. The AMA opposes inappropriate expansion of bundled services in a manner that reduces payment to participating physicians. Medically indicated patient services that are not included in the existing maternity care payment, such as consultations and diagnostic procedures provided by physicians, should be paid separately and not be inappropriately bundled.

A multitude of varying models should be avoided where maternal care is concerned, as having multiple models for maternity care increases the odds that models will be applied inaccurately. CMMI has been working on a model that considers risk appropriate care and risk adjustment. The AMA recommends that this model be tested before other models are considered, in order to minimize confusion.

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[7] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm
[8] https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html
[9] https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm?s_cid=mm6606a1_w
[10] https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml

d) Improving access to and collaboration among health care providers including non-physician providers; and

The AMA supports physician-led team-based care with each member of the team drawing on his or her specific strengths, working together, and sharing decisions and information for the benefit of the patient. All teams need a leader and as the health care professional with the highest level of education and training, physicians should lead the health care team. Certified nurse midwives, who are certified by the American College of Nurse-Midwives, are an important and valuable member of the health care team, their skills are complementary not interchangeable with that of a physician.

e) Advancing quality measures, collaboration, coordination and reporting for maternal and infant health; among others.

The AMA believes that quality measurement is a science that evolves over time and what might appear critical at one moment may be considered obsolete in the future. **Although quality measurement can improve maternal health outcomes by providing needed information regarding limitations in care over the pregnancy spectrum, the AMA remains concerned that by advancing certain prescriptive quality measures in statute, Congress will hamper the ability of physicians to be nimble, innovative, and quickly and effectively address any programmatic shortfalls.**

2. Coverage and Standards of Care to Improve Maternal Health

The AMA believes that poor network adequacy and low Medicaid reimbursement for physicians pose substantial barriers to improving maternal mortality and morbidity in this country and we urge Congress to work in a bipartisan manner to address this issue. While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot remain economically viable if they lose money on the care they provide. Without an adequate supply of participating physicians, Medicaid patients may have coverage but not real access to care. Too often beneficiaries must wait for unreasonable periods of time to receive needed care, travel long distances to find Medicaid participating physicians, or go without care altogether. Lack of access to participating physicians puts beneficiaries at risk of harm or even death and is contrary to the intent of Congress and the overriding purpose of the Medicaid Act. Despite the Congressional mandate, Medicaid reimbursement rates lag behind private insurance and Medicare, participating physicians remain sparse in many areas of the country, and access to health care services remains unequal.

3. Addressing Disparities and Disparate Outcomes

Health Equity and Social Determinants of Health (SDOH)

The AMA defines health equity as "optimal health for all" and recognizes the importance and urgency of advancing health equity and addressing SDOH to ensure that all people and communities reach their full health potential. The World Health Organization (WHO) defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." This definition clarifies that inequities and disparities do not have to exist, but that inequities are produced; they do not just happen; the people who are negatively impacted by experiencing the injustice are not to blame; and there is something that we can actually do to close the gap.

Health disparities—i.e., differences in health outcomes—in maternal health are the result of conditions that are similar for other disparities that exist. These conditions are widely understood to be the SDOH. According to Healthy People 2020, the "social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health,

functioning, and quality of life outcomes and risk." These social determinants include education, housing, wealth, income, and employment. We all experience conditions that socially determine our health or the SDOH. However, we do not all experience them equally.

The SDOH are impacted by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In this country, these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and therefore affect health itself. These larger, powerful systems of racism and gender oppression—also known as the root cause inequities—are upstream to the social determinants of health. They have shaped the social conditions in which women and families live, and they work to produce inequities across society in complex ways, especially for those marginalized at the intersection of race and gender, i.e., Black and Native American women.

