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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

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A BILL

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

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

SECTION 1. SHORT TITLE.

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

SEC. 2. FINDINGS.

Congress finds the following:

(1) Every year, across the United States, 4,000,000 women give birth, about 700 women suffer fatal complications during pregnancy, while giving birth or during the postpartum period, and 70,000 women suffer near-fatal, partum-related complications.

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

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

(4) It is estimated that more than 60 percent of maternal deaths in the United States are preventable.

(5) According to the Centers for Disease Control and Prevention, the maternal mortality rate varies drastically for women by race and ethnicity. There are 12.7 deaths per 100,000 live births for White women, 43.5 deaths per 100,000 live births for African-American women, and 14.4 deaths per 100,000 live births for women of other ethnicities. While maternal mortality disparately impacts African-American women, this urgent public health crisis traverses race, ethnicity, socioeconomic status, educational background, and geography.

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

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

academics, members of the business community, and providers across the obstetrical continuum represented by organizations such as March of Dimes; the Preeclampsia Foundation; the American College of Obstetricians and Gynecologists; the Society for Maternal-Fetal Medicine; the Association of Women's Health, Obstetric, and Neonatal Nurses; the California Maternal Quality Care Collaborative; Black Women's Health Imperative; the National Birth Equity Collaborative; Black Mamas Matter Alliance; EverThrive Illinois; the National Association of Certified Professional Midwives; PCOS Challenge: The National Polycystic Ovary Syndrome Association; and the American College of Nurse Midwives.

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

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

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

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

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

standardization across States. While the Centers for Disease Control and Prevention has the capacity and system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and standard format across States such that the Centers for Disease Control and Prevention is able to identify causes of maternal death and best practices for the prevention of such death.

(12) Vital statistics systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetrical providers or persons trained to recognize pregnancy-related mortality. Thus, these vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute

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

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

(14) Leaders in maternal wellness highly recommend that maternal deaths be investigated at the State level first, and that standardized, streamlined, de-identified data regarding maternal deaths be sent annually to the Centers for Disease Control and Prevention. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries of the Centers for Disease Control and Prevention and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortalities and morbidities registry and surveillance system would help providers, academicians, lawmakers, 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

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

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

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

(19) Hospitals and health systems across the United States lack standardization of emergency obstetrical protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetrical emergency that does not consider both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based maternal quality collaborative organizations, such as the California Maternal Quality Care Collaborative or entities participating in the Alliance for Innovation on Maternal Health (AIM), have formed obstetrical protocols, tool kits, and other resources to improve system care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia.

(20) The Centers for Disease Control and Prevention reports that nearly half of all maternal

deaths occur in the immediate postpartum period—the 42 days following a pregnancy—whereas more than one-third of pregnancy-related or pregnancy-associated deaths occur while a person is still pregnant. Yet, for women eligible for the Medicaid program on the basis of pregnancy, such Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

(21) The experience of serious traumatic events, such as being exposed to domestic violence, substance use disorder, or pervasive racism, can over-activate the body's stress-response system. Known as toxic stress, the repetition of high-doses of cortisol to the brain, can harm healthy neurological development, which can have cascading physical and mental health consequences, as documented in the Adverse Childhood Experiences study of the Centers for Disease Control and Prevention.

(22) A growing body of evidence-based research has shown the correlation between the stress associated with one's race—the stress of racism—and one's birthing outcomes. The stress of sex and race discrimination and institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational

age, maternal age, socioeconomic status, or individual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). African-American women remain the most at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example, which is related to obesity, African-American women of normal weight remain the most at risk of dying during the perinatal period compared to non-African-American obese women.

(23) The rising maternal mortality rate in the United States is driven predominantly by the disproportionately high rates of African-American maternal mortality.

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

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

der discrimination, contributing to higher rates of maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress often extends across the life course and is situated in everyday spaces where African-American women establish livelihood. Structural barriers, lack of access to care, and genetic predispositions to health vulnerabilities exacerbate African-American women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

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

(27) Racism is deeply ingrained in United States systems, including in health care delivery systems between patients and providers, often resulting in disparate treatment for pain, irreverence for cultural norms with respect to health, and dismissiveness. Research has demonstrated that patients respond more warmly and adhere to medical treatment plans at a higher degree with providers of the same race or ethnicity or with providers with

great ability to exercise empathy. However, the provider pool is not primed with many people of color, nor are providers (whether student-doctors in training or licensed practitioners) consistently required to undergo implicit bias, cultural competency, or empathy training on a consistent, on-going basis.

