

Reference Committee G

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REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Access to Health Plan Information regarding Lower-Cost Prescription Options
(Resolution 213-NOV-20)
(Reference Committee G)

EXECUTIVE SUMMARY

At the November 2020 Meeting, the House of Delegates referred Resolution 213, “Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary,” which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until the patient attempts to purchase the drug at a pharmacy that the selected pharmaceutical was unaffordable for the patient.

This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-N-21

Subject: Access to Health Plan Information regarding Lower-Cost Prescription Options
(Resolution 213-NOV-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

1 At the November 2020 Meeting, the House of Delegates referred Resolution 213, “Pharmacies to
2 Inform Physicians when Lower Cost Medication Options are on Formulary,” which was sponsored
3 by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American
4 Medical Association (AMA) to support legislation or regulatory action to require that in the event a
5 patient cannot afford the medication prescribed, either because it is not on the formulary or it is
6 priced higher than other medications on the formulary, the pharmacist must communicate to the
7 prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to
8 the patient. Reference committee testimony at the meeting was mixed regarding Resolution 213.
9 While testimony supported the intent of Resolution 213, testimony also expressed concern that
10 Resolution 213 could lead to unintended consequences of creating unnecessary administrative
11 burdens on physicians, confusion for patients, and potential pharmacy scope of practice expansion.
12 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the
13 House of Delegates. This report studies the communication challenges that arise among patients,
14 physicians, pharmacies, and health plans when patients are unable to afford prescribed medication
15 and health information technology (HIT) solutions that can help. In addition, this report highlights
16 ongoing AMA advocacy to improve prescription drug price transparency and presents policy
17 recommendations.

18 19 BACKGROUND

20
21 Patients are directly impacted by high prescription drug prices when they are still in the deductible
22 period of their insurance plans, when the drugs prescribed are not covered by their insurance, when
23 a nonpreferred formulary status for a particular drug leads to a higher patient cost-share, when
24 Medicare Part D beneficiaries are in the “donut hole,” or when patients are uninsured. As the
25 number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise,
26 more patients may struggle with prescription affordability challenges. Resolution 213-NOV-20
27 highlights the untenable position patients and their physicians encounter as they attempt to choose
28 among appropriate prescription drug options with incomplete information. When recommending a
29 pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient
30 preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of
31 joint decision-making, patients and their physicians often lack access to critical prescription drug
32 price information. Instead, patients and their physicians may choose a clinically appropriate
33 prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy
34 Benefit Manager (PBM) formulary and utilization management information, they may not know
35 until patients attempt to purchase their drugs at the pharmacy that the selected pharmaceuticals are
36 unaffordable for the patient.

1 Pharmacists play an important role in identifying instances of prescription drug prices impairing
 2 access to care. Critically, a pharmacist may be the first, and potentially only health care
 3 professional, who knows that a patient has declined a prescribed medication due to cost. The
 4 prescribing physician should be informed when a patient declines to fill a prescription as soon as
 5 possible, but as noted in testimony on Resolution 213-NOV-20, requiring pharmacists to
 6 communicate to the prescriber a lower-cost medication option can be problematic. Ideally, patient
 7 out-of-pocket costs associated with prescription options would be easily available through the
 8 electronic systems used by physicians and pharmacists, but that information is not currently
 9 universally available. In the absence of a technology tool, the only way to know which medications
 10 are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or
 11 call the insurance plan or PBM. Clearly, such a process is burdensome for everyone. Since the
 12 ultimate decision regarding which medication is most appropriate for a patient is made directly
 13 between physicians and patients, requiring pharmacists to research patients' formularies and
 14 discuss their research with the physician unnecessarily adds burden to both physicians and
 15 pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may
 16 increase confusion among patients and scope of practice concerns as patients seek prescription
 17 guidance from their pharmacists. Rather than imposing burdensome new legal requirements on
 18 pharmacists, the goal of improved prescription drug price transparency at the point of prescribing
 19 could be accomplished via improved HIT.

20

21 PRICE TRANSPARENCY AT POINT OF PRESCRIBING AND REAL-TIME PRESCRIPTION
 22 BENEFIT TECHNOLOGY

23

24 To empower informed joint decision-making, patients and physicians must have a way to obtain
 25 real-time, patient-specific prescription drug coverage information at the point of prescribing in
 26 physicians' electronic health records (EHR)s.¹ Having access to accurate, current information
 27 about a patient's prescription benefit will enable physicians and patients to evaluate drug costs and
 28 consider possible alternative therapies when selecting a medication regimen. Drug price
 29 transparency at the point of care has the potential to reduce drug costs for patients (and public and
 30 private payers). Additionally, provision of such data within the e-prescribing workflow will ensure
 31 physician awareness of utilization management requirements, such as prior authorization
 32 requirements, step therapy protocols, and quantity limitations at the point of prescribing.
 33 Transparency of patient out-of-pocket costs and coverage restrictions in EHRs can therefore help
 34 mitigate medication nonadherence and treatment abandonment. Finally, by leveraging a technology
 35 solution embedded into existing EHRs, neither patients, physicians, pharmacists, nor payers would
 36 be burdened with the time-consuming process of manually cross-checking current formularies and
 37 potential medication alternatives. This technology solution currently exists in proprietary form, and
 38 a standardized version is on the horizon.

39

40 Real-Time Prescription Benefit (RTPB) technology, also known as Real-Time Benefit Tool
 41 (RTBT) technology in federal regulatory language, is a prescription drug decision-making tool that
 42 embeds real-time, patient-specific benefit information in the e-prescribing workflow.² RTPB tools
 43 allow prescribers to access accurate, patient-specific coverage and benefit information, including
 44 the expected out-of-pocket cost, for a chosen medication and pharmacy. RTPB tools also present
 45 prescribers with utilization management restrictions and plan-preferred alternative medication
 46 options, which may be more cost-effective for the patient.³ RTPB tools represent a significant
 47 improvement over the drug formulary information otherwise incorporated into EHRs and e-
 48 prescribing. Existing drug formulary information is often inaccurate, outdated, and generally
 49 unreliable due to delayed updates and lack of patient specificity. The significant limitations in drug
 50 formulary information embedded into EHRs have caused some physicians to distrust (and
 51 consequently ignore) the formulary data currently available in EHRs.

1 Several proprietary RTPB tools are already being used by some physicians and health systems, but
 2 the proprietary nature of these tools limits their impact. Currently, physicians' ability to access
 3 RTPB information for a specific patient depends on whether there is a business relationship
 4 between the physician practice's RTPB tool software provider and the patient's drug plan. For
 5 example, Surescripts is collaborating with several EHR companies and leveraging information
 6 from the PBMs CVS Health and Express Scripts to provide RTPB tools for the patients and
 7 physicians in their network.⁴ Similarly, OptumRx and UnitedHealthcare are collaborating to
 8 provide a similar tool, specifically for their enrollees.⁵ Accordingly, some physicians may have
 9 access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit
 10 information across all prescription drug plans, and tools do not yet integrate with all EHRs/e-
 11 prescribing systems. To achieve that level of universal access and transparency, a non-proprietary
 12 RTPB standard is required.

13
 14 To test the hypothesized benefits of a standard RTPB tool, a research team at Johns Hopkins
 15 Medicine recently studied the impact of an RTPB tool integrated into the EHR at their institution.⁶
 16 The study found that the RTPB tool reduced physician prior authorization burden, achieved patient
 17 cost savings, and facilitated improved medication adherence. Specifically, the cost and day-supply
 18 information provided by the RTPB tool frequently led physicians and patients to choose a 3-month
 19 supply of medication instead of a 1-month supply, as many PBMs discount the copay on 3-month
 20 supplies, making the 3-month supply more cost effective. This has important health outcomes
 21 implications, as medication adherence increases with longer day-supply of prescriptions.⁷ The most
 22 common changes in drug selection involved switching to alternatives with minimal clinical, but
 23 notable financial, significance. In addition, the information provided by the RTPB tool was able to
 24 guide prescribers in choosing medication alternatives without prior authorization requirements, and
 25 to convert from an agent covered with restrictions to one covered without restrictions, or to convert
 26 from an agent not covered to one covered with restrictions. These features reduced administrative
 27 burden on prescribers and increased the likelihood of patients being able to obtain their medication
 28 without delay. The study found patient cost savings of up to \$2,370 when a prescription was
 29 switched from a retail to mail order pharmacy. The average patient out-of-pocket cost savings due
 30 to changes in prescription was approximately \$21. Essential to building physician trust in the tool,
 31 the study found that the price estimates provided by the RTPB tool were accurate in 98 percent of
 32 the orders. The research team emphasized that webinars and in-person meetings were held to
 33 promote increased adoption and appropriate use of the RTPB tool, and since going live with the
 34 tool, they observed a significant increase in awareness from prescribers about the tool.

35
 36 CMS intensified the need for standardized RTPB technology with its May 2019 final rule requiring
 37 that each Medicare Part D plan adopt one or more RTBTs that are capable of integrating with at
 38 least one EHR or e-prescribing system by January 1, 2021.⁸ While this mandate could potentially
 39 help accelerate physician practices' access to RTPB tools, the CMS rule is significantly limited.
 40 The CMS rule allows Medicare Part D plans to support a single RTBT that is required to integrate
 41 with only one physician EHR/e-prescribing system. As such, physicians and their EHR vendors
 42 could presumably need to support a different RTBT for every Medicare Part D plan in order to
 43 have access to prescription benefit information for every Medicare patient treated by the practice.
 44 This would be an overwhelming, expensive, and burdensome proposition for vendors and
 45 physicians and would likely discourage adoption of this technology. Alternatively, since CMS is
 46 only requiring *one* RTBT capable of integrating with at least *one* e-prescribing system or EHR,
 47 some physicians may find that they have RTPB information for some, but not all, of their patients.
 48 Such incomplete access to RTPB information may lead to greater confusion and frustration, both
 49 among physicians and patients. An RTPB standard is needed to progress beyond the current
 50 proprietary and incomplete RTPB technology landscape and allow all physicians access through
 51 any EHR to any patient's specific benefit information.

1 The National Council for Prescription Drug Programs (NCPDP) has been developing an electronic
2 standard for RTPB technology since 2014.⁹ The NCPDP's Real Time Prescription Benefit
3 Standard Task Group (RTPB Task Group) is responsible for developing the RTPB standard,¹⁰ and
4 the AMA has participated in the RTPB Task Group since its inception. At its August 2021 Virtual
5 Interim Work Group meeting, the RTPB Task Group agreed to recommend that CMS recognize,
6 via the federal rulemaking process, the RTPB standard that has been developed by NCPDP.¹¹ It is
7 anticipated that the RTPB standard will have an implementation time-period of 2 years following
8 the publication of a final rule.

9
10 As articulated in Resolution 213-NOV-20, currently it can be impossible for insured patients and
11 their physicians to know at the point of prescribing what a prescribed drug will cost the patient. A
12 standardized RTPB tool embedded into physicians' EHRs will close the current information gap
13 among insurance plans, PBMs, pharmacies, patients and their physicians. The universality of a
14 standardized RTPB tool is expected to significantly improve interoperability, expand transparency,
15 increase prescription drug adherence, and promote informed communication and trust between
16 patients and their physicians.¹²

17 18 ENHANCED PHYSICIAN EDUCATION REGARDING APPLICATION OF RTPB 19 TECHNOLOGY

20
21 The Council commends the resolution sponsors for highlighting the critical problem of cost-related
22 non-adherence and prescription abandonment and the urgent need for tools that will enhance
23 communication among physicians and pharmacists on behalf of patients. Resolution 213-NOV-20
24 also illustrates that RTPB technology is not currently a top-of-mind solution for the majority of
25 physicians. The AMA's 2020 Physician Practice Benchmark Survey (2020 Benchmark Survey),
26 which is a nationally representative survey of US physicians who provide patient care, and which
27 included an explanation of RTPB technology, found that only 35.7 percent of physicians had heard
28 of RTPB technology prior to taking the survey.¹³ Moreover, among that portion of the physician
29 population who had heard of RTPB technology, only about 55 percent of those physicians had
30 access to RTPB technology. This may be due to the proprietary nature of the currently available
31 RTPB tools. However, the physicians who have access to RTPB technology overwhelmingly
32 choose to take advantage of the tool. In fact, the 2020 Benchmark Survey found that physicians
33 who have access to RTPB tools are over four times as likely to use the RTPB technology available
34 to them than not. Accordingly, not only is there an urgent need for a standard RTPB tool that will
35 provide all physicians access to all patients' specific benefit information at the point of prescribing,
36 but there is also an urgent need to help the approximately 64 percent of physicians who are
37 unfamiliar with RTPB technology understand the tool's significant value so that they will be
38 prepared to optimally utilize RTPB technology, once it is available to them.

39 40 ADDITIONAL TOOLS TO FILL PRESCRIPTION DRUG COST INFORMATION GAPS

41
42 The Council recognizes that RTPB technology is not a panacea that can solve the much broader
43 problem of prescription drug cost transparency in all contexts. As the "Benefit" element of the
44 RTPB name implies, RTPB tools will only increase point of prescribing price transparency for
45 insured patients. Yet, out-of-pocket prescription drug cost transparency is essential for all patients.
46 Some patients are uninsured or underinsured, and formulary status may not be relevant to these
47 patients. Some local pharmacies may charge lower retail prices for certain prescription drugs than
48 others, and there may be prescription discount programs available for some medications (e.g.,
49 directly through manufacturers or through drug discount aggregator websites, such as GoodRx).
50 Clearly, there is an urgent need for ongoing HIT innovation to enhance prescription drug price
51 transparency in all contexts, and the AMA continues to advocate for improvements.

1 While the health care industry awaits implementation of a standard RTPB tool to provide price
2 transparency for insured patients and awaits additional future tools to provide optimal prescription
3 out-of-pocket cost information at the point of prescribing for all patients, physicians may want to
4 further explore how tools within their current EHR systems could be used to mitigate concerns
5 about prescription abandonment. Among the features that are legally required to be included in all
6 EHR software are tools that facilitate communication between pharmacies and prescribers, and
7 these tools could be used to help identify and respond to patients who encounter cost barriers when
8 attempting to fill their prescriptions. For example, the “RxFill transaction” can be used to
9 communicate between a pharmacy and a prescriber, informing a prescriber whether a specific
10 prescription was dispensed (or partially dispensed) to a patient.¹⁴ Accordingly, if a physician is
11 notified that a patient has never picked up an essential medication, the physician can follow-up
12 with the patient to determine why the prescription was abandoned and if an alternative medication
13 is appropriate. Physicians can choose to receive RxFill notifications for certain patients who are
14 prescribed certain medications (e.g., insulin for patients with diabetes), but not for others (e.g.,
15 prescriptions for seasonal allergy medication). EHRs may allow physicians to further customize
16 how and when they are notified. Similarly, physicians can communicate electronically with
17 pharmacies to discuss prescription options. If a patient declines a drug, pharmacies can use the
18 “RxChangeRequest Transaction” to send prescribers options regarding potential alternatives to
19 originally prescribed medications.¹⁵ For example, pharmacists may suggest a generic alternative to
20 a brand-name drug, or they may suggest another drug that is available at a cheaper price. Upon
21 receiving an RxChangeRequest, a prescriber can respond with an “RxChangeResponse transaction”
22 to either approve or decline the RxChangeRequest, and the prescriber is able to provide additional
23 comments in the response.¹⁶ Importantly, both EHR vendor implementation and pharmacy
24 information systems technology implementation of these e-prescribing tools varies. Physicians who
25 believe that the use of RxFill and/or RxChangeRequest and RxChangeResponse could support their
26 practice are encouraged to seek additional information from their EHR vendor and local
27 pharmacies.

28
29 Physicians can also encourage their patients to utilize currently available consumer-facing
30 prescription drug price transparency tools. For example, when shopping for a Medicare plan,
31 Medicare patients can look-up the cost of their prescription medications under various Medicare
32 plan options.¹⁷ There are a variety of drug discount programs, including drug discount aggregator
33 websites, that allow patients to compare prescription drug prices and obtain coupons that can be
34 used at local pharmacies. Drug discount aggregator websites allow patients to view and compare
35 prices of brand name and generic versions of prescription drugs and provide coupons that patients
36 may choose to use when filling their prescriptions. These coupons can be especially helpful and
37 straightforward for patients who do not have insurance coverage for prescription drugs, but because
38 medications purchased using a coupon may not automatically be counted towards insured patients’
39 deductibles, they may not always provide overall cost-savings for insured patients.¹⁸ A federal
40 regulation finalized in 2020 provides insured patients with greater out-of-pocket cost transparency
41 beginning in 2023.¹⁹ The Transparency in Coverage final rule requires most individual and group
42 health plans to make available to participants, beneficiaries and enrollees personalized out-of-
43 pocket cost information for all covered health care items and services, including prescription drugs,
44 through an internet-based self-service tool and in paper form upon request.²⁰ This will allow
45 patients to obtain real-time, accurate out-of-pocket cost estimates that they can share with their
46 physicians as they engage in joint decision-making and care planning. In addition to providing
47 greater real-time cost transparency for patients and their physicians, starting in 2022, the
48 Transparency in Coverage final rule will require disclosure of in-network negotiated rates and
49 historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location
50 level.²¹ Researchers and third-party developers and innovators can use this data to create private
51 sector solutions to achieve greater price transparency.²²

1 AMA POLICY AND ADVOCACY

2
3 Long-standing AMA policy supports ongoing advocacy for the development of HIT tools, such as
4 an RTPB standard, that enhance prescription drug price transparency. Policy H-450.938 states that
5 physicians should have easy access to and review the best available data associated with costs at
6 the point of decision-making, which necessitates cost data to be delivered in a reasonable and
7 useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to
8 seek opportunities to improve their information technology infrastructures to include new and
9 innovative technologies to facilitate increased access to needed and useable evidence and
10 information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health
11 insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the
12 point of prescribing, and promotes the value of online access to up-to-date and accurate
13 prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy
14 H-110.990 supports the development and use of tools and technology that enable physicians and
15 patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior
16 to making prescribing decisions, so that physicians and patients can jointly decide on treatment.
17 Recent Policy H-125.974 states that our AMA will advocate to the Office of the National
18 Coordinator for Health Information Technology (ONC) and CMS to work with physician and
19 hospital organizations, and HIT developers, in identifying RTPB implementations and published
20 standards that provide real-time information across all prescription drug plans, patient portals and
21 other viewing applications, and EHR vendors. This policy also states that the AMA will advocate
22 to the ONC and CMS that any policies requiring HIT developers to integrate RTPB within their
23 products do so with minimal disruption to EHR usability and cost to physicians and hospitals.
24 Moreover, the policy establishes that the AMA will support alignment and real-time accuracy
25 between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

26
27 Additionally, AMA policy and advocacy promote open communication between pharmacists and
28 physicians when issues of prescription unaffordability arise and increased price transparency at the
29 pharmacy. Policy H-285.965 urges pharmacists to contact the prescribing physician if a
30 prescription written by the physician violates the managed care drug formulary under which the
31 patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which
32 may be on the formulary. Moreover, Policy H-110.991 advocates for greater prescription drug
33 price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the
34 patient's copay be listed on prescription receipts, (2) pursuing legislation that would require
35 pharmacies to inform patients of the cash price as well as the formulary price of any medication
36 prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that
37 would prohibit pharmacies from disclosing when a patient's copay is higher than the drug's cash
38 price (so called "gag clauses"). The AMA developed model legislation consistent with Policy
39 H-110.991, similar bills have been enacted in several states, and federal legislation was enacted to
40 prohibit gag clauses in Medicare, Medicare Advantage,²³ group, and individual health insurance
41 plans.²⁴ Related, in response to Policy H-110.987, the AMA developed model state legislation
42 entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost
43 Increases during the Plan Year" which addresses the issue of timely prescription decision support
44 and would authorize a pilot study to integrate transparency data at the point of care, with
45 information such as medicines' formulary status, cost-sharing tier, patient out-of-pocket cost, and
46 coverage restrictions being integrated into EHRs or e-prescribing systems.

47
48 The AMA continues to advocate extensively in support of an RTPB standard. Since 2014, the
49 AMA has been actively engaged in the development of the NCPDP RTPB standard to ensure that
50 any mandated standard will meet the needs of physician end-users and their patients. The AMA
51 serves as a member of the NCPDP's RTPB Task Group which is comprised of stakeholders from

1 across the health care industry, including organized medicine, hospitals, payers, HIT vendors, and
 2 pharmaceutical/life sciences companies. NCPDP has quarterly workgroup meetings, and the RTPB
 3 Task Group meets weekly to discuss and continue developing the RTPB standard. Collectively, the
 4 RTPB Task Group is committed to the goal of developing and publishing an RTPB standard that
 5 will meet the needs of and benefit every sector of the health care industry and that will be readily
 6 adopted by CMS.

7
 8 During recent testimony at the Congressional Hearing, “Lowering Prescription Drug Prices:
 9 Deconstructing the Drug Supply Chain,” the AMA emphasized the challenges patients and
 10 physicians encounter due their inability to access patient-specific formulary and cost-sharing
 11 information at the point of care.²⁵ The AMA has also recently submitted written comments to
 12 CMS²⁶ and presented to the ONC Health Information Technology Advisory Committee (HITAC)
 13 Intersection of Clinical and Administrative Data Task Force (ICAD) strongly supporting an RTPB
 14 standard. Additionally, the AMA recently submitted comments to CMS that highlighted the
 15 importance of physicians having access to real-time, patient-specific prescription drug coverage
 16 information at the point of prescribing in physicians’ EHRs, supported CMS’ efforts to expedite
 17 industry implementation of RTBT, and recommended that CMS require plans to support a single
 18 RTBT standard, when made available.²⁷

19
 20 Finally, in 2016, the AMA launched a grassroots campaign and website, TruthinRx.org, the goal of
 21 which is to address the opaque process that pharmaceutical companies, PBMs, and health insurers
 22 engage in when pricing prescription drugs. TruthinRx.org provides a platform through which
 23 individuals can sign petitions to members of Congress and template letters that website visitors can
 24 customize and directly send to their US Senators and US Representatives, calling on them to
 25 support increased transparency in prescription drug prices. Coordinated with AMA model
 26 legislation, and state and national engagement, TruthinRx.org is updated to reflect advances in
 27 AMA policy and pharmaceutical industry activities.

