I

115TH CONGRESS
2D SESSION

H. R. 5977

To improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 25, 2018

Ms. KELLY of Illinois introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Mothers and Offspring Mortality and Morbidity Awareness Act'' or the ''MOMMA's Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Every year, across the United States, four million women give birth, about 700 women suffer

fatal complications during pregnancy, while giving birth, or during the postpartum period, and 65,000 women suffer near-fatal, partum-related complications.

(2) The maternal mortality rate is often used as a proxy to measure the overall health of a population. While the infant mortality rate in the United States has reached its lowest point, the risk of death for women in the United States during pregnancy, childbirth, or the postpartum period is higher than such risk in any all other developed nations. The estimated maternal mortality rate (per 100,000 live births) for the 48 contiguous States and Washington DC increased from 18.8 percent in 2000 to 23.8 percent in 2014 to 26.6 percent in 2018. This estimated rate is on par with such rate for underdeveloped nations such as Iraq and Afghanistan.

(3) International studies estimate the 2015 U.S. maternal mortality rate as 26.4 per 100,000 live births, which is almost twice the 2015 World Health Organization (WHO) estimation of 14 per 100,000 live births.

(4) It is estimated that almost half of all maternal mortalities in the United States are preventable.

(5) African-American women experience maternal-related deaths at three to four times the rate of non-Hispanic White women.

(6) The findings described in paragraphs (1) through (5) are of major concern to researchers, academicians, and epidemiologists at the Centers for Disease Control and Prevention (CDC); providers across the obstetrical continuum represented by organizations such as the Preeclampsia Foundation; the American College of Obstetricians and Gynecologists; the Association of Women's Health, Obstetric, and Neonatal Nurses; the California Maternal Quality Care Collaborative; Black Women's Health Imperative; the National Birth Equity Collaborative; Black Mamas Matter Alliance; the National Association of Certified Professional Midwives; and the American College of Nurse Midwives.

(7) According to the CDC, the maternal mortality rate varies drastically for women by race and ethnicity. There are 12.7 deaths per 100,000 live births for White women, 43.5 deaths per 100,000 live births for African-American women, and 14.4 deaths per 100,000 live births for women of other ethnicities. While maternal mortality disparately impacts African-American women, the phenomenon

traverses race, ethnicity, socioeconomic status, educational background, and geography.

(8) Hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection, embolism, mental health conditions, preeclampsia and eclampsia, infection or sepsis, and anesthesia complications are the predominant causes of maternal-related deaths and complications. Such conditions are largely preventable or manageable.

(9) The United States has not been able to submit a formal maternal mortality rate to international data repositories since 2007. Thus, no official maternal mortality rate exists for the Nation. There can be no maternal mortality rate without streamlining maternal mortality-related data from the State level and extrapolating such data to the Federal level.

(10) In the United States, death reporting and analysis is a State function rather than a Federal process. States report all deaths—including maternal deaths—on a semi-voluntary basis, without standardization across States. While the CDC has the capacity and system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and

standard format across States such that the CDC is able to identify causes of maternal death and best practices for the prevention of such death.

(11) Vital registration systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetrical providers or persons trained to recognize pregnancy-related mortality. Thus, these vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute to such high maternal mortality rates within the United States compared to other developed nations. Non-standardization of data and lack of data sharing across States and between Federal entities, health networks, and research institutions keep the

Nation in the dark about ways to prevent maternal deaths.

(12) Having reliable and valid State data aggregated at the Federal level are critical to the Nation's ability to quell surges in maternal death and imperative for researchers to identify long-lasting interventions.

(13) Leaders in maternal wellness highly recommend that maternal deaths be investigated at the State level first. Then, have data regarding maternal deaths be standardized across States, streamlined, de-identified, and sent once a year to a federally supervised database, managed by a Federal agency at the discretion of the Secretary of Health and Human Services. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries housed at the CDC and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortality and morbidities registry and surveillance would help providers, academicians, lawmakers, and the public to address questions concerning the types of, causes of, and best practices to thwart, pregnancy-related or pregnancy-associated mortalities and morbidities.

(14) The United Nations' Millennium Development Goal 5a aimed to reduce by three quarters, between 1990 and 2015, the maternal mortality rate, yet this metric has not been achieved. In fact, the maternal mortality rate in the United States has been estimated to have more than doubled between 2000 and 2014. Yet, because national data are not fully available, the United States does not have an official maternal mortality rate.

(15) Many States have struggled to establish or maintain Maternal Mortality Review Committees (MMRC). On the State level, MMRCs have lagged because States have not had the resources to mount local reviews. State-level reviews are necessary as only the State departments of health have the authority to request medical records, autopsy reports, and police reports critical to the function of the MMRC.

