

115TH CONGRESS
2D SESSION

H. R. 5977

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

IN THE HOUSE OF REPRESENTATIVES

MAY 25, 2018

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

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:

9 (1) Every year, across the United States, four
10 million women give birth, about 700 women suffer

1 fatal complications during pregnancy, while giving
2 birth, or during the postpartum period, and 65,000
3 women suffer near-fatal, partum-related complica-
4 tions.

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

18 (3) International studies estimate the 2015
19 U.S. maternal mortality rate as 26.4 per 100,000
20 live births, which is almost twice the 2015 World
21 Health Organization (WHO) estimation of 14 per
22 100,000 live births.

23 (4) It is estimated that almost half of all mater-
24 nal mortalities in the United States are preventable.

1 (5) African-American women experience mater-
2 nal-related deaths at three to four times the rate of
3 non-Hispanic White women.

4 (6) The findings described in paragraphs (1)
5 through (5) are of major concern to researchers,
6 academicians, and epidemiologists at the Centers for
7 Disease Control and Prevention (CDC); providers
8 across the obstetrical continuum represented by or-
9 ganizations such as the Preeclampsia Foundation;
10 the American College of Obstetricians and Gyne-
11 cologists; the Association of Women’s Health, Ob-
12 stetric, and Neonatal Nurses; the California Mater-
13 nal Quality Care Collaborative; Black Women’s
14 Health Imperative; the National Birth Equity Col-
15 laborative; Black Mamas Matter Alliance; the Na-
16 tional Association of Certified Professional Midwives;
17 and the American College of Nurse Midwives.

18 (7) According to the CDC, the maternal mor-
19 tality rate varies drastically for women by race and
20 ethnicity. There are 12.7 deaths per 100,000 live
21 births for White women, 43.5 deaths per 100,000
22 live births for African-American women, and 14.4
23 deaths per 100,000 live births for women of other
24 ethnicities. While maternal mortality disparately im-
25 pacts African-American women, the phenomenon

1 traverses race, ethnicity, socioeconomic status, edu-
2 cational background, and geography.

3 (8) Hemorrhage, cardiovascular and coronary
4 conditions, cardiomyopathy, infection, embolism,
5 mental health conditions, preeclampsia and eclamp-
6 sia, infection or sepsis, and anesthesia complications
7 are the predominant causes of maternal-related
8 deaths and complications. Such conditions are large-
9 ly preventable or manageable.

10 (9) The United States has not been able to sub-
11 mit a formal maternal mortality rate to international
12 data repositories since 2007. Thus, no official ma-
13 ternal mortality rate exists for the Nation. There
14 can be no maternal mortality rate without stream-
15 lining maternal mortality-related data from the
16 State level and extrapolating such data to the Fed-
17 eral level.

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

1 standard format across States such that the CDC is
2 able to identify causes of maternal death and best
3 practices for the prevention of such death.

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

1 Nation in the dark about ways to prevent maternal
2 deaths.

3 (12) 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 (13) Leaders in maternal wellness highly rec-
9 ommend that maternal deaths be investigated at the
10 State level first. Then, have data regarding maternal
11 deaths be standardized across States, streamlined,
12 de-identified, and sent once a year to a federally su-
13 pervised database, managed by a Federal agency at
14 the discretion of the Secretary of Health and
15 Human Services. Such data standardization and col-
16 lection would be similar in operation and effect to
17 the National Program of Cancer Registries housed
18 at the CDC and akin to the Confidential Enquiry in
19 Maternal Deaths Programme in the United King-
20 dom. Such a maternal mortality and morbidities reg-
21 istry and surveillance would help providers, academi-
22 cians, lawmakers, and the public to address ques-
23 tions concerning the types of, causes of, and best
24 practices to thwart, pregnancy-related or pregnancy-
25 associated mortalities and morbidities.

1 (14) The United Nations' Millennium Develop-
2 ment Goal 5a aimed to reduce by three quarters, 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 (15) Many States have struggled to establish or
11 maintain Maternal Mortality Review Committees
12 (MMRC). On the State level, MMRCs have lagged
13 because States have not had the resources to mount
14 local reviews. State-level reviews are necessary as
15 only the State departments of health have the au-
16 thority to request medical records, autopsy reports,
17 and police reports critical to the function of the
18 MMRC.

19 (16) 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 their incidences of
2 preeclampsia to less than one in 10,000 women—its
3 lowest rate since 1952.

