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To improve the public health response to addressing maternal mortality and morbidity during the COVID–19 public health emergency.

IN THE SENATE OF THE UNITED STATES

DECEMBER 15, 2022

Ms. WARREN (for herself, Mr. BOOKER, Mrs. GILLIBRAND, and Ms. SMITH) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To improve the public health response to addressing maternal mortality and morbidity during the COVID–19 public health emergency.

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 "Maternal Health Pan-
5 demic Response Act of 2022".

6 **SEC. 2. FINDINGS.**

7 Congress finds as follows:
8 (1) The World Health Organization declared
9 COVID–19 a "Public Health Emergency of Inter-

1 national Concern'' on January 30, 2020. As of De-
2 cember 12, 2022, there have been over 643,875,000
3 confirmed cases of, and over 6,630,000 deaths asso-
4 ciated with, COVID–19 worldwide.
5 (2) In the United States, the number of cases
6 of COVID–19 has quickly surpassed the number of
7 such cases in every other nation, and as of Decem-
8 ber 12, 2022, over 99,000,000 cases and 1,080,000
9 deaths have been reported by the United States
10 alone.
11 (3) Longstanding systemic health and social in-
12 equities have put communities of color at increased
13 risk of contracting COVID–19 or experiencing se-
14 vere illness; age-adjusted hospitalization rates from
15 COVID–19 are highest for American Indian and
16 Alaska Native, Black, and Latinx people.
17 (4) Prior to the start of the COVID–19 pan-
18 demic, the United States was facing a maternal mor-
19 tality and morbidity crisis, in which the United
20 States has the highest maternal mortality rate in the
21 developed world, and the crisis is worsening.
22 (5) More than 50,000 women in the United
23 States annually experience severe maternal mor-
24 bidity, and much larger numbers experience more
25 common harmful challenges, such as prenatal and

1 postpartum mood disorders, including depression,
2 anxiety disorder, and PTSD; limited access to pre-
3 natal and postpartum care, diagnosis, and treatment
4 of complications; intimate partner violence; and lack
5 of support for meeting breastfeeding goals. Many
6 perinatal complications are preventable or treatable,
7 and most injuries, long-term adverse effects, and
8 deaths are preventable.

9 (6) Compared to White women, Black and
10 American Indian and Alaska Native women in the
11 United States are 2 to 4 times more likely to die
12 from pregnancy-related complications, and Black
13 and American Indian and Alaska Native women suf-
14 fer disproportionately high rates of maternal mor-
15 bidity. The maternal mortality rate for Hispanic
16 women, which historically has been lower than such
17 rate for White women, is increasing and is now
18 nearly the same as that of White women.

19 (7) The causes of maternal mortality and mor-
20 bidity are complex and include racial, ethnic, socio-
21 economic, and geographic inequities; racism, bias,
22 and discrimination; comorbidities; and inadequate
23 access to the health care system, including behav-
24 ioral health care, which are factors that have simi-

1 larly contributed to the racial disparities seen in
2 COVID–19 outcomes.
3 (8) The burden of morbidity and mortality in
4 the United States for both COVID–19 and maternal
5 health outcomes has also fallen disproportionately on
6 Black, Latinx, and American Indian and Alaska Na-
7 tive communities, who suffer the most from great
8 public health needs and are the most medically un-
9 derserved. Underserved women also include those liv-
10 ing in maternity care deserts, which lack obstetric
11 providers and hospitals or birth centers offering ob-
12 stetric care.
13 (9) According to the Centers for Disease Con-
14 trol and Prevention, ''pregnant and recently preg-
15 nant people with COVID–19 are at increased risk
16 for severe illness when compared with non-pregnant
17 people''. Additionally, ''pregnant people with
18 COVID–19 are also at increased risk for preterm
19 birth and some data suggest an increased risk for
20 other adverse pregnancy complications and out-
21 comes, such as preeclampsia, coagulopathy, and still-
22 birth, compared with pregnant people without
23 COVID–19''. Research has also shown that COVID–
24 19 infection during pregnancy may increase the risk
25 of preeclampsia; having preeclampsia and other

