AMA AMERICAN MEDICAL ASSOCIATION

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April 11, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments and recommendations to the Administration regarding the current maternal health crisis in the United States. The AMA supports the Administration's focus on this critically important issue, which disproportionately affects Black and Native American/Alaska Native pregnant and postpartum individuals. As the largest professional association for physicians and the umbrella organization for state and national medical specialty societies, the AMA is committed to working with all interested parties, and especially the Administration and Members of Congress, to support efforts to reduce and prevent the rising rates of maternal mortality and serious or near-fatal maternal morbidity.

The AMA appreciates all the work that the Administration has already done in this space and applauds the White House on its Blueprint for Addressing the Maternal Health Crisis and the U.S. Department of Health and Human Services for its Action Plan to Improve Maternal Health in America. The AMA is especially glad to see that the Administration has noted that the maternal health crisis is at the intersection of multiple complex issues, including health equity, adequate access to health care, socioeconomic factors, and more making the maternal health crisis an issue that will require large systemic changes to successfully address. We urge the Administration to do more to establish near-term goals and quantitative measures to track the performance of its longer-term maternal health efforts.

As such, in order to try and aid the Administration in its efforts to advance maternal health, the AMA has worked collaboratively over the last year with a variety of members of the Federation of Medicine, including relevant specialty societies, key state medical associations, and physicians from rural parts of the U.S. As a result of these efforts, the AMA has cultivated the following recommendations for the Administration that we believe will aid in the development of both near-term goals and quantitative measures, as well as provide additional support and information for the Administration's long-term goals as identified in the Blueprint. The AMA believes that with additional funding from Congress and the implementation of these recommendations maternal health across the country can be significantly improved.

FUND PATIENT-SAFETY BUNDLES, ACCESS TO SUBSTANCE USE DISORDER TREATMENT, AND MEDICAL-LEGAL PARTNERSHIPS TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 1a: Ensure feasibility and implementation of Core Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles and checklists.

The AMA strongly supports the Alliance for Innovation on Maternal Health (AIM) patient safety bundles, and we are encouraged that they are included in both the White House Blueprint and the new Transforming Maternal Health program. However, it is important for states and the federal government to recognize that the biggest barrier to implementing these bundles is a lack of resources and that additional funding, beyond what has already been invested, is needed to adequately implement the AIM bundles, especially in smaller institutions and institutions that do not have vast resources. **Therefore, the AMA strongly recommends that the Administration provide the financial resources necessary for implementation of the Core AIM bundles and seek input from physicians providing obstetrical services about the barriers to implementing the AIM patient safety bundles.** The AMA would welcome the opportunity to facilitate discussions between the Administration, the states, and physicians to help achieve this outcome.

AIM: Simulation Training

Multiple AIM bundles include requirements to "[c]onduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients." The American College of Obstetricians and Gynecologists (ACOG Simulations Working Group) has already created multiple simulation resources, including obstetric surgical skills, emergencies in clinical obstetrics, uterine atony, and cerclage. However, the cost of implementing simulations is always a concern, especially for smaller practices, practices located in historically minoritized areas, and rural practices. As such, it is vital that **funding be provided for consistent, up-to-date, holistic simulations that can improve maternal health. Moreover, these simulations should be available for every physician, and physician-led team, that engages in maternal care, including OBGYNs, maternal-fetal medicine specialists, family physicians, and emergency medicine physicians.**

Recommendation 1b: Expand evidence-based programs for pregnant and postpartum people with substance use disorder (SUD).

Among pregnant and postpartum persons, drug overdose mortality increased approximately 81 percent from 2017 to 2020, mirroring trends observed among persons of reproductive age overall. Pre-adolescent females and women who died from a drug overdose during pregnancy, compared to those who died from obstetric causes, were more likely to be aged 10 to 34, be non-college graduates, be unmarried, and die in "non-home, non-healthcare settings." From 2018 to 2021, the mortality ratio more than tripled among pregnant and postpartum women aged 35 to 44 years.

