

May 28, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information Regarding Maternal and Infant Health Care in Rural Communities

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) request for information regarding “Maternal and Infant Health Care in Rural Communities.” We commend CMS for focusing on improving health care access, quality, and outcomes for women and infants in rural communities before, during, and after pregnancy.

In working to reduce and prevent rising rates of maternal mortality and morbidity and to ensure access to high-quality care for patients in rural communities, we urge CMS to:

- Apply the increased relative values the agency adopted for standalone office visits to the office visit components of surgical and maternal (MMM) global codes to recognize the importance of preventive prenatal and postpartum care for the health of women and infants;
- Increase Medicaid payments to physicians in rural communities who care for mothers and infants to ensure they are able to sustain independent practices and cover their costs;
- Reduce or eliminate the difference in the rural health clinic productivity standards between physicians and other clinicians, particularly for very small clinics, to support more physicians in the community who can deliver babies as well as provide other maternity care services;
- Provide supplemental annual payments to rural hospitals that offer labor and delivery services;
- Explore all opportunities to address the social determinants of health affecting maternal and infant health in rural communities (e.g., housing, transportation, food insecurity);
- Improve access to treatment in rural areas for pregnant and postpartum women with opioid use disorder (OUD);
- Maintain expanded telehealth access, including coverage and payment parity for audio-only telephone visits;
- Encourage participation in the Alliance for Innovation on Maternal Health program; and
- Collaborate with agencies in the U.S. Department of Health and Human Services (HHS) and the state Medicaid agencies to ensure consistent data collection and effective evaluation to improve outcomes and quality.

Please see our detailed responses to the questions in the Request for Information below.

1. What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?

The myriad of factors facing rural areas are uniquely challenging. Vast rural areas disproportionately struggle to care for the sickest of patients; experience a dearth of primary health care professionals; and endure strenuous, disruptive financial burdens. Moreover, the impact of surging hospital closures in medically underserved areas detrimentally impacts overall patient well-being. About 2,000 of the nation's acute care hospitals are located in rural areas; 168 rural hospital closures have occurred between January 2005-March 2020.¹ These structural barriers to health care and access are exacerbated by deepening shortages of medical professionals and providers.

Rural health outcomes are also impacted by greater obesity and disease burden in children and adults, higher mortality rates, and shorter life expectancy compared to urban areas. These “red zones”, wherein life expectancy is on the decline, also have fewer employment and education opportunities, which are risk factors for poor health outcomes and can undermine population health. These broader challenges facing the health care system in rural areas are interwoven into the challenges facing women and infants in rural areas who experience barriers to accessing high-quality care.

Furthermore, health disparities affect maternal and infant mortality and morbidity across the country. 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 social determinants of health (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 impact our health or the SDOH. However, we do not all experience them equally. Marginalized and minoritized patients have and will suffer disproportionately during the COVID-19 pandemic. While COVID-19 is hurting all communities, the emerging data, while incomplete, show that the impact on racial and ethnic minorities, including children, is especially severe.

The SDOH are impacted by larger and powerful systems that may 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, Hispanic, Asian, and Native American women.

Birth inequities arise at the intersection of discrimination by race and gender for Black, Hispanic, Asian, and Native American women. 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

¹ The University of North Carolina at Chapel Hill, NC Rural Health Research Program, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> accessed March 24, 2020.

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.² 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. Additional notable findings include one in five Spanish-speaking Latinos reported not seeking medical care due to language barriers. In addition, the geographic availability of health care institutions, largely influenced by economic factors, may have a differential impact on racial and ethnic minorities, independent of insurance status.

2. What opportunities are there to improve the above areas (i.e., access, quality and outcomes)?

a. CMS should apply the increased evaluation and management (E/M) relative value units (RVUs) to surgical and maternal care the maternal (MMM) global codes.

