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116TH CONGRESS
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H. R. 2902

To support States in their work to end preventable morbidity and mortality in maternity care by using evidence-based quality improvement to protect the health of mothers during pregnancy, childbirth, and in the postpartum period and to reduce neonatal and infant mortality, to eliminate racial disparities in maternal health outcomes, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 22, 2019

Ms. ADAMS (for herself, Mr. BUTTERFIELD, Mr. KHANNA, Ms. HAALAND, Mr. CLAY, Ms. JOHNSON of Texas, Ms. WILSON of Florida, Ms. SCHAKOWSKY, Mrs. BEATTY, Ms. BARRAGÁN, and Mr. CRIST) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To support States in their work to end preventable morbidity and mortality in maternity care by using evidence-based quality improvement to protect the health of mothers during pregnancy, childbirth, and in the postpartum period and to reduce neonatal and infant mortality, to eliminate racial disparities in maternal health outcomes, 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 ''Maternal Care Access and Reducing Emergencies Act'' or the ''Maternal CARE Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) In the United States, maternal mortality rates are among the highest in the developed world and increased by 26.6 percent between 2000 and 2014.

(2) Of the 4,000,000 American women who give birth each year, about 700 suffer fatal complications during pregnancy, while giving birth, or during the postpartum period, and an additional 50,000 are severely injured.

(3) It is estimated that about 60 percent of the maternal mortalities in the United States could be prevented and half of the maternal injuries in the United States could be reduced or eliminated with better care.

(4) Data from the Centers for Disease Control and Prevention show that Black women are 3 to 4 times more likely to die from pregnancy-related causes than White women. There are 42.8 deaths per 100,000 live births for Black women, compared to 13 deaths per 100,000 live births for White

women and 17.2 deaths per 100,000 live births for women nationally.

(5) Black women's risk of maternal mortality has remained higher than White women's risk for the past 6 decades.

(6) Black women in the United States suffer from life-threatening pregnancy complications twice as often as their White counterparts.

(7) High rates of maternal mortality among Black women span income and education levels, as well as socioeconomic status; moreover, risk factors such as a lack of access to prenatal care and physical health conditions do not fully explain the racial disparity in maternal mortality.

(8) A growing body of evidence indicates that stress from racism and racial discrimination results in conditions—including hypertension and pre-eclampsia—that contribute to poor maternal health outcomes among Black women.

(9) Pervasive racial bias against Black women and unequal treatment of Black women exist in the health care system, often resulting in inadequate treatment for pain and dismissal of cultural norms with respect to health. A 2016 study by University of Virginia researchers found that White medical

students and residents often believed biological myths about racial differences in patients, including that Black patients have less-sensitive nerve endings and thicker skin than their White counterparts. Providers, however, are not consistently required to undergo implicit bias, cultural competency, or empathy training.

(10) North Carolina has established a statewide Pregnancy Medical Home (PMH) program, which aims to reduce adverse maternal health outcomes and maternal deaths by incentivizing maternal health care providers to provide integral health care services to pregnant women and new mothers. According to the North Carolina Department of Health and Human Services Center for Health Statistics, the pregnancy-related mortality rate for Black women was approximately 5.1 times higher than that of White women in 2004. Almost a decade later, in 2013, the pregnancy-related mortality rates for Black women and White women were 24.3 and 24.2 deaths per 100,000 live births, respectively. The PMH program has been credited with the convergence in pregnancy-related mortality rates because the program partners each high-risk pregnant

and postpartum woman that is covered under Medicaid with a pregnancy care manager.

SEC. 3. DEFINITIONS.

In this Act:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(2) STATE.—The term ''State'' has the meaning given that term in section 1101 of the Social Security Act (42 U.S.C. 1301) for purposes of title XIX of that Act (42 U.S.C. 1396 et seq.).

SEC. 4. IMPLICIT BIAS TRAINING FOR HEALTH CARE PROVIDERS.

(a) GRANT PROGRAM.—The Secretary shall establish a grant program under which such Secretary awards grants to accredited schools of allopathic medicine, accredited schools of osteopathic medicine, accredited nursing schools, other health professional training programs, and other entities for the purpose of supporting implicit bias training, with priority given to such training with respect to obstetrics and gynecology.

(b) COLLABORATION REQUIRED.—In developing requirements for implicit bias training carried out with grant funds awarded under this section, the Secretary shall collaborate with relevant stakeholders that specialize in addressing health equity, including—

(1) health care providers who serve pregnant women, including doctors, nurses, and midwives;

(2) academic institutions, including schools and training programs described in subsection (a);

(3) community-based health workers, including perinatal health workers, doulas, and home visitors; and

(4) community-based organizations.

