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

IN THE HOUSE OF REPRESENTATIVES

MARCH 27, 2019

Ms. KELLY of Illinois (for herself, Ms. DEGETTE, Ms. BASS, Ms. SCHAKOWSKY, Mr. KENNEDY, Ms. KUSTER of New Hampshire, Ms. LEE of California, Mr. RUSH, Ms. BLUNT ROCHESTER, Mrs. DAVIS of California, Mr. RASKIN, Mr. AGUILAR, Ms. WASSERMAN SCHULTZ, Mr. BLUMENAUER, Ms. MCCOLLUM, Ms. WILSON of Florida, Mr. KHANNA, Mr. LOWENTHAL, Mr. PAYNE, Mrs. BEATTY, Ms. CLARKE of New York, Mr. QUIGLEY, Mrs. DINGELL, and Mr. DANNY K. DAVIS of Illinois) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Mothers and Offspring
3 Mortality and Morbidity Awareness Act” or the
4 “MOMMA’s Act”.

5 **SEC. 2. FINDINGS.**

6 Congress finds the following:

7 (1) Every year, across the United States,
8 4,000,000 women give birth, about 700 women suf-
9 fer fatal complications during pregnancy, while giv-
10 ing birth or during the postpartum period, and
11 70,000 women suffer near-fatal, partum-related
12 complications.

13 (2) The maternal mortality rate is often used as
14 a proxy to measure the overall health of a popu-
15 lation. While the infant mortality rate in the United
16 States has reached its lowest point, the risk of death
17 for women in the United States during pregnancy,
18 childbirth, or the postpartum period is higher than
19 such risk in many other developed nations. The esti-
20 mated maternal mortality rate (per 100,000 live
21 births) for the 48 contiguous States and Wash-
22 ington, DC increased from 18.8 percent in 2000 to
23 23.8 percent in 2014 to 26.6 percent in 2018. This
24 estimated rate is on par with such rate for under-
25 developed nations such as Iraq and Afghanistan.

1 (3) International studies estimate the 2015 ma-
2 ternal mortality rate in the United States as 26.4
3 per 100,000 live births, which is almost twice the
4 2015 World Health Organization estimation of 14
5 per 100,000 live births.

6 (4) It is estimated that more than 60 percent
7 of maternal deaths in the United States are prevent-
8 able.

9 (5) According to the Centers for Disease Con-
10 trol and Prevention, the maternal mortality rate var-
11 ies drastically for women by race and ethnicity.
12 There are 12.7 deaths per 100,000 live births for
13 White women, 43.5 deaths per 100,000 live births
14 for African-American women, and 14.4 deaths per
15 100,000 live births for women of other ethnicities.
16 While maternal mortality disparately impacts Afri-
17 can-American women, this urgent public health crisis
18 traverses race, ethnicity, socioeconomic status, edu-
19 cational background, and geography.

20 (6) African-American women are 3 to 4 times
21 more likely to die from causes related to pregnancy
22 and childbirth compared to non-Hispanic White
23 women.

24 (7) The findings described in paragraphs (1)
25 through (6) are of major concern to researchers,

1 academics, members of the business community, and
2 providers across the obstetrical continuum rep-
3 resented by organizations such as March of Dimes;
4 the Preeclampsia Foundation; the American College
5 of Obstetricians and Gynecologists; the Society for
6 Maternal-Fetal Medicine; the Association of Wom-
7 en's Health, Obstetric, and Neonatal Nurses; the
8 California Maternal Quality Care Collaborative;
9 Black Women's Health Imperative; the National
10 Birth Equity Collaborative; Black Mamas Matter Al-
11 liance; EverThrive Illinois; the National Association
12 of Certified Professional Midwives; PCOS Challenge:
13 The National Polycystic Ovary Syndrome Associa-
14 tion; and the American College of Nurse Midwives.

15 (8) Hemorrhage, cardiovascular and coronary
16 conditions, cardiomyopathy, infection, embolism,
17 mental health conditions, preeclampsia and eclamp-
18 sia, polycystic ovary syndrome, infection and sepsis,
19 and anesthesia complications are the predominant
20 medical causes of maternal-related deaths and com-
21 plications. Most of these conditions are largely pre-
22 ventable or manageable.

23 (9) Oral health is an important part of
24 perinatal health. Reducing bacteria in a woman's
25 mouth during pregnancy can significantly reduce her

1 risk of developing oral diseases and spreading decay-
2 causing bacteria to her baby. Moreover, some evi-
3 dence suggests that women with periodontal disease
4 during pregnancy could be at greater risk for poor
5 birth outcomes, such as preeclampsia, pre-term
6 birth, and low-birth weight. Furthermore, a woman's
7 oral health during pregnancy is a good predictor of
8 her newborn's oral health, and since mothers can
9 unintentionally spread oral bacteria to their babies,
10 putting their children at higher risk for tooth decay,
11 prevention efforts should happen even before chil-
12 dren are born, as a matter of pre-pregnancy health
13 and prenatal care during pregnancy.

14 (10) The United States has not been able to
15 submit a formal maternal mortality rate to inter-
16 national data repositories since 2007. Thus, no offi-
17 cial maternal mortality rate exists for the United
18 States. There can be no maternal mortality rate
19 without streamlining maternal mortality-related data
20 from the State level and extrapolating such data to
21 the Federal level.

22 (11) In the United States, death reporting and
23 analysis is a State function rather than a Federal
24 process. States report all deaths—including mater-
25 nal deaths—on a semi-voluntary basis, without

1 standardization across States. While the Centers for
2 Disease Control and Prevention has the capacity and
3 system for collecting death-related data based on
4 death certificates, these data are not sufficiently re-
5 ported by States in an organized and standard for-
6 mat across States such that the Centers for Disease
7 Control and Prevention is able to identify causes of
8 maternal death and best practices for the prevention
9 of such death.