The AMA greatly appreciates that CMS aligned the previously finalized E/M office visit coding changes with the framework adopted by the CPT Editorial Panel and generally accepted the recommendations of the AMA/Specialty Society RVS Update Committee (RUC). However, CMS did not apply the increased E/M RVUs to office visit components of surgical and maternal (MMM) global codes. **We strongly urge CMS to implement the RUC recommendations to increase the office visits in these codes to retain relativity within the RBRVS and recognize the importance of preventive prenatal and postpartum care for the health of women and infants.**

There are 17 MMM codes that are used for billing maternity care services. The primary global codes are 59400, 59510, 59610, and 59618. All four of these codes include about 12 months of prenatal, labor and delivery, and postpartum care services. Much like primary care visits, the purpose of prenatal care visits is to conduct screenings and genetic tests, provide counseling, and establish healthy behaviors that will improve health outcomes for both the pregnant woman and her fetus. The preventative services that are provided in maternity care need adequate reimbursement for the resources required.

Evidence indicates that high-quality, timely prenatal care reduces the risk of adverse birth outcomes, such as low birth weight.^{3,4} Cardiovascular conditions also commonly present for the first time in a woman's life while she is pregnant. Rapid identification of these comorbid conditions allows obstetrics-gynecologists to minimize possible negative effects on both the pregnant woman and her fetus. Women with comorbid conditions can also be referred to sub-specialty care to assist with monitoring disease progress and well-being across the lifespan. The overall importance of regular prenatal visits is therefore to preserve the health of both patients, as well as reduce the risk of adverse outcomes and high-cost care later on.

The goals for the comprehensive postpartum care visit are similar. Obstetrics-gynecologists and other obstetric care practitioners perform a physical exam, blood pressure checks, and critical mental health

² 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>.

³ Alibekova R, Huang JP, Chen YH. Adequate prenatal care reduces the risk of adverse pregnancy outcomes in women with history of infertility: a nationwide population-based study. *PLoS One*. 2013;8(12):e84237. Published 2013 Dec 17. doi:10.1371/journal.pone.0084237.

⁴ Reiss HE. History, John William Ballantyne 1861–1923. *J Obstet Gynecol* 20(4):343–6. 2000.

screenings during postpartum visits. They also provide extensive counseling and work to smoothly transition healthy postpartum women to the care of their primary care physician.

We are particularly concerned with the impact of not increasing the E/M visit components of Medicare maternal care global services on Medicaid patients. States often set Medicaid payment rates at less than 100 percent of Medicare rates. **Low Medicaid reimbursement for physicians pose substantial barriers to improving maternal mortality and morbidity in this country.** 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. Evidence indicates that closures of rural obstetric units and entire hospitals have affected access to care for more than 28 million women of reproductive age (18-44) living in rural America.⁵ Failing to incorporate these E/M changes into the MMM global codes will lead to increasingly insufficient Medicaid payment rates, jeopardizing patients' ability to access health services.

b. CMS should increase payments for physicians who deliver maternal and infant care in rural areas.

The foundation for women to receive high-quality maternal and infant health care is access to physician practices and clinics that provide maternal and infant care services. Physician practices and clinics cannot survive in rural areas unless they can receive payments that will cover their costs. Consequently, an essential element of any CMS strategy for ensuring that families in rural communities have access to high-quality health care services before, during, and after pregnancy must be to ensure adequate payments for physician practices and clinics that deliver these services in rural areas. Particularly as rural practices face difficult decisions about how to keep their doors open while patients cancel visits during the COVID-19 emergency, investments in the small- and medium-sized independent medical practices which provide care for millions of Americans in rural communities are essential.

i. Provide supplemental Medicaid payments to primary care practices in rural areas that deliver maternity and infant care services.

In the smallest rural communities, it is likely that most maternal and infant health care will be delivered by primary care physician practices and clinics. This includes labor and delivery services as well as prenatal and post-partum care, since in small rural areas, family physicians deliver most babies. Medicare pays 10 percent more for services delivered by primary care physicians practicing in Health Professional Shortage Areas, but this is only for the services they deliver to Medicare beneficiaries. There is no similar requirement that Medicaid programs pay higher amounts to primary care physicians. The Affordable Care Act required that Medicaid payments to primary care physicians be equivalent to Medicare in 2013 and 2014 and Congress provided additional funding to support this, but the requirement and funding ended in 2014. A study by the Urban Institute found that most states did not continue the increased payments in

⁵ Hung P, Kozhimannil KB, Casey MM, Moscovice IS. 2016. Why are obstetric units in rural hospitals closing their doors? Health Services Research. DOI: 10.1111/1475-6773.12441. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946037/pdf/HESR-51-1546.pdf>.

their fee-for-service programs, and in 2016, Medicaid fees for primary care services averaged only 66 percent of Medicare rates (no data were available regarding what Medicaid Managed Care Organizations pay for primary care). If Medicaid payments for primary care services are low, the Medicare payment differential actually creates a disincentive for rural primary care physicians to deliver maternity and infant care, since the more pregnant women and infants they see, the fewer commercially insured beneficiaries they will have time to see, which will reduce their revenues and cause financial losses.

