

117TH CONGRESS
1ST SESSION

H. R. 959

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

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2021

Ms. UNDERWOOD (for herself, Ms. ADAMS, Mr. KHANNA, Ms. VELÁZQUEZ, Mrs. MCBATH, Mr. SMITH of Washington, Ms. SCANLON, Mr. CARSON, Mr. LAWSON of Florida, Mrs. HAYES, Mr. BUTTERFIELD, Mrs. BEATTY, Ms. MOORE of Wisconsin, Ms. STRICKLAND, Mr. MICHAEL F. DOYLE of Pennsylvania, Ms. OMAR, Ms. CLARK of Massachusetts, Mr. RYAN, Mr. BISHOP of Georgia, Mr. SCHIFF, Mr. JOHNSON of Georgia, Mr. HORSFORD, Ms. SEWELL, Ms. BLUNT ROCHESTER, Ms. WASSERMAN SCHULTZ, Ms. BARRAGÁN, Ms. CLARKE of New York, Mr. DEUTCH, Mr. PAYNE, Mr. MEEKS, Ms. MCCOLLUM, Ms. NORTON, Mr. SUOZZI, Ms. DEGETTE, Mr. BLUMENAUER, Ms. CRAIG, Ms. LOIS FRANKEL of Florida, Mr. MOULTON, Mr. SOTO, Mr. NADLER, Mr. TRONE, Mrs. LURIA, Mr. SARBANES, Ms. SPANBERGER, Ms. SPEIER, Ms. JOHNSON of Texas, Mrs. BUSTOS, Mr. DANNY K. DAVIS of Illinois, Ms. SCHAKOWSKY, Mr. BOWMAN, Ms. DAVIDS of Kansas, Ms. SCHRIER, Mr. HASTINGS, Ms. BASS, Mrs. WATSON COLEMAN, Ms. LEE of California, Ms. HOULAHAN, Ms. PRESSLEY, Mr. COHEN, Mr. ALLRED, Mr. EVANS, Ms. BUSH, Mr. CROW, Ms. CASTOR of Florida, Ms. CHU, Ms. TLAIB, Mr. CONNOLLY, Ms. JACOBS of California, Mrs. DEMINGS, Mr. BERA, Ms. KUSTER, Mrs. TORRES of California, Mr. TONKO, Mrs. FLETCHER, Ms. JACKSON LEE, Mr. MCNERNEY, Ms. PINGREE, Mr. STANTON, Mr. JONES, Ms. WILD, Mr. RASKIN, Ms. WILLIAMS of Georgia, and Mr. DAVID SCOTT of Georgia) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Financial Services, Transportation and Infrastructure, Education and Labor, the Judiciary, Natural Resources, Agriculture, and Veterans' Affairs, 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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Black Maternal Health
 5 Momnibus Act of 2021”.

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

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- Sec. 1101. Definitions.
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TITLE XII—MATERNAL VACCINATIONS

- Sec. 1201. Maternal vaccination awareness and equity campaign.

1 SEC. 3. DEFINITIONS.

2 In this Act:

3 (1) CULTURALLY CONGRUENT.—The term “cul-
4 turally congruent”, with respect to care or maternity
5 care, means care that is in agreement with the pre-
6 ferred cultural values, beliefs, worldview, language,
7 and practices of the health care consumer and other
8 stakeholders.

9 (2) MATERNITY CARE PROVIDER.—The term
10 “maternity care provider” means a health care pro-
11 vider who—

12 (A) is a physician, physician assistant,
13 midwife who meets at a minimum the inter-

1 national definition of the midwife and global
2 standards for midwifery education as estab-
3 lished by the International Confederation of
4 Midwives, nurse practitioner, or clinical nurse
5 specialist; and

6 (B) has a focus on maternal or perinatal
7 health.

8 (3) MATERNAL MORTALITY.—The term “mater-
9 nal mortality” means a death occurring during or
10 within a one-year period after pregnancy, caused by
11 pregnancy-related or childbirth complications, in-
12 cluding a suicide, overdose, or other death resulting
13 from a mental health or substance use disorder at-
14 tributed to or aggravated by pregnancy-related or
15 childbirth complications.

16 (4) PERINATAL HEALTH WORKER.—The term
17 “perinatal health worker” means a doula, commu-
18 nity health worker, peer supporter, breastfeeding
19 and lactation educator or counselor, nutritionist or
20 dietitian, childbirth educator, social worker, home
21 visitor, language interpreter, or navigator.

22 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
23 The terms “postpartum” and “postpartum period”
24 refer to the 1-year period beginning on the last day
25 of the pregnancy of an individual.

1 (6) PREGNANCY-ASSOCIATED DEATH.—The
2 term “pregnancy-associated death” means a death of
3 a pregnant or postpartum individual, by any cause,
4 that occurs during, or within 1 year following, the
5 individual’s pregnancy, regardless of the outcome,
6 duration, or site of the pregnancy.

7 (7) PREGNANCY-RELATED DEATH.—The term
8 “pregnancy-related death” means a death of a preg-
9 nant or postpartum individual that occurs during, or
10 within 1 year following, the individual’s pregnancy,
11 from a pregnancy complication, a chain of events
12 initiated by pregnancy, or the aggravation of an un-
13 related condition by the physiologic effects of preg-
14 nancy.

15 (8) RACIAL AND ETHNIC MINORITY GROUP.—
16 The term “racial and ethnic minority group” has the
17 meaning given such term in section 1707(g)(1) of
18 the Public Health Service Act (42 U.S.C. 300u-
19 6(g)(1)).

20 (9) SEVERE MATERNAL MORBIDITY.—The term
21 “severe maternal morbidity” means a health condi-
22 tion, including mental health conditions and sub-
23 stance use disorders, attributed to or aggravated by
24 pregnancy or childbirth that results in significant

1 short-term or long-term consequences to the health
2 of the individual who was pregnant.

3 (10) SOCIAL DETERMINANTS OF MATERNAL
4 HEALTH DEFINED.—The term “social determinants
5 of maternal health” means non-clinical factors that
6 impact maternal health outcomes, including—

7 (A) economic factors, which may include
8 poverty, employment, food security, support for
9 and access to lactation and other infant feeding
10 options, housing stability, and related factors;

11 (B) neighborhood factors, which may in-
12 clude quality of housing, access to transpor-
13 tation, access to child care, availability of
14 healthy foods and nutrition counseling, avail-
15 ability of clean water, air and water quality,
16 ambient temperatures, neighborhood crime and
17 violence, access to broadband, and related fac-
18 tors;

19 (C) social and community factors, which
20 may include systemic racism, gender discrimi-
21 nation or discrimination based on other pro-
22 tected classes, workplace conditions, incarcer-
23 ation, and related factors;

24 (D) household factors, which may include
25 ability to conduct lead testing and abatement,

1 car seat installation, indoor air temperatures,
2 and related factors;

3 (E) education access and quality factors,
4 which may include educational attainment, lan-
5 guage and literacy, and related factors; and

6 (F) health care access factors, including
7 health insurance coverage, access to culturally
8 congruent health care services, providers, and
9 non-clinical support, access to home visiting
10 services, access to wellness and stress manage-
11 ment programs, health literacy, access to tele-
12 health and items required to receive telehealth
13 services, and related factors.

14 **SEC. 4. SENSE OF CONGRESS.**

15 It is the sense of Congress that—

16 (1) the respect and proper care that birthing
17 people deserve is inclusive; and

18 (2) regardless of race, ethnicity, gender iden-
19 tity, sexual orientation, religion, marital status, fa-
20 milial status, socioeconomic status, immigration sta-
21 tus, incarceration status, or disability, all deserve
22 dignity.

1 **TITLE I—SOCIAL**
2 **DETERMINANTS FOR MOMS**

3 **SEC. 101. TASK FORCE TO DEVELOP A STRATEGY TO AD-**
4 **DRESS SOCIAL DETERMINANTS OF MATER-**
5 **NAL HEALTH.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall convene a task force (in this section
8 referred to as the “Task Force”) to develop a strategy
9 to coordinate efforts between Federal agencies to address
10 social determinants of maternal health with respect to
11 pregnant and postpartum individuals.

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

14 (1) The Secretary of Health and Human Serv-
15 ices (or a designee thereof).

16 (2) The Secretary of Housing and Urban Devel-
17 opment (or a designee thereof).

18 (3) The Secretary of Transportation (or a des-
19 ignee thereof).

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

22 (5) The Secretary of Labor (or a designee
23 thereof).

24 (6) The Administrator of the Environmental
25 Protection Agency (or a designee thereof).

1 (7) The Assistant Secretary for the Administra-
2 tion for Children and Families (or a designee there-
3 of).

4 (8) The Administrator of the Centers for Medi-
5 care & Medicaid Services (or a designee thereof).

6 (9) The Director of the Indian Health Service
7 (or a designee thereof).

8 (10) The Director of the National Institutes of
9 Health (or a designee thereof).

10 (11) The Administrator of the Health Re-
11 sources and Services Administration (or a designee
12 thereof).

13 (12) The Deputy Assistant Secretary for Minor-
14 ity Health of the Department of Health and Human
15 Services (or a designee thereof).

16 (13) The Deputy Assistant Secretary for Wom-
17 en's Health of the Department of Health and
18 Human Services (or a designee thereof).

19 (14) The Director of the Centers for Disease
20 Control and Prevention (or a designee thereof).

21 (15) The Director of the Office on Violence
22 Against Women at the Department of Justice (or a
23 designee thereof).

24 (c) APPOINTED MEMBERS.—In addition to the ex
25 officio members of the Task Force, the Secretary of

1 Health and Human Services shall appoint the following
2 members of the Task Force:

3 (1) At least two representatives of patients, to
4 include—

5 (A) a representative of patients who have
6 suffered from severe maternal morbidity; or

7 (B) a representative of patients who is a
8 family member of an individual who suffered a
9 pregnancy-related death.

10 (2) At least two leaders of community-based or-
11 ganizations that address maternal mortality and se-
12 vere maternal morbidity with a specific focus on ra-
13 cial and ethnic disparities. In appointing such lead-
14 ers under this paragraph, the Secretary of Health
15 and Human Services shall give priority to individ-
16 uals who are leaders of organizations led by individ-
17 uals from racial and ethnic minority groups.

18 (3) At least two perinatal health workers.

19 (4) A professionally diverse panel of maternity
20 care providers.

21 (d) CHAIR.—The Secretary of Health and Human
22 Services shall select the chair of the Task Force from
23 among the members of the Task Force.

1 (e) REPORT.—Not later than 2 years after the date
2 of the enactment of this Act, the Task Force shall submit
3 to Congress a report on—

4 (1) the strategy developed under subsection (a);

5 (2) recommendations on funding amounts with
6 respect to implementing such strategy;

7 (3) recommendations for how to expand cov-
8 erage of social services to address social deter-
9 minants of maternal health under Medicaid managed
10 care organizations and State Medicaid programs.

11 (f) TERMINATION.—Section 14 of the Federal Advi-
12 sory Committee Act (5 U.S.C. App.) shall not apply to
13 the Task Force with respect to termination.

14 **SEC. 102. HOUSING FOR MOMS GRANT PROGRAM.**

15 (a) IN GENERAL.—The Secretary of Housing and
16 Urban Development shall establish a Housing for Moms
17 grant program under this section to make grants to eligi-
18 ble entities to increase access to safe, stable, affordable,
19 and adequate housing for pregnant and postpartum indi-
20 viduals and their families.

21 (b) APPLICATION.—To be eligible to receive a grant
22 under this section, an eligible entity shall submit to the
23 Secretary an application at such time, in such manner,
24 and containing such information as the Secretary may
25 provide.

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 a community-based organization or will
5 partner with a community-based organization to im-
6 plement initiatives to increase access to safe, stable,
7 affordable, and adequate housing for pregnant and
8 postpartum individuals and their families;

9 (2) is operating in an area with high rates of
10 adverse maternal health outcomes or significant ra-
11 cial or ethnic disparities in maternal health out-
12 comes, to the extent such data are available; and

13 (3) is operating in an area with a high poverty
14 rate or significant number of individuals who lack
15 consistent access to safe, stable, affordable, and ade-
16 quate housing.

17 (d) USE OF FUNDS.—An eligible entity that receives
18 a grant under this section shall use funds under the grant
19 for the purposes of—

20 (1) identifying and conducting outreach to
21 pregnant and postpartum individuals who are low-in-
22 come and lack consistent access to safe, stable, af-
23 fordable, and adequate housing;

24 (2) providing safe, stable, affordable, and ade-
25 quate housing options to such individuals;

1 (3) connecting such individuals with local orga-
2 nizations offering safe, stable, affordable, and ade-
3 quate housing options;

4 (4) providing application assistance to such in-
5 dividuals seeking to enroll in programs offering safe,
6 stable, affordable, and adequate housing options;

7 (5) providing direct financial assistance to such
8 individuals for the purposes of maintaining safe, sta-
9 ble, and adequate housing for the duration of the in-
10 dividual’s pregnancy and postpartum periods; and

11 (6) working with relevant stakeholders to en-
12 sure that local housing and homeless shelter infra-
13 structure is supportive to pregnant and postpartum
14 individuals, including through—

15 (A) health-promoting housing codes;

16 (B) enforcement of housing codes;

17 (C) proactive rental inspection programs;

18 (D) code enforcement officer training; and

19 (E) partnerships between regional offices
20 of the Department of Housing and Urban De-
21 velopment and community-based organizations
22 to ensure housing laws are understood and vio-
23 lations are discovered.

24 (e) REPORTING.—

1 (1) ELIGIBLE ENTITIES.—The Secretary shall
2 require each eligible entity receiving a grant under
3 this section to annually submit to the Secretary and
4 make publicly available a report on the status of ac-
5 tivities conducted using the grant.

6 (2) SECRETARY.—Not later than the end of
7 each fiscal year in which grants are made under this
8 section, the Secretary shall submit to the Congress
9 and make publicly available a report that—

10 (A) summarizes the reports received under
11 paragraph (1);

12 (B) evaluates the effectiveness of grants
13 awarded under this section in increasing access
14 to safe, stable, affordable, and adequate hous-
15 ing for pregnant and postpartum individuals
16 and their families; and

17 (C) makes recommendations with respect
18 to ensuring activities described subsection (d)
19 continue after grant amounts made available
20 under this section are expended.

21 (f) DEFINITIONS.—In this section:

22 (1) ELIGIBLE ENTITY.—The term “eligible enti-
23 ty” means—

24 (A) a community-based organization;

1 (B) a State or local governmental entity,
2 including a State or local public health depart-
3 ment;

4 (C) an Indian tribe or tribal organization
5 (as such terms are defined in section 4 of the
6 Indian Self-Determination and Education As-
7 sistance Act (25 U.S.C. 5304)); or

8 (D) an Urban Indian organization (as such
9 term is defined in section 4 of the Indian
10 Health Care Improvement Act (25 U.S.C.
11 1603)).

12 (2) SECRETARY.—The term “Secretary” means
13 the Secretary of Housing and Urban Development.

14 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 \$10,000,000 for fiscal year 2022, which shall remain
17 available until expended.

18 **SEC. 103. DEPARTMENT OF TRANSPORTATION.**

19 (a) REPORT.—Not later than one year after the date
20 of enactment of this Act, the Secretary of Transportation
21 shall submit to Congress and make publicly available a
22 report containing—

23 (1) an assessment of transportation barriers
24 preventing individuals from attending prenatal and
25 postpartum appointments, accessing maternal health

1 care services, or accessing services and resources re-
2 lated to social determinants maternal of health;

3 (2) recommendations on how to overcome the
4 barriers assessed under paragraph (1); and

5 (3) an assessment of transportation safety risks
6 for pregnant individuals and recommendations on
7 how to mitigate such risks.

8 (b) CONSIDERATIONS.—In carrying out subsection
9 (a), the Secretary shall give special consideration to solu-
10 tions for—

11 (1) pregnant and postpartum individuals living
12 in a health professional shortage area designated
13 under section 332 of the Public Health Service Act
14 (42 U.S.C. 254e);

15 (2) pregnant and postpartum individuals living
16 in areas with high maternal mortality or severe mor-
17 bidity rates or significant racial or ethnic disparities
18 in maternal health outcomes; or

19 (3) pregnant and postpartum individuals with a
20 disability that impacts mobility.

21 **SEC. 104. DEPARTMENT OF AGRICULTURE.**

22 (a) SPECIAL SUPPLEMENTAL NUTRITION PRO-
23 GRAM.—

24 (1) EXTENSION OF POSTPARTUM PERIOD.—
25 Section 17(b)(10) of the Child Nutrition Act of

1 1966 (42 U.S.C. 1786(b)(10)) is amended by strik-
2 ing “six months” and inserting “24 months”.

3 (2) EXTENSION OF BREASTFEEDING PERIOD.—
4 Section 17(d)(3)(A)(ii) of the Child Nutrition Act of
5 1966 (7 U.S.C. 1431(d)(3)(A)(ii)) is amended by
6 striking “1 year” and inserting “24 months”.

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

12 (A) maternal and infant health outcomes,
13 including racial and ethnic disparities with re-
14 spect to such outcomes;

15 (B) breastfeeding rates among postpartum
16 individuals;

17 (C) qualitative evaluations of family experi-
18 ences under the special supplemental nutrition
19 program under section 17 of the Child Nutri-
20 tion Act of 1966 (42 U.S.C. 1786); and

21 (D) other relevant information as deter-
22 mined by the Secretary.

23 (b) GRANT PROGRAM FOR HEALTHY FOOD AND
24 CLEAN WATER FOR PREGNANT AND POSTPARTUM INDI-
25 VIDUALS.—

1 (1) IN GENERAL.—The Secretary shall establish
2 a program to award grants, on a competitive basis,
3 to eligible entities to carry out the activities de-
4 scribed in paragraph (4).

5 (2) APPLICATION.—To be eligible for a grant
6 under this subsection, an eligible entity shall submit
7 to the Secretary an application at such time, in such
8 manner, and containing such information as the Sec-
9 retary determines appropriate.

10 (3) PRIORITY.—In awarding grants under this
11 subsection, the Secretary shall give priority to an eli-
12 gible entity that—

13 (A) is, or will partner with, a community-
14 based organization; and

15 (B) is operating in an area with high rates
16 of—

17 (i) adverse maternal health outcomes;

18 or

19 (ii) significant racial or ethnic dispari-
20 ties in maternal health outcomes.

21 (4) USE OF FUNDS.—An eligible entity shall
22 use grant funds awarded under this subsection to
23 deliver healthy food, infant formula, clean water, or
24 diapers to pregnant and postpartum individuals lo-
25 cated in areas that are food deserts, as determined

1 by the Secretary using data from the Food Access
2 Research Atlas of the Department of Agriculture.

3 (5) REPORTS.—

4 (A) ELIGIBLE ENTITY.—Not later than 1
5 year after an eligible entity first receives a
6 grant under this subsection, and annually there-
7 after, an eligible entity shall submit to the Sec-
8 retary a report on the status of activities con-
9 ducted using the grant, which shall contain
10 such information as the Secretary may require.

11 (B) SECRETARY.—

12 (i) IN GENERAL.—Not later than 2
13 years after the date on which the first
14 grant is awarded under this subsection, the
15 Secretary shall submit to Congress a re-
16 port that includes—

17 (I) a summary of the reports
18 submitted under subparagraph (A);

19 (II) an assessment of the extent
20 to which food distributed through the
21 grant program was purchased from
22 local and regional food systems;

23 (III) an evaluation of the effect
24 of the grant program under this sub-
25 section on maternal and infant health

1 outcomes, including racial and ethnic
2 disparities with respect to such out-
3 comes; and

4 (IV) recommendations with re-
5 spect to ensuring the activities de-
6 scribed in paragraph (4) continue
7 after the grant period funding such
8 activities expires.

9 (ii) PUBLICATION.—The Secretary
10 shall make the report submitted under
11 clause (i) publicly available on the website
12 of the Department of Agriculture.

13 (6) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated \$5,000,000
15 to carry out this subsection for fiscal years 2022
16 through 2024.

17 (c) DEFINITIONS.—In this section:

18 (1) ELIGIBLE ENTITY.—The term “eligible enti-
19 ty” means—

20 (A) a community-based organization;

21 (B) a State or local governmental entity,
22 including a State or local public health depart-
23 ment;

24 (C) an Indian tribe or tribal organization
25 (as such terms are defined in section 4 of the

1 Indian Self-Determination and Education As-
2 sistance Act (25 U.S.C. 5304)); or

3 (D) an Urban Indian organization (as such
4 term is defined in section 4 of the Indian
5 Health Care Improvement Act (25 U.S.C.
6 1603)).

7 (2) SECRETARY.—The term “Secretary” means
8 the Secretary of Agriculture.

9 **SEC. 105. ENVIRONMENTAL STUDY THROUGH NATIONAL**
10 **ACADEMIES.**

11 (a) IN GENERAL.—The Administrator of the Envi-
12 ronmental Protection Agency shall seek to enter an agree-
13 ment, not later than 60 days after the date of enactment
14 of this Act, with the National Academies of Sciences, En-
15 gineering, and Medicine (referred to in this section as the
16 “National Academies”) under which the National Acad-
17 emies agree to conduct a study on the impacts of water
18 and air quality, exposure to extreme temperatures, envi-
19 ronmental chemicals, environmental risks in the workplace
20 and the home, and pollution levels, on maternal and infant
21 health outcomes.

22 (b) STUDY REQUIREMENTS.—The agreement under
23 subsection (a) shall direct the National Academies to make
24 recommendations for—

1 (1) improving environmental conditions to im-
2 prove maternal and infant health outcomes; and

3 (2) reducing or eliminating racial and ethnic
4 disparities in such outcomes.

5 (c) REPORT.—The agreement under subsection (a)
6 shall direct the National Academies to complete the study
7 under this section, and transmit to the Congress and make
8 publicly available a report on the results of the study, not
9 later than 12 months after the date of enactment of this
10 Act.

11 **SEC. 106. CHILD CARE ACCESS.**

12 (a) GRANT PROGRAM.—The Secretary of Health and
13 Human Services (in this section referred to as the “Sec-
14 retary”) shall award grants to eligible organizations to
15 provide pregnant and postpartum individuals with free
16 and accessible drop-in child care services during prenatal
17 and postpartum appointments.

