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118TH CONGRESS
1ST SESSION

H. R. 3305

To end preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 15, 2023

Ms. UNDERWOOD (for herself, Ms. ADAMS, Mr. AGUILAR, Mr. ALLRED, Mr. AUCHINCLOSS, Ms. BALINT, Ms. BARRAGÁN, Mrs. BEATTY, Mr. BERA, Mr. BISHOP of Georgia, Mr. BLUMENAUER, Ms. BLUNT ROCHESTER, Ms. BONAMICI, Mr. BOWMAN, Mr. BOYLE of Pennsylvania, Ms. BROWN, Ms. BROWNLEY, Ms. BUDZINSKI, Ms. BUSH, Ms. CARAVEO, Mr. CARBAJAL, Mr. CÁRDENAS, Mr. CARSON, Mr. CARTER of Louisiana, Mr. CASTEN, Ms. CASTOR of Florida, Mrs. CHERFILUS-MCCORMICK, Ms. CHU, Mr. CICILLINE, Ms. CLARK of Massachusetts, Ms. CLARKE of New York, Mr. CLEAVER, Mr. COHEN, Mr. CONNOLLY, Mr. COURTNEY, Ms. CRAIG, Ms. CROCKETT, Mr. CROW, Ms. DAVIDS of Kansas, Mr. DAVIS of Illinois, Mr. DAVIS of North Carolina, Ms. DEAN of Pennsylvania, Ms. DEGETTE, Ms. DELAURO, Ms. DELBENE, Mr. DELUZIO, Mr. DESAULNIER, Mrs. DINGELL, Ms. ESCOBAR, Mr. ESPAILLAT, Mr. EVANS, Mrs. FLETCHER, Mr. FOSTER, Mrs. FOUSHEE, Ms. LOIS FRANKEL of Florida, Mr. FROST, Mr. GALLEGO, Mr. GARAMENDI, Ms. GARCIA of Texas, Mr. ROBERT GARCIA of California, Mr. GARCÍA of Illinois, Mr. GOLDMAN of New York, Mr. GOMEZ, Mr. GREEN of Texas, Mr. GRIJALVA, Mrs. HAYES, Mr. HIGGINS of New York, Mr. HORSFORD, Ms. HOULAHAN, Mr. HOYER, Mr. HUFFMAN, Mr. IVEY, Mr. JACKSON of North Carolina, Mr. JACKSON of Illinois, Ms. JACOBS, Ms. JAYAPAL, Mr. JOHNSON of Georgia, Ms. KAMLAGER-DOVE, Ms. KAPTUR, Mr. KEATING, Mr. KHANNA, Mr. KILDEE, Mr. KILMER, Mr. KIM of New Jersey, Mr. KRISHNAMOORTHI, Ms. KUSTER, Mr. LANDSMAN, Mr. LARSEN of Washington, Ms. LEE of Pennsylvania, Ms. LEE of California, Ms. JACKSON LEE, Ms. LEGER FERNANDEZ, Mr. LEVIN, Mr. LIEU, Ms. LOFGREN, Mr. LYNCH, Mr. MAGAZINER, Ms. MANNING, Ms. MATSUI, Mrs. MCBATH, Mrs. MCCLELLAN, Ms. MCCOLLUM, Mr. MCGARVEY, Mr. MCGOVERN, Mr. MEEKS, Mr. MENENDEZ, Ms. MENG, Mr. MFUME, Ms. MOORE of Wisconsin, Mr. MORELLE, Mr. MOSKOWITZ, Mr. MOULTON, Mr. MRVAN, Mr. MULLIN, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Mr. NORCROSS, Ms. NORTON, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PANETTA, Mr. PAPPAS, Mr. PASCRELL, Mr. PAYNE, Ms. PELOSI, Mrs. PELTOLA, Ms. PETTERSEN, Mr. PHILLIPS, Ms. PINGREE, Ms. PLASKETT, Mr. POCAN,

Ms. PORTER, Ms. PRESSLEY, Mr. QUIGLEY, Mrs. RAMIREZ, Mr. RASKIN, Ms. ROSS, Mr. RUIZ, Mr. RUPPERSBERGER, Ms. SALINAS, Mr. SARBANES, Ms. SCANLON, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCHNEIDER, Ms. SCHOLTEN, Ms. SCHRIER, Mr. SCOTT of Virginia, Mr. DAVID SCOTT of Georgia, Ms. SEWELL, Ms. SLOTKIN, Mr. SMITH of Washington, Mr. SORENSEN, Mr. SOTO, Ms. SPANBERGER, Ms. STANSBURY, Mr. STANTON, Ms. STEVENS, Ms. STRICKLAND, Mr. SWALWELL, Mrs. SYKES, Mr. TAKANO, Mr. THANEDAR, Mr. THOMPSON of Mississippi, Mr. THOMPSON of California, Ms. TLAIB, Ms. TOKUDA, Mr. TONKO, Mrs. TORRES of California, Mrs. TRAHAN, Mr. TRONE, Mr. VARGAS, Mr. VEASEY, Ms. VELÁZQUEZ, Ms. WASSERMAN SCHULTZ, Ms. WATERS, Mrs. WATSON COLEMAN, Ms. WEXTON, Ms. WILD, Ms. WILLIAMS of Georgia, and Ms. WILSON of Florida) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Veterans' Affairs, Natural Resources, and the Judiciary, 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 end preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States, 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 ''Black Maternal Health
5 Momnibus Act''.

6 **SEC. 2. TABLE OF CONTENTS.**

7 The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.
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Sec. 4. Sense of Congress.

TITLE I—SOCIAL DETERMINANTS FOR MOMS

Sec. 101. Task force to address the United States maternal health crisis.
Sec. 102. Sustained funding to address social determinants of maternal health.

TITLE II—EXTENDING WIC FOR NEW MOMS

Sec. 201. Extending WIC eligibility for new moms.

TITLE III—HONORING KIRA JOHNSON

Sec. 301. Sustained funding for community-based organizations to advance maternal health equity.
Sec. 302. Respectful maternity care training for all employees in maternity care settings.
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TITLE IV—MATERNAL HEALTH FOR VETERANS

Sec. 401. Support for maternity health care and coordination programs of the Department of Veterans Affairs.

TITLE V—PERINATAL WORKFORCE

Sec. 501. HHS agency directives.
Sec. 502. Grants to grow and diversify the perinatal workforce.
Sec. 503. Grants to grow and diversify the nursing workforce in maternal and perinatal health.
Sec. 504. GAO report.

TITLE VI—DATA TO SAVE MOMS

Sec. 601. Funding for maternal mortality review committees to promote representative community engagement.
Sec. 602. Data collection and review.
Sec. 603. Review of maternal health data collection processes and quality measures.
Sec. 604. Study on maternal health among American Indian and Alaska Native individuals.
Sec. 605. Grants to minority-serving institutions to study maternal mortality, severe maternal morbidity, and other adverse maternal health outcomes.

TITLE VII—MOMS MATTER

Sec. 701. Maternal mental health equity grant program.
Sec. 702. Grants to grow and diversify the maternal mental and behavioral health care workforce.

TITLE VIII—JUSTICE FOR INCARCERATED MOMS

Sec. 801. Ending the shackling of pregnant individuals.
Sec. 802. Creating model programs for the care of incarcerated individuals in the prenatal and postpartum periods.
Sec. 803. Grant program to improve maternal health outcomes for individuals in State and local prisons and jails.
Sec. 804. GAO report.

TITLE IX—TECH TO SAVE MOMS

Sec. 901. Integrated telehealth models in maternity care services.
Sec. 902. Grants to expand the use of technology-enabled collaborative learning and capacity models for pregnant and postpartum individuals.
Sec. 903. Grants to promote equity in maternal health outcomes through digital tools.
Sec. 904. Report on the use of technology in maternity care.

TITLE X—IMPACT TO SAVE MOMS

Sec. 1001. Perinatal Care Alternative Payment Model Demonstration Project.

TITLE XI—MATERNAL HEALTH PANDEMIC RESPONSE

Sec. 1101. Definitions.
Sec. 1102. Funding for data collection, surveillance, and research on maternal health outcomes during public health emergencies.
Sec. 1103. Public health emergency maternal health data collection and disclosure.
Sec. 1104. Public health communication regarding maternal care during public health emergencies.
Sec. 1105. Task force on birthing experience and safe, respectful, responsive, and empowering maternity care during public health emergencies.

TITLE XII—PROTECTING MOMS AND BABIES AGAINST CLIMATE CHANGE

Sec. 1201. Definitions.
Sec. 1202. Grant program to protect vulnerable mothers and babies from climate change risks.
Sec. 1203. Grant program for education and training at health profession schools.
Sec. 1204. NIH Consortium on Birth and Climate Change Research.
Sec. 1205. Strategy for identifying climate change risk zones for vulnerable mothers and babies.

TITLE XIII—MATERNAL VACCINATIONS

Sec. 1301. Maternal vaccination awareness and equity campaign.

1 **SEC. 3. DEFINITIONS.**

2 In this Act:

3 (1) CULTURALLY AND LINGUISTICALLY CON-
4 GRUENT.—The term "culturally and linguistically
5 congruent", with respect to care or maternity care,
6 means care that is in agreement with the preferred
7 cultural values, beliefs, worldview, language, and

1 practices of the health care consumer and other
2 stakeholders.
3 (2) MATERNAL MORTALITY.—The term ''mater-
4 nal mortality'' means a death occurring during or
5 within a 1-year period after pregnancy, caused by
6 pregnancy-related or childbirth complications, in-
7 cluding a suicide, overdose, or other death resulting
8 from a mental health or substance use disorder at-
9 tributed to or aggravated by pregnancy-related or
10 childbirth complications.
11 (3) MATERNITY CARE PROVIDER.—The term
12 ''maternity care provider'' means a health care pro-
13 vider who—
14 (A) is a physician, a physician assistant, a
15 midwife who meets, at a minimum, the inter-
16 national definition of a midwife and global
17 standards for midwifery education as estab-
18 lished by the International Confederation of
19 Midwives, an advanced practice registered
20 nurse, or a lactation consultant certified by the
21 International Board of Lactation Consultant
22 Examiners; and
23 (B) has a focus on maternal or perinatal
24 health.

1 (4) PERINATAL HEALTH WORKER.—The term
2 ''perinatal health worker'' means a nonclinical health
3 worker focused on maternal or perinatal health, such
4 as a doula, community health worker, peer sup-
5 porter, lactation educator or counselor, nutritionist
6 or dietitian, childbirth educator, social worker, home
7 visitor, patient navigator or coordinator, or language
8 interpreter.
9 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
10 The terms ''postpartum'' and ''postpartum period''
11 refer to the 1-year period beginning on the last day
12 of the pregnancy of an individual.
13 (6) PREGNANCY-ASSOCIATED DEATH.—The
14 term ''pregnancy-associated death'' means a death of
15 a pregnant or postpartum individual, by any cause,
16 that occurs during, or within 1 year following, the
17 individual's pregnancy, regardless of the outcome,
18 duration, or site of the pregnancy.
19 (7) PREGNANCY-RELATED DEATH.—The term
20 ''pregnancy-related death'' means a death of a preg-
21 nant or postpartum individual that occurs during, or
22 within 1 year following, the individual's pregnancy,
23 from a pregnancy complication, a chain of events
24 initiated by pregnancy, or the aggravation of an un-

1 related condition by the physiologic effects of preg-
2 nancy.

3 (8) RACIAL AND ETHNIC MINORITY GROUP.—
4 The term ''racial and ethnic minority group'' has the
5 meaning given such term in section 1707(g)(1) of
6 the Public Health Service Act (42 U.S.C. 300u–
7 6(g)(1)).

8 (9) SEVERE MATERNAL MORBIDITY.—The term
9 ''severe maternal morbidity'' means a health condi-
10 tion, including mental health conditions and sub-
11 stance use disorders, attributed to or aggravated by
12 pregnancy or childbirth that results in significant
13 short-term or long-term consequences to the health
14 of the individual who was pregnant.

15 (10) SOCIAL DETERMINANTS OF MATERNAL
16 HEALTH.—The term ''social determinants of mater-
17 nal health'' means nonclinical factors that impact
18 maternal health outcomes.

19 **SEC. 4. SENSE OF CONGRESS.**

20 It is the sense of Congress that—

21 (1) the respect and proper care that birthing
22 people deserve is inclusive; and

23 (2) regardless of race, ethnicity, gender iden-
24 tity, sexual orientation, religion, marital status, pri-
25 mary language, familial status, socioeconomic status,

immigration status, incarceration status, or disability, all deserve dignity.

TITLE I—SOCIAL DETERMINANTS FOR MOMS

SEC. 101. TASK FORCE TO ADDRESS THE UNITED STATES MATERNAL HEALTH CRISIS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall convene a task force (in this section referred to as the ''Task Force'') to develop strategies and coordinate efforts between Federal agencies and other stakeholders to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States, including actions to address clinical and nonclinical causes of maternal mortality, severe maternal morbidity, and maternal health disparities.

(b) EX OFFICIO MEMBERS.—The ex officio members of the Task Force shall consist of the following:

(1) The Secretary of Health and Human Services (or a designee thereof).

(2) The Secretary of Housing and Urban Development (or a designee thereof).

(3) The Secretary of Transportation (or a designee thereof).

(4) The Secretary of Agriculture (or a designee thereof).

1 (5) The Secretary of Labor (or a designee
2 thereof).
3 (6) The Administrator of the Environmental
4 Protection Agency (or a designee thereof).
5 (7) The Assistant Secretary for the Administra-
6 tion for Children and Families (or a designee there-
7 of).
8 (8) The Administrator of the Centers for Medi-
9 care & Medicaid Services (or a designee thereof).
10 (9) The Director of the Indian Health Service
11 (or a designee thereof).
12 (10) The Director of the National Institutes of
13 Health (or a designee thereof).
14 (11) The Director of the Eunice Kennedy
15 Shriver National Institute of Child Health and
16 Human Development (or a designee thereof).
17 (12) The Administrator of the Health Re-
18 sources and Services Administration (or a designee
19 thereof).
20 (13) The Deputy Assistant Secretary for Minor-
21 ity Health of the Department of Health and Human
22 Services (or a designee thereof).
23 (14) The Deputy Assistant Secretary for Wom-
24 en's Health of the Department of Health and
25 Human Services (or a designee thereof).

1 (15) The Director of the Centers for Disease
2 Control and Prevention (or a designee thereof).
3 (16) The Director of the Office on Violence
4 Against Women at the Department of Justice (or a
5 designee thereof).
6 (c) APPOINTED MEMBERS.—In addition to the ex
7 officio members of the Task Force, the Secretary of
8 Health and Human Services may appoint the following
9 members of the Task Force:
10 (1) Representatives of patients, to include—
11 (A) a representative of patients who have
12 suffered from severe maternal morbidity; or
13 (B) a representative of patients who is a
14 family member of an individual who suffered a
15 pregnancy-related death.
16 (2) Leaders of community-based organizations
17 that address maternal mortality, severe maternal
18 morbidity, and maternal health with a specific focus
19 on racial and ethnic disparities. In appointing such
20 leaders under this paragraph, the Secretary of
21 Health and Human Services shall give priority to in-
22 dividuals who are leaders of organizations led by in-
23 dividuals from demographic groups with elevated
24 rates of maternal mortality, severe maternal mor-

1 bidity, maternal health disparities, or other adverse
2 perinatal or childbirth outcomes.
3 (3) Perinatal health workers.
4 (4) A professionally and geographically diverse
5 panel of maternity care providers.
6 (5) Other maternal health stakeholders outside
7 of the Federal Government with expertise in mater-
8 nal health, including social determinants of maternal
9 health.
10 (d) CHAIR.—The Secretary of Health and Human
11 Services shall select the chair of the Task Force from
12 among the members of the Task Force.
13 (e) TOPICS.—In developing strategies coordinating
14 efforts between Federal agencies and other stakeholders
15 to eliminate preventable maternal mortality, severe mater-
16 nal morbidity, and maternal health disparities in the
17 United States under this section, the Task Force may ad-
18 dress topics such as—
19 (1) addressing barriers that prevent individuals
20 from attending prenatal and postpartum appoint-
21 ments, accessing maternal health care services, or
22 accessing services and resources related to social de-
23 terminants of maternal health;

1 (2) increasing access to safe, stable, affordable,
2 and adequate housing for pregnant and postpartum
3 individuals and their families;
4 (3) delivering healthy food, infant formula,
5 clean water, diapers, or other perinatal necessities to
6 pregnant and postpartum individuals located in
7 areas that are food deserts;
8 (4) addressing the impacts of water and air
9 quality, exposure to extreme temperatures, environ-
10 mental chemicals, environmental risks in the work-
11 place and the home, and pollution levels, on mater-
12 nal and infant health outcomes;
13 (5) offering free and accessible drop-in
14 childcare services during prenatal and postpartum
15 appointments;
16 (6) addressing the clinical and nonclinical needs
17 of postpartum individuals and their families for the
18 duration of the postpartum period;
19 (7) engaging with nongovernmental entities to
20 address social determinants of maternal health, in-
21 cluding through public-private partnerships;
22 (8) addressing the impact of domestic or inti-
23 mate partner violence on maternal health outcomes;
24 and

1 (9) other topics determined by the chair of the
2 Task Force.
3 (f) REPORT.—Not later than 2 years after the date
4 of enactment of this Act, and every year thereafter, the
5 Task Force shall submit to Congress and make publicly
6 available on the website of the Department of Health and
7 Human Services a report—
8 (1) describing the Task Force's efforts to de-
9 velop strategies and coordinate efforts between Fed-
10 eral agencies and other stakeholders to eliminate
11 preventable maternal mortality, severe maternal
12 morbidity, and maternal health disparities in the
13 United States;
14 (2) providing an overview of actions taken by
15 each member of the Task Force listed under sub-
16 section (b) to eliminate preventable maternal mor-
17 tality, severe maternal morbidity, and maternal
18 health disparities in the United States;
19 (3) providing recommendations on Federal
20 funding amounts and authorities needed to imple-
21 ment strategies developed by the Task Force to
22 eliminate preventable maternal mortality, severe ma-
23 ternal morbidity, and maternal health disparities in
24 the United States;

1 (4) providing recommendations on actions that
2 stakeholders outside of the Federal Government can
3 take to eliminate preventable maternal mortality, se-
4 vere maternal morbidity, and maternal health dis-
5 parities in the United States; and
6 (5) addressing other topics as determined by
7 the chair of the Task Force.
8 (g) TERMINATION.—Section 1013 of title 5, United
9 States Code, shall not apply to the Task Force with re-
10 spect to termination.

11 **SEC. 102. SUSTAINED FUNDING TO ADDRESS SOCIAL DE-**
12 **TERMINANTS OF MATERNAL HEALTH.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services (in this section referred to as the ''Sec-
15 retary'') shall award grants to eligible entities to address
16 social determinants of maternal health to eliminate mater-
17 nal mortality, severe maternal morbidity, and maternal
18 health disparities.
19 (b) ELIGIBLE ENTITIES.—In this section, the term
20 ''eligible entity'' means—
21 (1) a community-based organization, Indian
22 Tribe or Tribal organization, or Urban Indian orga-
23 nization;

1 (2) a public health department or nonprofit or-
2 ganization working with an entity listed in para-
3 graph (1); or

4 (3) a consortium of entities listed in paragraph
5 (1) or (2) that includes at minimum one entity listed
6 in paragraph (1).

7 (c) APPLICATION.—To be eligible to receive a grant
8 under this section, an eligible entity shall submit to the
9 Secretary an application at such time, in such manner,
10 and containing such information as the Secretary may
11 provide.

12 (d) PRIORITIZATION.—In awarding grants under
13 subsection (a), the Secretary shall give priority to an eligi-
14 ble entity that is operating in an area with—

15 (1) high rates of maternal mortality, severe ma-
16 ternal morbidity, maternal health disparities, or
17 other adverse perinatal or childbirth outcomes; and

18 (2) a high poverty rate.

19 (e) ACTIVITIES.—An eligible entity that receives a
20 grant under this section may use the grant to address so-
21 cial determinants of maternal health such as—

22 (1) housing;

23 (2) transportation;

24 (3) nutrition;

1 (4) employment, workplace conditions, and
2 other economic factors;
3 (5) environmental conditions;
4 (6) intimate partner violence; and
5 (7) other nonclinical factors that impact mater-
6 nal health outcomes.
7 (f) TECHNICAL ASSISTANCE.—The Secretary shall
8 provide to grant recipients under this section technical as-
9 sistance to plan for sustaining programs to address social
10 determinants of maternal health after the period of the
11 grant.
12 (g) REPORTING.—
13 (1) GRANTEES.—Not later than 1 year after an
14 eligible entity first receives a grant under this sec-
15 tion, and annually thereafter, an eligible entity shall
16 submit to the Secretary, and make publicly available,
17 a report on the status of activities conducted using
18 the grant. Each such report shall include data on
19 the effects of such activities, disaggregated by race,
20 ethnicity, gender, primary language, geography, so-
21 cioeconomic status, and other relevant factors.
22 (2) SECRETARY.—Not later than the end of fis-
23 cal year 2028, the Secretary shall submit to Con-
24 gress a report that includes—

(A) a summary of the reports under paragraph (1); and

(B) recommendations for future Federal grant allocations to address social determinants of maternal health.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $100,000,000 for each of fiscal years 2024 through 2028.