28
 29 DISCUSSION

30
 31 Resolution 213-NOV-20 highlighted physicians’ need for patient-specific, real-time formulary and
 32 cost-sharing information, and an RTPB standard would fill that need. A standardized RTPB tool
 33 integrated into EHR systems will allow physicians to have real-time access, at the point of
 34 prescribing, to a current report of whether a specific medication is on a specific patient’s
 35 prescription formulary. A standardized RTPB tool will provide patient-specific out-of-pocket cost
 36 for a selected medication at that patient’s designated primary pharmacy, and it will alert physicians
 37 to applicable utilization management restrictions. A standardized RTPB tool will present
 38 physicians with options of alternative medications that are covered by a patient’s insurance plan,
 39 and this will empower physicians and patients to decide together, before the patient leaves the
 40 examination room, whether the medication is not only clinically, but also financially, well-suited
 41 for the patient. If the medication is unaffordable, the physician can pull up this same information
 42 for other medications equally clinically appropriate for the specific patient, and it will allow
 43 physicians to see the drug discount program prices for the queried pharmacy. Accordingly, the
 44 Council recommends that the AMA continue to zealously advocate for the development,
 45 publication, adoption, and mandated use of standardized RTPB tools with minimal burden on
 46 physicians. In addition, the Council recognizes that many practicing physicians have not been made
 47 aware of how a standard RTPB tool will enhance their practice, or how HIT tools already available
 48 within their EHR and/or e-prescribing systems can enhance communication between physicians
 49 and pharmacists. For this reason, the Council recommends that the AMA develop and disseminate
 50 educational materials that will empower physicians to leverage these HIT tools to enhance their
 51 practices.

1 The Council recognizes that the question of whether a particular prescription drug is on a patient's
2 insurance formulary is just one component of the much larger prescription drug affordability
3 challenge. The AMA will continue to advocate for technology tools to efficiently address the broad
4 range of prescription price transparency and affordability challenges unrelated to insurance
5 benefits. For these reasons, the Council recommends amending Policy H-110.990 to specifically
6 call for the development and use of tools and technology that enable physicians and patients to
7 determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs,
8 taking into account insurance status or payer type, prior to making prescribing decisions, so that
9 physicians and patients can work together to determine the most efficient and effective treatment
10 for the patient's medical condition. Related, the Council recommends amending Policy H-125.974
11 which supports alignment and real-time accuracy between the prescription drug data offered in
12 physician-facing and consumer-facing RTPB tools, and advocates that regulators work with
13 physician and hospital organizations, and HIT developers, in identifying real-time pharmacy
14 benefit implementations and published standards that provide real-time or near-time formulary
15 information across all prescription drug plans, patient portals and other viewing applications, and
16 EHR vendors. The Council recommends adding to this strong policy to also specify that the AMA
17 will advocate that regulators include proven and established real-time pharmacy benefit criterion
18 within EHR certification programs and that integration of RTPB tools within HIT be accomplished
19 without disruption to EHR usability and minimal to no cost to physicians and hospitals. Finally, the
20 Council recommends reaffirming Policy H-450.990 which calls for physician access to the best
21 available cost data at the point of decision-making.

22 23 RECOMMENDATIONS

24
25 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
26 213-NOV-20 and that the remainder of the report be filed:

- 27
28 1. That our American Medical Association (AMA) continue to support efforts to publish a Real-
29 Time Prescription Benefit (RTPB) standard that meets the needs of all physicians, utilizing any
30 electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD
31 Policy)
- 32
33 2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be
34 required to implement and keep up to date an RTPB standard tool that integrates with all EHR
35 vendors, and that any changes that must be made to accomplish RTPB tool integration be
36 accomplished with minimal disruption to EHR usability and cost to physicians and hospitals.
37 (New HOD Policy)
- 38
39 3. That our AMA develop and disseminate educational materials that will empower physicians to
40 be prepared to optimally utilize RTPB tools and other health information technology tools that
41 can be used to enhance communications between physicians and pharmacists to reduce the
42 incidence of prescription abandonment. (Directive to Take Action)
- 43
44 4. That our AMA amend Policy H-110.990[3] by addition, as follows:

45
46 Our AMA: ... 3. supports the development and use of tools and technology that enable
47 physicians and patients to determine the actual price and patient-specific out-of-pocket costs of
48 individual prescription drugs, taking into account insurance status or payer type, prior to
49 making prescribing decisions, so that physicians and patients can work together to determine
50 the most efficient and effective treatment for the patient's medical condition. (Modify Current
51 HOD Policy)

- 1 5. That our AMA amend Policy H-125.974 by addition and deletion as follows:
2
3 Our AMA will: . . .
4 (4) will advocate to the Office of the National Coordinator for Health Information Technology
5 (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and
6 hospital organizations, and health information technology developers, in identifying real-time
7 pharmacy benefit implementations and published standards that provide real-time or near-time
8 formulary information across all prescription drug plans, patient portals and other viewing
9 applications, and electronic health record (EHR) vendors;
10 (5) will advocate to the ONC to include proven and established real-time pharmacy benefit
11 criteria within its certification program;
12 ~~(5)~~ will advocate to the ONC and the CMS that any policies requiring health information
13 technology developers to integrate real-time pharmacy benefit systems (RTPB) within their
14 products do so without ~~minimal~~ disruption to EHR usability and minimal to no cost to
15 physicians and hospitals; and... (Modify Current HOD Policy)
16
17 6. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access
18 to and review the best available data associated with costs at the point of decision-making,
19 which necessitates that cost data be delivered in a reasonable and useable manner by third-
20 party payers and purchasers. The policy also calls for physicians to seek opportunities to
21 improve their information technology infrastructures to include new and innovative
22 technologies to facilitate increased access to needed and useable evidence and information at
23 the point of decision-making. (Reaffirm HOD Policy)

Fiscal Note: Less than \$2,500.

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APPENDIX

Policy Recommended for Amendment or Reaffirmation

H-110.990 Cost Sharing Arrangements for Prescription Drugs

Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13 Reaffirmed in lieu of: Res. 205, A-17 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: CMS Rep. 07, A-18)

H-125.974 Continuity of Care for Patients Discharged from Hospital Settings

Our AMA:

- (1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
- (2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
- (3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
- (4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
- (5) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals; and
- (6) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (CMS Rep. 2, A-21)

H-450.938 Value-Based Decision-Making in the Health Care System

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and

useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17 Reaffirmed: CMS Rep. 06, A-19)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Financing of Home and Community-Based Services
(Reference Committee G)

EXECUTIVE SUMMARY

The Council on Medical Service initiated this report to provide an overview of the current financing mechanisms for home and community-based services (HCBS) and to raise awareness about the importance of identifying sustainable methods of broader long-term services and supports (LTSS) financing. This report builds on the long-standing policy of the American Medical Association (AMA) regarding LTSS and presents policy recommendations to modify the current financing structure of HCBS.

The United States (US) is undergoing a population shift. By 2040, about one in five Americans will be 65 or older. By 2050, those over age 85 are projected to more than triple, and it is estimated that 70 percent of seniors reaching age 65 are expected to require some type of long-term care (LTC) assistance in their lifetime. LTC includes both medical and non-medical care, such as assistance with activities of daily living (ADLs). ADLs include a range of activities such as help with bathing, dressing, meal preparation, medication management, housekeeping, and transportation. Hundreds of thousands of older and disabled individuals live in institutionalized care settings not because they need the level of specialized medical care provided in those settings, but because Medicaid payment rules make that the only option with daily care that they can afford. The current LTSS financing structure and incentives generally favor expensive institutional care settings like skilled nursing facilities over less expensive and usually more desirable care settings like adult day care and home care. However, under the Medicaid statute, states must cover institutional LTSS services, but covering HCBS like home health aides and adult day care is optional. Therefore, Medicaid coverage for services in the home or community varies by state with some states not offering HCBS altogether.

Concurrent with demographic shifts, the COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as LTC facilities and the weaknesses in the nation's system of caring for older adults and individuals with disabilities and limitations. It is estimated that nursing home deaths are believed to account for about one-third of total COVID-19 deaths. This grim reality has highlighted the need for a better system of caring for these older and disabled populations.

The Council believes the AMA should seize this opportunity to rethink the current long-term care system and to build upon the AMA's current body of long-term care policy to recommend fundamental reforms, specifically reforms strengthening the nation's system of HCBS. HCBS presents a compelling shift away from institutionalized care. Not only is there currently an unmet need for HCBS, but also, this need is expected to increase with a growing elderly population. Through the Council's set of recommendations, states and the federal government are encouraged to develop and expand HCBS offerings as lower-cost and more preferred alternatives to providing institutional care.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-N-21

Subject: Financing of Home and Community-Based Services

Presented by: Asa Lockhart, MD, Chair

Referred to: Reference Committee G

1 The COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as
2 long-term care (LTC) facilities and the weaknesses in the nation’s system of caring for older adults
3 and individuals with disabilities and limitations. It is estimated that about eight percent of people
4 living in LTC facilities have died of COVID-19, a percentage that is considered an undercount.¹ In
5 particular, nursing home deaths are believed to account for about one-third of total COVID-19
6 deaths. This grim reality has highlighted the need for a better system of caring for these older and
7 disabled populations. The Council recognizes that COVID-19 pandemic has created an opportunity
8 to review the current LTC system and to build upon the American Medical Association’s (AMA’s)
9 current body of LTC policy to recommend fundamental reforms, specifically reforms strengthening
10 the nation’s system of home and community-based services (HCBS).

11
12 This report, initiated by the Council, provides an overview of LTC needs in the United States (US),
13 highlights the myriad ways that HCBS is funded, outlines current HCBS legislative proposals,
14 summarizes relevant AMA policy, and recommends policy to create a stronger foundation and
15 financing structure for HCBS.

16 17 BACKGROUND

18
19 The US is undergoing a population shift. By 2040, about one in five Americans will be 65 or older.
20 By 2050, those over age 85 are projected to more than triple.² According to the US Department of
21 Health and Human Services (HHS), 70 percent of seniors reaching age 65 are expected to require
22 some type of LTC assistance in their lifetime.³ LTC includes both medical and non-medical care,
23 such as assistance with activities of daily living (ADLs). ADLs include a range of activities such as
24 help with bathing, dressing, meal preparation, medication management, help with housekeeping,
25 and transportation.

26
27 Hundreds of thousands of older and disabled individuals live in institutionalized care settings not
28 because they need the level of specialized medical care provided in those settings, but because
29 Medicaid payment rules make that the only option with daily care that they can afford. The current
30 long-term services and supports (LTSS) financing structure and incentives generally favor
31 expensive institutional care settings like skilled nursing facilities over less expensive and usually
32 more desirable care settings like adult day care and home care. The average annual cost for a
33 nursing home room is \$105,850. Alternatively, the average annual cost for a full-time home health
34 aide is about \$48,000, and the cost of adult day care is about \$17,000.^{4,5} However, under the
35 Medicaid statute, states must cover institutional LTSS services, but covering HCBS like home
36 health aides and adult day care is optional.⁶ Therefore, Medicaid coverage for services in the home
37 or community varies by state with some states not offering HCBS altogether. According to

1 Congressional Budget Office projections, federal LTSS expenditures under Medicaid are projected
 2 to reach \$113 billion per year by 2025 compared with the \$74 billion spent in 2014.⁷

3
 4 Many residents in institutional facilities only need assistance with ADLs, and many would prefer to
 5 be living in their own communities. Seventy-six percent of people aged 50 and older would prefer
 6 to remain in their home for as long as possible, and 90 percent would prefer to age in place either in
 7 their homes or community settings such as adult day care centers.⁸ Access to HCBS has emerged as
 8 an alternative to institutionalized care settings to help older Americans and those with disabilities
 9 live independently while receiving assistance with daily needs.

10
 11 Medicaid beneficiaries with LTSS needs account for 6.4 percent of the Medicaid population but
 12 45.6 percent of Medicaid expenditures.⁹ Exacerbating the financial challenge of providing LTSS
 13 care to an aging population is a significant birth decline. The latest US census revealed that the US
 14 has one of the slowest rates of population growth in decades. The decline is largely due to
 15 declining immigration and a declining birthrate, which means there will continue to be fewer
 16 workers to support the aging population.¹⁰ Today, there are 2.8 workers per Medicare beneficiary.
 17 However, that number is expected to decline to 2.3 workers by 2030.¹¹ This demographic shift puts
 18 a substantial strain on state and federal budgets and causes great instability in the programs on
 19 which the elderly and disabled rely. Therefore, it is critical to explore financially stable alternatives
 20 to providing LTSS to this population. In keeping people out of more expensive institutions and in
 21 the community, HCBS provides one method to stabilize LTSS funding.

22
 23 **MECHANISMS TO PROVIDE HCBS FINANCING AND SERVICES**

24
 25 *Section 1915(c) and Section 1115 Waivers*

26
 27 For the last 40 years, states have used waivers to provide HCBS to Medicaid beneficiaries. Nearly
 28 all HCBS beneficiaries receive services through an optional authority. Section 1915(c) of the
 29 Social Security Act authorizes a waiver program allowing states to meet the care needs of their
 30 populations through LTSS in their homes or communities rather than in an institutional care
 31 setting. Section 1115 waivers give states the option to waive certain Medicaid requirements and
 32 allow states to use Medicaid funds for pilot or demonstration projects.¹² For example, states can
 33 target waivers to areas of the state where need is the greatest. States can also make waiver services
 34 available to certain groups of people who are at risk of institutionalization, such as those with a
 35 particular diagnosis. States can provide Medicaid to people who would otherwise only be eligible
 36 for coverage in an institutional setting. Using their waiver authority, states are permitted to offer a
 37 variety of services. Therefore, states can use waivers to provide a combination of standard medical
 38 and non-medical services. Services may include case management, home health aides, personal
 39 care, adult day care centers, and respite care. Moreover, states can implement other types of
 40 services that may assist in diverting or transitioning individuals from institutional care settings.^{13,14}

41
 42 Nearly all states and DC offer services through HCBS waivers. However, states continue to face an
 43 arduous federal waiver process. Obtaining a waiver generally requires negotiations between states
 44 and the federal government. There currently are more than 300 HCBS waiver programs in effect
 45 nationwide. Relying upon such a patchwork system makes the availability of HCBS services highly
 46 dependent on the state in which a beneficiary resides.¹⁵

47
 48 *State Plan Amendments*

49
 50 A Medicaid state plan is an agreement between the state and the federal government detailing how
 51 the state administers its Medicaid program. In it, the state attests that it will follow federal rules and

1 may claim federal matching funds for its Medicaid program activities. Additionally, the state plan
2 outlines who will be covered under its activities, what services will be provided, payment
3 methodologies for providers, and the state's administrative activities.¹⁶

4
5 States can amend their plans through a state plan amendment (SPA). States can submit a proposed
6 SPA to Centers for Medicare & Medicaid Services (CMS) for review and approval. Over the years,
7 Congress has enacted several SPAs designed to make it easier for states to expand HCBS. Using an
8 SPA, states can provide Medicaid to people who would otherwise only be eligible for coverage in
9 an institutional setting. States can also target services to individuals with particular needs, risk
10 factors, or those with a specific disease or condition.¹⁷

11 12 *Money Follows the Person*

13
14 Medicaid's Money Follows the Person (MFP) demonstration has been in place since 2008. The
15 initiative's intent is to rebalance Medicaid's bias for institutional care and seek to move seniors and
16 people with disabilities from institutions and into the community. The program uses enhanced
17 federal matching funds to incentivize states to operationalize the program. Since its inception, the
18 MFP program has helped more than 100,000 individuals transition from institutional to community
19 care settings. Notably, the national MFP program evaluation found that enrollees experienced
20 significant increases in quality-of-life measures after transitioning back to their communities. The
21 evaluation also found that some individuals would not have made the transition away from
22 institutional care if not for MFP. The program also helped states control spending, which is
23 attributed to the fact that HCBS typically costs less than institutional care. The evaluation found
24 that state Medicaid programs saved about \$978 million during the first year after transition for
25 MFP enrollees.¹⁸ The availability of the program relies on federal funding reauthorization, which is
26 set to expire in 2023.¹⁹

27 28 *Federal Medical Assistance Percentages*

29
30 The Federal Medical Assistance Percentages (FMAPs) are used to determine the federal share for
31 most Medicaid health care services.²⁰ It is calculated by a formula that is designed so that the
32 federal government pays a larger portion of Medicaid costs in states with lower per capita incomes
33 compared to the national average.²¹ For example, the FMAP rate in Mississippi is 84.51 percent
34 while the rate in Massachusetts is 56.2 percent.²²

35
36 The FMAP is critical to the provision of Medicaid services in states. Medicaid accounts for nearly
37 30 percent of state budgets, and state budgets are particularly constrained due to the economic
38 strain of the COVID-19 pandemic. State budgets require Medicaid predictability and limiting the
39 number of beneficiaries and services allows states to accurately estimate HCBS expenditures.²³
40 Absent increased federal matching funds, states are unlikely to expand HCBS services and
41 eligibility despite significant unmet need.

42 43 **WORKFORCE**

44
45 A key barrier to meaningful expansion of HCBS is an unstable workforce. States regularly mention
46 workforce shortages as an obstacle to expanding HCBS, and the shortages have only been
47 exacerbated by the COVID-19 pandemic. Currently, there are about 4.5 million direct care workers
48 (DCWs) providing care to older adults and individuals with disabilities. Between 2019 and 2029,
49 the Bureau of Labor Statistics estimates a 1.9 million increase in family caregiving jobs, which
50 represents a 37 percent increase in over 10 years. The expected increased demand for DCWs is
51 more than any other occupation in the economy.²⁴

1 The current workforce is primarily comprised of women of color who earn low wages and do not
2 receive employee benefits such as paid leave, health care, job training, or advancement
3 opportunities. On average, DCWs make about \$16,200 per year. Despite their valuable work, one
4 in eight DCWs lives in poverty.²⁵ Due to these suboptimal benefits and demanding working
5 conditions, DCW turnover is about 60-80 percent annually.²⁶

6
7 Additionally, the current workforce lacks standardization, which could provide beneficiaries with
8 more consistent and reliable care. The federal government currently requires nursing home and
9 home health aides to undergo 75 hours of training before they can provide care, and some states do
10 not require personal care aides certified through Medicaid to be trained at all.²⁷ Moreover,
11 certification often costs DCWs hundreds of dollars, and three-quarters of the workforce earn less
12 than the average state living wage. The financial obstacle requirements exemplify the lack of
13 consideration and value placed on a critical workforce.

14
15 As of 2018, Medicare's conditions of participation formally recognize home health aides as
16 members of the interdisciplinary care team who are expected to report on a beneficiary's change in
17 condition. Despite this responsibility, little has been done to help integrate aides into care teams.
18 This lack of team integration is unfortunate because home health aides could demonstrate value on
19 care team models including post-acute home care, hospital at home, and ambulatory case
20 management.

21 22 FEDERAL AGENCIES AND HOME AND COMMUNITY-BASED SERVICES

23
24 The current administration of HCBS services relies on five federal agencies. The agencies include
25 the CMS, the Administration on Aging, the Department of Housing and Urban Development, the
26 Department of Transportation, and the Department of Agriculture. Collectively, the agencies fund
27 multiple programs that aid the elderly population with services like nutrition assistance, in-home
28 care, affordable housing, and transportation.²⁸

29
30 The Older Americans Act of 1965 requires HHS's Administration on Aging to facilitate cross-
31 agency collaboration to administer HCBS. However, a recent US Government Accountability
32 Office (GAO) report found that the five agencies operate largely independently of one another with
33 minimal collaboration.²⁹ The GAO's report studied interagency collaboration and found that,
34 though cross-agency collaboration is important for federal efforts, limited resources and competing
35 priorities can preclude cooperation.

36 37 HOSPITAL AT HOME

38
39 Several countries pay for delivering services equivalent to hospital inpatient care to patients in their
40 own homes. These "hospital at home" services have been successful in allowing patients with
41 specific conditions that qualify for inpatient care to receive services in the home and avoid the risks
42 associated with inpatient admission. Patients with conditions such as congestive heart failure,
43 chronic obstructive pulmonary disease, and cellulitis are often candidates for the model. Patients
44 must be sick enough to be hospitalized but stable enough to be treated at home. The at-home care is
45 provided by visiting physicians, nurses, and other clinical staff. The services are more intensive
46 than can be supported through traditional home health care payments. The care model has been
47 shown to reduce costs, improve patient outcomes, and enhance the patient experience.³⁰

48
49 Although some hospitals in the US have been delivering hospital at home care and some Medicare
50 Advantage plans are paying for it, the service is difficult to sustain or expand without payment
51 from Medicare because a minimum number of patients need to participate for the service to be

1 cost-effective. The Physician-Focused Payment Model Technical Advisory Committee has
 2 recommended two different “hospital at home” payment models to HHS, but neither has been
 3 implemented to date.³¹

4
 5 The pandemic has highlighted the flaws of institutionalized care and accelerated the availability of
 6 hospital at home. During the pandemic, CMS has allowed hospitals to deliver services in non-
 7 traditional settings, and it pressed many private insurers to do the same. The CMS program, the
 8 Acute Hospital Care at Home Program, gives participating hospitals the ability to reduce inpatient
 9 volume by treating certain acute care patients at home using a telehealth platform that allows for
 10 daily check-ins and monitoring. Telehealth has been successfully employed in the care model to
 11 help transition patients away from institutional care settings, and the technology has greatly
 12 assisted physicians and patients at a time when maintaining physical distance is critical to health
 13 and safety. The Brigham and Women’s Hospital was one hospital to take advantage of CMS’s
 14 program. A 95-day study took place evaluating the model, which cared for 65 acutely ill patients.
 15 Throughout the study, the hospital at home program was staffed by one physician, one or two
 16 nurses, and one mobile integrated health paramedic. The study showed that the program cost a
 17 fraction of the cost of caring for patients in the hospital and that such programs can serve as
 18 complements to traditional hospital-based care.³² However, it is unclear whether CMS’s Hospital
 19 Care at Home Program will be extended after the COVID-19 public health emergency ends.

