Statement for the Record Submitted by the Association of American Medical Colleges before the Senate Health, Education, Labor, and Pensions Committee hearing, titled "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"
May 2, 2024

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record for the Senate Health, Education, Labor, and Pensions Committee's May 2, 2024, hearing, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?" The AAMC appreciates the Committee's focus on increasing diversity in the health care workforce and addressing the maternal health crisis in the United States.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The United States is an increasingly diverse country that deserves a diverse workforce. The AAMC believes that diversity in medical education and training is an important component to helping ensure that all physicians are prepared to serve our diverse nation regardless of their race, ethnicity, socioeconomic status, or where they live. According to the AAMC Medical School Enrollment Survey, virtually all medical schools have specific programs or policies designed to recruit a more diverse student body.[1] The majority of respondents to that survey had established or expected to establish programs/policies geared toward students who are underrepresented in medicine, students from disadvantaged backgrounds, and students from underserved communities. Schools also reported a variety of approaches, with a focus on outreach at high schools and local four-year colleges, and admission strategies such as holistic review. In addition to these efforts, AAMC believes earlier, and greater intervention is necessary to diversify the physician workforce.

[1] Results of the AAMC Medical School Enrollment Survey: 2017, May 2018. https://www.aamc.org/media/8276/download

For myriad reasons, there has been limited progress in increasing the number of physicians from diverse perspectives and experiences including racial, ethnic, education, veteran status, and other backgrounds. We need more assertive efforts to cultivate a more diverse and culturally prepared workforce. We need to better understand how systemic barriers such as inconsistent access to quality education, beginning with pre-K, negatively affect diversity in the health care workforce. We must explore socioeconomic and geographic barriers that impede the pathway to medicine. We must also design bolder interventions to address the insufficient number of Black men and the near invisibility of American Indians and Alaska Natives in medical school and the physician workforce.

The AAMC is committed to significantly increasing the number of diverse medical school applicants and matriculants, and recently launched a new strategic plan that will take a multi-tiered approach with sustained investment, collaboration, and attention over time to significantly increase the diversity of medical students. Our goal is to continue increasing the number of students from underrepresented groups until they are no longer underrepresented in medicine. While AAMC enrollment data show we are moving slowly in the right direction to recruit more students from underrepresented groups entering medical school, there is still much work to be done across academic medicine to ensure our diverse nation is reflected in a diverse physician workforce.

In the 2023-2024 medical school class enrollees we saw:

- The number of American Indian or Alaska Native matriculants rose 14.7% and Hispanic, Latino, or of Spanish Origin matriculants increased 4.5% since 2022-23.
- Matriculants with a parent whose highest level of education was less than a bachelor's degree or any degree with an occupation categorized as "service, clerical, skilled, and unskilled" increased slightly (0.2%) over 2022-23, from 4,887 to 4,897.
- The number of first-generation matriculants increased 2.5% over last year, from 2,543 to 2,606.
- 171 matriculants are military veterans, an 11% increase over 2022-23.[2]

While these statistics are promising, the number of Black or African American matriculants remained stable, falling slightly by 0.1%, and Native Hawaiian or Other Pacific Islander matriculants fell 6.9% since last year. Black or African American students made up 10.0% of total matriculants in 2023-24, a slight decrease from 10.2% in 2022-23 but up from 8.4% in 2016-17. The AAMC is committed to using these data to inform our work to further diversify the physician workforce.

[2] 2023 Fall Applicant, Matriculant, and Enrollment Data Tables.
https://www.aamc.org/media/71336/download?attachment

For example, the AAMC has focused on finding solutions to addressing the dearth of Black men in medicine. In its 2015 report, Altering the Course: Black Males in Medicine, the AAMC found that the number of Black male medical students had actually declined over the previous four decades – from 542 in 1978 to just 515 in 2014. This was the first report to bring to light the decline in Black male applicants and matriculants. Recognizing that systemic change and collaboration across the education continuum are key to diversifying the physician workforce and improving health everywhere, the AAMC and the National Medical Association (NMA) created the Action Collaborative for Black Men in Medicine to address persistent barriers that Black men face.

