



**The American College of
Obstetricians and Gynecologists**
WOMEN'S HEALTH CARE PHYSICIANS

November 29, 2019

Re: The Committee on Ways and Means' Request for Information for the purpose of providing input to the Rural and Underserved Communities Health Task Force

The American College of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners dedicated to improving the health of women, thanks the Committee on Ways and Means (the Committee) for the opportunity to provide comments on the Rural and Underserved Communities Health Task Force's Request for Information (RFI) as it works to develop bipartisan legislation to improve health care outcomes within underserved communities. As physicians dedicated to providing quality care to women, ACOG appreciates the Committee's commitment to improving access to health care for people in rural and underserved areas and makes the recommendations below to aid the Committee in achieving this goal.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Women living in rural areas have less access to health care and experience poorer health outcomes than women living in urban areas, a trend exacerbated by the rapid rate of rural hospital closures and shuttering of obstetric units. In 2010, 49% of U.S. counties, home to 10.2 million women in the US, lacked an obstetrician-gynecologist (ob-gyn).ⁱ Less than one half of rural women live within a thirty-minute drive to the nearest hospital offering perinatal services. In some rural areas, family physicians provide all available obstetric care, but data show that even this type of access is declining, with only 19.2% of family physicians providing routine deliveries.ⁱⁱ In 2011, the Health Resources and Services Administration's (HRSA) National Advisory Committee on Rural Health and Human Services found that the successful retention of primary care practitioners in rural communities is contingent on the ability to expand rural training opportunities and use new recruitment strategies, while also strengthening existing programs.ⁱⁱⁱ ACOG encourages the Committee to consider pathways that incentivize ob-gyns, including residents and young physicians, to train and practice in rural communities increasing the likelihood that they will remain in those areas.

Medicaid is the largest single payer of maternity care in the U.S., covering 42.6% of births,^{iv} and an estimated 50-60% of births in rural areas.^v However, pregnancy-related Medicaid coverage ends at roughly 60-days postpartum. As many state-based maternal mortality review committees have found, and the Centers for Disease Control and Prevention (CDC) has confirmed, about 33% of pregnancy-related deaths occur during the time between 7 days to one year following childbirth, and greater than one third of those deaths occurred 43-365 days postpartum.^{vi} Deaths

from preventable causes, including overdose and suicide, occur more frequently during this 12-month postpartum period.^{vii} Closing this critical gap in coverage during this vulnerable time can mean the difference between life and death for many mothers.

To address this problem, H.R. 4996, the Helping Medicaid Offer Maternity Services Act, would incentivize states to extend pregnancy-related Medicaid coverage for women to 365 days postpartum. This bill would help ensure that women covered by Medicaid have access to a full scope of health care services during this critical time. H.R. 4996 was recently unanimously reported out of the Committee on Energy and Commerce with full bipartisan support. ACOG strongly encourages the Committee to urge House leadership to bring H.R. 4996 to the House Floor for a vote as early as possible.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Rural residents are more likely to be poor, lack health insurance, or rely substantially on Medicaid and Medicare; they also travel longer distances to receive care or to access a range of medical, dental, and mental health specialty services.^{viii} Less than one half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services. Within a 60-minute drive, the proportion increases to 87.6% in rural towns and 78.7% in the most isolated areas.^{ix,x} During 2008–2010, rural women aged 18–64 years reported the highest rates of delayed care or no medical care due to cost (18.6%) and no health insurance coverage (23.1%), both rates increased since 2002–2004.^{xi} Additionally, approximately 2.3 million people (2.2% of all US households) live in low-income, rural areas that are more than 10 miles from a supermarket.^{xii} This can often cause severe limitations in access to nutritious foods for pregnant and breastfeeding women and can contribute to poorer health outcomes for women and their babies.

In a 2019 issue brief titled “Improving Access to Maternal Health Care in Rural Communities”, the Centers for Medicare and Medicaid Services states that “a lack of access to maternal health care can result in a number of negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression. Poor or absent prenatal care can contribute to these outcomes. Women in rural communities are more likely to begin prenatal care late. Less formal education, lower health literacy, unplanned pregnancies, and poor transportation have all been associated with late prenatal care.”^{xiii} As part of addressing social and socio-economic factors that contribute to poor maternal health outcomes, ACOG urges the Committee to protect and fortify discretionary programs, including the Indian Health Service, Special Supplemental Nutrition Program for Women and Children (WIC); and programs to improve pre-pregnancy care, family planning, and breastfeeding.