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

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

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

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

(A) the Director, in consultation with relevant patient and provider groups, shall issue best practices to State maternal mortality review committees on how best to identify and review maternal mortality cases, taking into account any data made available by States relating to maternal mortality, including data on oral, mental, and breastfeeding health, and utilization of any emergency services; and

(B) the Director, working in collaboration with the Health Resources and Services Administration, shall issue best practices to hospitals, State professional society groups, and perinatal quality collaboratives on how best to prevent maternal mortality.

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

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

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through

the Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration, shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of—

(A) directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams; and

(B) collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

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

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

(B) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder, national organization with a national data-driven maternal safety and quality improvement initiative based on implementation approaches that have been proven to improve maternal safety and outcomes in the United States.

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

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

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

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

factoring in the results and findings of relevant data reviews, such as reviews conducted by a State maternal mortality review committee; and

(ii) address topics such as—

(I) obstetric hemorrhage;

(II) maternal mental health;

(III) the maternal venous system;

(IV) obstetric care for women with substance use disorders, including opioid use disorder;

(V) postpartum care basics for maternal safety;

(VI) reduction of peripartum racial and ethnic disparities;

(VII) reduction of primary caesarean birth;

(VIII) severe hypertension in pregnancy;

(IX) severe maternal morbidity reviews;

(X) support after a severe maternal morbidity event;

(XI) thromboembolism;

(XII) optimization of support for breastfeeding; and

(XIII) maternal oral health; and

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

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

(5) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2019 through 2023.

(d) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

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

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

(2) GRANT AMOUNTS.—Grants awarded under this subsection shall be in amounts not to exceed $250,000 per year, for the duration of the grant period.

(3) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this subsection, the term ''State-based perinatal quality collaborative'' means a network of multidisciplinary teams that—

(A) work to improve measurable outcomes for maternal and infant health by advancing evidence-informed clinical practices using quality improvement principles;

(B) work with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, 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-response data to provide timely feedback to hospital and other clinical teams to track progress, and quality improvement science to provide support 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 authorized 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 Social Security Act (42 U.S.C. 1396d) is amended—

(i) in subsection (a)(4)—

(I) by striking ''; and (D)'' and inserting ''; (D)''; and

(II) by inserting ''; and (E) oral health services for pregnant and postpartum women (as defined in subsection (ee))'' after ''subsection (bb))''; and

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

''(ee) ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

''(1) IN GENERAL.—For purposes of this title, the term 'oral health services for pregnant and postpartum women' means dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions that are furnished to a woman during pregnancy (or during the 1-year period beginning on the last day of the pregnancy).

''(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health services for pregnant and postpartum women, a State shall, at a minimum, provide coverage for preventive, diagnostic, periodontal, and restorative care consistent

with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.''.

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

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

(A) in subsection (e)—

(i) in paragraph (5)—

(I) by inserting ''(including oral health services for pregnant and postpartum women (as defined in section 1905(ee))'' after ''postpartum medical assistance under the plan''; and

(II) by striking ''60-day'' and inserting ''1-year''; and

(ii) in paragraph (6), by striking ''60-day'' and inserting ''1-year''; and

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

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

(4) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(5) MAINTENANCE OF EFFORT.—

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

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

nant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver that are in effect on the date of enactment of this paragraph.''.

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

''(4) IN ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to women on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant women (as defined in section 2112(d)), pregnancy-related assistance provided to women who are eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of

such plan) which is provided to women on the basis of being pregnant) shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under such plan (or waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(6) INFORMATION ON BENEFITS.—The Secretary of Health and Human Services shall make publicly available on the Internet website of the Department of Health and Human Services, information regarding benefits available to pregnant and postpartum women and under the Medicaid program and the Children's Health Insurance Program, including information on—

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

(B) optional benefits that States may provide to pregnant and postpartum women under such programs; and

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

including oral health and mental health benefits, under such programs.

(7) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM WOMEN.—

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (1), is further amended—

(i) in subsection (b), by striking ''and (aa)'' and inserting ''(aa), and (ff)''; and

(ii) by adding at the end the following:

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

''(1) 100 percent for the first 20 calendar quarters during which this subsection is in effect; and

''(2) 90 percent for calendar quarters thereafter.''.

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

''(12) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT WOMEN.—Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a woman who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant woman (as defined in section 2112(d)), pregnancy-related assistance provided to a woman who is eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a woman who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided

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

"(A) 100 percent for the first 20 calendar quarters during which this paragraph is in effect; and

"(B) 90 percent for calendar quarters thereafter.".

(8) EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is one year after the date of enactment of this Act.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its fail-

ure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

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

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

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias and cultural competency in patient-provider interactions education for the purpose of enhancing and improving how health care pro-

fessionals are educated in implicit bias and delivering culturally competent health care.