TITLE II—EXTENDING WIC FOR NEW MOMS

SEC. 201. EXTENDING WIC ELIGIBILITY FOR NEW MOMS.

(a) EXTENSION OF POSTPARTUM PERIOD.—Section 17(b)(10) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(10)) is amended by striking ''six months'' and inserting ''24 months''.

(b) EXTENSION OF BREASTFEEDING PERIOD.—Section 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended by striking ''1 year'' and inserting ''24 months''.

(c) REPORT.—Not later than 2 years after the date of the enactment of this section, the Secretary shall submit to Congress a report that includes an evaluation of the effect of each of the amendments made by this section on—

1 (1) maternal and infant health outcomes, in-
2 cluding racial and ethnic disparities with respect to
3 such outcomes;
4 (2) breastfeeding rates among postpartum indi-
5 viduals;
6 (3) qualitative evaluations of family experiences
7 under the special supplemental nutrition program
8 under section 17 of the Child Nutrition Act of 1966
9 (42 U.S.C. 1786); and
10 (4) other relevant information as determined by
11 the Secretary.

12 TITLE III—HONORING KIRA 13 JOHNSON

14 SEC. 301. SUSTAINED FUNDING FOR COMMUNITY-BASED 15 ORGANIZATIONS TO ADVANCE MATERNAL 16 HEALTH EQUITY.

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the ''Sec-
19 retary'') shall award grants to eligible entities to establish
20 or expand programs to advance maternal health equity.
21 (b) TIMING.—Following the 1-year period described
22 in subsection (d), the Secretary shall commence awarding
23 the grants authorized by subsection (a).
24 (c) ELIGIBLE ENTITIES.—To be eligible to seek a
25 grant under this section, an entity shall be a community-

1 based organization offering programs and resources
2 aligned with evidence-based practices for improving mater-
3 nal health outcomes for demographic groups with elevated
4 rates of maternal mortality, severe maternal morbidity,
5 maternal health disparities, or other adverse perinatal or
6 childbirth outcomes.

7 (d) OUTREACH AND TECHNICAL ASSISTANCE PE-
8 RIOD.—During the 1-year period beginning on the date
9 of enactment of this Act, the Secretary shall—

10 (1) conduct outreach to encourage eligible enti-
11 ties to apply for grants under this section; and

12 (2) provide technical assistance to eligible enti-
13 ties on best practices for applying for grants under
14 this section.

15 (e) SPECIAL CONSIDERATION.—

16 (1) OUTREACH.—In conducting outreach under
17 subsection (d), the Secretary shall give special con-
18 sideration to eligible entities that—

19 (A) are based in, and provide support for,
20 communities with elevated rates of maternal
21 mortality, severe maternal morbidity, maternal
22 health disparities, or other adverse perinatal or
23 childbirth outcomes, to the extent such data are
24 available;

1 (B) are led by individuals from demo-
2 graphic groups with elevated rates of maternal
3 mortality, severe maternal morbidity, maternal
4 health disparities, or other adverse perinatal or
5 childbirth outcomes; and
6 (C) offer programs and resources that are
7 aligned with evidence-based practices for im-
8 proving maternal health outcomes for individ-
9 uals from demographic groups with elevated
10 rates of maternal mortality, severe maternal
11 morbidity, maternal health disparities, or other
12 adverse perinatal or childbirth outcomes.
13 (2) AWARDS.—In awarding grants under this
14 section, the Secretary shall give special consideration
15 to eligible entities that—
16 (A) are described in subparagraphs (A),
17 (B), and (C) of paragraph (1);
18 (B) offer programs and resources designed
19 in consultation with and intended for individ-
20 uals from demographic groups with elevated
21 rates of maternal mortality, severe maternal
22 morbidity, maternal health disparities, or other
23 adverse perinatal or childbirth outcomes;

1 (C) offer programs and resources in the
2 communities in which the respective eligible en-
3 tities are located that—
4 (i) promote maternal mental health
5 and maternal substance use disorder treat-
6 ments and supports that are aligned with
7 evidence-based practices for improving ma-
8 ternal mental and behavioral health out-
9 comes for individuals from demographic
10 groups with elevated rates of maternal
11 mortality, severe maternal morbidity, ma-
12 ternal health disparities, or other adverse
13 perinatal or childbirth outcomes;
14 (ii) address social determinants of ma-
15 ternal health;
16 (iii) promote evidence-based health lit-
17 eracy and pregnancy, childbirth, and par-
18 enting education;
19 (iv) provide support from perinatal
20 health workers;
21 (v) provide culturally and linguis-
22 tically congruent training to perinatal
23 health workers;
24 (vi) conduct or support research on
25 maternal health issues disproportionately

1 impacting individuals from demographic
2 groups with elevated rates of maternal
3 mortality, severe maternal morbidity, ma-
4 ternal health disparities, or other adverse
5 perinatal or childbirth outcomes;
6 (vii) offer group prenatal care or
7 group postpartum care;
8 (viii) coordinate mutual aid efforts
9 during infant formula shortages, including
10 community milk depots, donor human milk
11 banks and exchanges, and forums for com-
12 munity outreach and education;
13 (ix) provide support to individuals or
14 family members of individuals who suffered
15 a pregnancy loss, pregnancy-associated
16 death, or pregnancy-related death; or
17 (x) operate midwifery practices that
18 provide culturally and linguistically con-
19 gruent maternal health care and support,
20 including for the purposes of—
21 (I) supporting additional edu-
22 cation, training, and certification pro-
23 grams, including support for distance
24 learning;

1 (II) providing financial support
2 to current and future midwives to ad-
3 dress education costs, debts, and
4 other needs;
5 (III) clinical site investments;
6 (IV) supporting preceptor devel-
7 opment trainings;
8 (V) expanding the midwifery
9 practice; or
10 (VI) related needs identified by
11 the midwifery practice and described
12 in the practice's application; and
13 (D) have developed other programs and re-
14 sources that address community-specific needs
15 for pregnant and postpartum individuals and
16 are aligned with evidence-based practices for
17 improving maternal health outcomes for individ-
18 uals from demographic groups with elevated
19 rates of maternal mortality, severe maternal
20 morbidity, maternal health disparities, or other
21 adverse perinatal or childbirth outcomes.
22 (f) TECHNICAL ASSISTANCE.—The Secretary shall
23 provide to grant recipients under this section technical as-
24 sistance on—

1 (1) capacity building to establish or expand pro-
2 grams to advance maternal health equity;
3 (2) best practices in data collection, measure-
4 ment, evaluation, and reporting; and
5 (3) planning for sustaining programs to ad-
6 vance maternal health equity after the period of the
7 grant.
8 (g) EVALUATION.—Not later than the end of fiscal
9 year 2028, the Secretary shall submit to the Congress an
10 evaluation of the grant program under this section that—
11 (1) assesses the effectiveness of outreach efforts
12 during the application process in diversifying the
13 pool of grant recipients;
14 (2) makes recommendations for future outreach
15 efforts to diversify the pool of grant recipients for
16 Department of Health and Human Services grant
17 programs and funding opportunities related to ma-
18 ternal health;
19 (3) assesses the effectiveness of programs fund-
20 ed by grants under this section in improving mater-
21 nal health outcomes for individuals from demo-
22 graphic groups with elevated rates of maternal mor-
23 tality, severe maternal morbidity, maternal health
24 disparities, or other adverse perinatal or childbirth
25 outcomes, to the extent practicable; and

1 (4) makes recommendations for future Depart-
2 ment of Health and Human Services grant programs
3 and funding opportunities that deliver funding to
4 community-based organizations that provide pro-
5 grams and resources that are aligned with evidence-
6 based practices for improving maternal health out-
7 comes for individuals from demographic groups with
8 elevated rates of maternal mortality, severe maternal
9 morbidity, maternal health disparities, or other ad-
10 verse perinatal or childbirth outcomes.

11 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
12 out this section, there is authorized to be appropriated
13 $100,000,000 for each of fiscal years 2024 through 2028.

14 **SEC. 302. RESPECTFUL MATERNITY CARE TRAINING FOR**
15 **ALL EMPLOYEES IN MATERNITY CARE SET-**
16 **TINGS.**

17 Part B of title VII of the Public Health Service Act
18 (42 U.S.C. 293 et seq.) is amended by adding at the end
19 the following new section:

20 **"SEC. 742. RESPECTFUL MATERNITY CARE TRAINING FOR**
21 **ALL EMPLOYEES IN MATERNITY CARE SET-**
22 **TINGS.**

23 "(a) GRANTS.—The Secretary shall award grants for
24 programs to reduce and prevent bias, racism, and dis-
25 crimination in maternity care settings and to advance re-

1 spectful, culturally and linguistically congruent, trauma-
2 informed care.

3 ''(b) SPECIAL CONSIDERATION.—In awarding grants
4 under subsection (a), the Secretary shall give special con-
5 sideration to applications for programs that would—

6 ''(1) apply to all maternity care providers and
7 any employees who interact with pregnant and
8 postpartum individuals in the provider setting, in-
9 cluding front desk employees, sonographers, sched-
10 ulers, health care professionals, hospital or health
11 system administrators, security staff, and other em-
12 ployees;

13 ''(2) emphasize periodic, as opposed to one-
14 time, trainings for all birthing professionals and em-
15 ployees described in paragraph (1);

16 ''(3) address implicit bias, racism, and cultural
17 humility;

18 ''(4) be delivered in ongoing education settings
19 for providers maintaining their licenses, with a pref-
20 erence for trainings that provide continuing edu-
21 cation units;

22 ''(5) include trauma-informed care best prac-
23 tices and an emphasis on shared decision making be-
24 tween providers and patients;

25 ''(6) include antiracism training and programs;

1 "(7) be delivered in undergraduate programs
2 that funnel into health professions schools;
3 "(8) be delivered in settings that apply to pro-
4 viders of the special supplemental nutrition program
5 for women, infants, and children under section 17 of
6 the Child Nutrition Act of 1966;
7 "(9) integrate bias training in obstetric emer-
8 gency simulation trainings or related trainings;
9 "(10) include training for emergency depart-
10 ment employees and emergency medical technicians
11 on recognizing warning signs for severe pregnancy-
12 related complications;
13 "(11) offer training to all maternity care pro-
14 viders on the value of racially, ethnically, and profes-
15 sionally diverse maternity care teams to provide cul-
16 turally and linguistically congruent care; or
17 "(12) be based on one or more programs de-
18 signed by a historically Black college or university or
19 other minority-serving institution.
20 "(c) APPLICATION.—To seek a grant under sub-
21 section (a), an entity shall submit an application at such
22 time, in such manner, and containing such information as
23 the Secretary may require.
24 "(d) REPORTING.—Each recipient of a grant under
25 this section shall annually submit to the Secretary a report

1 on the status of activities conducted using the grant, in-
2 cluding, as applicable, a description of the impact of train-
3 ing provided through the grant on patient outcomes and
4 patient experience for pregnant and postpartum individ-
5 uals from racial and ethnic minority groups and their fam-
6 ilies.

7 ''(e) BEST PRACTICES.—Based on the annual reports
8 submitted pursuant to subsection (d), the Secretary—

9 ''(1) shall produce an annual report on the find-
10 ings resulting from programs funded through this
11 section;

12 ''(2) shall disseminate such report to all recipi-
13 ents of grants under this section and to the public;
14 and

15 ''(3) may include in such report findings on
16 best practices for improving patient outcomes and
17 patient experience for pregnant and postpartum in-
18 dividuals from racial and ethnic minority groups and
19 their families in maternity care settings.

20 ''(f) DEFINITIONS.—In this section:

21 ''(1) The term 'postpartum' means the 1-year
22 period beginning on the last day of an individual's
23 pregnancy.

24 ''(2) The term 'culturally and linguistically con-
25 gruent' means in agreement with the preferred cul-

1 tural values, beliefs, worldview, language, and prac-
2 tices of the health care consumer and other stake-
3 holders.

4 ''(3) The term 'racial and ethnic minority
5 group' has the meaning given such term in section
6 1707(g)(1).

7 ''(g) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this section, there is authorized to be appro-
9 priated $5,000,000 for each of fiscal years 2024 through
10 2028.''.

11 **SEC. 303. STUDY ON REDUCING AND PREVENTING BIAS,**
12 **RACISM, AND DISCRIMINATION IN MATER-**
13 **NITY CARE SETTINGS.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall seek to enter into an agreement,
16 not later than 90 days after the date of enactment of this
17 Act, with the National Academies of Sciences, Engineer-
18 ing, and Medicine (referred to in this section as the ''Na-
19 tional Academies'') under which the National Academies
20 agree to—

21 (1) conduct a study on the design and imple-
22 mentation of programs to reduce and prevent bias,
23 racism, and discrimination in maternity care settings
24 and to advance respectful, culturally and linguis-
25 tically congruent, trauma-informed care; and

1 (2) not later than 24 months after the date of
2 enactment of this Act—
3 (A) complete the study; and
4 (B) transmit a report on the results of the
5 study to the Congress.
6 (b) POSSIBLE TOPICS.—The agreement entered into
7 pursuant to subsection (a) may provide for the study of
8 any of the following:
9 (1) The development of a scorecard or other
10 evaluation standards for programs designed to re-
11 duce and prevent bias, racism, and discrimination in
12 maternity care settings to assess the effectiveness of
13 such programs in improving patient outcomes and
14 patient experience for pregnant and postpartum in-
15 dividuals from racial and ethnic minority groups and
16 their families.
17 (2) Determination of the types and frequency of
18 training to reduce and prevent bias, racism, and dis-
19 crimination in maternity care settings that are dem-
20 onstrated to improve patient outcomes or patient ex-
21 perience for pregnant and postpartum individuals
22 from racial and ethnic minority groups and their
23 families.

1 **SEC. 304. RESPECTFUL MATERNITY CARE COMPLIANCE**
2 **PROGRAM.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the ''Sec-
5 retary'') shall award grants to accredited hospitals, health
6 systems, and other maternity care settings to establish as
7 an integral part of quality implementation initiatives with-
8 in one or more hospitals or other birth settings a respect-
9 ful maternity care compliance program.

10 (b) PROGRAM REQUIREMENTS.—A respectful mater-
11 nity care compliance program funded through a grant
12 under this section shall—

13 (1) institutionalize mechanisms to allow pa-
14 tients receiving maternity care services, the families
15 of such patients, or perinatal health workers sup-
16 porting such patients to report instances of racism
17 or evidence of bias on the basis of race, ethnicity, or
18 another protected class;

19 (2) institutionalize response mechanisms
20 through which representatives of the program can
21 directly follow up with the patient, if possible, and
22 the patient's family in a timely manner;

23 (3) prepare and make publicly available a
24 hospital- or health system-wide strategy to reduce
25 bias on the basis of race, ethnicity, or another pro-

1 tected class in the delivery of maternity care that in-
2 cludes—
3 (A) information on the training programs
4 to reduce and prevent bias, racism, and dis-
5 crimination on the basis of race, ethnicity, or
6 another protected class for all employees in ma-
7 ternity care settings;
8 (B) information on the number of cases re-
9 ported to the compliance program; and
10 (C) the development of methods to rou-
11 tinely assess the extent to which bias, racism,
12 or discrimination on the basis of race, ethnicity,
13 or another protected class is present in the de-
14 livery of maternity care to patients from racial
15 and ethnic minority groups;
16 (4) develop mechanisms to routinely collect and
17 publicly report hospital-level data related to patient-
18 reported experience of care; and
19 (5) provide annual reports to the Secretary with
20 information about each case reported to the compli-
21 ance program over the course of the year containing
22 such information as the Secretary may require, such
23 as—

1 (A) deidentified demographic information
2 on the patient in the case, such as race, eth-
3 nicity, gender identity, and primary language;
4 (B) the content of the report from the pa-
5 tient or the family of the patient to the compli-
6 ance program;
7 (C) the response from the compliance pro-
8 gram; and
9 (D) to the extent applicable, institutional
10 changes made as a result of the case.
11 (c) SECRETARY REQUIREMENTS.—
12 (1) PROCESSES.—Not later than 180 days after
13 the date of enactment of this Act, the Secretary
14 shall establish processes for—
15 (A) disseminating best practices for estab-
16 lishing and implementing a respectful maternity
17 care compliance program within a hospital or
18 other birth setting;
19 (B) promoting coordination and collabora-
20 tion between hospitals, health systems, and
21 other maternity care delivery settings on the es-
22 tablishment and implementation of respectful
23 maternity care compliance programs; and
24 (C) evaluating the effectiveness of respect-
25 ful maternity care compliance programs on ma-

1 ternal health outcomes and patient and family
2 experiences, especially for patients from racial
3 and ethnic minority groups and their families.
4 (2) STUDY.—
5 (A) IN GENERAL.—Not later than 2 years
6 after the date of enactment of this Act, the Sec-
7 retary shall, through a contract with an inde-
8 pendent research organization, conduct a study
9 on strategies to address—
10 (i) racism or bias on the basis of race,
11 ethnicity, or another protected class in the
12 delivery of maternity care services; and
13 (ii) successful implementation of re-
14 spectful care initiatives.
15 (B) COMPONENTS OF STUDY.—The study
16 shall include the following:
17 (i) An assessment of the reports sub-
18 mitted to the Secretary from the respectful
19 maternity care compliance programs pur-
20 suant to subsection (b)(5).
21 (ii) Based on such assessment, rec-
22 ommendations for potential accountability
23 mechanisms related to cases of racism or
24 bias on the basis of race, ethnicity, or an-
25 other protected class in the delivery of ma-

1 ternity care services at hospitals and other
2 birth settings. Such recommendations shall
3 take into consideration medical and non-
4 medical factors that contribute to adverse
5 patient experiences and maternal health
6 outcomes.

7 (C) REPORT.—The Secretary shall submit
8 to the Congress and make publicly available a
9 report on the results of the study under this
10 paragraph.

11 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
12 out this section, there are authorized to be appropriated
13 such sums as may be necessary for fiscal years 2024
14 through 2029.

15 **SEC. 305. GAO REPORT.**

16 (a) IN GENERAL.—Not later than 2 years after the
17 date of enactment of this Act and annually thereafter, the
18 Comptroller General of the United States shall submit to
19 the Congress and make publicly available a report on the
20 establishment of respectful maternity care compliance pro-
21 grams within hospitals, health systems, and other mater-
22 nity care settings.

23 (b) MATTERS INCLUDED.—The report under sub-
24 section (a) shall include the following:

1 (1) Information regarding the extent to which
2 hospitals, health systems, and other maternity care
3 settings have elected to establish respectful mater-
4 nity care compliance programs, including—
5 (A) which hospitals and other birth set-
6 tings elect to establish compliance programs
7 and when such programs are established;
8 (B) to the extent practicable, impacts of
9 the establishment of such programs on mater-
10 nal health outcomes and patient and family ex-
11 periences in the hospitals and other birth set-
12 tings that have established such programs, es-
13 pecially for patients from racial and ethnic mi-
14 nority groups and their families;
15 (C) information on geographic areas, and
16 types of hospitals or other birth settings, where
17 respectful maternity care compliance programs
18 are not being established and information on
19 factors contributing to decisions to not establish
20 such programs; and
21 (D) recommendations for establishing re-
22 spectful maternity care compliance programs in
23 geographic areas, and types of hospitals or
24 other birth settings, where such programs are
25 not being established.

1 (2) Whether the funding made available to
2 carry out this section has been sufficient and, if ap-
3 plicable, recommendations for additional appropria-
4 tions to carry out this section.
5 (3) Such other information as the Comptroller
6 General determines appropriate.

7 TITLE IV—MATERNAL HEALTH
8 FOR VETERANS

9 SEC. 401. SUPPORT FOR MATERNITY HEALTH CARE AND
10 COORDINATION PROGRAMS OF THE DEPART-
11 MENT OF VETERANS AFFAIRS.

12 (a) REPORT TO CONGRESS.—Not later than 1 year
13 after the date of the enactment of this Act, and annually
14 thereafter until September 30, 2028, the Secretary of Vet-
15 erans Affairs shall submit to the Committees on Veterans'
16 Affairs of the House of Representatives and the Senate,
17 and make publicly available, a report that contains the fol-
18 lowing:
19 (1) A summary of the activities carried out
20 under the programs of the Department of Veterans
21 Affairs relating to maternity health care or coordina-
22 tion.
23 (2) Data on maternal health outcomes of vet-
24 erans who receive care furnished by the Secretary of

1 Veterans Affairs, including pursuant to such pro-
2 grams.

3 (3) Recommendations by the Secretary of Vet-
4 erans Affairs to improve the maternal health out-
5 comes of veterans, with a particular focus on vet-
6 erans from demographic groups with elevated rates
7 of maternal mortality, severe maternal morbidity,
8 maternal health disparities, or other adverse
9 perinatal or childbirth outcomes.

10 (b) AUTHORIZATION OF APPROPRIATIONS.—

11 (1) IN GENERAL.—There is authorized to be
12 appropriated to the Secretary of Veterans Affairs
13 $15,000,000 for each of fiscal years 2024, 2025,
14 2026, 2027, and 2028, for the programs of the De-
15 partment of Veterans Affairs relating to maternity
16 care coordination and related programs, including
17 the maternity care coordination program described
18 in Veterans Health Administration Directive
19 1330.03.