In order to directly address current payment shortfalls, **CMS should provide a supplemental annual Medicaid payment to primary care practices located in rural areas that deliver a minimum level of maternity and infant care services.**

ii. CMS should eliminate the productivity differential that penalizes use of primary care physicians in small Rural Health Clinics.

In many of the most rural parts of the country, the combination of low payment rates and low patient volume has made it impossible for physicians to sustain independent primary care practices. Rural Health Clinics (RHCs) fill all or part of that gap. However, CMS financially penalizes RHCs that employ more physicians instead of nurse practitioners or physician assistants. Under CMS payment rules, the Medicare payment to the RHC is reduced if physicians employed in the clinic have fewer than 4,200 patient visits per FTE physician per year, whereas nurse practitioners and physician assistants are only required to have 2,100 visits/FTE/year. If the community is small, or if a physician spends more time delivering prenatal care, post-partum care, or newborn care, particularly with higher-need patients, it may be impossible for a physician to meet this standard, and the RHC's revenues will be reduced. This will also make it more difficult to have one or more family physicians in the community who can deliver babies as well as provide other maternity care services.

To address this, **CMS should reduce or eliminate the difference in the RHC productivity standards between physicians and other clinicians, particularly for very small clinics.**

iii. Provide supplemental payments to OB/GYNs providing services in rural areas.

Many women with higher-risk pregnancies will need to receive some or all of their maternity care services from an obstetrician. Larger rural communities may have enough pregnancies and deliveries to justify having a locally-based obstetrician, but even if there are enough patients, an obstetrics practice will not be able to survive in a rural area unless the payments for obstetric services are adequate. More than 40 percent of births are covered by Medicaid, with higher percentages in many rural areas, so payment adequacy will depend heavily on Medicaid payment rates. In 2016, Medicaid payments for obstetric services averaged only 81 percent of Medicare rates, and in some states, the payments were less than half of Medicare rates.

In the smallest rural communities, there will not be enough patients to justify a full-time obstetric practice, and it can be both impractical and unsafe to expect pregnant women to travel a long distance in order to see an obstetrician in person or to deliver their baby. High-quality maternity care in these rural communities will require that obstetricians who are based in larger communities (1) travel to the rural community on a part-time basis to provide in-person care and deliver babies and (2) provide telemedicine support for local primary physicians. Obstetricians who travel to rural communities incur additional time and expenses to do so, and so even payment amounts that would be adequate in an urban area or larger

rural area will be inadequate to support the physicians who do this. Telemedicine payments are typically limited to visits with the patients, and do not support training or consultations between a primary care physician and specialist.

To address this, **CMS should provide supplemental annual payments to (1) obstetrics practices located in rural areas; (2) obstetrics practices that provide in-person services in rural areas; and (3) obstetrics practices that provide telemedicine support in partnership with primary care practices located in rural areas and Rural Health Clinics.**

iv. Make supplemental payments through permanent programs, rather than temporary demonstration projects.

In order to move to a rural area and either work in an existing practice or start a new practice, physicians need assurance that they will be able to receive adequate payments for a long enough period to recover the personal costs they incur in relocation and the investments they make in building a practice. Supplemental payments made through short-term demonstration projects do not provide that assurance, which means that such demonstration projects cannot provide a valid “test” of the impact of a long-term change in payment on the shortage of physicians in rural areas. As with any payment program, the impact of a permanent change can be evaluated over time, and additional changes can be made in response to the evaluation.

v. Provide Supplemental Payments to Small Rural Hospitals, Particularly Those That Offer Labor and Delivery Services

More and more communities around the country are losing maternity care services because of inadequate funding for rural hospitals. In many rural areas, the loss of the hospital means the loss of primary care and specialty medical services as well as inpatient services, because rural hospitals subsidize physician clinics and Rural Health Clinics in order to attract and retain primary care and specialty physician services that would not be sustainable otherwise.