We recognize that early interventions are needed and will focus our efforts on areas of the continuum where the AAMC and the NMA may have the greatest impact, which is from the last two years of high school through the first two years of medical school. The Action Collaborative recently partnered with Blue Cross Blue Shield of Illinois to create the Illinois Black Men in Medicine Innovation Grant, to fund up to five grants that are specifically allocated for projects focused on addressing systemic barriers that influence physician diversity and health equity in Illinois. The aim is to examine the root causes, such as institutional structures, policies, and cultural conventions, that impact the distribution of resources and opportunities.

The AAMC remains committed to the full scope of science, health care, social service, diversity, and preparing future generations to enter health professions. In 1989, we launched the Summer Health Professions Education Program (SHPEP), which is a free summer program for students to explore their interest in medicine, dentistry, nursing, optometry, pharmacy, physical therapy, public health, and more. The program is jointly funded by the Robert Wood Johnson Foundation, takes place at 12 partner institutions, and offers students a chance to develop competencies for becoming successful applicants to health profession programs, plan academic journeys, get clinical exposure, and network. Since its inception, SHPEP has had more than 30,000 alums and assisted 990 scholars being accepted into various medical programs; of those, 564 scholars qualified for a Federal Pell Grant, and 73.74% of scholars are from underrepresented backgrounds.

Ensuring a diverse and representative health care workforce can improve patient experiences and outcomes, address health disparities, and advance health equity. For example, some recent research shows that greater representation of Black physicians is associated with longer life expectancy and lower all-cause mortality among Black patients[3]. This is particularly true for pregnant patients, who face unique challenges and barriers to accessing timely and culturally informed care. These challenges are reflected in the statistics – the U.S. reports unacceptably high rates of maternal injury and death compared to its peer nations. The burden of our maternal health crisis is disproportionately borne by Black, American Indian, and Alaska Native women,

[3] Snyder, John E.; Upton, Rachel D.; Hassett, Thomas C.; Lee, Hyunjung; Nouri, Zakia; & Michael Dill. 2023. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. JAMA Network Open. 2023; 6(4):e236687. DOI:10.1001/jamanetworkopen.2023.6687.

who are more likely to die from pregnancy-related causes than their white counterparts, even after controlling for individual-level characteristics such as age, education, and socioeconomic status. To help address this crisis, we must cultivate a diverse and culturally competent maternity care workforce. In addition, we must address systemic barriers to care, including the ever-increasing prevalence of maternity care deserts in rural and underserved communities.

The AAMC believes that Congress can take the following actions to diversify the health care workforce and address the maternal health crisis:

- Significantly Increase Funding for HRSA Title VII and Title VIII Workforce Development Programs
- Protect the Existing Workforce
- Address Medical Education Debt and Promote Public Service
- Support Pathway to Practice
- Expand Graduate Medical Education
- Bolster the Maternity Care System
- Ensure Access to Coverage and Care
- Promote Whole-Person Health
- Foster Cross-Sector Partnerships
- Ensure Financial Support for Teaching Health Systems and Hospitals
- Support the Role of Medical Schools and Teaching Health Systems and Hospitals in Educating the Physician Workforce

Significantly Increase Funding for HRSA Title VII and Title VIII Workforce Development Programs

We recognize the value of diversity in health care and the health workforce, and we realize that diversity may take many different forms. The HRSA Title VII health professions and Title VIII nursing programs play an important role in connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those communities.[4]

[4] Stewart, K., Brown, S. L., Wrensford, G., & Hurley, M. M. (2020). Creating a Comprehensive Approach to Exposing Underrepresented Pre-health Professions Students to Clinical Medicine and Health Research. Journal of the National Medical Association, 112(1), 36-43. doi:10.1016/j.jnma.2019.12.003.
Goodfellow A, Ulloa JG, Dowling PT, Talamantes E, Chheda S, Bone C, Moreno G. Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review. Acad Med. 2016 Sep;91(9):1313-21. doi: 10.1097/ACM.0000000000001203. PMID: 27119328; PMCID: PMC5007145.

Title VII's health professions diversity programs include:

- Health Careers Opportunity Program (HCOP), which invests in K-16 health outreach and education programs through partnerships between health professions schools and local community-based organizations;
- Centers of Excellence (COE) program, which provides grants for higher education mentorship and training programs for underrepresented health professions students and faculty;
- Faculty Loan Repayment, which provides loan repayment awards to retain minority health professions faculty in academic settings to serve as mentors to the next generation of providers; and
- Scholarships for Disadvantaged Students (SDS), which grants scholarships for health professions students from minority and/or socioeconomically disadvantaged backgrounds.

