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S. 916

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

IN THE SENATE OF THE UNITED STATES

MARCH 27, 2019

Mr. DURBIN (for himself, Ms. DUCKWORTH, Mr. BLUMENTHAL, Mr. VAN HOLLEN, Mr. MERKLEY, Mr. BROWN, Mr. SANDERS, Ms. SMITH, and Mr. KING) introduced the following bill; which was read twice and referred to the Committee on Finance

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,*

3 **SECTION 1. SHORT TITLE.**

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

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1 (1) Every year, across the United States,
2 4,000,000 women give birth, about 700 women suf-
3 fer fatal complications during pregnancy, while giv-
4 ing birth or during the postpartum period, and
5 70,000 women suffer near-fatal, partum-related
6 complications.

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

20 (3) International studies estimate the 2015 ma-
21 ternal mortality rate in the United States as 26.4
22 per 100,000 live births, which is almost twice the
23 2015 World Health Organization estimation of 14
24 per 100,000 live births.

1 (4) It is estimated that more than 60 percent
2 of maternal deaths in the United States are prevent-
3 able.

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

15 (6) African-American women are 3 to 4 times
16 more likely to die from causes related to pregnancy
17 and childbirth compared to non-Hispanic White
18 women.

19 (7) The findings described in paragraphs (1)
20 through (6) are of major concern to researchers,
21 academics, members of the business community, and
22 providers across the obstetrical continuum rep-
23 resented by organizations such as March of Dimes;
24 the Preeclampsia Foundation; the American College
25 of Obstetricians and Gynecologists; the Society for

1 Maternal-Fetal Medicine; the Association of Women's Health, Obstetric, and Neonatal Nurses; the
2 California Maternal Quality Care Collaborative;
3 Black Women's Health Imperative; the National
4 Birth Equity Collaborative; Black Mamas Matter Alliance; EverThrive Illinois; the National Association
5 of Certified Professional Midwives; PCOS Challenge:
6 The National Polycystic Ovary Syndrome Association;
7 and the American College of Nurse Midwives.

10 (8) Hemorrhage, cardiovascular and coronary
11 conditions, cardiomyopathy, infection, embolism,
12 mental health conditions, preeclampsia and eclampsia,
13 polycystic ovary syndrome, infection and sepsis,
14 and anesthesia complications are the predominant
15 medical causes of maternal-related deaths and complications.
16 Most of these conditions are largely preventable or manageable.
17

18 (9) Oral health is an important part of
19 perinatal health. Reducing bacteria in a woman's
20 mouth during pregnancy can significantly reduce her
21 risk of developing oral diseases and spreading decay-causing
22 bacteria to her baby. Moreover, some evidence suggests that women with periodontal disease
23 during pregnancy could be at greater risk for poor
24 birth outcomes, such as preeclampsia, pre-term
25

1 birth, and low-birth weight. Furthermore, a woman's
2 oral health during pregnancy is a good predictor of
3 her newborn's oral health, and since mothers can
4 unintentionally spread oral bacteria to their babies,
5 putting their children at higher risk for tooth decay,
6 prevention efforts should happen even before chil-
7 dren are born, as a matter of pre-pregnancy health
8 and prenatal care during pregnancy.

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

17 (11) In the United States, death reporting and
18 analysis is a State function rather than a Federal
19 process. States report all deaths—including mater-
20 nal deaths—on a semi-voluntary basis, without
21 standardization across States. While the Centers for
22 Disease Control and Prevention has the capacity and
23 system for collecting death-related data based on
24 death certificates, these data are not sufficiently re-
25 ported by States in an organized and standard for-

1 mat across States such that the Centers for Disease
2 Control and Prevention is able to identify causes of
3 maternal death and best practices for the prevention
4 of such death.

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

1 networks, and research institutions keep the Nation
2 in the dark about ways to prevent maternal deaths.