20
 21 In May 2021, Mayo Clinic and Kaiser Permanente announced that they were teaming up to scale
 22 the hospital at home model. The two health care giants join a growing list of hospitals around the
 23 country that have implemented this model of care. It is estimated that 30 percent of hospitalized
 24 patients can benefit from the hospital at home model.^{33,34}

25
 26 **AMA POLICY**

27
 28 Policy H-280.945 was established with the adoption of CMS Report 5-A-18 on the financing of
 29 LTSS. The policy states that our AMA supports policies that standardize and simplify private long-
 30 term care insurance (LTCI) to achieve increased coverage and improved affordability; supports
 31 adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an
 32 opt-out provision potentially available to both current employees and retirees; supports allowing
 33 employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including
 34 supporting penalty-free withdrawals from retirement savings accounts for purchase of private
 35 LTCI; and supports innovations in LTCI product design, including the insurance of HCBS and the
 36 marketing of LTC products with health insurance, life insurance and annuities. The policy also
 37 supports expanding LTSS benefits by permitting Medigap plans to offer a limited LTSS benefit as
 38 an optional supplemental benefit or as a separate insurance policy and Medicare Advantage plans
 39 offering LTSS in their benefit packages. In addition, the policy supports permitting Medigap and
 40 Medicare Advantage plans to offer a respite care benefit as an optional benefit and supports a back-
 41 end public catastrophic LTCI program. Particularly salient to this report, the policy also supports
 42 incentivizing states to expand the availability of and access to home and community-based services
 43 and calls for better integration of health and social services and supports, including the Program of
 44 All-Inclusive Care for the Elderly.

45
 46 Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals
 47 for LTC. It states that programs to finance LTC should cover needed services in a timely and
 48 coordinated manner in the least restrictive setting appropriate to the health care needs of the
 49 individual and coordinate benefits across different LTC financing programs. The policy suggests
 50 providing coverage for the medical components of LTC through Medicaid for all individuals with
 51 income below 100 percent of the poverty level and providing sliding scale subsidies for the

1 purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty
 2 level. Policy H-290.958 supports increases in states' FMAPs or other funding during significant
 3 economic downturns to allow state Medicaid programs to continue serving Medicaid patients and
 4 cover rising enrollment.

5
 6 Policy H-280.991 supports tax incentives and employer-based LTC coverage to help fund LTC
 7 including creating tax incentives to allow individuals to prospectively finance the cost of LTC
 8 coverage and encouraging employers to offer such policies as a part of employee benefit packages
 9 and otherwise treat employer-provided coverage in the same fashion as health insurance coverage
 10 and allow tax-free withdrawals from Individual Retirement Accounts and Employee Trusts for
 11 payment of LTCI premiums and expenses. Additionally, the policy supports the use of a tax
 12 deduction or credit to encourage family caregiving. Policy H-280.991 states that consumer
 13 information programs should be expanded to emphasize the need for funding anticipated costs for
 14 LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap
 15 policies. State medical associations should be encouraged to seek appropriate legislation or
 16 regulation in their jurisdictions to provide an environment within their states that permit innovative
 17 LTC financing and delivery arrangements and assure that private LTC financing and delivery
 18 systems, once developed, provide the appropriate safeguards for the delivery of high-quality care.
 19 Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991
 20 supports health system reform legislative initiatives that could increase states' flexibility to design
 21 and implement long-term care delivery and financing programs.

22
 23 Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between
 24 persons who can be served in a home or community-based setting and those who can only be
 25 served safely and cost-effectively in a nursing facility. Such criteria should include measures of
 26 functional impairment that account for impairments caused by cognitive and mental disorders and
 27 measures of medically related LTC needs. The policy supports buy-ins for home and community-
 28 based care for persons with incomes and assets above Medicaid eligibility limits and supports
 29 providing grants to states to develop new LTC infrastructure and to encourage expansion of LTC
 30 financing to middle-income families who need assistance.

31
 32 **CURRENT HCBS PROPOSALS**

33
 34 In Spring 2021, the Biden Administration announced a \$400 billion plan to expand Medicaid
 35 HCBS and support home care workers as part of his American Jobs Plan infrastructure package.
 36 The plan does not increase funding for non-Medicaid programs critical to living at home, and it
 37 does not help middle-income Americans who make too little to pay for LTCI but earn too much to
 38 qualify for Medicaid. However, the plan proposes extending and expanding the MFP program.

39
 40 Subsequently, in June 2021, a bipartisan congressional team introduced the Better Care Better Jobs
 41 Act, which would expand HCBS. The legislation formed the basis of President Biden's \$400
 42 billion plan to expand HCBS access. A main provision of the bill calls to permanently increase the
 43 FMAP by 10 percent. To receive the increase, states would have to address payment rates to
 44 promote the recruitment and retention of DCWs.³⁵ Another key provision would make the MFP
 45 program permanent.

46
 47 However, in late June 2021, President Biden agreed to forego his \$400 billion plan to expand
 48 HCBS as a concession to reach a deal with congressional leaders on a broader infrastructure bill.
 49 Nonetheless, a scaled-back iteration of the \$400 billion plan may be incorporated into the \$3.5
 50 trillion 2022 domestic spending reconciliation bill that will be considered in Fall 2021, and
 51 provisions of the Better Care Better Jobs Act are anticipated to be included.

1 DISCUSSION

2
 3 As the US population ages, beneficiary preferences evolve, and demographic shifts continue,
 4 HCBS provides a desirable and cost-effective way of delivering LTSS to seniors and those with
 5 disabilities. State Medicaid programs will confront increasing pressure to meet the LTSS needs of
 6 an aging population. Meanwhile, the COVID-19 pandemic has exposed the vulnerabilities of
 7 institutionalized care settings such as nursing homes and represents an opportunity to expand
 8 HCBS. The Council believes the AMA should seize this moment to establish fundamental policy to
 9 address the fractured LTSS system through a multi-pronged approach. The Council notes that this
 10 important issue is relevant to Council on Medical Service Report 1-NOV-21, which specifically
 11 addresses end of life payment. Notably, CMS Report 1-NOV-21 recommends supporting Medicare
 12 coverage of supportive care services, including assistance with activities of daily living, under
 13 Medicare’s hospice benefit, and appropriate payment for those services.

14
 15 Acknowledging the AMA’s existing policy on LTSS and laying the foundation for new
 16 recommendations, the Council recommends reaffirming Policy H-280.945. The policy provides a
 17 comprehensive set of principles to improve the financing of LTSS and supports incentivizing states
 18 to expand the availability of and access to HCBS. Recognizing the importance of federal matching
 19 funds to the continuation and expansion of LTSS services, the Council also recommends
 20 reaffirming Policy H-290.958 supporting increases in states’ FMAP or other funding during
 21 significant economic downturns to allow state Medicaid programs to continue serving Medicaid
 22 patients and cover rising enrollment.

23
 24 Moreover, the Council recommends that states simplify their state plan options and Medicaid
 25 waivers to allow states additional flexibility to offer HCBS. By streamlining the current patchwork
 26 system of HCBS waivers and SPAs, states could promote infrastructure development, increase
 27 administrative efficiency, improve budget predictability, and better care for beneficiaries. The
 28 Council believes that continued use of CMS waiver templates is a positive step forward.
 29 Streamlining state plan options and waivers can help eliminate Medicaid’s bias for institutional
 30 care and provide states the flexibility to offer services that better meet the needs of their
 31 populations.

32
 33 The Council also recommends that Medicaid’s MFP program, set to expire in 2023, be extended or
 34 made permanent. Doing so would enable states to expand the settings that qualify as community
 35 care settings, create broader eligibility pathways, and offer new HCBS benefits. The program has
 36 demonstrated that it saves state Medicaid programs money and provides increased and sustained
 37 enrollee quality-of-life. The Council believes that the program has made important contributions to
 38 the rebalancing of LTSS away from institutional settings and into community settings and believes
 39 that these state efforts should be continued with the requisite support.

40
 41 Investing in the HCBS workforce is critical to meeting the needs of an aging population and
 42 modernizing the LTSS system. To address the needs of this aging population and to support the
 43 needed caregivers, the Council recommends supporting federal funding for payment rates that
 44 promote access and greater utilization of HCBS. The Council also recommends supporting policies
 45 that help to train, retain, and develop the HCBS workforce. Steps must be taken to professionalize
 46 the HCBS workforce. The Council notes that the training and skills required will vary yet
 47 workforce standardization is critical. For example, the skills required to care for a hospital at home
 48 patient will differ from the skills required to care for an adult needing basic ADL assistance. HCBS
 49 workforce reforms would help build a pipeline of workers while stabilizing the workforce and
 50 improving quality of care. Ultimately, HCBS and LTSS reforms will only be effective if the
 51 supporting workforce is invested in and valued. Increased federal funding for payment and policy

1 changes to promote the workforce will help serve the needs of individuals in the most appropriate
2 care settings.

3
4 The Council believes that strategic coordination between the five federal agencies that fund and
5 implement HCBS activities could ensure that resources are being used efficiently and effectively
6 for not only the government but also for beneficiaries. Accordingly, the Council recommends
7 supporting cross-agency and federal-state strategies that can help avoid disconnects among HCBS
8 programs and streamline funding and the provision of services. To further streamline programs, the
9 Council recommends that HCBS programs track protocols and outcomes. Doing so could help
10 make meaningful comparisons across states and identify best practices. It can also help promote
11 quality care and ensure that care is aligned with patient goals.

12
13 Finally, the hospital at home model is an important component of the shift away from
14 institutionalized care and has been successful in allowing patients with particular conditions to
15 remain in their homes and avoid risks associated with inpatient admission and care. Accordingly,
16 the Council recommends that CMS and private insurers offer flexibility to implement hospital at
17 home programs for the subset of patients who meet the criteria.

18
19 HCBS presents a compelling shift away from institutionalized care. Not only is there currently an
20 unmet need for HCBS, but also, this need is expected to increase with a growing elderly
21 population. States and the federal government should be encouraged to develop and expand HCBS
22 offerings as lower-cost and more preferred alternatives to providing institutional care.

23 24 RECOMMENDATIONS

25
26 The Council on Medical Service recommends that the following be adopted and the remainder of
27 the report be filed:

- 28
29 1. That our American Medical Association (AMA) support federal funding for payment rates that
30 promote access and greater utilization of home and community-based services (HCBS). (New
31 HOD Policy)
- 32
33 2. That our AMA support policies that help train, retain, and develop an adequate HCBS
34 workforce (New HOD Policy)
- 35
36 3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to
37 allow additional state flexibility to offer HCBS. (New HOD Policy)
- 38
39 4. That our AMA support that Medicaid's Money Follows the Person demonstration program be
40 extended or made permanent. (New HOD Policy)
- 41
42 5. That our AMA support cross-agency and federal-state strategies that can help improve
43 coordination among HCBS programs and streamline funding and the provision of services.
44 (New HOD Policy)
- 45
46 6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful
47 comparisons across states and identify best practices. (New HOD Policy)
- 48
49 7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers
50 offer flexibility to implement hospital at home programs for the subset of patients who meet
51 the criteria used by hospital at home programs. (New HOD Policy)

- 1 8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to
2 improve the financing of long-term services and supports and supports incentivizing states to
3 expand the availability of and access to HCBS and permitting Medigap and Medicare
4 Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)
5
- 6 9. That our AMA reaffirm Policy H-290.958 which supports increases in states' Federal Medical
7 Assistance Percentages or other funding during significant economic downturns to allow state
8 Medicaid programs to continue serving Medicaid patients and cover rising enrollment.
9 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Reducing Inequities and Improving Access to Insurance for Maternal Health Care
(Reference Committee G)

EXECUTIVE SUMMARY

The Council on Medical Service and the Council on Science and Public Health present this joint report as our first in an anticipated series of reports focused on improving maternal health. The Councils decided to pursue this report in light of the enduring maternal health crisis in the United States (US). The US is one of only 13 countries in the world where the maternal mortality rate (MMR) is worse now than it was 25 years ago, and it is the only industrialized country with a rising MMR.¹ In addition to maternal deaths, at least 50,000 women experience potentially life-threatening complications in childbirth each year, and the rate of severe maternal morbidity (SMM) doubled between 1998 and 2011.²

The reasons for the overall increase in pregnancy-related mortality are complex and multifactorial, and the CDC highlights “considerable racial/ethnic disparities in pregnancy-related mortality.”³ These disparities reflect the unique nature of maternal health at the intersection of race and gender. In addition, health insurance is critical to obtaining access to maternal health care, but maternity coverage under Medicaid (which covers nearly half of American deliveries⁴) ends at 60 days postpartum.⁵ While some women successfully transition to other sources of coverage, many are left uninsured shortly after a major medical event.⁶

The maternal health crisis is a challenge that cannot be adequately addressed in a single report. Instead, the Councils present this narrowly focused initial report to strengthen American Medical Association (AMA) existing policy foundation and empower advocacy on two especially urgent issues:

- Expanding access to insurance for the most vulnerable new mothers, and
- Addressing inequities in maternal health care.

This initial report discusses challenges women face in pursuing maternal health care, highlights especially relevant AMA policy and advocacy, and presents a series of policy recommendations. The AMA is committed to continuing to study issues essential to improving maternal health, to take action where appropriate, and to recommend actions to be taken by others to improve maternal health and eliminate maternal health inequities.

JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report N-21

Subject: Reducing Inequities and Improving Access to Insurance for Maternal Health Care

Presented by: Asa C. Lockhart, MD, MBA, Chair, Council on Medical Service
Alexander Ding, MD, MS, MBA, Chair, Council on Science and Public Health

Referred to: Reference Committee G

1 The Council on Medical Service and the Council on Science and Public Health present this joint
2 report as our first in an anticipated series of reports focused on improving maternal health. Our first
3 report is narrowly focused on two issues that are especially timely and foundational: expanding
4 access to insurance for the most vulnerable new mothers and addressing inequities in maternal
5 health care. The Councils decided to pursue this report in light of the enduring maternal health
6 crisis in the United States (US). We discuss challenges women face in pursuing maternal health
7 care, highlight especially relevant American Medical Association (AMA) policy and advocacy, and
8 present a series of policy recommendations.

9
10 TERMINOLOGY

11
12 In our report we use the terms “women” and “mothers” to describe people who are pregnant or
13 recently gave birth because these terms align with the language in the Social Security Act, which
14 defines Medicaid eligibility for pregnant and postpartum women.⁷ Nevertheless, the Councils
15 acknowledge that not all people who become pregnant or give birth identify as women, and the
16 Councils are committed to use of respectful, inclusive language. Additionally, the Councils
17 acknowledge that this report uses several different terms when referring to the death of a patient
18 prenatal, peripartum, or postpartum. A variety of data collection methods are used throughout the
19 country that count prenatal, peripartum, and postpartum deaths differently (see Appendix B).
20 Similarly, this report uses several different terms to describe stages of maternal health care. To
21 ensure accurate characterization of research findings, this report preserves the terminology used in
22 the source material.

23
24 REPORT SCOPE

25
26 The US maternal health crisis is a complex, multifactorial challenge that cannot be adequately
27 addressed in a single report. Instead, the Councils present this narrowly focused initial report, the
28 first in an anticipated series of reports, to strengthen the AMA’s existing policy foundation and
29 empower advocacy on two especially urgent issues:

- 30
31
 - Expanding access to insurance for the most vulnerable new mothers, and
 - Addressing inequities in maternal health care.

32
33
34 The AMA is committed to continuing to study issues essential to improving maternal health. Key
35 topics for future study may include:

- 1 • Maternal behavioral health (including substance use disorder and suicide), and
- 2 • Roles that health care payers (including insurance plans and employers) can play in
- 3 promoting the health of growing families.

4
5 BACKGROUND

6
7 The maternal health crisis in the US is well-documented and continues to be well-studied;
8 nevertheless, it endures. The US is one of only 13 countries in the world where the maternal
9 mortality rate (MMR) is worse now than it was 25 years ago, and it is the only industrialized
10 country with a rising MMR.⁸ The Centers for Disease Control and Prevention (CDC) defines a
11 “pregnancy-related death” as the death of a woman while pregnant or within one year of the end of
12 pregnancy from any cause related to or aggravated by the pregnancy.⁹ Approximately 700 to 900
13 pregnancy-related deaths occur in the US per year.¹⁰ Approximately two-thirds of these deaths are
14 preventable, and an increasing percentage are happening in the late postpartum period (more than
15 43 days after the end of pregnancy).¹¹ Moreover, the US’ MMR is widely considered to be an
16 underestimate, as varying methods are used to count deaths related to pregnancy, and reporting is
17 inconsistent.¹² In addition to maternal deaths, at least 50,000 women experience potentially life-
18 threatening complications in childbirth each year, and the rate of severe maternal morbidity (SMM)
19 doubled between 1998 and 2011.¹³

20
21 The reasons for the overall increase in pregnancy-related mortality are complex and multifactorial,
22 and the CDC highlights “considerable racial/ethnic disparities in pregnancy-related mortality.”¹⁴
23 These disparities reflect the unique nature of maternal health at the intersection of race and gender.
24 During 2014 to 2017, the pregnancy-related mortality ratios were (in deaths per 100,000 live
25 births): 41.7 for non-Hispanic Black (Black) women, 28.3 for non-Hispanic American Indian or
26 Alaska Native women, 13.8 for non-Hispanic Asian or Pacific Islander women, 13.4 for non-
27 Hispanic White (White) women, and 11.6 for Hispanic or Latina women.¹⁵ Black women have
28 been found to be at an elevated risk regardless of income, education, or geographical location.¹⁶
29 The CDC explains that racial and ethnic disparities may be due to several factors including access
30 to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases.¹⁷ In
31 addition to being three to four times more likely to die from pregnancy-related causes, Black
32 women have more than a twofold greater risk of SMM than White women.¹⁸ SMM is also higher in
33 other racially minoritized women than in White women.¹⁹ For example, elevated risks of morbidity
34 and mortality (MMM) also have been reported for Native American women and some Asian and
35 Latinx population subgroups of women.²⁰ As with pregnancy-related mortality, the factors
36 underlying racial and ethnic disparities in SMM are unclear, but most studies have found that these
37 differences persist after adjustment for sociodemographic and clinical characteristics.²¹ Moreover,
38 aggregated data can obscure critical distinctions within broad racial or ethnic categories. Robust
39 MMM data that accurately reflect patient race and ethnicity information is needed to better
40 identify, understand, and eliminate inequities.

41
42 In addition to this stark quantitative evidence of the crisis in US maternal health, the tragic stories
43 of families devastated by the loss of mothers drives efforts to advance public policy and evidence-
44 based interventions to promote maternal health and compels the health care system to strive to
45 provide better care. Regardless of medical knowledge, education, socioeconomic status, and
46 presence of supportive loved ones, women are dying. Three recent examples can be found within
47 the medical community alone. Dr. Chaniece Wallace, a 30-year old chief resident in pediatrics at
48 the Indiana University School of Medicine, died four days after her daughter was born.²² Dr.
49 Shalon Irving, a 36-year old Lieutenant Commander in the US Public Health Service
50 Commissioned Corps and a CDC epidemiologist with a dual doctorate in sociology and
51 gerontology, died three weeks after giving birth to her daughter.²³ Drs. Wallace’s and Irving’s

1 deaths demonstrate the racial disparities in maternal mortality for Black women in the US.
 2 Extensive medical and health system knowledge and experience could not protect the Bloomstein
 3 family, either—Lauren Bloomstein, a 33-year-old neonatal intensive care nurse, supported by her
 4 physician husband, died shortly after giving birth to her daughter, in the hospital where both health
 5 care professionals had worked.²⁴

6
 7 Health insurance is critical to obtaining access to maternal health care. Insurance coverage for
 8 births in the US is essentially split between private insurance (49 percent of births in 2018) and
 9 Medicaid (43 percent of births in 2018).²⁵ However maternity coverage under Medicaid ends at 60
 10 days postpartum.²⁶ While some women successfully transition to other sources of coverage, many
 11 are left uninsured shortly after the major medical event of childbirth.²⁷ In general, one in three
 12 women in the US experiences discontinuous insurance coverage (“churn”) before, during, or after
 13 pregnancy.²⁸ Reducing this churn in the postpartum period can help to decrease disparities in
 14 maternal health outcomes.²⁹

15
 16 **CRITICAL CHALLENGES IN MATERNAL HEALTH CARE**

17
 18 While pursuing a narrow focus on improving access to affordable health insurance for the most
 19 vulnerable new mothers and eliminating racial and ethnic inequities in maternal care, it is important
 20 to place the US maternal health crisis in context. Doing so requires recognition of the complex and
 21 interconnected causes of MMM: challenges in accessing essential prenatal, peripartum, and
 22 postpartum care; stark racial and ethnic inequities in care and outcomes; and challenges posed by
 23 uninsurance. Moreover, structural inequities embedded into the current health care system can
 24 create the illusion that patients who have been minoritized and marginalized are more susceptible
 25 to certain chronic conditions and poorer outcomes.³⁰ Specifically, both intra-hospital disparities,
 26 where minoritized communities have been found to receive lower-quality care within a given
 27 facility, along with inter-hospital disparities, where minoritized patients tend to receive care at
 28 facilities with lower quality scores, underlie minoritized patients’ poorer health outcomes.³¹
 29 HealthyPeople 2030 defines the social determinants of health (SDOH) as “the conditions in the
 30 environments where people are born, live, learn, work, play, worship, and age that affect a wide
 31 range of health, functioning, and quality-of-life outcomes and risks.”³² As the CDC explains,
 32 differences in SDOH contribute to the stark and persistent chronic disease disparities in the US
 33 among racial, ethnic, and socioeconomic groups, systematically limiting opportunities for members
 34 of some groups to be healthy.³³ Ultimately, to improve maternal health in general and eliminate
 35 racial and ethnic inequities in health outcomes, the health care community must strive to improve
 36 the many interconnected factors at issue, both at the level of individual patients and at the broader
 37 structural and systemic levels of the communities where they live.³⁴

38
 39 *Multifactorial Causes of Maternal Morbidity and Mortality*

40
 41 Given the largely preventable nature of MMM, it is logical to seek straightforward causes that
 42 could be mitigated, but MMM results from a complex web of many interconnecting factors.
 43 According to the CDC, for every pregnancy-related death, an average of three to four contributing
 44 factors were identified, at multiple levels, including community, health facility, patient/family,
 45 provider, and system.³⁵ One may be inclined to look to poverty, lack of education, age, geography,
 46 or the prevalence of comorbidities as logical root causes. However, research shows that while each
 47 of those factors plays a role in the US maternal health crisis, none of them is dispositive. Studies
 48 adjusting for sociodemographic and reproductive factors have not explained the racial gap in
 49 pregnancy-related mortality in most studies.³⁶ For example, in one study, adjustment for maternal
 50 age, income, hypertension, gestational age at delivery, and receipt of prenatal care only reduced the
 51 odds ratios for pregnancy-related mortality from 3.07 to 2.65.³⁷ Moreover, another study found the

1 largest racial disparity among women with the lowest risk of pregnancy-related disease.³⁸ Patients
2 with Medicaid have been found to have similar rates of SMM to those with private insurance
3 within the same hospital.³⁹ Additionally, college-educated Black women have been found to be at a
4 60 percent greater risk for a maternal death than White or Hispanic women with less than a high
5 school education.⁴⁰ Pregnancy exacerbates existing chronic diseases, including hypertension, but
6 deaths from hypertensive disorders in pregnancy are preventable. Studies that control for age,
7 chronic disease, and obesity have found that the MMR in the US far exceeds rates in similarly
8 wealthy nations,⁴¹ and that women in other wealthy countries with similarly increased rates of
9 pregnancy comorbidities are not facing the rising MMR found in the US.⁴² The health care
10 community is increasingly recognizing the role that structural racism and implicit bias inherent in
11 American society, including in the health care system, play in contributing to stark health
12 inequities.