18 (b) APPLICATION.—To be eligible to receive a grant
19 under this section, an eligible entity shall submit to the
20 Secretary an application at such time, in such manner,
21 and containing such information as the Secretary may re-
22 quire.

23 (c) ELIGIBLE ORGANIZATIONS.—

24 (1) ELIGIBILITY.—To be eligible to receive a
25 grant under this section, an organization shall be an

1 organization that provides child care services and
2 can carry out programs providing pregnant and
3 postpartum individuals with free and accessible
4 drop-in child care services during prenatal and
5 postpartum appointments.

6 (2) PRIORITIZATION.—In selecting grant recipi-
7 ents under this section, the Secretary shall give pri-
8 ority to eligible organizations that operate in an area
9 with high rates of adverse maternal health outcomes
10 or significant racial or ethnic disparities in maternal
11 health outcomes, to the extent such data are avail-
12 able.

13 (d) TIMING.—The Secretary shall commence the
14 grant program under subsection (a) not later than 1 year
15 after the date of enactment of this Act.

16 (e) REPORTING.—

17 (1) GRANTEES.—Each recipient of a grant
18 under this section shall annually submit to the Sec-
19 retary and make publicly available a report on the
20 status of activities conducted using the grant. Each
21 such report shall include—

22 (A) an analysis of the effect of the funded
23 program on prenatal and postpartum appoint-
24 ment attendance rates;

1 (B) summaries of qualitative assessments
2 of the funded program from—

3 (i) pregnant and postpartum individ-
4 uals participating in the program; and

5 (ii) the families of such individuals;
6 and

7 (C) such additional information as the Sec-
8 retary may require.

9 (2) SECRETARY.—Not later than the end of fis-
10 cal year 2024, the Secretary shall submit to the
11 Congress and make publicly available a report con-
12 taining the following:

13 (A) A summary of the reports under para-
14 graph (1).

15 (B) An assessment of the effects, if any, of
16 the funded programs on maternal health out-
17 comes, with a specific focus on racial and ethnic
18 disparities in such outcomes.

19 (C) A description of actions the Secretary
20 can take to ensure that pregnant and
21 postpartum individuals eligible for medical as-
22 sistance under a State plan under title XIX of
23 the Social Security Act (42 U.S.C. 1936 et
24 seq.) have access to free and accessible drop-in
25 child care services during prenatal and

1 postpartum appointments, including identifica-
2 tion of the funding necessary to carry out such
3 actions.

4 (f) DROP-IN CHILD CARE SERVICES DEFINED.—In
5 this section, the term “drop-in child care services” means
6 child care and early childhood education services that
7 are—

8 (1) delivered at a facility that meets the re-
9 quirements of all applicable laws and regulations of
10 the State or local government in which it is located,
11 including the licensing of the facility as a child care
12 facility; and

13 (2) provided in single encounters without re-
14 quiring full-time enrollment of a person in a child
15 care program.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there is authorized to be appropriated
18 \$5,000,000 for the period of fiscal years 2022 through
19 2024.

20 **SEC. 107. GRANTS TO LOCAL ENTITIES ADDRESSING SO-**
21 **CIAL DETERMINANTS OF MATERNAL**
22 **HEALTH.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services (in this section referred to as the “Sec-
25 retary”) shall award grants to eligible entities to—

1 (1) address social determinants of maternal
2 health for pregnant and postpartum individuals; and

3 (2) eliminate racial and ethnic disparities in
4 maternal health outcomes.

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

10 (c) PRIORITIZATION.—In awarding grants under sub-
11 section (a), the Secretary shall give priority to an eligible
12 entity that—

13 (1) is, or will partner with, a community-based
14 organization to carrying out the activities under sub-
15 section (d);

16 (2) is operating in an area with high rates of
17 adverse maternal health outcomes or significant ra-
18 cial or ethnic disparities in maternal health out-
19 comes; and

20 (3) is operating in an area with a high poverty
21 rate.

22 (d) ACTIVITIES.—An eligible entity that receives a
23 grant under this section may—

24 (1) hire and retain staff;

1 (2) develop and distribute a list of available re-
2 sources with respect to social service programs in a
3 community;

4 (3) establish a resource center that provides
5 multiple social service programs in a single location;

6 (4) offer programs and resources in the commu-
7 nities in which the respective eligible entities are lo-
8 cated to address social determinants of health for
9 pregnant and postpartum individuals; and

10 (5) consult with such pregnant and postpartum
11 individuals to conduct an assessment of the activities
12 under this subsection.

13 (e) TECHNICAL ASSISTANCE.—The Secretary shall
14 provide to grant recipients under this section technical as-
15 sistance to plan for sustaining programs to address social
16 determinants of maternal health among pregnant and
17 postpartum individuals after the period of the grant.

18 (f) REPORTING.—

19 (1) GRANTEES.—Not later than 1 year after an
20 eligible entity first receives a grant under this sec-
21 tion, and annually thereafter, an eligible entity shall
22 submit to the Secretary, and make publicly available,
23 a report on the status of activities conducted using
24 the grant. Each such report shall include data on

1 the effects of such activities, disaggregated by race,
2 ethnicity, gender, and other relevant factors.

3 (2) SECRETARY.—Not later than the end of fis-
4 cal year 2026, the Secretary shall submit to Con-
5 gress a report that includes—

6 (A) a summary of the reports under para-
7 graph (1); and

8 (B) recommendations for—

9 (i) improving maternal health out-
10 comes; and

11 (ii) reducing or eliminating racial and
12 ethnic disparities in maternal health out-
13 comes.

14 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 \$15,000,000 for each of fiscal years 2022 through 2026.

17 **TITLE II—HONORING KIRA**
18 **JOHNSON**

19 **SEC. 201. INVESTMENTS IN COMMUNITY-BASED ORGANIZA-**
20 **TIONS TO IMPROVE BLACK MATERNAL**
21 **HEALTH OUTCOMES.**

22 (a) AWARDS.—Following the 1-year period described
23 in subsection (c), the Secretary of Health and Human
24 Services (in this section referred to as the “Secretary”)
25 shall award grants to eligible entities to establish or ex-

1 pand programs to prevent maternal mortality and severe
2 maternal morbidity among Black pregnant and
3 postpartum individuals.

4 (b) ELIGIBILITY.—To be eligible to seek a grant
5 under this section, an entity shall be a community-based
6 organization offering programs and resources aligned with
7 evidence-based practices for improving maternal health
8 outcomes for Black pregnant and postpartum individuals.

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

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

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

17 (d) SPECIAL CONSIDERATION.—

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

21 (A) are based in, and provide support for,
22 communities with high rates of adverse mater-
23 nal health outcomes or significant racial and
24 ethnic disparities in maternal health outcomes,
25 to the extent such data are available;

1 (B) are led by Black women; and

2 (C) offer programs and resources that are
3 aligned with evidence-based practices for im-
4 proving maternal health outcomes for Black
5 pregnant and postpartum individuals.

6 (2) AWARDS.—In awarding grants under this
7 section, the Secretary shall give special consideration
8 to eligible entities that—

9 (A) are described in subparagraphs (A),
10 (B), and (C) of paragraph (1);

11 (B) offer programs and resources designed
12 in consultation with and intended for Black
13 pregnant and postpartum individuals; and

14 (C) offer programs and resources in the
15 communities in which the respective eligible en-
16 tities are located that—

17 (i) promote maternal mental health
18 and maternal substance use disorder treat-
19 ments and supports that are aligned with
20 evidence-based practices for improving ma-
21 ternal mental and behavioral health out-
22 comes for Black pregnant and postpartum
23 individuals;

- 1 (ii) address social determinants of ma-
2 ternal health for pregnant and postpartum
3 individuals;
- 4 (iii) promote evidence-based health lit-
5 eracy and pregnancy, childbirth, and par-
6 enting education for pregnant and
7 postpartum individuals;
- 8 (iv) provide support from perinatal
9 health workers to pregnant and
10 postpartum individuals;
- 11 (v) provide culturally congruent train-
12 ing to perinatal health workers;
- 13 (vi) conduct or support research on
14 maternal health issues disproportionately
15 impacting Black pregnant and postpartum
16 individuals;
- 17 (vii) provide support to family mem-
18 bers of individuals who suffered a preg-
19 nancy-associated death or pregnancy-re-
20 lated death;
- 21 (viii) operate midwifery practices that
22 provide culturally congruent maternal
23 health care and support, including for the
24 purposes of—

- 1 (I) supporting additional edu-
2 cation, training, and certification pro-
3 grams, including support for distance
4 learning;
- 5 (II) providing financial support
6 to current and future midwives to ad-
7 dress education costs, debts, and
8 other needs;
- 9 (III) clinical site investments;
- 10 (IV) supporting preceptor devel-
11 opment trainings;
- 12 (V) expanding the midwifery
13 practice; or
- 14 (VI) related needs identified by
15 the midwifery practice and described
16 in the practice’s application; or
- 17 (ix) have developed other programs
18 and resources that address community-spe-
19 cific needs for pregnant and postpartum
20 individuals and are aligned with evidence-
21 based practices for improving maternal
22 health outcomes for Black pregnant and
23 postpartum individuals.

1 (e) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide to grant recipients under this section technical as-
3 sistance on—

4 (1) capacity building to establish or expand pro-
5 grams to prevent adverse maternal health outcomes
6 among Black pregnant and postpartum individuals;

7 (2) best practices in data collection, measure-
8 ment, evaluation, and reporting; and

9 (3) planning for sustaining programs to prevent
10 maternal mortality and severe maternal morbidity
11 among Black pregnant and postpartum individuals
12 after the period of the grant.

13 (f) EVALUATION.—Not later than the end of fiscal
14 year 2026, the Secretary shall submit to the Congress an
15 evaluation of the grant program under this section that—

16 (1) assesses the effectiveness of outreach efforts
17 during the application process in diversifying the
18 pool of grant recipients;

19 (2) makes recommendations for future outreach
20 efforts to diversify the pool of grant recipients for
21 Department of Health and Human Services grant
22 programs and funding opportunities related to ma-
23 ternal health;

24 (3) assesses the effectiveness of programs fund-
25 ed by grants under this section in improving mater-

1 nal health outcomes for Black pregnant and
2 postpartum individuals, to the extent practicable;
3 and

4 (4) makes recommendations for future Depart-
5 ment of Health and Human Services grant programs
6 and funding opportunities that deliver funding to
7 community-based organizations that provide pro-
8 grams and resources that are aligned with evidence-
9 based practices for improving maternal health out-
10 comes for Black pregnant and postpartum individ-
11 uals.

12 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there is authorized to be appropriated
14 \$10,000,000 for each of fiscal years 2022 through 2026.

15 **SEC. 202. INVESTMENTS IN COMMUNITY-BASED ORGANIZA-**
16 **TIONS TO IMPROVE MATERNAL HEALTH OUT-**
17 **COMES IN UNDERSERVED COMMUNITIES.**

18 (a) AWARDS.—Following the 1-year period described
19 in subsection (c), the Secretary of Health and Human
20 Services (in this section referred to as the “Secretary”)
21 shall award grants to eligible entities to establish or ex-
22 pand programs to prevent maternal mortality and severe
23 maternal morbidity among underserved groups.

24 (b) ELIGIBILITY.—To be eligible to seek a grant
25 under this section, an entity shall be a community-based

1 organization offering programs and resources aligned with
2 evidence-based practices for improving maternal health
3 outcomes for pregnant and postpartum individuals.

4 (c) OUTREACH AND TECHNICAL ASSISTANCE PE-
5 RIOD.—During the 1-year period beginning on the date
6 of enactment of this Act, the Secretary shall—

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

9 (2) provide technical assistance to eligible enti-
10 ties on best practices for applying for grants under
11 this section.

12 (d) SPECIAL CONSIDERATION.—

13 (1) OUTREACH.—In conducting outreach under
14 subsection (c), the Secretary shall give special con-
15 sideration to eligible entities that—

16 (A) are based in, and provide support for,
17 communities with high rates of adverse mater-
18 nal health outcomes or significant racial and
19 ethnic disparities in maternal health outcomes,
20 to the extent such data are available;

21 (B) are led by individuals from racially,
22 ethnically, and geographically diverse back-
23 grounds; and

24 (C) offer programs and resources that are
25 aligned with evidence-based practices for im-

1 proving maternal health outcomes for pregnant
2 and postpartum individuals.

3 (2) AWARDS.—In awarding grants under this
4 section, the Secretary shall give special consideration
5 to eligible entities that—

6 (A) are described in subparagraphs (A),
7 (B), and (C) of paragraph (1);

8 (B) offer programs and resources designed
9 in consultation with and intended for pregnant
10 and postpartum individuals from underserved
11 groups; and

12 (C) offer programs and resources in the
13 communities in which the respective eligible en-
14 tities are located that—

15 (i) promote maternal mental health
16 and maternal substance use disorder treat-
17 ments and support that are aligned with
18 evidence-based practices for improving ma-
19 ternal mental and behavioral health out-
20 comes for pregnant and postpartum indi-
21 viduals;

22 (ii) address social determinants of ma-
23 ternal health for pregnant and postpartum
24 individuals;

1 (iii) promote evidence-based health lit-
2 eracy and pregnancy, childbirth, and par-
3 enting education for pregnant and
4 postpartum individuals;

5 (iv) provide support from perinatal
6 health workers to pregnant and
7 postpartum individuals;

8 (v) provide culturally congruent train-
9 ing to perinatal health workers;

10 (vi) conduct or support research on
11 maternal health outcomes and disparities;

12 (vii) provide support to family mem-
13 bers of individuals who suffered a preg-
14 nancy-associated death or pregnancy-re-
15 lated death;

16 (viii) operate midwifery practices that
17 provide culturally congruent maternal
18 health care and support, including for the
19 purposes of—

20 (I) supporting additional edu-
21 cation, training, and certification pro-
22 grams, including support for distance
23 learning;

24 (II) providing financial support
25 to current and future midwives to ad-

1 dress education costs, debts, and
2 other needs;

3 (III) clinical site investments;

4 (IV) supporting preceptor devel-
5 opment trainings;

6 (V) expanding the midwifery
7 practice; or

8 (VI) related needs identified by
9 the midwifery practice and described
10 in the practice's application; or

11 (ix) have developed other programs
12 and resources that address community-spe-
13 cific needs for pregnant and postpartum
14 individuals and are aligned with evidence-
15 based practices for improving maternal
16 health outcomes for pregnant and
17 postpartum individuals.

18 (e) TECHNICAL ASSISTANCE.—The Secretary shall
19 provide to grant recipients under this section technical as-
20 sistance on—

21 (1) capacity building to establish or expand pro-
22 grams to prevent adverse maternal health outcomes
23 among pregnant and postpartum individuals from
24 underserved groups;

1 (2) best practices in data collection, measure-
2 ment, evaluation, and reporting; and

3 (3) planning for sustaining programs to prevent
4 maternal mortality and severe maternal morbidity
5 among pregnant and postpartum individuals from
6 underserved groups after the period of the grant.

7 (f) EVALUATION.—Not later than the end of fiscal
8 year 2026, the Secretary shall submit to the Congress an
9 evaluation of the grant program under this section that—

10 (1) assesses the effectiveness of outreach efforts
11 during the application process in diversifying the
12 pool of grant recipients;

13 (2) makes recommendations for future outreach
14 efforts to diversify the pool of grant recipients for
15 Department of Health and Human Services grant
16 programs and funding opportunities related to ma-
17 ternal health;

18 (3) assesses the effectiveness of programs fund-
19 ed by grants under this section in improving mater-
20 nal health outcomes for pregnant and postpartum
21 individuals from underserved groups, to the extent
22 practicable; and

23 (4) makes recommendations for future Depart-
24 ment of Health and Human Services grant programs
25 and funding opportunities that deliver funding to

1 community-based organizations that provide pro-
2 grams and resources that are aligned with evidence-
3 based practices for improving maternal health out-
4 comes for pregnant and postpartum individuals.

5 (g) DEFINITION.—In this section, the term “under-
6 served groups” refers to pregnant and postpartum individ-
7 uals—

8 (1) from racial and ethnic minority groups (as
9 such term is defined in section 1707(g)(1) of the
10 Public Health Service Act (42 U.S.C. 300u-
11 6(g)(1)));

12 (2) whose household income is equal to or less
13 than 150 percent of the Federal poverty line;

14 (3) who live in health professional shortage
15 areas (as such term is defined in section 332 of the
16 Public Health Service Act (42 U.S.C. 254e(a)(1)));

17 (4) who live in counties with no hospital offer-
18 ing obstetric care, no birth center, and no obstetric
19 provider; or

20 (5) who live in counties with a level of vulner-
21 ability of moderate-to-high or higher, according to
22 the Social Vulnerability Index of the Centers for
23 Disease Control and Prevention.

1 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there is authorized to be appropriated
3 \$10,000,000 for each of fiscal years 2022 through 2026.

4 **SEC. 203. RESPECTFUL MATERNITY CARE TRAINING FOR**
5 **ALL EMPLOYEES IN MATERNITY CARE SET-**
6 **TINGS.**

7 Part B of title VII of the Public Health Service Act
8 (42 U.S.C. 293 et seq.) is amended by adding at the end
9 the following new section:

10 **“SEC. 742. RESPECTFUL MATERNITY CARE TRAINING FOR**
11 **ALL EMPLOYEES IN MATERNITY CARE SET-**
12 **TINGS.**

13 “(a) GRANTS.—The Secretary shall award grants for
14 programs to reduce and prevent bias, racism, and dis-
15 crimination in maternity care settings and to advance re-
16 spectful, culturally congruent, trauma-informed care.

17 “(b) SPECIAL CONSIDERATION.—In awarding grants
18 under subsection (a), the Secretary shall give special con-
19 sideration to applications for programs that would—

20 “(1) apply to all maternity care providers and
21 any employees who interact with pregnant and
22 postpartum individuals in the provider setting, in-
23 cluding front desk employees, sonographers, sched-
24 ulers, health care professionals, hospital or health

1 system administrators, security staff, and other em-
2 ployees;

3 “(2) emphasize periodic, as opposed to one-
4 time, trainings for all birthing professionals and em-
5 ployees described in paragraph (1);

6 “(3) address implicit bias, racism, and cultural
7 humility;

8 “(4) be delivered in ongoing education settings
9 for providers maintaining their licenses, with a pref-
10 erence for trainings that provide continuing edu-
11 cation units;

12 “(5) include trauma-informed care best prac-
13 tices and an emphasis on shared decision making be-
14 tween providers and patients;

15 “(6) include antiracism training and programs;

16 “(7) be delivered in undergraduate programs
17 that funnel into health professions schools;

18 “(8) be delivered in settings that apply to pro-
19 viders of the special supplemental nutrition program
20 for women, infants, and children under section 17 of
21 the Child Nutrition Act of 1966;

22 “(9) integrate bias training in obstetric emer-
23 gency simulation trainings or related trainings;

24 “(10) include training for emergency depart-
25 ment employees and emergency medical technicians

1 on recognizing warning signs for severe pregnancy-
2 related complications;

3 “(11) offer training to all maternity care pro-
4 viders on the value of racially, ethnically, and profes-
5 sionally diverse maternity care teams to provide cul-
6 turally congruent care; or

7 “(12) be based on one or more programs de-
8 signed by a historically Black college or university or
9 other minority-serving institution.

10 “(c) APPLICATION.—To seek a grant under sub-
11 section (a), an entity shall submit an application at such
12 time, in such manner, and containing such information as
13 the Secretary may require.

14 “(d) REPORTING.—Each recipient of a grant under
15 this section shall annually submit to the Secretary a report
16 on the status of activities conducted using the grant, in-
17 cluding, as applicable, a description of the impact of train-
18 ing provided through the grant on patient outcomes and
19 patient experience for pregnant and postpartum individ-
20 uals from racial and ethnic minority groups and their fam-
21 ilies.

22 “(e) BEST PRACTICES.—Based on the annual reports
23 submitted pursuant to subsection (d), the Secretary—

1 “(1) shall produce an annual report on the find-
2 ings resulting from programs funded through this
3 section;

4 “(2) shall disseminate such report to all recipi-
5 ents of grants under this section and to the public;
6 and

7 “(3) may include in such report findings on
8 best practices for improving patient outcomes and
9 patient experience for pregnant and postpartum in-
10 dividuals from racial and ethnic minority groups and
11 their families in maternity care settings.

12 “(f) DEFINITIONS.—In this section:

13 “(1) The term ‘postpartum’ means the one-year
14 period beginning on the last day of an individual’s
15 pregnancy.

16 “(2) The term ‘culturally congruent’ means in
17 agreement with the preferred cultural values, beliefs,
18 world view, language, and practices of the health
19 care consumer and other stakeholders.

20 “(3) The term ‘racial and ethnic minority
21 group’ has the meaning given such term in section
22 1707(g)(1).

23 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
24 carry out this section, there is authorized to be appro-

1 priated \$5,000,000 for each of fiscal years 2022 through
2 2026.”.

3 **SEC. 204. STUDY ON REDUCING AND PREVENTING BIAS,**
4 **RACISM, AND DISCRIMINATION IN MATER-**
5 **NITY CARE SETTINGS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall seek to enter into an agreement,
8 not later than 90 days after the date of enactment of this
9 Act, with the National Academies of Sciences, Engineer-
10 ing, and Medicine (referred to in this section as the “Na-
11 tional Academies”) under which the National Academies
12 agree to—

13 (1) conduct a study on the design and imple-
14 mentation of programs to reduce and prevent bias,
15 racism, and discrimination in maternity care settings
16 and to advance respectful, culturally congruent,
17 trauma-informed care; and

18 (2) not later than 24 months after the date of
19 enactment of this Act—

20 (A) complete the study; and

21 (B) transmit a report on the results of the
22 study to the Congress.

23 (b) POSSIBLE TOPICS.—The agreement entered into
24 pursuant to subsection (a) may provide for the study of
25 any of the following:

1 (1) The development of a scorecard or other
2 evaluation standards for programs designed to re-
3 duce and prevent bias, racism, and discrimination in
4 maternity care settings to assess the effectiveness of
5 such programs in improving patient outcomes and
6 patient experience for pregnant and postpartum in-
7 dividuals from racial and ethnic minority groups and
8 their families.