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

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

1 (15) The United Nations’ Millennium Develop-
2 ment Goal 5a aimed to reduce by 75 percent, be-
3 tween 1990 and 2015, the maternal mortality rate,
4 yet this metric has not been achieved. In fact, the
5 maternal mortality rate in the United States has
6 been estimated to have more than doubled between
7 2000 and 2014. Yet, because national data are not
8 fully available, the United States does not have an
9 official maternal mortality rate.

10 (16) Many States have struggled to establish or
11 maintain Maternal Mortality Review Committees
12 (referred to in this section as “MMRC”). On the
13 State level, MMRCs have lagged because States have
14 not had the resources to mount local reviews. State-
15 level reviews are necessary as only the State depart-
16 ments of health have the authority to request med-
17 ical records, autopsy reports, and police reports crit-
18 ical to the function of the MMRC.

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

1 has been able to reduce its incidence of preeclampsia
2 to less than one in 10,000 women—its lowest rate
3 since 1952.

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

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

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

22 (20) The Centers for Disease Control and Pre-
23 vention reports that nearly half of all maternal
24 deaths occur in the immediate postpartum period—
25 the 42 days following a pregnancy—whereas more

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

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

17 (22) A growing body of evidence-based research
18 has shown the correlation between the stress associ-
19 ated with one's race—the stress of racism—and
20 one's birthing outcomes. The stress of sex and race
21 discrimination and institutional racism has been
22 demonstrated to contribute to a higher risk of ma-
23 ternal mortality, irrespective of one's gestational
24 age, maternal age, socioeconomic status, or indi-
25 vidual-level health risk factors, including poverty,

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

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

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

20 (25) Compared to women from other racial and
21 ethnic demographics, African-American women
22 across the socioeconomic spectrum experience pro-
23 longed, unrelenting stress related to racial and gen-
24 der discrimination, contributing to higher rates of
25 maternal mortality, giving birth to low-weight ba-

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

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

15 (27) Racism is deeply ingrained in United
16 States systems, including in health care delivery sys-
17 tems between patients and providers, often resulting
18 in disparate treatment for pain, irreverence for cul-
19 tural norms with respect to health, and
20 dismissiveness. Research has demonstrated that pa-
21 tients respond more warmly and adhere to medical
22 treatment plans at a higher degree with providers of
23 the same race or ethnicity or with providers with
24 great ability to exercise empathy. However, the pro-
25 vider pool is not primed with many people of color,

1 nor are providers (whether student-doctors in train-
2 ing or licensed practitioners) consistently required to
3 undergo implicit bias, cultural competency, or empa-
4 thy training on a consistent, on-going basis.

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

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

20 (b) BEST PRACTICES RELATING TO PREVENTION OF
21 MATERNAL MORTALITY.—

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

24 (A) the Director, in consultation with rel-
25 evant patient and provider groups, shall issue

1 best practices to State maternal mortality re-
2 view committees on how best to identify and re-
3 view maternal mortality cases, taking into ac-
4 count any data made available by States relat-
5 ing to maternal mortality, including data on
6 oral, mental, and breastfeeding health, and uti-
7 lization of any emergency services; and

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

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

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

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

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

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

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

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

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

24 (B) demonstrate in such application that
25 the entity is an interdisciplinary, multi-stake-

1 holder, national organization with a national
2 data-driven maternal safety and quality im-
3 provement initiative based on implementation
4 approaches that have been proven to improve
5 maternal safety and outcomes in the United
6 States.

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

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

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

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

1 ducted by a State maternal mortality re-
2 view committee; and

3 (ii) address topics such as—

4 (I) obstetric hemorrhage;

5 (II) maternal mental health;

6 (III) the maternal venous system;

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

10 (V) postpartum care basics for
11 maternal safety;

12 (VI) reduction of peripartum ra-
13 cial and ethnic disparities;

14 (VII) reduction of primary cae-
15 sarean birth;

16 (VIII) severe hypertension in
17 pregnancy;

18 (IX) severe maternal morbidity
19 reviews;

20 (X) support after a severe mater-
21 nal morbidity event;

22 (XI) thromboembolism;

23 (XII) optimization of support for
24 breastfeeding; and

25 (XIII) maternal oral health; and

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

5 (4) MATERNAL SAFETY BUNDLE DEFINED.—
6 For purposes of this subsection, the term “maternal
7 safety bundle” means standardized, evidence-in-
8 formed processes for maternal health care.