4 (17) 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 they
15 have determined the most prevalent causes of mater-
16 nal mortality and recorded and shared data with
17 providers and researchers, who have developed and
18 implemented safety bundles and care protocols re-
19 lated to preeclampsia, maternal hemorrhage, and the
20 like. In this way, the State of California has been
21 able to leverage its maternal mortality review board
22 system, generate data, and apply those data to effect
23 changes in maternal care-related protocol. To date,
24 the State of California has stymied its maternal

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

3 (18) 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 take into account both clin-
11 ical and public health approaches falls woefully
12 under the mark of excellent care delivery. State-
13 based maternal quality collaborative organizations,
14 including the Alliance for Innovation on Maternal
15 Health (AIMs) and California Maternal Quality
16 Care Collaborative, have formed obstetrical proto-
17 cols, tool kits, and other resources to improve system
18 care and response as they relate to maternal com-
19 plications and warning signs for such conditions as
20 maternal hemorrhage, hypertension, and
21 preeclampsia. State perinatal quality collaboratives
22 are working to identify health care processes that
23 need to be improved and use the best available meth-
24 ods to make those changes as quickly as possible,
25 while the Alliance for Innovation on Maternal

1 Health is working with States and health systems to
2 align national, State, and hospital level quality im-
3 provement efforts through the creation and dissemi-
4 nation of maternal safety bundles to improve overall
5 maternal health outcomes.

6 (19) The CDC reports that more than half of
7 all maternal deaths occur in the immediate
8 postpartum period—between 42 days up to a full
9 year—whereas more than one-third of pregnancy-re-
10 lated or pregnancy-associated deaths occur while a
11 person is still pregnant. Yet, for pregnant women,
12 Medicaid coverage lapses at the end of the month on
13 which the 60th postpartum day lands.

14 (20) A growing body of evidence-based research
15 has shown the correlation between the stress associ-
16 ated with one's race—the stress of racism—and
17 one's birthing outcomes. The stress of sex and race
18 discrimination and institutional racism has been
19 demonstrated to contribute to a higher risk of ma-
20 ternal mortality, irrespective of one's gestational
21 age, maternal age, socioeconomic status, or indi-
22 vidual-level health risk factors, including poverty,
23 limited access to prenatal care, and poor physical
24 and mental health (although these are not nominal
25 factors). African-American women remain the most

1 at risk for pregnancy-associated or pregnancy-re-
2 lated causes of death. When it comes to
3 preeclampsia, for example—which is related to obe-
4 sity—African-American women of normal weight re-
5 main the most at risk of dying during the perinatal
6 period compared to non-African-American obese
7 women.

8 (21) The rising U.S. maternal mortality rate is
9 predominantly driven by the disproportionately high
10 rates of African-American maternal mortality.

11 (22) African-American women are three to four
12 times more likely to die from pregnancy or maternal-
13 related distress than are White women, yielding one
14 of the greatest and most disconcerting racial dispari-
15 ties in public health.

16 (23) Compared to women from other racial and
17 ethnic demographics, African-American women
18 across the socioeconomic spectrum experience pro-
19 longed, unrelenting stress related to racial and gen-
20 der discrimination, contributing to higher rates of
21 maternal mortality, giving birth to low-weight ba-
22 bies, and experiencing pre-term birth. Racism is a
23 risk-factor for these aforementioned experiences.
24 This cumulative stress often extends across the life
25 course and is situated in everyday spaces where Afri-

1 can-American women establish livelihood. Structural
2 barriers, lack of access to care, and genetic pre-
3 dispositions to health vulnerabilities exacerbate Afri-
4 can-American women’s likelihood to experience poor
5 or fatal birthing outcomes, but do not fully account
6 for the great disparity.

7 (24) African-American women are twice as like-
8 ly to experience postpartum depression, and dis-
9 proportionately higher rates of preeclampsia com-
10 pared to White women.

11 (25) Racism is deeply ingrained in United
12 States systems, including in health care delivery sys-
13 tems between patients and providers, often resulting
14 in disparate treatment for pain, irreverence for cul-
15 tural norms with respect to health, and
16 dismissiveness. Research has demonstrated that pa-
17 tients respond more warmly and adhere to medical
18 treatment plans at a higher degree with providers of
19 the same race or ethnicity or with providers with
20 great ability to exercise empathy. However, the pro-
21 vider pool is not primed with many people of color,
22 nor are providers (whether student-doctors in train-
23 ing or licensed practitioners) consistently required to
24 undergo implicit bias, cultural competency, or empa-
25 thy training on a consistent, on-going basis.

