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 deliveries[4]) 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
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CMS/CSAPH Joint Report N-21

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

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Referred to: Reference Committee G

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. Our first report is narrowly focused on two issues that are especially timely and foundational: expanding access to insurance for the most vulnerable new mothers and addressing inequities in maternal health care. The Councils decided to pursue this report in light of the enduring maternal health crisis in the United States (US). We discuss challenges women face in pursuing maternal health care, highlight especially relevant American Medical Association (AMA) policy and advocacy, and present a series of policy recommendations.

TERMINOLOGY

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

REPORT SCOPE

The US maternal health crisis is a complex, multifactorial challenge that cannot be adequately addressed in a single report. Instead, the Councils present this narrowly focused initial report, the first in an anticipated series of reports, to strengthen the AMA's 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.

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

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

BACKGROUND

The maternal health crisis in the US is well-documented and continues to be well-studied; nevertheless, it endures. 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.[8] The Centers for Disease Control and Prevention (CDC) defines a "pregnancy-related death" as the death of a woman while pregnant or within one year of the end of pregnancy from any cause related to or aggravated by the pregnancy.[9] Approximately 700 to 900 pregnancy-related deaths occur in the US per year.[10] Approximately two-thirds of these deaths are preventable, and an increasing percentage are happening in the late postpartum period (more than 43 days after the end of pregnancy).[11] Moreover, the US' MMR is widely considered to be an underestimate, as varying methods are used to count deaths related to pregnancy, and reporting is inconsistent.[12] 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.[13]

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

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

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

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

CRITICAL CHALLENGES IN MATERNAL HEALTH CARE

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

Multifactorial Causes of Maternal Morbidity and Mortality

Given the largely preventable nature of MMM, it is logical to seek straightforward causes that could be mitigated, but MMM results from a complex web of many interconnecting factors. According to the CDC, for every pregnancy-related death, an average of three to four contributing factors were identified, at multiple levels, including community, health facility, patient/family, provider, and system.[35] One may be inclined to look to poverty, lack of education, age, geography, or the prevalence of comorbidities as logical root causes. However, research shows that while each of those factors plays a role in the US maternal health crisis, none of them is dispositive. Studies adjusting for sociodemographic and reproductive factors have not explained the racial gap in pregnancy-related mortality in most studies.[36] For example, in one study, adjustment for maternal age, income, hypertension, gestational age at delivery, and receipt of prenatal care only reduced the odds ratios for pregnancy-related mortality from 3.07 to 2.65.[37] Moreover, another study found the

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

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

Accessing Prenatal, Peripartum, and Postpartum Care

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

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

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

Managing Chronic Conditions Before, During, and After Pregnancy

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

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

Elevated Risks for 12 Months Postpartum

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

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

Stark Inequities in Maternal Health

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

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

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

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

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

At the medical team and health care facility levels, there is a growing body of evidence demonstrating that implicit and explicit biases negatively impact quality of care and patient safety.[102] This was described originally in the Institute of Medicine (now the National Academy of Medicine) report, *Unequal Treatment*, in 2003.[103] More recently, the Agency for Healthcare Research and Quality (AHRQ) highlighted that Black patients received significantly worse quality of care relative to White patients in 40 percent of examined quality measures.[104] Racial and ethnic inequities exist both between hospitals and within hospitals.[105] For example, Black patients more commonly receive treatment in hospitals of poorer quality, and receive poorer quality care within a

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

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

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

Availability of Affordable Health Care Insurance

Access to affordable, comprehensive health care and insurance throughout a woman's life is critical to achieving optimal maternal health outcomes,[116] yet systemic barriers, including racism and sexism, and inequities in SDOH impact income levels and insurance status.[117] Two key provisions of the Affordable Care Act (ACA) contributed to insurance coverage gains: Medicaid expansion to adults with incomes of up to 138 percent of the federal poverty level (FPL) in some states, and the availability of subsidized insurance coverage through Marketplace plans for people with incomes of up to 400 percent of FPL. The ACA Medicaid expansion has been found to be associated with reductions in maternal mortality.[118] Expanding Medicaid reduced uninsurance among women of reproductive age overall, and specifically, it reduced uninsurance preconception, during pregnancy, and postpartum.[119] Expanding Medicaid led to improved access to care, increased use of health services, and better self-reported health among women of reproductive age.[120] Insurance preconception and postpartum improves women's health in multiple ways, including increasing opportunities for managing chronic conditions and family planning.[121] Expansion states also experienced significant reductions in Black–White disparities in adverse birth outcomes.[122] Despite these gains, nearly 12 percent of new mothers were uninsured in 2016 to 2018.[123] Moreover, in 2015 to 2017, approximately 29 percent of new mothers experienced a change in insurance status between delivery and six months postpartum.[124] While the ACA provided incentives for states to expand Medicaid, as of this writing, 12 states have chosen not to do so.[125] In addition, immigration status prevents some women from qualifying for publicly subsidized health insurance.[126]