1 pregnancy complications also increases the risks of
2 serious COVID–19 infection.
3 (10) As of December 2022, the latest informa-
4 tion from the Centers for Disease Control and Pre-
5 vention indicates that pregnant women are more
6 likely to be hospitalized and are at higher risk for
7 intensive care unit admissions than nonpregnant
8 women due to COVID–19, and Latinx and Black
9 pregnant people have been disproportionately in-
10 fected by COVID–19, as well as more likely to expe-
11 rience severe disease.
12 (11) Our understanding of the specific impact
13 of COVID–19 on pregnant people has grown signifi-
14 cantly. Pregnant and newly delivered women are
15 more susceptible to serious infection from COVID–
16 19, a direct impact. In addition, the COVID–19
17 pandemic has further strained the health care sys-
18 tem and decreased access to preconception, prenatal,
19 and postpartum care. The lack of access to care, in-
20 cluding mental health care, increases the risks of
21 maternal mortality and morbidity, pregnancy loss,
22 and infant mortality. It has also added another layer
23 of fear and vulnerability for pregnant people, with
24 disproportionate effects on people of color.

1 (12) As of March 7, 2022, over 180,000 preg-
2 nant people in the United States have tested positive
3 for COVID–19 and 293 pregnant people have died
4 as a result of COVID–19.
5 (13) The World Health Organization states
6 that everyone "has the right to safe and positive
7 childbirth experience, whether or not they have a
8 confirmed COVID–19 infection, this includes the
9 right to respect and dignity, a companion of choice,
10 clear communication by maternity staff, pain relief
11 strategies, and mobility in labor when possible and
12 the position of choice".
13 (14) A COVID–19 public health response with-
14 out concerted Federal action and focus on maternal
15 health care access and quality, research, data collec-
16 tion, mitigation of negative socioeconomic con-
17 sequences of the pandemic, and protection of the
18 right to safe and positive childbirth experience has
19 exacerbated the maternal mortality and morbidity
20 crisis. Risk has also increased for pregnant women
21 who have not been provided with a continuum of re-
22 spectful, responsive, and empowering care from pre-
23 conception through postpartum, during the pan-
24 demic and beyond.

1 **SEC. 3. DEFINITIONS.**

2 In this Act:

3 (1) COVID–19 PUBLIC HEALTH EMERGENCY.—
4 The term "COVID–19 public health emergency"
5 means the period beginning on the date that the
6 public health emergency declared by the Secretary of
7 Health and Human Services under section 319 of
8 the Public Health Service Act (42 U.S.C. 247d) on
9 January 31, 2020, with respect to COVID–19 took
10 effect, and ending on the later of the end of such
11 public health emergency or January 1, 2023.

12 (2) CULTURALLY CONGRUENT.—The term "cul-
13 turally congruent", with respect to care or maternity
14 care, means care that is anti-racist and is in agree-
15 ment with the preferred cultural values, beliefs,
16 worldview, and practices of the health care consumer
17 and other stakeholders.

18 (3) INDIAN TRIBE, TRIBAL ORGANIZATION, AND
19 URBAN INDIAN ORGANIZATION.—The terms "Indian
20 Tribe" and "Tribal organization" have the meanings
21 given the terms "Indian tribe" and "tribal organiza-
22 tion", respectively, in section 4 of the Indian Self-
23 Determination and Education Assistance Act (25
24 U.S.C. 5304), and the term "urban Indian organiza-
25 tion" has the meaning given such term in section 4

1 of the Indian Health Care Improvement Act (25
2 U.S.C. 1603).

3 (4) MATERNAL MORTALITY.—The term ''mater-
4 nal mortality'' means a death occurring during preg-
5 nancy or within one year of the end of pregnancy,
6 from a pregnancy complication, a chain of events
7 initiated by pregnancy, or the aggravation of an un-
8 related condition by the physiologic effects of preg-
9 nancy.

10 (5) POSTPARTUM.—The term ''postpartum''
11 means the 1-year period beginning on the last day
12 of a person's pregnancy.

13 (6) RESPECTFUL MATERNITY CARE.—The term
14 ''respectful maternity care'' means care organized
15 for, and provided to, all pregnant and postpartum
16 people in a manner that—

17 (A) is culturally congruent and linguis-
18 tically appropriate;

19 (B) maintains a person's dignity, privacy,
20 and confidentiality;

21 (C) ensures freedom from harm and mis-
22 treatment; and

23 (D) enables informed choice and contin-
24 uous support during labor, childbirth, and
25 postpartum.