Increasing access to holistic care for pregnant and postpartum women with SUD is vitally important, and one of the issues addressed in the core AIM bundles. As such, **we recommend that the AIM bundles be built out to cover additional care concerns connected with SUD and maternal health and to incorporate some additional best care practices.**

There are many evidence-based programs and other efforts underway in the states to extend Medicaid and the Children's Health Insurance Program (CHIP) coverage to pregnant people with SUD. **The AMA**

urges the Administration to highlight those efforts and encourage states to build on evidence-based practices to improve care, reduce inequities and support pregnant people, their newborns, and families. This includes support for removing harmful policies that stigmatize and punish pregnant and postpartum individuals who receive medications for opioid use disorder (MOUD). MOUD is recognized as part of the standard of care for treating pregnant individuals with an opioid use disorder (OUD). Too many pregnant people, however, fear prosecution for taking MOUD, as well as threats to being able to keep their newborn if taking MOUD through a pregnancy or postpartum period. The AMA appreciates the efforts of Centers for Disease Control and Prevention , Substance Abuse and Mental Health Services Administration , Office of National Drug Control Policy , National Institute on Drug Abuse and other agencies that highlight the benefits of MOUD during pregnancy, and the AMA would be pleased to work with you to further emphasize the medical and public health benefits.

Correctional facilities and judicially supervised diversion programs should provide all justice-involved people, including pregnant and postpartum individuals, with access to FDA-approved MOUD and universal screening for SUD. Rates of SUD and OUD among incarcerated individuals are disproportionately high; the U.S. Department of Justice (DOJ) estimates that more than half of those incarcerated in state prisons and jails meet the criteria for a SUD, compared to one in 20 people in the general population.[1] Despite DOJ guidance that denial of MOUD in jails and prisons violates the Americans with Disabilities Act, and federal court decisions protecting the right to receive MOUD in carceral settings, jails and prisons still provide far less access to MOUD than do community providers.[2] It is contrary to all medical evidence to force individuals to undergo discontinuation or abrupt cessation of MOUD, leading to withdrawal, which is associated with both physical and psychological harm. **The AMA encourages the Administration to help ensure pregnant people in jails and prisons have access to their rights under the law, including access to MOUD during pregnancy and postpartum periods.**[3]

The AMA commends the Administration for creating a pathway for states to use Section 1115 Medicaid demonstrations to provide Medicaid financed pre-release services in state or local correctional facilities to support reentry to the community. This type of flexibility allows states to design state-specific, justice-involved reentry demonstrations for Medicaid-eligible individuals, including prerelease case management services, MOUD, and a 30-day supply of all prescription medications at the point of release. **The AMA also supports the ability of states to provide family planning services, rehabilitative or preventive services, screening for chronic conditions that are likely to impact the carceral population (i.e., hypertension, diabetes, hepatitis C or HIV), treatment for hepatitis C, and durable medical equipment.** As of December 2023, both California and Washington have secured approval from CMS to provide reentry services to justice-involved populations and 15 other states have submitted reentry demonstration requests. This is the type of state-federal partnership that helps improve care for pregnant

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[1] Bronson J, Stroop J, Zimmer S, Berzofsky M. Department of Justice Office of Justice Programs, Bureau of Justice Statistics Special Report. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009 Revised August 10, 2020.

[2] *See*, *Smith v. Aroostook County. U.S. Court of Appeals*. First Circuit. No. 19-1340. Ms. Smith was to be denied continuing to receive buprenorphine while incarcerated. On appeal, the court affirmed the District Court decision requiring the jail to ensure Ms. Smith's access to buprenorphine.

[3] The AMA recently issued a comprehensive set of recommendations to enhance access to care for individuals with an opioid use disorder who are pregnant or postpartum. "Improving Access to Care for Pregnant and Postpartum People with an Opioid Use Disorder: Recommendations for Policymakers" is available here: https://end-overdose-epidemic.org/wp-content/uploads/2024/02/AMA-Manatt-2024-Improving-Access-to-Care-Pregnant-Parenting-People-with-SUD.pdf

people and their families. We urge the Administration to work with all states to support these beneficial initiatives.

