

116TH CONGRESS
2D SESSION

H. R. 6142

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

MARCH 9, 2020

Ms. UNDERWOOD (for herself, Ms. ADAMS, Ms. SEWELL of Alabama, Ms. NORTON, Ms. SCANLON, Mrs. WATSON COLEMAN, Ms. BARRAGÁN, Ms. OMAR, Mr. RYAN, Ms. MOORE, Mr. CLAY, Mr. KHANNA, Ms. BASS, Ms. BLUNT ROCHESTER, Mr. KENNEDY, Ms. SCHAKOWSKY, Mrs. LURIA, Ms. HAALAND, Ms. PRESSLEY, Mr. LAWSON of Florida, Ms. SHALALA, Ms. SPANBERGER, Ms. SCHRIER, and Mr. MOULTON) 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,*

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Black Maternal Health
3 Momnibus Act of 2020”.

4 SEC. 2. TABLE OF CONTENTS.

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

- Sec. 1. Short title.
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- Sec. 3. Definitions.

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- Sec. 101. Task force to coordinate efforts to address social determinants of health for women in the prenatal and postpartum periods.
- Sec. 102. Requirements for guidance relating to social determinants of health for pregnant women.
- Sec. 103. Department of Housing and Urban Development.
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- Sec. 201. Investments in community-based organizations to improve Black maternal health outcomes.
- Sec. 202. Training for all employees in maternity care settings.
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TITLE III—PROTECTING MOMS WHO SERVED

- Sec. 301. Support for maternity care coordination.
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TITLE IV—PERINATAL WORKFORCE

- Sec. 401. HHS agency directives.
- Sec. 402. Grants to grow and diversify the perinatal workforce.
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- Sec. 404. GAO report on barriers to maternity care.

TITLE V—DATA TO SAVE MOMS

- Sec. 501. Funding for maternal mortality review committees to promote representative community engagement.
- Sec. 502. Data collection and review.
- Sec. 503. Task force on maternal health data and quality measures.
- Sec. 504. Indian Health Service study on maternal mortality.
- Sec. 505. Grants to minority-serving institutions to study maternal mortality, severe maternal morbidity, and other adverse maternal health outcomes.

TITLE VI—MOMS MATTER

- Sec. 601. Innovative models to reduce maternal mortality.

TITLE VII—JUSTICE FOR INCARCERATED MOMS

- Sec. 701. Sense of Congress.
- Sec. 702. Ending the shackling of pregnant individuals.
- Sec. 703. Creating model programs for the care of incarcerated individuals in the prenatal and postpartum periods.
- Sec. 704. Grant program to improve maternal health outcomes for individuals in State and local prisons and jails.
- Sec. 705. GAO report.
- Sec. 706. MACPAC report.

TITLE VIII—TECH TO SAVE MOMS

- Sec. 801. CMI modeling of integrated telehealth models in maternity care services.
- Sec. 802. Grants to expand the use of technology-enabled collaborative learning and capacity models that provide care to pregnant and postpartum women.
- Sec. 803. Grants to promote equity in maternal health outcomes by increasing access to digital tools.
- Sec. 804. Report on the use of technology to reduce maternal mortality and severe maternal morbidity and to close racial and ethnic disparities in outcomes.

TITLE IX—IMPACT TO SAVE MOMS

- Sec. 901. Perinatal Care Alternative Payment Model Demonstration Project.
- Sec. 902. MACPAC report.

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, and prac-

1 tices of the health care consumer and other stake-
2 holders.

3 (2) MATERNAL MORTALITY.—The term “mater-
4 nal mortality” means a death occurring during or
5 within a one-year period after pregnancy caused by
6 pregnancy or childbirth complications.

7 (3) POSTPARTUM.—The term “postpartum”
8 means the one-year period beginning on the last day
9 of a woman’s pregnancy.

10 (4) SEVERE MATERNAL MORBIDITY.—The term
11 “severe maternal morbidity” means an unexpected
12 outcome caused by labor and delivery of a woman
13 that results in significant short-term or long-term
14 consequences to the health of the woman.

15 **TITLE I—SOCIAL**
16 **DETERMINANTS FOR MOMS**

17 **SEC. 101. TASK FORCE TO COORDINATE EFFORTS TO AD-**
18 **DRESS SOCIAL DETERMINANTS OF HEALTH**
19 **FOR WOMEN IN THE PRENATAL AND**
20 **POSTPARTUM PERIODS.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services shall convene a task force (in this section
23 referred to as the “Task Force”) to develop strategies to
24 coordinate efforts across the Federal Government to ad-

1 dress social determinants of health for women in the pre-
2 natal and postpartum periods.

3 (b) MEMBERS.—The members of the Task Force
4 shall consist of the following:

5 (1) The Secretary of Health and Human Serv-
6 ices (or the Secretary’s designee).

7 (2) The Secretary of Housing and Urban Devel-
8 opment (or the Secretary’s designee).

9 (3) The Secretary of Transportation (or the
10 Secretary’s designee).

11 (4) The Secretary of Agriculture (or the Sec-
12 retary’s designee).

13 (5) The Administrator of the Environmental
14 Protection Agency (or the Administrator’s designee).

15 (6) The Assistant Secretary for the Administra-
16 tion for Children and Families (or the Assistant Sec-
17 retary’s designee).

18 (7) The Administrator of the Centers for Medi-
19 care & Medicaid Services (or the Administrator’s
20 designee).

21 (8) The Director of the Indian Health Service
22 (or the Director’s designee).

23 (9) The Director of the National Institutes of
24 Health (or the Director’s designee).

1 (10) The Administrator of the Health Re-
2 sources and Services Administration (or the Admin-
3 istrator’s designee).

4 (11) The Deputy Assistant Secretary for Minor-
5 ity Health of the Department of Health and Human
6 Services (or the Deputy Assistant Secretary’s des-
7 ignee).

8 (12) The Deputy Assistant Secretary for Wom-
9 en’s Health of the Department of Health and
10 Human Services (or the Deputy Assistant Sec-
11 retary’s designee).

12 (13) The Director of the Centers for Disease
13 Control and Prevention (or the Director’s designee).

14 (14) A woman who has experienced severe ma-
15 ternal morbidity or a family member of a woman
16 who has suffered a pregnancy-related death.