1 (7) SECRETARY.—The term ''Secretary'' means
2 the Secretary of Health and Human Services.
3 (8) SEVERE MATERNAL MORBIDITY.—The term
4 ''severe maternal morbidity'' means an unexpected
5 outcome caused by labor and delivery that results in
6 significant short-term or long-term consequences to
7 the health of the pregnant person.

8 **SEC. 4. EMERGENCY FUNDING FOR FEDERAL DATA COL-**
9 **LECTION, SURVEILLANCE, AND RESEARCH**
10 **ON MATERNAL HEALTH OUTCOMES DURING**
11 **THE COVID–19 PUBLIC HEALTH EMERGENCY**
12 **OR A FUTURE PUBLIC HEALTH EMERGENCY.**

13 To conduct or support data collection, surveillance,
14 and research on maternal health as a result of the
15 COVID–19 public health emergency or a future public
16 health emergency, including support to assist in the capac-
17 ity building for State, Tribal, territorial, and local public
18 health departments to collect and transmit racial, ethnic,
19 and other demographic data related to maternal health,
20 there are authorized to be appropriated—
21 (1) $100,000,000 for the Surveillance for
22 Emerging Threats to Mothers and Babies program
23 of the Centers for Disease Control and Prevention,
24 to support the Centers for Disease Control and Pre-
25 vention in its efforts to—

1 (A) work with public health, clinical, and
2 community-based organizations to provide time-
3 ly, continually updated guidance to families and
4 health care providers on ways to reduce health
5 risks to mothers and babies and tailor interven-
6 tions to improve their long-term health;
7 (B) partner with more State, Tribal, terri-
8 torial, and local public health programs in the
9 collection and analysis of clinical data on the
10 impact of COVID–19 and future public health
11 emergencies on pregnant and postpartum pa-
12 tients and their newborns, including among
13 pregnant people of color; and
14 (C) establish regionally based centers of
15 excellence to offer medical, public health, and
16 other knowledge to ensure communities, espe-
17 cially communities of color, rural communities,
18 and other underserved communities can help
19 pregnant and postpartum patients and infants
20 get the care they need;
21 (2) $30,000,000 for the Enhancing Reviews
22 and Surveillance to Eliminate Maternal Mortality
23 program (commonly known as the ''ERASE MM
24 program'') of the Centers for Disease Control and
25 Prevention, to support the Centers for Disease Con-

1 trol and Prevention in expanding its partnerships
2 with States and Indian Tribes and provide technical
3 assistance to existing Maternal Mortality Review
4 Committees;
5 (3) $45,000,000 for the Pregnancy Risk As-
6 sessment Monitoring System (commonly known as
7 the ''PRAMS'') of the Centers for Disease Control
8 and Prevention, to support the Centers for Disease
9 Control and Prevention in its efforts to—
10 (A) create a COVID–19 supplement to its
11 PRAMS questionnaire;
12 (B) add questions around experiences of
13 respectful, responsive, and empowering mater-
14 nity care in prenatal, intrapartum, and
15 postpartum care;
16 (C) conduct a rapid assessment of
17 COVID–19 awareness, impact on care and ex-
18 periences, and use of preventive measures
19 among pregnant, laboring and birthing, and
20 postpartum people during the COVID–19 pub-
21 lic health emergency; and
22 (D) work to transition the survey to an
23 electronic platform and expand the survey to a
24 larger population, with a special focus on reach-
25 ing underrepresented communities and under-

1 served communities, and with sensitivity to individuals who lack access to such a platform;
3 and

4 (4) $15,000,000 for the National Institute of Child Health and Human Development, to conduct or support research for interventions to mitigate the effects of the COVID–19 public health emergency on pregnant and postpartum people, including Black, Latinx, Asian-American and Pacific Islander, and American Indian and Alaska Native people, as well as people living in areas with limited maternity care.