9 (5) AUTHORIZATION OF APPROPRIATIONS.—For
10 purposes of carrying out this subsection, there is au-
11 thorized to be appropriated \$10,000,000 for each of
12 fiscal years 2019 through 2023.

13 (d) FUNDING FOR STATE-BASED PERINATAL QUAL-
14 ITY COLLABORATIVES DEVELOPMENT AND SUSTAIN-
15 ABILITY.—

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

1 perinatal quality collaboratives in every State, the
2 District of Columbia, and eligible territories, in
3 order to measurably improve perinatal care and
4 perinatal health outcomes for pregnant and
5 postpartum women and their infants.

6 (2) GRANT AMOUNTS.—Grants awarded under
7 this subsection shall be in amounts not to exceed
8 \$250,000 per year, for the duration of the grant pe-
9 riod.

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

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

19 (B) work with hospital-based or outpatient
20 facility-based clinical teams, experts, and stake-
21 holders, including patients and families, to
22 spread best practices and optimize resources to
23 improve perinatal care and outcomes;

24 (C) employ strategies that include the use
25 of the collaborative learning model to provide

1 opportunities for hospitals and clinical teams to
 2 collaborate on improvement strategies, rapid-re-
 3 sponse data to provide timely feedback to hos-
 4 pital and other clinical teams to track progress,
 5 and quality improvement science to provide sup-
 6 port and coaching to hospital and clinical
 7 teams; and

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

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

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

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

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

22 (i) in subsection (a)(4)—

23 (I) by striking “; and (D)” and
 24 inserting “; (D)”; and

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

6 (ii) by adding at the end the following
 7 new subsection:

8 “(ee) ORAL HEALTH SERVICES FOR PREGNANT AND
 9 POSTPARTUM WOMEN.—

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

18 “(2) COVERAGE REQUIREMENTS.—To satisfy
 19 the requirement to provide oral health services for
 20 pregnant and postpartum women, a State shall, at
 21 a minimum, provide coverage for preventive, diag-
 22 nostic, periodontal, and restorative care consistent
 23 with recommendations for perinatal oral health care
 24 and dental care during pregnancy from the Amer-

1 ican Academy of Pediatric Dentistry and the Amer-
 2 ican College of Obstetricians and Gynecologists.”.

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

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

12 (A) in subsection (e)—

13 (i) in paragraph (5)—

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

20 (II) by striking “60-day” and in-
 21 sserting “1-year”; and

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

24 (B) in subsection (l)(1)(A), by striking
 25 “60-day” and inserting “1-year”.

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

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

11 (5) MAINTENANCE OF EFFORT.—

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

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

1 that are more restrictive than the eligibility standards,
2 methodologies, or procedures, respectively, under such
3 plan or waiver that are in effect on the date of enactment
4 of this paragraph.”.

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

9 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
10 GETED LOW-INCOME PREGNANT WOMEN.—During
11 the period that begins on the date of enactment of
12 this paragraph and ends on the date that is five
13 years after such date of enactment, as a condition
14 of receiving payments under subsection (a) and sec-
15 tion 1903(a), a State that elects to provide assist-
16 ance to women on the basis of being pregnant (in-
17 cluding pregnancy-related assistance provided to tar-
18 geted low-income pregnant women (as defined in
19 section 2112(d)), pregnancy-related assistance pro-
20 vided to women who are eligible for such assistance
21 through application of section 1902(v)(4)(A)(i)
22 under section 2107(e)(1), or any other assistance
23 under the State child health plan (or a waiver of
24 such plan) which is provided to women on the basis
25 of being pregnant) shall not have in effect, with re-

1 spect to such women, eligibility standards, meth-
2 odologies, or procedures under such plan (or waiver)
3 that are more restrictive than the eligibility stand-
4 ards, methodologies, or procedures, respectively,
5 under such plan (or waiver) that are in effect on the
6 date of enactment of this paragraph.”.