However, the loss of maternity care services in rural areas is even greater than the loss of other kinds of services because many rural hospitals that have remained open have stopped providing labor and delivery services. Research shows that in communities that lose labor and delivery services, there are more preterm births and more out-of-hospital births, as well as more births in a hospital that is not adequately staffed or equipped for childbirth.

Special Medicare payment programs for rural hospitals (i.e., Critical Access Hospital status, Sole Community Hospital status, Medicare Dependent Hospital status, and low volume payments) have not only failed to prevent rural hospital closures, they do nothing directly to support maternity care services. In fact, a Critical Access Hospital can be harmed financially by offering labor and delivery services, since a smaller share of its costs will be eligible for cost-based payments from Medicare.

To address this, CMS should provide supplemental annual payments to rural hospitals that offer labor and delivery services.

- c. CMS should explore all opportunities to address the social determinants of health affecting maternal and infant health in rural communities (e.g., housing, transportation, food insecurity).**

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 own commitment to health equity 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 its role as identifying their importance and urging and educating those who can have a direct role to act.

The AMA supports efforts designed to integrate training in SDOH 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 Reimaging 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 allows physicians and their staff to thrive in the evolving health care environment by working smarter, not harder.⁶ 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 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. Earlier this year, 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.

⁶ <https://edhub.ama-assn.org/steps-forward>

d. We urge CMS to improve access to treatment in rural areas for pregnant and postpartum women with opioid use disorder (OUD).

Although estimates vary regarding the proportion of maternal deaths that are attributable to opioid overdoses or otherwise opioid-related, there is no disagreement that the epidemic of opioid overdose deaths is a significant contributor to maternal mortality and morbidity. Highly effective medications to treat OUD are underutilized throughout the U.S., with a gap between those needing medication-assisted treatment (MAT) and those receiving it in the millions, but this gap is most acute in rural counties. An analysis by the Pew Trust found that nearly a third of rural counties had **no** physicians or other health professionals with the waiver from the Drug Enforcement Administration (DEA) that is required for office-based treatment of OUD with buprenorphine and associated medical and psychosocial services.⁷

To help address this gap, the AMA recommends elimination of the requirement for physicians to obtain this special waiver and be subject to limits on the numbers of patients they can treat with buprenorphine as well as audits of their medical records by the DEA. There is already a shortage of physicians in rural counties, but it would help considerably if all physicians could prescribe buprenorphine to treat OUD without unnecessary regulatory barriers.

Medicaid coverage for pregnant women has increased their access to MAT, but pregnant women face considerable stigma in seeking treatment for OUD when they are pregnant. Many women fear that their babies will be taken from them if their opioid use is revealed. In addition, transitions in care are when patients with OUD are at most risk of overdose deaths. Women who do get treated with MAT while they are pregnant may lose access to the medication when their Medicaid coverage lapses during the postpartum period. Having lost their tolerance for opioids, a patient who is forced to discontinue MAT due to losing Medicaid is highly likely to overdose and die, increasing maternal mortality. The opioid epidemic also contributes to significant opioid-related morbidity that increases maternal mortality risk.

In addition to eliminating the need for a waiver to prescribe buprenorphine, the AMA urges CMS to implement the recommendations of the HHS Interagency Pain Management Best Practices Task Force, which highlighted pregnant women as a special population.⁸ The Task Force report recommended more research and innovation to address pain management in peripartum women, and that women of childbearing age be counseled on the risks of opioids and non-opioid medications in pregnancy, including risks to the fetus and newborns.

e. CMS should maintain expanded telehealth access, including coverage and payment parity for audio-only telephone calls.

In response to the COVID-19 pandemic, CMS and other federal agencies have relaxed many regulatory barriers to furnishing telehealth services. The AMA applauds CMS for lifting Medicare restrictions on where a patient may be located to receive remote services, for allowing physicians to provide telehealth services to new and established patients, for allowing physicians to provide telehealth services to patients in their homes, and for expanding the list of services that may be conducted using audio-only and audio-

⁷ Opioid Use Disorder: Challenges and Opportunities in Rural Communities, *The Pew Charitable Trusts*, Feb. 7, 2019, retrieved from: <https://pew.org/2HWn0iP>.