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

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care professionals, which may be a health system, teaching hospital, community health center, medical school, school of public health, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) focused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

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

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

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

''(d) DISSEMINATION OF INFORMATION.—

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

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

''(3) DISTRIBUTION.—The Secretary shall share evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

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

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

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

(1) by striking the clause designation and heading and all that follows through ''A State'' and inserting the following:

''(ii) WOMEN.—

''(I) BREASTFEEDING WOMEN.—A State'';

(2) in subclause (I) (as so designated), by striking ''1 year'' and all that follows through ''earlier'' and inserting ''2 years postpartum''; and

(3) by adding at the end the following:

''(II) POSTPARTUM WOMEN.—A State may elect to certify a postpartum woman for a period of 2 years.''.

(h) DEFINITIONS.—In this section:

(1) MATERNAL MORTALITY.—The term ''maternal mortality'' means death of a woman that occurs

during pregnancy or within the one-year period following the end of such pregnancy.

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

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

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

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

(c) TAX PARITY FOR SMOKELESS TOBACCO.—

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

(A) in paragraph (1), by striking ''$1.51'' and inserting ''$26.84'';

(B) in paragraph (2), by striking ''50.33 cents'' and inserting ''$10.74''; and

(C) by adding at the end the following:

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

(2) Section 5702(m) of such Code is amended—

(A) in paragraph (1), by striking ''or chewing tobacco'' and inserting '', chewing tobacco, or discrete single-use unit'';

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

(C) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked; and

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

(d) TAX PARITY FOR SMALL CIGARS.—Paragraph (1) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(e) TAX PARITY FOR LARGE CIGARS.—

(1) IN GENERAL.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''52.75 percent'' and all that follows through the period and inserting the following: ''$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.''.

(2) GUIDANCE.—The Secretary of the Treasury, or the Secretary's delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

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

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

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

''(i) OTHER TOBACCO PRODUCTS.—Any product not otherwise described under this section that has been determined to be a tobacco product by the Food and Drug Administration through its authorities under the Family Smoking Prevention and Tobacco Control Act shall be taxed at a level of tax equivalent to the tax rate for cigarettes on an estimated per use basis as determined by the Secretary.''.

(2) ESTABLISHING PER USE BASIS.—For purposes of section 5701(i) of the Internal Revenue Code of 1986, not later than 12 months after the later of the date of the enactment of this Act or the date that a product has been determined to be a tobacco product by the Food and Drug Administration, the Secretary of the Treasury (or the Secretary of the Treasury's delegate) shall issue final regulations establishing the level of tax for such product that is equivalent to the tax rate for cigarettes on an estimated per use basis.

(h) CLARIFYING DEFINITION OF TOBACCO PRODUCTS.—

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

''(c) TOBACCO PRODUCTS.—The term 'tobacco products' means—

''(1) cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco, and

''(2) any other product subject to tax pursuant to section 5701(i).''.

(2) CONFORMING AMENDMENTS.—Subsection (d) of section 5702 of such Code is amended by striking ''cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco'' each place it appears and inserting ''tobacco products''.

(i) INCREASING TAX ON CIGARETTES.—

(1) SMALL CIGARETTES.—Section 5701(b)(1) of such Code is amended by striking ''$50.33'' and inserting ''$100.66''.

(2) LARGE CIGARETTES.—Section 5701(b)(2) of such Code is amended by striking ''$105.69'' and inserting ''$211.38''.

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

''(j) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any calendar year beginning after 2018, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2017' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $0.01, such amount shall be rounded to the next highest multiple of $0.01.''.

(k) FLOOR STOCKS TAXES.—

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

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

1986 on the article if the article had been removed on such date, over

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

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

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products on any tax increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act; or

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

(5) DEFINITIONS.—For purposes of this subsection—

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

(B) TAX INCREASE DATE.—The term ''tax increase date'' means the effective date of any

increase in any tobacco product excise tax rate pursuant to the amendments made by this section (other than subsection (j) thereof).

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

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

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

(l) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue

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

(2) DISCRETE SINGLE-USE UNITS AND PROCESSED TOBACCO.—The amendments made by subsections (c)(1)(C), (c)(2), and (f) shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the date that is 6 months after the date of the enactment of this Act.

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

(4) OTHER TOBACCO PRODUCTS.—The amendments made by subsection (g)(1) shall apply to products removed after the last day of the month which includes the date that the Secretary of the Treasury (or the Secretary of the Treasury's delegate) issues final regulations establishing the level of tax for such product.

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