12 **SEC. 5. COVID–19 MATERNAL HEALTH DATA COLLECTION AND DISCLOSURE.**

14 (a) DATA COLLECTION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the Administrator of the Centers for Medicare & Medicaid Services, shall make publicly available, on the website of the Centers for Disease Control and Prevention, pregnancy and postpartum data collected across all surveillance systems relating to COVID–19, disaggregated by race, ethnicity, primary language, disability status, gender identity, sexual orientation, immigration status, insurance status, and State and Tribal location, including the following:

1 (1) Data related to all COVID–19 diagnostic
2 testing, including the number of pregnant people
3 and postpartum people tested and the number of
4 positive cases.
5 (2) Data related to all suspected cases of
6 COVID–19 in pregnant, birthing, and postpartum
7 people who did not undergo testing.
8 (3) Data related to all COVID–19 serologic
9 testing, including the number of pregnant and
10 postpartum people tested and the number of such
11 serologic tests that were positive.
12 (4) Data related to treatment for COVID–19,
13 including hospitalizations, emergency room, and in-
14 tensive care unit admissions of pregnant, birthing,
15 and postpartum people related to COVID–19.
16 (5) Data related to COVID–19 outcomes, in-
17 cluding total fatalities and case fatality (expressed
18 as the proportion of people who were infected with
19 COVID–19 and died from the virus) of pregnant
20 and postpartum people.
21 (6) Data related to pregnancy and infant health
22 outcomes for pregnant people with confirmed or sus-
23 pected COVID–19, which may include stillbirths,
24 maternal mortality and morbidity, infant mortality,

1 preterm births, low-birth weight infants, and cesar-
2 ean section births.
3 (7) Data related to all long-term effects of
4 COVID–19 related to cases contracted during the
5 pregnancy or postpartum period.
6 (b) TIMELINE.—The Secretary shall update the data
7 made available under this section not less frequently than
8 monthly, during the COVID–19 public health emergency
9 and for at least one month after the end of the COVID–
10 19 public health emergency.
11 (c) PRIVACY.—In publishing data under this section,
12 the Secretary shall take all necessary steps to protect the
13 privacy of people whose information is included in such
14 data, including by complying with—
15 (1) privacy protections under the regulations
16 promulgated under section 264(c) of the Health In-
17 surance Portability and Accountability Act of 1996
18 (42 U.S.C. 1320d–2 note); and
19 (2) protections from all inappropriate internal
20 use by an entity that collects, stores, or receives the
21 data, including use of such data in determinations of
22 eligibility (or continued eligibility) in health plans,
23 and from inappropriate uses.
24 (d) INDIAN HEALTH SERVICE.—The Director of the
25 Indian Health Service and Director of the Centers for Dis-

1 ease Control and Prevention shall consult with Indian
2 Tribes and confer with urban Indian organizations on data
3 collection and reporting for purposes of this section.
4 (e) DATA COLLECTION GUIDANCE.—The Secretary
5 shall issue guidance to States and local public health de-
6 partments to ensure that all relevant demographic data,
7 including pregnancy and postpartum status, are collected
8 and included when sending COVID–19 testing specimen
9 to laboratories, and State and local health departments
10 and Indian Tribes are disaggregating data on COVID–19
11 status in data on maternal and infant morbidity and mor-
12 tality. The Secretary shall ensure that the guidance is de-
13 veloped in consultation with Indian Tribes to ensure that
14 it includes Tribally developed best practices on reducing
15 misclassification of American Indian and Alaska Native
16 people in Federal, State, and local public health surveil-
17 lance systems.

18 **SEC. 6. PUBLIC HEALTH COMMUNICATION REGARDING MA-**
19 **TERNAL CARE DURING COVID–19.**

20 (a) PUBLIC HEALTH CAMPAIGN.—The Director of
21 the Centers for Disease Control and Prevention shall un-
22 dertake a robust public health education effort to enhance
23 access by pregnant people, their employers, and their pro-
24 viders to accurate, evidence-based health information
25 about COVID–19 and pregnancy, safety, and risk, with

1 a particular focus on reaching pregnant and postpartum
2 people in underserved communities.

3 (b) EMERGENCY TEMPORARY STANDARD.—

4 (1) IN GENERAL.—In consideration of the grave
5 risk presented by COVID–19 and the need to
6 strengthen protections for employees, pursuant to
7 section 6(c)(1) of the Occupational Safety and
8 Health Act of 1970 (29 U.S.C. 655(c)(1)) and not-
9 withstanding the provisions of law and the executive
10 order described in paragraph (3), not later than 7
11 days after the date of enactment of this Act, the
12 Secretary of Labor shall promulgate an emergency
13 temporary standard to protect all employees at occu-
14 pational risk from occupational exposure to SARS–
15 CoV–2.

16 (2) PREGNANT AND POSTPARTUM EMPLOY-
17 EES.—The emergency temporary standard promul-
18 gated under this subsection shall include consider-
19 ation of the risks and needs specific to pregnant and
20 postpartum employees.