20 (2) SUPPLEMENT NOT SUPPLANT.—Amounts
21 authorized under paragraph (1) are authorized in
22 addition to any other amounts authorized for mater-
23 nity health care and coordination for the Depart-
24 ment of Veterans Affairs.

1 # TITLE V—PERINATAL
2 # WORKFORCE

3 **SEC. 501. HHS AGENCY DIRECTIVES.**

4 (a) GUIDANCE TO STATES.—

5 (1) IN GENERAL.—Not later than 2 years after
6 the date of enactment of this Act, the Secretary of
7 Health and Human Services shall issue and dissemi-
8 nate guidance to States to educate providers, man-
9 aged care entities, and other insurers about the
10 value and process of delivering respectful maternal
11 health care through diverse and multidisciplinary
12 care provider models.

13 (2) CONTENTS.—The guidance required by
14 paragraph (1) shall address how States can encour-
15 age and incentivize hospitals, health systems, mid-
16 wifery practices, freestanding birth centers, other
17 maternity care provider groups, managed care enti-
18 ties, and other insurers—

19 (A) to recruit and retain maternity care
20 providers, mental and behavioral health care
21 providers acting in accordance with State law,
22 and registered dietitians or nutrition profes-
23 sionals (as such term is defined in section
24 1861(vv)(2) of the Social Security Act (42
25 U.S.C. 1395x(vv)(2)))—

1 (i) from racially, ethnically, and lin-
2 guistically diverse backgrounds;
3 (ii) with experience practicing in ra-
4 cially and ethnically diverse communities;
5 and
6 (iii) who have undergone training on
7 implicit bias and racism;
8 (B) to incorporate into maternity care
9 teams—
10 (i) midwives who meet, at a minimum,
11 the international definition of a midwife
12 and global standards for midwifery edu-
13 cation as established by the International
14 Confederation of Midwives;
15 (ii) perinatal health workers;
16 (iii) physician assistants;
17 (iv) advanced practice registered
18 nurses; and
19 (v) lactation consultants certified by
20 the International Board of Lactation Con-
21 sultant Examiners;
22 (C) to provide collaborative, culturally and
23 linguistically congruent care; and
24 (D) to provide opportunities for individuals
25 enrolled in accredited midwifery education pro-

1 grams to participate in job shadowing with ma-
2 ternity care teams in hospitals, health systems,
3 midwifery practices, and freestanding birth cen-
4 ters.

5 (b) STUDY ON RESPECTFUL AND CULTURALLY AND
6 LINGUISTICALLY CONGRUENT MATERNITY CARE.—

7 (1) STUDY.—The Secretary of Health and
8 Human Services acting through the Director of the
9 National Institutes of Health (in this subsection re-
10 ferred to as the "Secretary") shall conduct a study
11 on best practices in respectful and culturally and lin-
12 guistically congruent maternity care.

13 (2) REPORT.—Not later than 2 years after the
14 date of enactment of this Act, the Secretary shall—

15 (A) complete the study required by para-
16 graph (1);

17 (B) submit to the Congress and make pub-
18 licly available a report on the results of such
19 study; and

20 (C) include in such report—

21 (i) a compendium of examples of hos-
22 pitals, health systems, midwifery practices,
23 freestanding birth centers, other maternity
24 care provider groups, managed care enti-
25 ties, and other insurers that are delivering

respectful and culturally and linguistically congruent maternal health care;

(ii) a compendium of examples of hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers that have made progress in reducing disparities in maternal health outcomes and improving birthing experiences for pregnant and postpartum individuals from racial and ethnic minority groups; and

(iii) recommendations to hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers, for best practices in respectful and culturally and linguistically congruent maternity care.

SEC. 502. GRANTS TO GROW AND DIVERSIFY THE PERINATAL WORKFORCE.

Title VII of the Public Health Service Act is amended by inserting after section 757 (42 U.S.C. 294f) the following new section:

1 **"SEC. 758. PERINATAL WORKFORCE GRANTS.**

2 ''(a) IN GENERAL.—The Secretary shall award
3 grants to entities to establish or expand programs de-
4 scribed in subsection (b) to grow and diversify the
5 perinatal workforce.

6 ''(b) USE OF FUNDS.—Recipients of grants under
7 this section shall use the grants to grow and diversify the
8 perinatal workforce by—

9 ''(1) establishing accredited schools or pro-
10 grams that provide education and training to indi-
11 viduals seeking appropriate licensing and certifi-
12 cation as—

13 ''(A) physician assistants who will complete
14 clinical training in the field of maternal and
15 perinatal health;

16 ''(B) perinatal health workers; or

17 ''(C) midwives who meet, at a minimum,
18 the international definition of a midwife and
19 global standards for midwifery education as es-
20 tablished by the International Confederation of
21 Midwives; and

22 ''(2) expanding the capacity of existing accred-
23 ited schools or programs described in paragraph (1),
24 for the purposes of increasing the number of stu-
25 dents enrolled in such accredited schools or pro-
26 grams, such as by awarding scholarships for stu-

1 dents (including students from racially, ethnically,
2 and linguistically diverse backgrounds).
3 ‘‘(c) PRIORITIZATION.—In awarding grants under
4 this section, the Secretary shall give priority to a school
5 or program described in subsection (b) that—
6 ‘‘(1) has demonstrated a commitment to re-
7 cruiting and retaining students and faculty from ra-
8 cial and ethnic minority groups;
9 ‘‘(2) has developed a strategy to recruit and re-
10 tain a diverse pool of students into the school or pro-
11 gram described in subsection (b) that is supported
12 by funds received through the grant, particularly
13 from racial and ethnic minority groups and other
14 underserved populations;
15 ‘‘(3) has developed a strategy to recruit and re-
16 tain students who plan to practice in a health pro-
17 fessional shortage area designated under section
18 332;
19 ‘‘(4) has developed a strategy to recruit and re-
20 tain students who plan to practice in an area with
21 significant racial and ethnic disparities in maternal
22 health outcomes, to the extent practicable; and
23 ‘‘(5) includes in the standard curriculum for all
24 students within the school or program described in
25 subsection (b) a bias, racism, or discrimination

1 training program that includes training on implicit
2 bias and racism.

3 ‘‘(d) REPORTING.—As a condition on receipt of a
4 grant under this section for a school or program described
5 in subsection (b), an entity shall agree to submit to the
6 Secretary an annual report on the activities conducted
7 through the grant, including—

8 ‘‘(1) the number and demographics of students
9 participating in the school or program;

10 ‘‘(2) the extent to which students in the school
11 or program are entering careers in—

12 ‘‘(A) health professional shortage areas
13 designated under section 332; and

14 ‘‘(B) areas with elevated rates of maternal
15 mortality, severe maternal morbidity, maternal
16 health disparities, or other adverse perinatal or
17 childbirth outcomes, to the extent such data are
18 available; and

19 ‘‘(3) whether the school or program has in-
20 cluded in the standard curriculum for all students a
21 bias, racism, or discrimination training program that
22 includes explicit and implicit bias, and if so the ef-
23 fectiveness of such training program.

24 ‘‘(e) PERIOD OF GRANTS.—The period of a grant
25 under this section shall be up to 5 years.

1 "(f) APPLICATION.—To seek a grant under this sec-
2 tion, an entity shall submit to the Secretary an application
3 at such time, in such manner, and containing such infor-
4 mation as the Secretary may require, including any infor-
5 mation necessary for prioritization under subsection (c).
6 "(g) TECHNICAL ASSISTANCE.—The Secretary shall
7 provide, directly or by contract, technical assistance to en-
8 tities seeking or receiving a grant under this section on
9 the development, use, evaluation, and postgrant period
10 sustainability of the school or program described in sub-
11 section (b) that is proposed to be, or is being, established
12 or expanded through the grant.
13 "(h) REPORT BY THE SECRETARY.—Not later than
14 4 years after the date of enactment of this section, the
15 Secretary shall prepare and submit to the Congress, and
16 post on the internet website of the Department of Health
17 and Human Services, a report on the effectiveness of the
18 grant program under this section at—
19 "(1) recruiting students from racial and ethnic
20 minority groups;
21 "(2) increasing the number of health profes-
22 sionals described in subparagraphs (A), (B), and (C)
23 of subsection (b)(1) from racial and ethnic minority
24 groups and other underserved populations;

1 “(3) increasing the number of such health pro-
2 fessionals working in health professional shortage
3 areas designated under section 332; and
4 “(4) increasing the number of such health pro-
5 fessionals working in areas with significant racial
6 and ethnic disparities in maternal health outcomes,
7 to the extent such data are available.
8 “(i) DEFINITION.—In this section, the term ‘racial
9 and ethnic minority group’ has the meaning given such
10 term in section 1707(g)(1).
11 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this section, there is authorized to be appro-
13 priated $15,000,000 for each of fiscal years 2024 through
14 2028.”.

15 **SEC. 503. GRANTS TO GROW AND DIVERSIFY THE NURSING**
16 **WORKFORCE IN MATERNAL AND PERINATAL**
17 **HEALTH.**

18 Title VIII of the Public Health Service Act is amend-
19 ed by inserting after section 811 of that Act (42 U.S.C.
20 296j) the following:

21 **“SEC. 812. PERINATAL NURSING WORKFORCE GRANTS.**

22 “(a) IN GENERAL.—The Secretary shall award
23 grants to schools of nursing to grow and diversify the
24 perinatal nursing workforce.

1 "(b) USE OF FUNDS.—Recipients of grants under
2 this section shall use the grants to grow and diversify the
3 perinatal nursing workforce by providing scholarships to
4 students seeking to become—

5 "(1) nurse practitioners whose education in-
6 cludes a focus on maternal and perinatal health;

7 "(2) certified nurse-midwives; or

8 "(3) clinical nurse specialists whose education
9 includes a focus on maternal and perinatal health.

10 "(c) PRIORITIZATION.—In awarding grants under
11 this section, the Secretary shall give priority to any school
12 of nursing that—

13 "(1) has developed a strategy to recruit and re-
14 tain a diverse pool of students seeking to enter ca-
15 reers focused on maternal and perinatal health, par-
16 ticularly students from racial and ethnic minority
17 groups and other underserved populations;

18 "(2) has developed a partnership with a prac-
19 tice setting in a health professional shortage area
20 designated under section 332 for the clinical place-
21 ments of the school's students;

22 "(3) has developed a strategy to recruit and re-
23 tain students who plan to practice in an area with
24 significant racial and ethnic disparities in maternal
25 health outcomes, to the extent practicable; and

1 "(4) includes in the standard curriculum for all
2 students seeking to enter careers focused on mater-
3 nal and perinatal health a bias, racism, or discrimi-
4 nation training program that includes education on
5 implicit bias and racism.

6 "(d) REPORTING.—As a condition on receipt of a
7 grant under this section, a school of nursing shall agree
8 to submit to the Secretary an annual report on the activi-
9 ties conducted through the grant, including, to the extent
10 practicable—

11 "(1) the number and demographics of students
12 in the school of nursing seeking to enter careers fo-
13 cused on maternal and perinatal health;

14 "(2) the extent to which such students are pre-
15 paring to enter careers in—

16 "(A) health professional shortage areas
17 designated under section 332; and

18 "(B) areas with elevated rates of maternal
19 mortality, severe maternal morbidity, maternal
20 health disparities, or other adverse perinatal or
21 childbirth outcomes, to the extent such data are
22 available; and

23 "(3) whether the standard curriculum for all
24 students seeking to enter careers focused on mater-
25 nal and perinatal health includes a bias, racism, or

1 discrimination training program that includes edu-
2 cation on implicit bias and racism.

3 "(e) PERIOD OF GRANTS.—The period of a grant
4 under this section shall be up to 5 years.

5 "(f) APPLICATION.—To seek a grant under this sec-
6 tion, an entity shall submit to the Secretary an applica-
7 tion, at such time, in such manner, and containing such
8 information as the Secretary may require, including any
9 information necessary for prioritization under subsection
10 (c).

11 "(g) TECHNICAL ASSISTANCE.—The Secretary shall
12 provide, directly or by contract, technical assistance to
13 schools of nursing seeking or receiving a grant under this
14 section on the processes of awarding and evaluating schol-
15 arships through the grant.

16 "(h) REPORT BY THE SECRETARY.—Not later than
17 4 years after the date of enactment of this section, the
18 Secretary shall prepare and submit to the Congress, and
19 post on the internet website of the Department of Health
20 and Human Services, a report on the effectiveness of the
21 grant program under this section at—

22 "(1) recruiting students from racial and ethnic
23 minority groups and other underserved populations;

24 "(2) increasing the number of advanced prac-
25 tice registered nurses entering careers focused on

1 maternal and perinatal health from racial and ethnic
2 minority groups and other underserved populations;
3 "(3) increasing the number of advanced prac-
4 tice registered nurses entering careers focused on
5 maternal and perinatal health working in health pro-
6 fessional shortage areas designated under section
7 332; and
8 "(4) increasing the number of advanced prac-
9 tice registered nurses entering careers focused on
10 maternal and perinatal health working in areas with
11 significant racial and ethnic disparities in maternal
12 health outcomes, to the extent such data are avail-
13 able.
14 "(i) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this section, there is authorized to be appro-
16 priated $15,000,000 for each of fiscal years 2024 through
17 2028.".
18 **SEC. 504. GAO REPORT.**
19 (a) IN GENERAL.—Not later than 2 years after the
20 date of enactment of this Act and every 5 years thereafter,
21 the Comptroller General of the United States shall submit
22 to Congress a report on barriers to maternal health edu-
23 cation and access to care in the United States. Such report
24 shall include the information and recommendations de-
25 scribed in subsection (b).

1 (b) CONTENT OF REPORT.—The report under sub-
2 section (a) shall include—
3 (1) an assessment of current barriers to enter-
4 ing and successfully completing accredited midwifery
5 education programs, and recommendations for ad-
6 dressing such barriers, particularly for low-income
7 women and women from racial and ethnic minority
8 groups;
9 (2) an assessment of current barriers to enter-
10 ing and successfully completing accredited education
11 programs for other health professional careers re-
12 lated to maternity care, including maternity care
13 providers, mental and behavioral health care pro-
14 viders acting in accordance with State law, and reg-
15 istered dietitians or nutrition professionals (as such
16 term is defined in section 1861(vv)(2) of the Social
17 Security Act (42 U.S.C. 1395x(vv)(2)), particularly
18 for low-income women and women from racial and
19 ethnic minority groups;
20 (3) an assessment of current barriers that pre-
21 vent midwives from meeting the international defini-
22 tion of a midwife and global standards for midwifery
23 education as established by the International Con-
24 federation of Midwives, and recommendations for
25 addressing such barriers, particularly for low-income

1 women and women from racial and ethnic minority
2 groups;
3 (4) an assessment of disparities in access to
4 maternity care providers, mental or behavioral
5 health care providers acting in accordance with
6 State law, and registered dietitians or nutrition pro-
7 fessionals (as such term is defined in section
8 1861(vv)(2) of the Social Security Act (42 U.S.C.
9 1395x(vv)(2))), and perinatal health workers, strati-
10 fied by race, ethnicity, gender identity, primary lan-
11 guage, geographic location, and insurance type and
12 recommendations to promote greater access equity;
13 and
14 (5) recommendations to promote greater equity
15 in compensation for perinatal health workers under
16 public and private insurers, particularly for such in-
17 dividuals from racially and ethnically diverse back-
18 grounds.

19 TITLE VI—DATA TO SAVE MOMS

20 SEC. 601. FUNDING FOR MATERNAL MORTALITY REVIEW 21 COMMITTEES TO PROMOTE REPRESENTA- 22 TIVE COMMUNITY ENGAGEMENT.

23 (a) IN GENERAL.—Section 317K(d) of the Public
24 Health Service Act (42 U.S.C. 247b–12(d)) is amended
25 by adding at the end the following:

1 "(9) GRANTS TO PROMOTE REPRESENTATIVE
2 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
3 TALITY REVIEW COMMITTEES.—
4 "(A) IN GENERAL.—The Secretary may,
5 using funds made available pursuant to sub-
6 paragraph (C), provide assistance to an applica-
7 ble maternal mortality review committee of a
8 State, Indian Tribe, Tribal organization, or
9 Urban Indian organization (as such terms are
10 defined in section 4 of the Indian Health Care
11 Improvement Act)—
12 "(i) to select for inclusion in the mem-
13 bership of such a committee community
14 members from the State, Indian Tribe,
15 Tribal organization, or Urban Indian orga-
16 nization by—
17 "(I) prioritizing community mem-
18 bers who can increase the diversity of
19 the committee's membership with re-
20 spect to race and ethnicity, location,
21 personal or family experiences of ma-
22 ternal mortality or severe maternal
23 morbidity, and professional back-
24 ground, including members with non-
25 clinical experiences; and

1 "(II) to the extent applicable,
2 using funds reserved under subsection
3 (f), to address barriers to maternal
4 mortality review committee participa-
5 tion for community members, includ-
6 ing required training, transportation
7 barriers, compensation, and other sup-
8 ports as may be necessary;
9 "(ii) to establish initiatives to conduct
10 outreach and community engagement ef-
11 forts within communities throughout the
12 State or Tribe to seek input from commu-
13 nity members on the work of such mater-
14 nal mortality review committee, with a par-
15 ticular focus on outreach to women from
16 racial and ethnic minority groups (as such
17 term is defined in section 1707(g)(1)); and
18 "(iii) to release public reports assess-
19 ing—
20 "(I) the pregnancy-related death
21 and pregnancy-associated death review
22 processes of the maternal mortality
23 review committee, with a particular
24 focus on the maternal mortality re-
25 view committee's sensitivity to the

1 unique circumstances of pregnant and
2 postpartum individuals from racial
3 and ethnic minority groups (as such
4 term is defined in section 1707(g)(1))
5 who have suffered pregnancy-related
6 deaths; and
7 ‘‘(II) the impact of the use of
8 funds made available pursuant to sub-
9 paragraph (C) on increasing the diver-
10 sity of the maternal mortality review
11 committee membership and promoting
12 community engagement efforts
13 throughout the State or Tribe.
14 ‘‘(B) TECHNICAL ASSISTANCE.—The Sec-
15 retary shall provide (either directly through the
16 Department of Health and Human Services or
17 by contract) technical assistance to any mater-
18 nal mortality review committee receiving a
19 grant under this paragraph on best practices
20 for increasing the diversity of the maternal
21 mortality review committee's membership and
22 for conducting effective community engagement
23 throughout the State or Tribe.
24 ‘‘(C) AUTHORIZATION OF APPROPRIA-
25 TIONS.—In addition to any funds made avail-

1 able under subsection (f), there is authorized to
2 be appropriated to carry out this paragraph
3 $10,000,000 for each of fiscal years 2024
4 through 2028.''.

5 (b) RESERVATION OF FUNDS.—Section 317K(f) of
6 the Public Health Service Act (42 U.S.C. 247b–12(f)) is
7 amended by adding at the end the following: ''Of the
8 amount made available under the preceding sentence for
9 a fiscal year, not less than $1,500,000 shall be reserved
10 for grants to Indian Tribes, Tribal organizations, or
11 Urban Indian organizations (as those terms are defined
12 in section 4 of the Indian Health Care Improvement
13 Act)''.

14 **SEC. 602. DATA COLLECTION AND REVIEW.**

15 Section 317K(d)(3)(A)(i) of the Public Health Serv-
16 ice Act (42 U.S.C. 247b–12(d)(3)(A)(i)) is amended—

17 (1) by redesignating subclauses (II) and (III)
18 as subclauses (V) and (VI), respectively; and

19 (2) by inserting after subclause (I) the fol-
20 lowing:

21 ''(II) to the extent practicable,
22 reviewing cases of severe maternal
23 morbidity, according to the most up-
24 to-date indicators;

1 "(III) to the extent practicable,
2 reviewing deaths during pregnancy or
3 up to 1 year after the end of a preg-
4 nancy from suicide, overdose, or other
5 death from a mental health condition
6 or substance use disorder attributed
7 to or aggravated by pregnancy or
8 childbirth complications;

9 "(IV) to the extent practicable,
10 consulting with local community-based
11 organizations representing pregnant
12 and postpartum individuals from de-
13 mographic groups with elevated rates
14 of maternal mortality, severe maternal
15 morbidity, maternal health disparities,
16 or other adverse perinatal or child-
17 birth outcomes to ensure that, in ad-
18 dition to clinical factors, nonclinical
19 factors that might have contributed to
20 a pregnancy-related death are appro-
21 priately considered;".