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

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

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

21 (C) the availability of different kinds of
22 benefits for pregnant and postpartum women,
23 including oral health and mental health bene-
24 fits, under such programs.

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

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

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

9 (ii) by adding at the end the fol-
10 lowing:

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

22 “(1) 100 percent for the first 20 calendar quar-
23 ters during which this subsection is in effect; and

24 “(2) 90 percent for calendar quarters there-
25 after.”.

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

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

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

4 “(B) 90 percent for calendar quarters
5 thereafter.”.

6 (8) EFFECTIVE DATE.—

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

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

1 beginning after the close of the first regular
2 session of the State legislature that begins after
3 the date of enactment of this Act. For purposes
4 of the previous sentence, in the case of a State
5 that has a 2-year legislative session, each year
6 of the session shall be considered to be a sepa-
7 rate regular session of the State legislature.

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

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

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

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

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

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

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

23 “(c) DIVERSITY.—In awarding a cooperative agree-
24 ment under subsection (a), the Secretary shall take into
25 account any regional differences among eligible entities

1 and make an effort to ensure geographic diversity among
2 award recipients.

3 “(d) DISSEMINATION OF INFORMATION.—

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

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

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

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

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
23 purposes of carrying out this section, there is authorized
24 to be appropriated \$5,000,000 for each of fiscal years
25 2019 through 2023.”.

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

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

8 “(ii) WOMEN.—

9 “(I) BREASTFEEDING WOMEN.—
 10 A State”;

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

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

15 “(II) POSTPARTUM WOMEN.—A
 16 State may elect to certify a
 17 postpartum woman for a period of 2
 18 years.”.

19 (h) DEFINITIONS.—In this section:

20 (1) MATERNAL MORTALITY.—The term “mater-
 21 nal mortality” means death of a woman that occurs
 22 during pregnancy or within the one-year period fol-
 23 lowing the end of such pregnancy.

24 (2) SEVERE MATERNAL MORBIDITY.—The term
 25 “severe maternal morbidity” includes unexpected

1 outcomes of labor and delivery that result in signifi-
 2 cant short-term or long-term consequences to a
 3 woman’s health.

4 **SEC. 4. INCREASING EXCISE TAXES ON CIGARETTES AND**
 5 **ESTABLISHING EXCISE TAX EQUITY AMONG**
 6 **ALL TOBACCO PRODUCT TAX RATES.**

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

10 (b) TAX PARITY FOR PIPE TOBACCO.—Section
 11 5701(f) of the Internal Revenue Code of 1986 is amended
 12 by striking “\$2.8311 cents” and inserting “\$49.56”.

13 (c) TAX PARITY FOR SMOKELESS TOBACCO.—

14 (1) Section 5701(e) of the Internal Revenue
 15 Code of 1986 is amended—

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

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

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

21 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
 22 SINGLE-USE UNITS.—On discrete single-use units,
 23 \$100.66 per thousand.”.

24 (2) Section 5702(m) of such Code is amend-
 25 ed—

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

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

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

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

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

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

15 (d) TAX PARITY FOR SMALL CIGARS.—Paragraph
16 (1) of section 5701(a) of the Internal Revenue Code of
17 1986 is amended by striking “\$50.33” and inserting
18 “\$100.66”.

19 (e) TAX PARITY FOR LARGE CIGARS.—

20 (1) IN GENERAL.—Paragraph (2) of section
21 5701(a) of the Internal Revenue Code of 1986 is
22 amended by striking “52.75 percent” and all that
23 follows through the period and inserting the fol-
24 lowing: “\$49.56 per pound and a proportionate tax

1 at the like rate on all fractional parts of a pound but
2 not less than 10.066 cents per cigar.”.

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

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

17 (g) CLARIFYING TAX RATE FOR OTHER TOBACCO
18 PRODUCTS.—

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

22 “(i) OTHER TOBACCO PRODUCTS.—Any product not
23 otherwise described under this section that has been deter-
24 mined to be a tobacco product by the Food and Drug Ad-
25 ministration through its authorities under the Family

1 Smoking Prevention and Tobacco Control Act shall be
2 taxed at a level of tax equivalent to the tax rate for ciga-
3 rettes on an estimated per use basis as determined by the
4 Secretary.”.