17 (15) A leader of a community-based organiza-
18 tion that addresses maternal mortality and severe
19 maternal morbidity with a specific focus on racial
20 and ethnic disparities.

21 (16) A maternal health care provider.

22 (c) CHAIR.—The Secretary of Health and Human
23 Services shall select the Chair of the Task Force from
24 among the members of the Task Force.

1 (d) REPORT.—Not later than 2 years after the date
2 of enactment of this Act, the Task Force shall—

3 (1) finalize strategies to coordinate efforts
4 across the Federal Government to address social de-
5 terminants of health for women in the prenatal and
6 postpartum periods; and

7 (2) submit a report on such strategies to the
8 Congress, including—

9 (A) plans for implementing such strategies;
10 and

11 (B) recommendations on the funding
12 amounts needed by each department and agen-
13 cy to implement such strategies.

14 (e) TERMINATION.—Termination under section 14 of
15 the Federal Advisory Committee Act (5 U.S.C. App.) shall
16 not apply to the Task Force.

17 **SEC. 102. REQUIREMENTS FOR GUIDANCE RELATING TO**
18 **SOCIAL DETERMINANTS OF HEALTH FOR**
19 **PREGNANT WOMEN.**

20 (a) IN GENERAL.—Not later than 1 year after the
21 date of the enactment of this Act, the Secretary of Health
22 and Human Services shall issue guidance with respect to
23 how medicaid managed care organizations and State Med-
24 icaid programs can use payments made pursuant to sec-
25 tion 1903 of the Social Security Act (42 U.S.C. 1396b)

1 to address the following issues related to social deter-
2 minants of health for high-risk mothers during the pre-
3 sumptive eligibility period for pregnant women:

4 (1) Housing.

5 (2) Transportation.

6 (3) Nutrition.

7 (4) Lactation and other infant feeding options
8 support.

9 (5) Lead testing and abatement.

10 (6) Air and water quality.

11 (7) Car seat installation.

12 (8) Child care access.

13 (9) Wellness and stress management programs.

14 (10) Other social determinants of health (as de-
15 termined by the Secretary).

16 (b) DEFINITIONS.—In this section:

17 (1) MEDICAID MANAGED CARE ORGANIZA-
18 TIONS.—The term “medicaid managed care organi-
19 zation” has the meaning given such term in section
20 1903(m)(1)(A) of the Social Security Act (42 U.S.C.
21 1396b(m)(1)(A)).

22 (2) PRESUMPTIVE ELIGIBILITY PERIOD.—The
23 term “presumptive eligibility period” has the mean-
24 ing given such term in section 1920(b)(1) of the So-
25 cial Security Act (42 U.S.C. 1396r-1(b)(1)).

1 **SEC. 103. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT.**
2 **OPMENT.**

3 The Secretary of Housing and Urban Development
4 shall establish a new Housing for Moms task force within
5 the Department that shall be responsible for ensuring that
6 women in the prenatal and postpartum periods have safe,
7 stable, affordable, and adequate housing for themselves
8 and their other children. The task force shall—

9 (1) study how the Department of Housing and
10 Urban Development can support women in the pre-
11 natal and postpartum periods and make rec-
12 ommendations to the Secretary;

13 (2) provide guidance to regional offices of the
14 Department on measures to ensure that local hous-
15 ing infrastructure is supportive to women in the pre-
16 natal and postpartum periods, including providing
17 information on—

18 (A) health-promoting housing codes;

19 (B) enforcement of housing codes;

20 (C) proactive rental inspection programs;

21 (D) code enforcement officer training; and

22 (E) partnerships between regional offices
23 of the Department and community organiza-
24 tions to ensure housing laws are understood
25 and violations are discovered; and

1 (3) not later than 2 years after the date of en-
2 actment of this Act, and annually thereafter, submit
3 to the Congress a report summarizing the activities
4 of the task force.

5 **SEC. 104. DEPARTMENT OF TRANSPORTATION.**

6 (a) REPORT.—Not later than 1 year after the date
7 of enactment of this Act, the Secretary of Transportation
8 shall submit to Congress a report containing—

9 (1) an assessment of transportation barriers
10 preventing individuals from attending prenatal and
11 postpartum appointments, accessing maternal health
12 care services, or accessing services and resources re-
13 lated to social determinants of health that affect ma-
14 ternal health outcomes, such as healthy foods;

15 (2) recommendations on how to overcome such
16 barriers; and

17 (3) an assessment of transportation safety risks
18 for pregnant individuals and recommendations on
19 how to mitigate such risks.

20 (b) CONSIDERATIONS.—In carrying out subsection
21 (a), the Secretary shall give special consideration to solu-
22 tions for—

23 (1) women living in a health professional short-
24 age area designated under section 332 of the Public
25 Health Service Act (42 U.S.C. 254e); and

1 (2) women living in areas with high maternal
2 mortality or severe morbidity rates and significant
3 racial or ethnic disparities in maternal health out-
4 comes.

5 **SEC. 105. DEPARTMENT OF AGRICULTURE.**

6 (a) SPECIAL SUPPLEMENTAL NUTRITION PRO-
7 GRAM.—

8 (1) EXTENSION OF POSTPARTUM PERIOD.—
9 Section 17(b)(10) of the Child Nutrition Act of
10 1966 (42 U.S.C. 1786(b)(10)) is amended by strik-
11 ing “six months” and inserting “24 months”.

12 (2) EXTENSION OF BREASTFEEDING PERIOD.—
13 Section 17(d)(3)(A)(ii) of the Child Nutrition Act of
14 1966 (7 U.S.C. 1431(d)(3)(A)(ii)) is amended by
15 striking “1 year” and inserting “24 months”.

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

21 (A) maternal and infant health outcomes,
22 including racial and ethnic disparities with re-
23 spect to such outcomes;

24 (B) qualitative evaluations of family expe-
25 riences under the special supplemental nutrition

1 program under section 17 of the Child Nutri-
2 tion Act of 1966 (42 U.S.C. 1786); and

3 (C) the cost effectiveness of such special
4 supplemental nutrition program.