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

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

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

OPPORTUNITIES TO IMPROVE EQUITABLE MATERNAL HEALTH CARE

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

Extend Medicaid and CHIP to 12 Months Postpartum

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

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

Eliminating Inequities and Strengthening the Patient-Physician Relationship

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

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

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

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

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

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

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

Public health communication is essential to raising awareness among both clinicians and patients regarding maternal health challenges. The CDC recently launched the Hear Her campaign to raise awareness of potentially life-threatening warning signs during and after pregnancy and improve communication between patients and their medical teams.[187] As part of this campaign, women share personal stories of pregnancy-related complications, such as a vignette about a woman named Valencia who reports that "she felt like no one heard her or took her seriously" as she struggled during a difficult first pregnancy.[188] The Hear Her campaign also provides guidance and resources specifically for health care providers including: guidance to promote communication with patients about urgent maternal warning signs, guidance regarding management of chronic conditions, opportunities to get involved with ACOG's "Every mom. Every time." awareness campaign, professional education regarding post-birth warning signs, information about toolkits and safety bundles, and information about causes and contributors to maternal mortality.[189] The AMA continues to support and amplify the reach of the Hear Her campaign on social media.[190] Physicians seeking additional professional education regarding maternal health care can also look to a CDC listing of selected activities, including activities relating to healthier pregnancy and perinatal behavioral health.[191] The AMA also provides educational resources for physicians with focuses on pregnant[192] and postpartum[193] patients, as well as inequities in maternal and infant care.[194] In addition, the AMA Ed Hub™ Health Equity Education Center continues to publish continuing medical education (CME) and other educational activities aimed at addressing the root causes of inequities, including racism and other structural determinants of health.[195] These educational activities will equip physicians and other learners with core health equity concepts needed to support them as they continue to take action and confront health injustice.

Utilizing Telehealth and Remote Patient Monitoring

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

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

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

Collaborating with Community Leadership

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

Improving Data

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

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

AMA POLICY

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

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

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

DISCUSSION

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

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

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

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

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

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

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) acknowledge that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color. (New HOD Policy)

2. That our AMA encourage physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust. (New HOD Policy)

3. That our AMA encourage physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourage physician leaders of health care teams to support similar appropriate professional education for all members of their teams. (New HOD Policy)

4. That our AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers. (New HOD Policy)

5. That our AMA promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
(a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
(b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and
(c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes. (Directive to Take Action)

6. That our AMA support the development of a standardized definition of maternal mortality and the allocation of resources to states to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity. (New HOD Policy)

7. That our AMA encourage hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families. (New HOD Policy)

8. That our AMA encourage the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient. (New HOD Policy)

9. That our AMA support adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care. (New HOD Policy)

10. That our AMA amend Policy D-290.974 by addition and deletion as follows:

    Our AMA will work with relevant stakeholders to support, at the state and federal levels, extension of Medicaid and State Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy ~~postpartum~~. (Modify Current HOD Policy)

11. That our AMA reaffirm Policy H-350.974, which highlights the elimination of racial and ethnic disparities in health care as an issue of highest priority for the AMA; encourages physicians to examine how their own practices help increase the awareness within the profession of racial disparities in medical treatment decisions; supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; and supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policy D-420.993, which states that the AMA will work with the Centers for Disease Control and Prevention, United States (US) Department of Health and Human Services, state and county health departments to decrease maternal mortality rates in the US; encourage and promote all state and county health departments to develop a maternal mortality surveillance system; and 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. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy D-290.979, which supports collaborative efforts with state and specialty medical societies to advocate at the state level for expanded Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm AMA Policy)

14. That our AMA reaffirm Policy H-165.855, which supports 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote continuity and coordination of care; and also supports development of a mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to 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,™ 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 though 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 2017[210]) 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 income 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 Ethic 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-11Appended: 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 Virginia[9] and Washington[10] have passed legislation to extend Medicaid coverage to 12 months postpartum, and Georgia[11] 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 2021[13] 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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