10 (12) Vital statistics systems often underesti-
11 mate maternal mortality and are insufficient data
12 sources from which to derive a full scope of medical
13 and social determinant factors contributing to ma-
14 ternal deaths. While the addition of pregnancy
15 checkboxes on death certificates since 2003 have
16 likely improved States' abilities to identify preg-
17 nancy-related deaths, they are not generally com-
18 pleted by obstetrical providers or persons trained to
19 recognize pregnancy-related mortality. Thus, these
20 vital forms may be missing information or may cap-
21 ture inconsistent data. Due to varying maternal
22 mortality-related analyses, lack of reliability, and
23 granularity in data, current maternal mortality
24 informatics do not fully encapsulate the myriad med-
25 ical and socially determinant factors that contribute

1 to such high maternal mortality rates within the
2 United States compared to other developed nations.
3 Lack of standardization of data and data sharing
4 across States and between Federal entities, health
5 networks, and research institutions keep the Nation
6 in the dark about ways to prevent maternal deaths.

7 (13) Having reliable and valid State data ag-
8 gregated at the Federal level are critical to the Na-
9 tion's ability to quell surges in maternal death and
10 imperative for researchers to identify long-lasting
11 interventions.

12 (14) Leaders in maternal wellness highly rec-
13 ommend that maternal deaths be investigated at the
14 State level first, and that standardized, streamlined,
15 de-identified data regarding maternal deaths be sent
16 annually to the Centers for Disease Control and Pre-
17 vention. Such data standardization and collection
18 would be similar in operation and effect to the Na-
19 tional Program of Cancer Registries of the Centers
20 for Disease Control and Prevention and akin to the
21 Confidential Enquiry in Maternal Deaths Pro-
22 gramme in the United Kingdom. Such a maternal
23 mortalities and morbidities registry and surveillance
24 system would help providers, academicians, law-
25 makers, and the public to address questions con-

cerning the types of, causes of, and best practices to thwart, pregnancy-related or pregnancy-associated mortality and morbidity.

(15) The United Nations' Millennium Development Goal 5a aimed to reduce by 75 percent, 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.

(16) Many States have struggled to establish or maintain Maternal Mortality Review Committees (referred to in this section as "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.

(17) 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

1 committee also establishes the predominant course of
2 maternal-related deaths from conditions such as
3 preeclampsia. Consequently, the United Kingdom
4 has been able to reduce its incidence of preeclampsia
5 to less than one in 10,000 women—its lowest rate
6 since 1952.

7 (18) The United States has no comparable, co-
8 ordinated Federal process by which to review cases
9 of maternal mortality, systems failures, or best prac-
10 tices. Many States have active MMRCs and leverage
11 their work to impact maternal wellness. For exam-
12 ple, the State of California has worked extensively
13 with their State health departments, health and hos-
14 pital systems, and research collaborative organiza-
15 tions, including the California Maternal Quality Care
16 Collaborative and the Alliance for Innovation on Ma-
17 ternal Health, to establish MMRCs, wherein such
18 State has determined the most prevalent causes of
19 maternal mortality and recorded and shared data
20 with providers and researchers, who have developed
21 and implemented safety bundles and care protocols
22 related to preeclampsia, maternal hemorrhage, and
23 the like. In this way, the State of California has
24 been able to leverage its maternal mortality review
25 board system, generate data, and apply those data

1 to effect changes in maternal care-related protocol.
2 To date, the State of California has reduced its ma-
3 ternal mortality rate, which is now comparable to
4 the low rates of the United Kingdom.

5 (19) Hospitals and health systems across the
6 United States lack standardization of emergency ob-
7 stetrical protocols before, during, and after delivery.
8 Consequently, many providers are delayed in recog-
9 nizing critical signs indicating maternal distress that
10 quickly escalate into fatal or near-fatal incidences.
11 Moreover, any attempt to address an obstetrical
12 emergency that does not consider both clinical and
13 public health approaches falls woefully under the
14 mark of excellent care delivery. State-based maternal
15 quality collaborative organizations, such as the Cali-
16 fornia Maternal Quality Care Collaborative or enti-
17 ties participating in the Alliance for Innovation on
18 Maternal Health (AIM), have formed obstetrical pro-
19 tocols, tool kits, and other resources to improve sys-
20 tem care and response as they relate to maternal
21 complications and warning signs for such conditions
22 as maternal hemorrhage, hypertension, and
23 preeclampsia.

24 (20) The Centers for Disease Control and Pre-
25 vention reports that nearly half of all maternal

1 deaths occur in the immediate postpartum period—
2 the 42 days following a pregnancy—whereas more
3 than one-third of pregnancy-related or pregnancy-as-
4 sociated deaths occur while a person is still preg-
5 nant. Yet, for women eligible for the Medicaid pro-
6 gram on the basis of pregnancy, such Medicaid cov-
7 erage lapses at the end of the month on which the
8 60th postpartum day lands.

9 (21) The experience of serious traumatic
10 events, such as being exposed to domestic violence,
11 substance use disorder, or pervasive racism, can
12 over-activate the body's stress-response system.
13 Known as toxic stress, the repetition of high-doses
14 of cortisol to the brain, can harm healthy neuro-
15 logical development, which can have cascading phys-
16 ical and mental health consequences, as documented
17 in the Adverse Childhood Experiences study of the
18 Centers for Disease Control and Prevention.

19 (22) A growing body of evidence-based research
20 has shown the correlation between the stress associ-
21 ated with one's race—the stress of racism—and
22 one's birthing outcomes. The stress of sex and race
23 discrimination and institutional racism has been
24 demonstrated to contribute to a higher risk of ma-
25 ternal mortality, irrespective of one's gestational

1 age, maternal age, socioeconomic status, or indi-
2 vidual-level health risk factors, including poverty,
3 limited access to prenatal care, and poor physical
4 and mental health (although these are not nominal
5 factors). African-American women remain the most
6 at risk for pregnancy-associated or pregnancy-re-
7 lated causes of death. When it comes to
8 preeclampsia, for example, which is related to obe-
9 sity, African-American women of normal weight re-
10 main the most at risk of dying during the perinatal
11 period compared to non-African-American obese
12 women.