(16) The United Kingdom regards maternal deaths as a health systems failure and a national committee of obstetrics experts review each maternal death or near-fatal childbirth complication. Such committee also establishes the predominant course of maternal-related deaths from conditions such as preeclampsia. Consequently, the United Kingdom

has been able to reduce their incidences of preeclampsia to less than one in 10,000 women—its lowest rate since 1952.

(17) The United States has no comparable, coordinated Federal process by which to review cases of maternal mortality, systems failures, or best practices. Many States have active MMRCs and leverage their work to impact maternal wellness. For example, the State of California has worked extensively with their State health departments, health and hospital systems, and research collaborative organizations, including the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health, to establish MMRCs, wherein they have determined the most prevalent causes of maternal mortality and recorded and shared data with providers and researchers, who have developed and implemented safety bundles and care protocols related to preeclampsia, maternal hemorrhage, and the like. In this way, the State of California has been able to leverage its maternal mortality review board system, generate data, and apply those data to effect changes in maternal care-related protocol. To date, the State of California has stymied its maternal

mortality rate, which is now comparable to the low rates of the United Kingdom.

(18) Hospitals and health systems across the United States lack standardization of emergency obstetrical protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetrical emergency that does not take into account both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based maternal quality collaborative organizations, including the Alliance for Innovation on Maternal Health (AIMs) and California Maternal Quality Care Collaborative, have formed obstetrical protocols, tool kits, and other resources to improve system care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia. State perinatal quality collaboratives are working to identify health care processes that need to be improved and use the best available methods to make those changes as quickly as possible, while the Alliance for Innovation on Maternal

Health is working with States and health systems to align national, State, and hospital level quality improvement efforts through the creation and dissemination of maternal safety bundles to improve overall maternal health outcomes.

(19) The CDC reports that more than half of all maternal deaths occur in the immediate postpartum period—between 42 days up to a full year—whereas more than one-third of pregnancy-related or pregnancy-associated deaths occur while a person is still pregnant. Yet, for pregnant women, Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

(20) A growing body of evidence-based research has shown the correlation between the stress associated with one's race—the stress of racism—and one's birthing outcomes. The stress of sex and race discrimination and institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational age, maternal age, socioeconomic status, or individual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). African-American women remain the most

at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example—which is related to obesity—African-American women of normal weight remain the most at risk of dying during the perinatal period compared to non-African-American obese women.

(21) The rising U.S. maternal mortality rate is predominantly driven by the disproportionately high rates of African-American maternal mortality.

(22) African-American women are three to four times more likely to die from pregnancy or maternal-related distress than are White women, yielding one of the greatest and most disconcerting racial disparities in public health.

(23) Compared to women from other racial and ethnic demographics, African-American women across the socioeconomic spectrum experience prolonged, unrelenting stress related to racial and gender discrimination, contributing to higher rates of maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress often extends across the life course and is situated in everyday spaces where Afri-

can-American women establish livelihood. Structural barriers, lack of access to care, and genetic predispositions to health vulnerabilities exacerbate African-American women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

(24) African-American women are twice as likely to experience postpartum depression, and disproportionately higher rates of preeclampsia compared to White women.

(25) Racism is deeply ingrained in United States systems, including in health care delivery systems between patients and providers, often resulting in disparate treatment for pain, irreverence for cultural norms with respect to health, and dismissiveness. Research has demonstrated that patients respond more warmly and adhere to medical treatment plans at a higher degree with providers of the same race or ethnicity or with providers with great ability to exercise empathy. However, the provider pool is not primed with many people of color, nor are providers (whether student-doctors in training or licensed practitioners) consistently required to undergo implicit bias, cultural competency, or empathy training on a consistent, on-going basis.

SEC. 3. IMPROVING FEDERAL EFFORTS WITH RESPECT TO PREVENTION OF MATERNAL MORTALITY.

(a) TECHNICAL ASSISTANCE FOR STATES WITH RESPECT TO REPORTING MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director'') shall provide technical assistance to States that elect to report on maternal mortality for the purpose of encouraging uniformity in the reporting of such data and to encourage the sharing of such data among the respective States.

(b) BEST PRACTICES RELATING TO PREVENTION OF MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director shall issue best practices to State maternal mortality review committees on how best to identify, review, and prevent maternal mortality. In issuing such best practices, the Director shall take into account any data made available by States relating to maternal mortality.

(c) ALLIANCE FOR INNOVATION ON MATERNAL HEALTH GRANT PROGRAM.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Associate Administrator of the Maternal

and Child Health Bureau of the Health Resources and Services Administration, shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams and collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

(2) ELIGIBLE ENTITIES.—In order to be eligible for a grant under paragraph (1), an entity shall—

(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(B) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder national organization with a national

data-driven maternal safety and quality improvement initiative based on implementation approaches that have been proven to improve maternal safety and outcomes in the United States.