Studies have demonstrated the effectiveness of such pathway programs in strengthening students' academic records, improving test scores, and helping racial and ethnic minority and students who are economically disadvantaged pursue careers in the health professions.[5] Title VII diversity pipeline programs reached over 22,998 students in the 2022-2023 academic year (AY), with HCOP reaching more than 4,805 disadvantaged trainees, SDS graduating nearly 2,613 students and COE reaching more than 4,512 health professionals – 77%, are also underrepresented minorities.[6] This success is even more impressive considering that only 21 schools have HCOP grants and only 26 have COE grants — down from 80 HCOP programs and 34 COE programs in 2005 before the programs' funding was cut substantially. One way for Congress to positively impact workforce diversity would be to provide additional funding for HCOP and COE health workforce programs.

There is broad agreement that there is a shortage of health providers in rural, frontier, and island or non-contiguous communities. Important to addressing shortages across the spectrum of health providers in these areas is conducting education and training in these communities and drawing on members of these areas to enter health professions. Medical students who grow up in rural communities are much more likely to return to these areas to practice medicine, including primary care. Many medical schools aim to identify potential candidates from rural communities and encourage them to pursue a career in medicine.[7] The HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as

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[5] Ojo, K. (2020). Preparing Minority Students For Careers in Health: A Case Study Investigation of a Health Careers Opportunity Program (HCOP) (Temple University Press). Temple University. doi:https://scholarshare.temple.edu/handle/20.500.12613/287

[6] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2025 Justification of Estimates for Appropriations Committees. budget-justification-fy2025.pdf (hrsa.gov) Accessed April 28, 2023.

[7] Attracting the next generation of physicians to rural medicine, Peter Jaret, Special to AAMCNews, Feb. 2020.

well as providing interdisciplinary health care delivery sites. Additionally, the HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education programs support education and training programs for future primary care physicians. The PCTEP funds new awards to support training for primary care physician assistants, and medical students' rotations in rural and underserved areas, that also integrate behavioral health conditions into primary care. Additionally, the MSEP provides grants to prepare and encourage medical students who are training in the most underserved states, to choose residencies and careers in primary care that serve rural communities, tribal communities, and/or medically underserved communities after graduation. Though we have seen progress toward diversifying the future physician workforce across the spectrum of our AAMC-member institutions, there is more work to be done.

The AAMC encourages increasing federal investment in minority-serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. AAMC also supports the Expanding Medical Education Act (S. 3175/ H.R. 4985), which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs and MSIs or those institutions that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist.

Title VIII's Nursing Workforce Diversity Program increases nursing education opportunities for individuals from disadvantaged backgrounds, through stipends and scholarships, and a variety of pre-entry and advanced education preparation. In AY 2022-2023, the program trained 2,033 nursing students enrolled in degree programs or academic support programs, and 65% of the 2021-2022 graduates worked or trained in medically underserved communities one year later.[8]

For FY 2025, the AAMC leads an alliance of national organizations, the Health Professions and Nursing Education Coalition, in recommending $1.51 billion for FY 2025 for Title VII ($980 million) and Title VIII ($530 million), which would nearly double funding for the programs and would help HRSA address pressing health challenges, health inequities, and patients' evolving needs across America.

Protect the Existing Workforce

Physicians and other health professionals dedicate their careers to keeping people healthy, but too often they do not receive the support they need to address their own well-being. AAMC data show that, like the overall U.S. physician population, a large percentage of medical school faculty have experienced higher levels of stress (particularly underrepresented minorities), and

[8] *Id.*

nearly a third of medical faculty face one or more symptoms of burnout.[9] In addition to their detrimental effect on health professionals and their families, burnout, stress, and other behavioral health issues negatively affect patient care, patient experience, and overall health outcomes.

To that end, we ask Congress to reauthorize the HRSA Title VII Preventing Burnout in the Health Workforce program authorized by the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105). This historic bipartisan legislation, the Lorna Breen Health Care Provider Reauthorization Act (S. 3679, H.R. 7153), aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among healthcare workers. We must reauthorize this bill to ensure we are continuing to do what we can to prevent burnout and protect the well-being of our health care workforce.

