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May 29, 2020

Centers for Medicare & Medicaid Services (CMS)
Office of Minority Health (OMH)
7500 Security Boulevard
Baltimore, MD 21244

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

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) request for information regarding rural maternal health care. The AAMC applauds this effort to reduce maternal health inequities and to learn about opportunities to improve access, quality, and outcomes for women in rural communities before, during, and after pregnancy.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The substandard maternal and infant health that exists in many parts of this country, including rural areas, is unacceptable. With rising maternal mortality and morbidity rates disproportionately affecting women residing in rural communities – primarily black, American Indian, and Alaska Native women[1] – the AAMC recognizes that such health and health care disparities derive from causes across various levels and systems. The built environment, combined with clinical, social and economic factors all contribute to health gaps endemic in the United States. Researchers, policymakers, health care providers, and other stakeholders are becoming increasingly aware that social and community conditions play a significant role in

[1] Callaghan WM. Overview of maternal mortality in the United States. Semin Perinatol. 2012 Feb;36(1):2–6.; [1] Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. Clinical obstetrics and gynecology, 61(2), 387–399. https://doi.org/10.1097/GRF.0000000000000349

facilitating or impeding the health and well-being of communities. These factors include both patient-level, health-related social needs such as limited household income, access to health care, personal food insecurity, housing instability, and transportation access; and community-level factors such as lack of supermarkets, lack of employment and educational opportunities.

AAMC-member hospitals and their faculty physicians have begun to address social risk factors of mothers by (a) screening and referring for health-related social needs (b) identifying challenges such as transportation barriers, low health literacy, and difficulty keeping regular appointments, and (c) using this information to customize interventions which address the unmet needs. However, despite growing traction in addressing certain social factors affecting health, there is a limited evidence-base of solutions tackling broader systemic issues such as racism, sexism, classism, etc., which are fundamental causes of health inequities. **The AAMC encourages CMS to partner with community-based stakeholders to co-develop programs and policies that address systemic issues (e.g., racism, discrimination, sexism, classism), which have an adverse effect on maternal health outcomes.**

In addition, a lack of quality maternal care services and providers in rural communities, hospital closures, and barriers to accessing care have exacerbated the inequities experienced by rural women. These issues are further compounded by a shortage of physicians, which is projected to reach between 46,900 and 121,900 primary care and specialty physicians by 2032.[2] To improve maternal health outcomes, it imperative to ensure a robust physician pipeline to guarantee there are enough physicians to meet growing demands in both rural and urban communities. To address the physician shortage, the AAMC strongly believes we must ease the outdated restrictions on Medicare support for physician training. Enacting (Passing?) the Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) would take a step toward addressing the physician shortage by gradually and responsibly increasing Medicare's cap on GME by 15,000 slots over five years. The additional primary care and specialist physicians trained by lifting the cap on Medicare-supported GME positions will allow the U.S. to more robustly respond to the needs of communities and patients across the country both in the near term and into the future.

Also, there is a declining pipeline of medical students from rural backgrounds; which is particularly pronounced for racial and ethnic minorities.[3] The Robert Wood Johnson Foundation has invested in the Summer Health Professions Education Program (started as the Minority Medical Education Program – MMEP in 1989), a successful 30-year model program that has

[2] 2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032. https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf

[3] The Decline In Rural Medical Students: A Growing Gap In Geographic Diversity Threatens The Rural Physician Workforce https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00924

served over 27,000 college students.[4] Data show that the Summer Health Professions Education Program has significantly increased the number of diverse candidates applying, matriculating, and graduating from medical and dental school. Health Resources and Services Administration (HRSA) Title VII programs such as the Health Career Opportunity Program (HCOP) and Centers of Excellence (COE), also have proven success records with recruiting and retaining students who are more likely to practice in rural and underserved areas.

More than 5 million women in the United States live in maternity care deserts without access to obstetric providers or facilities.[5] Increasingly, obstetric units in rural hospitals are being forced to close due to small hospital size, large amounts of uncompensated care, and financial constraints. Without the presence of OB units, physicians in rural communities can no longer provide obstetric care, creating a profound barrier for women receiving obstetrical services including delivery. **To further expand maternal health care access for women living in rural areas, the AAMC recommends that CMS support an expansion of telehealth models and work with other agencies and the private sector to improve broadband access.** In some communities without specialized care, providers are finding success using programs like Project ECHO (Extension for Community Healthcare Outcomes) to connect with specialists.[6] Project ECHO facilitates a dialogue between high risk OB/GYN specialists and advanced practice clinicians, midwives, family physicians located in rural communities to help them continue to care for pregnant patients when complications arise during pregnancy. To date, Project ECHO is available to health systems across 48 states with 517 programs. Additionally, in a state where 73 out of 75 counties are designated as medically underserved, the University of Arkansas for Medical Sciences launched the Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) program to increase access to care for pregnant women through a statewide telemedicine network. Since its launch in 2002, the program has seen a decrease in neonatal deaths over the years due to increased access to specialists and regular tele-education opportunities for providers across the state.