5 (b) GRANT PROGRAM FOR HEALTHY FOOD AND
6 CLEAN WATER FOR PREGNANT AND POSTPARTUM
7 WOMEN.—

8 (1) IN GENERAL.—The Secretary shall carry
9 out a grant program to make grants on a competi-
10 tive basis to eligible entities to carry out the nutri-
11 tional activities described in paragraph (4).

12 (2) APPLICATION.—To be eligible to receive a
13 grant under this subsection an eligible entity shall
14 submit to the Secretary an application at such time,
15 in such manner, and containing such information as
16 the Secretary may provide.

17 (3) PRIORITY.—In awarding grants under this
18 subsection, the Secretary shall give priority to an eli-
19 gible entity that proposes in an application under
20 paragraph (2) to use the grant funds to carry out
21 activities in areas with—

22 (A) high maternal mortality or severe ma-
23 ternal morbidity rates; and

24 (B) significant racial or ethnic disparities
25 in maternal health outcomes.

1 (4) USE OF FUNDS.—An eligible entity that re-
2 ceives a grant under this subsection shall use funds
3 under the grant to deliver healthy food, infant for-
4 mula, or clean water to pregnant and postpartum
5 women located in areas that are food deserts, as de-
6 termined by the Secretary using data from the Food
7 Access Research Atlas of the Department of Agri-
8 culture.

9 (5) REPORT.—Not later than 2 years after the
10 date of the enactment of this section, the Secretary
11 shall submit to Congress a report that includes—

12 (A) an evaluation of the effect of the grant
13 program under this subsection on maternal and
14 infant health outcomes, including racial and
15 ethnic disparities with respect to such out-
16 comes; and

17 (B) recommendations with respect to en-
18 suring the activities described in paragraph (4)
19 continue after the grant period funding such ac-
20 tivities expires.

21 (6) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated such sums
23 as may be necessary to carry out this subsection for
24 fiscal years 2021 through 2023.

25 (c) DEFINITIONS.—In this section:

1 (1) ELIGIBLE ENTITY.—The term “eligible enti-
2 ty” includes public entities, private community enti-
3 ties, community-based organizations, Indian tribes
4 and tribal organizations (as such terms are defined
5 in section 4 of the Indian Self-Determination and
6 Education Assistance Act (25 U.S.C. 5304)), and
7 urban Indian organizations (as such term is defined
8 in section 4 of the Indian Health Care Improvement
9 Act (25 U.S.C. 1603)).

10 (2) SECRETARY.—The term “Secretary” means
11 the Secretary of Agriculture.

12 **SEC. 106. ENVIRONMENTAL STUDY THROUGH NATIONAL**
13 **ACADEMIES.**

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

23 (b) STUDY REQUIREMENTS.—The agreement under
24 subsection (a) shall direct the National Academies to make
25 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 a report
8 on the results of the study not later than 24 months after
9 the date of enactment of this Act.

10 **SEC. 107. CHILD CARE ACCESS.**

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

17 (b) ELIGIBLE ORGANIZATIONS.—To be eligible to re-
18 ceive a grant under this section, an organization shall—

19 (1) be an organization that carries out pro-
20 grams providing pregnant and postpartum women
21 with free and accessible drop-in child care services
22 during prenatal and postpartum appointments in
23 areas which the Secretary determines have a high
24 maternal mortality and severe morbidity rate and

1 significant racial and ethnic disparities in maternal
2 health outcomes; and

3 (2) not have previously received a grant under
4 this section.

5 (c) DURATION.—The Secretary shall commence the
6 grant program under subsection (a) not later than 1 year
7 after the date of the enactment of this Act.

8 (d) EVALUATION.—The Secretary shall evaluate each
9 grant awarded under this section to determine the effects
10 of the grant on—

11 (1) prenatal and postpartum appointment at-
12 tendance rates;

13 (2) maternal health outcomes with a specific
14 focus on racial and ethnic disparities in such out-
15 comes;

16 (3) pregnant and postpartum women partici-
17 pating in the funded programs, and the families of
18 such women; and

19 (4) cost effectiveness.

20 (e) REPORT.—Not later than September 30, 2023,
21 the Secretary shall submit to the Congress a report con-
22 taining the following:

23 (1) A summary of the evaluations under sub-
24 section (d).

1 (2) A description of actions the Secretary can
2 take to ensure that pregnant and postpartum women
3 eligible for medical assistance under a State plan
4 under title XIX of the Social Security Act (42
5 U.S.C. 1936 et seq.) have access to free drop-in
6 child care services during prenatal and postpartum
7 appointments, including identification of the funding
8 necessary to carry out such actions.

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

13 (1) delivered at a facility that meets the re-
14 quirements of all applicable laws and regulations of
15 the State or local government in which it is located,
16 including the licensing of the facility as a child care
17 facility; and

18 (2) provided in single encounters without re-
19 quiring full-time enrollment of a person in a child
20 care program.

21 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
22 out this section, there is authorized to be appropriated
23 \$1,000,000 for each of fiscal years 2021 through 2023.

1 **SEC. 108. GRANTS TO STATE, LOCAL, AND TRIBAL PUBLIC**
2 **HEALTH DEPARTMENTS ADDRESSING SOCIAL**
3 **DETERMINANTS OF HEALTH FOR PREGNANT**
4 **AND POSTPARTUM WOMEN.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services (in this section referred to as the “Sec-
7 retary”) shall award grants to State, local, and Tribal
8 public health departments to address social determinants
9 of maternal health in order to reduce or eliminate racial
10 and ethnic disparities in maternal health outcomes.