9 (2) Determination of the types and frequency of
10 training to reduce and prevent bias, racism, and dis-
11 crimination in maternity care settings that are dem-
12 onstrated to improve patient outcomes or patient ex-
13 perience for pregnant and postpartum individuals
14 from racial and ethnic minority groups and their
15 families.

16 **SEC. 205. RESPECTFUL MATERNITY CARE COMPLIANCE**
17 **PROGRAM.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services (referred to in this section as the “Sec-
20 retary”) shall award grants to accredited hospitals, health
21 systems, and other maternity care settings to establish as
22 an integral part of quality implementation initiatives with-
23 in one or more hospitals or other birth settings a respect-
24 ful maternity care compliance program.

1 (b) PROGRAM REQUIREMENTS.—A respectful mater-
2 nity care compliance program funded through a grant
3 under this section shall—

4 (1) institutionalize mechanisms to allow pa-
5 tients receiving maternity care services, the families
6 of such patients, or perinatal health workers sup-
7 porting such patients to report instances of racism
8 or evidence of bias on the basis of race, ethnicity, or
9 another protected class;

10 (2) institutionalize response mechanisms
11 through which representatives of the program can
12 directly follow up with the patient, if possible, and
13 the patient’s family in a timely manner;

14 (3) prepare and make publicly available a
15 hospital- or health system-wide strategy to reduce
16 bias on the basis of race, ethnicity, or another pro-
17 tected class in the delivery of maternity care that in-
18 cludes—

19 (A) information on the training programs
20 to reduce and prevent bias, racism, and dis-
21 crimination on the basis of race, ethnicity, or
22 another protected class for all employees in ma-
23 ternity care settings;

24 (B) information on the number of cases re-
25 ported to the compliance program; and

1 (C) the development of methods to rou-
2 tinely assess the extent to which bias, racism,
3 or discrimination on the basis of race, ethnicity,
4 or another protected class are present in the de-
5 livery of maternity care to patients from racial
6 and ethnic minority groups;

7 (4) develop mechanisms to routinely collect and
8 publicly report hospital-level data related to patient-
9 reported experience of care; and

10 (5) provide annual reports to the Secretary with
11 information about each case reported to the compli-
12 ance program over the course of the year containing
13 such information as the Secretary may require, such
14 as—

15 (A) de-identified demographic information
16 on the patient in the case, such as race, eth-
17 nicity, gender identity, and primary language;

18 (B) the content of the report from the pa-
19 tient or the family of the patient to the compli-
20 ance program;

21 (C) the response from the compliance pro-
22 gram; and

23 (D) to the extent applicable, institutional
24 changes made as a result of the case.

25 (c) SECRETARY REQUIREMENTS.—

1 (1) PROCESSES.—Not later than 180 days after
2 the date of enactment of this Act, the Secretary
3 shall establish processes for—

4 (A) disseminating best practices for estab-
5 lishing and implementing a respectful maternity
6 care compliance program within a hospital or
7 other birth setting;

8 (B) promoting coordination and collabora-
9 tion between hospitals, health systems, and
10 other maternity care delivery settings on the es-
11 tablishment and implementation of respectful
12 maternity care compliance programs; and

13 (C) evaluating the effectiveness of respect-
14 ful maternity care compliance programs on ma-
15 ternal health outcomes and patient and family
16 experiences, especially for patients from racial
17 and ethnic minority groups and their families.

18 (2) STUDY.—

19 (A) IN GENERAL.—Not later than 2 years
20 after the date of enactment of this Act, the Sec-
21 retary shall, through a contract with an inde-
22 pendent research organization, conduct a study
23 on strategies to address—

1 (i) racism or bias on the basis of race,
2 ethnicity, or another protected class in the
3 delivery of maternity care services; and

4 (ii) successful implementation of re-
5 spectful care initiatives.

6 (B) COMPONENTS OF STUDY.—The study
7 shall include the following:

8 (i) An assessment of the reports sub-
9 mitted to the Secretary from the respectful
10 maternity care compliance programs pur-
11 suant to subsection (b)(5).

12 (ii) Based on such assessment, rec-
13 ommendations for potential accountability
14 mechanisms related to cases of racism or
15 bias on the basis of race, ethnicity, or an-
16 other protected class in the delivery of ma-
17 ternity care services at hospitals and other
18 birth settings. Such recommendations shall
19 take into consideration medical and non-
20 medical factors that contribute to adverse
21 patient experiences and maternal health
22 outcomes.

23 (C) REPORT.—The Secretary shall submit
24 to the Congress and make publicly available a

1 report on the results of the study under this
2 paragraph.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there is authorized to be appropriated
5 such sums as may be necessary for fiscal years 2022
6 through 2027.

7 **SEC. 206. GAO REPORT.**

8 (a) IN GENERAL.—Not later than 2 years after the
9 date of enactment of this Act and annually thereafter, the
10 Comptroller General of the United States shall submit to
11 the Congress and make publicly available a report on the
12 establishment of respectful maternity care compliance pro-
13 grams within hospitals, health systems, and other mater-
14 nity care settings.

15 (b) MATTERS INCLUDED.—The report under para-
16 graph (1) shall include the following:

17 (1) Information regarding the extent to which
18 hospitals, health systems, and other maternity care
19 settings have elected to establish respectful mater-
20 nity care compliance programs, including—

21 (A) which hospitals and other birth set-
22 tings elect to establish compliance programs
23 and when such programs are established;

24 (B) to the extent practicable, impacts of
25 the establishment of such programs on mater-

1 nal health outcomes and patient and family ex-
2 periences in the hospitals and other birth set-
3 tings that have established such programs, es-
4 pecially for patients from racial and ethnic mi-
5 nority groups and their families;

6 (C) information on geographic areas, and
7 types of hospitals or other birth settings, where
8 respectful maternity care compliance programs
9 are not being established and information on
10 factors contributing to decisions to not establish
11 such programs; and

12 (D) recommendations for establishing re-
13 spectful maternity care compliance programs in
14 geographic areas, and types of hospitals or
15 other birth settings, where such programs are
16 not being established.

17 (2) Whether the funding made available to
18 carry out this section has been sufficient and, if ap-
19 plicable, recommendations for additional appropria-
20 tions to carry out this section.

21 (3) Such other information as the Comptroller
22 General determines appropriate.

1 **TITLE III—PROTECTING MOMS**
2 **WHO SERVED**

3 **SEC. 301. SUPPORT FOR MATERNITY CARE COORDINATION.**

4 (a) PROGRAM ON MATERNITY CARE COORDINA-
5 TION.—

6 (1) IN GENERAL.—The Secretary of Veterans
7 Affairs shall carry out the maternity care coordina-
8 tion program described in Veterans Health Adminis-
9 tration Handbook 1330.03, or any successor hand-
10 book.

11 (2) TRAINING AND SUPPORT.—In carrying out
12 the program under paragraph (1), the Secretary
13 shall provide to community maternity care providers
14 training and support with respect to the unique
15 needs of pregnant and postpartum veterans, particu-
16 larly regarding mental and behavioral health condi-
17 tions relating to the service of the veterans in the
18 Armed Forces.

19 (b) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated to the Secretary
21 \$15,000,000 for fiscal year 2022 for the maternity care
22 coordination program. Such amounts are authorized in ad-
23 dition to any other amounts authorized for such purpose.

24 (c) DEFINITIONS.—In this section:

1 (1) The term “community maternity care pro-
2 viders” means maternity care providers located at
3 non-Department facilities who provide maternity
4 care to veterans under section 1703 of title 38,
5 United States Code, or other provisions of law ad-
6 ministered by the Secretary of Veterans Affairs.

7 (2) The term “non-Department facilities” has
8 the meaning given that term in section 1701 of title
9 38, United States Code.

10 **SEC. 302. REPORT ON MATERNAL MORTALITY AND SEVERE**
11 **MATERNAL MORBIDITY AMONG PREGNANT**
12 **AND POSTPARTUM VETERANS.**

13 (a) GAO REPORT.—Not later than two years after
14 the date of the enactment of this Act, the Comptroller
15 General of the United States shall submit to the Commit-
16 tees on Veterans’ Affairs of the Senate and the House of
17 Representatives, and make publicly available, a report on
18 maternal mortality and severe maternal morbidity among
19 pregnant and postpartum veterans, with a particular focus
20 on racial and ethnic disparities in maternal health out-
21 comes for veterans.

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

24 (1) To the extent practicable—

1 (A) the number of pregnant and
2 postpartum veterans who have experienced a
3 pregnancy-related death or pregnancy-associ-
4 ated death in the most recent 10 years of avail-
5 able data;

6 (B) the rate of pregnancy-related deaths
7 per 100,000 live births for pregnant and
8 postpartum veterans;

9 (C) the number of cases of severe maternal
10 morbidity among pregnant and postpartum vet-
11 erans in the most recent year of available data;

12 (D) the racial and ethnic disparities in ma-
13 ternal mortality and severe maternal morbidity
14 rates among pregnant and postpartum veterans;

15 (E) identification of the causes of maternal
16 mortality and severe maternal morbidity that
17 are unique to veterans, including post-traumatic
18 stress disorder, military sexual trauma, and in-
19 fertility or miscarriages that may be caused by
20 such service;

21 (F) identification of the causes of maternal
22 mortality and severe maternal morbidity that
23 are unique to veterans from racial and ethnic
24 minority groups;

1 (G) identification of any correlations be-
2 tween the former rank of veterans and their
3 maternal health outcomes;

4 (H) the number of veterans who have been
5 diagnosed with infertility by Veterans Health
6 Administration providers each year in the most
7 recent five years, disaggregated by age, race,
8 ethnicity, sex, marital status, sexual orientation,
9 gender identity, and geographical location;

10 (I) the number of veterans who receive a
11 clinical diagnosis of unexplained infertility by
12 Veterans Health Administration providers each
13 year in the most recent five years; and

14 (J) the extent to which the rate of inci-
15 dence of clinically diagnosed infertility among
16 veterans compare or differ to the rate of inci-
17 dence of clinically diagnosed infertility among
18 the civilian population.

19 (2) An assessment of the barriers to deter-
20 mining the information required under paragraph
21 (1) and recommendations for improvements in track-
22 ing maternal health outcomes among pregnant and
23 postpartum veterans—

24 (A) who have health care coverage through
25 the Department;

1 (B) enrolled in the TRICARE program;

2 (C) with employer-based or private insur-
3 ance;

4 (D) enrolled in the Medicaid program; and

5 (E) who are uninsured.

6 (3) Recommendations for legislative and admin-
7 istrative actions to increase access to mental and be-
8 havioral health care for pregnant and postpartum
9 veterans who screen positively for maternal mental
10 or behavioral health conditions.

11 (4) Recommendations to address homelessness,
12 food insecurity, poverty, and related issues among
13 pregnant and postpartum veterans.

14 (5) Recommendations on how to effectively edu-
15 cate maternity care providers on best practices for
16 providing maternity care services to veterans that
17 addresses the unique maternal health care needs of
18 veteran populations.

19 (6) Recommendations to reduce maternal mor-
20 tality and severe maternal morbidity among preg-
21 nant and postpartum veterans and to address racial
22 and ethnic disparities in maternal health outcomes
23 for each of the groups described in subparagraphs
24 (A) through (E) of paragraph (2).

1 (7) Recommendations to improve coordination
2 of care between the Department and non-Depart-
3 ment facilities for pregnant and postpartum vet-
4 erans, including recommendations to improve—

5 (A) health record interoperability; and

6 (B) training for the directors of the Vet-
7 erans Integrated Service Networks, directors of
8 medical facilities of the Department, chiefs of
9 staff of such facilities, maternity care coordina-
10 tors, and staff of relevant non-Department fa-
11 cilities.

12 (8) An assessment of the authority of the Sec-
13 retary of Veterans Affairs to access maternal health
14 data collected by the Department of Health and
15 Human Services and, if applicable, recommendations
16 to increase such authority.

17 (9) Any other information the Comptroller Gen-
18 eral determines appropriate with respect to the re-
19 duction of maternal mortality and severe maternal
20 morbidity among pregnant and postpartum veterans
21 and to address racial and ethnic disparities in ma-
22 ternal health outcomes for veterans.

TITLE IV—PERINATAL WORKFORCE

3 SEC. 401. 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 registered dietitians or nutrition professionals
23 (as such term is defined in section 1861(vv)(2)
24 of the Social Security Act (42 U.S.C.
25 1395x(vv)(2))), and lactation consultants cer-

1 tified by the International Board of Lactation
2 Consultants Examiners—

3 (i) from racially, ethnically, and lin-
4 guistically diverse backgrounds;

5 (ii) with experience practicing in ra-
6 cially and ethnically diverse communities;

7 and

8 (iii) who have undergone training on
9 implicit bias and racism;

10 (B) to incorporate into maternity care
11 teams—

12 (i) midwives who meet at a minimum
13 the international definition of the midwife
14 and global standards for midwifery edu-
15 cation as established by the International
16 Confederation of Midwives; and

17 (ii) perinatal health workers;

18 (C) to provide collaborative, culturally con-
19 gruent care; and

20 (D) to provide opportunities for individuals
21 enrolled in accredited midwifery education pro-
22 grams to participate in job shadowing with ma-
23 ternity care teams in hospitals, health systems,
24 midwifery practices, and freestanding birth cen-
25 ters.

1 (b) STUDY ON RESPECTFUL AND CULTURALLY CON-
2 GRUENT MATERNITY CARE.—

3 (1) STUDY.—The Secretary of Health and
4 Human Services acting through the Director of the
5 National Institutes of Health (in this subsection re-
6 ferred to as the “Secretary”) shall conduct a study
7 on best practices in respectful and culturally con-
8 gruent maternity care.

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

11 (A) complete the study required by para-
12 graph (1);

13 (B) submit to the Congress and make pub-
14 licly available a report on the results of such
15 study; and

16 (C) include in such report—

17 (i) a compendium of examples of hos-
18 pitals, health systems, midwifery practices,
19 freestanding birth centers, other maternity
20 care provider groups, managed care enti-
21 ties, and other insurers that are delivering
22 respectful and culturally congruent mater-
23 nal health care;

24 (ii) a compendium of examples of hos-
25 pitals, health systems, midwifery practices,

1 freestanding birth centers, other maternity
2 care provider groups, managed care enti-
3 ties, and other insurers that have made
4 progress in reducing disparities in mater-
5 nal health outcomes and improving birth-
6 ing experiences for pregnant and
7 postpartum individuals from racial and
8 ethnic minority groups; and

9 (iii) recommendations to hospitals,
10 health systems, midwifery practices, free-
11 standing birth centers, other maternity
12 care provider groups, managed care enti-
13 ties, and other insurers, for best practices
14 in respectful and culturally congruent ma-
15 ternity care.

16 **SEC. 402. GRANTS TO GROW AND DIVERSIFY THE**
17 **PERINATAL WORKFORCE.**

18 Title VII of the Public Health Service Act is amended
19 by inserting after section 757 (42 U.S.C. 294f) the fol-
20 lowing new section:

21 **“SEC. 758. PERINATAL WORKFORCE GRANTS.**

22 “(a) IN GENERAL.—The Secretary shall award
23 grants to entities to establish or expand programs de-
24 scribed in subsection (b) to grow and diversify the
25 perinatal workforce.

1 “(b) USE OF FUNDS.—Recipients of grants under
2 this section shall use the grants to grow and diversify the
3 perinatal workforce by—

4 “(1) establishing schools or programs that pro-
5 vide education and training to individuals seeking
6 appropriate licensing or certification as—

7 “(A) physician assistants who will complete
8 clinical training in the field of maternal and
9 perinatal health; or

10 “(B) perinatal health workers; and

11 “(2) expanding the capacity of existing schools
12 or programs described in paragraph (1), for the pur-
13 poses of increasing the number of students enrolled
14 in such schools or programs, including by awarding
15 scholarships for students.

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

19 “(1) has demonstrated a commitment to re-
20 cruiting and retaining students and faculty from ra-
21 cial and ethnic minority groups;

22 “(2) has developed a strategy to recruit and re-
23 tain a diverse pool of students into the perinatal
24 workforce program or school supported by funds re-
25 ceived through the grant, particularly from racial

1 and ethnic minority groups and other underserved
2 populations;

3 “(3) has developed a strategy to recruit and re-
4 tain students who plan to practice in a health pro-
5 fessional shortage area designated under section
6 332;

7 “(4) has developed a strategy to recruit and re-
8 tain students who plan to practice in an area with
9 significant racial and ethnic disparities in maternal
10 health outcomes, to the extent practicable; and

11 “(5) includes in the standard curriculum for all
12 students within the perinatal workforce program or
13 school a bias, racism, or discrimination training pro-
14 gram that includes training on implicit bias and rac-
15 ism.

16 “(d) REPORTING.—As a condition on receipt of a
17 grant under this section for a perinatal workforce program
18 or school, an entity shall agree to submit to the Secretary
19 an annual report on the activities conducted through the
20 grant, including—

21 “(1) the number and demographics of students
22 participating in the program or school;

23 “(2) the extent to which students in the pro-
24 gram or school are entering careers in—

1 “(A) health professional shortage areas
2 designated under section 332; and

3 “(B) areas with significant racial and eth-
4 nic disparities in maternal health outcomes, to
5 the extent such data are available; and

6 “(3) whether the program or school has in-
7 cluded in the standard curriculum for all students a
8 bias, racism, or discrimination training program that
9 includes explicit and implicit bias, and if so the ef-
10 fectiveness of such training program.

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

13 “(f) APPLICATION.—To seek a grant under this sec-
14 tion, an entity shall submit to the Secretary an application
15 at such time, in such manner, and containing such infor-
16 mation as the Secretary may require, including any infor-
17 mation necessary for prioritization under subsection (c).

18 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
19 provide, directly or by contract, technical assistance to en-
20 tities seeking or receiving a grant under this section on
21 the development, use, evaluation, and post-grant period
22 sustainability of the perinatal workforce programs or
23 schools proposed to be, or being, established or expanded
24 through the grant.

1 “(h) REPORT BY THE SECRETARY.—Not later than
2 4 years after the date of enactment of this section, the
3 Secretary shall prepare and submit to the Congress, and
4 post on the internet website of the Department of Health
5 and Human Services, a report on the effectiveness of the
6 grant program under this section at—

7 “(1) recruiting students from racial and ethnic
8 minority groups;

9 “(2) increasing the number of physician assist-
10 ants who will complete clinical training in the field
11 of maternal and perinatal health, and perinatal
12 health workers, from racial and ethnic minority
13 groups and other underserved populations;

14 “(3) increasing the number of physician assist-
15 ants who will complete clinical training in the field
16 of maternal and perinatal health, and perinatal
17 health workers, working in health professional short-
18 age areas designated under section 332; and

19 “(4) increasing the number of physician assist-
20 ants who will complete clinical training in the field
21 of maternal and perinatal health, and perinatal
22 health workers, working in areas with significant ra-
23 cial and ethnic disparities in maternal health out-
24 comes, to the extent such data are available.

1 “(i) DEFINITION.—In this section, the term ‘racial
2 and ethnic minority group’ has the meaning given such
3 term in section 1707(g).

4 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there is authorized to be appro-
6 priated \$15,000,000 for each of fiscal years 2022 through
7 2026.”.

8 **SEC. 403. GRANTS TO GROW AND DIVERSIFY THE NURSING**
9 **WORKFORCE IN MATERNAL AND PERINATAL**
10 **HEALTH.**

11 Title VIII of the Public Health Service Act is amend-
12 ed by inserting after section 811 of that Act (42 U.S.C.
13 296j) the following:

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

15 “(a) IN GENERAL.—The Secretary shall award
16 grants to schools of nursing to grow and diversify the
17 perinatal nursing workforce.

18 “(b) USE OF FUNDS.—Recipients of grants under
19 this section shall use the grants to grow and diversify the
20 perinatal nursing workforce by providing scholarships to
21 students seeking to become—

22 “(1) nurse practitioners whose education in-
23 cludes a focus on maternal and perinatal health; or

24 “(2) clinical nurse specialists whose education
25 includes a focus on maternal and perinatal health.

1 “(c) PRIORITIZATION.—In awarding grants under
2 this section, the Secretary shall give priority to any school
3 of nursing that—

4 “(1) has developed a strategy to recruit and re-
5 tain a diverse pool of students seeking to enter ca-
6 reers focused on maternal and perinatal health, par-
7 ticularly students from racial and ethnic minority
8 groups and other underserved populations;

9 “(2) has developed a partnership with a prac-
10 tice setting in a health professional shortage area
11 designated under section 332 for the clinical place-
12 ments of the school’s students;

13 “(3) has developed a strategy to recruit and re-
14 tain students who plan to practice in an area with
15 significant racial and ethnic disparities in maternal
16 health outcomes, to the extent practicable; and

17 “(4) includes in the standard curriculum for all
18 students seeking to enter careers focused on mater-
19 nal and perinatal health a bias, racism, or discrimi-
20 nation training program that includes education on
21 implicit bias and racism.

22 “(d) REPORTING.—As a condition on receipt of a
23 grant under this section, a school of nursing shall agree
24 to submit to the Secretary an annual report on the activi-

1 ties conducted through the grant, including, to the extent
2 practicable—

3 “(1) the number and demographics of students
4 in the school of nursing seeking to enter careers fo-
5 cused on maternal and perinatal health;

6 “(2) the extent to which such students are pre-
7 paring to enter careers in—

8 “(A) health professional shortage areas
9 designated under section 332; and

10 “(B) areas with significant racial and eth-
11 nic disparities in maternal health outcomes, to
12 the extent such data are available; and

13 “(3) whether the standard curriculum for all
14 students seeking to enter careers focused on mater-
15 nal and perinatal health includes a bias, racism, or
16 discrimination training program that includes edu-
17 cation on implicit bias and racism.

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

20 “(f) APPLICATION.—To seek a grant under this sec-
21 tion, an entity shall submit to the Secretary an applica-
22 tion, at such time, in such manner, and containing such
23 information as the Secretary may require, including any
24 information necessary for prioritization under subsection
25 (c).

1 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide, directly or by contract, technical assistance to
3 schools of nursing seeking or receiving a grant under this
4 section on the processes of awarding and evaluating schol-
5 arships through the grant.