13
14 As physicians and scientists, our instinct is to scour the data to find root causes that can be directly
15 addressed to solve glaring problems. However, current understanding of MMM, and especially the
16 disparities in outcomes, remains incomplete,⁴³ and efforts to eliminate racial and ethnic inequities
17 and promote equity in maternal health have been constrained by a lack of reliable data.⁴⁴ While
18 extensive work is underway to collect accurate, reliable, standardized data on MMM, the data
19 cannot yet provide the answers. As outlined by the CDC, there are three essential sources of data
20 on maternal mortality: (1) CDC's National Center for Health Statistics' National Vital Statistics
21 System (NVSS), (2) the CDC's Pregnancy Mortality Surveillance System (PMSS), and (3) state
22 and local Maternal Mortality Review Committees (MMRCs).⁴⁵ The data collected by each of these
23 sources are not standardized—they apply different definitions of maternal mortality, and they draw
24 on different sources. Appendix B provides an overview of essential differences among these data
25 sources and their impact on how maternal mortality is counted. In addition, there is no systematic
26 ongoing data collection for population-based maternal morbidity in the US.⁴⁶ The source of data for
27 CDC's national SMM estimates is the Nationwide Inpatient Sample (NIS). The Pregnancy Risk
28 Assessment Monitoring System (PRAMS) also provides insights into health problems among
29 mothers and babies. Appendix B also discusses NIS and PRAMS in more detail. Contributing to
30 data challenges is the fact that while patient identity data such as race, ethnicity, and language is
31 essential to understanding sources of disparities, patients may be hesitant to divulge private
32 information, especially if they do not know how their data may be used.⁴⁷ Moreover, for these data
33 to be useful, they must elicit information that accurately reflects the diversity within racial and
34 ethnic categories, and they must be collected and reported consistently. Accordingly, it is critical to
35 educate health care staff responsible for data collection on best practices to earn patient trust, elicit
36 candid responses, and accurately record and report the information. Similarly, data collection and
37 reporting legal requirements and policy must also include anti-discrimination protections to ensure
38 that the collection of race, ethnicity, and language data is used to reduce, rather than create or
39 exacerbate, inequities that harm individuals and populations. For additional discussion of the
40 critical need for improvements in public health data collection and reporting, including MMM data,
41 see CSAPH Rep. 2- NOV-21, "Full Commitment by our AMA to the Betterment and
42 Strengthening of Public Health Systems."

43 44 Accessing Prenatal, Peripartum, and Postpartum Care

45
46 The full range of prepregnancy, prenatal, delivery, and postpartum care are closely linked, and care at
47 each phase across the continuum can impact morbidity and mortality,⁴⁸ so access to care at each stage
48 is essential. Specifically, leading causes of maternal death have been found to be hemorrhage and
49 cardiovascular conditions during pregnancy, infection at birth and shortly after, and cardiomyopathy
50 and behavioral health conditions (including substance use and suicide) in the postpartum period.⁴⁹
51 Notably, the recognized leading causes of death may vary among data reporting organizations, as

1 methods of investigation and reporting vary.⁵⁰ Further, timing and receipt of prenatal care vary by
2 race and ethnicity,⁵¹ and it is important to understand potential barriers to care. First trimester prenatal
3 care initiation has been found to be highest among White and Asian women, followed by multiple
4 race and Hispanic women, and lowest for Black, American Indian/Alaska Native, and Native
5 Hawaiian/other Pacific Island women.⁵² Yet, accessing prenatal care sets the stage for pursuing
6 appropriate postpartum care, and the American College of Obstetricians and Gynecologists (ACOG)
7 specifically recommends developing a postpartum care plan during pregnancy, especially for women
8 at higher risk, and emphasizes the importance of providing anticipatory guidance and coordinated
9 care.⁵³

10
11 Women's health care outside of pregnancy is also essential to maternal health outcomes—it is
12 essential that women are cared for and provided the resources they need throughout their lives, not
13 only when they are pregnant. It is well-accepted that improving preconception health and
14 reproductive planning can improve pregnancy outcomes by improving the overall health of women.⁵⁴
15 A variety of AMA policy continues to be instrumental in supporting advocacy to improve maternal
16 health, and the full text of these policies is provided in Appendix C. For example, as outlined in Policy
17 H-425.976, the AMA strongly supports access to and health insurance coverage for preventive
18 women's health and preconception and inter-conception care. Moreover, the policy supports the
19 education of physicians and the public about the importance of preconception care as a vital
20 component of a woman's reproductive health, as well as integrating contraceptive screening into
21 routine well-care for both women and men. As recognized in Policy H-180.958, contraception is
22 essential preventive health care, and contraception is an important strategy to reduce MMM,
23 especially for women with certain medical conditions.⁵⁵ Accordingly, physicians should ask their
24 patients about their family planning goals so that they can jointly discuss and anticipate any factors
25 that may lead to higher-risk pregnancies, such as health conditions or short interpregnancy
26 intervals.⁵⁶

27 28 Managing Chronic Conditions Before, During, and After Pregnancy

29
30 Chronic diseases have emerged as key contributors to MMM,⁵⁷ so access to health care from
31 prepregnancy, through pregnancy, and postpartum is critical. An increasing number of pregnant
32 women in the US have been found to have chronic health conditions such as hypertension, diabetes,
33 and chronic heart disease,⁵⁸ and with these underlying conditions, preconception care is essential.⁵⁹ It
34 is also essential to recognize the significant racial and ethnic inequities in the presence of
35 comorbidities and maternal health outcomes. Compared with White women, Black and Hispanic
36 women have been found to experience higher rates for several comorbidities.⁶⁰ Data also suggest
37 that minoritized women, especially Black women, develop comorbid conditions at earlier ages, are
38 less likely to have their conditions adequately managed, and are more likely to have complications
39 and mortality from these conditions.⁶¹ Even when Black women do not have preexisting chronic
40 diseases, they have been found to experience higher rates of certain types of hemorrhage and
41 preeclampsia.⁶² Hispanic women have greater odds of postpartum hemorrhage, diabetes, and major
42 puerperal infections than White women.⁶³ In addition, studies suggest that rates of postpartum
43 hemorrhage, third and fourth degree lacerations, and major puerperal infections are higher among
44 Asian women than White women.⁶⁴ Finally, in addition to physical comorbidities, antepartum
45 depression affects 14 to 23 percent of women, and this can significantly affect the health of mothers
46 and developing babies.⁶⁵ Especially for women with chronic general medical and behavioral health
47 conditions, postpartum care, coordination of care, and treatment optimization is essential,⁶⁶ as
48 exacerbation of underlying illness can occur in the immediate postpartum period.⁶⁷ Moreover,
49 pregnancy-related complications can predict risk for subsequent diabetes and cardiovascular
50 disease.⁶⁸

1 Access to maternal-fetal medicine specialists and medicine subspecialists is recommended to improve
 2 outcomes among pregnant women with chronic illnesses and pregnancy-related complications, but
 3 many women are not referred for specialty care.⁶⁹ The extent of inequities in access to specialists and
 4 subspecialists for high risk pregnant women is unknown, but one survey found 31 percent of
 5 generalist obstetrician/gynecologists (OB/GYNs) were not satisfied with the maternal-fetal medicine
 6 services available to their patients.⁷⁰ Professional organizations and the CDC have developed
 7 resources to help clinicians and public health decision makers evaluate risk-appropriate care so that
 8 pregnant women at high risk for complications can receive care at facilities prepared to provide the
 9 level of specialized care that they need.⁷¹

10
 11 Elevated Risks for 12 Months Postpartum

12
 13 Postpartum care is essential not only for monitoring the health of women after the acute major
 14 medical event of childbirth, but also for managing women’s chronic conditions, promoting overall
 15 health and well-being, and serving as a link for vulnerable women to the health care system.⁷² The
 16 “fourth trimester,” (the first 12 weeks postpartum) can present considerable physical and
 17 behavioral health challenges.⁷³ Nearly 70 percent of women describe at least one physical health
 18 problem during the 12-month postpartum period, and 45 percent of these problems are deemed to
 19 be moderate to severe.⁷⁴ For example, during the 12-month postpartum period, women may
 20 experience urinary incontinence, fecal incontinence, perineal or genital pain, and impaired sexual
 21 function.⁷⁵ In addition to these physical complications, maternal behavioral health conditions
 22 (including depression, anxiety, and other illnesses) are the most common complications during
 23 pregnancy and 12 months postpartum, affecting one in five women.⁷⁶ Critically, both parents may
 24 experience behavioral health challenges postpartum, as 2 to 25 percent of fathers experience
 25 depression, with this statistic increasing to 50 percent when the mother experiences postpartum
 26 depression.⁷⁷

27
 28 More than half of pregnancy-related deaths occur after the birth of the infant.⁷⁸ Specifically, and
 29 critical to policy decisions regarding postpartum care, support, and insurance coverage,
 30 approximately 16 percent of pregnancy-related deaths occurred between 1-6 days postpartum, 19
 31 percent occurred between 7-42 days postpartum, and 24 percent occurred between 43-365 days
 32 postpartum.⁷⁹ ACOG recommends that postpartum care be an ongoing process, rather than a single
 33 visit, with services and support tailored to each woman’s needs.⁸⁰ Nevertheless, approximately 40
 34 percent of women do not attend a postpartum visit.⁸¹ Critical barriers to obtaining postpartum care
 35 include lack of child care, inability to get an appointment, mistrust of health care providers, and
 36 limited understanding of the value of the visit.⁸² These barriers are even more challenging for
 37 patients with limited resources, decreasing attendance rates and contributing to disparities.⁸³
 38 Notably, 23 percent of employed women return to work within 10 days of giving birth, and an
 39 additional 22 percent return to work between days 10 and 42 postpartum. Only 14 percent of
 40 American workers—and only five percent of low-wage workers—have access to paid leave.⁸⁴
 41 ACOG recommends that obstetric care physicians ensure that women, their families, and their
 42 employers understand the need for continued recovery and support for postpartum women.⁸⁵
 43 Recognizing the burden of traveling to and attending an office visit, especially with the new
 44 responsibility of an infant, ACOG explains that in-person care may not always be required.⁸⁶
 45 Telephone support during the postpartum period can reduce depression, improve breastfeeding
 46 outcomes, and increase patient satisfaction.⁸⁷

47
 48 *Stark Inequities in Maternal Health*

49
 50 In searching for the root causes of maternal health inequities, it is essential to examine the
 51 individual, social, and systemic factors impacting women’s health. On an individual level, in

1 addition to a woman’s medical history, SDOH impact health. SDOH include economic stability,
2 neighborhood, education and life opportunities, access to food, quality and safety of housing,
3 community/social support, and access to health care. While economic vulnerability contributes to
4 racial and ethnic disparities in maternal outcomes, socioeconomic factors alone do not account for
5 these disparities.⁸⁸ Instead, evidence from a variety of disciplines demonstrates that the pervasive
6 stress of racism within communities of color, combined with disinvestment in these communities
7 (including food deserts, discriminatory housing policies, and/or unequal funding for schools and
8 hospitals) are upstream to the SDOH and are root causes of health inequities.⁸⁹

9
10 Racial discrimination is a toxic stressor that is associated with poorer physical and psychological
11 health.⁹⁰ A growing body of research shows that centuries of racism in the US have had a
12 profoundly negative effect on communities of color.⁹¹ In maternal health, the intersectionality of
13 gender and race is synergistic, with Black women subjected to high levels of racism, sexism, and
14 discrimination at levels not experienced by Black men or White women.⁹² The “weathering”
15 hypothesis posits that Black individuals experience early health deterioration due to the acute and
16 chronic stress produced by social or economic adversity and political marginalization.⁹³ Black
17 individuals not only experience poor health at earlier ages than White individuals, but deterioration
18 in health of Black individuals accumulates, producing ever-greater racial inequality in health with
19 age through middle adulthood.⁹⁴

20
21 Related, ethno-racial trauma has been defined as “individual and/or collective psychological
22 distress and fear of danger that results from experiencing or witnessing discrimination, threats of
23 harm, violence, and intimidation directed at ethno-racial minority groups.”⁹⁵ Like other trauma-
24 and stress-related disorders, the chronic stress of untreated symptoms of ethno-racial trauma can
25 increase risk of physical illnesses such as hypertension, obesity, and cardiovascular disease—key
26 risk factors in maternal health.⁹⁶ Researchers emphasize the importance of recognizing that current
27 maternal health disparities have evolved within an historical context of servitude, exclusion, and
28 codified public policy inequities.⁹⁷ Moreover, further research is needed to better understand the
29 complex web of interconnecting factors of racial and gender discrimination, chronic stress, and
30 maternal health outcomes.

31
32 To eliminate racial and ethnic inequities in maternal care, it is essential to think of these inequities
33 as among the root causes of poor health outcomes, and “directly address factors that disadvantage
34 women based on race and ethnicity *per se*.”⁹⁸ There may be a tendency to focus on general quality
35 improvement efforts directed toward improvement of specific and well-defined pathologies, such
36 as postpartum hemorrhage or hypertension.⁹⁹ While such quality improvement efforts may improve
37 outcomes for all women, they may allow differential outcomes related to race and ethnicity to
38 persist.¹⁰⁰ Instead, “the goal of equity in care and outcomes can be accomplished only if it is treated
39 the same as the goal of other quality improvement initiatives—namely, as a desired end in and of
40 itself, embedded within a culture of safety, that is specifically acknowledged, discussed, measured,
41 monitored, and the subject of continuous quality improvement efforts.”¹⁰¹

42
43 At the medical team and health care facility levels, there is a growing body of evidence
44 demonstrating that implicit and explicit biases negatively impact quality of care and patient
45 safety.¹⁰² This was described originally in the Institute of Medicine (now the National Academy of
46 Medicine) report, *Unequal Treatment*, in 2003.¹⁰³ More recently, the Agency for Healthcare
47 Research and Quality (AHRQ) highlighted that Black patients received significantly worse quality
48 of care relative to White patients in 40 percent of examined quality measures.¹⁰⁴ Racial and ethnic
49 inequities exist both between hospitals and within hospitals.¹⁰⁵ For example, Black patients more
50 commonly receive treatment in hospitals of poorer quality, and receive poorer quality care within a

1 given hospital.¹⁰⁶ To mitigate facility level inequities, standardized approaches to addressing
2 obstetric emergencies can be implemented in hospitals that provide delivery services.¹⁰⁷

3
4 Researchers explain how clinicians' implicit biases play a role in maternal health care
5 disparities.¹⁰⁸ Implicit bias refers to attitudes that are subconscious and activated involuntarily, but
6 that affect understanding, actions, and decisions.¹⁰⁹ Adverse outcomes are frequently related to
7 patient-provider interactions, and this underscores the importance of communication and the
8 impact of clinician implicit biases.¹¹⁰ Moreover, implicit biases are more likely to be activated and
9 used in situations involving cognitive overload or high stress, such as in emergency departments
10 and in labor and delivery.¹¹¹ It is important to distinguish implicit bias from overt and intentional
11 discrimination. Recognition of implicit bias "is not meant to evoke guilt but spur awareness and the
12 concomitant commitment to overcome its effects; yet, given that implicit bias is unconscious, with
13 consequences that may thwart the explicit intentions of individuals devoted to equity, attempts to
14 counter its effects are challenging."¹¹² To mitigate implicit bias and improve communication,
15 patient-physician shared decision-making is a key communication strategy that may reduce
16 perinatal racial and ethnic disparities. However, best practices for shared decision-making are often
17 not used.¹¹³

18
19 Focusing on the lived experiences of minoritized women, a variety of qualitative initiatives have
20 been underway to better understand and respond to the challenges that pregnant individuals and
21 new mothers face. For example, national surveys found that, compared with White women, Black
22 women were more likely to report: being treated unfairly and with disrespect by providers because
23 of their race, not having decision autonomy during labor and delivery, feeling pressured to have a
24 cesarean section, and not exclusively breastfeeding at one week and six months postpartum.¹¹⁴
25 Moreover, the Black Mamas Matter Alliance (BMMA) emphasizes the importance of health care
26 teams knowing and acknowledging the history of non-consensual medical experimentation on
27 Black women in the US and the impact that history continues to have on patients.¹¹⁵

28 29 *Availability of Affordable Health Care Insurance*

30
31 Access to affordable, comprehensive health care and insurance throughout a woman's life is
32 critical to achieving optimal maternal health outcomes,¹¹⁶ yet systemic barriers, including racism
33 and sexism, and inequities in SDOH impact income levels and insurance status.¹¹⁷ Two key
34 provisions of the Affordable Care Act (ACA) contributed to insurance coverage gains: Medicaid
35 expansion to adults with incomes of up to 138 percent of the federal poverty level (FPL) in some
36 states, and the availability of subsidized insurance coverage through Marketplace plans for people
37 with incomes of up to 400 percent of FPL. The ACA Medicaid expansion has been found to be
38 associated with reductions in maternal mortality.¹¹⁸ Expanding Medicaid reduced uninsurance
39 among women of reproductive age overall, and specifically, it reduced uninsurance preconception,
40 during pregnancy, and postpartum.¹¹⁹ Expanding Medicaid led to improved access to care,
41 increased use of health services, and better self-reported health among women of reproductive
42 age.¹²⁰ Insurance preconception and postpartum improves women's health in multiple ways,
43 including increasing opportunities for managing chronic conditions and family planning.¹²¹
44 Expansion states also experienced significant reductions in Black-White disparities in adverse birth
45 outcomes.¹²² Despite these gains, nearly 12 percent of new mothers were uninsured in 2016 to
46 2018.¹²³ Moreover, in 2015 to 2017, approximately 29 percent of new mothers experienced a
47 change in insurance status between delivery and six months postpartum.¹²⁴ While the ACA
48 provided incentives for states to expand Medicaid, as of this writing, 12 states have chosen not to
49 do so.¹²⁵ In addition, immigration status prevents some women from qualifying for publicly
50 subsidized health insurance.¹²⁶

1 Accordingly, uninsurance challenges during and after pregnancy are due, in part, to the patchwork
 2 nature of publicly supported coverage options potentially available for pregnant and postpartum
 3 women that vary by state of residence, income, and immigration status.¹²⁷ For women with higher
 4 incomes, a steep “subsidy cliff” makes premium payments for Marketplace plans far more
 5 expensive as soon as income exceeds 400 percent FPL, potentially preventing women from
 6 obtaining affordable insurance.¹²⁸ This can be especially challenging when women unexpectedly
 7 lose access to employer-sponsored insurance, as has frequently been the case during the COVID-19
 8 pandemic.¹²⁹ Coverage options for women with lower incomes are even more complicated. In all
 9 but two states, the income thresholds for Medicaid and State Children’s Health Insurance Program
 10 (CHIP) qualification are higher for pregnancy-related coverage than for nonpregnant parents or
 11 other adults.¹³⁰ As a result, women who were insured by Medicaid or CHIP due to their pregnancy
 12 status, but who lose access to pregnancy-related coverage at 60 days postpartum, experience
 13 insurance churn in several ways:¹³¹

- 14
- 15 a) In states that expanded Medicaid, some women will be able to continue Medicaid coverage
 16 postpartum.¹³² For other women, premium tax credits could help them purchase subsidized
 17 insurance through the Marketplace.¹³³ However, Marketplace plans may require women to
 18 incur additional out-of-pocket costs and/or change physicians, and women recovering from
 19 giving birth and caring for an infant may not undertake the effort of finding a suitable
 20 Marketplace plan.¹³⁴
- 21 b) In states that have not expanded Medicaid, adult Medicaid eligibility is typically below the
 22 FPL. Low-income residents in these states fall into a “coverage gap,” having incomes that are
 23 too high to qualify for their state’s Medicaid but that are below the FPL, which is the minimum
 24 threshold for subsidized Marketplace coverage.¹³⁵ When women lose pregnancy-based
 25 Medicaid, they may not have an affordable coverage option.
- 26 c) Six states build on Medicaid’s foundation and offer CHIP coverage to pregnant women at
 27 higher income levels.¹³⁶ Accordingly, to protect new mothers in these six states, policies to
 28 extend public coverage until 12 months postpartum must reference both Medicaid and CHIP.
- 29 d) Due to their immigration status, some women will not qualify for Medicaid, CHIP, or
 30 subsidized insurance through the Marketplace, even if they meet the income qualifications.¹³⁷
 31 Accordingly, they may not have an affordable coverage option.

32

33 Of course, women’s need for medical care and insurance does not end at the 60th day postpartum.
 34 As outlined above, women are at elevated physical and behavioral health risk for 12 months
 35 following childbirth, so access to health care, and insurance coverage for that care, is essential.

36

37 **OPPORTUNITIES TO IMPROVE EQUITABLE MATERNAL HEALTH CARE**

38

39 To improve maternal health outcomes in the US, two foundational first steps are expanding access
 40 to affordable health insurance and eliminating racial and ethnic inequities in care and outcomes. A
 41 clear policy improvement is to extend Medicaid and CHIP to cover new mothers for the full 12-
 42 month postpartum period. Eliminating inequities that are deeply rooted in US history and policy is
 43 more complicated. The AMA can begin by committing itself to strengthening patient-physician
 44 relationships, especially relationships with marginalized and/or minoritized patients. To do so, it
 45 will be important to enhance the diversity of health care teams, strengthen patient-physician trust,
 46 improve communication, appropriately incorporate telehealth, collaborate with community
 47 leadership, and improve data collection (with safeguards) to facilitate research.