22 **SEC. 603. REVIEW OF MATERNAL HEALTH DATA COLLEC-**
23 **TION PROCESSES AND QUALITY MEASURES.**

24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services, acting through the Administrator of the

1 Centers for Medicare & Medicaid Services and the Direc-
2 tor of the Agency for Healthcare Research and Quality,
3 shall consult with relevant stakeholders—
4 (1) to review existing maternal health data col-
5 lection processes and quality measures; and
6 (2) to make recommendations to improve such
7 processes and measures, including topics described
8 under subsection (c).
9 (b) COLLABORATION.—In carrying out this section,
10 the Secretary shall consult with a diverse group of mater-
11 nal health stakeholders, which may include—
12 (1) pregnant and postpartum individuals and
13 their family members, and nonprofit organizations
14 representing such individuals, with a particular focus
15 on patients from racial and ethnic minority groups;
16 (2) community-based organizations that provide
17 support for pregnant and postpartum individuals,
18 with a particular focus on patients from demo-
19 graphic groups with elevated rates of maternal mor-
20 tality, severe maternal morbidity, maternal health
21 disparities, or other adverse perinatal or childbirth
22 outcomes;
23 (3) membership organizations for maternity
24 care providers;

1 (4) organizations representing perinatal health
2 workers;
3 (5) organizations that focus on maternal mental
4 or behavioral health;
5 (6) organizations that focus on intimate partner
6 violence;
7 (7) institutions of higher education, with a par-
8 ticular focus on minority-serving institutions;
9 (8) licensed and accredited hospitals, birth cen-
10 ters, midwifery practices, or other facilities that pro-
11 vide maternal health care services;
12 (9) relevant State and local public agencies, in-
13 cluding State maternal mortality review committees;
14 and
15 (10) the National Quality Forum, or such other
16 standard-setting organizations specified by the Sec-
17 retary.
18 (c) TOPICS.—The review of maternal health data col-
19 lection processes and recommendations to improve such
20 processes and measures required under subsection (a)
21 shall assess all available relevant information, including
22 information from State-level sources, and shall consider at
23 least the following:
24 (1) Current State and Tribal practices for ma-
25 ternal health, maternal mortality, and severe mater-

1 nal morbidity data collection and dissemination, in-
2 cluding consideration of—
3 (A) the timeliness of processes for amend-
4 ing a death certificate when new information
5 pertaining to the death becomes available to re-
6 flect whether the death was a pregnancy-related
7 death;
8 (B) relevant data collected with electronic
9 health records, including data on race, eth-
10 nicity, primary language, socioeconomic status,
11 geography, insurance type, and other relevant
12 demographic information;
13 (C) maternal health data collected and
14 publicly reported by hospitals, health systems,
15 midwifery practices, and birth centers;
16 (D) the barriers preventing States from
17 correlating maternal outcome data with data on
18 race, ethnicity, and other demographic charac-
19 teristics;
20 (E) processes for determining the cause of
21 a pregnancy-associated death in States that do
22 not have a maternal mortality review com-
23 mittee;
24 (F) whether maternal mortality review
25 committees include multidisciplinary and di-

1 verse membership (as described in section
2 317K(d)(1)(A) of the Public Health Service Act
3 (42 U.S.C. 247b–12(d)(1)(A)));
4 (G) whether members of maternal mor-
5 tality review committees participate in trainings
6 on bias, racism, or discrimination, and the qual-
7 ity of such trainings;
8 (H) the extent to which States have imple-
9 mented systematic processes of listening to the
10 stories of pregnant and postpartum individuals
11 and their family members, with a particular
12 focus on pregnant and postpartum individuals
13 from demographic groups with elevated rates of
14 maternal mortality, severe maternal morbidity,
15 maternal health disparities, or other adverse
16 perinatal or childbirth outcomes, and their fam-
17 ily members, to fully understand the causes of,
18 and inform potential solutions to, the maternal
19 mortality and severe maternal morbidity crisis
20 within their respective States;
21 (I) the extent to which maternal mortality
22 review committees are considering social deter-
23 minants of maternal health when examining the
24 causes of pregnancy-associated and pregnancy-
25 related deaths;

1 (J) the extent to which maternal mortality
2 review committees are making actionable rec-
3 ommendations based on their reviews of adverse
4 maternal health outcomes and the extent to
5 which such recommendations are being imple-
6 mented by appropriate stakeholders;
7 (K) the legal and administrative barriers
8 preventing the collection, collation, and dissemi-
9 nation of State maternity care data;
10 (L) the effectiveness of data collection and
11 reporting processes in separating pregnancy-as-
12 sociated deaths from pregnancy-related deaths;
13 and
14 (M) the current Federal, State, local, and
15 Tribal funding support for the activities re-
16 ferred to in subparagraphs (A) through (L).
17 (2) Whether the funding support referred to in
18 paragraph (1)(M) is adequate for States to carry out
19 optimal data collection and dissemination processes
20 with respect to maternal health, maternal mortality,
21 and severe maternal morbidity.
22 (3) Current quality measures for maternity
23 care, including prenatal measures, labor and delivery
24 measures, and postpartum measures, including top-
25 ics such as—

1 (A) effective quality measures for mater-
2 nity care used by hospitals, health systems,
3 midwifery practices, birth centers, health plans,
4 and other relevant entities;
5 (B) the sufficiency of current outcome
6 measures used to evaluate maternity care for
7 driving improved care, experiences, and out-
8 comes in maternity care payment and delivery
9 system models;
10 (C) maternal health quality measures that
11 other countries effectively use;
12 (D) validated measures that have been
13 used for research purposes that could be tested,
14 refined, and submitted for national endorse-
15 ment;
16 (E) barriers preventing maternity care pro-
17 viders and insurers from implementing quality
18 measures that are aligned with best practices;
19 (F) the frequency with which maternity
20 care quality measures are reviewed and revised;
21 (G) the strengths and weaknesses of the
22 Prenatal and Postpartum Care measures of the
23 Health Plan Employer Data and Information
24 Set measures established by the National Com-
25 mittee for Quality Assurance;

1 (H) the strengths and weaknesses of ma-
2 ternity care quality measures under the Med-
3 icaid program under title XIX of the Social Se-
4 curity Act (42 U.S.C. 1396 et seq.) and the
5 Children's Health Insurance Program under
6 title XXI of such Act (42 U.S.C. 1397 et seq.),
7 including the extent to which States voluntarily
8 report relevant measures;
9 (I) the extent to which maternity care
10 quality measures are informed by patient expe-
11 riences that include measures of patient-re-
12 ported experience of care;
13 (J) the current processes for collecting and
14 making publicly available, to the extent prac-
15 ticable, stratified data on race, ethnicity, and
16 other demographic characteristics of pregnant
17 and postpartum individuals in hospitals, health
18 systems, midwifery practices, and birth centers,
19 and for incorporating such demographically
20 stratified data in maternity care quality meas-
21 ures;
22 (K) the extent to which maternity care
23 quality measures account for the unique experi-
24 ences of pregnant and postpartum individuals
25 from racial and ethnic minority groups; and

1 (L) the extent to which hospitals, health
2 systems, midwifery practices, and birth centers
3 are implementing existing maternity care qual-
4 ity measures.
5 (4) Recommendations on authorizing additional
6 funds and providing additional technical assistance
7 to improve maternal mortality review committees
8 and State and Tribal maternal health data collection
9 and reporting processes.
10 (5) Recommendations for new authorities that
11 may be granted to maternal mortality review com-
12 mittees to be able to—
13 (A) access records from other Federal and
14 State agencies and departments that may be
15 necessary to identify causes of pregnancy-asso-
16 ciated and pregnancy-related deaths that are
17 unique to pregnant and postpartum individuals
18 from specific populations, such as veterans and
19 individuals who are incarcerated; and
20 (B) work with relevant experts who are not
21 members of the maternal mortality review com-
22 mittee to assist in the review of pregnancy-asso-
23 ciated deaths of pregnant and postpartum indi-
24 viduals from specific populations, such as vet-
25 erans and individuals who are incarcerated.

1 (6) Recommendations to improve and stand-
2 ardize current quality measures for maternity care,
3 with a particular focus on maternal health dispari-
4 ties.

5 (7) Recommendations to improve the coordina-
6 tion by the Department of Health and Human Serv-
7 ices of the efforts undertaken by the agencies and
8 organizations within the Department related to ma-
9 ternal health data and quality measures.

10 (d) REPORT.—Not later than 1 year after the enact-
11 ment of this Act, the Secretary shall submit to the Con-
12 gress and make publicly available a report on the results
13 of the review of maternal health data collection processes
14 and quality measures and recommendations to improve
15 such processes and measures required under subsection
16 (a).

17 (e) DEFINITION.—In this section, the term ''maternal
18 mortality review committee'' means a maternal mortality
19 review committee duly authorized by a State and receiving
20 funding under section 317K(a)(2)(D) of the Public Health
21 Service Act (42 U.S.C. 247b–12(a)(2)(D)).

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated such sums as may be
24 necessary to carry out this section for fiscal years 2024
25 through 2027.

1 **SEC. 604. STUDY ON MATERNAL HEALTH AMONG AMER-**
2 **ICAN INDIAN AND ALASKA NATIVE INDIVID-**
3 **UALS.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services (referred to in this section as the ''Sec-
6 retary'') shall, in coordination with entities described in
7 subsection (b)—

8 (1) not later than 90 days after the enactment
9 of this Act, enter into a contract with an inde-
10 pendent research organization or Tribal Epidemi-
11 ology Center to conduct a comprehensive study on
12 maternal mortality, severe maternal morbidity, and
13 other adverse perinatal or childbirth outcomes in the
14 populations of American Indian and Alaska Native
15 individuals; and

16 (2) not later than 3 years after the date of the
17 enactment of this Act, submit to Congress a report
18 on such study that contains recommendations for
19 policies and practices that can be adopted to im-
20 prove maternal health outcomes for American Indian
21 and Alaska Native individuals.

22 (b) PARTICIPATING ENTITIES.—The entities de-
23 scribed in this subsection shall consist of 12 members, se-
24 lected by the Secretary from among individuals nominated
25 by Indian Tribes and Tribal organizations (as such terms
26 are defined in section 4 of the Indian Self-Determination

1 and Education Assistance Act (25 U.S.C. 5304)), and
2 Urban Indian organizations (as such term is defined in
3 section 4 of the Indian Health Care Improvement Act (25
4 U.S.C. 1603)). In selecting such members, the Secretary
5 shall ensure that each of the 12 service areas of the Indian
6 Health Service is represented.

7 (c) CONTENTS OF STUDY.—The study conducted
8 pursuant to subsection (a) shall—

9 (1) examine the causes of maternal mortality
10 and severe maternal morbidity that are unique to
11 American Indian and Alaska Native individuals;

12 (2) include a systematic process of listening to
13 the stories of American Indian and Alaska Native
14 individuals to fully understand the causes of, and in-
15 form potential solutions to, the maternal health cri-
16 sis within their respective communities;

17 (3) distinguish between the causes of, landscape
18 of maternity care at, and recommendations to im-
19 prove maternal health outcomes within, the different
20 settings in which American Indian and Alaska Na-
21 tive individuals receive maternity care, such as—

22 (A) facilities operated by the Indian
23 Health Service;

24 (B) an Indian health program operated by
25 an Indian Tribe or Tribal organization pursu-

1 ant to a contract, grant, cooperative agreement,
2 or compact with the Indian Health Service pur-
3 suant to the Indian Self-Determination Act;
4 (C) an urban Indian health program oper-
5 ated by an Urban Indian organization pursuant
6 to a grant or contract with the Indian Health
7 Service pursuant to title V of the Indian Health
8 Care Improvement Act; and
9 (D) facilities outside of the Indian Health
10 Service in which American Indian and Alaska
11 Native individuals receive maternity care serv-
12 ices;
13 (4) review processes for coordinating programs
14 of the Indian Health Service with social services pro-
15 vided through other programs administered by the
16 Secretary of Health and Human Services (other
17 than the Medicare Program under title XVIII of the
18 Social Security Act (42 U.S.C. 1395 et seq.), the
19 Medicaid Program under title XIX of such Act (42
20 U.S.C. 1396 et seq.), and the Children's Health In-
21 surance Program under title XXI of such Act (42
22 U.S.C. 1397 et seq.);
23 (5) review current data collection and quality
24 measurement processes and practices;

1 (6) assess causes and frequency of maternal
2 mental health conditions and substance use dis-
3 orders;

4 (7) consider social determinants of health, in-
5 cluding poverty, lack of health insurance, unemploy-
6 ment, sexual and domestic violence, and environ-
7 mental conditions in Tribal areas;

8 (8) consider the role that historical mistreat-
9 ment of American Indian and Alaska Native women
10 has played in causing currently elevated rates of ma-
11 ternal mortality, severe maternal morbidity, and
12 other adverse perinatal or childbirth outcomes;

13 (9) consider how current funding of the Indian
14 Health Service affects the ability of the Service to
15 deliver quality maternity care;

16 (10) consider the extent to which the delivery of
17 maternity care services is culturally appropriate for
18 American Indian and Alaska Native individuals;

19 (11) make recommendations to reduce
20 misclassification of American Indian and Alaska Na-
21 tive individuals, including consideration of best prac-
22 tices in training for maternal mortality review com-
23 mittee members to be able to correctly classify
24 American Indian and Alaska Native individuals; and

(12) make recommendations informed by the stories shared by American Indian and Alaska Native individuals referred to in paragraph (2) to improve maternal health outcomes for such individuals.

(d) REPORT.—The agreement entered into under subsection (a) with an independent research organization or Tribal Epidemiology Center shall require that the organization or Center transmit to Congress a report on the results of the study conducted pursuant to that agreement not later than 36 months after the date of the enactment of this Act.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2024 through 2026.

SEC. 605. GRANTS TO MINORITY-SERVING INSTITUTIONS TO STUDY MATERNAL MORTALITY, SEVERE MATERNAL MORBIDITY, AND OTHER ADVERSE MATERNAL HEALTH OUTCOMES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a program under which the Secretary shall award grants to research centers, health professions schools and programs, and other entities at minority-serving institutions to study specific aspects of the maternal health crisis among pregnant and

1 postpartum individuals from racial and ethnic minority
2 groups. Such research may—
3 (1) include the development and implementation
4 of systematic processes of listening to the stories of
5 pregnant and postpartum individuals from racial
6 and ethnic minority groups, and perinatal health
7 workers supporting such individuals, to fully under-
8 stand the causes of, and inform potential solutions
9 to, the maternal mortality and severe maternal mor-
10 bidity crisis within their respective communities;
11 (2) assess the potential causes of relatively low
12 rates of maternal mortality among Hispanic individ-
13 uals, including potential racial misclassification and
14 other data collection and reporting issues that might
15 be misrepresenting maternal mortality rates among
16 Hispanic individuals in the United States;
17 (3) assess differences in rates of adverse mater-
18 nal health outcomes among subgroups identifying as
19 Hispanic, including disparities in access to early pre-
20 natal care; and
21 (4) include lactation education to promote ra-
22 cial and ethnic diversity within the workforce of
23 health care professionals with breastfeeding and lac-
24 tation expertise.

1 (b) APPLICATION.—To be eligible to receive a grant
2 under subsection (a), an entity described in such sub-
3 section shall submit to the Secretary an application at
4 such time, in such manner, and containing such informa-
5 tion as the Secretary may require.

6 (c) TECHNICAL ASSISTANCE.—The Secretary may
7 use not more than 10 percent of the funds made available
8 under subsection (g)—

9 (1) to conduct outreach to minority-serving in-
10 stitutions to raise awareness of the availability of
11 grants under subsection (a);

12 (2) to provide technical assistance in the appli-
13 cation process for such a grant; and

14 (3) to promote capacity building as needed to
15 enable entities described in such subsection to sub-
16 mit such an application.

17 (d) REPORTING REQUIREMENT.—Each entity award-
18 ed a grant under this section shall periodically submit to
19 the Secretary a report on the status of activities conducted
20 using the grant.

21 (e) EVALUATION.—Beginning 1 year after the date
22 on which the first grant is awarded under this section,
23 the Secretary shall submit to Congress an annual report
24 summarizing the findings of research conducted using
25 funds made available under this section.

1 (f) MINORITY-SERVING INSTITUTIONS DEFINED.—In
2 this section, the term ''minority-serving institution'' has
3 the meaning given the term in section 371(a) of the High-
4 er Education Act of 1965 (20 U.S.C. 1067q(a)).
5 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 $10,000,000 for each of fiscal years 2024 through 2028.

8 TITLE VII—MOMS MATTER

9 SEC. 701. MATERNAL MENTAL HEALTH EQUITY GRANT
10 PROGRAM.

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services, acting through the Assistant Secretary
13 for Mental Health and Substance Use, shall establish a
14 program to award grants to eligible entities to address ma-
15 ternal mental health conditions and substance use dis-
16 orders, with a focus on demographic groups with elevated
17 rates of maternal mortality, severe maternal morbidity,
18 maternal health disparities, or other adverse perinatal or
19 childbirth outcomes.
20 (b) APPLICATION.—To be eligible to receive a grant
21 under this section, an eligible entity shall submit to the
22 Secretary an application at such time, in such manner,
23 and containing such information as the Secretary may re-
24 quire.

1 (c) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary shall give priority to an eligible entity
3 that—
4 (1) is, or will partner with, a community-based
5 organization to address maternal mental health con-
6 ditions and substance use disorders described in sub-
7 section (a);
8 (2) is operating in an area with elevated rates
9 of maternal mortality, severe maternal morbidity,
10 maternal health disparities, or other adverse
11 perinatal or childbirth outcomes; and
12 (3) is operating in a health professional short-
13 age area designated under section 332 of the Public
14 Health Service Act (42 U.S.C. 254e).
15 (d) USE OF FUNDS.—An eligible entity that receives
16 a grant under this section shall use the grant for the fol-
17 lowing:
18 (1) Establishing or expanding maternity care
19 programs to improve the integration of maternal
20 mental health and behavioral health care services
21 into primary care settings where pregnant individ-
22 uals regularly receive health care services.
23 (2) Establishing or expanding group prenatal
24 care programs or postpartum care programs.

1 (3) Expanding existing programs that improve
2 maternal mental and behavioral health during the
3 prenatal and postpartum periods, with a focus on in-
4 dividuals from demographic groups with elevated
5 rates of maternal mortality, severe maternal mor-
6 bidity, maternal health disparities, or other adverse
7 perinatal or childbirth outcomes.

8 (4) Providing services and support for pregnant
9 and postpartum individuals with maternal mental
10 health conditions and substance use disorders, in-
11 cluding referrals to addiction treatment centers that
12 offer evidence-based treatment options.

13 (5) Addressing stigma associated with maternal
14 mental health conditions and substance use dis-
15 orders, with a focus on individuals from demo-
16 graphic groups with elevated rates of maternal mor-
17 tality, severe maternal morbidity, maternal health
18 disparities, or other adverse perinatal or childbirth
19 outcomes.

20 (6) Raising awareness of warning signs of ma-
21 ternal mental health conditions and substance use
22 disorders, with a focus on pregnant and postpartum
23 individuals from demographic groups with elevated
24 rates of maternal mortality, severe maternal mor-

1 bidity, maternal health disparities, or other adverse
2 perinatal or childbirth outcomes.

3 (7) Establishing or expanding programs to pre-
4 vent suicide or self-harm among pregnant and
5 postpartum individuals.

6 (8) Offering evidence-aligned programs at free-
7 standing birth centers that provide maternal mental
8 and behavioral health care education, treatments,
9 and services, and other services for individuals
10 throughout the prenatal and postpartum period.

11 (9) Establishing or expanding programs to pro-
12 vide education and training to maternity care pro-
13 viders with respect to—

14 (A) identifying potential warning signs for
15 maternal mental health conditions or substance
16 use disorders in pregnant and postpartum indi-
17 viduals, with a focus on individuals from demo-
18 graphic groups with elevated rates of maternal
19 mortality, severe maternal morbidity, maternal
20 health disparities, or other adverse perinatal or
21 childbirth outcomes; and

22 (B) in the case where such providers iden-
23 tify such warning signs, offering referrals to
24 mental and behavioral health care professionals.

1 (10) Developing a website, or other source, that
2 includes information on health care providers who
3 treat maternal mental health conditions and sub-
4 stance use disorders.

5 (11) Establishing or expanding programs in
6 communities to improve coordination between mater-
7 nity care providers and mental and behavioral health
8 care providers who treat maternal mental health
9 conditions and substance use disorders, including
10 through the use of toll-free hotlines.

11 (12) Carrying out other programs aligned with
12 evidence-based practices for addressing maternal
13 mental health conditions and substance use dis-
14 orders for pregnant and postpartum individuals from
15 demographic groups with elevated rates of maternal
16 mortality, severe maternal morbidity, maternal
17 health disparities, or other adverse perinatal or
18 childbirth outcomes.