6 “(h) REPORT BY THE SECRETARY.—Not later than
7 4 years after the date of enactment of this section, the
8 Secretary shall prepare and submit to the Congress, and
9 post on the internet website of the Department of Health
10 and Human Services, a report on the effectiveness of the
11 grant program under this section at—

12 “(1) recruiting students from racial and ethnic
13 minority groups and other underserved populations;

14 “(2) increasing the number of nurse practi-
15 tioners and clinical nurse specialists entering careers
16 focused on maternal and perinatal health from racial
17 and ethnic minority groups and other underserved
18 populations;

19 “(3) increasing the number of nurse practi-
20 tioners and clinical nurse specialists entering careers
21 focused on maternal and perinatal health working in
22 health professional shortage areas designated under
23 section 332; and

24 “(4) increasing the number of nurse practi-
25 tioners and clinical nurse specialists entering careers

1 focused on maternal and perinatal health working in
2 areas with significant racial and ethnic disparities in
3 maternal health outcomes, to the extent such data
4 are available.

5 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there is authorized to be appro-
7 priated \$15,000,000 for each of fiscal years 2022 through
8 2026.”.

9 **SEC. 404. GAO REPORT.**

10 (a) IN GENERAL.—Not later than two years after the
11 date of enactment of this Act and every five years there-
12 after, the Comptroller General of the United States shall
13 submit to Congress a report on barriers to maternal health
14 education and access to care in the United States. Such
15 report shall include the information and recommendations
16 described in subsection (b).

17 (b) CONTENT OF REPORT.—The report under sub-
18 section (a) shall include—

19 (1) an assessment of current barriers to enter-
20 ing accredited midwifery education programs, and
21 recommendations for addressing such barriers, par-
22 ticularly for low-income women and women from ra-
23 cial and ethnic minority groups;

24 (2) an assessment of current barriers to enter-
25 ing and successfully completing accredited education

1 programs for other health professional careers re-
2 lated to maternity care, including maternity care
3 providers, mental and behavioral health care pro-
4 viders acting in accordance with State law, reg-
5 istered dietitians or nutrition professionals (as such
6 term is defined in section 1861(vv)(2) of the Social
7 Security Act (42 U.S.C. 1395x(vv)(2))), and lacta-
8 tion consultants certified by the International Board
9 of Lactation Consultants Examiners, particularly for
10 low-income women and women from racial and eth-
11 nic minority groups;

12 (3) an assessment of current barriers that pre-
13 vent midwives from meeting the international defini-
14 tion of the midwife and global standards for mid-
15 wifery education as established by the International
16 Confederation of Midwives, and recommendations
17 for addressing such barriers, particularly for low-in-
18 come women and women from racial and ethnic mi-
19 nority groups;

20 (4) an assessment of disparities in access to
21 maternity care providers, mental or behavioral
22 health care providers acting in accordance with
23 State law, registered dietitians or nutrition profes-
24 sionals (as such term is defined in section
25 1861(vv)(2) of the Social Security Act (42 U.S.C.

1 1395x(vv)(2))), lactation consultants certified by the
 2 International Board of Lactation Consultants Exam-
 3 iners, and perinatal health workers, stratified by
 4 race, ethnicity, gender identity, geographic location,
 5 and insurance type and recommendations to promote
 6 greater access equity; and

7 (5) recommendations to promote greater equity
 8 in compensation for perinatal health workers under
 9 public and private insurers, particularly for such in-
 10 dividuals from racially and ethnically diverse back-
 11 grounds.

12 **TITLE V—DATA TO SAVE MOMS**

13 **SEC. 501. FUNDING FOR MATERNAL MORTALITY REVIEW**

14 **COMMITTEES TO PROMOTE REPRESENTA-** 15 **TIVE COMMUNITY ENGAGEMENT.**

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

19 “(9) GRANTS TO PROMOTE REPRESENTATIVE
 20 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
 21 TALITY REVIEW COMMITTEES.—

22 “(A) IN GENERAL.—The Secretary may,
 23 using funds made available pursuant to sub-
 24 paragraph (C), provide assistance to an applica-
 25 ble maternal mortality review committee of a

1 State, Indian tribe, tribal organization, or
2 urban Indian organization (as such term is de-
3 fined in section 4 of the Indian Health Care
4 Improvement Act (25 U.S.C. 1603))—

5 “(i) to select for inclusion in the mem-
6 bership of such a committee community
7 members from the State, Indian tribe, trib-
8 al organization, or urban Indian organiza-
9 tion by—

10 “(I) prioritizing community mem-
11 bers who can increase the diversity of
12 the committee’s membership with re-
13 spect to race and ethnicity, location,
14 and professional background, includ-
15 ing members with non-clinical experi-
16 ences; and

17 “(II) to the extent applicable,
18 using funds reserved under subsection
19 (f), to address barriers to maternal
20 mortality review committee participa-
21 tion for community members, includ-
22 ing required training, transportation
23 barriers, compensation, and other sup-
24 ports as may be necessary;

1 “(ii) to establish initiatives to conduct
2 outreach and community engagement ef-
3 forts within communities throughout the
4 State or Tribe to seek input from commu-
5 nity members on the work of such mater-
6 nal mortality review committee, with a par-
7 ticular focus on outreach to minority
8 women; and

9 “(iii) to release public reports assess-
10 ing—

11 “(I) the pregnancy-related death
12 and pregnancy-associated death review
13 processes of the maternal mortality
14 review committee, with a particular
15 focus on the maternal mortality re-
16 view committee’s sensitivity to the
17 unique circumstances of pregnant and
18 postpartum individuals from racial
19 and ethnic minority groups (as such
20 term is defined in section 1707(g)(1))
21 who have suffered pregnancy-related
22 deaths; and

23 “(II) the impact of the use of
24 funds made available pursuant to
25 paragraph (C) on increasing the diver-

1 sity of the maternal mortality review
2 committee membership and promoting
3 community engagement efforts
4 throughout the State or Tribe.

5 “(B) TECHNICAL ASSISTANCE.—The Sec-
6 retary shall provide (either directly through the
7 Department of Health and Human Services or
8 by contract) technical assistance to any mater-
9 nal mortality review committee receiving a
10 grant under this paragraph on best practices
11 for increasing the diversity of the maternal
12 mortality review committee’s membership and
13 for conducting effective community engagement
14 throughout the State or Tribe.

15 “(C) AUTHORIZATION OF APPROPRIA-
16 TIONS.—In addition to any funds made avail-
17 able under subsection (f), there are authorized
18 to be appropriated to carry out this paragraph
19 \$10,000,000 for each of fiscal years 2022
20 through 2026.”.

21 (b) RESERVATION OF FUNDS.—Section 317K(f) of
22 the Public Health Service Act (42 U.S.C. 247b–12(f)) is
23 amended by adding at the end the following: “Of the
24 amount made available under the preceding sentence for
25 a fiscal year, not less than \$1,500,000 shall be reserved

1 for grants to Indian tribes, tribal organizations, or urban
2 Indian organizations (as those terms are defined in section
3 4 of the Indian Health Care Improvement Act (25 U.S.C.
4 1603))”.

5 **SEC. 502. DATA COLLECTION AND REVIEW.**

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

8 (1) by redesignating subclauses (II) and (III)
9 as subclauses (V) and (VI), respectively; and

10 (2) by inserting after subclause (I) the fol-
11 lowing:

12 “(II) to the extent practicable,
13 reviewing cases of severe maternal
14 morbidity, according to the most up-
15 to-date indicators;

16 “(III) to the extent practicable,
17 reviewing deaths during pregnancy or
18 up to 1 year after the end of a preg-
19 nancy from suicide, overdose, or other
20 death from a mental health condition
21 or substance use disorder attributed
22 to or aggravated by pregnancy or
23 childbirth complications;

24 “(IV) to the extent practicable,
25 consulting with local community-based

1 organizations representing pregnant
2 and postpartum individuals from de-
3 mographic groups disproportionately
4 impacted by poor maternal health out-
5 comes to ensure that, in addition to
6 clinical factors, non-clinical factors
7 that might have contributed to a preg-
8 nancy-related death are appropriately
9 considered;”.

10 **SEC. 503. REVIEW OF MATERNAL HEALTH DATA COLLEC-**
11 **TION PROCESSES AND QUALITY MEASURES.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services, acting through the Administrator for
14 Centers for Medicare & Medicaid Services and the Direc-
15 tor of the Agency for Healthcare Research and Quality,
16 shall consult with relevant stakeholders—

17 (1) to review existing maternal health data col-
18 lection processes and quality measures; and

19 (2) make recommendations to improve such
20 processes and measures, including topics described
21 under subsection (c).

22 (b) COLLABORATION.—In carrying out this section,
23 the Secretary shall consult with a diverse group of mater-
24 nal health stakeholders, which may include—

- 1 (1) pregnant and postpartum individuals and
2 their family members, and nonprofit organizations
3 representing such individuals, with a particular focus
4 on patients from racial and ethnic minority groups;
- 5 (2) community-based organizations that provide
6 support for pregnant and postpartum individuals,
7 with a particular focus on patients from racial and
8 ethnic minority groups;
- 9 (3) membership organizations for maternity
10 care providers;
- 11 (4) organizations representing perinatal health
12 workers;
- 13 (5) organizations that focus on maternal mental
14 or behavioral health;
- 15 (6) organizations that focus on intimate partner
16 violence;
- 17 (7) institutions of higher education, with a par-
18 ticular focus on minority-serving institutions;
- 19 (8) licensed and accredited hospitals, birth cen-
20 ters, midwifery practices, or other medical practices
21 that provide maternal health care services to preg-
22 nant and postpartum patients;
- 23 (9) relevant State and local public agencies, in-
24 cluding State maternal mortality review committees;
25 and

1 (10) the National Quality Forum, or such other
2 standard-setting organizations specified by the Sec-
3 retary.

4 (c) TOPICS.—The review of maternal health data col-
5 lection processes and recommendations to improve such
6 processes and measures required under subsection (a)
7 shall assess all available relevant information, including
8 information from State-level sources, and shall consider at
9 least the following:

10 (1) Current State and Tribal practices for ma-
11 ternal health, maternal mortality, and severe mater-
12 nal morbidity data collection and dissemination, in-
13 cluding consideration of—

14 (A) the timeliness of processes for amend-
15 ing a death certificate when new information
16 pertaining to the death becomes available to re-
17 flect whether the death was a pregnancy-related
18 death;

19 (B) relevant data collected with electronic
20 health records, including data on race, eth-
21 nicity, socioeconomic status, insurance type,
22 and other relevant demographic information;

23 (C) maternal health data collected and
24 publicly reported by hospitals, health systems,
25 midwifery practices, and birth centers;

1 (D) the barriers preventing States from
2 correlating maternal outcome data with race
3 and ethnicity data;

4 (E) processes for determining the cause of
5 a pregnancy-associated death in States that do
6 not have a maternal mortality review com-
7 mittee;

8 (F) whether maternal mortality review
9 committees include multidisciplinary and di-
10 verse membership (as described in section
11 317K(d)(1)(A) of the Public Health Service Act
12 (42 U.S.C. 247b–12(d)(1)(A)));

13 (G) whether members of maternal mor-
14 tality review committees participate in trainings
15 on bias, racism, or discrimination, and the qual-
16 ity of such trainings;

17 (H) the extent to which States have imple-
18 mented systematic processes of listening to the
19 stories of pregnant and postpartum individuals
20 and their family members, with a particular
21 focus on pregnant and postpartum individuals
22 from racial and ethnic minority groups (as such
23 term is defined in section 1707(g)(1) of the
24 Public Health Service Act (42 U.S.C. 300u–
25 6(g)(1))) and their family members, to fully un-

1 derstand the causes of, and inform potential so-
2 lutions to, the maternal mortality and severe
3 maternal morbidity crisis within their respective
4 States;

5 (I) the extent to which maternal mortality
6 review committees are considering social deter-
7 minants of maternal health when examining the
8 causes of pregnancy-associated and pregnancy-
9 related deaths;

10 (J) the extent to which maternal mortality
11 review committees are making actionable rec-
12 ommendations based on their reviews of adverse
13 maternal health outcomes and the extent to
14 which such recommendations are being imple-
15 mented by appropriate stakeholders;

16 (K) the legal and administrative barriers
17 preventing the collection, collation, and dissemi-
18 nation of State maternity care data;

19 (L) the effectiveness of data collection and
20 reporting processes in separating pregnancy-as-
21 sociated deaths from pregnancy-related deaths;
22 and

23 (M) the current Federal, State, local, and
24 Tribal funding support for the activities re-
25 ferred to in subparagraphs (A) through (L).

1 (2) Whether the funding support referred to in
2 paragraph (1)(M) is adequate for States to carry out
3 optimal data collection and dissemination processes
4 with respect to maternal health, maternal mortality,
5 and severe maternal morbidity.

6 (3) Current quality measures for maternity
7 care, including prenatal measures, labor and delivery
8 measures, and postpartum measures, including top-
9 ics such as—

10 (A) effective quality measures for mater-
11 nity care used by hospitals, health systems,
12 midwifery practices, birth centers, health plans,
13 and other relevant entities;

14 (B) the sufficiency of current outcome
15 measures used to evaluate maternity care for
16 driving improved care, experiences, and out-
17 comes in maternity care payment and delivery
18 system models;

19 (C) maternal health quality measures that
20 other countries effectively use;

21 (D) validated measures that have been
22 used for research purposes that could be tested,
23 refined, and submitted for national endorse-
24 ment;

1 (E) barriers preventing maternity care pro-
2 viders and insurers from implementing quality
3 measures that are aligned with best practices;

4 (F) the frequency with which maternity
5 care quality measures are reviewed and revised;

6 (G) the strengths and weaknesses of the
7 Prenatal and Postpartum Care measures of the
8 Health Plan Employer Data and Information
9 Set measures established by the National Com-
10 mittee for Quality Assurance;

11 (H) the strengths and weaknesses of ma-
12 ternity care quality measures under the Med-
13 icaid program under title XIX of the Social Se-
14 curity Act (42 U.S.C. 1396 et seq.) and the
15 Children’s Health Insurance Program under
16 title XXI of such Act (42 U.S.C. 1397 et seq.),
17 including the extent to which States voluntarily
18 report relevant measures;

19 (I) the extent to which maternity care
20 quality measures are informed by patient expe-
21 riences that include measures of patient-re-
22 ported experience of care;

23 (J) the current processes for collecting
24 stratified data on the race and ethnicity of
25 pregnant and postpartum individuals in hos-

1 pitals, health systems, midwifery practices, and
2 birth centers, and for incorporating such ra-
3 cially and ethnically stratified data in maternity
4 care quality measures;

5 (K) the extent to which maternity care
6 quality measures account for the unique experi-
7 ences of pregnant and postpartum individuals
8 from racial and ethnic minority groups (as such
9 term is defined in section 1707(g)(1) of the
10 Public Health Service Act (42 U.S.C. 300u-
11 6(g)(1))); and

12 (L) the extent to which hospitals, health
13 systems, midwifery practices, and birth centers
14 are implementing existing maternity care qual-
15 ity measures.

16 (4) Recommendations on authorizing additional
17 funds and providing additional technical assistance
18 to improve maternal mortality review committees
19 and State and Tribal maternal health data collection
20 and reporting processes.

21 (5) Recommendations for new authorities that
22 may be granted to maternal mortality review com-
23 mittees to be able to—

24 (A) access records from other Federal and
25 State agencies and departments that may be

1 necessary to identify causes of pregnancy-asso-
2 ciated and pregnancy-related deaths that are
3 unique to pregnant and postpartum individuals
4 from specific populations, such as veterans and
5 individuals who are incarcerated; and

6 (B) work with relevant experts who are not
7 members of the maternal mortality review com-
8 mittee to assist in the review of pregnancy-asso-
9 ciated deaths of pregnant and postpartum indi-
10 viduals from specific populations, such as vet-
11 erans and individuals who are incarcerated.

12 (6) Recommendations to improve and stand-
13 ardize current quality measures for maternity care,
14 with a particular focus on racial and ethnic dispari-
15 ties in maternal health outcomes.

16 (7) Recommendations to improve the coordina-
17 tion by the Department of Health and Human Serv-
18 ices of the efforts undertaken by the agencies and
19 organizations within the Department related to ma-
20 ternal health data and quality measures.

21 (d) REPORT.—Not later than 1 year after the enact-
22 ment of this Act, the Secretary shall submit to the Con-
23 gress and make publicly available a report on the results
24 of the review of maternal health data collection processes
25 and quality measures and recommendations to improve

1 such processes and measures required under subsection
2 (a).

3 (e) DEFINITIONS.—In this section:

4 (1) MATERNAL MORTALITY REVIEW COM-
5 MITTEE.—The term “maternal mortality review
6 committee” means a maternal mortality review com-
7 mittee duly authorized by a State and receiving
8 funding under section 317k(a)(2)(D) of the Public
9 Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

10 (2) PREGNANCY-ASSOCIATED DEATH.—The
11 term “pregnancy-associated”, with respect to a
12 death, means a death of a pregnant or postpartum
13 individual, by any cause, that occurs during, or with-
14 in 1 year following, the individual’s pregnancy, re-
15 gardless of the outcome, duration, or site of the
16 pregnancy.

17 (3) PREGNANCY-RELATED DEATH.—The term
18 “pregnancy-related”, with respect to a death, means
19 a death of a pregnant or postpartum individual that
20 occurs during, or within 1 year following, the indi-
21 vidual’s pregnancy, from a pregnancy complication,
22 a chain of events initiated by pregnancy, or the ag-
23 gravation of an unrelated condition by the physio-
24 logic effects of pregnancy.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section for fiscal years 2022
4 through 2025.

5 **SEC. 504. INDIAN HEALTH SERVICE STUDY ON MATERNAL**
6 **MORTALITY AND SEVERE MATERNAL MOR-**
7 **BIDITY.**

8 (a) IN GENERAL.—The Director of the Indian Health
9 Service (referred to in this section as the “Director”)
10 shall, in coordination with entities described in subsection
11 (b)—

12 (1) not later than 90 days after the enactment
13 of this Act, enter into a contract with an inde-
14 pendent research organization or Tribal Epidemi-
15 ology Center to conduct a comprehensive study on
16 maternal mortality and severe maternal morbidity in
17 the populations of American Indian and Alaska Na-
18 tive individuals; and

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

1 (b) PARTICIPATING ENTITIES.—The entities de-
2 scribed in this subsection shall consist of 12 members, se-
3 lected by the Director from among individuals nominated
4 by Indian tribes and tribal organizations (as such terms
5 are defined in section 4 of the Indian Self-Determination
6 and Education Assistance Act (25 U.S.C. 5304)), and
7 urban Indian organizations (as such term is defined in
8 section 4 of the Indian Health Care Improvement Act (25
9 U.S.C. 1603)). In selecting such members, the Director
10 shall ensure that each of the 12 service areas of the Indian
11 Health Service is represented.

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

14 (1) examine the causes of maternal mortality
15 and severe maternal morbidity that are unique to
16 American Indian and Alaska Native individuals;

17 (2) include a systematic process of listening to
18 the stories of American Indian and Alaska Native
19 pregnant and postpartum individuals to fully under-
20 stand the causes of, and inform potential solutions
21 to, the maternal mortality and severe maternal mor-
22 bidity crisis within their respective communities;

23 (3) distinguish between the causes of, landscape
24 of maternity care at, and recommendations to im-
25 prove maternal health outcomes within, the different

1 settings in which American Indian and Alaska Na-
2 tive pregnant and postpartum individuals receive
3 maternity care, such as—

4 (A) facilities operated by the Indian
5 Health Service;

6 (B) an Indian health program operated by
7 an Indian tribe or tribal organization pursuant
8 to a contract, grant, cooperative agreement, or
9 compact with the Indian Health Service pursu-
10 ant to the Indian Self-Determination Act; and

11 (C) an urban Indian health program oper-
12 ated by an urban Indian organization pursuant
13 to a grant or contract with the Indian Health
14 Service pursuant to title V of the Indian Health
15 Care Improvement Act;

16 (4) review processes for coordinating programs
17 of the Indian Health Service with social services pro-
18 vided through other programs administered by the
19 Secretary of Health and Human Services (other
20 than the Medicare program under title XVIII of the
21 Social Security Act, the Medicaid program under
22 title XIX of such Act, and the Children's Health In-
23 surance Program under title XXI of such Act), in-
24 cluding coordination with the efforts of the Task
25 Force established under section 503;

1 (5) review current data collection and quality
2 measurement processes and practices;

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

6 (7) consider social determinants of health, in-
7 cluding poverty, lack of health insurance, unemploy-
8 ment, sexual violence, and environmental conditions
9 in Tribal areas;

10 (8) consider the role that historical mistreat-
11 ment of American Indian and Alaska Native women
12 has played in causing currently high rates of mater-
13 nal mortality and severe maternal morbidity;

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

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

21 (11) make recommendations to reduce
22 misclassification of American Indian and Alaska Na-
23 tive pregnant and postpartum individuals, including
24 consideration of best practices in training for mater-
25 nal mortality review committee members to be able

1 to correctly classify American Indian and Alaska
2 Native individuals; and

3 (12) make recommendations informed by the
4 stories shared by American Indian and Alaska Na-
5 tive pregnant and postpartum individuals in para-
6 graph (2) to improve maternal health outcomes for
7 such individuals.

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

15 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
16 authorized to be appropriated to carry out this section
17 \$2,000,000 for each of fiscal years 2022 through 2024.

18 **SEC. 505. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
19 **STUDY MATERNAL MORTALITY, SEVERE MA-**
20 **TERNAL MORBIDITY, AND OTHER ADVERSE**
21 **MATERNAL HEALTH OUTCOMES.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services shall establish a program under which
24 the Secretary shall award grants to research centers,
25 health professions schools and programs, and other enti-

1 ties at minority-serving institutions to study specific as-
2 pects of the maternal health crisis among pregnant and
3 postpartum individuals from racial and ethnic minority
4 groups. Such research may—

5 (1) include the development and implementation
6 of systematic processes of listening to the stories of
7 pregnant and postpartum individuals from racial
8 and ethnic minority groups, and perinatal health
9 workers supporting such individuals, to fully under-
10 stand the causes of, and inform potential solutions
11 to, the maternal mortality and severe maternal mor-
12 bidity crisis within their respective communities;

13 (2) assess the potential causes of relatively low
14 rates of maternal mortality among Hispanic individ-
15 uals, including potential racial misclassification and
16 other data collection and reporting issues that might
17 be misrepresenting maternal mortality rates among
18 Hispanic individuals in the United States; and

19 (3) assess differences in rates of adverse mater-
20 nal health outcomes among subgroups identifying as
21 Hispanic.