⁸ U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: <https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html>.

visual communications platforms. These important Medicare policy changes allow physicians flexibility to provide safe screening and treatment to patients through remote care. We have heard from many physicians that they have integrated telehealth and digital health technologies into patient care to provide uninterrupted care for patients, including pregnant and postpartum women.

Telehealth can play an especially critical role in ensuring access to care for women in rural and underserved areas. There is particular opportunity with telehealth services to overcome the barriers that women face in attending postpartum visits. For women who struggle with transportation, child care, and not having the ability to take time off work, postpartum telehealth visits can improve attendance rates and ensure that opportunities to identify postpartum risk factors are not missed.

In addition, telehealth can be used to increase women's access to behavioral health services and treatment for substance use disorder. In rural areas where obstetrics-gynecologists report they cannot refer patients to mental health physicians and other licensed clinicians because there are none in the area, telehealth could effectively fill that gap in care and ensure that the patient has access to all the health care services they require. In a recent study, researchers found that opioid use disorder treatment received via telehealth in obstetric practices was not associated with any statistically significant differences in outcomes compared to in-person treatment.⁹ Behavioral health services and substance use disorder treatment provided via telehealth for obstetric and postpartum patients ensures access to the continuation of comprehensive care, especially in rural areas. **For these reasons, we strongly urge CMS to maintain expanded telehealth coverage and associated flexibilities so physicians can optimize telehealth to meet the needs of their patients.**

Many patients in rural and underserved areas, as well as lower-income patients, do not have access to reliable internet connection, smartphones, or both, and therefore are unable to access audio-video telehealth visits. For these reasons, it is essential for patients to have access to care via audio-only telephone calls. We strongly support CMS' decision to provide Medicare coverage of audio-only telephone calls and payment parity with in-person and audio-visual evaluation and management visits during the COVID-19 public health emergency. We also appreciate CMS allowing certain behavioral health, counseling and education services payable when furnished using audio-only telephone calls. After the public health emergency concludes, there still may be many cases where patients are unable to come to the practice for an in-person visit or obtain an audio-video telehealth services. **For this reason, we strongly urge CMS to maintain coverage and payment parity for audio-only telephone services after the COVID-19 emergency to ensure women and infants maintain access to comprehensive care, particularly in rural and underserved areas of the country.** CMS should also recommend to Medicaid programs that they cover or continue covering telephone E/M and behavioral health visits and reimburse for telephone visits at the same rate as audio-visual visits for patients who cannot obtain an in-person or audio-video visit.

f. CMS should encourage hospital participation in the *Alliance for Innovation on Maternal Health (AIM) program.*

⁹ Guille C, Simpson AN, Douglas E, et al. Treatment of Opioid Use Disorder in Pregnant Women via Telemedicine: A Nonrandomized Controlled Trial. *JAMA Netw Open.* 2020;3(1):e1920177. Published 2020 Jan 3. doi:10.1001/jamanetworkopen.2019.20177. Retrieved from: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759839>.

Several states are currently committed to monitoring maternal morbidity in all hospitals and using the AIM bundles. The AIM program, developed in partnership with the Health Resources and Services Administration, is a national data-driven maternal safety and quality improvement initiative. It is based on multidisciplinary consensus-based practices designed to improve maternal outcomes. Enrollment in the AIM program occurs at the state-level; hospitals have the ability to engage in AIM initiatives through their state-based entities, often perinatal quality collaboratives (PQCs) or departments of health. Participants in the AIM program collaborate with experts in perinatal quality improvement to implement patient safety bundles and learn from other organizations that have successfully improved maternal health outcomes. The patient safety bundles utilized by the AIM program are designed to reduce variations in care and improve outcomes related to common complications, such as hypertension, venous thromboembolism, and obstetric hemorrhage. As part of their participation in AIM, hospitals submit structure, process, and outcome data to their state-based entities. This data is used to understand progress towards program goals and can be used for peer comparison and learning. This rapid cycle quality improvement methodology has been used by PQCs to improve maternal health outcomes