13 (23) The rising maternal mortality rate in the
14 United States is driven predominantly by the dis-
15 proportionately high rates of African-American ma-
16 ternal mortality.

17 (24) African-American women are 3 to 4 times
18 more likely to die from pregnancy or maternal-re-
19 lated distress than are White women, yielding one of
20 the greatest and most disconcerting racial disparities
21 in public health.

22 (25) Compared to women from other racial and
23 ethnic demographics, African-American women
24 across the socioeconomic spectrum experience pro-
25 longed, unrelenting stress related to racial and gen-

1 der discrimination, contributing to higher rates of
2 maternal mortality, giving birth to low-weight ba-
3 bies, and experiencing pre-term birth. Racism is a
4 risk-factor for these aforementioned experiences.
5 This cumulative stress often extends across the life
6 course and is situated in everyday spaces where Afri-
7 can-American women establish livelihood. Structural
8 barriers, lack of access to care, and genetic pre-
9 dispositions to health vulnerabilities exacerbate Afri-
10 can-American women’s likelihood to experience poor
11 or fatal birthing outcomes, but do not fully account
12 for the great disparity.

13 (26) African-American women are twice as like-
14 ly to experience postpartum depression, and dis-
15 proportionately higher rates of preeclampsia com-
16 pared to White women.

17 (27) Racism is deeply ingrained in United
18 States systems, including in health care delivery sys-
19 tems between patients and providers, often resulting
20 in disparate treatment for pain, irreverence for cul-
21 tural norms with respect to health, and
22 dismissiveness. Research has demonstrated that pa-
23 tients respond more warmly and adhere to medical
24 treatment plans at a higher degree with providers of
25 the same race or ethnicity or with providers with

1 great ability to exercise empathy. However, the pro-
2 vider pool is not primed with many people of color,
3 nor are providers (whether student-doctors in train-
4 ing or licensed practitioners) consistently required to
5 undergo implicit bias, cultural competency, or empa-
6 thy training on a consistent, on-going basis.

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

9 (a) TECHNICAL ASSISTANCE FOR STATES WITH RE-
10 SPECT TO REPORTING MATERNAL MORTALITY.—Not
11 later than one year after the date of enactment of this
12 Act, the Director of the Centers for Disease Control and
13 Prevention (referred to in this section as the “Director”),
14 in consultation with the Administrator of the Health Re-
15 sources and Services Administration, shall provide tech-
16 nical assistance to States that elect to report comprehen-
17 sive data on maternal mortality, including oral, mental,
18 and breastfeeding health information, for the purpose of
19 encouraging uniformity in the reporting of such data and
20 to encourage the sharing of such data among the respec-
21 tive States.

22 (b) BEST PRACTICES RELATING TO PREVENTION OF
23 MATERNAL MORTALITY.—

24 (1) IN GENERAL.—Not later than one year
25 after the date of enactment of this Act—

1 (A) the Director, in consultation with rel-
2 evant patient and provider groups, shall issue
3 best practices to State maternal mortality re-
4 view committees on how best to identify and re-
5 view maternal mortality cases, taking into ac-
6 count any data made available by States relat-
7 ing to maternal mortality, including data on
8 oral, mental, and breastfeeding health, and uti-
9 lization of any emergency services; and

10 (B) the Director, working in collaboration
11 with the Health Resources and Services Admin-
12 istration, shall issue best practices to hospitals,
13 State professional society groups, and perinatal
14 quality collaboratives on how best to prevent
15 maternal mortality.

16 (2) AUTHORIZATION OF APPROPRIATIONS.—For
17 purposes of carrying out this subsection, there is au-
18 thorized to be appropriated \$5,000,000 for each of
19 fiscal years 2019 through 2023.

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

22 (1) IN GENERAL.—Not later than one year
23 after the date of enactment of this Act, the Sec-
24 retary of Health and Human Services (referred to in
25 this subsection as the “Secretary”), acting through

1 the Associate Administrator of the Maternal and
2 Child Health Bureau of the Health Resources and
3 Services Administration, shall establish a grant pro-
4 gram to be known as the Alliance for Innovation on
5 Maternal Health Grant Program (referred to in this
6 subsection as “AIM”) under which the Secretary
7 shall award grants to eligible entities for the purpose
8 of—

9 (A) directing widespread adoption and im-
10 plementation of maternal safety bundles
11 through collaborative State-based teams; and

12 (B) collecting and analyzing process, struc-
13 ture, and outcome data to drive continuous im-
14 provement in the implementation of such safety
15 bundles by such State-based teams with the ul-
16 timate goal of eliminating preventable maternal
17 mortality and severe maternal morbidity in the
18 United States.

19 (2) ELIGIBLE ENTITIES.—In order to be eligi-
20 ble for a grant under paragraph (1), an entity
21 shall—

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

1 (B) demonstrate in such application that
2 the entity is an interdisciplinary, multi-stake-
3 holder, national organization with a national
4 data-driven maternal safety and quality im-
5 provement initiative based on implementation
6 approaches that have been proven to improve
7 maternal safety and outcomes in the United
8 States.