1 *Extend Medicaid and CHIP to 12 Months Postpartum*

2
3 If Medicaid and CHIP coverage were extended for the entire year of the postpartum period, an
4 estimated 70 percent of uninsured new mothers would be eligible for some kind of publicly
5 subsidized coverage.¹³⁸ Notably, nonexpansion states are home to 83 percent of the uninsured new
6 mothers who would become newly eligible for Medicaid/CHIP under a postpartum extension.¹³⁹ It
7 is also essential to recognize that while a Medicaid/CHIP extension would help reduce maternal
8 health disparities, it cannot eliminate the inequities that persist due to race, ethnicity, immigration
9 status, and geography (such as proximity to a hospital with obstetric care).¹⁴⁰

10
11 AMA policy supports a variety of mechanisms to expand affordable access to insurance coverage,
12 including supporting increased affordability of and auto-enrollment in Marketplace plans,
13 elimination of the “subsidy cliff” and “coverage gap,” state expansion of Medicaid, and
14 presumptive eligibility for Medicaid. (See Appendix C.) Specific to maternal health care, AMA
15 policy supports an extension of Medicaid coverage for 12 months postpartum, and several state and
16 federal-level initiatives are underway to accomplish that goal in varying ways. For example, three
17 states have received federal approval to extend coverage—Georgia, Illinois, and Missouri—and
18 several other state legislatures have instructed their states to seek such coverage. (See Appendix
19 D.)

20
21 *Eliminating Inequities and Strengthening the Patient-Physician Relationship*

22
23 The AMA recognizes racism in all forms as a serious threat to public health, to the advancement of
24 health equity, and a barrier to appropriate medical care. The elimination of racial and ethnic
25 inequities in health care is an issue of high priority for the AMA. The AMA joins leadership
26 nationwide in striving toward improved, equitable maternal health care and commends the many
27 advocates who have paved the way for this issue to capture the attention of public policy makers,
28 the media, and the broader health care sector. For example, the California Maternal Quality Care
29 Collaborative and the National Birth Equity Collaborative are leaders and advocates striving to
30 improve health outcomes, eliminate racial disparities, and amplify patient stories. ACOG is the
31 lead partner in the Alliance for Innovation on Maternal Health (AIM).¹⁴¹ AIM is a national data-
32 driven maternal safety and quality improvement initiative that is funded through a cooperative
33 agreement with the Maternal and Child Health Bureau (MCHB)-Health Resource Services
34 Administration.¹⁴² AIM works through state and community-based teams to align national, state,
35 and hospital level quality improvement efforts to improve maternal health outcomes and prevent
36 maternal mortality and SMM. AIM has developed 10 patient safety bundles, and they have
37 engaged 33 states and more than 1400 hospitals to implement these bundles.¹⁴³ Diversification of
38 the health care workforce so that clinical teams reflect the populations they serve and improved
39 communication between patients and their health care teams are two essential elements promoted
40 through the AIM program.¹⁴⁴ ACOG has also published a Committee Opinion on Racial and Ethnic
41 Disparities in Obstetrics and Gynecology, in which it makes several recommendations to reduce
42 disparities.¹⁴⁵ Similarly, our AMA *Code of Medical Ethics*, Opinion 8.5, Disparities in Health Care,
43 speaks to the challenge of subtle biases contributing to poorer health outcomes, and it outlines steps
44 that individual physicians should implement within their practices (see Appendix C).¹⁴⁶ Critically,
45 *Code of Medical Ethics* Opinion 8.5 calls for physicians to strive to increase the diversity of the
46 physician workforce, encourage shared decision-making, and cultivate effective communication
47 and trust by seeking to better understand factors that can influence patients’ health care decisions,
48 such as health beliefs, health literacy, and fears or misperceptions about the health care system.

Diversifying of Health Care Teams

To provide optimal care for diverse patients, greater diversity is needed on physician-led health care teams. For example, research indicates that race and language concordance between patients and clinicians may improve communication and outcomes.¹⁴⁷ A recent study found that while maternal health care physician-led teams are making strides in gender representation (approximately 59 percent of practicing OB/GYNs are women), they are lacking in racial and ethnic diversity (only approximately 11 percent of OB/GYNs are Black and only approximately 6 percent are Hispanic).¹⁴⁸ Moreover, 49 percent of the counties in the US, home to more than 10 million women, lack an OB/GYN.¹⁴⁹ In addition to OB/GYNs, family medicine physicians can play an essential role in reducing inequities in MMM due to their training in providing comprehensive care across the life course, including prenatal, perinatal, and postpartum care for the individuals in the communities where they live.¹⁵⁰ At the same time, the American Academy of Family Physicians (AAFP) has highlighted studies finding that while recent family medicine graduates have felt more prepared than previous cohorts, family medicine graduates are providing significantly less OB care.¹⁵¹ Only approximately eight percent of family medicine physicians include OB deliveries in their practice, and this is especially challenging in rural areas where family medicine physicians provide the majority of maternity care and where labor and delivery units are closing.¹⁵² Diversity is also needed throughout entire physician-led teams. For example, more than half of all OB/GYN offices employ “physician extenders” such as nurse practitioners, certified nurse-midwives, and physician assistants.¹⁵³ However, a recent survey demonstrated the lack of racial and ethnic diversity among nurses, as nearly 81 percent of respondent registered nurses (RNs) and nearly 70 percent of respondent Licensed Practical/Vocational Nurse (LPN/VNs) reported being White/Caucasian.¹⁵⁴

Non-clinical Support for Laboring Patients

When considering the people present in a delivery room, in addition to the importance of more diverse clinical care teams, it is also important to consider the non-clinical support present for laboring patients. ACOG suggests that, “in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor.”¹⁵⁵ ACOG cites evidence of shortened labor, decreased need for analgesia, fewer operative deliveries, and fewer reports of dissatisfaction with the experience of labor.¹⁵⁶ ACOG further explains that it may be effective to teach labor-support techniques to a friend or family member, as this approach has also resulted in significantly shorter duration of labor and higher Apgar scores.¹⁵⁷ ACOG further states that continuous labor support also may be cost-effective given the associated lower cesarean rate.¹⁵⁸ Accordingly, ACOG suggests physicians and health care organizations may want to develop programs and policies to integrate trained support personnel into the intrapartum care environment to provide continuous one-to-one emotional support for laboring women.¹⁵⁹ Recently, some state and federal policy support has emerged specifically for doulas. For example, six states provide or are preparing to cover doula services through their Medicaid programs,¹⁶⁰ and the 2021 Mothers and Offspring Mortality and Morbidity Awareness (MOMMA)’s Act provides guidance and options for states to adopt and pay for doula support services.¹⁶¹

Rebuilding Trust and Enhancing Communication

Narratives from the experiences of Black women indicate a rupture of trust between Black women and the health care system that must be repaired.¹⁶² As BMMA asserts, “Care partnership—where Black female patients plan for their care alongside their provider—is the only way forward.”¹⁶³ Similarly, AIM safety bundles, and others, recommend that educating clinicians and staff about

1 racial and ethnic disparities in maternal outcomes, and emphasizing the importance of shared-
2 decision making, cultural competency and humility, implicit bias, and enhanced communication
3 skills are important steps to rebuild trust and eliminate disparities in maternal health care.¹⁶⁴
4

5 Effective communication can have a profound impact on how patients and families perceive their
6 care.¹⁶⁵ Research demonstrates that patient engagement in health care leads to measurable
7 improvements in safety and quality.¹⁶⁶ Open communication between the medical team and
8 patients and families can broaden perspectives and reduce patient avoidance of physicians/facilities
9 and/or medical care in general.¹⁶⁷ To promote patient engagement, the AHRQ developed an
10 evidence-based resource called, “The Guide to Patient and Family Engagement in Hospital Quality
11 and Safety” to help hospitals partner with patients and families.¹⁶⁸ The Guide was developed,
12 implemented, and evaluated with the input of patients, family members, clinicians, hospital staff,
13 and hospital leaders, and it includes sections devoted to improving communication among patients,
14 family members, and clinicians and preparing patients and families to transition from hospital to
15 home. Similarly, AHRQ developed a “Guide to Improving Patient Safety in Primary Care Settings
16 by Engaging Patients and Families” with evidence-based strategies including those to improve
17 communication, engagement, health literacy, and handoffs among the health care team.¹⁶⁹
18

19 The mutual trust built between pregnant patients and their physicians is essential, but maternal
20 health care presents unique continuity of care challenges where patients may be handed off from
21 their primary physician to an in-hospital clinical team for delivery, and then handed again to their
22 primary team for postpartum care. Accordingly, effective clinician-to-clinician communication is
23 imperative to strengthen continuity of care, eliminate preventable errors, and provide a safe patient
24 environment.¹⁷⁰ There is clear room for improvement, as a systematic review found that timely
25 communication of discharge summaries between hospital-based and primary care physicians was
26 low, and approximately ten percent of discharge summaries were never transferred.¹⁷¹ Use of
27 structured and codified communication practices can promote consistent communication among
28 clinicians and reduce risk of adverse events stemming from breakdowns in communication.¹⁷² With
29 due attention paid to the privacy of maternal health information, health information technology,
30 including electronic health records (EHRs) and technology enabling women to access their health
31 information from any place at any time, can also help to build information bridges during
32 potentially fragmented maternal health care.¹⁷³
33

34 In addition to effective clinician-to-clinician communication, striving toward optimal patient-
35 clinician communication is also essential. Patient-centered communication, cultural humility, and
36 trauma-informed care offer principles that can improve communication and build trust. Patient-
37 centered communication that offers options and asks patients about how they can be made most
38 comfortable can lessen anxiety and promote trust and rapport.¹⁷⁴ Additionally, the patient-centered
39 care approach of “centering at the margins” facilitates clinicians engaging with “the experience of
40 disenfranchised groups and [acknowledging] the role of society and history in influencing both
41 their own understanding of their patient and their patient’s understanding of them.”¹⁷⁵
42

43 Cultural humility is an approach that focuses on optimizing interactions between patients and
44 clinicians with different values, backgrounds, and experiences, and it has been shown to strengthen
45 the therapeutic alliance and improve outcomes.¹⁷⁶ Hallmark features of cultural humility include
46 critical self-reflection, openness, nonjudgement, and curiosity.¹⁷⁷ Researchers and clinicians have
47 developed a variety of resources to support the adoption of cultural humility in clinical practice,
48 from clinician coaching tools to assessment measures.¹⁷⁸ A focus on structural determinants of
49 health and health inequities in medical education and clinical training may facilitate cross-cultural
50 understanding of individual patients and shift the way clinicians recognize the social and economic
51 forces that produce health outcomes.¹⁷⁹

1 A trauma-informed approach to care has been defined as, “a strengths-based service delivery
2 approach that is grounded in an understanding of and responsiveness to the impact of trauma, that
3 emphasizes physical, psychological, and emotional safety for both practitioners and survivors, and
4 that creates opportunities to rebuild a sense of control and empowerment.”¹⁸⁰ ACOG highlights
5 high rates of trauma experienced across communities.¹⁸¹ For example, a survey of adults who had
6 completed high school found that approximately 83 percent of the respondents reported at least one
7 standard or community-level adversity, and approximately 37 percent reported four or more.¹⁸²
8 Traumatic birth experiences, which may include unexpected outcomes, procedures, obstetric
9 emergencies, and neonatal complications continue to impact patients.¹⁸³ ACOG also notes the
10 impact of “obstetric violence,” which is a nonmedical term that is used to refer to situations in
11 which a pregnant or postpartum individual experiences disrespect, indignity, or abuse from a health
12 care practitioner or system that can stem from and lead to loss of autonomy.¹⁸⁴ Experiences of
13 trauma can affect individuals’ physical and behavioral health and such experiences can profoundly
14 impact their attitude toward medical care, leading to anxiety related to specific examinations or
15 procedures or anxiety about being in a medical setting.¹⁸⁵ ACOG emphasizes, “True trauma-
16 informed care empowers individuals by recognizing the significance of power differentials and the
17 historical diminishing of voice and choice in past coercive exchanges.”¹⁸⁶

18
19 Public health communication is essential to raising awareness among both clinicians and patients
20 regarding maternal health challenges. The CDC recently launched the Hear Her campaign to raise
21 awareness of potentially life-threatening warning signs during and after pregnancy and improve
22 communication between patients and their medical teams.¹⁸⁷ As part of this campaign, women
23 share personal stories of pregnancy-related complications, such as a vignette about a woman named
24 Valencia who reports that “she felt like no one heard her or took her seriously” as she struggled
25 during a difficult first pregnancy.¹⁸⁸ The Hear Her campaign also provides guidance and resources
26 specifically for health care providers including: guidance to promote communication with patients
27 about urgent maternal warning signs, guidance regarding management of chronic conditions,
28 opportunities to get involved with ACOG’s “Every mom. Every time.” awareness campaign,
29 professional education regarding post-birth warning signs, information about toolkits and safety
30 bundles, and information about causes and contributors to maternal mortality.¹⁸⁹ The AMA
31 continues to support and amplify the reach of the Hear Her campaign on social media.¹⁹⁰
32 Physicians seeking additional professional education regarding maternal health care can also look
33 to a CDC listing of selected activities, including activities relating to healthier pregnancy and
34 perinatal behavioral health.¹⁹¹ The AMA also provides educational resources for physicians with
35 focuses on pregnant¹⁹² and postpartum¹⁹³ patients, as well as inequities in maternal and infant
36 care.¹⁹⁴ In addition, the AMA Ed Hub™ Health Equity Education Center continues to publish
37 continuing medical education (CME) and other educational activities aimed at addressing the root
38 causes of inequities, including racism and other structural determinants of health.¹⁹⁵ These
39 educational activities will equip physicians and other learners with core health equity concepts
40 needed to support them as they continue to take action and confront health injustice.

41 42 Utilizing Telehealth and Remote Patient Monitoring

43
44 The Health Resources and Services Administration’s (HRSA’s) Maternal and Child Health Bureau
45 describes the current paradigm for prenatal care as including 15 face-to-face visits between the
46 patient and her maternal health care team, which provide critical medical services, risk
47 assessments, patient education, and opportunities to build trust.¹⁹⁶ However, many patients, both in
48 rural and urban communities, face personal barriers (e.g., work, childcare, transportation,
49 education, culture, or language), health system barriers (e.g., limited hours of operation, or lack of
50 services), and environmental barriers (e.g., location or connectivity) that prevent them from
51 attending some or all of their planned prenatal visits.¹⁹⁷ HRSA’s Remote Pregnancy Monitoring

1 Challenge strives to reduce these barriers by supporting innovative technology-based solutions that
 2 help medical teams remotely monitor pregnant women, which can promote building trusting,
 3 ongoing relationships among patients and their medical teams and empowering women to make
 4 informed decisions about their care.¹⁹⁸

5
 6 The expansion of telehealth services during the COVID-19 pandemic has provided evidence of the
 7 potential benefits of telehealth and remote patient monitoring. For example, a recent study
 8 conducted at a hospital predominantly serving Medicaid patients found that access to virtual
 9 prenatal care for some of the standard prenatal appointments was associated with greater
 10 attendance rates compared with in-person appointments alone, and there were no deleterious
 11 outcomes among the women or infants participating in virtual prenatal care.¹⁹⁹ To ensure that all
 12 participating clinicians and patients had access to the resources needed for telehealth visits, the
 13 study utilized synchronous audio-only visit types.²⁰⁰ Consistent with these findings, ACOG states
 14 that remote patient monitoring interventions result in fewer high-risk obstetric monitoring visits
 15 while maintaining maternal and fetal outcomes.²⁰¹ ACOG specifically supports facilitating access
 16 to telehealth and remote patient monitoring, broadening durable medical equipment benefits, and
 17 eliminating financial barriers and other inequities for patients.²⁰² These maternal health-specific
 18 considerations are all consistent with AMA Policies D-480.963 and H-480.937.

19
 20 Collaborating with Community Leadership

21
 22 There is growing evidence that programs that partner with communities may have a substantial
 23 impact on improving quality of care and reducing disparities.²⁰³ Collaboration among clinicians,
 24 public health professionals, and community partners (including nonprofit organizations, faith-based
 25 organizations, and residents) has been essential in efforts to improve maternal health and reduce
 26 disparities.²⁰⁴ ACOG specifically suggests that physicians work to educate staff and colleagues
 27 about community resources available to patients and that they work collaboratively with local
 28 public health authorities to address disparities in environmental exposures, health education and
 29 literacy, and women’s health services and outcomes.²⁰⁵ Community-engaged interdisciplinary
 30 initiatives can cultivate trust and promote education, and they can also leverage a variety of
 31 innovative and traditional methods to do so. For example, New York City recently implemented
 32 the Severe Maternal Morbidity Project (Project), which worked directly with clinical and
 33 community partners to improve maternal outcomes, promote health equity, and reduce racial/ethnic
 34 disparities in SMM in New York City.²⁰⁶ The Project team worked to cultivate trust and it engaged
 35 with the community via innovative social media projects and in-person community public
 36 meetings. The social media initiatives amplified the voices and experiences of women navigating
 37 maternal care and provided an educational platform for content from the Preeclampsia Foundation
 38 and District II of ACOG. In-person presentations intended to increase awareness were delivered at
 39 community board meetings in neighborhoods experiencing the highest rates of SMM and those
 40 adjacent to Project-affiliated hospitals.

41
 42 Improving Data

43
 44 The CDC states that robust, comprehensive data collection and analysis through state and local
 45 MMRCs offers the best opportunity for identifying and prioritizing strategies to reduce
 46 disparities.²⁰⁷ In addition, the US Department of Health and Human Services (HHS) Office on
 47 Women’s Health (OWH) initiated an \$8 million nationwide contract with Premier, Inc. to improve
 48 maternal health data and create a network of at least 200 hospitals to deploy clinical, evidence-
 49 based best practices in maternity care. The Maternal Morbidity and Mortality Data and Analysis
 50 Initiative builds upon HHS’s Improving Maternal Health in America Initiative as outlined in the
 51 President’s FY 2021 Budget. These data would inform policy and validate evidence-based practice

1 to improve maternal health outcomes.²⁰⁸ One of the most common examples of using data to
2 improve quality of prenatal care is via perinatal quality collaboratives (PCQs). Almost all states
3 have PCQs available or in development, and these PCQs identify health care processes that need
4 improvement and apply quality improvement principles to address gaps in care as quickly as
5 possible.²⁰⁹ Nevertheless, the lack of standardized data on maternal health outcomes and disparities
6 constrains both clinical and policy-driven prevention efforts.²¹⁰ For additional discussion of the
7 critical need for improvements in public health data collection and reporting, including MMM data,
8 see CSAPH Rep. 2-NOV-21, “Full Commitment by our AMA to the Betterment and Strengthening
9 of Public Health Systems.”

10 AMA POLICY

11
12
13 The AMA is deeply committed to improving maternal health and eliminating disparities, as
14 evidenced by extensive policy and activity throughout the AMA. (See Appendix C.) The AMA has
15 developed a strong body of policy striving to eliminate racial and ethnic disparities in care,
16 including Policies H-65.952 acknowledging racism as public health threat; H-65.953 explaining
17 how racism and systemic oppression result in racial health disparities; D-350.981 calling for AMA
18 collaboration to identify and address aspects of medical education and board examinations that may
19 perpetuate institutional and structural racism; H-165.822 outlining health plan initiatives addressing
20 social determinants of health; H-350.974 stating the AMA’s position of zero tolerance toward
21 racially or culturally based disparities in care, commitment to eliminating racial and ethnic
22 disparities in care, and support for implicit bias training; D-350.995 striving to reduce racial and
23 ethnic disparities in health care via studies, collaboration, and promoting diversity in the
24 profession; D-420.993 supporting initiatives to reduce disparities in maternal mortality such as
25 asking the Commission to End Health Care Disparities to issue recommendations on the issue,
26 collaborating with federal, state, and county health departments to decrease maternal mortality
27 rates, encouraging development of maternal mortality surveillance systems, and encouraging
28 research on evidence-based practices to reduce MMM; and *Code of Medical Ethics* 8.5 Disparities
29 in Health Care. In addition, Policy H-200.955 recognizes the need to enhance diversity both in
30 medical schools and in the physician workforce to improve access to care for minoritized and
31 marginalized patients, and Policy D-200.985 outlines strategies the AMA will deploy as a leader
32 and key collaborator in striving to enhance diversity in the physician workforce.

33
34 Strong AMA policy on expanded insurance coverage for prenatal and postpartum care, and on
35 adequate physician compensation to ensure access to this care, continues to be critical to AMA
36 advocacy on improving maternal health care. (See Appendix C.) Examples include Policies
37 D-290.974 supporting extension of Medicaid coverage for 12 months postpartum; D-290.979
38 supporting collaborative efforts with state medical societies to advocate for expanded Medicaid
39 eligibility as authorized by ACA; H-165.855 supporting 12-month continuous eligibility across
40 Medicaid, CHIP, and exchange plans and presumptive assessment of eligibility and retroactive
41 coverage; H-165.823 supporting auto-enrollment in health insurance coverage; H-165.824
42 supporting expanded eligibility for and generosity in premium tax credits and cost-sharing
43 reductions for exchange plans; H-160.896 supporting payment reform policy proposals that
44 incentivize screening for SDOH and referral to community support systems, D-480.963 and
45 H-480.937 supporting equitable access to and coverage for telehealth services that maximize both
46 physician and patient opportunities for participation; and D-290.979, H-290.987, H-290.997
47 speaking to the need for adequate physician payment to secure access to care. In addition,
48 recognizing the untenable challenges faced by low-income patients whose income is too high to
49 qualify for their state’s Medicaid, yet who live below the FPL, Policy H-290.966 supports
50 identifying coverage options for adults currently in the coverage gap and encourages states that are
51 not participating in the Medicaid expansion to develop waivers that support expansion plans to best

1 meet the needs and priorities of their low-income adult populations. CMS Report 3-NOV-21,
2 “Covering the Remaining Uninsured,” provides additional analysis and policy development.

3
4 DISCUSSION

5
6 The AMA is committed to being a leader and collaborating with stakeholders to prevent maternal
7 MMM, and specifically to promote increased access to affordable health insurance and to eliminate
8 racial and ethnic inequities. A first step in this leadership is to publicly acknowledge the roles that
9 structural racism and bias play in negatively impacting health care, including maternity care, for
10 people of color. Similarly, the Councils recommend reaffirming Policy H-350.974 to emphasize
11 that the elimination of racial and ethnic disparities in health care is an issue of highest priority for
12 the AMA. In addition to these acknowledgements, the Councils believe that the AMA and the
13 medical profession should use their platforms to amplify other voices essential to the maternal
14 health discussion.