The AAMC urges Congress to take action to protect health care workers by passing the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act (S. 2768/ H.R. 2584). Violence should have no place in the health care setting. Recent studies reveal that health care workers are five times more likely to experience physical attacks on the job compared to other workers.[10] Moreover, 44% of nurses have reported experiencing physical violence and 68% reported verbal abuse in the workplace.[11] These incidents of violence have far-reaching consequences, including disrupting and delaying care in hospitals, demoralizing staff, and complicating efforts to attract and retain health care workers. This situation strains health care systems, particularly in regions already facing worker shortages, such as rural and other underserved communities, by increasing delays, workloads, and operational costs.

The SAVE Act would address the aforementioned crises by providing federal-level protections for health care workers subjected to workplace violence like those protections afforded to airline and airport workers. This includes criminalizing assault and intimidation against health care workers under federal law, creating a safer work environment by deterring violent behavior, and ensuring that offenders face appropriate consequences. Enacting this legislation is pivotal for protecting health care workers, who have selflessly cared for patients throughout the COVID-19 pandemic and beyond.

Address Medical Education Debt and Promote Public Service

The AAMC continues to support a variety of federal programs aimed at easing the impact of medical education debt and urges Congress to provide robust support for these programs.

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[9] Dandar, V. M., Grigsby, R. K., & Bunton, S. A. (2019). Burnout Among U.S. Medical School Faculty. AAMC Analysis in Brief. Retrieved from: https://www.aamc.org/system/files/reports/1/february2019burnoutamongusmedicalschoolfaculty.pdf

[10] U.S. Bureau of Labor Statistics. Fatality data are from the Census of Fatal Occupational Injuries. Nonfatal injury and illness data are from the Survey of Occupational Injuries and Illnesses. https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm

[11] Byon HD, Sagherian K, Kim Y, Lipscomb J, Crandall M, Steege L. Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic. *Workplace Health & Safety*. 2022;70(9):412-420. doi:10.1177/21650799211031233

Medical education costs can also be a significant deterrent and burden for individuals interested in medicine, and the AAMC is deeply concerned about the impact these costs may have on the physician pathway.[12] Medical school leaders across the country are committed to serving the interests of medical students and reducing this burden. Some institutions have increased institutional aid, while a few have committed to eliminating debt or tuition altogether in the hopes of attracting diverse candidates and increasing interest in primary care.[13] In the 117th Congress, the AAMC endorsed the National Medical Corps Act (H.R. 9105) scholarship program to help address the financial debt burden for students who are underrepresented in medicine.

Public service loan repayment programs offered by HRSA, the National Institutes of Health, the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific vulnerable populations. Increasing federal investment in these programs is a proven way to increase the supply of health professionals serving Health Professional Shortage Areas (HPSAs), nonprofit facilities, and other underserved communities. For example, the Public Service Loan Forgiveness (PSLF) program administered by the Department of Education encourages physicians to pursue careers that benefit communities in need. The AAMC supports preserving physician eligibility for PSLF to help vulnerable patients and nonprofit medical facilities that use the program as a provider recruitment incentive.

The National Health Service Corps (NHSC) in particular has played a significant role in recruiting primary care physicians to federally-designated HPSAs through scholarships and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to the growing demand for health professionals across the country. Congress provided a historic $800 million supplemental NHSC funding under the American Rescue Plan, and we believe this will have a positive impact. Nevertheless, additional funding for the NHSC is needed.

Immigration must be mentioned as we consider health workforce shortages, as the US health workforce has been bolstered by individuals who have come from other countries to our nation. Over the last 15 years, the State Conrad 30 J-1 visa waiver program has brought more than 15,000 physicians to underserved areas — comparable to (if not more than) the NHSC, at no cost to the federal government. The AAMC-supported bipartisan Conrad State 30 and Physician Access Reauthorization Act (S. 665/H.R. 4942) would allow Conrad 30 to expand beyond 30 waivers per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing immigrating physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied the growth of the physician workforce.

[12] Physician Education Debt and the Cost to Attend Medical School: 2020 Update.
[13] Will free medical school lead to more primary care physicians? Ken Budd, Special to AAMCNews, Dec. 2019.

Support Pathway to Practice

The AAMC supports a proposal championed by House Ways and Means Committee Ranking Member Rep. Richie Neal (D-MA) in the 117th Congress, the Pathway to Practice Program. This new program would enable medical and postbaccalaureate students from rural and other disadvantaged communities who are underrepresented in the physician workforce to receive support earlier in the medical education pathway and throughout residency training. It would provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical school, or students participating in postbaccalaureate programs with the intention of applying to medical school. As terms of participating in the scholarship program, a student would be required to practice a year in a medically underserved area after residency for each year they receive the scholarship. Scholarship recipients who complete their residency at teaching hospitals with recognition by the Accreditation Council for Graduate Medical Education for certain training activities related to health equity would be exempt from the teaching hospital's graduate medical education (GME) cap. Importantly, the Pathway to Practice program prioritizes students who attended HBCUs, MSIs, or who participated in HRSA diversity pathway programs.