9 (3) USE OF FUNDS.—An eligible entity that re-
10 ceives a grant under paragraph (1) shall use such
11 grant funds—

12 (A) to develop and implement, through a
13 robust, multi-stakeholder process, maternal
14 safety bundles to assist States and health care
15 systems in aligning national, State, and hos-
16 pital-level quality improvement efforts to im-
17 prove maternal health outcomes, specifically the
18 reduction of maternal mortality and severe ma-
19 ternal morbidity;

20 (B) to ensure, in developing and imple-
21 menting maternal safety bundles under sub-
22 paragraph (A), that such maternal safety bun-
23 dles—

24 (i) satisfy the quality improvement
25 needs of a State or health care system by

1 factoring in the results and findings of rel-
2 evant data reviews, such as reviews con-
3 ducted by a State maternal mortality re-
4 view committee; and

5 (ii) address topics such as—

6 (I) obstetric hemorrhage;

7 (II) maternal mental health;

8 (III) the maternal venous system;

9 (IV) obstetric care for women
10 with substance use disorders, includ-
11 ing opioid use disorder;

12 (V) postpartum care basics for
13 maternal safety;

14 (VI) reduction of peripartum ra-
15 cial and ethnic disparities;

16 (VII) reduction of primary cae-
17 sarean birth;

18 (VIII) severe hypertension in
19 pregnancy;

20 (IX) severe maternal morbidity
21 reviews;

22 (X) support after a severe mater-
23 nal morbidity event;

24 (XI) thromboembolism;

1 (XII) optimization of support for
2 breastfeeding; and

3 (XIII) maternal oral health; and

4 (C) to provide ongoing technical assistance
5 at the national and State levels to support im-
6 plementation of maternal safety bundles under
7 subparagraph (A).

8 (4) MATERNAL SAFETY BUNDLE DEFINED.—

9 For purposes of this subsection, the term “maternal
10 safety bundle” means standardized, evidence-in-
11 formed processes for maternal health care.

12 (5) AUTHORIZATION OF APPROPRIATIONS.—For

13 purposes of carrying out this subsection, there is au-
14 thorized to be appropriated \$10,000,000 for each of
15 fiscal years 2019 through 2023.

16 (d) FUNDING FOR STATE-BASED PERINATAL QUAL-
17 ITY COLLABORATIVES DEVELOPMENT AND SUSTAIN-
18 ABILITY.—

19 (1) IN GENERAL.—Not later than one year
20 after the date of enactment of this Act, the Sec-
21 retary of Health and Human Services (referred to in
22 this subsection as the “Secretary”), acting through
23 the Division of Reproductive Health of the Centers
24 for Disease Control and Prevention, shall establish a
25 grant program to be known as the State-Based

1 Perinatal Quality Collaborative grant program under
2 which the Secretary awards grants to eligible entities
3 for the purpose of development and sustainability of
4 perinatal quality collaboratives in every State, the
5 District of Columbia, and eligible territories, in
6 order to measurably improve perinatal care and
7 perinatal health outcomes for pregnant and
8 postpartum women and their infants.

9 (2) GRANT AMOUNTS.—Grants awarded under
10 this subsection shall be in amounts not to exceed
11 \$250,000 per year, for the duration of the grant pe-
12 riod.

13 (3) STATE-BASED PERINATAL QUALITY COL-
14 LABORATIVE DEFINED.—For purposes of this sub-
15 section, the term “State-based perinatal quality col-
16 laborative” means a network of multidisciplinary
17 teams that—

18 (A) work to improve measurable outcomes
19 for maternal and infant health by advancing
20 evidence-informed clinical practices using qual-
21 ity improvement principles;

22 (B) work with hospital-based or outpatient
23 facility-based clinical teams, experts, and stake-
24 holders, including patients and families, to

spread best practices and optimize resources to
improve perinatal care and outcomes;

(C) employ strategies that include the use
of the collaborative learning model to provide
opportunities for hospitals and clinical teams to
collaborate on improvement strategies, rapid-re-
sponse data to provide timely feedback to hos-
pital and other clinical teams to track progress,
and quality improvement science to provide sup-
port and coaching to hospital and clinical
teams; and

(D) have the goal of improving population-
level outcomes in maternal and infant health.

(4) AUTHORIZATION OF APPROPRIATIONS.—For
purposes of carrying out this subsection, there is au-
thorized to be appropriated \$14,000,000 per year
for each of fiscal years 2020 through 2024.

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

(1) REQUIRING COVERAGE OF ORAL HEALTH
SERVICES FOR PREGNANT AND POSTPARTUM
WOMEN.—

(A) MEDICAID.—Section 1905 of the So-
cial Security Act (42 U.S.C. 1396d) is amend-
ed—

1 (i) in subsection (a)(4)—

2 (I) by striking “; and (D)” and
3 inserting “; (D)”; and

4 (II) by inserting “; and (E) oral
5 health services for pregnant and
6 postpartum women (as defined in sub-
7 section (ee))” after “subsection
8 (bb))”; and

9 (ii) by adding at the end the following
10 new subsection:

11 “(ee) ORAL HEALTH SERVICES FOR PREGNANT AND
12 POSTPARTUM WOMEN.—

13 “(1) IN GENERAL.—For purposes of this title,
14 the term ‘oral health services for pregnant and
15 postpartum women’ means dental services necessary
16 to prevent disease and promote oral health, restore
17 oral structures to health and function, and treat
18 emergency conditions that are furnished to a woman
19 during pregnancy (or during the 1-year period be-
20 ginning on the last day of the pregnancy).

21 “(2) COVERAGE REQUIREMENTS.—To satisfy
22 the requirement to provide oral health services for
23 pregnant and postpartum women, a State shall, at
24 a minimum, provide coverage for preventive, diag-
25 nostic, periodontal, and restorative care consistent

1 with recommendations for perinatal oral health care
 2 and dental care during pregnancy from the Amer-
 3 ican Academy of Pediatric Dentistry and the Amer-
 4 ican College of Obstetricians and Gynecologists.”.

5 (B) CHIP.—Section 2103(c)(5)(A) of the
 6 Social Security Act (42 U.S.C.
 7 1397cc(c)(5)(A)) is amended by inserting “or a
 8 targeted low-income pregnant woman” after
 9 “targeted low-income child”.