3. What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?

The supply of practicing physicians in rural settings in the United States has been insufficient to meet the demand for health care services of the rural population. Physician shortages in rural settings have been an enduring and widespread concern, with only 12 percent of primary care physicians, and eight percent in other specialties, working in rural areas.¹⁰ According to the 2010 Census, nearly 60 million people live in rural communities, and 20 percent of people in the U.S. are rural residents. The size of this population has been stable for several decades.¹¹ Additionally, more than 15 percent of these rural residents are members of racial/ethnic minoritized groups, and this percentage is growing.¹²

Addressing the gap of rural health services in the U.S. requires a multifaceted approach. In its role as convener of key organizations and stakeholders, our AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation's remote underserved areas. In addition, the AMA continues to advocate for state and national legislative action and other efforts that (1) expand the health careers pipeline for Americans in rural areas and others interested in serving these populations; (2) fund residency training in rural areas; (3) promote telehealth and training in telehealth as a promising paradigm to bridge the gaps in care in rural areas; and (4) address the rising tide of rural hospital closures that threatens to further weaken the health care infrastructure in the rural U.S.

There are several successful models which demonstrate a positive impact on addressing workforce shortages in rural/underserved areas:

¹⁰ Orłowski, J., and Dill, M. September 2017. Rural America Faces Shortage of Physicians to Care for Rapidly Aging Population. *Aging Today*. <https://www.asaging.org/blog/rural-america-faces-shortage-physicians-care-rapidly-aging-population>. Accessed May 12, 2020.

¹¹ Shipman, S. A., Wendling, A., Jones, K. C., Kovar-Gough, I., Orłowski, J. M., & Phillips, J. 2019. The Decline In Rural Medical Students: A Growing Gap In Geographic Diversity Threatens The Rural Physician Workforce. *Health Affairs*, 38(12), 2011-2018.

¹² Council, H. A. 2012. Race & ethnicity in rural America. *Rural Research Briefs*, April, 1283-88. Accessed May 12, 2020 from http://ruralhome.nonprofitsoapbox.com/storage/research_notes/rm-race-and-ethnicity-web.pdf.

- Launched in 2013 by the AMA, the Accelerating Change in Medical Education (ACE) initiative established and continues to foster a community of innovation and discovery by supporting the development and scaling of creative undergraduate medical education (UME) models across the country.¹³ Building on its work to accelerate change in UME, the AMA recently established the Reimagining Residency initiative—a new five-year, \$15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training.¹⁴
- Project ECHO (Extension of Community Health Outcomes)¹⁵: Using proven adult learning techniques and interactive video technology, the ECHO Model™ connects groups of community providers with specialists at centers of excellence in regular real-time collaborative sessions.

In addition, the federal government has established several programs to recruit and retain a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities such as rural settings. These programs include the National Health Service Corps (NHSC), Title VII of the Public Health Service Act, the Conrad 30 Waiver, and Area Health Education Centers (AHECs).

To offer an incentive to physicians who work in Medicare Health Professional Shortage Areas (HPSAs), CMS established the Health Professional Shortage Area Physician Bonus Program. The program provides a 10 percent bonus for Medicare-covered services to beneficiaries in a geographic HPSA. Paid quarterly, the bonus is based on the amount paid for professional services.

4. How can CMS/HHS support these efforts?

As outlined in response to question 2, we recommend CMS take several critical actions to improve access to high-quality care for women and infants in rural communities. We recommend additional strategies below.

CMS should work with other agencies within the HHS and the state Medicaid agencies to ensure consistent data collection and effective evaluation to improve outcomes and quality. The U.S. Centers for Disease Control and Prevention (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 a necessary step to developing strategies to address a problem is to first identify the specific problems. 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). 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.

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 has one. We

¹³ <https://www.ama-assn.org/education/accelerating-change-medical-education>

¹⁴ <https://www.ama-assn.org/education/improve-gme/ama-reimagining-residency-initiative>

¹⁵ <https://echo.unm.edu/>

The Honorable Seema Verma

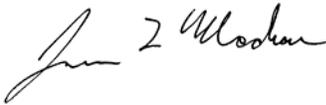
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are encouraged that the establishment of MMRCs are gaining momentum, but they remain in varying stages of formation. In addition, there should be a national system for state MMRCs to communicate/share findings and share strategies/educational materials developed to address problems.

The AMA appreciates the opportunity to provide input and thanks you for considering our views. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and "M".

James L. Madara, MD