(3) USE OF FUNDS.—An eligible entity that receives a grant under paragraph (1) shall use such grant funds—

(A) to develop and implement, through a robust, multi-stakeholder process, maternal safety bundles to assist States and health care systems in aligning national, State, and hospital-level quality improvement efforts to improve maternal health outcomes, specifically the reduction of maternal mortality and severe maternal morbidity;

(B) to ensure, in developing and implementing maternal safety bundles under subparagraph (A), that such maternal safety bundles—

(i) satisfy the quality improvement needs of a State or health care system by factoring in the results and findings of relevant data reviews, such as reviews con-

ducted by a State maternal mortality review committee; and

(ii) address topics such as—

(I) obstetric hemorrhage;

(II) maternal mental health;

(III) the maternal venous system;

(IV) obstetric care for women with opioid use disorder;

(V) postpartum care basics for maternal safety;

(VI) reduction of peripartum racial and ethnic disparities;

(VII) reduction of primary caesarean birth;

(VIII) severe hypertension in pregnancy;

(IX) severe maternal morbidity reviews;

(X) support after a several maternal morbidity event; and

(XI) thromboembolism; and

(C) to provide ongoing technical assistance at the national and State levels to support implementation of maternal safety bundles under subparagraph (A).

(4) MATERNAL SAFETY BUNDLE DEFINED.—For purposes of this subsection, the term ''maternal safety bundle'' means standardized, evidence-informed processes to improve variation in response to maternal care.

(5) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $5,000,000 for each of fiscal years 2019 through 2023.

(d) EXPANSION OF MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(1) EXTENDING MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (e)—

(i) in paragraph (5), by striking ''60-day'' and inserting ''one-year''; and

(ii) in paragraph (6), by striking ''60-day'' and inserting ''one-year''; and

(B) in subsection (l)(1)(A), by striking ''60-day'' and inserting ''one-year''.

(2) EXTENDING MEDICAID COVERAGE FOR LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of the Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is

amended by striking ''60-day'' and inserting ''one-year''.

(3) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''one-year''.

(4) MAINTENANCE OF EFFORT.—

(A) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

''(5)(A) Subject to subparagraph (B), during the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State, including a State described in paragraph (4)(B) that elects to meet the requirement of subsection (a)(10)(A)(i)(IV), shall not have in effect, with respect to women who are eligible for medical assistance because of such subsection (a)(10)(A)(i)(IV) or section 1903(v)(4)(A)(i), eligibility standards, methodologies, or procedures under the State plan (or a waiver of such plan) that are more restrictive

than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.

''(B) A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan (or a waiver of such plan) on the date of enactment of this paragraph for purposes of determining compliance with the requirement of subparagraph (A).''.

(B) CHIP.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following new paragraph:

''(4) IN ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide pregnancy-related assistance to targeted low-income pregnant women (as defined in section 2112(d)), or women who are eligible for such assistance through

the application of section 1903(v)(4)(A)(i) under section 2107(e)(1), shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under the State child health plan (or a waiver of such plan) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(5) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided and subject to subparagraph (B), the amendments made by this subsection shall take effect with respect to eligibility determinations made with respect to a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act on or after the date that is one year after the date of enactment of this Act.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary of Health and Human Services determines requires State legislation in order

for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(e) REGIONAL CENTERS OF EXCELLENCE.—Part P of title III of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 399V–7. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall, subject to the availability of

appropriations, award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias and cultural competency in patient-provider interactions education for the purpose of enhancing and improving how health care professionals are educated in implicit bias and delivering culturally competent health care.

''(b) ELIGIBILITY.—To be eligible to receive a cooperative agreement under subsection (a), an entity shall—

''(1) be an entity specified by the Secretary that provides educational opportunities for students in a health care profession, which may include a health system, teaching hospital, birthing center, community health center, physician's office, medical school, school of public health, or any other health professional school or a program at an institution of higher education focused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality;

''(2) demonstrate community engagement and participation through community partners such as mental health counselors and social workers; and

''(3) provide to the Secretary such information, at such time and in such manner, as the Secretary may require.

''(c) DIVERSITY.—In awarding a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

''(d) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the Internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(3).

''(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and disseminate the findings resulting from each such evaluation to the appropriate public and private entities.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death that occurs to a woman during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized

to be appropriated $5,000,000 for each of fiscal years 2019 through 2023.''.

(f) DEFINITIONS.—In this section:

(1) MATERNAL MORTALITY.—The term ''maternal mortality'' means death that occurs to a woman during pregnancy or within the one-year period following the end of such pregnancy.

(2) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' includes unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman's health.

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