15
16 First, within physician-led health care teams, the Councils recommend that physician team leaders
17 embrace opportunities to learn more about the unique physical and behavioral health risks
18 associated with pregnancy and the 12-month postpartum period, the stark disparities in health
19 outcomes that persist for patients of color, and how they can enhance their equitable, patient-
20 centered approaches to care. Physician team leaders should encourage their physician and non-
21 physician team members and hospital administrators to similarly embrace such professional
22 education. Physicians should also raise awareness among their colleagues about the prevalence and
23 health outcomes impact of racial and ethnic inequities, work to eliminate these inequities, and
24 promote an environment of trust. Additionally, reaffirming Policy H-350.974 encourages
25 physicians to examine their practices to help increase awareness within the profession of racial
26 disparities in medical treatment decisions, supports the development and implementation of
27 training regarding implicit bias, diversity and inclusion in all medical schools and residency
28 programs, and supports research to identify the most effective strategies for educating physicians
29 on how to eliminate disparities in health outcomes.

30
31 Next, to allow for greater understanding of the root causes of MMM and the stark racial and ethnic
32 disparities in maternal health, additional research is essential, and accurate, standardized data are
33 needed to empower research. Accordingly, the Councils recommend that the AMA continue to
34 monitor and promote ongoing research regarding the impacts of societal (e.g., racism or
35 unaffordable health insurance), facility-level (e.g., hospital quality), clinician-level (e.g., implicit
36 bias), and patient-level (e.g., comorbidities, chronic stress, or lack of transportation) barriers to
37 optimal care that contribute to adverse and disparate maternal health outcomes, as well as research
38 testing the effectiveness of interventions to address each of these barriers. Furthermore, the
39 Councils recommend that the AMA promote the adoption of federal standards for collection of
40 patient-identified race and ethnicity information in clinical and administrative data to better
41 identify inequities. Critically, these federal standards must be informed by research, including real-
42 world testing of technical standards and standardized definitions of race and ethnicity terms, to
43 ensure that the data collected accurately reflects diverse populations and highlights, rather than
44 obscures, critical distinctions that may exist within broad racial or ethnic categories. These federal
45 standards must also be carefully crafted in conjunction with clinician and patient input to protect
46 patient privacy and provide non-discrimination protections. These federal standards should be
47 accompanied by best practices to guide respectful and non-coercive collection of accurate,
48 standardized data relevant to maternal health outcomes. In addition, to enable stakeholders to better
49 understand the underlying causes of maternal deaths and to inform evidence-based policies to
50 improve maternal health outcomes and promote health equity, the Councils recommend that the
51 AMA support the development of a standardized definition of maternal mortality and the allocation

1 of resources to states to collect and analyze maternal mortality data (i.e., Maternal Mortality
2 Review Committees and vital statistics). The AMA remains committed to collaborating with the
3 HHS, CDC, and state and local health departments to decrease maternal mortality rates in the US,
4 and the Councils recommend reaffirming Policy D-420.993 which affirms this commitment and
5 promotes state and local health department efforts to develop maternal mortality surveillance
6 systems.

7
8 To strengthen trusting patient-physician relationships, the AMA and the physician profession
9 should prioritize listening to and amplifying the voices of their patients, patients' families, and
10 patients' communities. The Councils recognize that non-clinical community organizations often
11 develop close bonds with members of minoritized and marginalized communities. Non-clinical
12 community organizations can play a key role in connecting women and families who may be
13 reluctant to, or face barriers preventing them from, seeking medical care. Accordingly, the
14 Councils recommend that the AMA encourage hospitals, health systems, and state and national
15 medical specialty societies to collaborate with non-clinical community organizations with close ties
16 to minoritized and other at-risk populations to identify opportunities to best support pregnant
17 women and new families. Similarly, health care literacy and awareness of the unique needs of
18 women while pregnant and during the 12-month postpartum period is essential. The Councils
19 recommend that the AMA encourage the development and funding of resources and outreach
20 initiatives to help pregnant individuals, their families, their communities, and their workplaces to
21 recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care.
22 These resources and initiatives should encourage women to pursue both physical and behavioral
23 health care and strive to reduce barriers to pursuing care, including by highlighting care that is
24 available at little or no cost to the patient. Finally, the Councils recognize that access to affordable
25 health insurance is essential to improving maternal health. Broadly, the Councils recommend that
26 the AMA develop policy supporting adequate payment for the full spectrum of evidence-based
27 prepregnancy, prenatal, peripartum, and postpartum physical and behavioral care.

28
29 With Medicaid and CHIP covering nearly half of all deliveries in the US, adequate Medicaid and
30 CHIP coverage is critical. The Councils commend the strong policy foundation the AMA has built
31 to empower advocacy for access to adequate Medicaid coverage. For example, Policy D-290.974,
32 which supports extension of Medicaid coverage for 12 months postpartum, has provided an
33 excellent foundation for the AMA's ongoing zealous maternal health advocacy. To clarify the
34 policy base for ongoing advocacy, the Councils recommend amending Policy D-290.974 to
35 explicitly include extension of CHIP coverage for at least 12 months after the end of pregnancy.
36 Additionally, the Councils recommend reaffirming policies that can continue to propel advocacy to
37 increase access to affordable health insurance and reduce inequities. Attempting to reach the 12
38 states that have not yet chosen to expand Medicaid, Policy D-290.979 supports collaborative efforts
39 with state and specialty medical societies to advocate for expanded Medicaid eligibility as
40 authorized by the ACA. To limit patient churn and promote continuity and coordination of care,
41 Policy H-165.855 supports 12-month continuous eligibility across Medicaid, CHIP, and exchange
42 plans, and it supports development of a safety net mechanism that would allow for presumptive
43 assessment of eligibility and retroactive coverage to the time at which an eligible person seeks
44 medical care. The narrow focus of the Councils' recommendations establishes foundational policy
45 on improving maternal health care, and we are committed to exploring additional policy
46 development.

47 48 RECOMMENDATIONS

49
50 The Council on Medical Service and the Council on Science and Public Health recommend that the
51 following be adopted and that the remainder of the report be filed:

- 1 1. That our American Medical Association (AMA) acknowledge that structural racism and bias
2 negatively impact the ability to provide optimal health care, including maternity care, for
3 people of color. (New HOD Policy)
4
- 5 2. That our AMA encourage physicians to raise awareness among colleagues, residents and
6 fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities
7 and the effect on health outcomes, work to eliminate these inequities, and promote an
8 environment of trust. (New HOD Policy)
9
- 10 3. That our AMA encourage physicians to pursue educational opportunities focused on
11 embedding equitable, patient-centered care for patients who are pregnant and/or within 12
12 months postpartum into their clinical practices and encourage physician leaders of health care
13 teams to support similar appropriate professional education for all members of their teams.
14 (New HOD Policy)
15
- 16 4. That our AMA continue to monitor and promote ongoing research regarding the impacts of
17 societal (e.g., racism or unaffordable health insurance), facility-level (e.g., hospital quality),
18 clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack
19 of transportation) barriers to optimal care that contribute to adverse and disparate maternal
20 health outcomes, as well as research testing the effectiveness of interventions to address each
21 of these barriers. (New HOD Policy)
22
- 23 5. That our AMA promote the adoption of federal standards for clinician collection of patient-
24 identified race and ethnicity information in clinical and administrative data to better identify
25 inequities. The federal data collection standards should be:
26 (a) informed by research (including real-world testing of technical standards and standardized
27 definitions of race and ethnicity terms to ensure that the data collected accurately reflect
28 diverse populations and highlight, rather than obscure, critical distinctions that may exist
29 within broad racial or ethnic categories),
30 (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy
31 and provide non-discrimination protections, and
32 (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of
33 accurate, standardized data relevant to maternal health outcomes. (Directive to Take Action)
34
- 35 6. That our AMA support the development of a standardized definition of maternal mortality and
36 the allocation of resources to states to collect and analyze maternal mortality data (i.e.,
37 Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better
38 understand the underlying causes of maternal deaths and to inform evidence-based policies to
39 improve maternal health outcomes and promote health equity. (New HOD Policy)
40
- 41 7. That our AMA encourage hospitals, health systems, and state medical associations and national
42 medical specialty societies to collaborate with non-clinical community organizations with close
43 ties to minoritized and other at-risk populations to identify opportunities to best support
44 pregnant persons and new families. (New HOD Policy)
45
- 46 8. That our AMA encourage the development and funding of resources and outreach initiatives to
47 help pregnant individuals, their families, their communities, and their workplaces to recognize
48 the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These
49 resources and initiatives should encourage patients to pursue both physical and behavioral
50 health care, strive to reduce barriers to pursuing care, and highlight care that is available at
51 little or no cost to the patient. (New HOD Policy)

- 1 9. That our AMA support adequate payment from all payers for the full spectrum of evidence-
2 based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
3 (New HOD Policy)
4
- 5 10. That our AMA amend Policy D-290.974 by addition and deletion as follows:
6
7 Our AMA will work with relevant stakeholders to support, at the state and federal levels,
8 extension of Medicaid and State Children’s Health Insurance Program (CHIP) coverage to at
9 least 12 months ~~after the end of pregnancy~~ ~~postpartum~~. (Modify Current HOD Policy)
10
- 11 11. That our AMA reaffirm Policy H-350.974, which highlights the elimination of racial and
12 ethnic disparities in health care as an issue of highest priority for the AMA; encourages
13 physicians to examine how their own practices help increase the awareness within the
14 profession of racial disparities in medical treatment decisions; supports the use of evidence-
15 based guidelines to promote the consistency and equity of care for all persons; supports the
16 development and implementation of training regarding implicit bias, diversity and inclusion in
17 all medical schools and residency programs; and supports research to identify the most
18 effective strategies for educating physicians on how to eliminate disparities in health outcomes
19 in all at-risk populations. (Reaffirm HOD Policy)
20
- 21 12. That our AMA reaffirm Policy D-420.993, which states that the AMA will work with the
22 Centers for Disease Control and Prevention, United States (US) Department of Health and
23 Human Services, state and county health departments to decrease maternal mortality rates in
24 the US; encourage and promote all state and county health departments to develop a maternal
25 mortality surveillance system; and work with stakeholders to encourage research on identifying
26 barriers and developing strategies toward the implementation of evidence-based practices to
27 prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and
28 maternal mortality in racial and ethnic minorities. (Reaffirm HOD Policy)
29
- 30 13. That our AMA reaffirm Policy D-290.979, which supports collaborative efforts with state and
31 specialty medical societies to advocate at the state level for expanded Medicaid eligibility as
32 authorized by the Affordable Care Act. (Reaffirm AMA Policy)
33
- 34 14. That our AMA reaffirm Policy H-165.855, which supports 12-month continuous eligibility
35 across Medicaid, Children’s Health Insurance Program, and exchange plans to limit patient
36 churn and promote continuity and coordination of care; and also supports development of a
37 mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to
38 the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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This Consensus Statement reflects contributions by “all the major women's health professional organizations,” including the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the Society for Obstetric Anesthesia and Perinatology, and the American Academy of Family Physicians.

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Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix A – AMA Advocacy and Activity

Advocacy

Over the last several years, the AMA has been increasingly active in advocating for maternal health. The COVID-19 pandemic has highlighted inequities in our health care system, including maternal health, and as a result, there has been an even greater focus on maternal mortality and morbidity at the federal level. The potential for maternal mortality bills introduced during the 117th Congressional Session being passed and signed into law is higher than in years past.

AMA Advocacy in 2021 (on-going)

- In July 2021, the AMA joined a sign-on [letter](#) urging Congress to direct \$20M to the U.S. Centers for Disease Control & Prevention (CDC) Hospitals Promoting the Breastfeeding line item in the Fiscal Year (FY) 2022 Labor, Health and Human Services, and Related Agencies appropriations bill, an increase of \$10.5M above the President’s budget level.
- In July 2021, the AMA sent a [letter](#) expressing our support for H.R. 3407, the “Mothers and Offspring Mortality and Morbidity Awareness Act” or the “MOMMA’s Act.”
- In July 2021, the AMA sent a letter voicing our support for the “Medicaid Reentry Act” which would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual’s release. ([House](#); [Senate](#))
- In June 2021, the AMA sent a [letter](#) expressing our support for S. 1675, the “Maternal Health Quality Improvement Act.” This legislation would provide grants to identify, develop, and disseminate best practices to improve maternal health care quality and outcomes. Additionally, provisions within this bill would encourage collaboration with state maternal mortality review committees to identify issues and reduce preventable maternal mortality and severe maternal morbidity, promote perinatal quality collaborative activities, and implement integrated health care services for pregnant and postpartum women.
- In June 2021, the AMA signed onto a [letter](#) urging Congress, as they develop the appropriations legislation for Fiscal Year 2022, to prioritize the highest possible funding level for programs that seek to prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health overall.
- In May 2021, the AMA sent letters to the House and Senate voicing our support for H.R.1218 and S. 198, the “Data Mapping to Save Moms’ Lives Act.” This legislation would instruct the Federal Communications Commission to consult with the CDC to determine ways to incorporate data on maternal health outcomes for at least one year postpartum into broadband health mapping tools in an effort to reduce maternal mortality and morbidity in the U.S.
- In May 2021, the AMA also sent letters voicing our support for [S. 796](#) and [H.R. 958](#), the “Protecting Moms Who Served Act.” The AMA believes that all women should have access to reproductive health services, especially those who have served our country. The Protecting Moms Who Served Act would require the Department of Veterans Affairs (VA) to implement the maternity care coordination program with community maternity care providers (i.e., non-VA maternity care providers) who have the necessary training to address the unique needs of pregnant and postpartum veterans. Additionally, the legislation would require the U.S. Government Accountability Office (GAO) to produce reports on maternal mortality and severe

maternal morbidity among pregnant and postpartum veterans, with a focus on veteran racial and ethnic disparities in maternal health outcomes.

- In May 2021, the AMA submitted a [Statement for the Record](#) to the U.S. House of Representatives Committee on Oversight and Reform as part of the hearing entitled, Birthing While Black: Examining America’s Black Maternal Health Crisis.
- In April 2021, the AMA signed onto a letter urging the [House](#) and [Senate](#) to direct \$20M to the CDC for the Hospitals Promoting Breastfeeding line item in the Fiscal Year (FY) 2022 Labor, Health and Human Services, and Related Agencies appropriations bill.
- In April 2021, the AMA sent a [comment letter](#) to the US Senate in support of the “Connected Maternal Online Monitoring Act” (or the “Connected MOM Act”), which would require CMS to send a report to Congress that identifies barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under State Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.
- Maternal health was among the top issues we encouraged AMA members to advocate for and discuss during their Members of Congress during the AMA National Advocacy Conference (NAC) February 23-24, 2021 and during the AMA Medical Student Advocacy Conference (MAC) on March 4, 2021. During these Conferences, AMA members and medical students urged their Members of Congress to cosponsor the Mothers and Offspring Mortality and Morbidity Awareness ([MOMMA](#)) Act, [S. 411](#), that was introduced on February 24, 2021. The MOMMA Act uses a six-pronged approach to address and reduce maternal deaths by: (1) establishing national obstetric emergency protocols through a federal expert committee, (2) ensuring dissemination of best shared practices and coordination amongst maternal mortality review committees, (3) standardizing data collection and reporting, (4) improving access to culturally competent care throughout the care continuum, (5) providing guidance and options for states to adopt and pay for doula support services, and (6) expanding Medicaid coverage to new mother’s entire post-partum period (1 year).
- In February 2021, in response to the AMA’s comments to the CMS’ Request for Information regarding, “Maternal and Infant Health Care in Rural Communities” and the 2021 Medicare Physician Fee Schedule proposed rule, the agency agreed to apply the increased relative values the agency adopted for standalone office visits to the office visit components of maternal (MMM) global codes to recognize the importance of preventive prenatal and postpartum care for the health of women and infants.
- In February 2021 the AMA joined a sign-on [letter](#) urging CMS to act expeditiously and to approve pending section 1115 demonstration projects aimed at extending the Medicaid postpartum coverage to a full year after the end of pregnancy.
- The AMA has voiced its support for the Connected Maternal Online Monitoring Act” (or the “Connected MOM Act”), which would require the CMS to send a report to Congress that identifies barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under State Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.
- The AMA also [urged](#) Congressional leaders to support at least \$750 million for the Title V Maternal and Child Health (MCH) Services Block Grant in the FY2022 Labor, Health and Human Services, Education & Related Agencies Appropriations bill. Continued robust support

of the MCH Services Block Grant is important in furthering our national goal of improving the health of mothers and children.

- The AMA also urged House Congressional leaders to support the highest possible funding level in FY2022 for programs at HRSA, CDC, and NIH that seek to prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health.

AMA Advocacy in 2020

- In December 2020, the AMA submitted extensive comments and suggested edits on the Black Maternal Health Momnibus Act of 2021 (a collection of 12 standalone bills) to the bill sponsor, Rep. Lauren Underwood. Below is a very brief, non-exhaustive, top-line summary of some of the concerns that AMA staff raised with the office.
 - The bill does not provide 12 months postpartum coverage (neither Medicaid nor CHIP).
 - Though other health care providers are specifically named and included on task forces the MOMNIBUS creates (e.g., the Task Force on Maternal Health Data and Quality Measures; or the Task Force to Coordinate Efforts to Address Social Determinants of Health for Women in the Prenatal and Postpartum Periods), physicians such as OBGYNs and fetal-medicine specialists are not.
 - Though grant programs were established for other health care providers, including nurse practitioners, physicians are not included in the grant programs to grow the health care workforce, despite a need for additional OBGYNs, fetal-medicine specialists, and rural physicians. The AMA also suggested, as an alternative, that perhaps a separate HRSA scholarship or loan forgiveness program could be developed as a targeted approach to grow and/or diversify OBGYNs/fetal-medicine specialists/rural physicians, providing some additional training and/or resources to deliver babies for high-risk mothers. This program would be more robust than the National Health Service Corps (NHSC) Loan Repayment Program (LRP). However, this suggestion was not incorporated into the current version of the bill.
 - The bill requires midwives to meet the International Confederation of Midwives standards but the AMA [supports](#) the American College of Nurse-Midwives (ACNM) standards (a higher threshold) and state scope of practice requirements. [NOTE: Although ACNM is a member association of ICM, there are gaps in the standards which can be found [here](#).]
 - The bill supports the establishment of the Respectful Maternity Care Compliance Programs to address bias and racism, and to promote accountability in maternity care settings. While the AMA supports the goal of this provision, we expressed concerns that as the bill is currently written, patients or their families could potentially ultimately report disrespect or evidence of bias and then upon the completion of the studies noted in the bill, result in an accountability mechanism against the physician for a claim that may be later found to be baseless. It is unclear what the full potentially negative impact of the studies and their findings could have on physicians, especially in a rural setting where there may be only a few OBGYNs. It is also unclear how much of the information, if later found unsubstantiated, would be made public via the HHS study/GAO report.

- On July 27, Dr. Patrice Harris [participated](#) in the 2nd Annual Black Maternal Health Caucus (BMHC) Stakeholder Summit hosted by Caucus co-chairs U.S. Reps. Lauren Underwood (D-IL) and Alma Adams (D-NC). The Caucus has over 100 House members of Congress; its mission is to eliminate health disparities and in particular, address the Black maternal health crisis in the U.S.
- In May, the AMA, along with a coalition of national physician organizations and heart health experts, launched a campaign called, [Release the Pressure](#), with ESSENCE—the nation’s leading lifestyle magazine brand for Black women—aimed at partnering with Black women to improve their heart health and be part of a movement for healthy blood pressure. The prevalence of high blood pressure among Black adults in the U.S. is among the highest in the world, with the prevalence of high blood pressure in Black women nearly 40% higher than white women in the U.S. Two of the leading causes of pregnancy-related deaths are heart conditions and stroke, which cause more than 1 in 3 deaths.
- On May 28, in response to a request for information regarding “Maternal and Infant Health Care in Rural Communities” by CMS, the AMA submitted [comments](#) outlining actions that CMS could take to improve health outcomes for pregnant women.
- Also, on May 28, AMA Advocacy staff participated in a U.S. Senate Committee on Finance staff briefing on maternal health. During the briefing, AMA Advocacy staff reiterated many of the AMA’s policies on this important issue, such as expanding access to health care and social services for women for one-year postpartum under Medicaid and CHIP. We also noted several areas where the AMA, under the leadership of the Center for Health Equity, is working to address these issues, such as [West Side United](#), a \$6 million collaborative social impact investment pact aimed at closing health equity gaps in Chicago’s west side.
- On April 1, the AMA submitted [comments](#) to the U.S. Senate Committee on Finance’s request for information regarding, “Solutions to Improve Maternal Health.” The AMA urged Congress to take several actions, such as working in a bipartisan manner to ensure Medicaid and CHIP coverage for women for one-year postpartum in an effort to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity.
- The AMA [supported H.R. 1897/S. 916](#), the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA’s) Act, introduced by Rep. Robin Kelly (D-IL). The bill would enhance federal efforts to support states in collecting, standardizing, and sharing maternal mortality and morbidity data, and authorizes and expands existing federal grant programs dedicated to scaling best practices to improve maternity care. The MOMMA’s Act would also authorize states to expand coverage under Medicaid, CHIP, and the Special Supplemental Nutrition Program for Women, Infants, and Children through a longer post-partum period for women. The bill would also ensure improved access to culturally competent care training and workforce practices throughout the care delivery system. *Note: This bill has been reintroduced in the 117th Congress as [S. 411](#).
- The AMA supported [H.R. 4996](#), the Helping MOMS Act of 2019, introduced by Rep. Robin Kelly (D-IL) which would allow states to provide one year of postpartum coverage under Medicaid and CHIP; current law allows only 60 days of postpartum coverage. Additionally, the Medicaid and CHIP Payment and Access Commission must report on specified information relating to coverage of doula services under the state Medicaid program, including coverage barriers and recommendations for improvement.
- The AMA supported [H.R. 4995](#), the Maternal Health Quality Improvement Act of 2019, introduced by Rep. Eliot Engel (D-NY-16), which would improve data collection in rural communities, support the Alliance for Innovation on Maternal Health, and promote perinatal

quality collaborative activities. The bill also directs the U.S. Department of Health and Human Services (HHS) to promote best practices to reduce and prevent implicit bias.