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

16 (h) CLARIFYING DEFINITION OF TOBACCO PROD-
17 UCTS.—

18 (1) IN GENERAL.—Subsection (c) of section
19 5702 of the Internal Revenue Code of 1986 is
20 amended to read as follows:

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

23 “(1) cigars, cigarettes, smokeless tobacco, pipe
24 tobacco, and roll-your-own tobacco, and

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

3 (2) CONFORMING AMENDMENTS.—Subsection
4 (d) of section 5702 of such Code is amended by
5 striking “cigars, cigarettes, smokeless tobacco, pipe
6 tobacco, or roll-your-own tobacco” each place it ap-
7 pears and inserting “tobacco products”.

8 (i) INCREASING TAX ON CIGARETTES.—

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

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

15 (j) TAX RATES ADJUSTED FOR INFLATION.—Section
16 5701 of such Code, as amended by subsection (g), is
17 amended by adding at the end the following new sub-
18 section:

19 “(j) INFLATION ADJUSTMENT.—

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

24 “(A) such dollar amount, multiplied by

1 “(B) the cost-of-living adjustment deter-
2 mined under section 1(f)(3) for the calendar
3 year, determined by substituting ‘calendar year
4 2017’ for ‘calendar year 2016’ in subparagraph
5 (A)(ii) thereof.

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

10 (k) FLOOR STOCKS TAXES.—

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

17 (A) the tax which would be imposed under
18 section 5701 of the Internal Revenue Code of
19 1986 on the article if the article had been re-
20 moved on such date, over

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

23 (2) CREDIT AGAINST TAX.—Each person shall
24 be allowed as a credit against the taxes imposed by
25 paragraph (1) an amount equal to \$500. Such credit

1 shall not exceed the amount of taxes imposed by
2 paragraph (1) on such date for which such person
3 is liable.

4 (3) LIABILITY FOR TAX AND METHOD OF PAY-
5 MENT.—

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

10 (B) METHOD OF PAYMENT.—The tax im-
11 posed by paragraph (1) shall be paid in such
12 manner as the Secretary shall prescribe by reg-
13 ulations.

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

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

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

6 (B) such article is held on such date under
7 the supervision of an officer of the United
8 States Customs and Border Protection of the
9 Department of Homeland Security pursuant to
10 the 2d proviso of such section 3(a).

11 (5) DEFINITIONS.—For purposes of this sub-
12 section—

13 (A) IN GENERAL.—Any term used in this
14 subsection which is also used in section 5702 of
15 such Code shall have the same meaning as such
16 term has in such section.

17 (B) TAX INCREASE DATE.—The term “tax
18 increase date” means the effective date of any
19 increase in any tobacco product excise tax rate
20 pursuant to the amendments made by this sec-
21 tion (other than subsection (j) thereof).

22 (C) SECRETARY.—The term “Secretary”
23 means the Secretary of the Treasury or the
24 Secretary’s delegate.

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

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

15 (1) EFFECTIVE DATES.—

16 (1) IN GENERAL.—Except as provided in para-
17 graphs (2) through (4), the amendments made by
18 this section shall apply to articles removed (as de-
19 fined in section 5702(j) of the Internal Revenue
20 Code of 1986) after the last day of the month which
21 includes the date of the enactment of this Act.

22 (2) DISCRETE SINGLE-USE UNITS AND PROC-
23 ESSED TOBACCO.—The amendments made by sub-
24 sections (c)(1)(C), (c)(2), and (f) shall apply to arti-
25 cles removed (as defined in section 5702(j) of the

1 Internal Revenue Code of 1986) after the date that
2 is 6 months after the date of the enactment of this
3 Act.

4 (3) LARGE CIGARS.—The amendments made by
5 subsection (e) shall apply to articles removed after
6 December 31, 2019.

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

○