11 (b) USE OF FUNDS.—A public health department re-
12 ceiving a grant under this section may use funds received
13 through the grant to—

14 (1) build capacity and hire staff to coordinate
15 efforts of the public health department to address
16 social determinants of maternal health;

17 (2) develop, and provide for distribution of, re-
18 source lists of available social services for women in
19 the prenatal and postpartum periods, which social
20 services may include—

21 (A) transportation vouchers;

22 (B) housing supports;

23 (C) child care access;

24 (D) healthy food access;

25 (E) nutrition counseling;

26 (F) lactation supports;

1 (G) lead testing and abatement;

2 (H) clean water;

3 (I) infant formula;

4 (J) maternal mental and behavioral health
5 care services;

6 (K) wellness and stress management pro-
7 grams; and

8 (L) other social services as determined by
9 the public health department;

10 (3) in consultation with local stakeholders, es-
11 tablish or designate a “one-stop” resource center
12 that provides coordinated social services in a single
13 location for women in the prenatal or postpartum
14 period; or

15 (4) directly address specific social determinant
16 needs for the community that are related to mater-
17 nal health as identified by the public health depart-
18 ment, such as—

19 (A) transportation;

20 (B) housing;

21 (C) child care;

22 (D) healthy foods;

23 (E) infant formula;

24 (F) nutrition counseling;

25 (G) lactation supports;

1 (H) lead testing and abatement;

2 (I) air and water quality;

3 (J) wellness and stress management pro-
4 grams; and

5 (K) other social determinants as deter-
6 mined by the public health department.

7 (c) SPECIAL CONSIDERATION.—In awarding grants
8 under subsection (a), the Secretary shall give special con-
9 sideration to State, local, and Tribal public health depart-
10 ments that—

11 (1) propose to use the grants to reduce or end
12 racial and ethnic disparities in maternal mortality
13 and severe morbidity rates; and

14 (2) operate in areas with high rates of—

15 (A) maternal mortality and severe mor-
16 bidity; or

17 (B) significant racial and ethnic disparities
18 in maternal mortality and severe morbidity
19 rates.

20 (d) GUIDANCE ON STRATEGIES.—In carrying out this
21 section, the Secretary shall provide guidance to grantees
22 on strategies for long-term viability of programs funded
23 through this section after such funding ends.

24 (e) REPORTING.—

1 (1) BY GRANTEES.—As a condition on receipt
2 of a grant under this section, a grantee shall agree
3 to—

4 (A) evaluate the activities funded through
5 the grant with respect to—

6 (i) maternal health outcomes with a
7 specific focus on racial and ethnic dispari-
8 ties;

9 (ii) the subjective assessment of such
10 activities by the beneficiaries of such ac-
11 tivities, including mothers and their fami-
12 lies; and

13 (iii) cost effectiveness and return on
14 investment; and

15 (B) not later than 180 days after the end
16 of the period of the grant, submit a report on
17 the results of such evaluation to the Secretary.

18 (2) BY SECRETARY.—Not later than the end of
19 fiscal year 2026, the Secretary shall submit a report
20 to the Congress—

21 (A) summarizing the evaluations submitted
22 under paragraph (1); and

23 (B) making recommendations for improv-
24 ing maternal health and reducing or eliminating
25 racial and ethnic disparities in maternal health

1 outcomes, based on the results of grants under
2 this section.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$15,000,000 for each of fiscal years 2021 through 2025.

6 **TITLE II—HONORING KIRA**
7 **JOHNSON**

8 **SEC. 201. INVESTMENTS IN COMMUNITY-BASED ORGANIZA-**
9 **TIONS TO IMPROVE BLACK MATERNAL**
10 **HEALTH OUTCOMES.**

11 (a) AWARDS.—Following the 1-year period described
12 in subsection (c), the Secretary of Health and Human
13 Services (in this section referred to as the “Secretary”),
14 acting through the Administrator of the Health Resources
15 and Services Administration, shall award grants to eligible
16 entities to establish or expand programs to prevent mater-
17 nal mortality and severe maternal morbidity among Black
18 women.

19 (b) ELIGIBILITY.—To be eligible to seek a grant
20 under this section, an entity shall be a community-based
21 organization offering programs and resources aligned with
22 evidence-based practices for improving maternal health
23 outcomes for Black women.

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

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

6 (2) provide technical assistance to eligible enti-
7 ties on best practices for applying for grants under
8 this section.

9 (d) SPECIAL CONSIDERATION.—

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

13 (A) are based in, and provide support for,
14 communities with—

15 (i) high rates of adverse maternal
16 health outcomes; and

17 (ii) significant racial and ethnic dis-
18 parities in maternal health outcomes;

19 (B) are led by Black women; and

20 (C) offer programs and resources that are
21 aligned with evidence-based practices for im-
22 proving maternal health outcomes for Black
23 women.

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

4 (A) are described in subparagraphs (A),
5 (B), and (C) of paragraph (1);

6 (B) offer programs and resources designed
7 in consultation with and intended for Black
8 women; and

9 (C) offer programs and resources in the
10 communities in which the respective eligible en-
11 tities are located that—

12 (i) promote maternal mental health
13 and maternal substance use disorder treat-
14 ments that are aligned with evidence-based
15 practices for improving maternal mental
16 health outcomes for Black women;

17 (ii) address social determinants of
18 health for women in the prenatal and
19 postpartum periods, including—

20 (I) housing;

21 (II) transportation;

22 (III) nutrition counseling;

23 (IV) healthy foods;

24 (V) lactation support;

- 1 (VI) lead abatement and other
2 efforts to improve air and water qual-
3 ity;
- 4 (VII) child care access;
- 5 (VIII) car seat installation;
- 6 (IX) wellness and stress manage-
7 ment programs; or
- 8 (X) coordination across safety-
9 net and social support services and
10 programs;
- 11 (iii) promote evidence-based health lit-
12 eracy and pregnancy, childbirth, and par-
13 enting education for women in the prenatal
14 and postpartum periods;
- 15 (iv) provide support from doulas and
16 other perinatal health workers to women
17 from pregnancy through the postpartum
18 period;
- 19 (v) provide culturally congruent train-
20 ing to perinatal health workers such as
21 doulas, community health workers, peer
22 supporters, certified lactation consultants,
23 nutritionists and dietitians, social workers,
24 home visitors, and navigators;

1 (vi) conduct or support research on
2 Black maternal health issues; or

3 (vii) have developed other programs
4 and resources that address community-spe-
5 cific needs for women in the prenatal and
6 postpartum periods and are aligned with
7 evidence-based practices for improving ma-
8 ternal health outcomes for Black women.

9 (e) TECHNICAL ASSISTANCE.—The Secretary shall
10 provide to grant recipients under this section technical as-
11 sistance on—

12 (1) capacity building to establish or expand pro-
13 grams to prevent adverse maternal health outcomes
14 among Black women;

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

17 (3) planning for sustaining programs to prevent
18 maternal mortality and severe maternal morbidity
19 among Black women after the period of the grant.