10 (2) EXTENDING MEDICAID COVERAGE FOR
 11 PREGNANT AND POSTPARTUM WOMEN.—Section
 12 1902 of the Social Security Act (42 U.S.C. 1396a)
 13 is amended—

14 (A) in subsection (e)—

15 (i) in paragraph (5)—

16 (I) by inserting “(including oral
 17 health services for pregnant and
 18 postpartum women (as defined in sec-
 19 tion 1905(ee))” after “postpartum
 20 medical assistance under the plan”;
 21 and

22 (II) by striking “60-day” and in-
 23 serting “1-year”; and

24 (ii) in paragraph (6), by striking “60-
 25 day” and inserting “1-year”; and

1 (B) in subsection (l)(1)(A), by striking
2 “60-day” and inserting “1-year”.

3 (3) EXTENDING MEDICAID COVERAGE FOR
4 LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of the
5 Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is
6 amended by striking “60-day” and inserting “1-
7 year”.

8 (4) EXTENDING CHIP COVERAGE FOR PREG-
9 NANT AND POSTPARTUM WOMEN.—Section
10 2112(d)(2)(A) of the Social Security Act (42 U.S.C.
11 1397ll(d)(2)(A)) is amended by striking “60-day”
12 and inserting “1-year”.

13 (5) MAINTENANCE OF EFFORT.—

14 (A) MEDICAID.—Section 1902(l) of the So-
15 cial Security Act (42 U.S.C. 1396a(l)) is
16 amended by adding at the end the following
17 new paragraph:

18 “(5) During the period that begins on the date of
19 enactment of this paragraph and ends on the date that
20 is five years after such date of enactment, as a condition
21 for receiving any Federal payments under section 1903(a)
22 for calendar quarters occurring during such period, a
23 State shall not have in effect, with respect to women who
24 are eligible for medical assistance under the State plan
25 or under a waiver of such plan on the basis of being preg-

1 nant or having been pregnant, eligibility standards, meth-
 2 odologies, or procedures under the State plan or waiver
 3 that are more restrictive than the eligibility standards,
 4 methodologies, or procedures, respectively, under such
 5 plan or waiver that are in effect on the date of enactment
 6 of this paragraph.”.

7 (B) CHIP.—Section 2105(d) of the Social
 8 Security Act (42 U.S.C. 1397ee(d)) is amended
 9 by adding at the end the following new para-
 10 graph:

11 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
 12 GETED LOW-INCOME PREGNANT WOMEN.—During
 13 the period that begins on the date of enactment of
 14 this paragraph and ends on the date that is five
 15 years after such date of enactment, as a condition
 16 of receiving payments under subsection (a) and sec-
 17 tion 1903(a), a State that elects to provide assist-
 18 ance to women on the basis of being pregnant (in-
 19 cluding pregnancy-related assistance provided to tar-
 20 geted low-income pregnant women (as defined in
 21 section 2112(d)), pregnancy-related assistance pro-
 22 vided to women who are eligible for such assistance
 23 through application of section 1902(v)(4)(A)(i)
 24 under section 2107(e)(1), or any other assistance
 25 under the State child health plan (or a waiver of

1 such plan) which is provided to women on the basis
2 of being pregnant) shall not have in effect, with re-
3 spect to such women, eligibility standards, meth-
4 odologies, or procedures under such plan (or waiver)
5 that are more restrictive than the eligibility stand-
6 ards, methodologies, or procedures, respectively,
7 under such plan (or waiver) that are in effect on the
8 date of enactment of this paragraph.”.

9 (6) INFORMATION ON BENEFITS.—The Sec-
10 retary of Health and Human Services shall make
11 publicly available on the Internet website of the De-
12 partment of Health and Human Services, informa-
13 tion regarding benefits available to pregnant and
14 postpartum women and under the Medicaid program
15 and the Children’s Health Insurance Program, in-
16 cluding information on—

17 (A) benefits that States are required to
18 provide to pregnant and postpartum women
19 under such programs;

20 (B) optional benefits that States may pro-
21 vide to pregnant and postpartum women under
22 such programs; and

23 (C) the availability of different kinds of
24 benefits for pregnant and postpartum women,

1 including oral health and mental health bene-
2 fits, under such programs.

3 (7) FEDERAL FUNDING FOR COST OF EX-
4 TENDED MEDICAID AND CHIP COVERAGE FOR
5 POSTPARTUM WOMEN.—

6 (A) MEDICAID.—Section 1905 of the So-
7 cial Security Act (42 U.S.C. 1396d), as amend-
8 ed by paragraph (1), is further amended—

9 (i) in subsection (b), by striking “and
10 (aa)” and inserting “(aa), and (ff)”;

11 (ii) by adding at the end the fol-
12 lowing:

13 “(ff) INCREASED FMAP FOR EXTENDED MEDICAL
14 ASSISTANCE FOR POSTPARTUM WOMEN.—Notwith-
15 standing subsection (b), the Federal medical assistance
16 percentage for a State, with respect to amounts expended
17 by such State for medical assistance for a woman who is
18 eligible for such assistance on the basis of being pregnant
19 or having been pregnant that is provided during the 305-
20 day period that begins on the 60th day after the last day
21 of her pregnancy (including any such assistance provided
22 during the month in which such period ends), shall be
23 equal to—

24 “(1) 100 percent for the first 20 calendar quar-
25 ters during which this subsection is in effect; and

1 “(2) 90 percent for calendar quarters there-
2 after.”.