19 (e) REPORTING.—

20 (1) ELIGIBLE ENTITIES.—An eligible entity
21 that receives a grant under subsection (a) shall sub-
22 mit annually to the Secretary, and make publicly
23 available, a report on the activities conducted using
24 funds received through a grant under this section.
25 Such reports shall include quantitative and quali-

1 tative evaluations of such activities, including the ex-
2 perience of individuals who received health care
3 through such grant.
4 (2) SECRETARY.—Not later than the end of fis-
5 cal year 2027, the Secretary shall submit to Con-
6 gress a report that includes—
7 (A) a summary of the reports received
8 under paragraph (1);
9 (B) an evaluation of the effectiveness of
10 grants awarded under this section;
11 (C) recommendations with respect to ex-
12 panding coverage of evidence-based screenings
13 and treatments for maternal mental health con-
14 ditions and substance use disorders; and
15 (D) recommendations with respect to en-
16 suring activities described under subsection (d)
17 continue after the end of a grant period.
18 (f) DEFINITIONS.—In this section:
19 (1) ELIGIBLE ENTITY.—The term ''eligible enti-
20 ty'' means—
21 (A) a community-based organization serv-
22 ing pregnant and postpartum individuals, in-
23 cluding such organizations serving individuals
24 from demographic groups with elevated rates of
25 maternal mortality, severe maternal morbidity,

1 maternal health disparities, or other adverse
2 perinatal or childbirth outcomes;
3 (B) a nonprofit or patient advocacy organi-
4 zation with expertise in maternal mental and
5 behavioral health;
6 (C) a maternity care provider;
7 (D) a mental or behavioral health care pro-
8 vider who treats maternal mental health condi-
9 tions or substance use disorders;
10 (E) a State or local governmental entity,
11 including a State or local public health depart-
12 ment;
13 (F) an Indian Tribe or Tribal organization
14 (as such terms are defined in section 4 of the
15 Indian Self-Determination and Education As-
16 sistance Act (25 U.S.C. 5304)); and
17 (G) an Urban Indian organization (as such
18 term is defined in section 4 of the Indian
19 Health Care Improvement Act (25 U.S.C.
20 1603)).
21 (2) FREESTANDING BIRTH CENTER.—The term
22 "freestanding birth center" has the meaning given
23 that term under section 1905(l) of the Social Secu-
24 rity Act (42 U.S.C. 1396d(1)).

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

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $25,000,000 for each of fiscal years 2024 through 2027.

SEC. 702. GRANTS TO GROW AND DIVERSIFY THE MATERNAL MENTAL AND BEHAVIORAL HEALTH CARE WORKFORCE.

Title VII of the Public Health Service Act is amended by inserting after section 758 of such Act (42 U.S.C. 294f), as added by section 402 of this Act, the following new section:

''SEC. 758A. MATERNAL MENTAL AND BEHAVIORAL HEALTH CARE WORKFORCE GRANTS.

''(a) IN GENERAL.—The Secretary may award grants to entities to establish or expand programs described in subsection (b) to grow and diversify the maternal mental and behavioral health care workforce.

''(b) USE OF FUNDS.—Recipients of grants under this section shall use the grants to grow and diversify the maternal mental and behavioral health care workforce by—

''(1) establishing schools or programs that provide education and training to individuals seeking appropriate licensing or certification as mental or

behavioral health care providers who will specialize in maternal mental health conditions or substance use disorders; or

"(2) expanding the capacity of existing schools or programs described in paragraph (1), for the purposes of increasing the number of students enrolled in such schools or programs, including by awarding scholarships for students.

"(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to any entity that—

"(1) has demonstrated a commitment to recruiting and retaining students and faculty from racial and ethnic minority groups;

"(2) has developed a strategy to recruit and retain a diverse pool of students into the maternal mental or behavioral health care workforce program or school supported by funds received through the grant, particularly from racial and ethnic minority groups and other underserved populations;

"(3) has developed a strategy to recruit and retain students who plan to practice in a health professional shortage area designated under section 332;

1 "(4) has developed a strategy to recruit and re-
2 tain students who plan to practice in an area with
3 significant maternal health disparities, to the extent
4 practicable; and
5 "(5) includes in the standard curriculum for all
6 students within the maternal mental or behavioral
7 health care workforce program or school a bias, rac-
8 ism, or discrimination training program that in-
9 cludes training on implicit bias and racism.
10 "(d) REPORTING.—As a condition on receipt of a
11 grant under this section for a maternal mental or behav-
12 ioral health care workforce program or school, an entity
13 shall agree to submit to the Secretary an annual report
14 on the activities conducted through the grant, including—
15 "(1) the number and demographics of students
16 participating in the program or school;
17 "(2) the extent to which students in the pro-
18 gram or school are entering careers in—
19 "(A) health professional shortage areas
20 designated under section 332; and
21 "(B) areas with significant maternal health
22 disparities, to the extent such data are avail-
23 able; and
24 "(3) whether the program or school has in-
25 cluded in the standard curriculum for all students a

1 bias, racism, or discrimination training program that
2 includes training on implicit bias and racism, and if
3 so the effectiveness of such training program.

4 "(e) PERIOD OF GRANTS.—The period of a grant
5 under this section shall be up to 5 years.

6 "(f) APPLICATION.—To seek a grant under this sec-
7 tion, an entity shall submit to the Secretary an application
8 at such time, in such manner, and containing such infor-
9 mation as the Secretary may require, including any infor-
10 mation necessary for prioritization under subsection (c).

11 "(g) TECHNICAL ASSISTANCE.—The Secretary shall
12 provide, directly or by contract, technical assistance to en-
13 tities seeking or receiving a grant under this section on
14 the development, use, evaluation, and postgrant period
15 sustainability of the maternal mental or behavioral health
16 care workforce programs or schools proposed to be, or
17 being, established or expanded through the grant.

18 "(h) REPORT BY THE SECRETARY.—Not later than
19 4 years after the date of enactment of this section, the
20 Secretary shall prepare and submit to the Congress, and
21 post on the internet website of the Department of Health
22 and Human Services, a report on the effectiveness of the
23 grant program under this section at—

24 "(1) recruiting students from racial and ethnic
25 minority groups and other underserved populations;

1 "(2) increasing the number of mental or behav-
2 ioral health care providers specializing in maternal
3 mental health conditions or substance use disorders
4 from racial and ethnic minority groups and other
5 underserved populations;

6 "(3) increasing the number of mental or behav-
7 ioral health care providers specializing in maternal
8 mental health conditions or substance use disorders
9 working in health professional shortage areas des-
10 ignated under section 332; and

11 "(4) increasing the number of mental or behav-
12 ioral health care providers specializing in maternal
13 mental health conditions or substance use disorders
14 working in areas with significant maternal health
15 disparities, to the extent such data are available.

16 "(i) DEFINITIONS.—In this section:

17 "(1) RACIAL AND ETHNIC MINORITY GROUP.—
18 The term 'racial and ethnic minority group' has the
19 meaning given such term in section 1707(g)(1).

20 "(2) MENTAL OR BEHAVIORAL HEALTH CARE
21 PROVIDER.—The term 'mental or behavioral health
22 care provider' refers to a health care provider in the
23 field of mental and behavioral health, including sub-
24 stance use disorders, acting in accordance with State
25 law.

1 "(j) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated $15,000,000 for each of fiscal years 2024 through
4 2028.".

5 TITLE VIII—JUSTICE FOR 6 INCARCERATED MOMS

7 SEC. 801. ENDING THE SHACKLING OF PREGNANT INDIVID- 8 UALS.

9 (a) IN GENERAL.—Beginning on the date that is 6
10 months after the date of enactment of this Act, and annu-
11 ally thereafter, in each State that receives a grant under
12 subpart 1 of part E of title I of the Omnibus Crime Con-
13 trol and Safe Streets Act of 1968 (34 U.S.C. 10151 et
14 seq.) (commonly referred to as the "Edward Byrne Memo-
15 rial Justice Grant Program") and that does not have in
16 effect throughout the State for such fiscal year laws re-
17 stricting the use of restraints on pregnant individuals in
18 prison that are substantially similar to the rights, proce-
19 dures, requirements, effects, and penalties set forth in sec-
20 tion 4322 of title 18, United States Code, the amount of
21 such grant that would otherwise be allocated to such State
22 under such subpart for the fiscal year shall be decreased
23 by 25 percent.

24 (b) REALLOCATION.—Amounts not allocated to a
25 State for failure to comply with subsection (a) shall be

1 reallocated in accordance with subpart 1 of part E of title
2 I of the Omnibus Crime Control and Safe Streets Act of
3 1968 (34 U.S.C. 10151 et seq.) to States that have com-
4 plied with such subsection.

5 **SEC. 802. CREATING MODEL PROGRAMS FOR THE CARE OF**
6 **INCARCERATED INDIVIDUALS IN THE PRE-**
7 **NATAL AND POSTPARTUM PERIODS.**

8 (a) IN GENERAL.—Not later than 1 year after the
9 date of enactment of this Act, the Attorney General, act-
10 ing through the Director of the Bureau of Prisons, shall
11 establish, in not fewer than 6 Bureau of Prisons facilities,
12 programs to optimize maternal health outcomes for preg-
13 nant and postpartum individuals incarcerated in such fa-
14 cilities. The Attorney General shall establish such pro-
15 grams in consultation with stakeholders such as—

16 (1) relevant community-based organizations,
17 particularly organizations that represent incarcer-
18 ated and formerly incarcerated individuals and orga-
19 nizations that seek to improve maternal health out-
20 comes for pregnant and postpartum individuals from
21 demographic groups with elevated rates of maternal
22 mortality, severe maternal morbidity, maternal
23 health disparities, or other adverse perinatal or
24 childbirth outcomes;

1 (2) relevant organizations representing patients,
2 with a particular focus on patients from demo-
3 graphic groups with elevated rates of maternal mor-
4 tality, severe maternal morbidity, maternal health
5 disparities, or other adverse perinatal or childbirth
6 outcomes;
7 (3) organizations representing maternity care
8 providers and maternal health care education pro-
9 grams;
10 (4) perinatal health workers; and
11 (5) researchers and policy experts in fields re-
12 lated to maternal health care for incarcerated indi-
13 viduals.
14 (b) START DATE.—Each selected facility shall begin
15 facility programs not later than 18 months after the date
16 of enactment of this Act.
17 (c) FACILITY PRIORITY.—In carrying out subsection
18 (a), the Director shall give priority to a facility based on—
19 (1) the number of pregnant and postpartum in-
20 dividuals incarcerated in such facility and, among
21 such individuals, the number of pregnant and
22 postpartum individuals from demographic groups
23 with elevated rates of maternal mortality, severe ma-
24 ternal morbidity, maternal health disparities, or
25 other adverse perinatal or childbirth outcomes; and

1 (2) the extent to which the leaders of such facil-
2 ity have demonstrated a commitment to developing
3 exemplary programs for pregnant and postpartum
4 individuals incarcerated in such facility.

5 (d) PROGRAM DURATION.—The programs established
6 under this section shall be for a 5-year period.

7 (e) PROGRAMS.—Bureau of Prisons facilities selected
8 by the Director shall establish programs for pregnant and
9 postpartum incarcerated individuals, and such programs
10 may—

11 (1) provide access to perinatal health workers
12 from pregnancy through the postpartum period;

13 (2) provide access to healthy foods and coun-
14 seling on nutrition, recommended activity levels, and
15 safety measures throughout pregnancy;

16 (3) train correctional officers to ensure that
17 pregnant incarcerated individuals receive safe and
18 respectful treatment;

19 (4) train medical personnel to ensure that preg-
20 nant incarcerated individuals receive trauma-in-
21 formed, culturally and linguistically congruent care
22 that promotes the health and safety of the pregnant
23 individuals;

24 (5) provide counseling and treatment for indi-
25 viduals who have suffered from—

1 (A) diagnosed mental or behavioral health
2 conditions, including trauma and substance use
3 disorders;
4 (B) trauma or violence, including domestic
5 violence;
6 (C) human immunodeficiency virus;
7 (D) sexual abuse;
8 (E) pregnancy or infant loss; or
9 (F) chronic conditions;
10 (6) provide evidence-based pregnancy and child-
11 birth education, parenting support, and other rel-
12 evant forms of health literacy;
13 (7) provide clinical education opportunities to
14 maternity care providers in training to expand path-
15 ways into maternal health care careers serving incar-
16 cerated individuals;
17 (8) offer opportunities for postpartum individ-
18 uals to maintain contact with the individual's new-
19 born child to promote bonding, including enhanced
20 visitation policies, access to prison nursery pro-
21 grams, or breastfeeding support;
22 (9) provide reentry assistance, particularly to—
23 (A) ensure access to health insurance cov-
24 erage and transfer of health records to commu-
25 nity providers if an incarcerated individual exits

1 the criminal justice system during such individ-
2 ual's pregnancy or in the postpartum period;
3 and

4 (B) connect individuals exiting the criminal
5 justice system during pregnancy or in the
6 postpartum period to community-based re-
7 sources, such as referrals to health care pro-
8 viders, substance use disorder treatments, and
9 social services that address social determinants
10 maternal of health; or

11 (10) establish partnerships with local public en-
12 tities, private community entities, community-based
13 organizations, Indian Tribes and Tribal organiza-
14 tions (as such terms are defined in section 4 of the
15 Indian Self-Determination and Education Assistance
16 Act (25 U.S.C. 5304)), and Urban Indian organiza-
17 tions (as such term is defined in section 4 of the In-
18 dian Health Care Improvement Act (25 U.S.C.
19 1603)) to establish or expand pretrial diversion pro-
20 grams as an alternative to incarceration for preg-
21 nant and postpartum individuals. Such programs
22 may include—

23 (A) evidence-based childbirth education or
24 parenting classes;

25 (B) prenatal health coordination;

1 (C) family and individual counseling;
2 (D) evidence-based screenings, education,
3 and, as needed, treatment for mental and be-
4 havioral health conditions, including drug and
5 alcohol treatments;
6 (E) family case management services;
7 (F) domestic violence education and pre-
8 vention;
9 (G) physical and sexual abuse counseling;
10 and
11 (H) programs to address social deter-
12 minants of health such as employment, housing,
13 education, transportation, and nutrition.
14 (f) IMPLEMENTATION AND REPORTING.—A selected
15 facility shall be responsible for—
16 (1) implementing programs, which may include
17 the programs described in subsection (e); and
18 (2) not later than 3 years after the date of en-
19 actment of this Act, and 6 years after the date of
20 enactment of this Act, reporting results of the pro-
21 grams to the Director, including information de-
22 scribing—
23 (A) relevant quantitative indicators of suc-
24 cess in improving the standard of care and
25 health outcomes for pregnant and postpartum

1 incarcerated individuals in the facility, including
2 data stratified by race, ethnicity, sex, gender,
3 primary language, age, geography, disability
4 status, the category of the criminal charge
5 against such individual, rates of pregnancy-re-
6 lated deaths, pregnancy-associated deaths, cases
7 of infant mortality and morbidity, rates of
8 preterm births and low-birthweight births, cases
9 of severe maternal morbidity, cases of violence
10 against pregnant or postpartum individuals, di-
11 agnoses of maternal mental or behavioral health
12 conditions, and other such information as ap-
13 propriate;
14 (B) relevant qualitative and quantitative
15 evaluations from pregnant and postpartum in-
16 carcerated individuals who participated in such
17 programs, including measures of patient-re-
18 ported experience of care; and
19 (C) strategies to sustain such programs
20 after fiscal year 2028 and expand such pro-
21 grams to other facilities.
22 (g) REPORT.—Not later than 6 years after the date
23 of enactment of this Act, the Director shall submit to the
24 Attorney General and to the Congress a report describing
25 the results of the programs funded under this section.

(h) OVERSIGHT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall award a contract to an independent organization or independent organizations to conduct oversight of the programs described in subsection (e).

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2024 through 2028.

SEC. 803. GRANT PROGRAM TO IMPROVE MATERNAL HEALTH OUTCOMES FOR INDIVIDUALS IN STATE AND LOCAL PRISONS AND JAILS.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Attorney General, acting through the Director of the Bureau of Justice Assistance, shall award Justice for Incarcerated Moms grants to States to establish or expand programs in State and local prisons and jails for pregnant and postpartum incarcerated individuals. The Attorney General shall award such grants in consultation with stakeholders such as—

(1) relevant community-based organizations, particularly organizations that represent incarcerated and formerly incarcerated individuals and organizations that seek to improve maternal health outcomes for pregnant and postpartum individuals from

1 demographic groups with elevated rates of maternal
2 mortality, severe maternal morbidity, maternal
3 health disparities, or other adverse perinatal or
4 childbirth outcomes;
5 (2) relevant organizations representing patients,
6 with a particular focus on patients from demo-
7 graphic groups with elevated rates of maternal mor-
8 tality, severe maternal morbidity, maternal health
9 disparities, or other adverse perinatal or childbirth
10 outcomes;
11 (3) organizations representing maternity care
12 providers and maternal health care education pro-
13 grams;
14 (4) perinatal health workers; and
15 (5) researchers and policy experts in fields re-
16 lated to maternal health care for incarcerated indi-
17 viduals.
18 (b) APPLICATIONS.—Each applicant for a grant
19 under this section shall submit to the Director of the Bu-
20 reau of Justice Assistance an application at such time, in
21 such manner, and containing such information as the Di-
22 rector may require.
23 (c) USE OF FUNDS.—A State that is awarded a grant
24 under this section shall use such grant to establish or ex-

1 pand programs for pregnant and postpartum incarcerated
2 individuals, and such programs may—
3 (1) provide access to perinatal health workers
4 from pregnancy through the postpartum period;
5 (2) provide access to healthy foods and coun-
6 seling on nutrition, recommended activity levels, and
7 safety measures throughout pregnancy;
8 (3) train correctional officers to ensure that
9 pregnant incarcerated individuals receive safe and
10 respectful treatment;
11 (4) train medical personnel to ensure that preg-
12 nant incarcerated individuals receive trauma-in-
13 formed, culturally and linguistically congruent care
14 that promotes the health and safety of the pregnant
15 individuals;
16 (5) provide counseling and treatment for indi-
17 viduals who have suffered from—
18 (A) diagnosed mental or behavioral health
19 conditions, including trauma and substance use
20 disorders;
21 (B) trauma or violence, including domestic
22 violence;
23 (C) human immunodeficiency virus;
24 (D) sexual abuse;
25 (E) pregnancy or infant loss; or

1 (F) chronic conditions;
2 (6) provide evidence-based pregnancy and child-
3 birth education, parenting support, and other rel-
4 evant forms of health literacy;
5 (7) provide clinical education opportunities to
6 maternity care providers in training to expand path-
7 ways into maternal health care careers serving incar-
8 cerated individuals;
9 (8) offer opportunities for postpartum individ-
10 uals to maintain contact with the individual's new-
11 born child to promote bonding, including enhanced
12 visitation policies, access to prison nursery pro-
13 grams, or breastfeeding support;
14 (9) provide reentry assistance, particularly to—
15 (A) ensure access to health insurance cov-
16 erage and transfer of health records to commu-
17 nity providers if an incarcerated individual exits
18 the criminal justice system during such individ-
19 ual's pregnancy or in the postpartum period;
20 and
21 (B) connect individuals exiting the criminal
22 justice system during pregnancy or in the
23 postpartum period to community-based re-
24 sources, such as referrals to health care pro-
25 viders, substance use disorder treatments, and

1 social services that address social determinants
2 of maternal health; or
3 (10) establish partnerships with local public en-
4 tities, private community entities, community-based
5 organizations, Indian Tribes and Tribal organiza-
6 tions (as such terms are defined in section 4 of the
7 Indian Self-Determination and Education Assistance
8 Act (25 U.S.C. 5304)), and Urban Indian organiza-
9 tions (as such term is defined in section 4 of the In-
10 dian Health Care Improvement Act (25 U.S.C.
11 1603)) to establish or expand pretrial diversion pro-
12 grams as an alternative to incarceration for preg-
13 nant and postpartum individuals. Such programs
14 may include—
15 (A) evidence-based childbirth education or
16 parenting classes;
17 (B) prenatal health coordination;
18 (C) family and individual counseling;
19 (D) evidence-based screenings, education,
20 and, as needed, treatment for mental and be-
21 havioral health conditions, including drug and
22 alcohol treatments;
23 (E) family case management services;
24 (F) domestic violence education and pre-
25 vention;

1 (G) physical and sexual abuse counseling;
2 and
3 (H) programs to address social deter-
4 minants of health such as employment, housing,
5 education, transportation, and nutrition.
6 (d) PRIORITY.—In awarding grants under this sec-
7 tion, the Director of the Bureau of Justice Assistance
8 shall give priority to applicants based on—
9 (1) the number of pregnant and postpartum in-
10 dividuals incarcerated in the State and, among such
11 individuals, the number of pregnant and postpartum
12 individuals from demographic groups with elevated
13 rates of maternal mortality, severe maternal mor-
14 bidity, maternal health disparities, or other adverse
15 perinatal or childbirth outcomes; and
16 (2) the extent to which the State has dem-
17 onstrated a commitment to developing exemplary
18 programs for pregnant and postpartum individuals
19 incarcerated in the prisons and jails in the State.
20 (e) GRANT DURATION.—A grant awarded under this
21 section shall be for a 5-year period.
22 (f) IMPLEMENTING AND REPORTING.—A State that
23 receives a grant under this section shall be responsible
24 for—

1 (1) implementing the program funded by the
2 grant; and
3 (2) not later than 3 years after the date of en-
4 actment of this Act, and 6 years after the date of
5 enactment of this Act, reporting results of such pro-
6 gram to the Attorney General, including information
7 describing—
8 (A) relevant quantitative indicators of the
9 program's success in improving the standard of
10 care and health outcomes for pregnant and
11 postpartum incarcerated individuals in the facil-
12 ity, including data stratified by race, ethnicity,
13 sex, gender, primary language, age, geography,
14 disability status, category of the criminal
15 charge against such individual, incidence rates
16 of pregnancy-related deaths, pregnancy-associ-
17 ated deaths, cases of infant mortality and mor-
18 bidity, rates of preterm births and low-birth-
19 weight births, cases of severe maternal mor-
20 bidity, cases of violence against pregnant or
21 postpartum individuals, diagnoses of maternal
22 mental or behavioral health conditions, and
23 other such information as appropriate;
24 (B) relevant qualitative and quantitative
25 evaluations from pregnant and postpartum in-

carcerated individuals who participated in such programs, including measures of patient-reported experience of care; and

(C) strategies to sustain such programs beyond the duration of the grant and expand such programs to other facilities.