The AMA also recommends that the Administration implement the recommendations of the U.S. Department of Health and Human Services Interagency Pain Management Best Practices Task Force, which highlighted pregnant women as a special population. 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 balancing the risks and benefits to the pregnant person, fetus, and newborn. The AMA cautions, however, that pregnancy is not a reason to avoid evidence-based treatment for pain. To help guide policymakers, the AMA relies on guidance from professional medical associations, including the American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians, American Academy of Pediatrics and American Society of Addiction Medicine. At their core, each of these societies highlight the need for individualized patient care decisions made between the physician and patient—a guiding principle the AMA strongly supports.

Recommendation 1c: Address Social Determinants of Health (SDOH) within the pregnant and postpartum population by enhancing medical-legal partnerships.

"Perinatal medical–legal partnerships [(MLPs)] share responsibility across a diverse team, integrate legal care as needed, and leverage law and policies to help manage vulnerabilities that are exacerbated by an advancing pregnancy…Encouraging the use of medical—legal partnership in more perinatal settings is warranted as obstetric visits offer an advantageous moment for the types of interventions offered." Moreover, some very successful MLPs have been established across the country, such as the Georgetown University Health Justice Alliance's Perinatal Legal Assistance and Well-being (LAW) Project—one of the first MLPs to focus specifically on perinatal needs. These MLPs show a reproduceable pathway to helping patients navigate the healthcare system. As such, **the AMA urges both the Administration and Congress to work together to provide funding to expand MLPs across the U.S. so that every birthing person can have access to the benefits they are entitled to ensure a healthy pregnancy.**

LEVERAGE DIGITAL HEALTH TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 2a: Promote telehealth and home monitoring during pregnancy and the postpartum period and address barriers to providing remote patient care.

Infrastructure for Remote Patient Care

We applaud CMS for creating the State Medicaid & CHIP Telehealth Toolkit, as well as a Supplement to facilitate state implementation of telehealth policies and promote greater provision of telehealth services in the maternal health space. However, in order to guarantee that remote maternal care can be offered, it is vital to first ensure that the infrastructure for remote care services is in place. Accordingly, **it is imperative that there are reliable broadband connections at both the site of the physician and the patient to ensure that consistent, reliable, maternal care can be provided virtually. Thus, the Administration should build out, and make permanent, initiatives like the Connected Care Pilot Program,** which provides funding for "eligible costs of broadband connectivity, network equipment, and information services..." Moreover, it is exceptionally important that these initiatives focus on rural areas that tend to have the worst broadband access. Consequently, **programs like the Rural Health Care Program and the Rural Telehealth Initiative Task Force should be provided with additional**

support, potentially through the Internet for All Initiative, so that broadband access can be provided to these communities as quickly as possible.

Coverage of Telehealth

While maternity care is covered without cost-sharing by private plans and the Medicaid expansion program under the Affordable Care Act , there are no federal requirements for coverage or reimbursement of telehealth care provided during or after pregnancy. However, due to the increased reliance on telemedicine over the past few years, Medicaid programs have begun to permanently expand coverage of telemedicine as a modality to provide health care services. However, maternal and postpartum virtual care are not always included in these policies. **The AMA believes that telehealth and remote patient monitoring are a critical part of the future of effective, efficient, and equitable delivery of health care in the U.S. and encourages the Administration to help ensure comprehensive Medicaid coverage of virtual maternal health care services.**

Monitoring of Hypertension During Pregnancy and Postpartum

Over the last decade, the AMA has developed and disseminated an evidence-based quality improvement program, AMA MAP™ hypertension (HTN), that has demonstrated improvement in blood pressure (BP) control for adult patients with hypertension in primary care settings. In addition, the AMA has collaborated with other interested groups to increase access to tools, resources and services to improve the clinical management of hypertension, including clinical services and home devices for self-measured blood pressure (SMBP), specifically increasing Medicaid coverage. SMBP is an evidence-based strategy for BP control that is incorporated into AMA MAP HTN and other AMA solutions.

The AMA is convening clinical subject matter experts to identify effective strategies and best practices to improve care of patients with HDP. Expected deliverables include clinical resources, issue briefs/commentaries, and peer-reviewed publications for national dissemination. The AMA collaborates regularly with organizations and leaders in maternal health who are national experts on Hypertensive Disorders of Pregnancy (HDP) to build upon the AMA work to develop an SMBP postpartum strategy.