3 (B) CHIP.—Section 2105(c) of the Social
4 Security Act (42 U.S.C. 1397ee(c)) is amended
5 by adding at the end the following new para-
6 graph:

7 “(12) ENHANCED PAYMENT FOR EXTENDED
8 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—

9 Notwithstanding subsection (b), the enhanced
10 FMAP, with respect to payments under subsection
11 (a) for expenditures under the State child health
12 plan (or a waiver of such plan) for assistance pro-
13 vided under the plan (or waiver) to a woman who is
14 eligible for such assistance on the basis of being
15 pregnant (including pregnancy-related assistance
16 provided to a targeted low-income pregnant woman
17 (as defined in section 2112(d)), pregnancy-related
18 assistance provided to a woman who is eligible for
19 such assistance through application of section
20 1902(v)(4)(A)(i) under section 2107(e)(1), or any
21 other assistance under the plan (or waiver) provided
22 to a woman who is eligible for such assistance on the
23 basis of being pregnant) during the 305-day period
24 that begins on the 60th day after the last day of her
25 pregnancy (including any such assistance provided

1 during the month in which such period ends), shall
2 be equal to—

3 “(A) 100 percent for the first 20 calendar
4 quarters during which this paragraph is in ef-
5 fect; and

6 “(B) 90 percent for calendar quarters
7 thereafter.”.

8 (8) EFFECTIVE DATE.—

9 (A) IN GENERAL.—Subject to subpara-
10 graph (B), the amendments made by this sub-
11 section shall take effect on the first day of the
12 first calendar quarter that begins on or after
13 the date that is one year after the date of en-
14 actment of this Act.

15 (B) EXCEPTION FOR STATE LEGISLA-
16 TION.—In the case of a State plan under title
17 XIX of the Social Security Act or a State child
18 health plan under title XXI of such Act that
19 the Secretary of Health and Human Services
20 determines requires State legislation in order
21 for the respective plan to meet any requirement
22 imposed by amendments made by this sub-
23 section, the respective plan shall not be re-
24 garded as failing to comply with the require-
25 ments of such title solely on the basis of its fail-

1 ure to meet such an additional requirement be-
 2 fore the first day of the first calendar quarter
 3 beginning after the close of the first regular
 4 session of the State legislature that begins after
 5 the date of enactment of this Act. For purposes
 6 of the previous sentence, in the case of a State
 7 that has a 2-year legislative session, each year
 8 of the session shall be considered to be a sepa-
 9 rate regular session of the State legislature.

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

13 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
 14 **DRESSING IMPLICIT BIAS AND CULTURAL**
 15 **COMPETENCY IN PATIENT-PROVIDER INTER-**
 16 **ACTIONS EDUCATION.**

17 “(a) IN GENERAL.—Not later than one year after the
 18 date of enactment of this section, the Secretary, in con-
 19 sultation with such other agency heads as the Secretary
 20 determines appropriate, shall award cooperative agree-
 21 ments for the establishment or support of regional centers
 22 of excellence addressing implicit bias and cultural com-
 23 petency in patient-provider interactions education for the
 24 purpose of enhancing and improving how health care pro-

1 professionals are educated in implicit bias and delivering cul-
2 turally competent health care.

3 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
4 ative agreement under subsection (a), an entity shall—

5 “(1) be a public or other nonprofit entity speci-
6 fied by the Secretary that provides educational and
7 training opportunities for students and health care
8 professionals, which may be a health system, teach-
9 ing hospital, community health center, medical
10 school, school of public health, dental school, social
11 work school, school of professional psychology, or
12 any other health professional school or program at
13 an institution of higher education (as defined in sec-
14 tion 101 of the Higher Education Act of 1965) fo-
15 cused on the prevention, treatment, or recovery of
16 health conditions that contribute to maternal mor-
17 tality and the prevention of maternal mortality and
18 severe maternal morbidity;

19 “(2) demonstrate community engagement and
20 participation, such as through partnerships with
21 home visiting and case management programs; and

22 “(3) provide to the Secretary such information,
23 at such time and in such manner, as the Secretary
24 may require.

1 “(c) DIVERSITY.—In awarding a cooperative agree-
2 ment under subsection (a), the Secretary shall take into
3 account any regional differences among eligible entities
4 and make an effort to ensure geographic diversity among
5 award recipients.

6 “(d) DISSEMINATION OF INFORMATION.—

7 “(1) PUBLIC AVAILABILITY.—The Secretary
8 shall make publicly available on the internet website
9 of the Department of Health and Human Services
10 information submitted to the Secretary under sub-
11 section (b)(3).

12 “(2) EVALUATION.—The Secretary shall evalu-
13 ate each regional center of excellence established or
14 supported pursuant to subsection (a) and dissemi-
15 nate the findings resulting from each such evalua-
16 tion to the appropriate public and private entities.

17 “(3) DISTRIBUTION.—The Secretary shall share
18 evaluations and overall findings with State depart-
19 ments of health and other relevant State level offices
20 to inform State and local best practices.

21 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
22 tion, the term ‘maternal mortality’ means death of a
23 woman that occurs during pregnancy or within the one-
24 year period following the end of such pregnancy.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
 2 purposes of carrying out this section, there is authorized
 3 to be appropriated \$5,000,000 for each of fiscal years
 4 2019 through 2023.”.

5 (g) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
 6 FOR WOMEN, INFANTS, AND CHILDREN.—Section
 7 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42
 8 U.S.C. 1786(d)(3)(A)(ii)) is amended—

9 (1) by striking the clause designation and head-
 10 ing and all that follows through “A State” and in-
 11 serting the following:

12 “(ii) WOMEN.—

13 “(I) BREASTFEEDING WOMEN.—

14 A State”;

15 (2) in subclause (I) (as so designated), by strik-
 16 ing “1 year” and all that follows through “earlier”
 17 and inserting “2 years postpartum”; and

18 (3) by adding at the end the following:

19 “(II) POSTPARTUM WOMEN.—A

20 State may elect to certify a

21 postpartum woman for a period of 2

22 years.”.

23 (h) DEFINITIONS.—In this section:

24 (1) MATERNAL MORTALITY.—The term “mater-
 25 nal mortality” means death of a woman that occurs

1 during pregnancy or within the one-year period fol-
 2 lowing the end of such pregnancy.