Birth inequities arise at the intersection of discrimination by race and gender for Black and Native American women. We know that in some places across the country, Black women with at least a college degree had higher severe maternal morbidity rates than women of other races/ethnicities who never graduated high school. It is clear that racism and discrimination—at the provider, institutional, and societal levels—is an attributable etiology of the increased proportion of Black and Native American mothers inclusive of inequitable access to and quality of care, institutional racism, mistrust for health care institutions, and delayed response to medical emergencies by both medical providers and patients, and a culture of disrespect that can lead to mistrust for health care institutions. Stories from Black women also tell us about a culture of disrespect as well as realities of not being listened to or heard.

At the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases exist that negatively impact the quality of health care equity and patient safety and drive these inequities. This was described originally in an Institute of Medicine (now the National Academy of Medicine) report, more than 16 years ago.[11] The evidence shows that Blacks are more likely to receive poorer quality of care and less likely to receive the standard of care even when controlling for insurance status and income. This was linked with higher death rates for Blacks.

In addition, there has been a growing body of work examining the impact of structural racism on health in this country. In 2017, Dr. Zinzi Bailey et al published a study in the Lancet, "Structural Racism and Health Inequities in the US: Evidence and Interventions," that explains structural racism to be the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.[12] These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources." One key example of structural racism included how "residential segregation systemically shapes health care access, utilization, and quality at the neighborhood level, health care system, and provider levels."

This spring, the *New England Journal of Medicine* published "Structural Racism—A 60-Year-Old Black Woman with Breast Cancer," exposing the impact of racism, not just race, on health outcomes.[13] One of the authors, our Chicagoan colleague and partner from Rush Medical Center, Dr. David Ansell, says "we must be willing to identify the health impact of racism. The biological differences between groups are

[11] Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260
[12] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30569-X/fulltext
[13] https://www.nejm.org/doi/full/10.1056/NEJMp1811499?query=TOC

tiny, yet the gaps in outcomes are simply too wide to continue to see race as a disease risk factor when the root cause is racism."

While more research is needed on the relationship of discrimination and chronic stress of racism on maternal and infant health outcomes, there is evidence that experiences of discrimination and racism have a "weathering" effect on the body. Dr. Arline Geronimus, who coined the "weathering" hypothesis, explained that "Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" over one's life course.[14] This physiologic pressure, also later described as allostatic load, can cause stress hormones, such as cortisol, and cause organ and cardiovascular, metabolic, and immune systems damage over time. In addition, chronic stress and trauma due to discrimination that occurs as early in-utero and early childhood, also known as adverse childhood experiences, have been associated with poor health outcomes and early death as an adult.

A commitment to health equity means we must address the SDOH and we must elevate and name the root causes of why health inequities exist and how they came to be—both in society and at the institutional level. The AMA demonstrates its commitment through addressing the social conditions that impact health, increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection. Although the AMA and physicians cannot control all factors that need to change to achieve health equity, the AMA views as its role to identify their importance and to urge and educate those who can have a direct role to act.

The AMA supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that medical students are prepared to provide patients with safe, high quality, and patient-centered care. In 2013, the AMA launched the "Accelerating Change in Medical Education" initiative. Today, the 37-member consortium, which represents one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to nearly 24,000 medical students—students who will provide care to a potential 41 million patients annually. One of the earliest innovations to come from the Consortium was the new and innovative curriculum on health systems science, which includes a chapter on the social determinants of health. Nearly all the 37 schools in the consortium are addressing the social determinants of health with a focus on ensuring that students recognize the impact of social determinants on health outcomes and are working with inter-professional colleagues to address them.

In 2019, the AMA announced its Reimagining Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system. Many of the applications to the graduate medical education initiative have included health systems science training in their proposals.

For practicing physicians, the AMA launched STEPSforward™ an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment by working smarter, not harder.[15] This series includes a continuing medical education module on "Addressing Social Determinants of Health: Beyond the Clinic Walls." The interactive module helps physicians identify how to best understand the needs of their community, define

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[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/
[15] https://edhub.ama-assn.org/steps-forward

a plan to begin addressing social determinants of health, and explains the tools available to screen patients and link them to resources.

