

115TH CONGRESS
2D SESSION

S. 3363

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 SENATE OF THE UNITED STATES

AUGUST 22, 2018

Ms. HARRIS (for herself, Mrs. GILLIBRAND, Mr. CARDIN, Mr. WYDEN, Mr. BLUMENTHAL, Mr. NELSON, Mr. JONES, Mr. MERKLEY, Ms. DUCKWORTH, Mr. CARPER, Mr. BROWN, Ms. BALDWIN, Ms. HIRONO, and Ms. STABENOW) introduced the following bill; which was read twice and referred to the Committee on Finance

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 half of the maternal
17 mortalities in the United States could be prevented
18 and half of the maternal injuries in the United
19 States could be reduced or eliminated with better
20 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 40 deaths per
25 100,000 live births for Black women, compared to
26 12.4 deaths per 100,000 live births for White women

1 and 17.8 deaths per 100,000 live births for women
2 of other races.

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

5 (a) GRANT PROGRAM.—The Secretary of Health and
6 Human Services (referred to in this Act as the “Sec-
7 retary”) shall establish a grant program under which such
8 Secretary awards grants to accredited schools of allopathic
9 medicine, schools of osteopathic medicine, nursing schools,
10 and other health professional training programs for the
11 purpose of supporting evidence-based implicit bias train-
12 ing, with priority given to such training with respect to
13 obstetrics and gynecology.

14 (b) IMPLICIT BIAS DEFINED.—In this section, the
15 term “implicit bias” means—

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

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

1 (c) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated for purposes of carrying
 3 out the grant program under subsection (a), \$5,000,000
 4 for each of fiscal years 2019 through 2023.

5 **SEC. 4. PREGNANCY MEDICAL HOME DEMONSTRATION**
 6 **PROJECT.**

7 (a) IN GENERAL.—The Secretary, acting through the
 8 Administrator for the Centers for Medicare & Medicaid
 9 Services and the Administrator of the Health Resources
 10 and Services Administration, shall award grants to States
 11 for the purpose of establishing or operating State preg-
 12 nancy medical home programs that meet the requirements
 13 of subsection (b) to deliver integrated health care services
 14 to pregnant women and new mothers and reduce adverse
 15 maternal health outcomes, maternal deaths, and racial
 16 health disparities in maternal mortality and morbidity.

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

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

22 (A) State and local agencies responsible for
 23 Medicaid, public health, social services, mental
 24 health, and substance abuse treatment and sup-
 25 port;

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

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

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

10 (i) the highest overall rates of mater-
 11 nal mortality and morbidity; and

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

14 (2) the State selects obstetric providers to par-
 15 ticipate in the program as pregnancy medical homes,
 16 and requires that any provider that wishes to par-
 17 ticipate in the program as a pregnancy medical
 18 home—

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

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

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

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

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

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

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

21 (c) GRANTS.—

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

24 (2) TERM OF GRANTS.—Grants under this sec-
 25 tion shall be made for a term of 5 years.

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

5 (d) REPORT ON GRANT IMPACT AND DISSEMINATION
6 OF BEST PRACTICES.—

7 (1) REPORT.—Not later than January 1, 2024,
8 the Administrator of the Health Resources and Serv-
9 ices Administration shall submit a report to Con-
10 gress that describes—

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

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

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

20 (2) DISSEMINATION OF BEST PRACTICES.—Not
21 later than January 1, 2024, the Administrator of
22 the Health Resources and Services Administration
23 shall disseminate information on best practices and
24 models of care used by recipients of grants under
25 this section (including best practices and models of

1 care relating to the reduction of racial disparities in
2 rates of maternal and infant mortality and mor-
3 bidity) to interested parties, including health pro-
4 viders, medical schools, relevant State and local
5 agencies, and the general public.

6 (e) AUTHORIZATION.—There are authorized to be ap-
7 propriated to carry out this section, \$25,000,000 for each
8 of fiscal years 2019 through 2023, to remain available
9 until expended.

10 **SEC. 5. NATIONAL ACADEMY OF MEDICINE STUDY.**

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

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

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