Expand Graduate Medical Education

The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population) leading to a projected total physician shortage of up to 86,000 physicians by 2036. Make no mistake – these shortages in the physician supply will have real impact on patients, particularly those living in rural, frontier, island or non-contiguous settings, and other already underserved communities. Additionally, the AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need an additional 117,100 to 202,800 physicians just to meet *current* demand.[14]

Addressing the nation's physician workforce shortages in both primary care and among needed specialists requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, such as implementing team-based care and better use of technology. We are open to and in fact, ask for, innovative solutions to address health workforce shortages. Since the academic year 2002-2003, total medical school enrollment has grown by more than 38% as medical schools have expanded class sizes and more than 32 new medical schools have opened. While this increase is encouraging, additional action is needed to address the physician shortage.

Growth in GME or residency training is also needed to address projected physician shortages. Dating back to 1997, Congress placed a cap on the number of GME positions Medicare supports at each teaching hospital.[15] According to an analysis of FY 2021 Medicare Cost Report data,

[14] The Complexities of Physician Supply and Demand: Projections From 2021 to 2036, Prepared for the AAMC by IHS Markit Ltd., March 2024.
[15] P.L. 105-33.

there are approximately 125,238 medical trainees in GME positions. Medicare provides support for only 93,885 of those medical trainees at or below the direct GME (DGME) cap established in 1997. According to the same cost report analysis, the average actual cost per medical trainee for a facility was $184,313, while the average actual Medicare DGME payment per resident was only $53,823.[16] The majority of the difference in the cost to train and the Medicare DGME payment must be shouldered by the clinical revenue at a teaching hospital and given the financial solvency issues facing many of these facilities, funding to train residents is another challenge.

One key element of addressing the physician shortage and diversifying the workforce is increasing Medicare support for GME, which will help boost access to high-quality care, particularly for rural and other underserved populations. The AAMC strongly supports the Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389), which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas, hospitals serving patients from federally designated HPSAs, hospitals in states with new medical schools or branch campuses, and hospitals already training residents in excess of their Medicare caps. The legislation has broad stakeholder support and has been endorsed by over seventy members of the GME Advocacy Coalition, which represents a broad range of disciplines. Additionally, this bipartisan legislation directs the Comptroller General of the United States to conduct a study and issue a report on strategies for increasing the diversity of the health professional workforce.

GME programs administered by HRSA, including Children's Hospitals GME and Teaching Health Centers, are important complements to Medicare GME that help to increase the number of residents training in children's hospitals and community health centers, respectively. To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and start-up funding to rural hospitals under the Rural Residency Planning and Development programs. Funding for these programs at HRSA specifically targeting GME at children's hospitals and teaching health centers, and rural areas will have an impact on the physician workforce shortage in those settings.

The AAMC also recommends that Congress pass the Rural Residency Planning and Development Act of 2024 (H.R. 7855). While additional physician training programs and increased Medicare support for graduate medical education are fundamental to addressing the physician shortage, we believe that it is imperative to provide teaching hospitals with the resources that they need to develop more rural training programs. Sponsoring and supporting physician training is a barrier unto itself, but starting new residency programs is also particularly difficult due to obstacles associated with recruiting and developing faculty, recruiting and training residents, securing and maintaining accreditation, and developing curriculum. The Rural

[16] AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

Residency Planning and Development Act of 2024 codifies an existing, effective federal grant program that provides funding for the startup costs associated with residency programs in rural areas. From 2019 to 2023, the program funded the development of 39 new accredited rural residency or rural track programs across 36 states.[17] This translates to 521 new residency positions in rural areas. Not only are these positions already producing physicians, but as part of the program, the Health Resources and Services Administration has provided key technical assistance to teaching hospitals to aid in the development of new residency programs. While no Senate bill has yet been introduced, the AAMC recommends that the Committee consider introduction and passage of this legislation.