(g) REPORT.—Not later than 6 years after the date of enactment of this Act, the Attorney General shall submit to the Congress a report describing the results of such grant programs.

(h) OVERSIGHT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall award a contract to an independent organization or independent organizations to conduct oversight of the programs described in subsection (c).

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2024 through 2028.

SEC. 804. GAO REPORT.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on adverse maternal and infant health outcomes among incarcerated individuals and infants born to such individuals, with a particular focus on racial and ethnic dispari-

1 ties in maternal and infant health outcomes for incarcer-
2 ated individuals.

3 (b) CONTENTS OF REPORT.—The report described in
4 this section shall include—

5 (1) to the extent practicable—

6 (A) the number of pregnant individuals
7 who are incarcerated in Bureau of Prisons fa-
8 cilities;

9 (B) the number of incarcerated individuals,
10 including those incarcerated in Federal, State,
11 and local correctional facilities, who have expe-
12 rienced a pregnancy-related death, pregnancy-
13 associated death, or the death of an infant in
14 the most recent 10 years of available data;

15 (C) the number of cases of severe maternal
16 morbidity among incarcerated individuals, in-
17 cluding those incarcerated in Federal, State,
18 and local detention facilities, in the most recent
19 10 years of available data;

20 (D) the number of preterm and low-birth-
21 weight births of infants born to incarcerated in-
22 dividuals, including those incarcerated in Fed-
23 eral, State, and local correctional facilities, in
24 the most recent 10 years of available data; and

1 (E) statistics on the racial and ethnic dis-
2 parities in maternal and infant health outcomes
3 and severe maternal morbidity rates among in-
4 carcerated individuals, including those incarcer-
5 ated in Federal, State, and local detention fa-
6 cilities;

7 (2) in the case that the Comptroller General of
8 the United States is unable determine the informa-
9 tion required in subparagraphs (A) through (C) of
10 paragraph (1), an assessment of the barriers to de-
11 termining such information and recommendations
12 for improvements in tracking maternal health out-
13 comes among incarcerated individuals, including
14 those incarcerated in Federal, State, and local deten-
15 tion facilities;

16 (3) the implications of pregnant and
17 postpartum incarcerated individuals being ineligible
18 for medical assistance under a State plan under title
19 XIX of the Social Security Act (42 U.S.C. 1396 et
20 seq.) including information about—

21 (A) the effects of such ineligibility on ma-
22 ternal health outcomes for pregnant and
23 postpartum incarcerated individuals, with em-
24 phasis given to such effects for pregnant and

1 postpartum individuals from racial and ethnic
2 minority groups; and
3 (B) potential implications on maternal
4 health outcomes resulting from temporarily sus-
5 pending, rather than permanently terminating,
6 such eligibility when a pregnant or postpartum
7 individual is incarcerated;
8 (4) the extent to which Federal, State, and
9 local correctional facilities are holding pregnant and
10 postpartum individuals who test positive for illicit
11 drug use in detention with special conditions, such
12 as additional bond requirements, due to the individ-
13 ual's drug use, and the effect of such detention poli-
14 cies on maternal and infant health outcomes;
15 (5) causes of adverse maternal health outcomes
16 that are unique to incarcerated individuals, including
17 those incarcerated in Federal, State, and local deten-
18 tion facilities;
19 (6) causes of adverse maternal health outcomes
20 and severe maternal morbidity that are unique to in-
21 carcerated individuals from racial and ethnic minor-
22 ity groups;
23 (7) recommendations to reduce maternal mor-
24 tality and severe maternal morbidity among incar-
25 cerated individuals and to address racial and ethnic

disparities in maternal health outcomes for incarcerated individuals in Bureau of Prisons facilities and State and local prisons and jails; and

(8) such other information as may be appropriate to reduce the occurrence of adverse maternal health outcomes among incarcerated individuals and to address racial and ethnic disparities in maternal health outcomes for such individuals.

TITLE IX—TECH TO SAVE MOMS

SEC. 901. INTEGRATED TELEHEALTH MODELS IN MATERNITY CARE SERVICES.

(a) IN GENERAL.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following:

"(xxviii) Focusing on title XIX, providing for the adoption of and use of telehealth tools that allow for screening, monitoring, and management of common health complications with respect to an individual receiving medical assistance during such individual's pregnancy and for not more than a 1-year period beginning on the last day of the pregnancy.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

SEC. 902. GRANTS TO EXPAND THE USE OF TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY MODELS FOR PREGNANT AND POSTPARTUM INDIVIDUALS.

Title III of the Public Health Service Act is amended by inserting after section 330P (42 U.S.C. 254c–22) the following:

"SEC. 330Q. EXPANDING CAPACITY FOR MATERNAL HEALTH OUTCOMES.

"(a) ESTABLISHMENT.—Beginning not later than 1 year after the date of enactment of this Act, the Secretary shall award grants to eligible entities to evaluate, develop, and expand the use of technology-enabled collaborative learning and capacity building models and improve maternal health outcomes—

"(1) in health professional shortage areas;

"(2) in areas with high rates of maternal mortality and severe maternal morbidity;

"(3) in rural and underserved areas;

"(4) in areas with significant maternal health disparities; and

1 "(5) for medically underserved populations and
2 American Indians and Alaska Natives, including In-
3 dian Tribes, Tribal organizations, and Urban Indian
4 organizations.
5 "(b) USE OF FUNDS.—
6 "(1) REQUIRED USES.—Recipients of grants
7 under this section shall use the grants to—
8 "(A) train maternal health care providers,
9 students, and other similar professionals
10 through models that include—
11 "(i) methods to increase safety and
12 health care quality;
13 "(ii) implicit bias, racism, and dis-
14 crimination;
15 "(iii) best practices in screening for
16 and, as needed, evaluating and treating
17 maternal mental health conditions and
18 substance use disorders;
19 "(iv) training on best practices in ma-
20 ternity care for pregnant and postpartum
21 individuals during public health emer-
22 gencies;
23 "(v) methods to screen for social de-
24 terminants of maternal health risks in the
25 prenatal and postpartum; and

1 ‘‘(vi) the use of remote patient moni-
2 toring tools for pregnancy-related com-
3 plications described in section
4 1115A(b)(2)(B)(xxviii);
5 ‘‘(B) evaluate and collect information on
6 the effect of such models on—
7 ‘‘(i) access to and quality of care;
8 ‘‘(ii) outcomes with respect to the
9 health of an individual; and
10 ‘‘(iii) the experience of individuals who
11 receive pregnancy-related health care;
12 ‘‘(C) develop qualitative and quantitative
13 measures to identify best practices for the ex-
14 pansion and use of such models;
15 ‘‘(D) study the effect of such models on
16 patient outcomes and maternity care providers;
17 and
18 ‘‘(E) conduct any other activity determined
19 by the Secretary.
20 ‘‘(2) PERMISSIBLE USES.—Recipients of grants
21 under this section may use grants to support—
22 ‘‘(A) the use and expansion of technology-
23 enabled collaborative learning and capacity
24 building models, including hardware and soft-
25 ware that—

1 ‘‘(i) enables distance learning and
2 technical support; and
3 ‘‘(ii) supports the secure exchange of
4 electronic health information; and
5 ‘‘(B) maternity care providers, students,
6 and other similar professionals in the provision
7 of maternity care through such models.
8 ‘‘(c) APPLICATION.—
9 ‘‘(1) IN GENERAL.—An eligible entity seeking a
10 grant under subsection (a) shall submit to the Sec-
11 retary an application, at such time, in such manner,
12 and containing such information as the Secretary
13 may require.
14 ‘‘(2) ASSURANCE.—An application under para-
15 graph (1) shall include an assurance that such entity
16 shall collect information on and assess the effect of
17 the use of technology-enabled collaborative learning
18 and capacity building models, including with respect
19 to—
20 ‘‘(A) maternal health outcomes;
21 ‘‘(B) access to maternal health care serv-
22 ices;
23 ‘‘(C) quality of maternal health care; and

1 "(D) retention of maternity care providers
2 serving areas and populations described in sub-
3 section (a).
4 "(d) LIMITATIONS.—
5 "(1) NUMBER.—The Secretary may not award
6 more than 1 grant under this section.
7 "(2) DURATION.—A grant awarded under this
8 section shall be for a 5-year period.
9 "(e) ACCESS TO BROADBAND.—In administering
10 grants under this section, the Secretary may coordinate
11 with other agencies to ensure that funding opportunities
12 are available to support access to reliable, high-speed
13 internet for grantees.
14 "(f) TECHNICAL ASSISTANCE.—The Secretary shall
15 provide (either directly or by contract) technical assistance
16 to eligible entities, including recipients of grants under
17 subsection (a), on the development, use, and sustainability
18 of technology-enabled collaborative learning and capacity
19 building models to expand access to maternal health care
20 services provided by such entities, including—
21 "(1) in health professional shortage areas;
22 "(2) in areas with high rates of maternal mor-
23 tality and severe maternal morbidity or significant
24 maternal health disparities;
25 "(3) in rural and underserved areas; and

1 "(4) for medically underserved populations or
2 American Indians and Alaska Natives.
3 "(g) RESEARCH AND EVALUATION.—The Secretary,
4 in consultation with experts, shall develop a strategic plan
5 to research and evaluate the evidence for technology-en-
6 abled collaborative learning and capacity building models.
7 "(h) REPORTING.—
8 "(1) ELIGIBLE ENTITIES.—An eligible entity
9 that receives a grant under subsection (a) shall sub-
10 mit to the Secretary a report, at such time, in such
11 manner, and containing such information as the Sec-
12 retary may require.
13 "(2) SECRETARY.—Not later than 4 years after
14 the date of enactment of this section, the Secretary
15 shall submit to the Congress, and make available on
16 the website of the Department of Health and
17 Human Services, a report that includes—
18 "(A) a description of grants awarded
19 under subsection (a) and the purpose and
20 amounts of such grants;
21 "(B) a summary of—
22 "(i) the evaluations conducted under
23 subsection (b)(1)(B);
24 "(ii) any technical assistance provided
25 under subsection (f); and

1 "(iii) the activities conducted under
2 subsection (a); and
3 "(C) a description of any significant find-
4 ings with respect to—
5 "(i) patient outcomes; and
6 "(ii) best practices for expanding,
7 using, or evaluating technology-enabled col-
8 laborative learning and capacity building
9 models.
10 "(i) AUTHORIZATION OF APPROPRIATIONS.—There is
11 authorized to be appropriated to carry out this section,
12 $6,000,000 for each of fiscal years 2024 through 2028.
13 "(j) DEFINITIONS.—In this section:
14 "(1) ELIGIBLE ENTITY.—
15 "(A) IN GENERAL.—The term 'eligible en-
16 tity' means an entity that provides, or supports
17 the provision of, maternal health care services
18 or other evidence-based services for pregnant
19 and postpartum individuals—
20 "(i) in health professional shortage
21 areas;
22 "(ii) in rural or underserved areas;
23 "(iii) in areas with high rates of ad-
24 verse maternal health outcomes or signifi-

1 cant racial and ethnic disparities in mater-
2 nal health outcomes; and
3 ''(iv) who are—
4 ''(I) members of medically under-
5 served populations; or
6 ''(II) American Indians and Alas-
7 ka Natives, including Indian Tribes,
8 Tribal organizations, and Urban In-
9 dian organizations.
10 ''(B) INCLUSIONS.—An eligible entity may
11 include entities that lead, or are capable of
12 leading a technology-enabled collaborative learn-
13 ing and capacity building model.
14 ''(2) HEALTH PROFESSIONAL SHORTAGE
15 AREA.—The term 'health professional shortage area'
16 means a health professional shortage area des-
17 ignated under section 332.
18 ''(3) INDIAN TRIBE.—The term 'Indian Tribe'
19 has the meaning given such term in section 4 of the
20 Indian Self-Determination and Education Assistance
21 Act.
22 ''(4) MATERNAL MORTALITY.—The term 'ma-
23 ternal mortality' means a death occurring during or
24 within 1-year period after pregnancy caused by preg-
25 nancy-related or childbirth complications, including a

1 suicide, overdose, or other death resulting from a
2 mental health or substance use disorder attributed
3 to or aggravated by pregnancy or childbirth com-
4 plications.

5 "(5) MEDICALLY UNDERSERVED POPU-
6 LATION.—The term 'medically underserved popu-
7 lation' has the meaning given such term in section
8 330(b)(3).

9 "(6) POSTPARTUM.—The term 'postpartum'
10 means the 1-year period beginning on the last date
11 of an individual's pregnancy.

12 "(7) SEVERE MATERNAL MORBIDITY.—The
13 term 'severe maternal morbidity' means a health
14 condition, including a mental health or substance
15 use disorder, attributed to or aggravated by preg-
16 nancy or childbirth that results in significant short-
17 term or long-term consequences to the health of the
18 individual who was pregnant.

19 "(8) TECHNOLOGY-ENABLED COLLABORATIVE
20 LEARNING AND CAPACITY BUILDING MODEL.—The
21 term 'technology-enabled collaborative learning and
22 capacity building model' means a distance health
23 education model that connects health care profes-
24 sionals, and other specialists, through simultaneous
25 interactive video conferencing for the purpose of fa-

cilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

"(9) TRIBAL ORGANIZATION.—The term 'Tribal organization' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

"(10) URBAN INDIAN ORGANIZATION.—The term 'Urban Indian organization' has the meaning given such term in section 4 of the Indian Health Care Improvement Act.".

SEC. 903. GRANTS TO PROMOTE EQUITY IN MATERNAL HEALTH OUTCOMES THROUGH DIGITAL TOOLS.

(a) IN GENERAL.—Beginning not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make grants to eligible entities to reduce maternal health disparities by increasing access to digital tools related to maternal health care, including provider-facing technologies, such as early warning systems and clinical decision support mechanisms.

(b) APPLICATIONS.—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary an application at such time, in such manner,

and containing such information as the Secretary may require.

(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall prioritize an eligible entity—

(1) in an area with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(2) in a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) or a rural or underserved area; and

(3) that promotes technology that addresses maternal health disparities.

(d) LIMITATIONS.—

(1) NUMBER.—The Secretary may award not more than 1 grant under this section.

(2) DURATION.—A grant awarded under this section shall be for a 5-year period.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to an eligible entity on the development, use, evaluation, and postgrant sustainability of digital tools for purposes of promoting equity in maternal health outcomes.

(f) REPORTING.—

1 (1) ELIGIBLE ENTITIES.—An eligible entity
2 that receives a grant under subsection (a) shall sub-
3 mit to the Secretary a report, at such time, in such
4 manner, and containing such information as the Sec-
5 retary may require.
6 (2) SECRETARY.—Not later than 4 years after
7 the date of the enactment of this Act, the Secretary
8 shall submit to Congress a report that includes—
9 (A) an evaluation on the effectiveness of
10 grants awarded under this section to improve
11 maternal health outcomes, particularly for preg-
12 nant and postpartum individuals from racial
13 and ethnic minority groups;
14 (B) recommendations on new grant pro-
15 grams that promote the use of technology to
16 improve such maternal health outcomes; and
17 (C) recommendations with respect to—
18 (i) technology-based privacy and secu-
19 rity safeguards in maternal health care;
20 (ii) reimbursement rates for maternal
21 telehealth services;
22 (iii) the use of digital tools to analyze
23 large data sets to identify potential preg-
24 nancy-related complications;

1 (iv) barriers that prevent maternity
2 care providers from providing telehealth
3 services across States;
4 (v) the use of consumer digital tools
5 such as mobile phone applications, patient
6 portals, and wearable technologies to im-
7 prove maternal health outcomes;
8 (vi) barriers that prevent access to
9 telehealth services, including a lack of ac-
10 cess to reliable, high-speed internet or elec-
11 tronic devices;
12 (vii) barriers to data sharing between
13 the Special Supplemental Nutrition Pro-
14 gram for Women, Infants, and Children
15 program and maternity care providers, and
16 recommendations for addressing such bar-
17 riers; and
18 (viii) lessons learned from expanded
19 access to telehealth related to maternity
20 care during the COVID–19 public health
21 emergency.
22 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 $6,000,000 for each of fiscal years 2024 through 2028.

SEC. 904. REPORT ON THE USE OF TECHNOLOGY IN MATERNITY CARE.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall seek to enter an agreement with the National Academies of Sciences, Engineering, and Medicine (referred to in this Act as the ''National Academies'') under which the National Academies shall conduct a study on the use of technology and patient monitoring devices in maternity care.

(b) CONTENT.—The agreement entered into pursuant to subsection (a) shall provide for the study of the following:

(1) The use of innovative technology (including artificial intelligence) in maternal health care, including the extent to which such technology has affected racial or ethnic biases in maternal health care.

(2) The use of patient monitoring devices (including pulse oximeter devices) in maternal health care, including the extent to which such devices have affected racial or ethnic biases in maternal health care.

(3) Best practices for reducing and preventing racial or ethnic biases in the use of innovative tech-

1 nology and patient monitoring devices in maternity
2 care.
3 (4) Best practices in the use of innovative tech-
4 nology and patient monitoring devices for pregnant
5 and postpartum individuals from racial and ethnic
6 minority groups.
7 (5) Best practices with respect to privacy and
8 security safeguards in such use.
9 (c) REPORT.—The agreement under subsection (a)
10 shall direct the National Academies to complete the study
11 under this section, and transmit to Congress a report on
12 the results of the study, not later than 24 months after
13 the date of enactment of this Act.

14 TITLE X—IMPACT TO SAVE 15 MOMS

16 SEC. 1001. PERINATAL CARE ALTERNATIVE PAYMENT 17 MODEL DEMONSTRATION PROJECT.

18 (a) IN GENERAL.—For the period of fiscal years
19 2024 through 2028, the Secretary of Health and Human
20 Services (referred to in this section as the ‘‘Secretary’’),
21 acting through the Administrator of the Centers for Medi-
22 care & Medicaid Services, shall establish and implement,
23 in accordance with the requirements of this section, a
24 demonstration project, to be known as the Perinatal Care
25 Alternative Payment Model Demonstration Project (re-

1 ferred to in this section as the ''Demonstration Project''),
2 for purposes of allowing States to test payment models
3 under their State plans under title XIX of the Social Secu-
4 rity Act (42 U.S.C. 1396 et seq.) and State child health
5 plans under title XXI of such Act (42 U.S.C. 1397aa et
6 seq.) with respect to maternity care provided to pregnant
7 and postpartum individuals enrolled in such State plans
8 and State child health plans.