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

3 (a) TECHNICAL ASSISTANCE FOR STATES WITH RE-
4 SPECT TO REPORTING MATERNAL MORTALITY.—Not
5 later than one year after the date of enactment of this
6 Act, the Director of the Centers for Disease Control and
7 Prevention (referred to in this section as the “Director”)
8 shall provide technical assistance to States that elect to
9 report on maternal mortality for the purpose of encour-
10 aging uniformity in the reporting of such data and to en-
11 courage the sharing of such data among the respective
12 States.

13 (b) BEST PRACTICES RELATING TO PREVENTION OF
14 MATERNAL MORTALITY.—Not later than one year after
15 the date of enactment of this Act, the Director shall issue
16 best practices to State maternal mortality review commit-
17 tees on how best to identify, review, and prevent maternal
18 mortality. In issuing such best practices, the Director shall
19 take into account any data made available by States relat-
20 ing to maternal mortality.

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

23 (1) IN GENERAL.—Not later than one year
24 after the date of enactment of this Act, the Sec-
25 retary of Health and Human Services, acting
26 through the Associate Administrator of the Maternal

1 and Child Health Bureau of the Health Resources
2 and Services Administration, shall establish a grant
3 program to be known as the Alliance for Innovation
4 on Maternal Health Grant Program (referred to in
5 this subsection as “AIM”) under which the Sec-
6 retary shall award grants to eligible entities for the
7 purpose of directing widespread adoption and imple-
8 mentation of maternal safety bundles through col-
9 laborative State-based teams and collecting and ana-
10 lyzing process, structure, and outcome data to drive
11 continuous improvement in the implementation of
12 such safety bundles by such State-based teams with
13 the ultimate goal of eliminating preventable mater-
14 nal mortality and severe maternal morbidity in the
15 United States.

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

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

23 (B) demonstrate in such application that
24 the entity is an interdisciplinary, multi-stake-
25 holder national organization with a national

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

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

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

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

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

ducted 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 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; and

(XI) thromboembolism; and

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

1 (4) MATERNAL SAFETY BUNDLE DEFINED.—

2 For purposes of this subsection, the term “maternal
3 safety bundle” means standardized, evidence-in-
4 formed processes to improve variation in response to
5 maternal care.

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

10 (d) EXPANSION OF MEDICAID AND CHIP COVERAGE
11 FOR PREGNANT AND POSTPARTUM WOMEN.—

12 (1) EXTENDING MEDICAID COVERAGE FOR
13 PREGNANT AND POSTPARTUM WOMEN.—Section
14 1902 of the Social Security Act (42 U.S.C. 1396a)
15 is amended—

16 (A) in subsection (e)—

17 (i) in paragraph (5), by striking “60-
18 day” and inserting “one-year”; and

19 (ii) in paragraph (6), by striking “60-
20 day” and inserting “one-year”; and

21 (B) in subsection (l)(1)(A), by striking
22 “60-day” and inserting “one-year”.

23 (2) EXTENDING MEDICAID COVERAGE FOR
24 LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of the
25 Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is

1 amended by striking “60-day” and inserting “one-
2 year”.

3 (3) EXTENDING CHIP COVERAGE FOR PREG-
4 NANT AND POSTPARTUM WOMEN.—Section
5 2112(d)(2)(A) of the Social Security Act (42 U.S.C.
6 1397ll(d)(2)(A)) is amended by striking “60-day”
7 and inserting “one-year”.

8 (4) MAINTENANCE OF EFFORT.—

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

13 “(5)(A) Subject to subparagraph (B), during the pe-
14 riod that begins on the date of enactment of this para-
15 graph and ends on the date that is five years after such
16 date of enactment, as a condition for receiving any Federal
17 payments under section 1903(a) for calendar quarters oc-
18 curring during such period, a State, including a State de-
19 scribed in paragraph (4)(B) that elects to meet the re-
20 quirement of subsection (a)(10)(A)(i)(IV), shall not have
21 in effect, with respect to women who are eligible for med-
22 ical assistance because of such subsection
23 (a)(10)(A)(i)(IV) or section 1903(v)(4)(A)(i), eligibility
24 standards, methodologies, or procedures under the State
25 plan (or a waiver of such plan) that are more restrictive

1 than the eligibility standards, methodologies, or proce-
2 dures, respectively, under such plan (or waiver) that are
3 in effect on the date of enactment of this paragraph.