3 (2) SEVERE MATERNAL MORBIDITY.—The term
 4 “severe maternal morbidity” includes unexpected
 5 outcomes of labor and delivery that result in signifi-
 6 cant short-term or long-term consequences to a
 7 woman’s health.

8 **SEC. 4. INCREASING EXCISE TAXES ON CIGARETTES AND**
 9 **ESTABLISHING EXCISE TAX EQUITY AMONG**
 10 **ALL TOBACCO PRODUCT TAX RATES.**

11 (a) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—
 12 Section 5701(g) of the Internal Revenue Code of 1986 is
 13 amended by striking “\$24.78” and inserting “\$49.56”.

14 (b) TAX PARITY FOR PIPE TOBACCO.—Section
 15 5701(f) of the Internal Revenue Code of 1986 is amended
 16 by striking “\$2.8311 cents” and inserting “\$49.56”.

17 (c) TAX PARITY FOR SMOKELESS TOBACCO.—

18 (1) Section 5701(e) of the Internal Revenue
 19 Code of 1986 is amended—

20 (A) in paragraph (1), by striking “\$1.51”
 21 and inserting “\$26.84”;

22 (B) in paragraph (2), by striking “50.33
 23 cents” and inserting “\$10.74”; and

24 (C) by adding at the end the following:

1 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
2 SINGLE-USE UNITS.—On discrete single-use units,
3 \$100.66 per thousand.”.

4 (2) Section 5702(m) of such Code is amend-
5 ed—

6 (A) in paragraph (1), by striking “or chew-
7 ing tobacco” and inserting “, chewing tobacco,
8 or discrete single-use unit”;

9 (B) in paragraphs (2) and (3), by inserting
10 “that is not a discrete single-use unit” before
11 the period in each such paragraph; and

12 (C) by adding at the end the following:

13 “(4) DISCRETE SINGLE-USE UNIT.—The term
14 ‘discrete single-use unit’ means any product con-
15 taining tobacco that—

16 “(A) is not intended to be smoked; and

17 “(B) is in the form of a lozenge, tablet,
18 pill, pouch, dissolvable strip, or other discrete
19 single-use or single-dose unit.”.

20 (d) TAX PARITY FOR SMALL CIGARS.—Paragraph
21 (1) of section 5701(a) of the Internal Revenue Code of
22 1986 is amended by striking “\$50.33” and inserting
23 “\$100.66”.

24 (e) TAX PARITY FOR LARGE CIGARS.—

1 (1) IN GENERAL.—Paragraph (2) of section
2 5701(a) of the Internal Revenue Code of 1986 is
3 amended by striking “52.75 percent” and all that
4 follows through the period and inserting the fol-
5 lowing: “\$49.56 per pound and a proportionate tax
6 at the like rate on all fractional parts of a pound but
7 not less than 10.066 cents per cigar.”.

8 (2) GUIDANCE.—The Secretary of the Treas-
9 ury, or the Secretary’s delegate, may issue guidance
10 regarding the appropriate method for determining
11 the weight of large cigars for purposes of calculating
12 the applicable tax under section 5701(a)(2) of the
13 Internal Revenue Code of 1986.

14 (f) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
15 AND CERTAIN PROCESSED TOBACCO.—Subsection (o) of
16 section 5702 of the Internal Revenue Code of 1986 is
17 amended by inserting “, and includes processed tobacco
18 that is removed for delivery or delivered to a person other
19 than a person with a permit provided under section 5713,
20 but does not include removals of processed tobacco for ex-
21 portation” after “wrappers thereof”.

22 (g) CLARIFYING TAX RATE FOR OTHER TOBACCO
23 PRODUCTS.—

1 (1) IN GENERAL.—Section 5701 of the Internal
2 Revenue Code of 1986 is amended by adding at the
3 end the following new subsection:

4 “(i) OTHER TOBACCO PRODUCTS.—Any product not
5 otherwise described under this section that has been deter-
6 mined to be a tobacco product by the Food and Drug Ad-
7 ministration through its authorities under the Family
8 Smoking Prevention and Tobacco Control Act shall be
9 taxed at a level of tax equivalent to the tax rate for ciga-
10 rettes on an estimated per use basis as determined by the
11 Secretary.”.

12 (2) ESTABLISHING PER USE BASIS.—For pur-
13 poses of section 5701(i) of the Internal Revenue
14 Code of 1986, not later than 12 months after the
15 later of the date of the enactment of this Act or the
16 date that a product has been determined to be a to-
17 bacco product by the Food and Drug Administra-
18 tion, the Secretary of the Treasury (or the Secretary
19 of the Treasury’s delegate) shall issue final regula-
20 tions establishing the level of tax for such product
21 that is equivalent to the tax rate for cigarettes on
22 an estimated per use basis.

23 (h) CLARIFYING DEFINITION OF TOBACCO PROD-
24 UCTS.—

1 (1) IN GENERAL.—Subsection (c) of section
 2 5702 of the Internal Revenue Code of 1986 is
 3 amended to read as follows:

4 “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-
 5 ucts’ means—

6 “(1) cigars, cigarettes, smokeless tobacco, pipe
 7 tobacco, and roll-your-own tobacco, and

8 “(2) any other product subject to tax pursuant
 9 to section 5701(i).”.

10 (2) CONFORMING AMENDMENTS.—Subsection
 11 (d) of section 5702 of such Code is amended by
 12 striking “cigars, cigarettes, smokeless tobacco, pipe
 13 tobacco, or roll-your-own tobacco” each place it ap-
 14 pears and inserting “tobacco products”.

15 (i) INCREASING TAX ON CIGARETTES.—

16 (1) SMALL CIGARETTES.—Section 5701(b)(1)
 17 of such Code is amended by striking “\$50.33” and
 18 inserting “\$100.66”.