The University of Texas Medical Branch in Galveston’s Department of Obstetrics and Gynecology is addressing these factors through its Regional Maternal & Child Health Program to serve geographically underserved women in multiple off-site clinics. The program addresses culturally relevant services and transportation needs, and uses electronic medical records to

facilitate continuity of care. It also provides housing in its Regional Perinatal Residence for high-risk women and their family members living in distant locations to facilitate their access to regional center care when hospitalization is not necessary.^{xiv}

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

ACOG recommends that maternal health care should be risk-appropriate and enhance the ability of women to give birth safely in their communities while providing support for circumstances when higher level resources are needed. Central to ACOG's recommendation is the development of collaborative relationships between hospitals of differing resource levels in maternal care, ensuring that every hospital has the personnel and resources to care for unexpected obstetric emergencies; that risk assessment be judiciously applied; and that consultation and referral are readily available when high-risk care is needed. In remote or rural areas, hospitals with low delivery volumes are often the only local delivery option. Considering that 59% of hospital births in the U.S. occur at hospitals where fewer than one thousand newborns are delivered annually,^{xv} it is critical that low-volume hospitals are adequately staffed and equipped to care for unexpected obstetric emergencies, including hemorrhage, infection, and cardiovascular emergencies.

To aid with increasing access to a broad spectrum of health care services in rural areas, ACOG urges the Committee to foster and facilitate efforts to utilize effective telemedicine technologies. Telehealth's applicability across professions, among health care providers, and in a broad range of nontraditional venues makes it an increasingly accessible and cost-effective option of care, particularly in team-based settings. As such, telehealth should be considered a legitimate evidence-based method for communication and provision of care and should be integrated into team-based practices when appropriate and necessary.^{xvi}

Telehealth programs are already working in many parts of the country. Many women in rural communities have been monitored remotely during pregnancy for high-risk conditions using telehealth and a collaborative team-based approach. Telehealth has been used remotely to read ultrasonograms, interpret tests, counsel patients, manage diabetes, manage postpartum depression, and support parents and children postpartum.^{xvii} For example, the Arkansas Medicaid Program and the University of Arkansas for Medical Sciences are collaborating with the state's medical community to enhance primary obstetric care in rural Arkansas and increase risk-appropriate referrals to maternal-fetal medicine subspecialists. The system uses telemedicine and clinic networks to facilitate access to maternal-fetal medicine consultation services and to provide continuing education for practitioners.^{xviii}

In 2018, CMS issued changes to the 2019 Medicare Physician Fee Schedule that would expand coverage of remote patient monitoring (RPM) and other telehealth services. While Medicare reimbursement for telehealth services should improve access to care, Medicaid coverage and reimbursement of telehealth services remains disparate.^{xix} Given that Medicaid covers almost 1 in 4 nonelderly individuals living in rural areas,^{xx} it is critical that Medicaid programs cover a

broad range of telemedicine services at rates that provide incentive and sustainability for physicians.

Despite these challenges, an ACOG Fellow in South Dakota is already providing care through an innovative RPM program that targets the needs of women with gestational diabetes within the Indian Health Service. Preliminary data from this program are showing promising results. Abnormally high blood sugar is detected and addressed sooner. In addition to improving outcomes, this innovative model of care reduces the time women must take off of work to see their ob-gyn or maternal-fetal medicine specialist. Women covered by Medicaid should be able to consistently access innovative models of care like this one.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

A variety of initiatives have been established to address the difficulties in providing care to rural women, funded by a range of state and federal programs and medical school department budgets. Examples of recent or current approaches include:

- Twenty-four family medicine residency programs have incorporated a rural training track. Graduates of these programs are two to three times more likely to practice in rural areas than graduates of family medicine residencies overall. The majority of those physicians initially selecting rural sites remained in rural locations 2 years after graduation.^{xxi}
- In 2016, the University of Wisconsin-Madison Department of Obstetrics and Gynecology launched the nation's first rural residency training track for rural women's health. This program recruits residents who grew up in rural areas, have completed a rural-based medical training program, and have demonstrated an interest in the practice of obstetrics and gynecology to address health disparities in rural areas. The program has received a surplus of applications for its one residency spot.^{xxii}
- Wyoming, a state with no tertiary care centers for pregnant women or infants and few pediatric specialists, approves out-of-state health care providers and facilities as state Medicaid providers, allowing the state to reimburse transport to and care and delivery in an out-of-state subspecialty hospital when medically necessary.^{xxiii}
- Oregon enacted legislation to offer financial incentives, such as a state income tax credit for rural practitioners and assistance with medical liability insurance, for obstetricians practicing in rural areas. An evaluation of the program 2 years after full implementation found that the subsidy had not halted the overall decrease in rural clinicians who performed deliveries in that time frame. Clinicians receiving the subsidy, however, indicated that it was an important reason that they were able to continue maternity care.^{xxiv}