Improving Care for Patients with Hypertensive Disorders of Pregnancy (HDP)

HDP are one of the leading causes of pregnancy-related deaths that occur in the first six weeks postpartum. The rate of patients entering pregnancy with chronic HTN and the overall rate of HDP have risen considerably in recent years. The use of SMBP has been shown to increase compliance with ACOG recommendations for BP monitoring, increase patient satisfaction, and decrease readmissions for HDP. SMBP has also shown promise in reducing inequities in the monitoring and treatment of BP in postpartum patients. Multiple barriers prevent the widespread adoption and use of SMBP for which there are potential solutions. These include:

Coverage and Access

Medicaid covers 42 percent of all births in the U.S. Coverage varies by states including the inclusion of an extra appropriately sized cuff, often needed to ensure clinical accuracy. This variation and others are barriers to scaling SMBP. Even when coverage exists there are still access issues. Some states prohibit shipping a covered device directly to the patients or require patients to go to a specific DME supplier rather than a more convenient location. For SMBP coverage to be clinically impactful, it necessitates that patients have coverage and access to devices that are appropriately sized and clinically validated.

- Therefore, we recommend policies that support increased coverage and access to SMBP devices clinically validated for pregnancy and appropriate cuff sizing options.

Clinical Infrastructure

SMBP requires investments in clinical personnel and technology integration into clinical practice.

Therefore, we recommend policies that support:

- Improved interoperability of apps/platforms to support the transfer of BP measurement data from patients to clinical teams.
- Increased reimbursement for physician-led team-based care in order to increase patient access to programs that improve care for patients with HDP.

Clinical Quality Improvement

Clinical teams require access to data to drive and measure quality improvement programs, as well as research efforts. Dedicated funding to scale promising interventions nationally and measure the impact on outcomes is also needed to identify the most effective solutions and strategies.

Therefore, we recommend policies that support:

- Increased availability of standardized clinical and billing data for use in quality improvement.
- Increased funding for clinical, dissemination and implementation research on HTN and CVD during pregnancy and postpartum in order to identify and measure effective interventions to improve quality of care and health outcomes.

Additional factors that may impact the use of SMBP are the availability of maternity care, the status of policies related to caregiving (for example, parental leave) and the status of health insurance coverage availability (for example, Medicaid expansion).

Teleconsultation

In many rural and underserved areas that lack regular and reliable access to physician specialists and subspecialists, such as maternal-fetal medicine physicians and fetal cardiologists, primary care physicians routinely manage pregnancy care. These primary care physicians need access to specialist consultations to help address complex clinical challenges that may arise over the course of pregnancy or delivery. One way to support multidisciplinary peer collaboration is through a telehealth hub-and-spoke model in which one large “hub” hospital provides additional support and training for smaller “spoke” facilities. This model, introduced through Project ECHO, enables physicians in rural areas to connect with specialists in facilities with capacity to provide higher levels of maternal care via telehealth. **These models should continue to be supported to enable patients to access higher levels and more specialized care without having to leave their communities.**

Recommendation 2b: Ensure the acquisition of the right type of data.

Advancing Interoperability for Maternal Health

Standardization is the first step in forming robust research datasets and is especially important for studies on maternal health. One of the first improvements that must be made in the collection and usage of maternal health data is ensuring that the data are complete. For example, maternal health and child health are inextricably linked, but relevant data are often held in separate, unconnected health records. In order to address this issue, models are being developed to support data exchange for predictive analysis, risk assessment, and retrospective maternal health research. One such project is HL7's Longitudinal Maternal & Infant Health Information for Research. **This project, and projects like it, should be supported and built out so that the necessary data linkages between individuals and their infants' health can be made and a holistic picture of the maternal mortality crisis can be achieved.**

To further aid in creating this holistic picture of maternal and infant health, Medicaid eligibility and claims data should be used, in conjunction with vital statistics and data from the Pregnancy Risk Assessment Monitoring System to help review maternal and infant health data points that could indicate trends in care across Medicaid and the Children's Health Insurance Program. Moreover, **federal policies should support the expansion of the Pregnancy Mortality Surveillance System (PMSS).** To aid in this, standards are needed to support physician collection of patient-identified race and ethnicity information to better detect inequities because better electronic health record data in clinical settings and standardization across health systems is essential for meaningful and unbiased research.