19 (2) LARGE CIGARETTES.—Section 5701(b)(2)
 20 of such Code is amended by striking “\$105.69” and
 21 inserting “\$211.38”.

22 (j) TAX RATES ADJUSTED FOR INFLATION.—Section
 23 5701 of such Code, as amended by subsection (g), is
 24 amended by adding at the end the following new sub-
 25 section:

1 “(j) INFLATION ADJUSTMENT.—

2 “(1) IN GENERAL.—In the case of any calendar
3 year beginning after 2018, the dollar amounts pro-
4 vided under this chapter shall each be increased by
5 an amount equal to—

6 “(A) such dollar amount, multiplied by

7 “(B) the cost-of-living adjustment deter-
8 mined under section 1(f)(3) for the calendar
9 year, determined by substituting ‘calendar year
10 2017’ for ‘calendar year 2016’ in subparagraph
11 (A)(ii) thereof.

12 “(2) ROUNDING.—If any amount as adjusted
13 under paragraph (1) is not a multiple of \$0.01, such
14 amount shall be rounded to the next highest multiple
15 of \$0.01.”.

16 (k) FLOOR STOCKS TAXES.—

17 (1) IMPOSITION OF TAX.—On tobacco products
18 manufactured in or imported into the United States
19 which are removed before any tax increase date and
20 held on such date for sale by any person, there is
21 hereby imposed a tax in an amount equal to the ex-
22 cess of—

23 (A) the tax which would be imposed under
24 section 5701 of the Internal Revenue Code of

1 1986 on the article if the article had been re-
2 moved on such date, over

3 (B) the prior tax (if any) imposed under
4 section 5701 of such Code on such article.

5 (2) CREDIT AGAINST TAX.—Each person shall
6 be allowed as a credit against the taxes imposed by
7 paragraph (1) an amount equal to \$500. Such credit
8 shall not exceed the amount of taxes imposed by
9 paragraph (1) on such date for which such person
10 is liable.

11 (3) LIABILITY FOR TAX AND METHOD OF PAY-
12 MENT.—

13 (A) LIABILITY FOR TAX.—A person hold-
14 ing tobacco products on any tax increase date
15 to which any tax imposed by paragraph (1) ap-
16 plies shall be liable for such tax.

17 (B) METHOD OF PAYMENT.—The tax im-
18 posed by paragraph (1) shall be paid in such
19 manner as the Secretary shall prescribe by reg-
20 ulations.

21 (C) TIME FOR PAYMENT.—The tax im-
22 posed by paragraph (1) shall be paid on or be-
23 fore the date that is 120 days after the effective
24 date of the tax rate increase.

1 (4) ARTICLES IN FOREIGN TRADE ZONES.—
2 Notwithstanding the Act of June 18, 1934 (com-
3 monly known as the Foreign Trade Zone Act, 48
4 Stat. 998, 19 U.S.C. 81a et seq.), or any other pro-
5 vision of law, any article which is located in a for-
6 eign trade zone on any tax increase date shall be
7 subject to the tax imposed by paragraph (1) if—

8 (A) internal revenue taxes have been deter-
9 mined, or customs duties liquidated, with re-
10 spect to such article before such date pursuant
11 to a request made under the 1st proviso of sec-
12 tion 3(a) of such Act; or

13 (B) such article is held on such date under
14 the supervision of an officer of the United
15 States Customs and Border Protection of the
16 Department of Homeland Security pursuant to
17 the 2d proviso of such section 3(a).

18 (5) DEFINITIONS.—For purposes of this sub-
19 section—

20 (A) IN GENERAL.—Any term used in this
21 subsection which is also used in section 5702 of
22 such Code shall have the same meaning as such
23 term has in such section.

24 (B) TAX INCREASE DATE.—The term “tax
25 increase date” means the effective date of any

1 increase in any tobacco product excise tax rate
2 pursuant to the amendments made by this sec-
3 tion (other than subsection (j) thereof).

4 (C) SECRETARY.—The term “Secretary”
5 means the Secretary of the Treasury or the
6 Secretary’s delegate.

7 (6) CONTROLLED GROUPS.—Rules similar to
8 the rules of section 5061(e)(3) of such Code shall
9 apply for purposes of this subsection.

10 (7) OTHER LAWS APPLICABLE.—All provisions
11 of law, including penalties, applicable with respect to
12 the taxes imposed by section 5701 of such Code
13 shall, insofar as applicable and not inconsistent with
14 the provisions of this subsection, apply to the floor
15 stocks taxes imposed by paragraph (1), to the same
16 extent as if such taxes were imposed by such section
17 5701. The Secretary may treat any person who bore
18 the ultimate burden of the tax imposed by para-
19 graph (1) as the person to whom a credit or refund
20 under such provisions may be allowed or made.

21 (l) EFFECTIVE DATES.—

22 (1) IN GENERAL.—Except as provided in para-
23 graphs (2) through (4), the amendments made by
24 this section shall apply to articles removed (as de-
25 fined in section 5702(j) of the Internal Revenue

1 Code of 1986) after the last day of the month which
2 includes the date of the enactment of this Act.

3 (2) DISCRETE SINGLE-USE UNITS AND PROC-
4 ESSED TOBACCO.—The amendments made by sub-
5 sections (c)(1)(C), (c)(2), and (f) shall apply to arti-
6 cles removed (as defined in section 5702(j) of the
7 Internal Revenue Code of 1986) after the date that
8 is 6 months after the date of the enactment of this
9 Act.

10 (3) LARGE CIGARS.—The amendments made by
11 subsection (e) shall apply to articles removed after
12 December 31, 2019.

13 (4) OTHER TOBACCO PRODUCTS.—The amend-
14 ments made by subsection (g)(1) shall apply to prod-
15 ucts removed after the last day of the month which
16 includes the date that the Secretary of the Treasury
17 (or the Secretary of the Treasury’s delegate) issues
18 final regulations establishing the level of tax for
19 such product.

○