22 (b) APPLICATION.—To be eligible to receive a grant
23 under subsection (a), an entity described in such sub-
24 section shall submit to the Secretary an application at

1 such time, in such manner, and containing such informa-
2 tion as the Secretary may require.

3 (c) TECHNICAL ASSISTANCE.—The Secretary may
4 use not more than 10 percent of the funds made available
5 under subsection (f)—

6 (1) to conduct outreach to Minority-Serving In-
7 stitutions to raise awareness of the availability of
8 grants under this subsection (a);

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

11 (3) to promote capacity building as needed to
12 enable entities described in such subsection to sub-
13 mit such an application.

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

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

23 (f) MINORITY-SERVING INSTITUTIONS DEFINED.—In
24 this section, the term “minority-serving institution” has

1 the meaning given the term in section 371(a) of the High-
2 er Education Act of 1965 (20 U.S.C. 1067q(a)).

3 (g) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$10,000,000 for each of fiscal years 2022 through 2026.

6 **TITLE VI—MOMS MATTER**

7 **SEC. 601. MATERNAL MENTAL HEALTH EQUITY GRANT** 8 **PROGRAM.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services, acting through the Assistant Secretary
11 for Mental Health and Substance Use, shall establish a
12 program to award grants to eligible entities to address ma-
13 ternal mental health conditions and substance use dis-
14 orders with respect to pregnant and postpartum individ-
15 uals, with a focus on racial and ethnic minority groups.

16 (b) APPLICATION.—To be eligible to receive a grant
17 under this section an eligible entity shall submit to the
18 Secretary an application at such time, in such manner,
19 and containing such information as the Secretary may
20 provide, including how such entity will use funds for activi-
21 ties described in subsection (d) that are culturally con-
22 gruent.

23 (c) PRIORITY.—In awarding grants under this sec-
24 tion, the Secretary shall give priority to an eligible entity
25 that—

1 (1) is, or will partner with, a community-based
2 organization to address maternal mental health con-
3 ditions and substance use disorders described in sub-
4 section (a);

5 (2) is operating in an area with high rates of—

6 (A) adverse maternal health outcomes; or

7 (B) significant racial or ethnic disparities
8 in maternal health outcomes; and

9 (3) is operating in a health professional short-
10 age area designated under section 332 of the Public
11 Health Service Act (42 U.S.C. 254e).

12 (d) USE OF FUNDS.—An eligible entity that receives
13 a grant under this section shall use funds for the fol-
14 lowing:

15 (1) Establishing or expanding maternity care
16 programs to improve the integration of maternal
17 health and behavioral health care services into pri-
18 mary care settings where pregnant individuals regu-
19 larly receive health care services.

20 (2) Establishing or expanding group prenatal
21 care programs or postpartum care programs.

22 (3) Expanding existing programs that improve
23 maternal mental and behavioral health during the
24 prenatal and postpartum periods, with a focus on in-
25 dividuals from racial and ethnic minority groups.

1 (4) Providing services and support for pregnant
2 and postpartum individuals with maternal mental
3 health conditions and substance use disorders, in-
4 cluding referrals to addiction treatment centers that
5 offer evidence-based treatment options.

6 (5) Addressing stigma associated with maternal
7 mental health conditions and substance use dis-
8 orders, with a focus on racial and ethnic minority
9 groups.

10 (6) Raising awareness of warning signs of ma-
11 ternal mental health conditions and substance use
12 disorders, with a focus on pregnant and postpartum
13 individuals from racial and ethnic minority groups.

14 (7) Establishing or expanding programs to pre-
15 vent suicide or self-harm among pregnant and
16 postpartum individuals.

17 (8) Offering evidence-aligned programs at free-
18 standing birth centers that provide maternal mental
19 and behavioral health care education, treatments,
20 and services, and other services for individuals
21 throughout the prenatal and postpartum period.

22 (9) Establishing or expanding programs to pro-
23 vide education and training to maternity care pro-
24 viders with respect to—

1 (A) identifying potential warning signs for
2 maternal mental health conditions or substance
3 use disorders in pregnant and postpartum indi-
4 viduals, with a focus on individuals from racial
5 and ethnic minority groups; and

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

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

13 (11) Establishing or expanding programs in
14 communities to improve coordination between mater-
15 nity care providers and mental and behavioral health
16 care providers who treat maternal mental health
17 conditions and substance use disorders, including
18 through the use of toll-free hotlines.

19 (12) Carrying out other programs aligned with
20 evidence-based practices for addressing maternal
21 mental health conditions and substance use dis-
22 orders for pregnant and postpartum individuals from
23 racial and ethnic minority groups.

24 (e) REPORTING.—

1 (1) ELIGIBLE ENTITIES.—An eligible entity
2 that receives a grant under subsection (a) shall sub-
3 mit annually to the Secretary, and make publicly
4 available, a report on the activities conducted using
5 funds received through a grant under this section.
6 Such reports shall include quantitative and quali-
7 tative evaluations of such activities, including the ex-
8 perience of individuals who received health care
9 through such grant.

10 (2) SECRETARY.—Not later than the end of fis-
11 cal year 2024, the Secretary shall submit to Con-
12 gress a report that includes—

13 (A) a summary of the reports received
14 under paragraph (1);

15 (B) an evaluation of the effectiveness of
16 grants awarded under this section;

17 (C) recommendations with respect to ex-
18 panding coverage of evidence-based screenings
19 and treatments for maternal mental health con-
20 ditions and substance use disorders; and

21 (D) recommendations with respect to en-
22 suring activities described under subsection (d)
23 continue after the end of a grant period.

24 (f) DEFINITIONS.—In this section:

1 (1) ELIGIBLE ENTITY.—The term “eligible enti-
2 ty” means—

3 (A) a community-based organization serv-
4 ing pregnant and postpartum individuals, in-
5 cluding such organizations serving individuals
6 from racial and ethnic minority groups and
7 other underserved populations;

8 (B) a nonprofit or patient advocacy organi-
9 zation with expertise in maternal mental and
10 behavioral health;

11 (C) a maternity care provider;

12 (D) a mental or behavioral health care pro-
13 vider who treats maternal mental health condi-
14 tions or substance use disorders;

15 (E) a State or local governmental entity,
16 including a State or local public health depart-
17 ment;

18 (F) an Indian Tribe or Tribal organization
19 (as such terms are defined in section 4 of the
20 Indian Self-Determination and Education As-
21 sistance Act (25 U.S.C. 5304)); and

22 (G) an Urban Indian organization (as such
23 term is defined in section 4 of the Indian
24 Health Care Improvement Act (25 U.S.C.
25 1603)).

1 (2) FREESTANDING BIRTH CENTER.—The term
2 “freestanding birth center” has the meaning given
3 that term under section 1905(l) of the Social Secu-
4 rity Act (42 U.S.C. 1396d(1)).

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

7 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there is authorized to be appropriated
9 \$25,000,000 for each of fiscal years 2022 through 2025.

10 **SEC. 602. GRANTS TO GROW AND DIVERSIFY THE MATER-**
11 **NAL MENTAL AND BEHAVIORAL HEALTH**
12 **CARE WORKFORCE.**

13 Title VII of the Public Health Service Act is amended
14 by inserting after section 758 of such Act (42 U.S.C.
15 294f), as added by section 402 of this Act, the following
16 new section:

17 **“SEC. 758A. MATERNAL MENTAL AND BEHAVIORAL HEALTH**
18 **CARE WORKFORCE GRANTS.**

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

23 “(b) USE OF FUNDS.—Recipients of grants under
24 this section shall use the grants to grow and diversify the

1 maternal mental and behavioral health care workforce
2 by—

3 “(1) establishing schools or programs that pro-
4 vide education and training to individuals seeking
5 appropriate licensing or certification as mental or
6 behavioral health care providers who will specialize
7 in maternal mental health conditions or substance
8 use disorders; or

9 “(2) expanding the capacity of existing schools
10 or programs described in paragraph (1), for the pur-
11 poses of increasing the number of students enrolled
12 in such schools or programs, including by awarding
13 scholarships for students.

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

17 “(1) has demonstrated a commitment to re-
18 cruiting and retaining students and faculty from ra-
19 cial and ethnic minority groups;

20 “(2) has developed a strategy to recruit and re-
21 tain a diverse pool of students into the maternal
22 mental or behavioral health care workforce program
23 or school supported by funds received through the
24 grant, particularly from racial and ethnic minority
25 groups and other underserved populations;

1 “(3) has developed a strategy to recruit and re-
2 tain students who plan to practice in a health pro-
3 fessional shortage area designated under section
4 332;

5 “(4) has developed a strategy to recruit and re-
6 tain students who plan to practice in an area with
7 significant racial and ethnic disparities in maternal
8 health outcomes, to the extent practicable; and

9 “(5) includes in the standard curriculum for all
10 students within the maternal mental or behavioral
11 health care workforce program or school a bias, rac-
12 ism, or discrimination training program that in-
13 cludes training on implicit bias and racism.

14 “(d) REPORTING.—As a condition on receipt of a
15 grant under this section for a maternal mental or behav-
16 ioral health care workforce program or school, an entity
17 shall agree to submit to the Secretary an annual report
18 on the activities conducted through the grant, including—

19 “(1) the number and demographics of students
20 participating in the program or school;

21 “(2) the extent to which students in the pro-
22 gram or school are entering careers in—

23 “(A) health professional shortage areas
24 designated under section 332; and

1 “(B) areas with significant racial and eth-
2 nic disparities in maternal health outcomes, to
3 the extent such data are available; and

4 “(3) whether the program or school has in-
5 cluded in the standard curriculum for all students a
6 bias, racism, or discrimination training program that
7 includes training on implicit bias and racism, and if
8 so the effectiveness of such training program.

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

11 “(f) APPLICATION.—To seek a grant under this sec-
12 tion, an entity shall submit to the Secretary an application
13 at such time, in such manner, and containing such infor-
14 mation as the Secretary may require, including any infor-
15 mation necessary for prioritization under subsection (e).

16 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
17 provide, directly or by contract, technical assistance to en-
18 tities seeking or receiving a grant under this section on
19 the development, use, evaluation, and post-grant period
20 sustainability of the maternal mental or behavioral health
21 care workforce programs or schools proposed to be, or
22 being, established or expanded through the grant.

23 “(h) REPORT BY THE SECRETARY.—Not later than
24 4 years after the date of enactment of this section, the
25 Secretary shall prepare and submit to the Congress, and

1 post on the internet website of the Department of Health
2 and Human Services, a report on the effectiveness of the
3 grant program under this section at—

4 “(1) recruiting students from racial and ethnic
5 minority groups and other underserved populations;

6 “(2) increasing the number of mental or behav-
7 ioral health care providers specializing in maternal
8 mental health conditions or substance use disorders
9 from racial and ethnic minority groups and other
10 underserved populations;

11 “(3) 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 health professional shortage areas des-
15 igned under section 332; and

16 “(4) increasing the number of mental or behav-
17 ioral health care providers specializing in maternal
18 mental health conditions or substance use disorders
19 working in areas with significant racial and ethnic
20 disparities in maternal health outcomes, to the ex-
21 tent such data are available.

22 “(i) DEFINITIONS.—In this section:

23 “(1) RACIAL AND ETHNIC MINORITY GROUP.—
24 The term ‘racial and ethnic minority group’ has the
25 meaning given such term in section 1707(g)(1).

1 “(2) MENTAL OR BEHAVIORAL HEALTH CARE
 2 PROVIDER.—The term ‘mental or behavioral health
 3 care provider’ refers to a health care provider in the
 4 field of mental and behavioral health, including sub-
 5 stance use disorders, acting in accordance with State
 6 law.

7 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
 8 carry out this section, there is authorized to be appro-
 9 priated \$15,000,000 for each of fiscal years 2022 through
 10 2026.”.

11 **TITLE VII—JUSTICE FOR** 12 **INCARCERATED MOMS**

13 **SEC. 701. ENDING THE SHACKLING OF PREGNANT INDIVID-**
 14 **UALS.**

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

1 tion 4322 of title 18, United States Code, the amount of
2 such grant that would otherwise be allocated to such State
3 under such subpart for the fiscal year shall be decreased
4 by 25 percent.

5 (b) REALLOCATION.—Amounts not allocated to a
6 State for failure to comply with subsection (a) shall be
7 reallocated in accordance with subpart 1 of part E of title
8 I of the Omnibus Crime Control and Safe Streets Act of
9 1968 (34 U.S.C. 10151 et seq.) to States that have com-
10 plied with such subsection.

11 **SEC. 702. CREATING MODEL PROGRAMS FOR THE CARE OF**
12 **INCARCERATED INDIVIDUALS IN THE PRE-**
13 **NATAL AND POSTPARTUM PERIODS.**

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

22 (1) relevant community-based organizations,
23 particularly organizations that represent incarcer-
24 ated and formerly incarcerated individuals and orga-
25 nizations that seek to improve maternal health out-

1 comes for pregnant and postpartum individuals from
2 racial and ethnic minority groups;

3 (2) relevant organizations representing patients,
4 with a particular focus on patients from racial and
5 ethnic minority groups;

6 (3) organizations representing maternity care
7 providers and maternal health care education pro-
8 grams;

9 (4) perinatal health workers; and

10 (5) researchers and policy experts in fields re-
11 lated to maternal health care for incarcerated indi-
12 viduals.

13 (b) **START DATE.**—Each selected facility shall begin
14 facility programs not later than 18 months after the date
15 of enactment of this Act.

16 (c) **FACILITY PRIORITY.**—In carrying out subsection
17 (a), the Director shall give priority to a facility based on—

18 (1) the number of pregnant and postpartum in-
19 dividuals incarcerated in such facility and, among
20 such individuals, the number of pregnant and
21 postpartum individuals from racial and ethnic mi-
22 nority groups; and

23 (2) the extent to which the leaders of such facil-
24 ity have demonstrated a commitment to developing

1 exemplary programs for pregnant and postpartum
2 individuals incarcerated in such facility.

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

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

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

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

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

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

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

23 (A) diagnosed mental or behavioral health
24 conditions, including trauma and substance use
25 disorders;

1 (B) trauma or violence, including domestic
2 violence;

3 (C) human immunodeficiency virus;

4 (D) sexual abuse;

5 (E) pregnancy or infant loss; or

6 (F) chronic conditions;

7 (6) provide evidence-based pregnancy and child-
8 birth education, parenting support, and other rel-
9 evant forms of health literacy;

10 (7) provide clinical education opportunities to
11 maternity care providers in training to expand path-
12 ways into maternal health care careers serving incar-
13 cerated individuals;

14 (8) offer opportunities for postpartum individ-
15 uals to maintain contact with the individual's new-
16 born child to promote bonding, including enhanced
17 visitation policies, access to prison nursery pro-
18 grams, or breastfeeding support;

19 (9) provide reentry assistance, particularly to—

20 (A) ensure access to health insurance cov-
21 erage and transfer of health records to commu-
22 nity providers if an incarcerated individual exits
23 the criminal justice system during such individ-
24 ual's pregnancy or in the postpartum period;
25 and

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

8 (10) establish partnerships with local public en-
9 tities, private community entities, community-based
10 organizations, Indian Tribes and tribal organizations
11 (as such terms are defined in section 4 of the Indian
12 Self-Determination and Education Assistance Act
13 (25 U.S.C. 5304)), and urban Indian organizations
14 (as such term is defined in section 4 of the Indian
15 Health Care Improvement Act (25 U.S.C. 1603)) to
16 establish or expand pretrial diversion programs as
17 an alternative to incarceration for pregnant and
18 postpartum individuals. Such programs may in-
19 clude—

20 (A) evidence-based childbirth education or
21 parenting classes;

22 (B) prenatal health coordination;

23 (C) family and individual counseling;

24 (D) evidence-based screenings, education,
25 and, as needed, treatment for mental and be-

1 havioral health conditions, including drug and
2 alcohol treatments;

3 (E) family case management services;

4 (F) domestic violence education and pre-
5 vention;

6 (G) physical and sexual abuse counseling;
7 and

8 (H) programs to address social deter-
9 minants of health such as employment, housing,
10 education, transportation, and nutrition.

11 (f) IMPLEMENTATION AND REPORTING.—A selected
12 facility shall be responsible for—

13 (1) implementing programs, which may include
14 the programs described in subsection (e); and

15 (2) not later than 3 years after the date of en-
16 actment of this Act, and 6 years after the date of
17 enactment of this Act, reporting results of the pro-
18 grams to the Director, including information de-
19 scribing—

20 (A) relevant quantitative indicators of suc-
21 cess in improving the standard of care and
22 health outcomes for pregnant and postpartum
23 incarcerated individuals in the facility, including
24 data stratified by race, ethnicity, sex, gender,
25 age, geography, disability status, the category

1 of the criminal charge against such individual,
2 rates of pregnancy-related deaths, pregnancy-
3 associated deaths, cases of infant mortality and
4 morbidity, rates of preterm births and low-
5 birthweight births, cases of severe maternal
6 morbidity, cases of violence against pregnant or
7 postpartum individuals, diagnoses of maternal
8 mental or behavioral health conditions, and
9 other such information as appropriate;

10 (B) relevant qualitative and quantitative
11 evaluations from pregnant and postpartum in-
12 carcerated individuals who participated in such
13 programs, including measures of patient-re-
14 ported experience of care; and

15 (C) strategies to sustain such programs
16 after fiscal year 2026 and expand such pro-
17 grams to other facilities.

18 (g) REPORT.—Not later than 6 years after the date
19 of enactment of this Act, the Director shall submit to the
20 Attorney General and to the Congress a report describing
21 the results of the programs funded under this section.

22 (h) OVERSIGHT.—Not later than 1 year after the
23 date of enactment of this Act, the Attorney General shall
24 award a contract to an independent organization or inde-

1 pendent organizations to conduct oversight of the pro-
2 grams described in subsection (e).

3 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$10,000,000 for each of fiscal years 2022 through 2026.

6 **SEC. 703. GRANT PROGRAM TO IMPROVE MATERNAL**
7 **HEALTH OUTCOMES FOR INDIVIDUALS IN**
8 **STATE AND LOCAL PRISONS AND JAILS.**

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

18 (1) relevant community-based organizations,
19 particularly organizations that represent incarcer-
20 ated and formerly incarcerated individuals and orga-
21 nizations that seek to improve maternal health out-
22 comes for pregnant and postpartum individuals from
23 racial and ethnic minority groups;

1 (2) relevant organizations representing patients,
2 with a particular focus on patients from racial and
3 ethnic minority groups;

4 (3) organizations representing maternity care
5 providers and maternal health care education pro-
6 grams;

7 (4) perinatal health workers; and

8 (5) researchers and policy experts in fields re-
9 lated to maternal health care for incarcerated indi-
10 viduals.

11 (b) APPLICATIONS.—Each applicant for a grant
12 under this section shall submit to the Director of the Bu-
13 reau of Justice Assistance an application at such time, in
14 such manner, and containing such information as the Di-
15 rector may require.

16 (c) USE OF FUNDS.—A State that is awarded a grant
17 under this section shall use such grant to establish or ex-
18 pand programs for pregnant and postpartum incarcerated
19 individuals, and such programs may—

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

22 (2) provide access to healthy foods and coun-
23 seling on nutrition, recommended activity levels, and
24 safety measures throughout pregnancy;

1 (3) train correctional officers to ensure that
2 pregnant incarcerated individuals receive safe and
3 respectful treatment;

4 (4) train medical personnel to ensure that preg-
5 nant incarcerated individuals receive trauma-in-
6 formed, culturally congruent care that promotes the
7 health and safety of the pregnant individuals;

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

10 (A) diagnosed mental or behavioral health
11 conditions, including trauma and substance use
12 disorders;

13 (B) trauma or violence, including domestic
14 violence;

15 (C) human immunodeficiency virus;

16 (D) sexual abuse;

17 (E) pregnancy or infant loss; or

18 (F) chronic conditions;

19 (6) provide evidence-based pregnancy and child-
20 birth education, parenting support, and other rel-
21 evant forms of health literacy;

22 (7) provide clinical education opportunities to
23 maternity care providers in training to expand path-
24 ways into maternal health care careers serving incar-
25 cerated individuals;

1 (8) offer opportunities for postpartum individ-
2 uals to maintain contact with the individual's new-
3 born child to promote bonding, including enhanced
4 visitation policies, access to prison nursery pro-
5 grams, or breastfeeding support;

6 (9) provide reentry assistance, particularly to—

7 (A) ensure access to health insurance cov-
8 erage and transfer of health records to commu-
9 nity providers if an incarcerated individual exits
10 the criminal justice system during such individ-
11 ual's pregnancy or in the postpartum period;
12 and

13 (B) connect individuals exiting the criminal
14 justice system during pregnancy or in the
15 postpartum period to community-based re-
16 sources, such as referrals to health care pro-
17 viders, substance use disorder treatments, and
18 social services that address social determinants
19 of maternal health; or

20 (10) establish partnerships with local public en-
21 tities, private community entities, community-based
22 organizations, Indian Tribes and tribal organizations
23 (as such terms are defined in section 4 of the Indian
24 Self-Determination and Education Assistance Act
25 (25 U.S.C. 5304)), and urban Indian organizations

1 (as such term is defined in section 4 of the Indian
2 Health Care Improvement Act (25 U.S.C. 1603)) to
3 establish or expand pretrial diversion programs as
4 an alternative to incarceration for pregnant and
5 postpartum individuals. Such programs may in-
6 clude—

7 (A) evidence-based childbirth education or
8 parenting classes;

9 (B) prenatal health coordination;

10 (C) family and individual counseling;

11 (D) evidence-based screenings, education,
12 and, as needed, treatment for mental and be-
13 havioral health conditions, including drug and
14 alcohol treatments;

15 (E) family case management services;

16 (F) domestic violence education and pre-
17 vention;

18 (G) physical and sexual abuse counseling;

19 and

20 (H) programs to address social deter-
21 minants of health such as employment, housing,
22 education, transportation, and nutrition.