Data Standardization and the United States Core Data for Interoperability (USCDI)

Additional resources should be used to standardize the maternal health data that is captured for comparative analysis within the USCDI. Therefore, to strengthen the collection of maternal mortality and maternal morbidity data, **additional data capture points should be added to the USCDI that further incorporate maternal morbidity, severe maternal morbidity, and maternal mortality information.**

Data Governance and Privacy

Prior to initiating a data collection effort or expanding the type of data collected, **an entity must first evaluate if the necessary technical, governance, and legal protections are in place to maintain an individual's privacy and trust**. Without guardrails in place, the misuse of data could further disparities and decrease individuals' confidence in government data collection efforts. Therefore, in efforts to promote maternal health care, **the Administration must consider what steps it can take to reassure individuals that their personal information, including maternal and infant health information, remains private and secure**. Moreover, **any efforts to increase maternity health information exchange should ensure patient data are protected, safe, and secure**.

GROW AND RETAIN THE PHYSICIAN WORKFORCE TO PROVIDE COMPLEX CARE TO HIGHER-RISK PREGNANT, BIRTHING, AND POSTPARTUM PATIENTS

Recommendation 3a: Address physician workforce needs in maternity care.

A greater emphasis is needed on increasing and retaining the number of physicians in the maternal and infant care space to decrease maternal care deserts and improve health outcomes. In order to help with the retention of physicians who provide maternal care, the Administration should:

The Physician Residency Cap and Training

- Work to help remove the cap on physician residency slots. If this is not possible, the Administration should work to increase the cap on physician residency slots and ensure that the cap is not stagnant, but rather, is increased as needed. Moreover, the cap-building period for new residency programs should be increased.
- Expand maternal care education and training, especially to those physicians that are likely to have to administer care to pregnant or postpartum individuals but are not OBGYNs or maternal-fetal medicine specialists.

Teaching Health Center Graduate Medical Education

- Increase funding for Teaching Health Center Graduate Medical Education (THCGME) Programs. Since 2010, this program has helped 21 OBGYNs complete their residency and enter the workforce. Though this is an excellent start, additional funding, and support for this program, and in particular OBGYNs in the THCGME Program, is needed.

National Health Service Corps

- Increase funding for the National Health Service Corps (NHSC) and ensure that a higher percentage of physicians are accepted to the NHSC Loan Repayment Programs and Scholarship Programs.
- Ensure that further information about the Maternity Care Target Area (MCTA) addition to the NHSC is provided to the public and grant more funding for the MCTA addition so that an adequate number of maternity care physicians can be placed in HPSAs through the NHSC.

Indian Health Service

- The Indian Health Service (IHS) should establish an Office of Academic Affiliations responsible for coordinating partnerships with the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, accredited medical schools, and residency programs accredited by the Accreditation Council for Graduate Medical Education. Furthermore, to support these partnerships, funding streams should be developed to promote rotations and learning opportunities at IHS, Tribal, and Urban Indian Health Programs.
- The IHS Loan Repayment Program should be strengthened. The payments received through the program are taxable. In order to align this loan repayment program with other similar programs, the loan repayments received should be tax-free.

- Compensation for IHS physicians should be increased to a level competitive with other Federal agencies and additional funding should be provided to the IHS Loan Repayment Program to increase the number of physicians that can be supported, especially in the maternal care space.
- Additional funding should be provided for the IHS Maternal Child Health (MCH) program. The IHS MCH should ensure that the funds it receives are used to increase access to OBGYNs and maternal-fetal medicine specialists for American Indian/Alaska Native (AI/AN) pregnant individuals.
- The CDC should increase its engagement in the following ongoing initiatives (this list is not exhaustive): develop awards to fund support for Maternal Mortality Review Committees for AI Tribes, expand materials on the Hear Her Campaign website for AI Tribes, and continue support for the Healthy Native Babies Project (HNBP) to assist local programs in addressing safe infant sleep in AI/AN communities.

Residency

Additional specific training tracks for maternal and infant care should be created and expanded. Rural track programs (RTP) already exist and are designed to encourage the training of residents in rural areas. Specifically, Maternal Health and Obstetrics Pathway within the Rural Residency Planning and Development Program is available for both OBGYN rural residency programs and family medicine rural residency programs that have enhanced obstetrical training.