21 (3) INAPPLICABLE PROVISIONS OF LAW AND
22 EXECUTIVE ORDER.—The requirements of chapter 6
23 of title 5, United States Code (commonly referred to
24 as the ''Regulatory Flexibility Act''), subchapter I of
25 chapter 35 of title 44, United States Code (com-

1 monly referred to as the ''Paperwork Reduction
2 Act''), the Unfunded Mandates Reform Act of 1995
3 (2 U.S.C. 1501 et seq.), and Executive Order 12866
4 (58 Fed. Reg. 190; relating to regulatory planning
5 and review) shall not apply to the standard promul-
6 gated under this subsection.

7 (c) TASK FORCE ON BIRTHING EXPERIENCE AND
8 SAFE, RESPECTFUL, RESPONSIVE, AND EMPOWERING
9 MATERNITY CARE DURING PANDEMICS AND OTHER PUB-
10 LIC HEALTH EMERGENCIES.—

11 (1) ESTABLISHMENT.—The Secretary, in con-
12 sultation with the Director of the Centers for Dis-
13 ease Control and Prevention and the Administrator
14 of the Health Resources and Services Administra-
15 tion, shall convene a task force to develop Federal
16 recommendations regarding respectful, responsive,
17 and empowering maternity care, including safe birth
18 care and postpartum care, during public health
19 emergencies.

20 (2) DUTIES.—The task force established under
21 paragraph (1) shall develop, publicly post, and up-
22 date Federal recommendations in multiple languages
23 to ensure quality, provide nondiscriminatory mater-
24 nity care, promote positive birthing experiences, and
25 improve maternal health outcomes during the

1 COVID–19 public health emergency and future pub-
2 lic health emergencies, with a particular focus on
3 outcomes for communities of color and rural popu-
4 lations. Such guidelines and recommendations
5 shall—

6 (A) address, with particular attention to
7 ensuring equitable treatment on the basis of
8 race and ethnicity—

9 (i) measures to facilitate respectful,
10 responsive, and empowering maternity
11 care;

12 (ii) measures to facilitate telehealth
13 maternity care for pregnant people who
14 cannot regularly access in-person care;

15 (iii) strategies to increase access to
16 specialized care for those with high-risk
17 pregnancies or pregnant individuals with
18 elevated risk factors;

19 (iv) diagnostic testing for pregnant
20 and laboring patients;

21 (v) birthing without one's chosen com-
22 panions, with one's chosen companions,
23 and with smartphone or other telehealth
24 connection to one's chosen companions;

1 (vi) newborn separation after birth in
2 relation to maternal infection status;
3 (vii) breast milk feeding in relation to
4 maternal infection status;
5 (viii) licensure, training, scope of
6 practice, and Medicaid and other insurance
7 reimbursement for certified midwives, cer-
8 tified nurse-midwives, certified professional
9 midwives, in a manner that facilitates in-
10 clusion of midwives of color and midwives
11 from underserved communities;
12 (ix) financial support and training for
13 perinatal health workers who provide non-
14 clinical support to people from pregnancy
15 through the postpartum period, such as a
16 doula, community health worker, peer sup-
17 porter, lactation consultant, nutritionist or
18 dietitian, social worker, home visitor, or a
19 patient navigator in a manner that facili-
20 tates inclusion from underserved commu-
21 nities;
22 (x) strategies to ensure and expand
23 doula coverage under State Medicaid pro-
24 grams;

1 (xi) how to identify, address, and
2 treat prenatal and postpartum mental and
3 behavioral health conditions, such as anx-
4 iety, substance use disorder, and depres-
5 sion, which may have arisen or increased
6 during the COVID–19 public health emer-
7 gency, and how to mitigate the impact of
8 future public health emergencies on mater-
9 nal mental health;

10 (xii) how to identify and address in-
11 stances of intimate partner violence during
12 pregnancy which may arise or intensify
13 during public health emergencies, and how
14 to mitigate the impact of future public
15 health emergencies on maternal mental
16 health;

17 (xiii) strategies to address hospital ca-
18 pacity concerns in communities with a
19 surge in infectious disease cases and to
20 provide childbearing people with options
21 that reduce potential for cross-contamina-
22 tion and increase the ability to implement
23 their care preferences while maintaining
24 safety and quality, such as the use of aux-