4 “(B) A State’s determination of income in accordance
5 with subsection (e)(14) shall not be considered to be eligi-
6 bility standards, methodologies, or procedures that are
7 more restrictive than the standards, methodologies, or pro-
8 cedures in effect under the State plan (or a waiver of such
9 plan) on the date of enactment of this paragraph for pur-
10 poses of determining compliance with the requirement of
11 subparagraph (A).”.

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

16 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
17 GETED LOW-INCOME PREGNANT WOMEN.—During
18 the period that begins on the date of enactment of
19 this paragraph and ends on the date that is five
20 years after such date of enactment, as a condition
21 of receiving payments under subsection (a) and sec-
22 tion 1903(a), a State that elects to provide preg-
23 nancy-related assistance to targeted low-income
24 pregnant women (as defined in section 2112(d)), or
25 women who are eligible for such assistance through

1 the application of section 1903(v)(4)(A)(i) under
2 section 2107(e)(1), shall not have in effect, with re-
3 spect to such women, eligibility standards, meth-
4 odologies, or procedures under the State child health
5 plan (or a waiver of such plan) that are more re-
6 strictive than the eligibility standards, methodolo-
7 gies, or procedures, respectively, under such plan (or
8 waiver) that are in effect on the date of enactment
9 of this paragraph.”.

10 (5) EFFECTIVE DATE.—

11 (A) IN GENERAL.—Except as otherwise
12 provided and subject to subparagraph (B), the
13 amendments made by this subsection shall take
14 effect with respect to eligibility determinations
15 made with respect to a State plan under title
16 XIX of the Social Security Act or a State child
17 health plan under title XXI of such Act on or
18 after the date that is one year after the date of
19 enactment of this Act.

20 (B) EXCEPTION FOR STATE LEGISLA-
21 TION.—In the case of a State plan under title
22 XIX of the Social Security Act or a State child
23 health plan under title XXI of such Act that
24 the Secretary of Health and Human Services
25 determines requires State legislation in order

1 for the respective plan to meet any requirement
 2 imposed by amendments made by this sub-
 3 section, the respective plan shall not be re-
 4 garded as failing to comply with the require-
 5 ments of such title solely on the basis of its fail-
 6 ure to meet such an additional requirement be-
 7 fore the first day of the first calendar quarter
 8 beginning after the close of the first regular
 9 session of the State legislature that begins after
 10 the date of enactment of this Act. For purposes
 11 of the previous sentence, in the case of a State
 12 that has a 2-year legislative session, each year
 13 of the session shall be considered to be a sepa-
 14 rate regular session of the State legislature.

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

18 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
 19 **DRESSING IMPLICIT BIAS AND CULTURAL**
 20 **COMPETENCY IN PATIENT-PROVIDER INTER-**
 21 **ACTIONS EDUCATION.**

22 “(a) IN GENERAL.—Not later than one year after the
 23 date of enactment of this section, the Secretary, in con-
 24 sultation with such other agency heads as the Secretary
 25 determines appropriate, shall, subject to the availability of

1 appropriations, award cooperative agreements for the es-
2 tablishment or support of regional centers of excellence ad-
3 dressing implicit bias and cultural competency in patient-
4 provider interactions education for the purpose of enhanc-
5 ing and improving how health care professionals are edu-
6 cated in implicit bias and delivering culturally competent
7 health care.

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

10 “(1) be an entity specified by the Secretary that
11 provides educational opportunities for students in a
12 health care profession, which may include a health
13 system, teaching hospital, birthing center, commu-
14 nity health center, physician’s office, medical school,
15 school of public health, or any other health profes-
16 sional school or a program at an institution of high-
17 er education focused on the prevention, treatment,
18 or recovery of health conditions that contribute to
19 maternal mortality and the prevention of maternal
20 mortality;

21 “(2) demonstrate community engagement and
22 participation through community partners such as
23 mental health counselors and social workers; and

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

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

9 “(d) DISSEMINATION OF INFORMATION.—

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

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

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

24 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
25 purposes of carrying out this section, there is authorized

1 to be appropriated \$5,000,000 for each of fiscal years
2 2019 through 2023.”.

3 (f) DEFINITIONS.—In this section:

4 (1) MATERNAL MORTALITY.—The term “mater-
5 nal mortality” means death that occurs to a woman
6 during pregnancy or within the one-year period fol-
7 lowing the end of such pregnancy.

8 (2) SEVERE MATERNAL MORBIDITY.—The term
9 “severe maternal morbidity” includes unexpected
10 outcomes of labor and delivery that result in signifi-
11 cant short-term or long-term consequences to a
12 woman’s health.

○