9 (b) COORDINATION.—In establishing the Demonstra-
10 tion Project, the Secretary shall coordinate with stake-
11 holders such as—

12 (1) State Medicaid programs;

13 (2) maternity care providers and organizations
14 representing maternity care providers;

15 (3) relevant organizations representing patients,
16 with a particular focus on patients from demo-
17 graphic groups with elevated rates of maternal mor-
18 tality, severe maternal morbidity, maternal health
19 disparities, or other adverse perinatal or childbirth
20 outcomes;

21 (4) relevant community-based organizations,
22 particularly organizations that seek to improve ma-
23 ternal health outcomes for individuals from demo-
24 graphic groups with elevated rates of maternal mor-
25 tality, severe maternal morbidity, maternal health

1 disparities, or other adverse perinatal or childbirth
2 outcomes;
3 (5) perinatal health workers;
4 (6) relevant health insurance issuers;
5 (7) hospitals, health systems, midwifery prac-
6 tices, freestanding birth centers (as such term is de-
7 fined in paragraph (3)(B) of section 1905(l) of the
8 Social Security Act (42 U.S.C. 1396d(l))), Feder-
9 ally-qualified health centers (as such term is defined
10 in paragraph (2)(B) of such section), and rural
11 health clinics (as such term is defined in section
12 1861(aa) of such Act (42 U.S.C. 1395x(aa)));
13 (8) researchers and policy experts in fields re-
14 lated to maternity care payment models; and
15 (9) any other stakeholders as the Secretary de-
16 termines appropriate, with a particular focus on
17 stakeholders from demographic groups with elevated
18 rates of maternal mortality, severe maternal mor-
19 bidity, maternal health disparities, or other adverse
20 perinatal or childbirth outcomes.
21 (c) CONSIDERATIONS.—In establishing the Dem-
22 onstration Project, the Secretary shall consider any alter-
23 native payment model that—
24 (1) is designed to improve maternal health out-
25 comes for individuals from demographic groups with

1 elevated rates of maternal mortality, severe maternal
2 morbidity, maternal health disparities, or other ad-
3 verse perinatal or childbirth outcomes;
4 (2) includes methods for stratifying patients by
5 pregnancy risk level and, as appropriate, adjusting
6 payments under such model to take into account
7 pregnancy risk level, including consideration of the
8 appropriate transfer of patients by pregnancy risk
9 level;
10 (3) establishes evidence-based quality metrics
11 for such payments;
12 (4) includes consideration of nonhospital birth
13 settings such as freestanding birth centers (as so de-
14 fined);
15 (5) includes consideration of social deter-
16 minants of maternal health;
17 (6) includes diverse maternity care teams that
18 include—
19 (A) maternity care providers, mental and
20 behavioral health care providers acting in ac-
21 cordance with State law, and registered dieti-
22 tians or nutrition professionals (as such term is
23 defined in section 1395x(vv)(2) of title 42,
24 United States Code)—

1 (i) from racially, ethnically, and pro-
2 fessionally diverse backgrounds;
3 (ii) with experience practicing in ra-
4 cially and ethnically diverse communities;
5 or
6 (iii) who have undergone training on
7 implicit bias and racism; and
8 (B) perinatal health workers; or
9 (7) includes consideration of maternal mental
10 health conditions and substance use disorders.
11 (d) ELIGIBILITY.—To be eligible to participate in the
12 Demonstration Project, a State shall submit an applica-
13 tion to the Secretary at such time, in such manner, and
14 containing such information as the Secretary may require.
15 (e) EVALUATION.—The Secretary shall conduct an
16 evaluation of the Demonstration Project to determine the
17 impact of the Demonstration Project on—
18 (1) maternal health outcomes, with data strati-
19 fied by race, ethnicity, primary language, socio-
20 economic status, geography, insurance type, and
21 other factors as the Secretary determines appro-
22 priate;
23 (2) spending on maternity care by States par-
24 ticipating in the Demonstration Project;

1 (3) to the extent practicable, qualitative and
2 quantitative measures of patient experience; and
3 (4) any other areas of assessment that the Sec-
4 retary determines relevant.
5 (f) REPORT.—Not later than one year after the com-
6 pletion or termination date of the Demonstration Project,
7 the Secretary shall submit to the Congress, and make pub-
8 licly available, a report containing—
9 (1) the results of any evaluation conducted
10 under subsection (e); and
11 (2) a recommendation regarding whether the
12 Demonstration Project should be continued after fis-
13 cal year 2028 and expanded on a national basis.
14 (g) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated such sums as are nec-
16 essary to carry out this section.
17 (h) DEFINITIONS.—In this section:
18 (1) ALTERNATIVE PAYMENT MODEL.—The
19 term ''alternative payment model'' has the meaning
20 given such term in section 1833(z)(3)(C) of the So-
21 cial Security Act (42 U.S.C. 1395l(z)(3)(C)).
22 (2) PERINATAL.—The term ''perinatal'' means
23 the period beginning on the day an individual be-
24 comes pregnant and ending on the last day of the

1-year period beginning on the last day of such individual's pregnancy.

TITLE XI—MATERNAL HEALTH PANDEMIC RESPONSE

SEC. 1101. DEFINITIONS.

In this title:

(1) RESPECTFUL MATERNITY CARE.—The term ''respectful maternity care'' refers to care organized for, and provided to, pregnant and postpartum individuals in a manner that—

(A) is culturally and linguistically congruent;

(B) maintains their dignity, privacy, and confidentiality;

(C) ensures freedom from harm and mistreatment; and

(D) enables informed choice and continuous support.

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

1 **SEC. 1102. FUNDING FOR DATA COLLECTION, SURVEIL-**
2 **LANCE, AND RESEARCH ON MATERNAL**
3 **HEALTH OUTCOMES DURING PUBLIC**
4 **HEALTH EMERGENCIES.**

5 To conduct or support data collection, surveillance,
6 and research on maternal health as a result of public
7 health emergencies and infectious diseases that pose a risk
8 to maternal and infant health, including support to assist
9 in the capacity building for State, Tribal, territorial, and
10 local public health departments to collect and transmit ra-
11 cial, ethnic, and other demographic data related to mater-
12 nal health, there are authorized to be appropriated—

13 (1) $100,000,000 for the Surveillance for
14 Emerging Threats to Mothers and Babies program
15 of the Centers for Disease Control and Prevention,
16 to support the Centers for Disease Control and Pre-
17 vention in its efforts to—

18 (A) work with public health, clinical, and
19 community-based organizations to provide time-
20 ly, continually updated guidance to families and
21 health care providers on ways to reduce risk to
22 pregnant and postpartum individuals and their
23 newborns and tailor interventions to improve
24 their long-term health;

25 (B) partner with more State, Tribal, terri-
26 torial, and local public health programs in the

1 collection and analysis of clinical data on the
2 impact of public health emergencies and infec-
3 tious diseases that pose a risk to maternal and
4 infant health on pregnant and postpartum pa-
5 tients and their newborns, particularly among
6 patients from racial and ethnic minority groups;
7 and

8 (C) establish regionally based centers of
9 excellence to offer medical, public health, and
10 other knowledge to ensure communities can
11 help pregnant and postpartum individuals and
12 newborns get the care and support they need,
13 particularly in areas with large populations of
14 individuals from demographic groups with ele-
15 vated rates of maternal mortality, severe mater-
16 nal morbidity, maternal health disparities, or
17 other adverse perinatal or childbirth outcomes;

18 (2) $30,000,000 for the Enhancing Reviews
19 and Surveillance to Eliminate Maternal Mortality
20 program (commonly known as the ''ERASE MM
21 program'') of the Centers for Disease Control and
22 Prevention, to support the Centers for Disease Con-
23 trol and Prevention in expanding its partnerships
24 with States and Indian Tribes and provide technical

1 assistance to existing Maternal Mortality Review
2 Committees;
3 (3) $45,000,000 for the Pregnancy Risk As-
4 sessment Monitoring System (commonly known as
5 the "PRAMS") of the Centers for Disease Control
6 and Prevention, to support the Centers for Disease
7 Control and Prevention in its efforts to—
8 (A) create a supplement to its PRAMS
9 survey related to public health emergencies and
10 infectious diseases that pose a risk to maternal
11 and infant health;
12 (B) add questions around experiences of
13 respectful maternity care in prenatal,
14 intrapartum, and postpartum care; and
15 (C) work to transition such PRAMS survey
16 to an electronic platform and expand such
17 PRAMS survey to a larger population, with a
18 special focus on reaching underrepresented
19 communities, and other program improvements;
20 and
21 (4) $15,000,000 for the National Institute of
22 Child Health and Human Development, to conduct
23 or support research for interventions to mitigate the
24 effects of public health emergencies and infectious
25 diseases that pose a risk to maternal and infant

1 health, with a particular focus on individuals from
2 demographic groups with elevated rates of maternal
3 mortality, severe maternal morbidity, maternal
4 health disparities, or other adverse perinatal or
5 childbirth outcomes.

6 **SEC. 1103. PUBLIC HEALTH EMERGENCY MATERNAL**
7 **HEALTH DATA COLLECTION AND DISCLO-**
8 **SURE.**

9 (a) AVAILABILITY OF COLLECTED DATA.—The Sec-
10 retary, acting through the Director of the Centers for Dis-
11 ease Control and Prevention and the Administrator of the
12 Centers for Medicare & Medicaid Services, shall make pub-
13 licly available on the website of the Centers for Disease
14 Control and Prevention data described in subsection (b).

15 (b) DATA DESCRIBED.—The data described in this
16 subsection are data collected through Federal surveillance
17 systems under the Centers for Disease Control and Pre-
18 vention with respect to public health emergencies and indi-
19 viduals who are pregnant or in a postpartum period. Such
20 data shall include the following:

21 (1) Diagnostic testing, confirmed cases, hos-
22 pitalizations, deaths, and other health outcomes re-
23 lated to an infectious disease outbreak among preg-
24 nant and postpartum individuals.

1 (2) Maternal and infant health outcomes among
2 individuals who test positive for an infectious disease
3 during or after pregnancy.

4 (c) AMERICAN INDIAN AND ALASKA NATIVE HEALTH
5 OUTCOMES.—In carrying out subsection (a), the Secretary
6 shall consult with Indian Tribes and confer with Urban
7 Indian organizations.

8 (d) DISAGGREGATED INFORMATION.—In carrying
9 out subsection (a), the Secretary shall disaggregate data
10 by race, ethnicity, gender, primary language, geography,
11 socioeconomic status, and other relevant factors.

12 (e) UPDATE.—During public health emergencies, the
13 Secretary shall update the data made available under this
14 section—

15 (1) at least on a monthly basis; and

16 (2) not less than one month after the end of
17 such public health emergency.

18 (f) PRIVACY.—In carrying out subsection (a), the
19 Secretary shall take steps to protect the privacy of individ-
20 uals pursuant to regulations promulgated under section
21 264(c) of the Health Insurance Portability and Account-
22 ability Act of 1996 (42 U.S.C. 1320d–2 note).

23 (g) GUIDANCE.—

24 (1) IN GENERAL.—Not later than 30 days after
25 the declaration of a public health emergency under

1 section 319 of the Public Health Service Act (42
2 U.S.C. 247d), the Secretary shall issue guidance to
3 States and local public health departments to ensure
4 that—

5 (A) laboratories that test specimens for an
6 infectious disease receive all relevant demo-
7 graphic data on race, ethnicity, pregnancy sta-
8 tus, and other demographic data as determined
9 by the Secretary; and

10 (B) data described in subsection (b) are
11 disaggregated by race, ethnicity, gender, pri-
12 mary language, geography, socioeconomic sta-
13 tus, and other relevant factors.

14 (2) CONSULTATION.—In carrying out para-
15 graph (1), the Secretary shall consult with Indian
16 Tribes—

17 (A) to ensure that such guidance includes
18 tribally developed best practices; and

19 (B) to reduce misclassification of American
20 Indians and Alaska Natives.

21 **SEC. 1104. PUBLIC HEALTH COMMUNICATION REGARDING**
22 **MATERNAL CARE DURING PUBLIC HEALTH**
23 **EMERGENCIES.**

24 The Director of the Centers for Disease Control and
25 Prevention shall conduct public health education cam-

1 paigns during public health emergencies to ensure that
2 pregnant and postpartum individuals, their employers,
3 and their health care providers have accurate, evidence-
4 based information on maternal and infant health risks
5 during the public health emergency, with a particular
6 focus on reaching pregnant and postpartum individuals in
7 underserved communities.

8 **SEC. 1105. TASK FORCE ON BIRTHING EXPERIENCE AND**
9 **SAFE, RESPECTFUL, RESPONSIVE, AND EM-**
10 **POWERING MATERNITY CARE DURING PUB-**
11 **LIC HEALTH EMERGENCIES.**

12 (a) ESTABLISHMENT.—The Secretary, in consulta-
13 tion with the Director of the Centers for Disease Control
14 and Prevention and the Administrator of the Health Re-
15 sources and Services Administration, shall convene a task
16 force (in this subsection referred to as the ''Task Force'')
17 to develop Federal recommendations regarding respectful,
18 responsive, and empowering maternity care, including safe
19 birth care and postpartum care, during public health
20 emergencies.

21 (b) DUTIES.—The Task Force shall develop, publicly
22 post, and update Federal recommendations in multiple
23 languages to ensure high-quality, nondiscriminatory ma-
24 ternity care, promote positive birthing experiences, and
25 improve maternal health outcomes during public health

1 emergencies, with a particular focus on outcomes for indi-
2 viduals from demographic groups with elevated rates of
3 maternal mortality, severe maternal morbidity, maternal
4 health disparities, or other adverse perinatal or childbirth
5 outcomes. Such recommendations shall—

6 (1) address, with particular attention to ensur-
7 ing equitable treatment on the basis of race and eth-
8 nicity—

9 (A) measures to facilitate respectful, re-
10 sponsive, and empowering maternity care;

11 (B) measures to facilitate telehealth mater-
12 nity care for pregnant people who cannot regu-
13 larly access in-person care;

14 (C) strategies to increase access to special-
15 ized care for those with high-risk pregnancies
16 or pregnant individuals with elevated risk fac-
17 tors;

18 (D) diagnostic testing for pregnant and la-
19 boring patients;

20 (E) birthing without one's chosen compan-
21 ions, with one's chosen companions, and with
22 smartphone or other telehealth connection to
23 one's chosen companions;

24 (F) newborn separation after birth in rela-
25 tion to maternal infection status;

1 (G) breast milk feeding in relation to ma-
2 ternal infection status;
3 (H) licensure, training, scope of practice,
4 and Medicaid and other insurance reimburse-
5 ment for certified midwives, certified nurse-mid-
6 wives, and certified professional midwives, in a
7 manner that facilitates inclusion of midwives of
8 color and midwives from underserved commu-
9 nities;
10 (I) financial support and training for
11 perinatal health workers who provide nonclinical
12 support to people from pregnancy through the
13 postpartum period in a manner that facilitates
14 inclusion from underserved communities;
15 (J) strategies to ensure and expand doula
16 coverage under State Medicaid programs;
17 (K) how to identify, address, and treat
18 prenatal and postpartum mental and behavioral
19 health conditions, such as anxiety, substance
20 use disorder, and depression, during public
21 health emergencies;
22 (L) how to identify and address instances
23 of intimate partner violence during pregnancy
24 which may arise or intensify during public
25 health emergencies;

1 (M) strategies to address hospital capacity
2 concerns in communities with a surge in infec-
3 tious disease cases and to provide childbearing
4 people with options that reduce the potential for
5 cross-contamination and increase the ability to
6 implement their care preferences while main-
7 taining safety and quality, such as the use of
8 auxiliary maternity units and freestanding birth
9 centers;
10 (N) provision of child care services during
11 prenatal and postpartum appointments for
12 mothers whose children are unable to attend as
13 a result of restrictions relating to the public
14 health emergencies;
15 (O) how to identify and address racism,
16 bias, and discrimination in the delivery of ma-
17 ternity care services to pregnant and
18 postpartum people, including evaluating the
19 value of training for hospital staff on implicit
20 bias and racism, respectful, responsive, and em-
21 powering maternity care, and demographic data
22 collection;
23 (P) how to address the needs of undocu-
24 mented pregnant individuals and new mothers
25 who may be afraid or unable to seek needed

1 care during the COVID–19 public health emer-
2 gency;
3 (Q) how to address the needs of uninsured
4 pregnant individuals who have historically relied
5 on emergency departments for care;
6 (R) how to identify pregnant and
7 postpartum individuals at risk for depression,
8 anxiety disorder, psychosis, obsessive-compul-
9 sive disorder, and other maternal mood dis-
10 orders before, during, and after pregnancy, and
11 how to treat those diagnosed with a postpartum
12 mood disorder;
13 (S) how to effectively and compassionately
14 screen for substance use disorder during preg-
15 nancy and postpartum and help pregnant and
16 postpartum individuals find support and effec-
17 tive treatment;
18 (T) how to ensure access to infant nutri-
19 tion during public health emergencies; and
20 (U) such other matters as the Task Force
21 determines appropriate;
22 (2) identify barriers to the implementation of
23 the recommendations;
24 (3) take into consideration existing State and
25 other programs that have demonstrated effectiveness

1 in addressing pregnancy, birth, and postpartum care
2 during public health emergencies; and
3 (4) identify policies specific to COVID–19 that
4 should be discontinued when safely possible and
5 those that should be continued as the public health
6 emergency abates.
7 (c) MEMBERSHIP.—The Secretary shall appoint the
8 members of the Task Force. Such members shall be com-
9 prised of—
10 (1) representatives of the Department of Health
11 and Human Services, including representatives of—
12 (A) the Secretary;
13 (B) the Director of the Centers for Disease
14 Control and Prevention;
15 (C) the Administrator of the Health Re-
16 sources and Services Administration;
17 (D) the Administrator of the Centers for
18 Medicare & Medicaid Services;
19 (E) the Director of the Agency for
20 Healthcare Research and Quality;
21 (F) the Commissioner of Food and Drugs;
22 (G) the Assistant Secretary for Mental
23 Health and Substance Use; and
24 (H) the Director of the Indian Health
25 Service;

1 (2) at least 3 State, local, or territorial public
2 health officials representing departments of public
3 health, who shall represent jurisdictions from dif-
4 ferent regions of the United States with relatively
5 high concentrations of historically marginalized pop-
6 ulations;
7 (3) at least 1 Tribal public health official rep-
8 resenting departments of public health;
9 (4) 1 or more representatives of community-
10 based organizations that address adverse maternal
11 health outcomes with a specific focus on racial and
12 ethnic inequities in maternal health outcomes, with
13 special consideration given to representatives of such
14 organizations that are led by a person of color or
15 from communities with significant minority popu-
16 lations;
17 (5) a professionally diverse panel of maternity
18 care providers and perinatal health workers;
19 (6) 1 or more patients who were pregnant or
20 gave birth during the COVID–19 public health
21 emergency;
22 (7) 1 or more patients who contracted COVID–
23 19 and later gave birth;
24 (8) 1 or more patients who have received sup-
25 port from a perinatal health worker; and

(9) racially and ethnically diverse representation from at least 3 independent experts with knowledge or field experience with racial and ethnic disparities in public health, women's health, or maternal mortality and severe maternal morbidity.

TITLE XII—PROTECTING MOMS AND BABIES AGAINST CLIMATE CHANGE

SEC. 1201. DEFINITIONS.

In this title, the following definitions apply:

(1) ADVERSE MATERNAL AND INFANT HEALTH OUTCOMES.—The term ''adverse maternal and infant health outcomes'' includes the outcomes of preterm birth, low birth weight, stillbirth, infant or maternal mortality, and severe maternal morbidity.

(2) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(3) MINORITY-SERVING INSTITUTION.—The term ''minority-serving institution'' means an entity specified in any of paragraphs (1) through (7) of section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

1 (4) RISKS ASSOCIATED WITH CLIMATE
2 CHANGE.—The term ''risks associated with climate
3 change'' includes risks associated with extreme heat,
4 air pollution, extreme weather events, and other en-
5 vironmental issues associated with climate change
6 that can result in adverse maternal and infant
7 health outcomes.
8 (5) SECRETARY.—The term ''Secretary'' means
9 the Secretary of Health and Human Services.
10 (6) STAKEHOLDER ORGANIZATION.—The term
11 ''stakeholder organization'' means—
12 (A) a community-based organization with
13 expertise in providing assistance to vulnerable
14 individuals;
15 (B) a nonprofit organization with expertise
16 in—
17 (i) maternal or infant health; or
18 (ii) environmental or climate justice;
19 and
20 (C) a patient advocacy organization rep-
21 resenting vulnerable individuals.
22 (7) VULNERABLE INDIVIDUAL.—The term ''vul-
23 nerable individual'' means—
24 (A) an individual who is pregnant;

1 (B) an individual who was pregnant during
2 any portion of the preceding 1-year period; and
3 (C) an individual under 3 years of age.

4 **SEC. 1202. GRANT PROGRAM TO PROTECT VULNERABLE**
5 **MOTHERS AND BABIES FROM CLIMATE**
6 **CHANGE RISKS.**

7 (a) IN GENERAL.—Not later than 180 days after the
8 date of the enactment of this Act, the Secretary shall es-
9 tablish a grant program to protect vulnerable individuals
10 from risks associated with climate change.

11 (b) GRANT AUTHORITY.—In carrying out the Pro-
12 gram, the Secretary may award, on a competitive basis,
13 grants to 10 covered entities.

14 (c) APPLICATIONS.—To be eligible for a grant under
15 the Program, a covered entity shall submit to the Sec-
16 retary an application at such time, in such form, and con-
17 taining such information as the Secretary may require,
18 which shall include, at a minimum, a description of the
19 following:

20 (1) Plans for the use of grant funds awarded
21 under the Program and how patients and stake-
22 holder organizations were involved in the develop-
23 ment of such plans.

24 (2) How such grant funds will be targeted to
25 geographic areas that have disproportionately high

1 levels of risks associated with climate change for vul-
2 nerable individuals.

3 (3) How such grant funds will be used to ad-
4 dress racial and ethnic disparities in—

5 (A) adverse maternal and infant health
6 outcomes; and

7 (B) exposure to risks associated with cli-
8 mate change for vulnerable individuals.

9 (4) Strategies to prevent an initiative assisted
10 with such grant funds from causing—

11 (A) adverse environmental impacts;

12 (B) displacement of residents and busi-
13 nesses;

14 (C) rent and housing price increases; or

15 (D) disproportionate adverse impacts on
16 racial and ethnic minority groups and other un-
17 derserved populations.

18 (d) SELECTION OF GRANT RECIPIENTS.—

19 (1) TIMING.—Not later than 270 days after the
20 date of enactment of this Act, the Secretary shall se-
21 lect the recipients of grants under the Program.