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

23 (1) assesses the effectiveness of outreach efforts
24 during the application process in diversifying the
25 pool of grant recipients;

1 (2) makes recommendations for future outreach
2 efforts to diversify the pool of grant recipients for
3 Department of Health and Human Services grant
4 programs and funding opportunities;

5 (3) assesses the effectiveness of programs fund-
6 ed by grants under this section in improving mater-
7 nal health outcomes for Black women; and

8 (4) makes recommendations for future Depart-
9 ment of Health and Human Services grant programs
10 and funding opportunities that deliver funding to
11 community-based organizations to improve Black
12 maternal health outcomes through programs and re-
13 sources that are aligned with evidence-based prac-
14 tices for improving maternal health outcomes for
15 Black women.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there is authorized to be appropriated
18 \$5,000,000 for each of fiscal years 2021 through 2025.

19 **SEC. 202. TRAINING FOR ALL EMPLOYEES IN MATERNITY**
20 **CARE SETTINGS.**

21 Part B of title VII of the Public Health Service Act
22 (42 U.S.C. 293 et seq.) is amended by adding at the end
23 the following new section:

1 **“SEC. 742. TRAINING FOR ALL EMPLOYEES IN MATERNITY**
2 **CARE SETTINGS.**

3 “(a) GRANTS.—The Secretary shall award grants for
4 programs to reduce and prevent bias, racism, and dis-
5 crimination in maternity care settings.

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

9 “(1) apply to all birthing professionals and any
10 employees who interact with pregnant and postpar-
11 tum women in the provider setting, including front
12 desk employees, sonographers, schedulers, health
13 care professionals, hospital or health system admin-
14 istrators, and security staff;

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

18 “(3) address implicit bias and explicit bias;

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

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

1 “(6) include a service-learning component that
2 sends providers to work in underserved communities
3 to better understand patients’ lived experiences;

4 “(7) be delivered in undergraduate programs
5 that funnel into medical schools, like biology and
6 pre-medicine majors;

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

11 “(9) integrate bias training in obstetric emer-
12 gency simulation trainings;

13 “(10) offer training to all maternity care pro-
14 viders on the value of racially, ethnically, and profes-
15 sionally diverse maternity care teams to provide cul-
16 turally congruent care, including doulas, community
17 health workers, peer supporters, certified lactation
18 consultants, nutritionists and dietitians, social work-
19 ers, home visitors, and navigators; or

20 “(11) be based on one or more programs de-
21 signed by a historically Black college or university.

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

1 “(d) REPORTING.—Each recipient of a grant under
2 this section shall annually submit to the Secretary a report
3 on the status of activities conducted using the grant, in-
4 cluding, as applicable, a description of the impact of train-
5 ing provided through the grant on patient outcomes and
6 patient experience for women of color and their families.

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

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

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

15 “(3) may include in such report findings on
16 best practices for improving patient outcomes and
17 patient experience for women of color and their fam-
18 ilies in maternity care settings.

19 “(f) DEFINITIONS.—In this section:

20 “(1) The term ‘postpartum’ means the one-year
21 period beginning on the last day of a woman’s preg-
22 nancy.

23 “(2) The term ‘culturally congruent’ means in
24 agreement with the preferred cultural values, beliefs,

1 worldview, and practices of the health care consumer
2 and other stakeholders.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there is authorized to be appro-
5 priated \$5,000,000 for each of fiscal years 2021 through
6 2025.”.

7 **SEC. 203. STUDY ON REDUCING AND PREVENTING BIAS,**
8 **RACISM, AND DISCRIMINATION IN MATER-**
9 **NITY CARE SETTINGS.**

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

17 (1) conduct a study on the design and imple-
18 mentation of programs to reduce and prevent bias,
19 racism, and discrimination in maternity care set-
20 tings; and

21 (2) not later than 24 months after the date of
22 enactment of this Act, complete the study and trans-
23 mit a report on the results of the study to the Con-
24 gress.

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

4 (1) The development of a scorecard for pro-
5 grams designed to reduce and prevent bias, racism,
6 and discrimination in maternity care settings to as-
7 sess the effectiveness of such programs in improving
8 patient outcomes and patient experience for women
9 of color and their families.

10 (2) Determination of the types of training to re-
11 duce and prevent bias, racism, and discrimination in
12 maternity care settings that are demonstrated to im-
13 prove patient outcomes or patient experience for
14 women of color and their families.

15 **SEC. 204. RESPECTFUL MATERNITY CARE COMPLIANCE**
16 **PROGRAM.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services (referred to in this section as the “Sec-
19 retary”) shall award grants to accredited hospitals, health
20 systems, and other maternity care delivery settings to es-
21 tablish within one or more hospitals or other birth settings
22 a respectful maternity care compliance office.

23 (b) OFFICE REQUIREMENTS.—A respectful maternity
24 care compliance office funded through a grant under this
25 section shall—

1 (1) institutionalize mechanisms to allow pa-
2 tients receiving maternity care services, the families
3 of such patients, or doulas or other perinatal work-
4 ers supporting such patients to report instances of
5 disrespect or evidence of bias on the basis of race,
6 ethnicity, or another protected class;

7 (2) institutionalize response mechanisms
8 through which representatives of the office can di-
9 rectly follow up with the patient, if possible, and the
10 patient’s family in a timely manner;

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

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

21 (B) the development of methods to rou-
22 tinely assess the extent to which bias, racism,
23 or discrimination on the basis of race, ethnicity,
24 or another protected class are present in the de-

1 livery of maternity care to minority patients;
2 and

3 (4) provide annual reports to the Secretary with
4 information about each case reported to the compli-
5 ance office over the course of the year containing
6 such information as the Secretary may require, such
7 as—

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

11 (B) the content of the report from the pa-
12 tient or the family of the patient to the compli-
13 ance office; and

14 (C) the response from the compliance of-
15 fice.