The AMA also supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems. Last month, the AMA and UnitedHealthcare announced a new collaboration to better identify and address social determinants of health to improve access to care and patient outcomes. The goal is to standardize data collection, processing, and integration regarding critical social and environmental factors that contribute to patient well-being through the creation of nearly two dozen new ICD-10 codes related to SDOH. By combining traditional medical data with self-reported SDOH data, the codes trigger referrals to social and government services to address people's unique needs, connecting them directly to local and national resources in their communities.

Addressing Workforce Shortages in Health Professional Shortage Areas (HPSAs)

The AMA supports continuing the development of a more diverse physician work force, by supporting programs such as the Health Careers Opportunity Program (HCOP), Centers of Excellence (COE), Faculty Loan Repayment, and Scholarships for Disadvantaged Students (SDS). According to HRSA's own data, these programs are making an impact.[16] For example, in Academic Year 2016-2017, HCOP supported 169 different training programs and activities to promote interest in the health professions among prospective, disadvantaged students. In total, HCOP grantees reached 2,442 disadvantaged trainees across the country through structured programs.[17]

4. Data Collection and Effective Evaluation to Improve Outcomes and Quality

The CDC currently operates a voluntary Pregnancy Mortality Surveillance System by which the 50 states, New York City, and Washington, DC voluntarily send copies of death certificates for all women who died during pregnancy or within one year of pregnancy, and copies of the matching birth or fetal death certificates, if they have the ability to perform such record links. **We urge the development of a national maternal morbidity and mortality data collection strategy so that states gather data in a consistent manner**. We believe this a necessary step to developing strategies to address a problem is to first identify what the specific problems are. In addition, it is our understanding that a total of 14 Maternal Mortality Review Committees (MMRCs) voluntarily shared 2008-2017 data with CDC through the Maternal Mortality Review Information Application (MMRIA).[18] Among 1,347 deaths to women during or within a year of pregnancy, a pregnancy-relatedness determination was made for 1,260 (93.5%). Among these, 454 (36.0%) were determined by the 14 MMRCs to be pregnancy-related. As you know, MMRCs study local maternal death cases to identify how to make pregnancies safer and prevent tragic outcomes. **We believe every state should have a MMRC, but unfortunately not every state does.** We are encouraged that the establishment of MMRCs are gaining momentum, but they remain in varying stages of formation.

Congress can help improve the health and safety of pregnant women and save families from devastating losses by investing in local MMRCs. In addition, there should be a national system for state MMRCs to communicate/share findings and share strategies/educational materials developed to address problems. We also urge Congress to increase funding for state perinatal quality collaboratives (PQCs)–

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[16] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2019.pdf
[17] Id.
[18] https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf

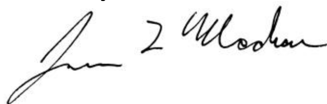
state or multi-state networks of teams working to improve the quality of care for mothers and babies. Many states currently have active collaboratives, and others are in development.

5. Social Services Aimed at Supporting Mother and Child Wellbeing

Community organizations and consortiums of medical providers, social service workers, and faith groups have historically been the leaders in providing local-based, accessible, and culturally competent social services to mothers, mothers-to-be, and their families. The National Healthy Start Association, for instance, convenes federal Healthy Start programs, and promotes local efforts designed to bring parity in birthing outcomes and infant health across racial groups. Majority of Healthy Start beneficiaries are African American, Hispanic and/or Native American families. Some services they can access include pre- and post-natal screening, support for fathers, parenting education and like supports. These programmatic interventions have been cited to help reduce incidences of low birth weight in historically underweight babies.[19] Programs that support the non-clinical yet critical needs of families—food security, transportation needs, affordable housing—have a net positive impact on mothers' health and that of their newborns.

The AMA appreciates the opportunity to provide these comments. If you have questions, please contact Jason Marino, Director, Congressional Affairs at jason.marino@ama-assn.org or 202-789-8511.

Sincerely,



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[19] National Healthy Start Association. Available at, http://www.nationalhealthystart.org/healthy_start_initiative/healthy_start_to_the_rescue