- The AMA supported [S. 1365](#)/H.R. 2569, the Comprehensive Addiction Resources Emergency (CARE) Act, introduced by Sen. Elizabeth Warren (D-MA) and the late Rep. Elijah E. Cummings (D-MD). The CARE Act was modeled directly on the Ryan White Comprehensive AIDS Resources Emergency Act, which passed in Congress in 1990 to provide significant new funding to help state and local governments combat the HIV/AIDS epidemic. The CARE Act would provide emergency assistance to States, territories, Tribal nations, and local areas affected by the opioid epidemic to provide for the development, organization, coordination, and operation of more effective and cost-efficient systems for the delivery of essential services to individuals with substance use disorder and their families. There are three sections of the bill that provide for the treatment of pregnant women.
- The AMA supported [H.R. 1329](#), the Medicaid Reentry Act, introduced by Rep. Paul Tonko (D-NY). The bill would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release. Such coverage is critical to help start treatment for individuals with substance use disorders (SUDs) before they are released back to the community and will help prevent opioid and other drug overdose deaths following release. By allowing Medicaid assistance for eligible incarcerated individuals up to 30 days prior to their release, the bill would help to provide for critically needed health care services, care coordination activities, and linkages to care for these individuals. *Note: This bill has been reintroduced in the 117th Congress as [H.R. 955](#).
- In February 2020, the AMA joined the Healthy Mothers, Healthy Babies Coalition of Georgia and successfully supported enactment of Georgia [H.B. 1114](#) in June 2020 to extend Medicaid coverage for six-months postpartum.

AMA Advocacy in 2019

- The AMA provided both written and oral [testimony](#) to the Committee on Energy & Commerce, Subcommittee on Health, as part of the hearing on Improving Maternal Health.
- The AMA also gave written and oral [testimony](#) to the Committee on Ways & Means as part of the hearing on the Maternal Mortality Crisis.
- The AMA participated in the BMHC's first Black Maternal Health Stakeholder Summit on Capitol Hill.

AMA Advocacy in 2018

- The AMA [supported](#) H.R. 1318, the Preventing Maternal Deaths Act of 2018.
- The AMA [supported](#) S. 1112, the Maternal Health Accountability Act of 2017.
- The AMA joined stakeholders in a [sign-on letter](#) supporting H.R. 1318 and S. 1112.

Additional AMA Business Unit Activity

From Health, Science, and Ethics, to the Center for Health Equity (CHE), to Improving Health Outcomes, to Medical Education, business units across the AMA continue to be actively engaged in initiatives to improve maternal health care and reduce disparities. The AMA is deeply committed to addressing the social conditions that impact health, increase health workforce diversity,

advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection/reporting. Key highlights include:

- The AMA supports efforts designed to integrate training in the Social Determinants of Health (SDOH) and cultural competence into physician education.
 - In 2013, the AMA launched the “Accelerating Change in Medical Education” initiative. Currently, the 37-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually.
 - In 2019, the AMA announced its Reimaging Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system.
 - For practicing physicians, the AMA launched STEPSforward,TM an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment. This series includes a continuing medical education module on “Addressing Social Determinants of Health: Beyond the Clinic Walls” that helps physicians identify how to best understand the needs of their community, define a plan to begin addressing the SDOH, and explains the tools available to screen patients and link them to resources.
- The AMA also demonstrates its commitment to health equity broadly and women’s health equity specifically through its development of and support for CHE, leading the [Release the Pressure](#) collaboration [aimed at ensuring](#) Black communities have the power, knowledge, opportunities and resources to achieve optimal health, and [amplifying the reach of the CDC’s Hear Her](#) campaign.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix B – Data Sources

Maternal Mortality Data

(1) CDC’s National Center for Health Statistics’ National Vital Statistics System (NVSS)

NVSS only counts deaths that occur while pregnant for within 42 days postpartum, and it does not include accidental or incidental causes of death. Further, NVSS relies upon only two pieces of information to identify maternal deaths – the pregnancy checkbox on the death certificate (which was not consistently used across all 50 states until 2017²¹⁰) and the certified recording of the cause of death.²¹⁰ PLEASE NOTE THAT ALL THE FOOTNOTES GOING FORWARD ARE LISTED AS 210 – THAT NEEDS TO BE FIXED.

(2) the CDC’s Pregnancy Mortality Surveillance System (PMSS)

PMSS casts a wider net in counting pregnancy-related deaths. PMSS includes deaths during pregnancy through one year postpartum, and in addition to the data reviewed by NVSS, in its identification process, PMSS reviews information from linkages between death records of women of reproductive age to birth and fetal death records within one year of the death, media searches, and reporting from public health agencies, health care providers and the public.²¹⁰ These records are reviewed by medical epidemiologists to determine the pregnancy-related mortality ratio.

(3) State and local Maternal Mortality Review Committees (MMRCs)²¹⁰

The most comprehensive data is collected at the state and local level by MMRCs.²¹⁰ Like PMSS, MMRCs reviews deaths that occur during or within one year of pregnancy. MMRCs have access to multiple sources of information that can provide a deeper understanding of the circumstances surrounding a death. This also allows MMRCs to make determinations of pregnancy-relatedness on a broader set of deaths than is possible for PMSS, such as deaths due to injury. However, there are substantial differences in the quality of state maternal mortality data, and for many states, the data are based on small numbers that are statistically unreliable.²¹⁰

The CDC has granted 24 awards, supporting 25 states for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program.²¹⁰ This funding directly supports agencies and organizations that coordinate and manage MMRCs to identify, review, and characterize maternal deaths and identify prevention opportunities. This work builds understanding of drivers of maternal mortality and morbidity and the associated disparities; determines what interventions at patient, provider, facility, system, and community levels will have the most effect; and informs implementation of initiatives to help the families and communities who need them most.

Maternal Health and Morbidity Data

(1) Nationwide Inpatient Sample (NIS)

The NIS is the source of data for CDC’s national SMM estimates, and it is the largest all-payer hospital inpatient care database in the US. The NIS is a stratified sample of approximately 20 percent of all community hospitals.²¹⁰

(2) Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a surveillance project of the CDC and state health departments that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.²¹⁰ PRAMS data are used by researchers to investigate emerging issues in the field of reproductive health and by state and local governments to plan and review programs and policies aimed at reducing health problems among mothers and babies.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix C – Key AMA Policy

Expanding Coverage

D-290.974 Extending Medicaid Coverage for One Year Postpartum

Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum. (Res. 221, A-19)

D-290.979 Medicaid Expansion

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. (Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19)

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
- b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
- d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
- e. The public option is financially self-sustaining and has uniform solvency requirements.
- f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
- g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
- b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.

- c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
- d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
- e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
- f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
- g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
- h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period. (CMS Rep. 1, I-20)

H-165.824 Improving Affordability in the Health Insurance Exchanges

- 1. Our AMA will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level; (c) support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; and (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
- 2. Our AMA supports: (a) eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18 Appended: CMS Rep. 02, A-19)

H-165.855 Medical Care for Patients with Low Incomes

It is the policy of our AMA that:

- (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.
- (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
- (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
- (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity.

Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.

(5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.

(6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.

(7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)

(8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation I-07 Modified: CMS Rep. 1, A-12 Reaffirmed in lieu of Res. 101, A-13 Reaffirmed: CMS Rep. 02, A-16 Reaffirmation: A-18)

H-180.958 Coverage of Contraceptives by Insurance

1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.

2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care. (Res. 221, A-98 Reaffirmation A-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmation: I-17 Modified: BOT Rep. 10, A-18)

H-290.966 Medicaid Expansion Options and Alternatives

1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap. 2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations. 3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. 4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. (CMS Rep. 5, I-14 Reaffirmed: CMS Rep. 02, A-16)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility", whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial

capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of

functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;

(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

(BOT Rep. 31, I-97 Reaffirmed by CMS Rep. 2, A-98 Reaffirmation A-99 and Reaffirmed: Res. 104, A-99 Appended: CMS Rep 2, A-99 Reaffirmation A-00 Appended: CMS Rep. 6, A-01 Reaffirmation A-02 Modified: CMS Rep. 8, A-03 Reaffirmed: CMS Rep. 1, A-05 Reaffirmation A-05 Reaffirmation A-07 Modified: CMS Rep. 8, A-08 Reaffirmation A-11 Modified: CMS Rep. 3, I-11 Reaffirmed: CMS Rep. 02, A-19)

H-290.987 Medicaid Waivers for Managed Care Demonstration Projects

- (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

H-290.997 Medicaid - Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. (BOT Rep. UU, A-88; Reaffirmed: CMS Rep. G, A-93; Reaffirmation I-96; Reaffirmation A-00; Reaffirmed:

BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-05; Reaffirmed: Res. 804, I-09; Reaffirmed: CMS Rep. 01, A-19)

H-420.972 Prenatal Services to Prevent Low Birthweight Infants

Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. (Res. 231, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmation A-07 Reaffirmation I-07 Reaffirmed: Res. 227, A-11)

H-420.978 Access to Prenatal Care

(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account. (Res. 33, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-05 Reaffirmation A-07 Reaffirmed: Res. 227, A-11)

H-425.976 Preconception Care

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
- (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
- (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
- (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and inter-conception care;
- (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
- (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
- (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record. (Res. 414, A-06 Reaffirmation I-07 Reaffirmed: CSAPH Rep. 01, A-17 Appended: Res. 401, A-19)

Disparities, Bias, and Racism

8.5 Disparities in Health Care (Code of Medical Ethics)

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I, IV, VII, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. (Issued: 2016)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19)

Infant Mortality D-245.994

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives. (Res. 410, A-10 Reaffirmed: CSAPH Rep. 01, A-20)

D-350.981 Racial Essentialism in Medicine

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine. (Res. 10, I-20)

D-350.984 Reducing Discrimination in the Practice of Medicine and Health Care Education

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign. (BOT Action in response to referred for decision Res. 602, I-15)

D-350.990 Collaboration with the National Medical Association to Address Health Disparities

Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support efforts to increase the cultural competence of clinicians, and reduce health disparities. (BOT Action in response to referred for decision Res. 606, A-09 Modified: CSAPH Rep. 01, A-19)

D-350.991 Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities

Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these

principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. (Res. 409, A-09 Appended: Res. 416, A-11)

D-350.995 Reducing Racial and Ethnic Disparities in Health Care

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03 Reaffirmation A-11 Reaffirmation: A-16 Reaffirmed: CMS Rep. 10, A-19)

D-420.993 Disparities in Maternal Mortality

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (CSAPH Rep. 3, A-09 Appended: Res. 403, A-11 Appended: Res. 417, A-18)

H-65.952 Racism as a Public Health Threat

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies. (Res. 5, I-20)

H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Res. 11, I-20)

H-65.963 Discriminatory Policies that Create Inequities in Health Care

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Res. 001, A-18)

H-165.822 Health Plan Initiatives Addressing Social Determinants of Health

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (CMS Rep. 7, I-20)

H-245.986 Infant Mortality in the United States

It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. (BOT Rep. U, I-91 Modified by BOT Rep. 8, A-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmation A-07 Modified: CSAPH Rep. 01, A-17)

H-295.897 Enhancing the Cultural Competence of Physicians

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.

3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.

4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. (CME Rep. 5, A-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-11 Appended: Res. 304, I-16 Modified: CME Rep. 01, A-17 Appended: Res. 320, A-17 Reaffirmed: CMS Rep. 02, I-17 Appended: Res. 315, A-18)

H-350.971 AMA Initiatives Regarding Minorities

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:

- (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
- (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
- (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
- (4) Response to inquiries and concerns of minority physicians and medical students; and

(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98CLRPD Rep. 1, A-08Reaffirmed: CEJA Rep. 01, A-20)

H-350.972 Improving the Health of Black and Minority Populations

Our AMA supports:

- (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
- (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
- (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
- (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. (CLRPD Rep. 3, I-98 Reaffirmation A-01 Modified: CSAPH Rep. 1, A-11)

H-350.974 Racial and Ethnic Disparities in Health Care

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
 - A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
 - B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
 - C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard

to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (CLRPD Rep. 3, I-98 Appended and Reaffirmed: CSA Rep.1, I-02 Reaffirmed: BOT Rep. 4, A-03 Reaffirmed in lieu of Res. 106, A-12 Appended: Res. 952, I-17 Reaffirmed: CMS Rep. 10, A-19)

H-440.869 Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities

Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. (Res. 914, I-07 Modified: BOT Rep. 22, A-17)

H-450.943 Effects of Pay-for-Performance on Minority Health Disparities

Our AMA urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs. (Res. 210, A-06 Reaffirmed: CMS Rep. 01, A-16)

Maternal Mortality Review Committees

H-60.909 State Maternal Mortality Review Committees

Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees. (Res. 911, I-17)

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix D – Advances Toward Medicaid Extension

Recent state and federal-level progress towards extension of Medicaid coverage for 12 months postpartum includes:

- The Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act, S. 411, seeks to reduce the rising maternal and infant mortality rate in the US, especially for mothers and babies of color. Its many proposals include an extension of Medicaid and CHIP coverage for 12 months postpartum.¹ In April 2021, the AMA sent a comment letter to the Senate in support of the MOMMA's Act.
- The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended a mandatory extension of the postpartum coverage period for individuals who were eligible and enrolled in Medicaid or CHIP while pregnant to a full year of coverage, regardless of changes in income, with 100 percent federal matching rate.² MACPAC also recommended requiring states to provide full Medicaid benefits to individuals enrolled in pregnancy-related pathways.³
- The Department of Health and Human Services (HHS), through CMS, has approved several Medicaid Section 1115 waivers to extend postpartum Medicaid coverage in some states. Illinois' waiver will allow the state to extend its postpartum Medicaid coverage up to 12 months. The Biden Administration specifically invited all states to provide full Medicaid benefits during pregnancy and the extended postpartum period.⁴ Subsequently, CMS approved Georgia's waiver request to extend Medicaid coverage to six months postpartum,⁵ and CMS approved Missouri's request to extend postpartum coverage to one year postpartum, but only for beneficiaries diagnosed with a substance use disorder.⁶ As of this writing, several states are awaiting approval for 1115 waiver requests related to postpartum Medicaid extensions.⁷ In February 2021, the AMA joined a letter signed by 113 national organizations and 151 state and local organizations urging the CMS to approve pending section 1115 demonstration projects aimed at extending Medicaid coverage to 12 months postpartum.
- Several states have enacted and/or are pursuing legislation to extend postpartum Medicaid coverage.⁸ For example, West Virginia⁹ and Washington¹⁰ have passed legislation to extend Medicaid coverage to 12 months postpartum, and Georgia¹¹ has passed legislation to extend Medicaid coverage to six months postpartum.
- The March 2020 Families First Coronavirus Response Act provides a temporary extension of Medicaid coverage beyond 60 days postpartum for the duration of the COVID-19 national emergency declaration.¹²
- The American Rescue Plan Act of 2021¹³ gives states a new option to extend Medicaid and CHIP postpartum coverage from 60 days to 12 months. States that elect the new option must provide full Medicaid benefits during pregnancy and the extended postpartum period. The new option can take effect starting April 1, 2022 and would be available to states for five years.
- In April 2021, President Biden issued a discretionary funding request that includes significant funding to reduce maternal mortality and morbidity rates, improve health equity, and end race-

based disparities, including funding to implement implicit bias training for medical team members, create State pregnancy medical home programs, support MMRCs, and expand the Rural Maternity and Obstetrics Management Strategies (RMOMS) program.¹⁴

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(N-21)

Introduced by: Medical Student Section

Subject: Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid

Referred to: Reference Committee G

1 Whereas, From 2008 to 2017 across 14 states, the US Centers for Disease Control and
2 Prevention (CDC) reported that across 14 states from 2008 to 2017, 23.6% of pregnancy-
3 related deaths take place between 42 days and 12 months postpartum¹; and
4

5 Whereas, From 2008 to 2017 across 14 states, the CDC reported that 65% of pregnancy-
6 related deaths occurring before 12 months postpartum were preventable, with causes including
7 cardiovascular conditions, hemorrhage, infection, embolism, preeclampsia and eclampsia, and
8 mental illness (including suicide and overdose)¹; and
9

10 Whereas, The 2010 Affordable Care Act (ACA) expanded Medicaid and provides federal
11 subsidies to purchase private health insurance plans depending on an individual's income, but
12 10.8 million women in the US remain uninsured²; and
13

14 Whereas, More than 1 million women fall into the Medicaid coverage gap, in which they remain
15 uninsured because their income is too high to qualify for Medicaid, but too low to qualify for
16 federal subsidies to purchase private health insurance plans on ACA marketplaces²; and
17

18 Whereas, In most states, some patients who are usually ineligible for Medicaid can temporarily
19 qualify if they become pregnant, but in many states, this coverage expires after 60 days
20 postpartum, and undocumented immigrants are still often barred from qualifying at all³; and
21

22 Whereas, Undocumented immigrants are often uninsured and in many states are ineligible for
23 public assistance for healthcare coverage, such as Medicaid, the Children's Health Insurance
24 Program (CHIP), and federal subsidies for ACA marketplace private health insurance plans^{2,4};
25 and
26

27 Whereas, Even if they become pregnant, undocumented immigrants are still often barred from
28 qualifying for public assistance for healthcare coverage^{2,4}; and
29

30 Whereas, Based on the recommendations of many state maternal mortality review committees,
31 the American College of Obstetricians and Gynecologists (ACOG) supports the extension of
32 Medicaid coverage from 60 days (the limit in many states) to 12 months postpartum to improve
33 pregnancy-associated mortality and morbidity outcomes⁵; and
34

35 Whereas, The AMA's existing Policy D-290.974, "Extending Medicaid Coverage for One Year
36 Postpartum," states that the AMA "will work with relevant stakeholders to support the extension
37 of Medicaid coverage to 12 months postpartum"⁶; and

1 Whereas, Existing AMA policy does not adequately address the lack of pregnancy-associate
2 healthcare coverage for patients ineligible for Medicaid due to state restrictions or immigration
3 status^{2,3}; and
4

5 Whereas, Seventeen states offer pregnancy-associated healthcare coverage to patients
6 ineligible for Medicaid under CHIP, but vary in how long coverage may last, with Texas offering
7 only two postpartum visits for the mother^{7,8}; and
8

9 Whereas, In 2016, the US Centers for Medicare & Medicaid Services (CMS)' Center for
10 Medicaid & CHIP Services stated that "state Medicaid agencies may cover maternal depression
11 screening as part of a well-child visit," which created precedent for some parental healthcare
12 coverage under both Children's Medicaid and CHIP, and provided uninsured parents ineligible
13 for Medicaid a path to receiving some care⁹; and
14

15 Whereas, As of 2018, screening for peripartum depression during the pediatric well-child visit is
16 a covered benefit under state Children's Medicaid programs in twenty-five states¹⁰; and
17

18 Whereas, Screening for peripartum depression is a cost-effective healthcare intervention, with
19 one study showing upwards of \$13,000 gained per Quality Adjusted Life Year (QALY) compared
20 to no intervention¹¹; and
21

22 Whereas, If extension of Medicaid coverage to 12 months postpartum is important for public
23 health, this benefit should also be extended to uninsured patients ineligible for Medicaid,
24 including those who fall into the Medicaid coverage gap or are undocumented^{1,2}; therefore be it
25

26 RESOLVED, That our American Medical Association amend Policy H-290.974, "Extending
27 Medicaid Coverage for One Year Postpartum," by addition as follows to read as follows:
28

29 Extending Medicaid Coverage for One Year Postpartum D-290.974
30

31 1) Our AMA will work with relevant stakeholders to support extension of Medicaid
32 coverage to 12 months postpartum; and

33 2) Our AMA will work with relevant stakeholders to expand Medicaid eligibility for
34 pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be
35 it further

1 RESOLVED, That our AMA amend Policy H-165.828, "Health Insurance Affordability," by
2 addition as follows:

3
4 H-165.828 – HEALTH INSURANCE AFFORDABILITY
5

6 1. Our AMA supports modifying the eligibility criteria for premium credits and cost-
7 sharing subsidies for those offered employer-sponsored coverage by lowering the
8 threshold that determines whether an employee's premium contribution is affordable
9 to that which applies to the exemption from the individual mandate of the Affordable
10 Care Act (ACA).

11 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's
12 "family glitch," thus determining the affordability of employer-sponsored coverage
13 with respect to the cost of family-based or employee-only coverage.

14 3. Our AMA encourages the development of demonstration projects to allow
15 individuals eligible for cost-sharing subsidies, who forego these subsidies by
16 enrolling in a bronze plan, to have access to a health savings account (HSA)
17 partially funded by an amount determined to be equivalent to the cost-sharing
18 subsidy.

19 4. Our AMA supports capping the tax exclusion for employment-based health
20 insurance as a funding stream to improve health insurance affordability, including
21 for individuals impacted by the inconsistency in affordability definitions, individuals
22 impacted by the "family glitch," and individuals who forego cost-sharing subsidies
23 despite being eligible.

24 5. Our AMA supports additional education regarding deductibles and cost-sharing at
25 the time of health plan enrollment, including through the use of online prompts and
26 the provision of examples of patient cost-sharing responsibilities for common
27 procedures and services.

28 6. Our AMA supports efforts to ensure clear and meaningful differences between
29 plans offered on health insurance exchanges.

30 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired
31 with a Health Savings Account (HSA) with information on how to set up an HSA.

32 8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special
33 enrollment in the health insurance marketplace. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Maternal mortality is an urgent crisis in the U.S., with our country ranking 59th worldwide in terms of maternal deaths. Our numbers are even worse when broken down by race and ethnicity, revealing large and unconscionable health disparities. People who wish to have a child should not have to fear preventable death as a result of the birth. This ongoing crisis merits the continued application of evidence-based, innovative policy changes. Data have identified that 65% of deaths in the 12 months postpartum are preventable, and a lack of health insurance is associated with worse outcomes. This resolution aims to address both issues by supporting the expansion of Medicaid eligibility to pregnant and postpartum non-citizen immigrants, and further by supporting the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. These issues are timely and important, and they align well with our AMA's priorities. It is vital that our AMA continue the momentum toward addressing maternal health, especially as the effects of COVID-19 are being shown to be particularly catastrophic for pregnant women. This resolution represents and actionable, evidence-based, and timely avenue by which to do so.