16 (c) SECRETARY REQUIREMENTS.—

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

20 (A) disseminating best practices for estab-
21 lishing and implementing a respectful maternity
22 care compliance office within a hospital or other
23 birth setting;

24 (B) promoting coordination and collabora-
25 tion between hospitals, health systems, and

1 other maternity care delivery settings on the es-
2 tablishment and implementation of respectful
3 maternity care compliance offices; and

4 (C) evaluating the effectiveness of respect-
5 ful maternity care compliance offices on mater-
6 nal health outcomes and patient and family ex-
7 periences, especially for minority patients and
8 their families.

9 (2) STUDY.—

10 (A) IN GENERAL.—Not later than 2 years
11 after the date of enactment of this Act, the Sec-
12 retary shall, through a contract with an inde-
13 pendent research organization, conduct a study
14 on strategies to address disrespect or bias on
15 the basis of race, ethnicity, or another protected
16 class in the delivery of maternity care services.

17 (B) COMPONENTS OF STUDY.—The study
18 shall include the following:

19 (i) An assessment of the reports sub-
20 mitted to the Secretary from the respectful
21 maternity care compliance offices pursuant
22 to subsection (b)(4); and

23 (ii) Based on such assessment, rec-
24 ommendations for potential accountability
25 mechanisms related to cases of disrespect

1 or bias on the basis of race, ethnicity, or
2 another protected class in the delivery of
3 maternity care services at hospitals and
4 other birth settings. Such recommenda-
5 tions shall take into consideration medical
6 and non-medical factors that contribute to
7 adverse patient experiences and maternal
8 health outcomes.

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

13 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
14 out this section, there is authorized to be appropriated
15 such sums as may be necessary for fiscal years 2021
16 through 2026.

17 **SEC. 205. GAO REPORT.**

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

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

3 (1) Information regarding the extent to which
4 hospitals, health systems, and other maternity care
5 settings have elected to establish respectful mater-
6 nity care compliance offices, including—

7 (A) which hospitals and other birth set-
8 tings elect to establish compliance offices and
9 when such offices are established;

10 (B) to the extent practicable, impacts of
11 the establishment of such offices on maternal
12 health outcomes and patient and family experi-
13 ences in the hospitals and other birth settings
14 that have established such offices, especially for
15 minority women and their families;

16 (C) information on geographic areas, and
17 types of hospitals or other birth settings, where
18 respectful maternity care compliance offices are
19 not being established and information on fac-
20 tors contributing to decisions to not establish
21 such offices; and

22 (D) recommendations for establishing re-
23 spectful maternity care compliance offices in ge-
24 ographic areas, and types of hospitals or other

1 birth settings, where such offices are not being
2 established.

3 (2) Whether the funding made available to
4 carry out this section has been sufficient and, if ap-
5 plicable, recommendations for additional appropria-
6 tions to carry out this section.

7 (3) Such other information as the Comptroller
8 General determines appropriate.

9 **TITLE III—PROTECTING MOMS**
10 **WHO SERVED**

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

12 (a) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to the Secretary of Veterans
14 Affairs \$15,000,000 for fiscal year 2022 to improve ma-
15 ternity care coordination for women veterans throughout
16 pregnancy and the one-year postpartum period beginning
17 on the last day of the pregnancy. Such amounts are au-
18 thorized in addition to any other amounts authorized for
19 such purpose.

20 (b) PLAN.—

21 (1) IN GENERAL.—Not later than one year
22 after the date of the enactment of this Act, the Sec-
23 retary shall submit to the Committees on Veterans'
24 Affairs of the Senate and the House of Representa-
25 tives a plan to improve maternity care coordination

1 to fulfill the responsibilities and requirements de-
2 scribed in the Veterans Health Administration
3 Handbook 1330.03, or any successor handbook.

4 (2) ELEMENTS.—The plan under paragraph (1)
5 shall include the following:

6 (A) With respect to the amounts author-
7 ized to be appropriated by subsection (a), a de-
8 scription of how the Secretary will ensure such
9 amounts are used to—

10 (i) hire full-time maternity care coor-
11 dinators;

12 (ii) train maternity care coordinators;

13 and

14 (iii) improve support programs led by
15 maternity care coordinators.

16 (B) Recommendations for the amount of
17 funding the Secretary determines appropriate to
18 improve maternity care coordination as de-
19 scribed in paragraph (1) for each of the five fis-
20 cal years following the date of the plan.

21 (3) CONSULTATION.—The Secretary shall de-
22 velop the plan under paragraph (1) in consultation
23 with veterans service organizations, military service
24 organizations, women’s health care providers, and
25 community-based organizations representing women

1 from demographic groups disproportionately im-
2 pacted by poor maternal health outcomes, that the
3 Secretary determines appropriate.

4 **SEC. 302. SENSE OF CONGRESS ON VETERAN STATUS RE-**
5 **QUIREMENTS.**

6 It is the sense of Congress that each State should
7 list the veteran status of a mother—

8 (1) in fetal death records; and

9 (2) in maternal mortality review committee re-
10 views of pregnancy-related deaths and pregnancy-as-
11 sociated deaths.

12 **SEC. 303. REPORT ON MATERNAL MORTALITY AND SEVERE**
13 **MATERNAL MORBIDITY AMONG WOMEN VET-**
14 **ERANS.**

15 (a) GAO REPORT.—Not later than two years after
16 the date of the enactment of this Act, the Comptroller
17 General of the United States shall submit to the Commit-
18 tees on Veterans' Affairs of the Senate and the House of
19 Representatives, and make publicly available, a report on
20 maternal mortality and severe maternal morbidity among
21 women veterans, with a particular focus on racial and eth-
22 nic disparities in maternal health outcomes for women vet-
23 erans.

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

1 (1) To the extent practicable—

2 (A) the number of women veterans who
3 have experienced a pregnancy-related death or
4 pregnancy-associated death in the most recent
5 10 years of available data;

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

8 (C) the number of cases of severe maternal
9 morbidity among women veterans in the most
10 recent year of available data;

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

14 (E) identification of the causes of maternal
15 mortality and severe maternal morbidity that
16 are unique to women who have served in the
17 military, including post-traumatic stress dis-
18 order, military sexual trauma, and infertility or
19 miscarriages that may be caused by such serv-
20 ice;

21 (F) identification of the causes of maternal
22 mortality and severe maternal morbidity that
23 are unique to women veterans of color; and

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

4 (2) An assessment of the barriers to deter-
5 mining the information required under paragraph
6 (1) and recommendations for improvements in track-
7 ing maternal health outcomes among—

8 (A) women veterans who have health care
9 coverage through the Department;

10 (B) women veterans enrolled in the
11 TRICARE program;

12 (C) women veterans with employer-based
13 or private insurance; and

14 (D) women veterans enrolled in the Med-
15 icaid program.