In addition to diversifying the health care workforce, we encourage the committee to consider the following recommendations to address the maternal health crisis:

Bolster the Maternity Care System

Nationally, over 98% of live births occur in a hospital setting, and therefore, hospital financial challenges and related closures significantly contribute to the maternal health crisis.[18] Mounting financial difficulties stemming from insufficient reimbursement, workforce shortages, and rising costs have forced many hospitals across the country to shutter their maternity care units, or else close entirely. These closures seriously endanger the health and safety of pregnant patients, especially those living in rural and underserved communities. According to the American Hospital Association, between 2015 and 2019, there were at least 89 obstetric unit closures at U.S. rural hospitals, forcing patients to travel further distances to receive medically necessary prenatal and postpartum care.[19] Additionally, research shows that obstetric unit closures disproportionately harm Black patients, who already face an elevated risk of injury and death in giving birth.[20]

The closure of hospital-based maternity wards has contributed to the emergence of "maternity care deserts," defined as counties without a hospital or birth center offering obstetric care. In 2022, over 2.2 million women of childbearing age lived in a maternity care desert, and this challenge is expected to worsen in the coming years due to the profound financial pressures facing hospitals.[21] To address this challenge and ensure continued access to care for pregnant patients, Congress must provide adequate financial support for the maternity care system,

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[17] Rural Residency Planning and Development Program. Health Resources and Services Administration. https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd

[18] MacDorman, Marian F., and Eugene Declercq. "Trends and state variations in out-of-hospital births in the United States, 2004–2017." Birth 46, no. 2 (2019): 279–288.

[19] https://www.aha.org/system/files/media/file/2022/04/Infographic-rural-health-obstetrics-15ap22.pdf

[20] McGregor AJ, Hung P, Garman D, Amutah-Onukagha N, Cooper JA. Obstetrical unit closures and racial and ethnic differences in severe maternal morbidity in the state of New Jersey. Am J Obstet Gynecol MFM. 2021 Nov;3(6):100480. doi: 10.1016/j.ajogmf.2021.100480. Epub 2021 Sep 5. PMID: 34496307.

[21] Brigance, C., Lucas R., Jones, E., Davis, A., Oinuma, M., Mishkin, K. and Henderson, Z. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. (Report No. 3). March of Dimes. https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

including both hospitals and community-based providers. To this end, we urge Congress to reject harmful and misguided cuts to hospital outpatient departments, preserve and strengthen the 340B Drug Pricing Program, eliminate scheduled reductions to the Medicaid Disproportionate Share Hospital Program, and update hospital payments to account for inflation. Together, these critical programs help to ensure the long-term financial sustainability of teaching health systems and hospitals, thereby allowing these providers to continue to serve pregnant patients and their families.

Ensure Access to Coverage and Care

The AAMC supports policies to expand access to robust and affordable insurance coverage for parents, families, and infants. Medicaid, which finances over 40 percent of all births in the U.S., plays a critical role in supporting the health of pregnant patients.[22] The Affordable Care Act (ACA) has dramatically expanded access to coverage by incentivizing states to extend Medicaid eligibility to additional individuals. Research shows that Medicaid expansion is associated with improved health outcomes for both parents and infants, including lower rates of maternal and infant mortality, reduced risk of pre-term birth and low birth weight, and fewer hospitalizations during the early postpartum period. Unfortunately, in the remaining states that have failed to adopt Medicaid expansion, nearly 2 million people fall into the "coverage gap," meaning that their income is above the state's Medicaid eligibility threshold but below the poverty line, making them ineligible for subsidies in the ACA Marketplaces.[23] To address this challenge, the AAMC supports policies that incentivize states to adopt Medicaid expansion, including continued access to enhanced federal matching funds for new expansion states.

The one-year postpartum period is an especially risky time for patients, who may develop serious health complications, such as cardiovascular disease or behavioral health conditions. Despite these risks, a shocking percentage of postpartum patients report that they do not receive recommended care. Access to coverage is a key predictor of a patient's likelihood of receiving postpartum care. Although current federal statute requires that states provide just 60 days of postpartum Medicaid coverage, Congress and the administration recently provided states with the permanent option to extend coverage to 12 months postpartum. To date, 46 states and the District of Columbia have chosen to extend postpartum coverage.[24] While the AAMC applauds this progress, we urge Congress and the administration to continue to build on this momentum and advance policies that promote universal access to coverage. This includes maintaining

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[22] Osterman, Michelle J. K., et al. "Births: Final Data for 2020." National Vital Statistics Reports 70, no. 17 (2022). https://stacks.cdc.gov/view/cdc/112078.