The current COVID-19 pandemic has highlighted the potential for telehealth to improve patient access to care. Though teaching hospitals and faculty physicians have long been at the forefront of telehealth adoption and implementation, they have rapidly expanded their telehealth capacity in order to continue providing care to their patients who are unable to be seen in person due to COVID-19. Our members are reporting significant investment in telehealth – standing up vast telehealth capabilities in a matter of weeks and transforming the way they are delivering care. Some faculty physician practices are reporting a shift to providing approximately 50% of their ambulatory visits via telehealth. Members are reporting fewer appointment cancellations in their Medicaid populations as a result of their deployment of telehealth. This significant expansion of telehealth capabilities was made possible in large part

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[4] Summer Health Professions Education Program http://www.shpep.org/about/

[5] March of Dimes Nowhere to Go: https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf

[6] University of Utah Pregnancy Care ECHO: https://physicians.utah.edu/echo/clinical-support-areas/ob-clinic.php

by CMS' willingness to create new coverage and payment policies and provide waivers and regulatory changes**. The AAMC recommends that CMS, where possible, continue these policies as they have the potential to improve access to care particularly for vulnerable populations.**[7]

Academic medical centers have led several initiatives to better understand the disparities both underlying and within maternal mortality. **The AAMC encourages CMS to explore further the work of the California Maternal Quality Care Collaborative (CMQCC) founded by Stanford University School of Medicine and the State of California.** It uses research and evidence-based quality improvement toolkits to improve the health of mothers across the state. Through their efforts, California's maternal mortality rate decreased by 55 percent, but pregnancy-related disparities among racial and ethnic minority women remained.[8] **The AAMC also recommends further investigation and evaluation of other alternative care models (e.g., midwives, doulas, community health workers), which have the potential to expand health care access for women residing in rural communities.**

We applaud the collaborative efforts of HRSA and CMS in creating the Center for Medicare and Medicaid Innovation (CMMI) Maternal Opioid Misuse (MOM) Model. This model has the potential to increase the coordination of clinical care and the integration of other services critical for the health, well-being, and recovery of mothers with opioid use disorder.[9] Through this partnership, **AAMC strongly urges CMS to develop additional models that encourage the participation of hospitals in rural and underserved communities.**

Although the postpartum period can be a medically vulnerable period for many women, many states end Medicaid coverage following a 60-day postpartum period. This issue is particularly difficult in rural communities and women in these communities often do not get the postpartum care needed or seek postpartum care in emergency departments and other urgent care facilities. The providers in such setting often lack training and resources to provide optimal care for women during this vulnerable period. **AAMC recommends that CMS encourage states to consider the options to extend Medicaid coverage beyond sixty days after delivery to optimize outcomes for women after birth.** In addition, CMS should also ensure that hospitals are aware of the improved outcomes and reductions in maternal mortality and morbidity that accrue from the postpartum training for their providers, the use of postpartum protocols, and implementation of telehealth and other modalities for subspecialty consultation and coordination of care.

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[7] AAMC Letter to CMS on Telehealth in COVID-19: https://www.aamc.org/system/files/2020-05/ocomm-hca-aamclettertoCMS5132020.pdf

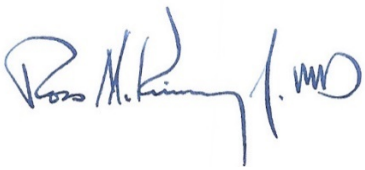
[8] California Maternal Quality Care Collaborative https://www.cmqcc.org/

[9] Maternal Opioid Misuse (MOM) Model https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model

Furthermore, as CMS continues to develop and refine policies to reduce maternal health and health care inequities, **we recommend leveraging existing partnerships with the Centers for Disease Control and Prevention (CDC) and HRSA to improve the coordination and collection of maternal health data.** There is currently limited maternal health data disaggregated by race and ethnicity for women residing in rural communities. In the absence of maternal health data, it is difficult to develop interventions and solutions to improve the health and well-being of racial/ethnic minority women living in rural areas. This enhanced maternal health data collection would include race and ethnicity as well as the social and environmental conditions in which women live, work, and play.[10] The AAMC fully supports the use of evidence-based approaches that address the societal and clinical factors to reduce maternal health and health care disparities among black, American Indian, Alaska Native, and rural women in the United States.

The AAMC appreciates the opportunity to provide comments to CMS on this issue and would be happy to provide any further information. Please contact me directly or my colleague, Karey M. Sutton, PhD., Director, Health Equity Research Workforce, at ksutton@aamc.org with any questions about these comments.

Sincerely,



Ross McKinney, Jr., M.D.
Chief Scientific Officer

cc: Karey M. Sutton, PhD.

[10] https://www.aamc.org/news-insights/press-releases/aamc-calls-enhanced-covid-19-data-collection-health-disparities