16 (3) Recommendations for legislative and admin-
17 istrative actions to increase access to mental and be-
18 havioral health care for women veterans who screen
19 positively for postpartum mental or behavioral
20 health conditions.

21 (4) Recommendations to address homelessness
22 among pregnant and postpartum women veterans.

23 (5) Recommendations on how to effectively edu-
24 cate maternity care providers on best practices for
25 providing maternity care services to women veterans

1 that addresses the unique maternal health care
2 needs of veteran populations.

3 (6) Recommendations to reduce maternal mor-
4 tality and severe maternal morbidity among women
5 veterans and to address racial and ethnic disparities
6 in maternal health outcomes for each of the groups
7 described in subparagraphs (A) through (D) of para-
8 graph (2).

9 (7) Recommendations to improve coordination
10 of care between the Department and non-Depart-
11 ment facilities for pregnant and postpartum women
12 veterans, including recommendations to improve
13 training for the directors of the Veterans Integrated
14 Service Networks, directors of medical facilities of
15 the Department, chiefs of staff of such facilities, ma-
16 ternity care coordinators, and relevant non-Depart-
17 ment facilities.

18 (8) An assessment of the authority of the Sec-
19 retary of Veterans Affairs to access maternal health
20 data collected by the Department of Health and
21 Human Services and, if applicable, recommendations
22 to increase such authority.

23 (9) Any other information the Comptroller Gen-
24 eral determines appropriate with respect to the re-
25 duction of maternal mortality and severe maternal

1 morbidity among women veterans and to address ra-
2 cial and ethnic disparities in maternal health out-
3 comes for women veterans.

4 **TITLE IV—PERINATAL** 5 **WORKFORCE**

6 **SEC. 401. HHS AGENCY DIRECTIVES.**

7 (a) GUIDANCE TO STATES.—

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

15 (2) CONTENTS.—The guidance required by
16 paragraph (1) shall address how States can encour-
17 age and incentivize hospitals, health systems, free-
18 standing birth centers, other maternity care provider
19 groups, and managed care entities—

20 (A) to recruit and retain maternity care
21 providers, such as obstetrician-gynecologists,
22 family physicians, physician assistants, mid-
23 wives who meet at a minimum the international
24 definition of the midwife and global standards
25 for midwifery education as established by the

1 International Confederation of Midwives, nurse
2 practitioners, and clinical nurse specialists—

3 (i) from racially and ethnically diverse
4 backgrounds;

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

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

10 (B) to incorporate into maternity care
11 teams midwives who meet at a minimum the
12 international definition of the midwife and glob-
13 al standards for midwifery education as estab-
14 lished by the International Confederation of
15 Midwives, doulas, community health workers,
16 peer supporters, certified lactation consultants,
17 nutritionists and dietitians, social workers,
18 home visitors, and navigators;

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

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

1 (b) STUDY ON CULTURALLY CONGRUENT MATER-
2 NITY 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 culturally congruent maternity
8 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, freestanding birth
19 centers, other maternity care provider
20 groups, and managed care entities that are
21 delivering culturally congruent maternal
22 health care;

23 (ii) a compendium of examples of hos-
24 pitals, health systems, freestanding birth
25 centers, other maternity care provider

1 groups, and managed care entities that
2 have low levels of racial and ethnic dispari-
3 ties in maternal health outcomes; and

4 (iii) recommendations to hospitals,
5 health systems, freestanding birth centers,
6 other maternity care provider groups, and
7 managed care entities for best practices in
8 culturally congruent maternity care.

9 **SEC. 402. GRANTS TO GROW AND DIVERSIFY THE**
10 **PERINATAL WORKFORCE.**

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

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

15 “(a) IN GENERAL.—The Secretary may award grants
16 to entities to establish or expand programs described in
17 subsection (b) to grow and diversify the perinatal work-
18 force.

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

22 “(1) establishing schools or programs that pro-
23 vide education and training to individuals seeking
24 appropriate licensing or certification as—

1 “(A) physician assistants who will complete
2 clinical training in the field of maternal and
3 perinatal health; and

4 “(B) other perinatal health workers such
5 as doulas, community health workers, peer sup-
6 porters, certified lactation consultants, nutri-
7 tionists and dietitians, social workers, home
8 visitors, and navigators; and

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 insti-
16 tution of higher education that—

17 “(1) has demonstrated a commitment to re-
18 cruiting and retaining minority students, particu-
19 larly from demographic groups experiencing high
20 rates of maternal mortality and severe maternal
21 morbidity;

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 demo-

1 graphic groups experiencing high rates of maternal
2 mortality and severe maternal morbidity;

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; 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 explicit and implicit
15 bias.

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; and

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

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

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

17 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
18 provide, directly or by contract, technical assistance to in-
19 stitutions of higher education seeking or receiving a grant
20 under this section on the development, use, evaluation,
21 and post-grant period sustainability of the perinatal work-
22 force programs or schools proposed to be, or being, estab-
23 lished or expanded through the grant.

24 “(h) REPORT BY SECRETARY.—Not later than 4
25 years after the date of enactment of this section, the Sec-

1 retary shall prepare and submit to the Congress, and post
2 on the internet website of the Department of Health and
3 Human Services, a report on the effectiveness of the grant
4 program under this section at—

5 “(1) recruiting minority students, particularly
6 from demographic groups experiencing high rates of
7 maternal mortality and severe maternal morbidity;

8 “(2) increasing the number of physician assist-
9 ants who will complete clinical training in the field
10 of maternal and perinatal health, and other
11 perinatal health workers, from demographic groups
12 experiencing high rates of maternal mortality and
13 severe maternal morbidity;

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 other
17 perinatal health workers, working in health profes-
18 sional shortage areas designated under section 332;
19 and

20 “(4) increasing the number of physician assist-
21 ants who will complete clinical training in the field
22 of maternal and perinatal health, and other
23 perinatal health workers, working in areas with sig-
24 nificant racial and ethnic disparities in maternal
25 health outcomes.