While the Maternal Health and Obstetrics Pathway is an important first step, it needs to be expanded so that additional maternal health pathways can be created. For example, additional training tracks should be created that allow for both rural and urban training for OBGYNs, maternal-fetal medicine specialists, family physicians, and other physicians that will likely have to provide maternal care. These training programs could be modeled off existing programs that are already accredited by the Accreditation Council for Graduate Medical Education, such as the family medicine RTP programs, which exist in the "1-2 format"—meaning the resident's first year is at a core family medicine program and the second and third years are at another site. Since there are already provisions of law and regulations that allow urban hospitals to create multiple RTPs and receive adjustments to their caps for newly established RTPs, it would be possible to create an educational format that allows for residents to train in urban and rural settings in maternal care, thereby, enabling physicians who will ultimately practice in rural areas to do rotations in hospitals with a high volume of deliveries, so they can receive ongoing training and experience with cesarean sections and pregnancy-related complications. As such, **more funding should be provided for the Maternal Health and Obstetrics Pathway and programs with similar goals should be created. Moreover, additional funding for rural clinics and hospitals should be provided to enable them to offer rotations for medical students and residents in rural obstetric care.**

Recommendation 3b: Utilize new payment models to prevent maternal deaths.

More than one-third of the rural hospitals that still have labor and delivery services are losing money on patient services overall, putting their ability to continue delivering maternity care at risk. Moreover, the number of providers that are needed to maintain labor and delivery units, such as physicians, nurses, and anesthesiologists, are costly. "As a result, payments per birth that are adequate at a large hospital are not enough to support maternity care at small rural hospitals with far fewer births." This lack of funding often results from the fact that the prenatal, perinatal, and postpartum care provided by physicians is paid for through a fixed "global" code, regardless of the complexity of the patient receiving the care. This fixed fee fails to support the additional services that are necessary to provide high-quality care for pregnant

individuals who have chronic conditions, undergo a high-risk pregnancy, or who experience health-related social needs. Therefore, it is imperative that additional payments are provided in the maternal health space.

Transforming Maternal Health

In a letter to CMS, the AMA recommended several steps that the Center for Medicare and Medicaid Innovation (CMMI) can take to ensure the new Transforming Maternal Health *(TMaH)* program will have a significant, positive impact on maternal health and birth outcomes for pregnant and postpartum women and their infants.

To be successful, TMaH must address problems leading to lack of access to high-quality health care, including inadequate payments from Medicaid programs and commercial insurance plans for maternity care services, particularly services for individuals with complex needs and those who have difficulty accessing and utilizing traditional services. To achieve significant improvements in maternity care, the AMA recommended that CMMI increase the amount of funding provided to each participating state. CMMI has sufficient resources from Congress to invest more in maternity care. Moreover, we believe that alternative payment models (APMs) will only be successful if they are developed in collaboration with physicians, if the models provide the resources physicians need to deliver high-quality care, and if the models hold physicians accountable for aspects of costs and outcomes that the physicians can control. **Therefore, the AMA urged CMMI to ensure that any APMs are developed in collaboration with physicians who provide maternity care and that the models provide adequate resources to support high-value care.**

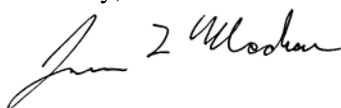
Acute Unscheduled Care Model

We urge you to consider the implementation of the Acute Unscheduled Care Model (AUCM) that was proposed by the American College of Emergency Physicians in 2018. This model would provide special payments to emergency physicians to allow them to have the time needed to focus on transitioning patients into the community safely. Pilot studies using AUCM had great success in connecting patients to primary care, and the AMA believes that a variation of AUCM would enable emergency physicians to connect pregnant patients to the prenatal or postpartum care that they need.

Conclusion

Thank you for your consideration of our recommendations to improve maternal health outcomes in the U.S. If you have any questions regarding our recommendations or if we can be of assistance to you in implementing the recommendations, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: Bipartisan Maternal Health Caucus
Black Maternal Health Caucus
Chiquita Brooks-LaSure