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RELEVANT AMA POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address

perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Res. 102, A-12; Modified: Res. 503, A-17

Extending Medicaid Coverage for One Year Postpartum D-290.974

Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

Res. 221, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(N-21)

Introduced by: Ohio

Subject: System Wide Prior and Post-Authorization Delays and Effects on Patient
Care Access

Referred to: Reference Committee G

1 Whereas, The time and effort spent on prior authorization is a burden which negatively impacts
2 the time physicians can spend caring for patients, negatively impacts the resiliency of
3 physicians and the ability to provide high quality access to all patients; and
4

5 Whereas, The AMA has policy prioritizing advocacy to ease prior authorization burdens and
6 further advance prior authorization reforms (H-320.939, D-285.960); and
7

8 Whereas, Current AMA policy, H-320.939, D-285.960 and related policies, have neither
9 satisfactorily unyoked the practicing physicians' burdens on the topic of prior authorizations, nor
10 created widespread real-time authentication best practice applications as may be seen in other
11 industries, and
12

13 Whereas, Health care insurers and Medicaid/Medicare Products have communication systems
14 that cause excessive response times through creation of websites that are difficult to navigate,
15 and submissions to these websites have neither a response to submissions nor a received
16 confirmation; and
17

18 Whereas, Prior authorization websites are inherently dysfunctional and promote delay, through
19 excessive downtime, phone systems that take an average of 45 minutes or often greater than
20 85 minutes in order to speak to a human insurance specialist, a high rate of disconnection while
21 waiting on the phone with no call back option, limitation of the number of patients that can be
22 authorized upon waiting with instructions to call back again to authorize other patients, Prior
23 Authorization taking up to 14 days from the time submitted to await a decision, etc. to just name
24 a few; and
25

26 Whereas, There is no overseeing entity to review these unfair business practices which are
27 substandard as compared with other entities who have upgraded their business models to
28 ensure end user functionality and efficiency; and
29

30 Whereas, It appears that these business practices by Health Care Insurers and
31 Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and
32 unintentionally rationing of health care services; therefore be it
33

34 RESOLVED, That our American Medical Association encourage and advocate health care
35 insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior
36 authorization include: live personnel access, simplification of website navigation, immediate
37 response with confirmation number of submission and an expedient decision for authorizations.
38 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The time and effort spent on prior authorization is a burden which negatively impacts the time physicians can spend caring for patients, negatively impacts the resiliency of physicians and the ability to provide high quality access to all patients. The American Medical Association has policy prioritizing advocacy to ease Prior Authorization burdens and further advance Prior Authorization reforms (H-320.939, D-285.960).

Current AMA policy, H-320.939, D-285.960 and related policies, have neither satisfactorily un-yoked the practicing physicians' burdens on the topic of Prior Authorizations, nor created widespread real-time authentication best practice applications as may be seen in other industries.

Prior authorization websites are inherently dysfunctional and promote delay. Prior authorization may take up to 14 days from the time submitted awaiting a decision. There is no overseeing entity to review these unfair business practices, hence AMA action is necessary.

These business practices by Health Care Insurers and Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and unintentionally rationing of health care services.

While this issue is important, it is one on which the AMA should take a stand and has a realistic potential to have a positive impact by modification of existing policy, we would classify it as a medium priority in that policy currently exists but it would benefit from the additions called for in our resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(N-21)

Introduced by: American Academy of Pediatrics

Subject: Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

Referred to: Reference Committee G

1 Whereas, The AMA 2021 Updates to Outpatient Office or Other Outpatient E/M Codes were
2 implemented on January 1, 2021 and include in the description of the CPT codes the
3 appropriate use based on Medical Decision Making or Time; and
4

5 Whereas, There are multiple instances where payers use means other than the code
6 descriptors to evaluate the appropriateness of E/M CPT code choice and adjudicate claims
7 based on a different level of CPT code; and
8

9 RESOLVED, That our American Medical Association identify and collect data regarding payer
10 deviation from CPT code descriptors to adjudicate claims, assess efficacy of and challenges in
11 existing appeals and hassle factor processes available to physicians, and prepare and present a
12 report at the 2022 House of Delegates Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Effective Jan. 1, 2021, the CMS adopted updated Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes. The revisions only apply to office visits and directly address the ongoing need for administrative simplification for physicians. The AMA has been working closely with EHR vendors, medical specialties, and payers to educate them about the changes and new requirements. Specifically, the goals of these changes are to reduce the administrative burden of documentation and coding, reduce the need for audits, reduce unnecessary documentation in the medical record (which is not needed for patient care), and to ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

The AAP has heard from its members that many payors have not implemented these updates, often resulting in CPT down-coding. Primary Care practices are already under financial strain due to COVID, and these coding updates are a welcome improvement. The lack of consistent implementation by health plans is adversely affecting Primary Care practices, making this a priority issue.

Current relevant AMA policy:

Improper Use of AMA-CPT by Carriers/Software Programs H-70.954
Bundling and Downcoding of CPT Codes H-70.937

These policies include language asking for a national policy for intervention with payers who use unreasonable business practices to recode or inappropriately bundle physician services, and calls on its members to identify specific CPT code bundling problems and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

RELEVANT AMA POLICY

Improper Use of AMA-CPT by Carriers/Software Programs H-70.954

Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement;

(2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and

(3) seeks legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers.

Citation: Sub. Res. 801, A-97; Appended: Res. 806, A-98; Appended: Res. 814, I-99;
Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07;
Reaffirmation A-10; Reaffirmed: CMS Rep. 01, A-20

Bundling and Downcoding of CPT Codes H-70.937

Our AMA:

(1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes,

guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(N-21)

Introduced by: Resident and Fellow Section

Subject: Expanding the AMA's Study on the Economic Impact of COVID-19

Referred to: Reference Committee G

1 Whereas, The 2019 Coronavirus Disease (COVID-19) pandemic has had a large impact on
2 healthcare spending, utilization, and employment; and
3

4 Whereas, The American healthcare system and hospital revenue drastically declined as a result
5 of COVID-19, experiencing monthly financial losses on average exceeding \$50 billion dollars
6 during the earliest months of the COVID-19 pandemic;¹ and
7

8 Whereas, It has been estimated that the cancellation of elective surgeries and procedures as a
9 result of the COVID-19 pandemic could cost the healthcare system and hospitals \$20-50 billion
10 in revenue each month, with monthly net income losses exceeding \$5 billion dollars^{1,2,3}; and
11

12 Whereas, The economic support for offsetting the financial strain of the COVID-19 pandemic
13 that was provided by the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act
14 likely disadvantaged healthcare systems treating at-risk populations because it initially used a
15 formula based on Medicare fee-for-service billings to distribute financial aid to hospitals^{3,4}; and
16

17 Whereas, Urban and rural hospitals, and other medical centers that disproportionately treat
18 underserved populations may face higher existential threats due to lost revenue, higher costs,
19 and other the economic burdens incurred during the COVID-19 pandemic^{3,5}; and
20

21 Whereas, The economic impact on residents and fellows seems to have been significant
22 regarding job loss⁶; and
23

24 Whereas, The AMA has become a predominant source of information regarding the economic
25 impact on physicians and their practices during the COVID-19 pandemic^{7,8}; and
26

27 Whereas, The AMA has yet to study how the economic impact of the COVID-19 pandemic on
28 hospitals, clinics, surgeons, students, residents, fellows, and patients with respect to lost
29 revenue and unanticipated healthcare costs; therefore be it
30

31 RESOLVED, That our American Medical Association work with relevant organizations and
32 stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic
33 on healthcare institutions in order to identify and better understand which groups of physicians,
34 patients and organizations may have been disproportionately affected by the financial burdens
35 of the COVID-19 pandemic (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA work with relevant organizations and stakeholders to study the
38 overall economic impact of office closures, cancellations of elective surgeries and interruptions
39 in patient care, as well as the economic impact of utilizing telemedicine for an increasing
40 percentage of patient care. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As we continue to proceed through the COVID-19 pandemic, so many groups including hospitals, clinics, physicians, trainees of all stages and our patients have experienced drastic changes in health care delivery, compensation, and opportunities. The AMA has been a leader in disseminating information during the pandemic, particularly regarding how physicians have been affected. This resolution seeks to have the AMA continue its advocacy and leadership to better understand the economic impact of the pandemic on our practice and our patients.

References:

1. American Hospital Association. Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19. 2020. Available at <https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf>.
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RELEVANT AMA POLICY

Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947

Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

Citation: Res. 114, I-20

Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923

1. Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic

preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness.

2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

Citation: Res. 211, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

Citation: Res. 202, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-385.951

Our AMA and the federation of medicine will work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

- Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;
- Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
- Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period.

Citation: Res. 202, I-20

Crisis Payment Reform Advocacy D-405.979

Our AMA will continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices.

Citation: Res. 218, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(N-21)

Introduced by: Texas

Subject: Advocating for Program Stability in the Merit-Based Incentive Payment System

Referred to: Reference Committee G

- 1 Whereas, On Jan. 1, 2022, under current law, Medicare participating physicians will receive a
2 9.75% payment cut; and
3
4 Whereas, Potential penalties under the Merit-Based Incentive Payment System (MIPS), which
5 apply to Medicare Physician Fee Schedule services, will increase, causing a 9% payment cut in
6 2022; and
7
8 Whereas, There is a statutory freeze in annual Medicare Physician Fee Schedule updates
9 under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last
10 until 2026; and
11
12 Whereas, Published [studies](#) report that the mean per-physician cost of participating in MIPS
13 was more than \$12,000 per year, consuming more than 200 hours of physician and
14 administrator time each year; and
15
16 Whereas, The alternative payment model pathway for physicians under MACRA has yet to be
17 realized, leaving the majority of practices trapped in the MIPS portion of the MACRA program;
18 and
19
20 Whereas, Physician practices are amid the COVID-19 public health emergency, requiring
21 continued infection control protocols that, while necessary, have increased the costs of
22 providing care; and
23
24 Whereas, The Centers for Medicare & Medicaid Services continues to propose annual changes
25 to MIPS that create additional complexity and confusion for physicians and patients; therefore
26 be it
27
28 RESOLVED, That our American Medical Association call on the Centers for Medicare &
29 Medicaid Services to implement an automatic hardship exception for participants in the
30 Merit-Based Incentive Payment System for the 2021 performance year due to the COVID-19
31 public health emergency. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The complexities and annual changes to the MIPS affect and burden all physicians.

With MIPS becoming increasingly punitive, it is important for the AMA to act at this meeting to avoid further financially punitive and administratively burdensome impacts that MIPS has on physician practices and their patients.

Reducing administrative burdens and avoiding payment penalties fits squarely within the AMA mission and strategic plan.

In reaction to the 2022 proposed MPFS, AMA needs additional policy to call on CMS to maintain the MIPS performance threshold at 50 points. Furthermore, AMA needs additional policy calling for hardship exceptions for the 2021 MIPS performance year due to the COVID-19 PHE.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(N-21)

Introduced by: Texas

Subject: Support for State Medical Record Retention Laws

Referred to: Reference Committee G

1 Whereas, The Centers for Medicare & Medicaid Services proposed in the 2022 Medicare
2 Physician Fee Schedule to modify the Provide Patients Electronic Access to Their Health
3 Information measure (a Merit-Based Incentive Payment System Promoting Interoperability
4 performance measure) to require that patient health information remain available for the patient
5 (or patient-authorized representative) to access indefinitely, starting with a date of service of
6 Jan.1, 2016; and
7
8 Whereas, State medical boards set medical record retention requirements for each state that
9 should not be superseded by a federal agency's policy; and
10
11 Whereas, This proposed requirement is a far reach beyond what Congress intended when the
12 Medicare Access and CHIP Reauthorization Act was designed; and
13
14 Whereas, The growing number of mergers and acquisitions in health care and the change in
15 technological platforms make it problematic and cost-prohibitive to maintain data records and
16 information as far back as 2016 in an electronic fashion; and
17
18 Whereas, Although patients' electronic access to their health information could be available
19 upon request, the Jan. 1, 2016, date can create problems for many practices that have changed
20 electronic health record systems or practice ownership, with information from older systems
21 having to be stored separately; and
22
23 Whereas, While it is important for patients to have access to their health information, American
24 Medical Association policy holds that medical considerations are the primary basis for deciding
25 how long to retain medical records; and
26
27 Whereas, Additional administrative burdens and compliance costs for physicians must be
28 avoided so they can focus on caring for patients; and
29
30 Whereas, The expectation that physicians can indefinitely maintain patient health information
31 adds a financial and workforce burden that is not feasible, and this kind of government
32 overreach will frustrate physicians and patients, causing further physician burnout and other
33 unintended consequences; and
34
35 Whereas, In addition to cost concerns and physician burden are privacy concerns when
36 maintaining the troves of data this requirement would create; therefore be it
37
38 RESOLVED, That our American Medical Association advocate that the Centers for Medicare &
39 Medicaid Services do not supersede state medical record retention laws in the U.S. (Directive to
40 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The CMS proposal in the 2022 proposed Medicare Physician Fee Schedule to require physicians to make patient health information to remain available to the patient (or patient-authorized representative) indefinitely, starting with a date of service of January 1, 2016 affects all Medicare participating physicians and their patients.

Given this agency proposal is not reflected in MACRA, AMA must act on this now as to not have a seriously deleterious impact on physician practices and their use of EHRs.

Given the proposals impact on all physicians, the resolution fits squarely within AMA's mission and strategic plan

The final 2022 regulation is expected in the Fall, thus AMA must advocate against the proposal in the near-term.

AMA policy on medical record retention is specific to medical considerations, but no AMA policy exists calling for the federal government to not supersede state medical record retention laws.

Due to the complexity and burden of complying with this proposal, immediate AMA action will have a positive impact and the AMA is most appropriate entity to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(N-21)

Introduced by: New York

Subject: Fifteen Month Lab Standing Orders

Referred to: Reference Committee G

-
- 1 Whereas, Federal Medicaid rules limits a laboratory standing order's validity to six months which
2 necessitates practitioners to reorder laboratory studies every six months for regular and routine
3 laboratory studies that often are required for a patient's lifetime (such as standard of care
4 monitoring of HemoglobinA1Cs every three to six months for diabetics); and
5
6 Whereas, There is no documented benefit to limiting laboratory orders to six months and
7 expiration of standing lab orders has led to patient and physician dissatisfaction; and
8
9 Whereas, "Busywork" that is not perceived as meaningful contributes to burnout which is a harm
10 negatively impacting the American medical work force and has deleterious implications on
11 patient care quality, outcomes and patient satisfaction; and
12
13 Whereas, Reordering laboratory studies only for the sake of a regulation leads to unnecessary
14 and not meaningful work, the kind of activity that contributes to burnout among practitioners and
15 increases the cost of healthcare because of the time and labor required for each practice to
16 reorder routine laboratory studies; therefore be it
17
18 RESOLVED, That our American Medical Association advocate the Centers for Medicare and
19 Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months.
20 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The current CMS regulation requiring lab orders to be renewed every six months with the concomitant review of results and reissue of prescriptions is unnecessary for patients who have been on maintenance medications for months and years. Many state regulations permit prescriptions to be valid for 12 months or more, therefore lab orders should be commensurate with that regulation. There is no benefit to the requirement of having patients be tested every 6 months especially in the case of patients who have been on longstanding maintenance medications and who have fared well. This would save patient, insurance and physician expense in addition to saving staff time and unnecessary paperwork and processing time. This change would also reduce administrative paperwork which contributes to physician burnout and stress.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(N-21)

Introduced by: New York

Subject: Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

Referred to: Reference Committee G

- 1 Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during
2 chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer
3 patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers; and
4
- 5 Whereas, The National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a
6 Category 2A designation indicating uniform NCCN consensus that the intervention is
7 appropriate; and
8
- 9 Whereas, Peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair
10 loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to
11 a control group where all patients experienced significant hair loss; and
12
- 13 Whereas, Scalp cooling treatment (Cold Cap Therapy) in peer reviewed studies was well-
14 tolerated with no scalp metastases observed; and
15
- 16 Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal
17 identity and self-esteem and appear normal as opposed to sick; and
18
- 19 Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer
20 diagnosis is significant to many patients; and
21
- 22 Whereas, Scalp cooling can give patients a sense of control in what can be an overwhelming
23 experience; and
24
- 25 Whereas, The American Medical Association (AMA) has issued two (2) separate Category III
26 CPT codes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and
27
- 28 Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling
29 medically necessary as a means to prevent hair loss during chemotherapy but insurance
30 coverage for scalp cooling is not yet standard in the United States; and
31
- 32 Whereas, Reimbursement varies depending on plan, coverage, and location with some
33 insurance companies covering up to \$2,000 for wigs but denying coverage for scalp cooling in
34 similar price range (\$1,500-\$3,000); and
35
- 36 Whereas, Many patients have encountered the circumstance where their health insurance
37 carrier will not provide coverage for scalp cooling therapy, forcing patients to pay out of pocket
38 for this essential therapy; and
39
- 40 Whereas, This significant out of pocket expense puts this treatment out of range for many; and

1 Whereas, Our AMA advocates for health equity; therefore be it

2

3 RESOLVED, That our American Medical Association advocate for and seek through legislation
4 and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive
5 to Take Action); and be it further

6

7 RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on
8 medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to
9 independent third-party reviewers. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Whether through personal experience or interactions with patients, physicians understand the devastating diagnosis of cancer. Patients requiring chemotherapy will undoubtedly experience hair loss as a result, adding to their misery. Scalp Cooling Therapy is proven to alleviate hair loss during chemo and would therefore improve a patient's self-image and positive outlook with regard to their cancer treatment. A positive response to chemo is not just about the treatments themselves, equally important is the patient's outlook and expectation that their health is improving from those treatments. Patients will not see (nor feel) improvement if the image in a mirror is one of themselves with no hair. Our sense of self is based in large part on physical appearance. Advocating for insurance coverage of Scalp Cooling Therapy would improve patient response to chemotherapy both physically and mentally. Because routine cancer screenings were in large part ignored during the COVID crisis, the expectation is that once resumed, the diagnoses of cancer will increase. Whereas Medicare and some health insurers will provide coverage for this therapy, other companies do not. An increase in cancer diagnoses makes this issue urgent and one that should be addressed with the insurance industry by the AMA as soon as possible.

1. NCCN scalp cooling recommendations from the [NCCN Clinical Practice Guidelines in Oncology \(NCCN Guidelines®\)](#). NCCN provides the following recommendations: breast cancer (Version 1.2019), ovarian cancer (Version 1.2020)

References

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- [2] Rugo HS, Melin SA, Voigt J. Scalp cooling with adjuvant/neoadjuvant chemotherapy for breast cancer and the risk of scalp metastases: systematic review and meta-analysis. *Breast Cancer Res Treat* 2017;163:199e205.
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- [8] Shin H, Jo SJ, Kim DH, Kwon O, Myung SK. Efficacy of interventions for prevention of chemotherapy-induced alopecia: a systematic review and meta-analysis. *Int J Cancer* 2015;136:E442e54.
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Number: 0290

Policy Effective Date 10/13/1998

Last Review: 7/1/2021

Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy.

Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate chemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(N-21)

Introduced by: New York

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

1 Whereas, The American Medical Association (AMA) has previously affirmed that physicians and
2 physician practices should be fairly compensated for work involved in prior authorizations; and
3

4 Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,
5 update, or modify CPT codes, descriptors, rules and guidelines; and
6

7 Whereas, Studies have shown that wrongful adverse determinations by health plans are
8 common, including denial of prior authorization and denial of payment for previously provided
9 services; and
10

11 Whereas, Costs involved in prior authorizations provide perverse disincentives and lead to sub-
12 optimal healthcare outcomes, especially for marginalized and economically vulnerable
13 communities; and
14

15 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,
16 all costs are incurred by physician practices, and all financial savings and benefits from prior
17 authorization accrue to health insurance plans leading to perverse incentives that disadvantage
18 patients and endanger their health; and
19

20 Whereas, Compensation for work performed by physician practices is accomplished via CPT
21 codes; therefore be it
22

23 RESOLVED, That our American Medical Association include in any model legislation and as a
24 basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied
25 services, including those for prior authorization reforms and that CPT codes must fully reflect
26 the aggregated time and effort expended by physician practices (Directive to Take Action); and
27 be it further
28

29 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®
30 Editorial Panel to account for administrative work involved in prior authorizations that reflects the
31 actual time expended by physician practices to advocate on behalf of patients and to comply
32 with insurer requirements (Directive to Take Action); and be it further
33

34 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®
35 Editorial Panel to account for administrative work that reflects the actual time expended by
36 physician practices and their billing vendors involved in successfully appealing wrongful pre-and
37 post-service denials. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000
Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The amount of time and effort physicians spend on administrative work rather than patient care continues to increase. Recognition of this burden and its contribution to physician burnout, career dissatisfaction, and patient dissatisfaction must be made. Repeated requests for documentation in order to pay denied claims, increased denial of claims, obtain pre-authorization for services continue to absorb more time in physician practices. These administrative tasks are not adequately compensated by the insurance industry. Physicians should not have to take time from patient care to deal with such matters. The AMA is the advocate for physicians in the United States and has a responsibility to address the issue of compensation for extensive administrative work. Appealing claim denials can drag on for months putting an additional burden on physician practices in terms of finances. Increased time spent on administrative work deserves compensation.

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res.

721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(N-21)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

1 Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the
2 musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful
3 exertions, vibrations, mechanical compression, or sustained or awkward positions; and
4

5 Whereas, RSI is a known work-related injury which falls under the purview of the Occupational
6 Safety and Health Administration (OSHA); and
7

8 Whereas, Most RSI results from cumulative trauma rather than a single event; and
9

10 Whereas, Repeated exposure to work-related stressors can result in physician burnout; and
11

12 Whereas, Cerebral centers and activity are most certainly within the domain of the nervous
13 system; and
14

15 Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI
16 and, as such, should fall under the aegis of OSHA; therefore be it
17

18 RESOLVED, That our American Medical Association seek legislation/regulation to add
19 physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and
20 Health Administration (OSHA) oversight. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

New York ranked this as vitally important – it has to do with physician health and well-being which has been sorely tested during the last year. Physicians are under enormous stress each and every day, and the COVID pandemic added immeasurably to that stress. The incidence of physician suicide increased during the last year – a clear indication of the added stress of COVID. Working without the necessary and proper equipment during the pandemic and watching colleagues die of COVID while doing their job has all added to the burden of being a physician. Physicians have few protections for their wellbeing and good health. Many feel that physicians should be “super-heroes” unaffected by the stress of providing health care in today’s very different environment. Adding physician burnout as an RSI subject to OSHA oversight would go a long way toward ensuring physicians work situation is monitored to ensure that they do not burnout.