1 iliary maternity units and freestanding
2 birth centers;
3 (xiv) provision of child care services
4 during prenatal appointments for mothers
5 whose children are unable to attend as a
6 result of restrictions relating to the public
7 health emergencies;
8 (xv) how to identify and address rac-
9 ism, bias, and discrimination in the deliv-
10 ery treatment and support to pregnant and
11 postpartum people, including evaluating
12 the value of training for hospital staff on
13 implicit bias and racism, respectful, re-
14 sponsive, and empowering maternity care,
15 and demographic data collection;
16 (xvi) how to address the needs of un-
17 documented pregnant women and new
18 mothers who may be afraid or unable to
19 seek needed care during the COVID–19
20 public health emergency;
21 (xvii) how to address the needs of un-
22 insured pregnant women who have histori-
23 cally relied on emergency departments for
24 care;

1 (xviii) how to identify women at risk
2 for depression, anxiety disorder, psychosis,
3 obsessive-compulsive disorder, and other
4 maternal mood disorders before, during,
5 and after pregnancy, and how to treat
6 those diagnosed with a postpartum mood
7 disorder;
8 (xix) how to effectively and compas-
9 sionately screen for substance abuse during
10 pregnancy and postpartum and help moms
11 find support and effective treatment; and
12 (xx) such other matters as the task
13 force determines appropriate;
14 (B) identify barriers to the implementation
15 of the guidelines and recommendations;
16 (C) take into consideration existing State
17 and other programs that have demonstrated ef-
18 fectiveness in addressing pregnancy, birth, and
19 postpartum care during the COVID–19 public
20 health emergency; and
21 (D) identify policies specific to COVID–19
22 that should be discontinued when safely possible
23 and those that should be continued as the pub-
24 lic health emergency abates.

1 (3) MEMBERSHIP.—The task force established
2 under paragraph (1) shall be comprised of—
3 (A) representatives of the Department of
4 Health and Human Services, including rep-
5 resentatives of—
6 (i) the Secretary;
7 (ii) the Director of the Centers for
8 Disease Control and Prevention;
9 (iii) the Administrator of the Health
10 Resources and Services Administration;
11 (iv) the Administrator of the Centers
12 for Medicare & Medicaid Services;
13 (v) the Director of the Agency for
14 Healthcare Research and Quality; and
15 (vi) the Director of the Indian Health
16 Service;
17 (B) at least 3 State, local, or territorial
18 public health officials representing departments
19 of public health, who shall represent jurisdic-
20 tions from different regions of the United
21 States with relatively high concentrations of
22 historically marginalized populations, to be ap-
23 pointed by the Secretary;
24 (C) at least 1 Tribal public health official
25 representing departments of public health;

1 (D) 1 or more representatives of a commu-
2 nity-based organization that addresses adverse
3 maternal health outcomes with a specific focus
4 on racial and ethnic inequities in maternal
5 health outcomes, appointed by the Secretary,
6 with special consideration given to organizations
7 led by a person of color or from communities
8 with significant minority populations;
9 (E) 1 or more obstetrician-gynecologist or
10 other physician who provides obstetric care,
11 with special consideration for physicians who
12 are from, or work in, communities experiencing,
13 or that have experienced, the highest rates of
14 COVID–19 mortality and morbidity;
15 (F) 1 or more nurse, such as a certified
16 nurse-midwife, women's health nurse practi-
17 tioner, or other nurse who provides obstetric
18 care, with special consideration for nurses who
19 are from, or work in, communities experiencing,
20 or that have experienced, the highest rates of
21 COVID–19 mortality and morbidity;
22 (G) 1 or more perinatal health workers
23 who provide non-clinical support to people from
24 pregnancy through postpartum period, such as
25 a doula, community health worker, peer sup-

1 porter, lactation consultant, nutritionist or die-
2 titian, social worker, home visitor, or patient
3 navigator;
4 (H) 1 or more patients who were pregnant
5 or gave birth during the COVID–19 public
6 health emergency;
7 (I) 1 or more patients who contracted
8 COVID–19 and later gave birth;
9 (J) 1 or more patients who have received
10 support from a perinatal health worker who
11 provides prenatal and postpartum support, such
12 as a doula, community health worker, peer sup-
13 porter, lactation consultant, nutritionist or die-
14 titian, social worker, home visitor, or a patient
15 navigator, or a spouse or family member of
16 such patient; and
17 (K) racially and ethnically diverse rep-
18 resentation from at least 3 independent experts
19 with knowledge or field experience with racial
20 and ethnic disparities in public health, women's
21 health, or maternal mortality and severe mater-
22 nal morbidity.

