

117TH CONGRESS
1ST SESSION

H. R. 2556

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

APRIL 15, 2021

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

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.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Maternal Care Access
3 and Reducing Emergencies Act” or the “Maternal CARE
4 Act”.

5 **SEC. 2. FINDINGS.**

6 Congress finds the following:

7 (1) In the United States, maternal mortality
8 rates are among the highest in the developed world
9 and increased by 26.6 percent between 2000 and
10 2014.

11 (2) Of the 4,000,000 American women who give
12 birth each year, about 700 suffer fatal complications
13 during pregnancy, while giving birth, or during the
14 postpartum period, and an additional 50,000 are se-
15 verely injured.

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

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

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

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

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

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

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

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

1 students and residents often believed biological
2 myths about racial differences in patients, including
3 that Black patients have less-sensitive nerve endings
4 and thicker skin than their White counterparts. Pro-
5 viders, however, are not consistently required to un-
6 dergo implicit bias, cultural competency, or empathy
7 training.

8 (10) North Carolina has established a statewide
9 Pregnancy Medical Home (PMH) program, which
10 aims to reduce adverse maternal health outcomes
11 and maternal deaths by incentivizing maternal
12 health care providers to provide integral health care
13 services to pregnant women and new mothers. Ac-
14 cording to the North Carolina Department of Health
15 and Human Services Center for Health Statistics,
16 the pregnancy-related mortality rate for Black
17 women was approximately 5.1 times higher than
18 that of White women in 2004. Almost a decade
19 later, in 2013, the pregnancy-related mortality rates
20 for Black women and White women were 24.3 and
21 24.2 deaths per 100,000 live births, respectively.
22 The PMH program has been credited with the con-
23 vergence in pregnancy-related mortality rates be-
24 cause the program partners each high-risk pregnant

1 and postpartum woman that is covered under Med-
2 icaid with a pregnancy care manager.

3 **SEC. 3. DEFINITIONS.**

4 In this Act:

5 (1) SECRETARY.—The term “Secretary” means
6 the Secretary of Health and Human Services.

7 (2) STATE.—The term “State” has the mean-
8 ing given that term in section 1101 of the Social Se-
9 curity Act (42 U.S.C. 1301) for purposes of title
10 XIX of that Act (42 U.S.C. 1396 et seq.).

11 **SEC. 4. IMPLICIT BIAS TRAINING FOR HEALTH CARE PRO-**
12 **VIDERS.**

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

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

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

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

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

8 (4) community-based organizations.

9 (c) IMPLICIT BIAS TRAINING DEFINED.—In this sec-
10 tion, the term “implicit bias training” means evidence-
11 based, on-going professional development and support,
12 with respect to—

13 (1) bias in judgment or behavior that results
14 from subtle cognitive processes, including implicit at-
15 titudes and implicit stereotypes, that often operate
16 at a level below conscious awareness and without in-
17 tentional control; or

18 (2) implicit attitudes and stereotypes that result
19 in beliefs or simple associations that a person makes
20 between an object and its evaluation that are auto-
21 matically activated by the mere presence (actual or
22 symbolic) of the attitude object.

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

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

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated for purposes of carrying
7 out the grant program under subsection (a), \$5,000,000
8 for each of fiscal years 2022 through 2026.

9 **SEC. 5. PREGNANCY MEDICAL HOME DEMONSTRATION**
10 **PROJECT.**

11 (a) AUTHORITY TO AWARD GRANTS.—The Secretary
12 shall award grants to States for the purpose of estab-
13 lishing or operating State pregnancy medical home pro-
14 grams that meet the requirements of subsection (b) to de-
15 liver integrated health care services to pregnant women
16 and new mothers and reduce adverse maternal health out-
17 comes, maternal deaths, and racial health disparities in
18 maternal mortality and morbidity.

19 (b) STATE PREGNANCY MEDICAL HOME PROGRAM
20 REQUIREMENTS.—A State pregnancy medical home pro-
21 gram meets the requirements of this subsection if—

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

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

1 health, and substance abuse treatment and sup-
2 port;

3 (B) health care providers who serve preg-
4 nant women, including doctors, nurses, and
5 midwives;

6 (C) community-based health workers, in-
7 cluding perinatal health workers, doulas, and
8 home visitors; and

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

12 (i) the highest overall rates of mater-
13 nal mortality and morbidity; and

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

16 (2) the State selects health care providers who
17 serve pregnant women, including doctors, nurses,
18 and midwives, to participate in the program as preg-
19 nancy medical homes, and requires that any provider
20 that wishes to participate in the program as a preg-
21 nancy medical home—

22 (A) commits to following evidence-based
23 practices for maternity care, as developed by
24 the State in consultation with relevant stake-
25 holders; and

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

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

9 (4) under the program, a care manager—

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

12 (B) coordinates care (including coordi-
13 nating resources and referrals for health care
14 and social services that are not available from
15 the pregnancy medical home) for each patient
16 of a pregnancy medical home who is eligible for
17 services under the program; and

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

23 (c) GRANTS.—

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

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

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

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

11 (1) submit a report to Congress that de-
12 scribes—

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

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

17 (C) obstacles faced by recipients of grants
18 under this section in delivering care, improving
19 maternal and child health, and reducing racial
20 disparities in rates of maternal and infant mor-
21 tality and morbidity; and

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

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

5 (e) AUTHORIZATION.—There are authorized to be ap-
6 propriated to carry out this section, \$25,000,000 for each
7 of fiscal years 2022 through 2026, to remain available
8 until expended.

9 **SEC. 6. NATIONAL ACADEMY OF MEDICINE STUDY.**

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

16 (b) REPORT.—The arrangement under subsection (a)
17 shall provide for submission by the National Academy of
18 Medicine to the Secretary and Congress, not later than
19 3 years after the date of enactment of this Act, of a report
20 on the results of the study that includes such rec-
21 ommendations.

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