23 (d) PRIORITY.—In awarding grants under this sec-
24 tion, the Director of the Bureau of Justice Assistance
25 shall give priority to applicants based on—

1 (1) the number of pregnant and postpartum in-
2 dividuals incarcerated in the State and, among such
3 individuals, the number of pregnant and postpartum
4 individuals from racial and ethnic minority groups;
5 and

6 (2) the extent to which the State has dem-
7 onstrated a commitment to developing exemplary
8 programs for pregnant and postpartum individuals
9 incarcerated in the prisons and jails in the State.

10 (e) GRANT DURATION.—A grant awarded under this
11 section shall be for a 5-year period.

12 (f) IMPLEMENTING AND REPORTING.—A State that
13 receives a grant under this section shall be responsible
14 for—

15 (1) implementing the program funded by the
16 grant; and

17 (2) not later than 3 years after the date of en-
18 actment of this Act, and 6 years after the date of
19 enactment of this Act, reporting results of such pro-
20 gram to the Attorney General, including information
21 describing—

22 (A) relevant quantitative indicators of the
23 program’s success in improving the standard of
24 care and health outcomes for pregnant and
25 postpartum incarcerated individuals in the facil-

1 ity, including data stratified by race, ethnicity,
2 sex, gender, age, geography, disability status,
3 category of the criminal charge against such in-
4 dividual, incidence rates of pregnancy-related
5 deaths, pregnancy-associated deaths, cases of
6 infant mortality and morbidity, rates of preterm
7 births and low-birthweight births, cases of se-
8 vere maternal morbidity, cases of violence
9 against pregnant or postpartum individuals, di-
10 agnoses of maternal mental or behavioral health
11 conditions, and other such information as ap-
12 propriate;

13 (B) relevant qualitative and quantitative
14 evaluations from pregnant and postpartum in-
15 carcerated individuals who participated in such
16 programs, including measures of patient-re-
17 ported experience of care; and

18 (C) strategies to sustain such programs be-
19 yond the duration of the grant and expand such
20 programs to other facilities.

21 (g) REPORT.—Not later than 6 years after the date
22 of enactment of this Act, the Attorney General shall sub-
23 mit to the Congress a report describing the results of such
24 grant programs.

1 (h) OVERSIGHT.—Not later than 1 year after the
2 date of enactment of this Act, the Attorney General shall
3 award a contract to an independent organization or inde-
4 pendent organizations to conduct oversight of the pro-
5 grams described in subsection (c).

6 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
7 authorized to be appropriated to carry out this section
8 \$10,000,000 for each of fiscal years 2022 through 2026.

9 **SEC. 704. GAO REPORT.**

10 (a) IN GENERAL.—Not later than 2 years after the
11 date of enactment of this Act, the Comptroller General
12 of the United States shall submit to Congress a report
13 on adverse maternal and infant health outcomes among
14 incarcerated individuals and infants born to such individ-
15 uals, with a particular focus on racial and ethnic dispari-
16 ties in maternal and infant health outcomes for incarcer-
17 ated individuals.

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

20 (1) to the extent practicable—

21 (A) the number of pregnant individuals
22 who are incarcerated in Bureau of Prisons fa-
23 cilities;

24 (B) the number of incarcerated individuals,
25 including those incarcerated in Federal, State,

1 and local correctional facilities, who have expe-
2 rienced a pregnancy-related death, pregnancy-
3 associated death, or the death of an infant in
4 the most recent 10 years of available data;

5 (C) the number of cases of severe maternal
6 morbidity among incarcerated individuals, in-
7 cluding those incarcerated in Federal, State,
8 and local detention facilities, in the most recent
9 10 years of available data;

10 (D) the number of preterm and low-birth-
11 weight births of infants born to incarcerated in-
12 dividuals, including those incarcerated in Fed-
13 eral, State, and local correctional facilities, in
14 the most recent 10 years of available data; and

15 (E) statistics on the racial and ethnic dis-
16 parities in maternal and infant health outcomes
17 and severe maternal morbidity rates among in-
18 carcerated individuals, including those incarcer-
19 ated in Federal, State, and local detention fa-
20 cilities;

21 (2) in the case that the Comptroller General of
22 the United States is unable determine the informa-
23 tion required in subparagraphs (A) through (C) of
24 paragraph (1), an assessment of the barriers to de-
25 termining such information and recommendations

1 for improvements in tracking maternal health out-
2 comes among incarcerated individuals, including
3 those incarcerated in Federal, State, and local deten-
4 tion facilities;

5 (3) causes of adverse maternal health outcomes
6 that are unique to incarcerated individuals, including
7 those incarcerated in Federal, State, and local deten-
8 tion facilities;

9 (4) causes of adverse maternal health outcomes
10 and severe maternal morbidity that are unique to in-
11 carcerated individuals from racial and ethnic minor-
12 ity groups;

13 (5) recommendations to reduce maternal mor-
14 tality and severe maternal morbidity among incar-
15 cerated individuals and to address racial and ethnic
16 disparities in maternal health outcomes for incarcer-
17 ated individuals in Bureau of Prisons facilities and
18 State and local prisons and jails; and

19 (6) such other information as may be appro-
20 priate to reduce the occurrence of adverse maternal
21 health outcomes among incarcerated individuals and
22 to address racial and ethnic disparities in maternal
23 health outcomes for such individuals.

1 **SEC. 705. MACPAC REPORT.**

2 (a) IN GENERAL.—Not later than 2 years after the
3 date of enactment of this Act, the Medicaid and CHIP
4 Payment and Access Commission (referred to in this sec-
5 tion as “MACPAC”) shall publish a report on the implica-
6 tions of pregnant and postpartum incarcerated individuals
7 being ineligible for medical assistance under a State plan
8 under title XIX of the Social Security Act (42 U.S.C.
9 1396 et seq.) that contains the information described in
10 subsection.

11 (b) INFORMATION DESCRIBED.—For purposes of
12 subsection (a), the information described in this sub-
13 section includes—

14 (1) information on the effect of ineligibility for
15 medical assistance under a State plan under title
16 XIX of the Social Security Act (42 U.S.C. 1396 et
17 seq.) on maternal health outcomes for pregnant and
18 postpartum incarcerated individuals, concentrating
19 on the effects of such ineligibility for pregnant and
20 postpartum individuals from racial and ethnic mi-
21 nority groups; and

22 (2) the potential implications on maternal
23 health outcomes resulting from suspending eligibility
24 for medical assistance under a State plan under
25 such title of such Act when a pregnant or
26 postpartum individual is incarcerated.

1 **TITLE VIII—TECH TO SAVE**
2 **MOMS**

3 **SEC. 801. INTEGRATED TELEHEALTH MODELS IN MATER-**
4 **NITY CARE SERVICES.**

5 (a) **IN GENERAL.**—Section 1115A(b)(2)(B) of the
6 Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amend-
7 ed by adding at the end the following:

8 “(xxviii) Focusing on title XIX, pro-
9 viding for the adoption of and use of tele-
10 health tools that allow for screening, moni-
11 toring, and management of common health
12 complications with respect to an individual
13 receiving medical assistance during such
14 individual’s pregnancy and for not more
15 than a 1-year period beginning on the last
16 day of the pregnancy.”.

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

1 **SEC. 802. GRANTS TO EXPAND THE USE OF TECHNOLOGY-**
2 **ENABLED COLLABORATIVE LEARNING AND**
3 **CAPACITY MODELS FOR PREGNANT AND**
4 **POSTPARTUM INDIVIDUALS.**

5 Title III of the Public Health Service Act is amended
6 by inserting after section 330M (42 U.S.C. 254c-19) the
7 following:

8 **“SEC. 330N. EXPANDING CAPACITY FOR MATERNAL**
9 **HEALTH OUTCOMES.**

10 “(a) **ESTABLISHMENT.**—Beginning not later than 1
11 year after the date of enactment of this Act, the Secretary
12 shall award grants to eligible entities to evaluate, develop,
13 and expand the use of technology-enabled collaborative
14 learning and capacity building models and improve mater-
15 nal health outcomes—

16 “(1) in health professional shortage areas;

17 “(2) in areas with high rates of maternal mor-
18 tality and severe maternal morbidity;

19 “(3) in areas with significant racial and ethnic
20 disparities in maternal health outcomes; and

21 “(4) for medically underserved populations and
22 American Indians and Alaska Natives, including In-
23 dian Tribes, Tribal organizations, and Urban Indian
24 organizations.

25 “(b) **USE OF FUNDS.**—

1 “(1) REQUIRED USES.—Recipients of grants
2 under this section shall use the grants to—

3 “(A) train maternal health care providers,
4 students, and other similar professionals
5 through models that include—

6 “(i) methods to increase safety and
7 health care quality;

8 “(ii) implicit bias, racism, and dis-
9 crimination;

10 “(iii) best practices in screening for
11 and, as needed, evaluating and treating
12 maternal mental health conditions and
13 substance use disorders;

14 “(iv) training on best practices in ma-
15 ternity care for pregnant and postpartum
16 individuals during the COVID–19 public
17 health emergency or future public health
18 emergencies;

19 “(v) methods to screen for social de-
20 terminants of maternal health risks in the
21 prenatal and postpartum; and

22 “(vi) the use of remote patient moni-
23 toring tools for pregnancy-related com-
24 plications described in section
25 1115A(b)(2)(B)(xxviii);

1 “(B) evaluate and collect information on
2 the effect of such models on—

3 “(i) access to and quality of care;

4 “(ii) outcomes with respect to the
5 health of an individual; and

6 “(iii) the experience of individuals who
7 receive pregnancy-related health care;

8 “(C) develop qualitative and quantitative
9 measures to identify best practices for the ex-
10 pansion and use of such models;

11 “(D) study the effect of such models on
12 patient outcomes and maternity care providers;
13 and

14 “(E) conduct any other activity determined
15 by the Secretary.

16 “(2) PERMISSIBLE USES.—Recipients of grants
17 under this section may use grants to support—

18 “(A) the use and expansion of technology-
19 enabled collaborative learning and capacity
20 building models, including hardware and soft-
21 ware that—

22 “(i) enables distance learning and
23 technical support; and

24 “(ii) supports the secure exchange of
25 electronic health information; and

1 “(B) maternity care providers, students,
2 and other similar professionals in the provision
3 of maternity care through such models.

4 “(c) APPLICATION.—

5 “(1) IN GENERAL.—An eligible entity seeking a
6 grant under subsection (a) shall submit to the Sec-
7 retary an application, at such time, in such manner,
8 and containing such information as the Secretary
9 may require.

10 “(2) ASSURANCE.—An application under para-
11 graph (1) shall include an assurance that such entity
12 shall collect information on and assess the effect of
13 the use of technology-enabled collaborative learning
14 and capacity building models, including with respect
15 to—

16 “(A) maternal health outcomes;

17 “(B) access to maternal health care serv-
18 ices;

19 “(C) quality of maternal health care; and

20 “(D) retention of maternity care providers
21 serving areas and populations described in sub-
22 section (a).

23 “(d) LIMITATIONS.—

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

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

3 “(e) ACCESS TO BROADBAND.—In administering
4 grants under this section, the Secretary may coordinate
5 with other agencies to ensure that funding opportunities
6 are available to support access to reliable, high-speed
7 internet for grantees.

8 “(f) TECHNICAL ASSISTANCE.—The Secretary shall
9 provide (either directly or by contract) technical assistance
10 to eligible entities, including recipients of grants under
11 subsection (a), on the development, use, and sustainability
12 of technology-enabled collaborative learning and capacity
13 building models to expand access to maternal health care
14 services provided by such entities, including—

15 “(1) in health professional shortage areas;

16 “(2) in areas with high rates of maternal mor-
17 tality and severe maternal morbidity or significant
18 racial and ethnic disparities in maternal health out-
19 comes; and

20 “(3) for medically underserved populations or
21 American Indians and Alaska Natives.

22 “(g) RESEARCH AND EVALUATION.—The Secretary,
23 in consultation with experts, shall develop a strategic plan
24 to research and evaluate the evidence for such models.

25 “(h) 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 enactment of this section, the Secretary
8 shall submit to the Congress, and make available on
9 the website of the Department of Health and
10 Human Services, a report that includes—

11 “(A) a description of grants awarded
12 under subsection (a) and the purpose and
13 amounts of such grants;

14 “(B) a summary of—

15 “(i) the evaluations conducted under
16 subsection (b)(B);

17 “(ii) any technical assistance provided
18 under subsection (g); and

19 “(iii) the activities conducted under
20 subsection (a); and

21 “(C) a description of any significant find-
22 ings with respect to—

23 “(i) patient outcomes; and

24 “(ii) best practices for expanding,
25 using, or evaluating technology-enabled col-

1 laborative learning and capacity building
2 models.

3 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section,
5 \$6,000,000 for each of fiscal years 2022 through 2026.

6 “(j) DEFINITIONS.—In this section:

7 “(1) ELIGIBLE ENTITY.—

8 “(A) IN GENERAL.—The term ‘eligible en-
9 tity’ means an entity that provides, or supports
10 the provision of, maternal health care services
11 or other evidence-based services for pregnant
12 and postpartum individuals—

13 “(i) in health professional shortage
14 areas;

15 “(ii) in areas with high rates of ad-
16 verse maternal health outcomes or signifi-
17 cant racial and ethnic disparities in mater-
18 nal health outcomes; and

19 “(iii) who are—

20 “(I) members of medically under-
21 served populations; or

22 “(II) American Indians and Alas-
23 ka Natives, including Indian Tribes,
24 Tribal organizations, and urban In-
25 dian organizations.

1 “(B) INCLUSIONS.—An eligible entity may
2 include entities that lead, or are capable of
3 leading a technology-enabled collaborative learn-
4 ing and capacity building model.

5 “(2) HEALTH PROFESSIONAL SHORTAGE
6 AREA.—The term ‘health professional shortage area’
7 means a health professional shortage area des-
8 ignated under section 332.

9 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
10 has the meaning given such term in section 4 of the
11 Indian Self-Determination and Education Assistance
12 Act.

13 “(4) MATERNAL MORTALITY.—The term ‘ma-
14 ternal mortality’ means a death occurring during or
15 within 1-year period after pregnancy caused by preg-
16 nancy-related or childbirth complications, including a
17 suicide, overdose, or other death resulting from a
18 mental health or substance use disorder attributed
19 to or aggravated by pregnancy or childbirth com-
20 plications.

21 “(5) MEDICALLY UNDERSERVED POPU-
22 LATION.—The term ‘medically underserved popu-
23 lation’ has the meaning given such term in section
24 330(b)(3).

1 “(6) POSTPARTUM.—The term ‘postpartum’
2 means the 1-year period beginning on the last date
3 of an individual’s pregnancy.

4 “(7) SEVERE MATERNAL MORBIDITY.—The
5 term ‘severe maternal morbidity’ means a health
6 condition, including a mental health or substance
7 use disorder, attributed to or aggravated by preg-
8 nancy or childbirth that results in significant short-
9 term or long-term consequences to the health of the
10 individual who was pregnant.

11 “(8) TECHNOLOGY-ENABLED COLLABORATIVE
12 LEARNING AND CAPACITY BUILDING MODEL.—The
13 term ‘technology-enabled collaborative learning and
14 capacity building model’ means a distance health
15 education model that connects health care profes-
16 sionals, and other specialists, through simultaneous
17 interactive videoconferencing for the purpose of fa-
18 cilitating case-based learning, disseminating best
19 practices, and evaluating outcomes in the context of
20 maternal health care.

21 “(9) TRIBAL ORGANIZATION.—The term ‘Tribal
22 organization’ has the meaning given such term in
23 section 4 of the Indian Self-Determination and Edu-
24 cation Assistance Act.

1 “(10) URBAN INDIAN ORGANIZATION.—The
2 term ‘urban Indian organization’ has the meaning
3 given such term in section 4 of the Indian Health
4 Care Improvement Act.”.

5 **SEC. 803. GRANTS TO PROMOTE EQUITY IN MATERNAL**
6 **HEALTH OUTCOMES THROUGH DIGITAL**
7 **TOOLS.**

8 (a) IN GENERAL.—Beginning not later than 1 year
9 after the date of the enactment of this Act, the Secretary
10 of Health and Human Services shall make grants to eligi-
11 ble entities to reduce racial and ethnic disparities in ma-
12 ternal health outcomes by increasing access to digital tools
13 related to maternal health care.

14 (b) APPLICATIONS.—To be eligible to receive a grant
15 under this section, an eligible entity shall submit to the
16 Secretary an application at such time, in such manner,
17 and containing such information as the Secretary may re-
18 quire.

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

21 (1) in an area with high rates of adverse mater-
22 nal health outcomes or significant racial and ethnic
23 disparities in maternal health outcomes;

1 (2) in a health professional shortage area des-
2 ignated under section 332 of the Public Health Serv-
3 ice Act (42 U.S.C. 254e); and

4 (3) that promotes technology that addresses ra-
5 cial and ethnic disparities in maternal health out-
6 comes.

7 (d) LIMITATIONS.—

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

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

12 (e) TECHNICAL ASSISTANCE.—The Secretary shall
13 provide technical assistance to an eligible entity on the de-
14 velopment, use, evaluation, and post-grant sustainability
15 of digital tools for purposes of promoting equity in mater-
16 nal health outcomes.

17 (f) REPORTING.—

18 (1) ELIGIBLE ENTITIES.—An eligible entity
19 that receives a grant under subsection (a) shall sub-
20 mit to the Secretary a report, at such time, in such
21 manner, and containing such information as the Sec-
22 retary may require.

23 (2) SECRETARY.—Not later than 4 years after
24 the date of the enactment of this Act, the Secretary
25 shall submit to Congress a report that includes—

1 (A) an evaluation on the effectiveness of
2 grants awarded under this section to improve
3 health outcomes for pregnant and postpartum
4 individuals from racial and ethnic minority
5 groups;

6 (B) recommendations on new grant pro-
7 grams that promote the use of technology to
8 improve such maternal health outcomes; and

9 (C) recommendations with respect to—

10 (i) technology-based privacy and secu-
11 rity safeguards in maternal health care;

12 (ii) reimbursement rates for maternal
13 telehealth services;

14 (iii) the use of digital tools to analyze
15 large data sets to identify potential preg-
16 nancy-related complications;

17 (iv) barriers that prevent maternity
18 care providers from providing telehealth
19 services across States;

20 (v) the use of consumer digital tools
21 such as mobile phone applications, patient
22 portals, and wearable technologies to im-
23 prove maternal health outcomes;

24 (vi) barriers that prevent access to
25 telehealth services, including a lack of ac-

1 cess to reliable, high-speed internet or elec-
2 tronic devices;

3 (vii) barriers to data sharing between
4 the Special Supplemental Nutrition Pro-
5 gram for Women, Infants, and Children
6 program and maternity care providers, and
7 recommendations for addressing such bar-
8 riers; and

9 (viii) lessons learned from expanded
10 access to telehealth related to maternity
11 care during the COVID–19 public health
12 emergency.

13 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
14 authorized to be appropriated to carry out this section
15 \$6,000,000 for each of fiscal years 2022 through 2026.

16 **SEC. 804. REPORT ON THE USE OF TECHNOLOGY IN MATER-**
17 **NITY CARE.**

18 (a) IN GENERAL.—Not later than 60 days after the
19 date of enactment of this Act, the Secretary of Health and
20 Human Services shall seek to enter an agreement with the
21 National Academies of Sciences, Engineering, and Medi-
22 cine (referred to in this Act as the “National Academies”)
23 under which the National Academies shall conduct a study
24 on the use of technology and patient monitoring devices
25 in maternity care.

1 (b) CONTENT.—The agreement entered into pursu-
2 ant to subsection (a) shall provide for the study of the
3 following:

4 (1) The use of innovative technology (including
5 artificial intelligence) in maternal health care, in-
6 cluding the extent to which such technology has af-
7 fected racial or ethnic biases in maternal health
8 care.

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

14 (3) Best practices for reducing and preventing
15 racial or ethnic biases in the use of innovative tech-
16 nology and patient monitoring devices in maternity
17 care.

18 (4) Best practices in the use of innovative tech-
19 nology and patient monitoring devices for pregnant
20 and postpartum individuals from racial and ethnic
21 minority groups.

22 (5) Best practices with respect to privacy and
23 security safeguards in such use.

24 (c) REPORT.—The agreement under subsection (a)
25 shall direct the National Academies to complete the study

1 under this section, and transmit to Congress a report on
2 the results of the study, not later than 24 months after
3 the date of enactment of this Act.

4 **TITLE IX—IMPACT TO SAVE**
5 **MOMS**

6 **SEC. 901. PERINATAL CARE ALTERNATIVE PAYMENT**
7 **MODEL DEMONSTRATION PROJECT.**

8 (a) IN GENERAL.—For the period of fiscal years
9 2022 through 2026, the Secretary of Health and Human
10 Services (referred to in this section as the “Secretary”),
11 acting through the Administrator of the Centers for Medi-
12 care & Medicaid Services, shall establish and implement,
13 in accordance with the requirements of this section, a
14 demonstration project, to be known as the Perinatal Care
15 Alternative Payment Model Demonstration Project (re-
16 ferred to in this section as the “Demonstration Project”),
17 for purposes of allowing States to test payment models
18 under their State plans under title XIX of the Social Secu-
19 rity Act (42 U.S.C. 1396 et seq.) and State child health
20 plans under title XXI of such Act (42 U.S.C. 1397aa et
21 seq.) with respect to maternity care provided to pregnant
22 and postpartum individuals enrolled in such State plans
23 and State child health plans.