[23] Rudowitz, Robin, et al. "How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible If All States Adopted the Medicaid Expansion?" Kaiser Family Foundation, March 31, 2023. https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-manycould-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[24] "Medicaid Postpartum Coverage Extension Tracker." Kaiser Family Foundation, January 17, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ 14 Jaffery, Jonathan. Advancing Interoperability and Improving Prior Authorization Processes [CMS-0057P]. Letter. Washington, DC: Association of American Medical Colleges (AAMC), 2023. https://www.aamc.org/media/65416/download.

coverage gains made during the COVID-19 pandemic by permanently extending enhanced premium subsidies provided by the American Rescue Plan Act of 2021 (P.L. 117-2), which are due to expire at the end of this year. These policies are critical to ensuring access to affordable coverage for pregnant patients, especially given the profound economic stress facing patients and families.

The AAMC also recognizes that coverage alone does not guarantee access to care for pregnant patients. Barriers imposed by insurers, including administratively burdensome prior authorization requirements, can reduce patients' access to care and contribute to provider burnout. This is particularly concerning in the context of maternity care, as prior authorization requirements can limit patients' access to time-sensitive diagnostic and treatment procedures, such as genetic testing. To address this challenge, the AAMC has urged Congress to scrutinize prior authorization practices and CMS to prohibit prior authorization for maternal care during the prenatal and one-year postpartum period.[25] To support continuity of care during this critical window, the AAMC also recommends requiring payers to honor prior authorization approvals issued by a previous payer during pregnancy and for one year postpartum. This policy would ensure that pregnant and postpartum patients have continued access to medically necessary care, regardless of whether their source of coverage has changed.

Promote Whole-Person Health

Perinatal behavioral health conditions, including depression and anxiety, are the most common complications of pregnancy and childbirth. An estimated one in five women experience these conditions, but few receive treatment.[26] Left untreated, perinatal behavioral health conditions can be deadly: suicide and overdose are the leading causes of pregnancy-related death in the one-year postpartum period.[27] The AAMC is committed to raising awareness of this troubling problem and empowering our members to expand access to mental and behavioral health services for pregnant patients and their families. We are proud to be part of Mind the Gap, a national coalition convened by Postpartum Support International that aims to increase screening, diagnosis, and treatment of maternal mental health conditions.

Through our strategic plan, the AAMC works to accelerate the coordination and integration of physical and behavioral health care. Integrated behavioral health (IBH) models involve a multi-disciplinary team of medical and behavioral health providers working together to address the

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[25] Jaffery, Jonathan. Advancing Interoperability and Improving Prior Authorization Processes [CMS-0057P]. Letter. Washington, DC: Association of American Medical Colleges (AAMC), 2023. https://www.aamc.org/media/65416/download.

[26] "Launch of the WHO guide for integration of perinatal mental health in maternal and child health services." World Health Organization, September 19, 2022. https://www.who.int/news/item/19-09-2022launch-of-the-who-guide-for-integration-of-perinatal-mentalhealth#:~:text=Almost%201%20in%205%20women,undertake%20acts%20of%20self%2Dharm.

[27] Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022.

medical, behavioral, and social factors that affect a patient's health and well-being. These models, which can be embedded into both primary and specialty care settings, are a proven strategy to reduce the stigma surrounding mental health services and expand access to care, particularly for historically under-resourced patients. The AAMC believes that behavioral health integration is an effective strategy to improve pregnant and postpartum patients' access to mental health and substance use disorder services. To promote the adoption of these care models, the AAMC urges Congress and the administration to invest in sustainable financing mechanisms that incentivize same-day care and ensure the long-term financial viability of behavioral health integration.[28]

Foster Cross-Sector Partnerships

The AAMC recognizes that non-clinical factors, including access to safe and affordable housing, reliable transportation, nutritious food, and a healthy environment, play an important role in a person's health. As anchor institutions in their communities, academic medical centers are well-positioned to forge federal, state, and local community partnerships to address these social determinants of health. Every day, our members collaborate with communities to ensure that all people have the opportunity to reach their full health potential — a state of health equity.