(c) IMPLICIT BIAS TRAINING DEFINED.—In this section, the term ''implicit bias training'' means evidence-based, on-going professional development and support, with respect to—

(1) bias in judgment or behavior that results from subtle cognitive processes, including implicit attitudes and implicit stereotypes, that often operate at a level below conscious awareness and without intentional control; or

(2) implicit attitudes and stereotypes that result in beliefs or simple associations that a person makes between an object and its evaluation that are automatically activated by the mere presence (actual or symbolic) of the attitude object.

(d) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to awarding grants to schools, programs, or entities located in or serv-

ing areas with the greatest needs, based such factors as the Secretary may consider, including racial disparities in maternal mortality and the incidence of severe maternal morbidity rates.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for purposes of carrying out the grant program under subsection (a), $5,000,000 for each of fiscal years 2020 through 2024.

SEC. 5. PREGNANCY MEDICAL HOME DEMONSTRATION PROJECT.

(a) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to States for the purpose of establishing or operating State pregnancy medical home programs that meet the requirements of subsection (b) to deliver integrated health care services to pregnant women and new mothers and reduce adverse maternal health outcomes, maternal deaths, and racial health disparities in maternal mortality and morbidity.

(b) STATE PREGNANCY MEDICAL HOME PROGRAM REQUIREMENTS.—A State pregnancy medical home program meets the requirements of this subsection if—

(1) the State works with relevant stakeholders to develop and carry out the program, including—

(A) State and local agencies responsible for Medicaid, public health, social services, mental

health, and substance abuse treatment and support;

(B) health care providers who serve pregnant women, including doctors, nurses, and midwives;

(C) community-based health workers, including perinatal health workers, doulas, and home visitors; and

(D) community-based organizations and individuals representing the communities with—

(i) the highest overall rates of maternal mortality and morbidity; and

(ii) the greatest racial disparities in rates of maternal mortality and morbidity;

(2) the State selects health care providers who serve pregnant women, including doctors, nurses, and midwives, to participate in the program as pregnancy medical homes, and requires that any provider that wishes to participate in the program as a pregnancy medical home—

(A) commits to following evidence-based practices for maternity care, as developed by the State in consultation with relevant stakeholders; and

(B) completes training to provide culturally and linguistically competent care;

(3) under the program, each pregnancy medical home is required to conduct a standardized medical, obstetric, and psychosocial risk assessment for every patient of the medical home who is pregnant at the patient's first prenatal appointment with the medical home;

(4) under the program, a care manager—

(A) is assigned to each pregnancy medical home; and

(B) coordinates care (including coordinating resources and referrals for health care and social services that are not available from the pregnancy medical home) for each patient of a pregnancy medical home who is eligible for services under the program; and

(5) the program prioritizes pregnant and postpartum women who are uninsured or enrolled in the State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a waiver of such plan.

(c) GRANTS.—

(1) LIMITATION.—The Secretary may award a grant under this section to up to 10 States.

(2) PERIOD.—Grants under this section shall be for a 5-year period.

(3) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to the States with the greatest racial disparities in maternal mortality and severe morbidity rates.

(d) REPORT ON GRANT IMPACT AND DISSEMINATION OF BEST PRACTICES.—Not later than 1 year after all the grant periods awarded under this section have ended, the Secretary shall—

(1) submit a report to Congress that describes—

(A) the impact of the grants awarded under this section on maternal and child health;

(B) best practices and models of care used by recipients of grants under this section; and

(C) obstacles faced by recipients of grants under this section in delivering care, improving maternal and child health, and reducing racial disparities in rates of maternal and infant mortality and morbidity; and

(2) disseminate information on best practices and models of care used by recipients of grants under this section (including best practices and models of care relating to the reduction of racial dispari-

ties in rates of maternal and infant mortality and morbidity) to interested parties, including health providers, medical schools, relevant State and local agencies, and the general public.

(e) AUTHORIZATION.—There are authorized to be appropriated to carry out this section, $25,000,000 for each of fiscal years 2020 through 2024, to remain available until expended.

SEC. 6. NATIONAL ACADEMY OF MEDICINE STUDY.

(a) IN GENERAL.—The Secretary shall enter into an arrangement with the National Academy of Medicine under which the National Academy agrees to study and make recommendations for incorporating bias recognition in clinical skills testing for accredited schools of allopathic medicine and accredited schools of osteopathic medicine.

(b) REPORT.—The arrangement under subsection (a) shall provide for submission by the National Academy of Medicine to the Secretary and Congress, not later than 3 years after the date of enactment of this Act, of a report on the results of the study that includes such recommendations.

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