22 (2) CONSULTATION.—In selecting covered enti-
23 ties for grants under the Program, the Secretary
24 shall consult with—

1 (A) representatives of stakeholder organi-
2 zations;
3 (B) the Administrator of the Environ-
4 mental Protection Agency;
5 (C) the Administrator of the National Oce-
6 anic and Atmospheric Administration; and
7 (D) from the Department of Health and
8 Human Services—
9 (i) the Deputy Assistant Secretary for
10 Minority Health;
11 (ii) the Administrator of the Centers
12 for Medicare & Medicaid Services;
13 (iii) the Administrator of the Health
14 Resources and Services Administration;
15 (iv) the Director of the National Insti-
16 tutes of Health; and
17 (v) the Director of the Centers for
18 Disease Control and Prevention.
19 (3) PRIORITY.—In selecting grantees under the
20 Program, the Secretary shall give priority to covered
21 entities that serve a county or locality—
22 (A) designated, or located in an area des-
23 ignated, as a nonattainment area pursuant to
24 section 107 of the Clean Air Act (42 U.S.C.
25 7407) for any air pollutant for which air quality

1 criteria have been issued under section 108(a)
2 of such Act (42 U.S.C. 7408(a));
3 (B) with a level of vulnerability of mod-
4 erate-to-high or higher, according to the Social
5 Vulnerability Index of the Centers for Disease
6 Control and Prevention, or a similar rating of
7 social vulnerability according to related Federal
8 mapping tools;
9 (C) with temperatures that pose a risk to
10 human health, as determined by the Secretary,
11 in consultation with the Administrator of the
12 National Oceanic and Atmospheric Administra-
13 tion and the Chair of the United States Global
14 Change Research Program, based on the best
15 available science;
16 (D) with elevated rates of maternal mor-
17 tality, severe maternal morbidity, maternal
18 health disparities, or other adverse perinatal or
19 childbirth outcomes;
20 (E) with a rating of very high or relatively
21 high risk according to the National Risk Index
22 for Natural Hazards of the Federal Emergency
23 Management Agency; or
24 (F) with other climate-sensitive hazards
25 with associations to adverse maternal or infant

1 health outcomes, as determined by the Sec-
2 retary.
3 (4) LIMITATION.—A recipient of grant funds
4 under the Program may not use such grant funds to
5 serve a county or locality that is served by any other
6 recipient of a grant under the Program.
7 (e) USE OF FUNDS.—A covered entity awarded grant
8 funds under the Program may only use such grant funds
9 for the following:
10 (1) Initiatives to identify risks associated with
11 climate change for vulnerable individuals and to pro-
12 vide services and support to such individuals that
13 address such risks, which may include—
14 (A) training for health care providers,
15 perinatal health workers, and other employees
16 in hospitals, birth centers, midwifery practices,
17 and other health care practices that provide
18 prenatal or labor and delivery services to vul-
19 nerable individuals on the identification of, and
20 patient counseling relating to, risks associated
21 with climate change for vulnerable individuals;
22 (B) hiring, training, or providing resources
23 to perinatal health workers who can help iden-
24 tify risks associated with climate change for
25 vulnerable individuals, provide patient coun-

1 seling about such risks, and carry out the dis-
2 tribution of relevant services and support;
3 (C) enhancing the monitoring of risks as-
4 sociated with climate change for vulnerable in-
5 dividuals, including by—
6 (i) collecting data on such risks in
7 specific census tracts, neighborhoods, or
8 other geographic areas; and
9 (ii) sharing such data with local
10 health care providers, perinatal health
11 workers, and other employees in hospitals,
12 birth centers, midwifery practices, and
13 other health care practices that provide
14 prenatal or labor and delivery services to
15 local vulnerable individuals; and
16 (D) providing vulnerable individuals—
17 (i) air conditioning units, residential
18 weatherization support, filtration systems,
19 household appliances, or related items;
20 (ii) direct financial assistance; and
21 (iii) services and support, including
22 housing assistance, evacuation assistance,
23 transportation assistance, access to cooling
24 shelters, and mental health counseling, to
25 prepare for or recover from extreme weath-

1 er events, which may include floods, hurri-
2 canes, wildfires, droughts, and related
3 events.
4 (2) Initiatives to mitigate levels of and exposure
5 to risks associated with climate change for vulner-
6 able individuals, which shall be based on the best
7 available science and which may include initiatives
8 to—
9 (A) develop, maintain, or expand urban or
10 community forestry initiatives and tree canopy
11 coverage initiatives;
12 (B) improve infrastructure, such as build-
13 ings and paved surfaces;
14 (C) develop or improve community out-
15 reach networks to provide culturally and lin-
16 guistically appropriate information and notifica-
17 tions about risks associated with climate change
18 for vulnerable individuals; and
19 (D) provide enhanced services to racial and
20 ethnic minority groups and other underserved
21 populations.
22 (f) LENGTH OF AWARD.—A grant under this section
23 shall be disbursed over 4 fiscal years.
24 (g) TECHNICAL ASSISTANCE.—The Secretary shall
25 provide technical assistance to a covered entity awarded

a grant under the Program to support the development, implementation, and evaluation of activities funded with such grant.

(h) REPORTS TO SECRETARY.—

(1) ANNUAL REPORT.—For each fiscal year during which a covered entity is disbursed grant funds under the Program, such covered entity shall submit to the Secretary a report that summarizes the activities carried out by such covered entity with such grant funds during such fiscal year, which shall include a description of the following:

(A) The involvement of stakeholder organizations in the implementation of initiatives assisted with such grant funds.

(B) Relevant health and environmental data, disaggregated, to the extent practicable, by race, ethnicity, primary language, socioeconomic status, geography, insurance type, pregnancy status, and other relevant demographic information.

(C) Qualitative feedback received from vulnerable individuals with respect to initiatives assisted with such grant funds.

(D) Criteria used in selecting the geographic areas assisted with such grant funds.

(E) Efforts to address racial and ethnic disparities in adverse maternal and infant health outcomes and in exposure to risks associated with climate change for vulnerable individuals.

(F) Any negative and unintended impacts of initiatives assisted with such grant funds, including—

(i) adverse environmental impacts;

(ii) displacement of residents and businesses;

(iii) rent and housing price increases; and

(iv) disproportionate adverse impacts on racial and ethnic minority groups and other underserved populations.

(G) How the covered entity will address and prevent any impacts described in subparagraph (F).

(2) PUBLICATION.—Not later than 30 days after the date on which a report is submitted under paragraph (1), the Secretary shall publish such report on a public website of the Department of Health and Human Services.

1 (i) REPORT TO CONGRESS.—Not later than the date
2 that is 5 years after the date on which the Program is
3 established, the Secretary shall submit to Congress and
4 publish on a public website of the Department of Health
5 and Human Services a report on the results of the Pro-
6 gram, including the following:

7 (1) Summaries of the annual reports submitted
8 under subsection (h).

9 (2) Evaluations of the initiatives assisted with
10 grant funds under the Program.

11 (3) An assessment of the effectiveness of the
12 Program in—

13 (A) identifying risks associated with cli-
14 mate change for vulnerable individuals;

15 (B) providing services and support to such
16 individuals;

17 (C) mitigating levels of and exposure to
18 such risks; and

19 (D) addressing racial and ethnic disparities
20 in adverse maternal and infant health outcomes
21 and in exposure to such risks.

22 (4) A description of how the Program could be
23 expanded, including—

24 (A) monitoring efforts or data collection
25 that would be required to identify areas with

1 high levels of risks associated with climate
2 change for vulnerable individuals;
3 (B) how such areas could be identified
4 using the strategy developed under section
5 1205; and
6 (C) recommendations for additional fund-
7 ing.
8 (j) DEFINITIONS.—In this section:
9 (1) The term ''covered entity'' means a consor-
10 tium of organizations serving a county that—
11 (A) shall include a community-based orga-
12 nization; and
13 (B) may include—
14 (i) another stakeholder organization;
15 (ii) the government of such county;
16 (iii) the governments of one or more
17 municipalities within such county;
18 (iv) a State or local public health de-
19 partment or emergency management agen-
20 cy;
21 (v) a local health care practice, which
22 may include a licensed and accredited hos-
23 pital, birth center, midwifery practice, or
24 other health care practice that provides

prenatal or labor and delivery services to vulnerable individuals;

(vi) an Indian tribe or Tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304));

(vii) an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)); and

(viii) an institution of higher education.

(2) The term ''Program'' means the grant program under this section.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $100,000,000 for the period of fiscal years 2024 through 2027.

SEC. 1203. GRANT PROGRAM FOR EDUCATION AND TRAINING AT HEALTH PROFESSION SCHOOLS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a grant program to provide funds to health profession schools to support the

1 development and integration of education and training
2 programs for identifying and addressing risks associated
3 with climate change for vulnerable individuals.
4 (b) GRANT AUTHORITY.—In carrying out the Pro-
5 gram, the Secretary may award, on a competitive basis,
6 grants to health profession schools.
7 (c) APPLICATION.—To be eligible for a grant under
8 the Program, a health profession school shall submit to
9 the Secretary an application at such time, in such form,
10 and containing such information as the Secretary may re-
11 quire, which shall include, at a minimum, a description
12 of the following:
13 (1) How such health profession school will en-
14 gage with vulnerable individuals, and stakeholder or-
15 ganizations representing such individuals, in devel-
16 oping and implementing the education and training
17 programs supported by grant funds awarded under
18 the Program.
19 (2) How such health profession school will en-
20 sure that such education and training programs will
21 address racial and ethnic disparities in exposure to,
22 and the effects of, risks associated with climate
23 change for vulnerable individuals.
24 (d) USE OF FUNDS.—A health profession school
25 awarded a grant under the Program shall use the grant

1 funds to develop, and integrate into the curriculum and
2 continuing education of such health profession school, edu-
3 cation and training on each of the following:
4 (1) Identifying risks associated with climate
5 change for vulnerable individuals and individuals
6 with the intent to become pregnant.
7 (2) How risks associated with climate change
8 affect vulnerable individuals and individuals with the
9 intent to become pregnant.
10 (3) Racial and ethnic disparities in exposure to,
11 and the effects of, risks associated with climate
12 change for vulnerable individuals and individuals
13 with the intent to become pregnant.
14 (4) Patient counseling and mitigation strategies
15 relating to risks associated with climate change for
16 vulnerable individuals.
17 (5) Relevant services and support for vulnerable
18 individuals relating to risks associated with climate
19 change and strategies for ensuring vulnerable indi-
20 viduals have access to such services and support.
21 (6) Implicit and explicit bias, racism, and dis-
22 crimination.
23 (7) Related topics identified by such health pro-
24 fession school based on the engagement of such
25 health profession school with vulnerable individuals

and stakeholder organizations representing such individuals.

(e) PARTNERSHIPS.—In carrying out activities with grant funds, a health profession school awarded a grant under the Program may partner with one or more of the following:

(1) A State or local public health department.

(2) A health care professional membership organization.

(3) A stakeholder organization.

(4) A health profession school.

(5) An institution of higher education.

(f) REPORTS TO SECRETARY.—

(1) ANNUAL REPORT.—For each fiscal year during which a health profession school is disbursed grant funds under the Program, such health profession school shall submit to the Secretary a report that describes the activities carried out with such grant funds during such fiscal year.

(2) FINAL REPORT.—Not later than the date that is 1 year after the end of the last fiscal year during which a health profession school is disbursed grant funds under the Program, the health profession school shall submit to the Secretary a final re-

1 port that summarizes the activities carried out with
2 such grant funds.
3 (g) REPORT TO CONGRESS.—Not later than the date
4 that is 6 years after the date on which the Program is
5 established, the Secretary shall submit to Congress and
6 publish on a public website of the Department of Health
7 and Human Services a report that includes the following:
8 (1) A summary of the reports submitted under
9 subsection (f).
10 (2) Recommendations to improve education and
11 training programs at health profession schools with
12 respect to identifying and addressing risks associ-
13 ated with climate change for vulnerable individuals.
14 (h) DEFINITIONS.—In this section:
15 (1) The term ''health profession school'' means
16 an accredited—
17 (A) medical school;
18 (B) school of nursing;
19 (C) midwifery program;
20 (D) physician assistant education program;
21 (E) teaching hospital;
22 (F) residency or fellowship program; or
23 (G) other school or program determined
24 appropriate by the Secretary.

1 (2) The term ''Program'' means the grant pro-
2 gram under this section.
3 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 $5,000,000 for the period of fiscal years 2024 through
6 2027.

7 **SEC. 1204. NIH CONSORTIUM ON BIRTH AND CLIMATE**
8 **CHANGE RESEARCH.**

9 (a) ESTABLISHMENT.—Not later than one year after
10 the date of the enactment of this Act, the Director of the
11 National Institutes of Health shall establish the Consor-
12 tium on Birth and Climate Change Research (in this sec-
13 tion referred to as the ''Consortium'').
14 (b) DUTIES.—
15 (1) IN GENERAL.—The Consortium shall co-
16 ordinate, across the institutes, centers, and offices of
17 the National Institutes of Health, research on the
18 risks associated with climate change for vulnerable
19 individuals.
20 (2) REQUIRED ACTIVITIES.—In carrying out
21 paragraph (1), the Consortium shall—
22 (A) establish research priorities, including
23 by prioritizing research that—
24 (i) identifies the risks associated with
25 climate change for vulnerable individuals

1 with a particular focus on disparities in
2 such risks among racial and ethnic minor-
3 ity groups and other underserved popu-
4 lations; and
5 (ii) identifies strategies to reduce lev-
6 els of, and exposure to, such risks, with a
7 particular focus on risks among racial and
8 ethnic minority groups and other under-
9 served populations;
10 (B) identify gaps in available data related
11 to such risks;
12 (C) identify gaps in, and opportunities for,
13 research collaborations;
14 (D) identify funding opportunities for com-
15 munity-based organizations and researchers
16 from racially, ethnically, and geographically di-
17 verse backgrounds;
18 (E) identify opportunities to increase pub-
19 lic awareness related to risks associated with
20 climate change for vulnerable individuals; and
21 (F) publish annual reports on the work
22 and findings of the Consortium on a public
23 website of the National Institutes of Health.
24 (c) MEMBERSHIP.—The Director shall appoint to the
25 Consortium representatives of such institutes, centers, and

1 offices of the National Institutes of Health as the Director
2 considers appropriate, including, at a minimum, rep-
3 resentatives of—
4 (1) the National Institute of Environmental
5 Health Sciences;
6 (2) the National Institute on Minority Health
7 and Health Disparities;
8 (3) the Eunice Kennedy Shriver National Insti-
9 tute of Child Health and Human Development;
10 (4) the National Institute of Mental Health;
11 (5) the National Institute of Nursing Research;
12 and
13 (6) the Office of Research on Women's Health.
14 (d) CHAIRPERSON.—The Chairperson of the Consor-
15 tium shall be designated by the Director and selected from
16 among the representatives appointed under subsection (c).
17 (e) CONSULTATION.—In carrying out the duties de-
18 scribed in subsection (b), the Consortium shall consult
19 with—
20 (1) the heads of relevant Federal agencies, in-
21 cluding—
22 (A) the Environmental Protection Agency;
23 (B) the National Oceanic and Atmospheric
24 Administration;

1 (C) the Occupational Safety and Health
2 Administration; and
3 (D) from the Department of Health and
4 Human Services—
5 (i) the Office of Minority Health in
6 the Office of the Secretary;
7 (ii) the Centers for Medicare & Med-
8 icaid Services;
9 (iii) the Health Resources and Serv-
10 ices Administration;
11 (iv) the Centers for Disease Control
12 and Prevention;
13 (v) the Indian Health Service; and
14 (vi) the Administration for Children
15 and Families; and
16 (2) representatives of—
17 (A) stakeholder organizations;
18 (B) health care providers and professional
19 membership organizations with expertise in ma-
20 ternal health or environmental justice;
21 (C) State and local public health depart-
22 ments;
23 (D) licensed and accredited hospitals, birth
24 centers, midwifery practices, or other health
25 care practices that provide prenatal or labor

1 and delivery services to vulnerable individuals;
2 and

3 (E) institutions of higher education, in-
4 cluding such institutions that are minority-serv-
5 ing institutions or have expertise in maternal
6 health or environmental justice.

7 **SEC. 1205. STRATEGY FOR IDENTIFYING CLIMATE CHANGE**
8 **RISK ZONES FOR VULNERABLE MOTHERS**
9 **AND BABIES.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Director of the Cen-
12 ters for Disease Control and Prevention, shall develop a
13 strategy (in this section referred to as the "Strategy") for
14 designating areas that the Secretary determines to have
15 a high risk of adverse maternal and infant health out-
16 comes among vulnerable individuals as a result of risks
17 associated with climate change.

18 (b) STRATEGY REQUIREMENTS.—

19 (1) IN GENERAL.—In developing the Strategy,
20 the Secretary shall establish a process to identify
21 areas where vulnerable individuals are exposed to a
22 high risk of adverse maternal and infant health out-
23 comes as a result of risks associated with climate
24 change in conjunction with other factors that can
25 impact such health outcomes, including—

1 (A) the incidence of diseases associated
2 with air pollution, extreme heat, and other envi-
3 ronmental factors;
4 (B) the availability and accessibility of ma-
5 ternal and infant health care providers;
6 (C) English-language proficiency among
7 women of reproductive age;
8 (D) the health insurance status of women
9 of reproductive age;
10 (E) the number of women of reproductive
11 age who are members of racial or ethnic groups
12 with disproportionately high rates of adverse
13 maternal and infant health outcomes;
14 (F) the socioeconomic status of women of
15 reproductive age, including with respect to—
16 (i) poverty;
17 (ii) unemployment;
18 (iii) household income; and
19 (iv) educational attainment; and
20 (G) access to quality housing, transpor-
21 tation, and nutrition.
22 (2) RESOURCES.—In developing the Strategy,
23 the Secretary shall identify, and incorporate a de-
24 scription of, the following:

1 (A) Existing mapping tools or Federal pro-
2 grams that identify—
3 (i) risks associated with climate
4 change for vulnerable individuals; and
5 (ii) other factors that can influence
6 maternal and infant health outcomes, in-
7 cluding the factors described in paragraph
8 (1).
9 (B) Environmental, health, socioeconomic,
10 and demographic data relevant to identifying
11 risks associated with climate change for vulner-
12 able individuals.
13 (C) Existing monitoring networks that col-
14 lect data described in subparagraph (B), and
15 any gaps in such networks.
16 (D) Federal, State, and local stakeholders
17 involved in maintaining monitoring networks
18 identified under subparagraph (C), and how
19 such stakeholders are coordinating their moni-
20 toring efforts.
21 (E) Additional monitoring networks, and
22 enhancements to existing monitoring networks,
23 that would be required to address gaps identi-
24 fied under subparagraph (C), including at the
25 subcounty and census tract level.

1 (F) Funding amounts required to establish
2 the monitoring networks identified under sub-
3 paragraph (E) and recommendations for Fed-
4 eral, State, and local coordination with respect
5 to such networks.
6 (G) Potential uses for data collected and
7 generated as a result of the Strategy, including
8 how such data may be used in determining re-
9 cipients of grants under the program estab-
10 lished by section 1202 or other similar pro-
11 grams.
12 (H) Other information the Secretary con-
13 siders relevant for the development of the Strat-
14 egy.
15 (c) COORDINATION AND CONSULTATION.—In devel-
16 oping the Strategy, the Secretary shall—
17 (1) coordinate with the Administrator of the
18 Environmental Protection Agency and the Adminis-
19 trator of the National Oceanic and Atmospheric Ad-
20 ministration; and
21 (2) consult with—
22 (A) stakeholder organizations;
23 (B) health care providers and professional
24 membership organizations with expertise in ma-
25 ternal health or environmental justice;

1 (C) State and local public health departments;
3 (D) licensed and accredited hospitals, birth centers, midwifery practices, or other health care providers that provide prenatal or labor and delivery services to vulnerable individuals; and
8 (E) institutions of higher education, including such institutions that are minority-serving institutions or have expertise in maternal health or environmental justice.

12 (d) NOTICE AND COMMENT.—At least 240 days before the date on which the Strategy is published in accordance with subsection (e), the Secretary shall provide—

15 (1) notice of the Strategy on a public website of the Department of Health and Human Services; and

18 (2) an opportunity for public comment of at least 90 days.

20 (e) PUBLICATION.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall publish on a public website of the Department of Health and Human Services—

24 (1) the Strategy;

1 (2) the public comments received under sub-
2 section (d); and
3 (3) the responses of the Secretary to such pub-
4 lic comments.

5 TITLE XIII—MATERNAL
6 VACCINATIONS

7 SEC. 1301. MATERNAL VACCINATION AWARENESS AND EQ-
8 UITY CAMPAIGN.

9 (a) CAMPAIGN.—Section 313 of the Public Health
10 Service Act (42 U.S.C. 245) is amended—
11 (1) in subsection (a), by inserting ''and among
12 pregnant and postpartum individuals,'' after ''low
13 rates of vaccination,'';
14 (2) in subsection (c)(3), by striking ''prenatal
15 and pediatric'' and inserting ''prenatal, obstetric,
16 and pediatric'';
17 (3) in subsection (d)(4)(B), by inserting ''preg-
18 nant and postpartum individuals and'' after ''includ-
19 ing''; and
20 (4) in subsection (g), by striking ''$15,000,000
21 for each of fiscal years 2021 through 2025'' and in-
22 serting ''$17,000,000 for each of fiscal years 2024
23 through 2028''.

1 (b) ADDITIONAL ACTIVITIES.—Section 317(k)(1)(E)
2 of the Public Health Service Act (42 U.S.C.
3 247b(k)(1)(E)) is amended—
4 (1) in clause (v), by striking "and" at the end;
5 and
6 (2) by adding at the end the following:
7 "(vii) increase vaccination rates of
8 pregnant and postpartum individuals, in-
9 cluding individuals from racial and ethnic
10 minority groups, and their children; and".

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