1 (b) COORDINATION.—In establishing the Demonstra-
2 tion Project, the Secretary shall coordinate with stake-
3 holders such as—

4 (1) State Medicaid programs;

5 (2) maternity care providers and organizations
6 representing maternity care providers;

7 (3) relevant organizations representing patients,
8 with a particular focus on patients from racial and
9 ethnic minority groups;

10 (4) relevant community-based organizations,
11 particularly organizations that seek to improve ma-
12 ternal health outcomes for pregnant and postpartum
13 individuals from racial and ethnic minority groups;

14 (5) perinatal health workers;

15 (6) relevant health insurance issuers;

16 (7) hospitals, health systems, midwifery prac-
17 tices, freestanding birth centers (as such term is de-
18 fined in paragraph (3)(B) of section 1905(l) of the
19 Social Security Act (42 U.S.C. 1396d(l))), Feder-
20 ally-qualified health centers (as such term is defined
21 in paragraph (2)(B) of such section), and rural
22 health clinics (as such term is defined in section
23 1861(aa) of such Act (42 U.S.C. 1395x(aa)));

24 (8) researchers and policy experts in fields re-
25 lated to maternity care payment models; and

1 (9) any other stakeholders as the Secretary de-
2 termines appropriate, with a particular focus on
3 stakeholders from racial and ethnic minority groups.

4 (c) CONSIDERATIONS.—In establishing the Dem-
5 onstrator Project, the Secretary shall consider any alter-
6 native payment model that—

7 (1) is designed to improve maternal health out-
8 comes for racial and ethnic groups with dispropor-
9 tionate rates of adverse maternal health outcomes;

10 (2) includes methods for stratifying patients by
11 pregnancy risk level and, as appropriate, adjusting
12 payments under such model to take into account
13 pregnancy risk level;

14 (3) establishes evidence-based quality metrics
15 for such payments;

16 (4) includes consideration of non-hospital birth
17 settings such as freestanding birth centers (as so de-
18 fined);

19 (5) includes consideration of social deter-
20 minants of maternal health; or

21 (6) includes diverse maternity care teams that
22 include—

23 (A) maternity care providers, mental and
24 behavioral health care providers acting in ac-
25 cordance with State law, registered dietitians or

1 nutrition professionals (as such term is defined
2 in 42 U.S.C. 1395x(vv)(2)), and International
3 Board Certified Lactation Consultants—

4 (i) from racially, ethnically, and pro-
5 fessionally diverse backgrounds;

6 (ii) with experience practicing in ra-
7 cially and ethnically diverse communities;

8 or

9 (iii) who have undergone training on
10 implicit bias and racism; and

11 (B) perinatal health workers.

12 (d) ELIGIBILITY.—To be eligible to participate in the
13 Demonstration Project, a State shall submit an applica-
14 tion to the Secretary at such time, in such manner, and
15 containing such information as the Secretary may require.

16 (e) EVALUATION.—The Secretary shall conduct an
17 evaluation of the Demonstration Project to determine the
18 impact of the Demonstration Project on—

19 (1) maternal health outcomes, with data strati-
20 fied by race, ethnicity, socioeconomic indicators, and
21 any 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 2026 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 1-year period beginning on the last day of such indi-
2 vidual's pregnancy.

3 (3) 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 **SEC. 902. MACPAC REPORT.**

9 Not later than two years after the date of the enact-
10 ment of this Act, the Medicaid and CHIP Payment and
11 Access Commission shall publish a report on issues relat-
12 ing to the continuity of coverage under State plans under
13 title XIX of the Social Security Act (42 U.S.C. 1396 et
14 seq.) and State child health plans under title XXI of such
15 Act (42 U.S.C. 1397aa et seq.) for pregnant and
16 postpartum individuals. Such report shall, at a minimum,
17 include the following:

18 (1) An assessment of any existing policies
19 under such State plans and such State child health
20 plans regarding presumptive eligibility for pregnant
21 individuals while their application for enrollment in
22 such a State plan or such a State child health plan
23 is being processed.

24 (2) An assessment of any existing policies
25 under such State plans and such State child health

1 plans regarding measures to ensure continuity of
2 coverage under such a State plan or such a State
3 child health plan for pregnant and postpartum indi-
4 viduals, including such individuals who need to
5 change their health insurance coverage during their
6 pregnancy or the postpartum period following their
7 pregnancy.

8 (3) An assessment of any existing policies
9 under such State plans and such State child health
10 plans regarding measures to automatically reenroll
11 individuals who are eligible to enroll under such a
12 State plan or such a State child health plan as a
13 parent.

14 (4) If determined appropriate by the Commis-
15 sion, any recommendations for the Department of
16 Health and Human Services, or such State plans
17 and such State child health plans, to ensure con-
18 tinuity of coverage under such a State plan or such
19 a State child health plan for pregnant and
20 postpartum individuals.

21 **TITLE X—MATERNAL HEALTH** 22 **PANDEMIC RESPONSE**

23 **SEC. 1001. DEFINITIONS.**

24 In this title:

1 (1) COVID–19 PUBLIC HEALTH EMERGENCY.—
2 The term “COVID–19 public health emergency”
3 means the period—

4 (A) beginning on the date that the Sec-
5 retary of Health and Human Services declared
6 a public health emergency under section 319 of
7 the Public Health Service Act (42 U.S.C.
8 247d), with respect to COVID–19; and

9 (B) ending on the later of the end of such
10 public health emergency, or January 1, 2023.

11 (2) RESPECTFUL MATERNITY CARE.—The term
12 “respectful maternity care” refers to care organized
13 for, and provided to, pregnant and postpartum indi-
14 viduals in a manner that—

15 (A) is culturally congruent;

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

18 (C) ensures freedom from harm and mis-
19 treatment; and

20 (D) enables informed choice and contin-
21 uous support.

22 (3) SECRETARY.—The term “Secretary” means
23 the Secretary of Health and Human Services.

1 **SEC. 1002. FUNDING FOR DATA COLLECTION, SURVEIL-**
2 **LANCE, AND RESEARCH ON MATERNAL**
3 **HEALTH OUTCOMES DURING THE COVID-19**
4 **PUBLIC HEALTH EMERGENCY.**

5 To conduct or support data collection, surveillance,
6 and research on maternal health as a result of the
7 COVID-19 public health emergency, including support to
8 assist in the capacity building for State, Tribal, territorial,
9 and local public health departments to collect and trans-
10 mit racial, ethnic, and other demographic data related to
11 maternal health, there are authorized to be appro-
12 priated—

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 COVID–19 on pregnant and
3 postpartum patients and their newborns, par-
4 ticularly among patients from racial and ethnic
5 minority groups; and

6 (C) establish regionally based centers of
7 excellence to offer medical, public health, and
8 other knowledge to ensure communities, espe-
9 cially communities with large populations of in-
10 dividuals from racial and ethnic minority
11 groups, can help pregnant and postpartum indi-
12 viduals and newborns get the care and support
13 they need;

14 (2) \$30,000,000 for the Enhancing Reviews
15 and Surveillance to Eliminate Maternal Mortality
16 program (commonly known as the “ERASE MM
17 program”) of the Centers for Disease Control and
18 Prevention, to support the Centers for Disease Con-
19 trol and Prevention in expanding its partnerships
20 with States and Indian Tribes and provide technical
21 assistance to existing Maternal Mortality Review
22 Committees;

23 (3) \$45,000,000 for the Pregnancy Risk As-
24 sessment Monitoring System (commonly known as
25 the “PRAMS”) of the Centers for Disease Control

1 and Prevention, to support the Centers for Disease
2 Control and Prevention in its efforts to—

3 (A) create a COVID–19 supplement to its
4 PRAMS questionnaire;

5 (B) add questions around experiences of
6 respectful maternity care in prenatal,
7 intrapartum, and postpartum care;

8 (C) conduct a rapid assessment of
9 COVID–19 awareness, impact on care and ex-
10 periences, and use of preventive measures
11 among pregnant, laboring and birthing, and
12 postpartum individuals during the COVID–19
13 public health emergency; and

14 (D) work to transition the survey to an
15 electronic platform and expand the survey to a
16 larger population, with a special focus on reach-
17 ing underrepresented communities; and

18 (4) \$15,000,000 for the National Institute of
19 Child Health and Human Development, to conduct
20 or support research for interventions to mitigate the
21 effects of the COVID–19 public health emergency on
22 pregnant and postpartum individuals, with a par-
23 ticular focus on individuals from racial and ethnic
24 minority groups.

1 **SEC. 1003. COVID-19 MATERNAL HEALTH DATA COLLEC-**
2 **TION AND DISCLOSURE.**

3 (a) AVAILABILITY OF COLLECTED DATA.—The Sec-
4 retary, acting through the Director of the Centers for Dis-
5 ease Control and Prevention and the Administrator of the
6 Centers for Medicare & Medicaid Services, shall make pub-
7 licly available on the website of the Centers for Disease
8 Control and Prevention data described in subsection (b).

9 (b) DATA DESCRIBED.—The data under subsection
10 (a) means data collected through Federal surveillance sys-
11 tems under the Centers for Disease Control and Preven-
12 tion with respect to COVID-19 and individuals who are
13 pregnant or in a postpartum period. Such data shall in-
14 clude the following:

15 (1) Diagnostic testing, including the number of
16 pregnant and postpartum individuals who are tested
17 for COVID-19 and the number of positive cases.

18 (2) Suspected cases of COVID-19 in pregnant
19 and birthing individuals and individuals in a
20 postpartum period.

21 (3) Serologic testing, including the number of
22 pregnant and postpartum individuals tested and the
23 number of such serologic tests that were positive.

24 (4) Health care treatment for individuals who
25 were infected with the virus, including hospitaliza-

1 tions, emergency room visits, and intensive care unit
2 admissions.

3 (5) Health outcomes for pregnant individuals
4 and infants confirmed or suspected of being infected
5 with the virus, including—

6 (A) the number of fatalities and case fa-
7 talities (expressed as the proportion of individ-
8 uals who were infected with the virus to individ-
9 uals who died from the virus); and

10 (B) the number of stillbirths, infant mor-
11 tality, pre-term births, infants born with a low-
12 birth weight, and cesarean section births.

13 (c) INDIAN HEALTH SERVICE.—In carrying out sub-
14 section (a), the Secretary shall consult with Indian Tribes
15 and confer with urban Indian organizations.

16 (d) DISAGGREGATED INFORMATION.—In carrying
17 out subsection (a), the Secretary shall disaggregate data
18 by race, ethnicity, and location.

19 (e) UPDATE.—During the COVID–19 public health
20 emergency, the Secretary shall update the data made
21 available under this section—

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

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

1 (f) PRIVACY.—In carrying out subsection (a), the
2 Secretary shall take steps to protect the privacy of individ-
3 uals pursuant to regulations promulgated under section
4 264(c) of the Health Insurance Portability and Account-
5 ability Act of 1996 (42 U.S.C. 1320d–2 note).

6 (g) GUIDANCE.—

7 (1) IN GENERAL.—Not later than 30 days after
8 the date of enactment of this Act, the Secretary
9 shall issue guidance to States and local public health
10 departments to ensure that—

11 (A) laboratories that test specimens for
12 COVID–19 receive all relevant demographic
13 data on race, ethnicity, pregnancy status, and
14 other demographic data as determined by the
15 Secretary; and

16 (B) data described in subsection (b) is
17 disaggregated by race, ethnicity, and location.

18 (2) CONSULTATION.—In carrying out para-
19 graph (1), the Secretary shall consult with Indian
20 Tribes—

21 (A) to ensure that such guidance includes
22 Tribally developed best practices; and

23 (B) to reduce misclassification of American
24 Indians and Alaska Natives.

1 **SEC. 1004. INCLUSION OF PREGNANT INDIVIDUALS AND**
2 **LACTATING INDIVIDUALS IN VACCINE AND**
3 **THERAPEUTIC DEVELOPMENT FOR COVID-19.**

4 The Director of the National Institutes of Health
5 shall when safe and appropriate, support and advance the
6 inclusion of pregnant and lactating individuals in thera-
7 peutic and vaccine clinical trials with respect to the treat-
8 ment or prevention of COVID-19, including prioritizing
9 recommendations made by the Task Force on Research
10 Specific to Pregnant Women and Lactating Women estab-
11 lished under section 2041 of the 21st Century Cures Act
12 (42 U.S.C. 289a-2 note) with respect to including such
13 individuals in such clinical trials.

14 **SEC. 1005. PUBLIC HEALTH COMMUNICATION REGARDING**
15 **MATERNAL CARE DURING COVID-19.**

16 The Director of the Centers for Disease Control and
17 Prevention shall conduct a public health education cam-
18 paign to increase access by pregnant individuals, their em-
19 ployers, and their health care providers to accurate, evi-
20 dence-based information on COVID-19 and pregnancy
21 risks, with a particular focus pregnant individuals in un-
22 derserved communities.

1 **SEC. 1006. TASK FORCE ON BIRTHING EXPERIENCE AND**
2 **SAFE MATERNITY CARE DURING A PUBLIC**
3 **HEALTH EMERGENCY.**

4 (a) **ESTABLISHMENT.**—The Secretary, in consulta-
5 tion with the Director of the Centers for Disease Control
6 and Prevention and the Administrator of the Health Re-
7 sources and Services Administration, shall convene a task
8 force (in this subsection referred to as the “Task Force”)
9 to develop recommendations, and make such recommenda-
10 tions publicly available in multiple languages, on respect-
11 ful maternity care during the COVID–19 public health
12 emergency and other public health emergencies, with a
13 particular focus on outcomes for individuals from racial
14 and ethnic minority groups and other underserved commu-
15 nities.

16 (b) **CONTENT.**—In developing recommendations
17 under paragraph (1), the Task Force shall address the
18 following:

19 (1) Measures to facilitate respectful maternity
20 care.

21 (2) Strategies to increase access to specialized
22 care for individuals with high-risk pregnancies.

23 (3) COVID–19 diagnostic testing for pregnant
24 individuals and individuals in labor.

25 (4) The designation of a companion during
26 birthing.

1 (5) The ability to communicate using an elec-
2 tronic mobile device during birthing.

3 (6) With respect to an individual who has the
4 virus that causes COVID–19—

5 (A) separation from a newborn after birth;
6 and

7 (B) ensuring safety while breastfeeding.

8 (7) Licensing, training, and reimbursement for
9 midwives from racial and ethnic minority groups and
10 underserved communities.

11 (8) Financial support for perinatal health work-
12 ers who provide nonclinical support to pregnant indi-
13 viduals and postpartum individuals from under-
14 served communities.

15 (9) The identification and treatment of prenatal
16 and postpartum mental and behavioral health condi-
17 tions may have developed during or worsened be-
18 cause of the COVID–19 public health emergency or
19 future public health emergencies, including anxiety,
20 substance use disorder, and depression.

21 (10) Strategies to address hospital capacity
22 issues in communities with an increase in COVID–
23 19 cases, or cases of other infectious diseases.

24 (11) Options for maternal care that reduce
25 cross-contamination and maintain safety and quality

1 of care, including auxiliary maternity units and free-
2 standing birth centers.

3 (12) Methods to identify and address racism,
4 bias, and discrimination in treatment and support to
5 pregnant and postpartum individuals, including—

6 (A) evaluating the training of hospital staff
7 on implicit bias and racism and respectful ma-
8 ternity care; and

9 (B) the collection of demographic data.

10 (13) Other matters the Task Force determines
11 appropriate.

12 (c) MEMBERSHIP.—

13 (1) CHAIR.—The Secretary shall select the
14 chair of the Task Force from among the members
15 of the Task Force.

16 (2) COMPOSITION.—The Task Force shall be
17 composed of—

18 (A) representatives of Federal agencies, in-
19 cluding the agencies listed in paragraph (3);

20 (B) three or more representatives of State,
21 local, or territorial public health departments
22 from different areas in the United States that
23 have a large historically marginalized popu-
24 lation;

1 (C) one or more representatives of Tribal
2 public health departments;

3 (D) one or more obstetrician-gynecologists
4 or other physicians who provide obstetric care,
5 with consideration for physicians who are from,
6 or work in, communities experiencing a high
7 rate of mortality and morbidity from COVID–
8 19;

9 (E) one or more nurses who provide ob-
10 stetric care, with consideration for physicians
11 who are from, or work in, communities experi-
12 encing a high rate of mortality and morbidity
13 from COVID–19;

14 (F) one or more perinatal health workers;

15 (G) one or more individuals who were
16 pregnant or gave birth during the COVID–19
17 public health emergency;

18 (H) one or more individuals who had the
19 virus that causes COVID–19 and later gave
20 birth;

21 (I) one or more individuals who have re-
22 ceived support from a perinatal health; and

23 (J) three or more independent experts who
24 are racially and ethnically diverse with knowl-
25 edge on racial and ethnic disparities in—

- 1 (i) public health;
- 2 (ii) maternal health; or
- 3 (iii) maternal mortality and severe
- 4 maternal morbidity.

5 (3) FEDERAL AGENCIES.—The agencies rep-

6 resented under paragraph (2)(A) shall include the

7 following:

8 (A) The Department of Health and

9 Human Services.

10 (B) The Centers for Disease Control and

11 Prevention.

12 (C) The Centers for Medicare & Medicaid

13 Services.

14 (D) The Health Resources and Services

15 Administration.

16 (E) The Indian Health Service.

17 (F) The National Institutes of Health.

18 **SEC. 1007. GAO REPORT ON MATERNAL HEALTH AND PUB-**

19 **LIC HEALTH EMERGENCY PREPAREDNESS.**

20 (a) IN GENERAL.—Not later than one year after date

21 of the enactment of this Act, the Comptroller General of

22 the United States shall submit to Congress a report on

23 maternal health and public health emergency prepared-

24 ness. Such report shall include the information and rec-

25 ommendations described in subsection (b).

1 (b) CONTENT OF REPORT.—The report under sub-
2 section (b) shall include the following:

3 (1) A review of prenatal, labor and delivery,
4 and postpartum experiences of individuals during
5 such public health emergency, including—

6 (A) barriers to accessing pregnancy, birth,
7 and postpartum care during a pandemic;

8 (B) public and private insurance coverage
9 with respect to maternal health care, including
10 telehealth services;

11 (C) to the extent practicable, maternal and
12 infant health outcomes by race and ethnicity
13 (including quality of care, mortality, morbidity,
14 cesarean section rates, preterm birth, preva-
15 lence of prenatal and postpartum mental health
16 conditions and substance use disorders);

17 (D) with respect to such health outcomes,
18 the impact of Federal and State policy changes
19 during such public health emergency;

20 (E) contributing factors to population-
21 based disparities in health outcomes, including
22 bias and discrimination toward individuals from
23 racial and ethnic minority groups; and

24 (F) the effect of increased unemployment,
25 paid family leave, changes in health care cov-

1 erage, and other social determinants of health
2 for pregnant and postpartum individuals during
3 the public health emergency.

4 (2) Recommendations on improving the public
5 health emergency response and preparedness efforts
6 of the Federal Government with respect to maternal
7 health, with a focus on outcomes for pregnant and
8 postpartum individuals from racial and ethnic mi-
9 nority groups, including—

10 (A) improving research, surveillance, and
11 data collection with respect to maternal health;

12 (B) factoring maternal health outcomes
13 and disparities into decisions regarding dis-
14 tribution of resources;

15 (C) improving the distribution of public
16 health funds, data, and information to Indian
17 Tribes and Tribal organizations with regard to
18 maternal health during a public health emer-
19 gency; and

20 (D) improving communications during a
21 public health emergency with—

22 (i) maternity care providers;

23 (ii) maternal mental and behavioral
24 health care providers;

1 (iii) researchers who specialize in ma-
2 ternal health, maternal mortality, or severe
3 maternal morbidity;

4 (iv) individuals who experienced preg-
5 nancy or childbirth during the COVID-19
6 public health emergency;

7 (v) representatives from community-
8 based organizations that address maternal
9 health; and

10 (vi) perinatal health workers.

11 **TITLE XI—PROTECTING MOMS**
12 **AND BABIES AGAINST CLI-**
13 **MATE CHANGE**

14 **SEC. 1101. DEFINITIONS.**

15 In this title, the following definitions apply:

16 (1) ADVERSE MATERNAL AND INFANT HEALTH
17 OUTCOMES.—The term “adverse maternal and in-
18 fant health outcomes” includes the outcomes of
19 preterm birth, low birth weight, stillbirth, infant or
20 maternal mortality, and severe maternal morbidity.

21 (2) INSTITUTION OF HIGHER EDUCATION.—The
22 term “institution of higher education” has the
23 meaning given such term in section 101 of the High-
24 er Education Act of 1965 (20 U.S.C. 1001).

1 (3) MINORITY-SERVING INSTITUTION.—The
2 term “minority-serving institution” means an entity
3 specified in any of paragraphs (1) through (7) of
4 section 371(a) of the Higher Education Act of 1965
5 (20 U.S.C. 1067q(a)).

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

10 (5) RISKS ASSOCIATED WITH CLIMATE
11 CHANGE.—The term “risks associated with climate
12 change” includes risks associated with extreme heat,
13 air pollution, extreme weather events, and other en-
14 vironmental issues associated with climate change
15 that can result in adverse maternal and infant
16 health outcomes.

17 (6) STAKEHOLDER ORGANIZATION.—The term
18 “stakeholder organization” means—

19 (A) a community-based organization with
20 expertise in providing assistance to vulnerable
21 individuals;

22 (B) a nonprofit organization with expertise
23 in maternal or infant health or environmental
24 justice; and

1 (C) a patient advocacy organization rep-
2 resenting vulnerable individuals.

3 (7) VULNERABLE INDIVIDUAL.—The term “vul-
4 nerable individual” means—

5 (A) an individual who is pregnant;

6 (B) an individual who was pregnant during
7 any portion of the preceding 1-year period; and

8 (C) an individual under 3 years of age.

9 **SEC. 1102. GRANT PROGRAM TO PROTECT VULNERABLE**
10 **MOTHERS AND BABIES FROM CLIMATE**
11 **CHANGE RISKS.**

12 (a) IN GENERAL.—Not later than 180 days after the
13 date of the enactment of this Act, the Secretary of Health
14 and Human Services shall establish a grant program (in
15 this section referred to as the “Program”) to protect vul-
16 nerable individuals from risks associated with climate
17 change.

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

21 (c) APPLICATIONS.—To be eligible for a grant under
22 the Program, a covered entity shall submit to the Sec-
23 retary an application at such time, in such form, and con-
24 taining such information as the Secretary may require,

1 which shall include, at a minimum, a description of the
2 following:

3 (1) Plans for the use of grant funds awarded
4 under the Program and how patients and stake-
5 holder organizations were involved in the develop-
6 ment of such plans.