As the Committee is aware, the Improving Access to Maternity Care Act (Public Law: 115-320), enacted in 2018, responded to our nation's growing maternity care shortage by requiring HRSA to create a maternity health professional shortage area designation for use by the National Health Service Corps (NHSC). The NHSC plays a critical role in providing health care services in

underserved areas while offering tuition assistance and loan repayment programs for physicians. ACOG encourages the Committee to engage with HRSA to ensure prompt and full implementation of the provisions within this Act and determine the maternity care areas of greatest need. Full implementation of this Act will create a pathway for obstetric providers to practice in rural communities with the greatest need.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Some of ACOG's members report challenges in completing referrals to mental health providers^{xxv} for women covered by Medicaid who have been identified as requiring additional mental health services. ACOG encourages the study of accessibility to mental health providers and services available in each state, including coverage limitations under state Medicaid plans on scope, duration, or frequency of such services; and an analysis of barriers to mental health services for postpartum women, including specific barriers faced by women living in rural areas and barriers experienced by mental health providers to participating in Medicaid.

Additionally, postpartum telemedicine visits could improve access to behavioral health services for women with depression, substance use disorder, and other mental illnesses. Telemedicine could also improve visit attendance for women who face barriers to adhering to visits, and especially for women with risk factors who may require more frequent visits; and improve identification of risk factors for mortality and morbidity. To ensure women have access to behavioral health services, Medicaid programs could be incentivized or required to develop networks of providers, including those available via telemedicine.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Although national data on women's health and outcomes according to residence are limited, disparities in rural women are apparent. General health conditions and behavior that U.S. rural women experience at higher rates than their urban counterparts include, self-reported fair or poor health status, unintentional injury and motor vehicle-related deaths, cerebrovascular disease deaths, suicide, cigarette smoking, obesity, difficulty with basic actions or limitation of complex activities, and incidence of cervical cancer.^{xxvi}

H.R. 4995, the Maternal Health Quality Improvement Act, would improve rural maternal and obstetric care data by requiring the Office of Women's Health within the Department of Health and Human Services to report on women's health conditions across sociocultural—including by race, ethnicity, language, class, and income—and geographic contexts and instructing the CDC to examine the relationship between maternal health services in rural areas and outcomes in delivery and postpartum care. Additionally, this bill would increase access to maternity care in

rural areas by supporting regional innovation obstetric networks, expanding existing telehealth grant programs, and establishing a rural maternal and obstetric care training demonstration to support training for providers of maternal care services in rural settings. H.R. 4995 was recently unanimously reported out of the Committee on Energy and Commerce with full bipartisan support. ACOG strongly encourages the Committee to urge House leadership to bring H.R. 4995 to the House Floor for a vote as early as possible.

ACOG thanks the Committee for the opportunity to provide comments to the RFI on improving health care outcomes in rural and underserved communities. ACOG commends the Committee for its work to develop policies that improve access to health care for women living in rural areas and offers itself as a resource and partner as the Committee continues its work. Please feel free to contact Tatiana Calderon, Federal Affairs Manager, with any questions at tcalderon@acog.org.

ⁱ Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:384–8.

ⁱⁱ *Ibid.*

ⁱⁱⁱ The Rural Implications of Key Primary Care Provisions in the Affordable Care Act. National Advisory Committee on Rural Health and Human Services. 2011. Retrieved from:

<https://www.hrsa.gov/advisorycommittees/rural/publications/wpacapprimarycareprovisions092011.pdf>

^{iv} Births: Final Data for 2016. National vital statistics reports; Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. 2018, January 31. Vol 67 No 1. Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

^v Medicaid is Rural America's Financial Midwife. Luthra, S. 2018. Kaiser Health News. Retrieved from: <https://khn.org/news/medicaid-is-rural-americas-financial-midwife/>

^{vi} Vital Signs: Pregnancy-Related Deaths, United States. Petersen EE, Davis NL, Goodman D, et al., 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. *MMWR Morb Mortal Wkly Rep* 2019;68:423–429. DOI: <http://dx.doi.org/10.15585/mmwr.mm6818e1>.

^{vii} For Addicted Women, the Year After Childbirth Is the Deadliest. Vestal, Christine. 2018. Pew Stateline. Retrieved from <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-isthe-deadliest>.

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^{ix} Drive times to hospitals with perinatal care in the United States. Rayburn WF, Richards ME, Elwell EC. 2012. *Obstet Gynecol*. 119:611–6.

^x The obstetrician-gynecologist distribution atlas. American Congress of Obstetricians and Gynecologists. 2013. Washington, DC.

^{xi} Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:384–8.

^{xii} Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences. United States Department of Agriculture Economic Research Service. 2009. Retrieved from: https://www.ers.usda.gov/webdocs/publications/42711/12716_ap036_1_.pdf

^{xiii} Improving Access to Maternal Health Care in Rural Communities. Centers for Medicare and Medicaid Services. 2019. Retrieved from: <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>

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- ^{xvi} Collaboration in Practice: Implementing Team-Based Care. American College of Obstetricians and Gynecologists. 2016. Retrieved from: <https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care>
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