To address this challenge, the AAMC supported the bipartisan Social Determinants Accelerator Act in the 117th Congress. This legislation would authorize an interagency technical advisory panel on the social determinants of health (SDOH) and create planning grants for state, local, and tribal governments to establish accelerator programs addressing SDOH. We encourage the reintroduction and swift enactment of this legislation as a first step in addressing the social drivers of maternal and child health inequities.

The AAMC understands that the availability of robust and comprehensive sociodemographic data is critical to identifying and addressing maternal health inequities. Per the AAMC Center for Health Justice's Principles of Trustworthiness, we believe that peoples' lived experiences with pregnancy and childbirth are integral to the research process, and therefore, data collection, analysis, and dissemination should be undertaken in partnership with the individuals and communities most impacted by maternal health inequities. For data to be useful and meaningful to these communities, researchers should strive to share their findings with pregnant patients, community members, and other relevant stakeholders. Transparent, comprehensive, and inclusive data can help researchers, providers, and policymakers understand who is most susceptible to maternal injury and death.

Maternal mortality review committees (MMRCs) are a powerful tool for understanding the root causes of pregnancy-related deaths. The committees, which are comprised of representatives from public health, medicine, and the community, analyze available data to identify and characterize pregnancy-related deaths, as well as recommend prevention measures. MMRCs help

[28] Focusing on Mental and Behavioral Health Care. Washington, DC: Association of American Medical Colleges (AAMC), 2022. https://www.aamc.org/media/61651/download

researchers, policymakers, and communities understand and address the key drivers of maternal deaths and disparities. To support these life-saving efforts, the AAMC endorses the Preventing Maternal Deaths Reauthorization Act of 2023 (H.R. 3838/S. 2415), which would reauthorize federal support for state-based MMRCs through fiscal year 2028. Absent congressional action, authorization for these programs is set to expire at the end of the current fiscal year 2024.

The AAMC also endorses the Data to Save Moms Act (S. 1599), which would expand data collection and research on maternal morbidity and mortality among communities of color. Under the legislation, the Secretary of the Department of Health and Human Services may furnish grants to MMRCs to support engagement with local communities, such as by inviting and supporting committee participation by community members with under-represented perspectives and experiences.

Ensure Financial Support for Teaching Health Systems and Hospitals

The AAMC remains committed to working with the HELP Committee and Congress to enhance and diversify the health care workforce. We continue to support efforts to increase the number of health care providers to address projected shortages and look forward to ongoing work with Congress to this end. However, we must also urge the Committee to avoid counterproductive proposals that would jeopardize patient access to care, drastically cut payments to teaching health systems and hospitals, weaken the nation's public health infrastructure, and ultimately harm the patients and communities our members serve.

Support the Role of Medical Schools and Teaching Health Systems and Hospitals in Educating the Physician Workforce

Each medical school is responsible for establishing a medical education program that is aligned with its mission and is designed to achieve its stated educational objectives within the framework of the accreditation standards of the Liaison Committee on Medical Education (LCME). Among the standards that LCME outlines is an expectation that "the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine." In accordance with this expectation and in light of the dynamic health care environment, the content of a medical education program is continually revised to reflect scientific advancements, medical breakthroughs, changes in health care delivery systems, and other issues affecting patients' health. For example, as scientific knowledge increases, many diseases that were once acute conditions are now chronic illnesses that can be managed over time. Accordingly, medical education is evolving to reflect these shifts. Similarly, while maintaining and augmenting a sound fundamental basic science and clinical curriculum, the faculty of LCME-accredited medical education programs have incorporated topics and themes such as geriatrics, pain management, palliative care, disease prevention and health promotion, population health, addiction, communication skills, social determinants of health, emergency preparedness, and medical informatics in their medical education programs. The LCME, which is recognized by the U.S. Department of Education as the reliable authority for the accreditation of medical education

programs leading to the M.D. degree in the United States, is the appropriate body to set and assess standards with respect to the medical education curriculum. The LCME standards are carefully designed and regularly updated to ensure that the graduates of all LCME-accredited programs possess the general professional competencies required for proficient medical care.

Congress should reject any efforts to legislate the content, structure, and administration of medical education programs, and instead should support the medical and educational expertise that has developed a medical education system and physician workforce that is the world's gold standard.

Conclusion

The AAMC remains committed to working with Congress to increase the diversity of the physician workforce and improve maternal health. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at dturnipseed@aamc.org, or AAMC Senior Director of Government Relations and Legislative Advocacy Len Marquez at lmarquez@aamc.org.