7 (2) How such grant funds will be targeted to
8 geographic areas that have disproportionately high
9 levels of risks associated with climate change for vul-
10 nerable individuals.

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

13 (A) adverse maternal and infant health
14 outcomes; and

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

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

19 (A) adverse environmental impacts;

20 (B) displacement of residents and busi-
21 nesses;

22 (C) rent and housing price increases; or

23 (D) disproportionate adverse impacts on
24 racial and ethnic minority groups and other un-
25 derserved populations.

1 (d) SELECTION OF GRANT RECIPIENTS.—

2 (1) TIMING.—Not later than 270 days after the
3 date of the enactment of this Act, the Secretary
4 shall select the recipients of grants under the Pro-
5 gram.

6 (2) CONSULTATION.—In selecting covered enti-
7 ties for grants under the Program, the Secretary
8 shall consult with—

9 (A) representatives of stakeholder organi-
10 zations;

11 (B) the Administrator of the Environ-
12 mental Protection Agency;

13 (C) the Administrator of the National Oce-
14 anic and Atmospheric Administration; and

15 (D) from the Department of Health and
16 Human Services—

17 (i) the Deputy Assistant Secretary for
18 Minority Health;

19 (ii) the Administrator of the Centers
20 for Medicare & Medicaid Services;

21 (iii) the Administrator of the Health
22 Resources and Services Administration;

23 (iv) the Director of the National Insti-
24 tutes of Health; and

1 (v) the Director of the Centers for
2 Disease Control and Prevention.

3 (3) PRIORITY.—In selecting a covered entity to
4 be awarded a grant under the Program, the Sec-
5 retary shall give priority to covered entities that
6 serve a county—

7 (A) designated, or located in an area des-
8 igned, as a nonattainment area pursuant to
9 section 107 of the Clean Air Act (42 U.S.C.
10 7407) for any air pollutant for which air quality
11 criteria have been issued under section 108(a)
12 of such Act (42 U.S.C. 7408(a));

13 (B) with a level of vulnerability of mod-
14 erate-to-high or higher, according to the Social
15 Vulnerability Index of the Centers for Disease
16 Control and Prevention; or

17 (C) with temperatures that pose a risk to
18 human health, as determined by the Secretary,
19 in consultation with the Administrator of the
20 National Oceanic and Atmospheric Administra-
21 tion and the Chair of the United States Global
22 Change Research Program, based on the best
23 available science.

24 (4) LIMITATION.—A recipient of grant funds
25 under the Program may not use such grant funds to

1 serve a county that is served by any other recipient
2 of a grant under the Program.

3 (e) USE OF FUNDS.—A covered entity awarded grant
4 funds under the Program may only use such grant funds
5 for the following:

6 (1) Initiatives to identify risks associated with
7 climate change for vulnerable individuals and to pro-
8 vide services and support to such individuals that
9 address such risks, which may include—

10 (A) training for health care providers,
11 doulas, and other employees in hospitals, birth
12 centers, midwifery practices, and other health
13 care practices that provide prenatal or labor
14 and delivery services to vulnerable individuals
15 on the identification of, and patient counseling
16 relating to, risks associated with climate change
17 for vulnerable individuals;

18 (B) hiring, training, or providing resources
19 to community health workers and perinatal
20 health workers who can help identify risks asso-
21 ciated with climate change for vulnerable indi-
22 viduals, provide patient counseling about such
23 risks, and carry out the distribution of relevant
24 services and support;

1 (C) enhancing the monitoring of risks as-
2 sociated with climate change for vulnerable in-
3 dividuals, including by—

4 (i) collecting data on such risks in
5 specific census tracts, neighborhoods, or
6 other geographic areas; and

7 (ii) sharing such data with local
8 health care providers, doulas, and other
9 employees in hospitals, birth centers, mid-
10 wifery practices, and other health care
11 practices that provide prenatal or labor
12 and delivery services to local vulnerable in-
13 dividuals; and

14 (D) providing vulnerable individuals—

15 (i) air conditioning units, residential
16 weatherization support, filtration systems,
17 household appliances, or related items;

18 (ii) direct financial assistance; and

19 (iii) services and support, including
20 housing and transportation assistance, to
21 prepare for or recover from extreme weath-
22 er events, which may include floods, hurri-
23 canes, wildfires, droughts, and related
24 events.

1 (2) Initiatives to mitigate levels of and exposure
2 to risks associated with climate change for vulner-
3 able individuals, which shall be based on the best
4 available science and which may include initiatives
5 to—

6 (A) develop, maintain, or expand urban or
7 community forestry initiatives and tree canopy
8 coverage initiatives;

9 (B) improve infrastructure, including
10 buildings and paved surfaces;

11 (C) develop or improve community out-
12 reach networks to provide culturally and lin-
13 guistically appropriate information and notifica-
14 tions about risks associated with climate change
15 for vulnerable individuals; and

16 (D) provide enhanced services to racial and
17 ethnic minority groups and other underserved
18 populations.

19 (f) LENGTH OF AWARD.—A grant under this section
20 shall be disbursed over 4 fiscal years.

21 (g) TECHNICAL ASSISTANCE.—The Secretary shall
22 provide technical assistance to a covered entity awarded
23 a grant under the Program to support the development,
24 implementation, and evaluation of activities funded with
25 such grant.

1 (h) REPORTS TO SECRETARY.—

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

9 (A) The involvement of stakeholder organi-
10 zations in the implementation of initiatives as-
11 sisted with such grant funds.

12 (B) Relevant health and environmental
13 data, disaggregated, to the extent practicable,
14 by race, ethnicity, gender, and pregnancy sta-
15 tus.

16 (C) Qualitative feedback received from vul-
17 nerable individuals with respect to initiatives
18 assisted with such grant funds.

19 (D) Criteria used in selecting the geo-
20 graphic areas assisted with such grant funds.

21 (E) Efforts to address racial and ethnic
22 disparities in adverse maternal and infant
23 health outcomes and in exposure to risks associ-
24 ated with climate change for vulnerable individ-
25 uals.

1 (F) Any negative and unintended impacts
2 of initiatives assisted with such grant funds, in-
3 cluding—

4 (i) adverse environmental impacts;

5 (ii) displacement of residents and
6 businesses;

7 (iii) rent and housing price increases;

8 and

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

12 (G) How the covered entity will address
13 and prevent any impacts described in subpara-
14 graph (F).

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

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

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

3 (2) Evaluations of the initiatives assisted with
4 grant funds under the Program.

5 (3) An assessment of the effectiveness of the
6 Program in—

7 (A) identifying risks associated with cli-
8 mate change for vulnerable individuals;

9 (B) providing services and support to such
10 individuals;

11 (C) mitigating levels of and exposure to
12 such risks; and

13 (D) addressing racial and ethnic disparities
14 in adverse maternal and infant health outcomes
15 and in exposure to such risks.

16 (4) A description of how the Program could be
17 expanded, including—

18 (A) monitoring efforts or data collection
19 that would be required to identify areas with
20 high levels of risks associated with climate
21 change for vulnerable individuals;

22 (B) how such areas could be identified
23 using the strategy developed under section 5;
24 and

1 (C) recommendations for additional fund-
2 ing.

3 (j) COVERED ENTITY DEFINED.—In this section, the
4 term “covered entity” means a consortium of organiza-
5 tions serving a county that—

6 (1) shall include a community-based organiza-
7 tion; and

8 (2) may include—

9 (A) another stakeholder organization;

10 (B) the government of such county;

11 (C) the governments of one or more mu-
12 nicipalities within such county;

13 (D) a State or local public health depart-
14 ment or emergency management agency;

15 (E) a local health care practice, which may
16 include a licensed and accredited hospital, birth
17 center, midwifery practice, or other health care
18 practice that provides prenatal or labor and de-
19 livery services to vulnerable individuals;

20 (F) an Indian tribe or tribal organization
21 (as such terms are defined in section 4 of the
22 Indian Self-Determination and Education As-
23 sistance Act (25 U.S.C. 5304));

1 (G) an Urban Indian organization (as de-
2 fined in section 4 of the Indian Health Care
3 Improvement Act (25 U.S.C. 1603)); and

4 (H) an institution of higher education.

5 (k) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 \$100,000,000 for the period of fiscal years 2022 through
8 2025.

9 **SEC. 1103. GRANT PROGRAM FOR EDUCATION AND TRAIN-**
10 **ING AT HEALTH PROFESSION SCHOOLS.**

11 (a) IN GENERAL.—Not later than 1 year after the
12 date of the enactment of this Act, the Secretary of Health
13 and Human Services shall establish a grant program (in
14 this section referred to as the “Program”) to provide
15 funds to health profession schools to support the develop-
16 ment and integration of education and training programs
17 for identifying and addressing risks associated with cli-
18 mate change for vulnerable individuals.

19 (b) GRANT AUTHORITY.—In carrying out the Pro-
20 gram, the Secretary may award, on a competitive basis,
21 grants to health profession schools.

22 (c) APPLICATION.—To be eligible for a grant under
23 the Program, a health profession school shall submit to
24 the Secretary an application at such time, in such form,
25 and containing such information as the Secretary may re-

1 quire, which shall include, at a minimum, a description
2 of the following:

3 (1) How such health profession school will en-
4 gage with vulnerable individuals, and stakeholder or-
5 ganizations representing such individuals, in devel-
6 oping and implementing the education and training
7 programs supported by grant funds awarded under
8 the Program.

9 (2) How such health profession school will en-
10 sure that such education and training programs will
11 address racial and ethnic disparities in exposure to,
12 and the effects of, risks associated with climate
13 change for vulnerable individuals.

14 (d) USE OF FUNDS.—A health profession school
15 awarded a grant under the Program shall use the grant
16 funds to develop, and integrate into the curriculum and
17 continuing education of such health profession school, edu-
18 cation and training on each of the following:

19 (1) Identifying risks associated with climate
20 change for vulnerable individuals and individuals
21 with the intent to become pregnant.

22 (2) How risks associated with climate change
23 affect vulnerable individuals and individuals with the
24 intent to become pregnant.

1 (3) Racial and ethnic disparities in exposure to,
2 and the effects of, risks associated with climate
3 change for vulnerable individuals and individuals
4 with the intent to become pregnant.

5 (4) Patient counseling and mitigation strategies
6 relating to risks associated with climate change for
7 vulnerable individuals.

8 (5) Relevant services and support for vulnerable
9 individuals relating to risks associated with climate
10 change and strategies for ensuring vulnerable indi-
11 viduals have access to such services and support.

12 (6) Implicit and explicit bias, racism, and dis-
13 crimination.

14 (7) Related topics identified by such health pro-
15 fession school based on the engagement of such
16 health profession school with vulnerable individuals
17 and stakeholder organizations representing such in-
18 dividuals.

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

23 (1) A State or local public health department.

24 (2) A health care professional membership or-
25 ganization.

1 (3) A stakeholder organization.

2 (4) A health profession school.

3 (5) An institution of higher education.

4 (f) REPORTS TO SECRETARY.—

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

11 (2) FINAL REPORT.—Not later than the date
12 that is 1 year after the end of the last fiscal year
13 during which a health profession school is disbursed
14 grant funds under the Program, the health profes-
15 sion school shall submit to the Secretary a final re-
16 port that summarizes the activities carried out with
17 such grant funds.

18 (g) REPORT TO CONGRESS.—Not later than the date
19 that is 6 years after the date on which the Program is
20 established, the Secretary shall submit to Congress and
21 publish on a public website of the Department of Health
22 and Human Services a report that includes the following:

23 (1) A summary of the reports submitted under
24 subsection (f).

1 (2) Recommendations to improve education and
2 training programs at health profession schools with
3 respect to identifying and addressing risks associ-
4 ated with climate change for vulnerable individuals.

5 (h) HEALTH PROFESSION SCHOOL DEFINED.—In
6 this section, the term “health profession school” means
7 an accredited—

8 (1) medical school;

9 (2) school of nursing;

10 (3) midwifery program;

11 (4) physician assistant education program;

12 (5) teaching hospital;

13 (6) residency or fellowship program; or

14 (7) other school or program determined appro-
15 priate by the Secretary.

16 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to carry out this section
18 \$5,000,000 for the period of fiscal years 2022 through
19 2025.

20 **SEC. 1104. NIH CONSORTIUM ON BIRTH AND CLIMATE**
21 **CHANGE RESEARCH.**

22 (a) ESTABLISHMENT.—Not later than one year after
23 the date of the enactment of this Act, the Director of the
24 National Institutes of Health shall establish the Consor-

1 tium on Birth and Climate Change Research (in this sec-
2 tion referred to as the “Consortium”).

3 (b) DUTIES.—

4 (1) IN GENERAL.—The Consortium shall co-
5 ordinate, across the institutes, centers, and offices of
6 the National Institutes of Health, research on the
7 risks associated with climate change for vulnerable
8 individuals.

9 (2) REQUIRED ACTIVITIES.—In carrying out
10 paragraph (1), the Consortium shall—

11 (A) establish research priorities, including
12 by prioritizing research that—

13 (i) identifies the risks associated with
14 climate change for vulnerable individuals
15 with a particular focus on disparities in
16 such risks among racial and ethnic minor-
17 ity groups and other underserved popu-
18 lations; and

19 (ii) identifies strategies to reduce lev-
20 els of, and exposure to, such risks, with a
21 particular focus on risks among racial and
22 ethnic minority groups and other under-
23 served populations;

24 (B) identify gaps in available data related
25 to such risks;

1 (C) identify gaps in, and opportunities for,
2 research collaborations;

3 (D) identify funding opportunities for com-
4 munity-based organizations and researchers
5 from racially, ethnically, and geographically di-
6 verse backgrounds; and

7 (E) publish annual reports on the work
8 and findings of the Consortium on a public
9 website of the National Institutes of Health.

10 (c) MEMBERSHIP.—The Director shall appoint to the
11 Consortium representatives of such institutes, centers, and
12 offices of the National Institutes of Health as the Director
13 considers appropriate, including, at a minimum, rep-
14 resentatives of—

15 (1) the National Institute of Environmental
16 Health Sciences;

17 (2) the National Institute on Minority Health
18 and Health Disparities;

19 (3) the Eunice Kennedy Shriver National Insti-
20 tute of Child Health and Human Development;

21 (4) the National Institute of Nursing Research;
22 and

23 (5) the Office of Research on Women’s Health.

1 (d) CHAIRPERSON.—The Chairperson of the Consor-
2 tium shall be designated by the Director and selected from
3 among the representatives appointed under subsection (c).

4 (e) CONSULTATION.—In carrying out the duties de-
5 scribed in subsection (b), the Consortium shall consult
6 with—

7 (1) the heads of relevant Federal agencies, in-
8 cluding—

9 (A) the Environmental Protection Agency;

10 (B) the National Oceanic and Atmospheric
11 Administration;

12 (C) the Occupational Safety and Health
13 Administration; and

14 (D) from the Department of Health and
15 Human Services—

16 (i) the Office of Minority Health in
17 the Office of the Secretary;

18 (ii) the Centers for Medicare & Med-
19 icaid Services;

20 (iii) the Health Resources and Serv-
21 ices Administration;

22 (iv) the Centers for Disease Control
23 and Prevention;

24 (v) the Indian Health Service; and

- 1 (vi) the Administration for Children
2 and Families; and
3 (2) representatives of—
4 (A) stakeholder organizations;
5 (B) health care providers and professional
6 membership organizations with expertise in ma-
7 ternal health or environmental justice;
8 (C) State and local public health depart-
9 ments;
10 (D) licensed and accredited hospitals, birth
11 centers, midwifery practices, or other health
12 care practices that provide prenatal or labor
13 and delivery services to vulnerable individuals;
14 and
15 (E) institutions of higher education, in-
16 cluding such institutions that are minority-serv-
17 ing institutions or have expertise in maternal
18 health or environmental justice.

19 **SEC. 1105. STRATEGY FOR IDENTIFYING CLIMATE CHANGE**
20 **RISK ZONES FOR VULNERABLE MOTHERS**
21 **AND BABIES.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services, acting through the Director of the Cen-
24 ters for Disease Control and Prevention, shall develop a
25 strategy (in this section referred to as the “Strategy”) for

1 designating areas that the Secretary determines to have
2 a high risk of adverse maternal and infant health out-
3 comes among vulnerable individuals as a result of risks
4 associated with climate change.

5 (b) STRATEGY REQUIREMENTS.—

6 (1) IN GENERAL.—In developing the Strategy,
7 the Secretary shall establish a process to identify
8 areas where vulnerable individuals are exposed to a
9 high risk of adverse maternal and infant health out-
10 comes as a result of risks associated with climate
11 change in conjunction with other factors that can
12 impact such health outcomes, including—

13 (A) the incidence of diseases associated
14 with air pollution, extreme heat, and other envi-
15 ronmental factors;

16 (B) the availability and accessibility of ma-
17 ternal and infant health care providers;

18 (C) English-language proficiency among
19 women of reproductive age;

20 (D) the health insurance status of women
21 of reproductive age;

22 (E) the number of women of reproductive
23 age who are members of racial or ethnic groups
24 with disproportionately high rates of adverse
25 maternal and infant health outcomes;

1 (F) the socioeconomic status of women of
2 reproductive age, including with respect to—

3 (i) poverty;

4 (ii) unemployment;

5 (iii) household income; and

6 (iv) educational attainment; and

7 (G) access to quality housing, transpor-
8 tation, and nutrition.

9 (2) RESOURCES.—In developing the Strategy,
10 the Secretary shall identify, and incorporate a de-
11 scription of, the following:

12 (A) Existing mapping tools or Federal pro-
13 grams that identify—

14 (i) risks associated with climate
15 change for vulnerable individuals; and

16 (ii) other factors that can influence
17 maternal and infant health outcomes, in-
18 cluding the factors described in paragraph
19 (1).

20 (B) Environmental, health, socioeconomic,
21 and demographic data relevant to identifying
22 risks associated with climate change for vulner-
23 able individuals.

1 (C) Existing monitoring networks that col-
2 lect data described in subparagraph (B), and
3 any gaps in such networks.

4 (D) Federal, State, and local stakeholders
5 involved in maintaining monitoring networks
6 identified under subparagraph (C), and how
7 such stakeholders are coordinating their moni-
8 toring efforts.

9 (E) Additional monitoring networks, and
10 enhancements to existing monitoring networks,
11 that would be required to address gaps identi-
12 fied under subparagraph (C), including at the
13 subcounty and census tract level.

14 (F) Funding amounts required to establish
15 the monitoring networks identified under sub-
16 paragraph (E) and recommendations for Fed-
17 eral, State, and local coordination with respect
18 to such networks.

19 (G) Potential uses for data collected and
20 generated as a result of the Strategy, including
21 how such data may be used in determining re-
22 cipients of grants under the program estab-
23 lished by section 2 or other similar programs.

1 (H) Other information the Secretary con-
2 siders relevant for the development of the Strat-
3 egy.

4 (c) COORDINATION AND CONSULTATION.—In devel-
5 oping the Strategy, the Secretary shall—

6 (1) coordinate with the Administrator of the
7 Environmental Protection Agency and the Adminis-
8 trator of the National Oceanic and Atmospheric Ad-
9 ministration; and

10 (2) consult with—

11 (A) stakeholder organizations;

12 (B) health care providers and professional
13 membership organizations with expertise in ma-
14 ternal health or environmental justice;

15 (C) State and local public health depart-
16 ments;

17 (D) licensed and accredited hospitals, birth
18 centers, midwifery practices, or other health
19 care providers that provide prenatal or labor
20 and delivery services to vulnerable individuals;
21 and

22 (E) institutions of higher education, in-
23 cluding such institutions that are minority-serv-
24 ing institutions or have expertise in maternal
25 health or environmental justice.

1 (d) NOTICE AND COMMENT.—At least 240 days be-
2 fore the date on which the Strategy is published in accord-
3 ance with subsection (e), the Secretary shall provide—

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

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

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

13 (1) the Strategy;

14 (2) the public comments received under sub-
15 section (d); and

16 (3) the responses of the Secretary to such pub-
17 lic comments.

18 **TITLE XII—MATERNAL**

19 **VACCINATIONS**

20 **SEC. 1201. MATERNAL VACCINATION AWARENESS AND EQ-**
21 **UITY CAMPAIGN.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services (in this section referred to as the “Sec-
24 retary”), acting through the Director of the Centers for

1 Disease Control and Prevention, shall carry out a national
2 campaign to—

3 (1) increase awareness of the importance of ma-
4 ternal vaccinations for the health of pregnant and
5 postpartum individuals and their children; and

6 (2) increase maternal vaccination rates, with a
7 focus on communities with historically high rates of
8 unvaccinated individuals.

9 (b) CONSULTATION.—In carrying out the campaign
10 under this title, the Secretary shall consult with relevant
11 community-based organizations, health care professional
12 associations and public health associations, State public
13 health departments and local public health departments,
14 Tribal-serving organizations, nonprofit organizations, and
15 nationally recognized private entities.

16 (c) ACTIVITIES.—The campaign under this section
17 shall—

18 (1) focus on increasing maternal vaccination
19 rates in communities with historically high rates of
20 unvaccinated individuals, including for pregnant and
21 postpartum individuals from racial and ethnic mi-
22 nority groups;

23 (2) include efforts to engage with pregnant and
24 postpartum individuals in communities with histori-
25 cally high rates of unvaccinated individuals to seek

1 input on the development and effectiveness of the
2 campaign;

3 (3) provide evidence-based, culturally congruent
4 resources and communications efforts; and

5 (4) be carried out in partnership with trusted
6 individuals and entities in communities with histori-
7 cally high rates of unvaccinated individuals, includ-
8 ing community-based organizations, community
9 health centers, perinatal health workers, and mater-
10 nity care providers.

11 (d) COLLABORATION.—The Secretary shall ensure
12 that the information and resources developed for the cam-
13 paign under this section are made publicly available and
14 shared with relevant Federal, State, and local entities.

15 (e) EVALUATION.—Not later than the end of fiscal
16 year 2025, the Secretary shall—

17 (1) establish quantitative and qualitative
18 metrics to evaluate the campaign under this section;
19 and

20 (2) submit a report detailing the campaign’s
21 impact to the Congress.

22 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there is authorized to be appropriated
24 \$2,000,000 for each of fiscal years 2022 through 2026.

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