1 **SEC. 7. GAO REPORT ON MATERNAL HEALTH AND PUBLIC**
2 **HEALTH EMERGENCY PREPAREDNESS.**

3 Not later than 1 year after the end of the public
4 health emergency declared by the Secretary of Health and
5 Human Services under section 319 of the Public Health
6 Service Act (42 U.S.C. 247d) on January 31, 2020, with
7 respect to COVID–19, the Comptroller General of the
8 United States shall submit to the appropriate committees
9 of Congress a report on maternal health and public health
10 emergency preparedness, including prenatal, labor and de-
11 livery, and postpartum care during the COVID–19 public
12 health emergency, including the following:

13 (1) A review of the prenatal, labor and delivery,
14 and postpartum experiences of people during the
15 COVID–19 public health emergency, which shall—

16 (A) identify barriers to accessing pre-
17 conception, pregnancy, birth, and postpartum
18 care during a pandemic, including maternal be-
19 havioral health care;

20 (B) assess the extent to which public and
21 private insurers were providing coverage for
22 maternal health care during the public health
23 emergency, including for telehealth services and
24 out-of-hospital births;

25 (C) review the impact of the continuous
26 enrollment condition included in the Families

1 First Coronavirus Response Act (Public Law
2 116–127) had on enrollment of postpartum peo-
3 ple in State Medicaid programs and analyze
4 health care services utilized by this population
5 in the postpartum period;

6 (D) to the extent practicable, analyze ma-
7 ternal and infant health outcomes by race and
8 ethnicity (including quality of care, mortality,
9 morbidity, cesarean section rates, preterm birth,
10 prevalence of prenatal and postpartum anxiety
11 and depression, and other mood disorders) dur-
12 ing the COVID–19 public health emergency and
13 the impact of Federal and State policy changes
14 made in response to the COVID–19 pandemic
15 on such outcomes;

16 (E) identify contributors to population-
17 based disparities seen in COVID–19 outcomes,
18 such as racial profiling of, and bias and dis-
19 crimination against, Black, American Indian
20 and Alaska Native, Latinx, and Asian-American
21 and Pacific Islander people;

22 (F) review the impact of increased unem-
23 ployment, paid family leave, changes in health
24 care coverage, and other social determinants of
25 health for pregnant and postpartum people dur-

1 ing the public health emergency, including inti-
2 mate partner violence; and
3 (G) assess the impact of the lack of inclu-
4 sion of pregnant and lactating people in clinical
5 trials for COVID–19 therapeutics and vaccines.
6 (2) Consultation with maternity care providers,
7 maternal behavioral health care specialists, research-
8 ers who specialize in women's health or maternal
9 mortality and severe maternal morbidity, people who
10 experienced pregnancy or childbirth during the
11 COVID–19 public health emergency, representatives
12 from community-based organizations that address
13 maternal health, and perinatal health workers who
14 provide nonclinical support to pregnant and
15 postpartum people (such as a doula, community
16 health worker, peer support, certified lactation con-
17 sultant, nutritionist or dietician, social worker, home
18 visitor, or navigator).
19 (3) Recommendations to improve the public
20 health emergency response and preparedness efforts
21 of the Federal Government specific to maternal
22 health, with a particular focus on outcomes for mi-
23 nority women, including—

1 (A) ways to improve research, surveillance,
2 and data collection of the Federal Government
3 related to maternal health;
4 (B) ways for the Federal Government to
5 factor maternal health outcomes and disparities
6 into decisions regarding distribution of re-
7 sources, including COVID–19 tests, personal
8 protective equipment, and emergency funding;
9 (C) the extent to which guidelines and rec-
10 ommendations of the Federal Government re-
11 lated to maternal health care during the
12 COVID–19 public health emergency were cul-
13 turally congruent and linguistically competent
14 for minority women;
15 (D) ways to improve the distribution of
16 public health funds, data, and information to
17 Indian Tribes and Tribal organizations with re-
18 gard to maternal health during public health
19 emergencies; and
20 (E) opportunities to incentivize or require
21 sponsors to include safety data on pregnant and
22 lactating people for therapeutics and vaccines in
23 emergency use authorization submissions.

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