1 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$15,000,000 for each of fiscal years 2021 through
4 2025.”.

5 **SEC. 403. GRANTS TO GROW AND DIVERSIFY THE NURSING**
6 **WORKFORCE IN MATERNAL AND PERINATAL**
7 **HEALTH.**

8 Title VIII of the Public Health Service Act is amend-
9 ed by inserting after section 811 of that Act (42 U.S.C.
10 296j) the following:

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

12 “(a) IN GENERAL.—The Secretary may award grants
13 to schools of nursing to grow and diversify the perinatal
14 nursing workforce.

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

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

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

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

1 “(1) has developed a strategy to recruit and re-
2 tain a diverse pool of students seeking to enter ca-
3 reers focused on maternal and perinatal health;

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

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

12 “(4) includes in the standard curriculum for all
13 students seeking to enter careers focused on mater-
14 nal and perinatal health a bias, racism, or discrimi-
15 nation training program that includes education on
16 explicit and implicit bias.

17 “(d) REPORTING.—As a condition on receipt of a
18 grant under this section, a school of nursing shall agree
19 to submit to the Secretary an annual report on the activi-
20 ties conducted through the grant, including, to the extent
21 practicable—

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

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

3 “(A) health professional shortage areas
4 designated under section 332; and

5 “(B) areas with significant racial and eth-
6 nic disparities in maternal health outcomes; and

7 “(3) whether the standard curriculum for all
8 students seeking to enter careers focused on mater-
9 nal and perinatal health includes a bias, racism, or
10 discrimination training program that includes edu-
11 cation on explicit and implicit bias.

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

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

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

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

7 “(1) recruiting minority students, particularly
8 from demographic groups experiencing high rates of
9 maternal mortality and severe maternal morbidity;

10 “(2) increasing the number of nurse practi-
11 tioners and clinical nurse specialists entering careers
12 focused on maternal and perinatal health from de-
13 mographic groups experiencing high rates of mater-
14 nal mortality and severe maternal morbidity;

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

20 “(4) increasing the number of nurse practi-
21 tioners and clinical nurse specialists entering careers
22 focused on maternal and perinatal health working in
23 areas with significant racial and ethnic disparities in
24 maternal health outcomes.

1 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$15,000,000 for each of fiscal years 2021 through
4 2025.”.

5 **SEC. 404. GAO REPORT ON BARRIERS TO MATERNITY CARE.**

6 (a) IN GENERAL.—Not later than two years after the
7 date of the enactment of this Act and every five years
8 thereafter, the Comptroller General of the United States
9 shall submit to Congress a report on barriers to maternity
10 care in the United States. Such report shall include the
11 information and recommendations described in subsection
12 (b).

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

15 (1) an assessment of current barriers to enter-
16 ing accredited midwifery education programs, and
17 recommendations for addressing such barriers, par-
18 ticularly for low-income and minority women;

19 (2) an assessment of current barriers to enter-
20 ing accredited education programs for other mater-
21 nity care professional careers, including obstetrician-
22 gynecologists, family physicians, physician assist-
23 ants, nurse practitioners, and clinical nurse special-
24 ists, particularly for low-income and minority
25 women;

1 (3) an assessment of current barriers that pre-
 2 vent midwives from meeting the international defini-
 3 tion of the midwife and global standards for mid-
 4 wifery education as established by the International
 5 Confederation of Midwives, and recommendations
 6 for addressing such barriers, particularly for low-in-
 7 come and minority women; and

8 (4) recommendations to promote greater equity
 9 in compensation for perinatal health workers, par-
 10 ticularly for such individuals from racially and eth-
 11 nically diverse backgrounds.

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 minority
18 women who have suffered pregnancy-
19 related deaths; and

20 “(II) the impact of the use of
21 funds made available pursuant to
22 paragraph (C) on increasing the diver-
23 sity of the maternal mortality review
24 committee membership and promoting

1 community engagement efforts
2 throughout the State or Tribe.

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

13 “(C) AUTHORIZATION OF APPROPRIA-
14 TIONS.—In addition to any funds made avail-
15 able under subsection (f), there are authorized
16 to be appropriated to carry out this paragraph
17 \$10,000,000 for each of fiscal years 2021
18 through 2025.”.

19 (b) RESERVATION OF FUNDS.—Section 317K(f) of
20 the Public Health Service Act (42 U.S.C. 247b–12(f)) is
21 amended by adding at the end the following: “Of the
22 amount made available under the preceding sentence for
23 a fiscal year, not less than \$1,500,000 shall be reserved
24 for grants to Indian tribes, tribal organizations, or urban
25 Indian organizations (as such term is defined in section

1 4 of the Indian Health Care Improvement Act (25 U.S.C.
2 1603))”.

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

4 (a) IN GENERAL.—Section 317K(d)(3)(A)(i) of the
5 Public Health Service Act (42 U.S.C. 247b–
6 12(d)(3)(A)(i)) is amended—

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

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

11 “(II) to the extent practicable,
12 reviewing cases of severe maternal
13 morbidity in which the patient re-
14 ceived a transfusion of four or more
15 units of blood and was admitted to an
16 intensive care unit;

17 “(III) to the extent practicable,
18 consulting with local community-based
19 organizations representing women
20 from demographic groups dispropor-
21 tionately impacted by poor maternal
22 health outcomes to ensure that, in ad-
23 dition to clinical factors, non-clinical
24 factors that might have contributed to

1 a pregnancy-related death are appro-
2 priately considered;”.

3 (b) SEVERE MATERNAL MORBIDITY DEFINED.—Sec-
4 tion 317K(e) of the Public Health Service Act (42 U.S.C.
5 247b–12(e)) is amended—

6 (1) in paragraph (2), by striking “and” at the
7 end;

8 (2) in paragraph (3), by striking the period at
9 the end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(4) the term ‘severe maternal morbidity’
12 means one or more unexpected outcomes of labor
13 and delivery that result in significant short-term or
14 long-term consequences to a woman’s health.”.

15 **SEC. 503. TASK FORCE ON MATERNAL HEALTH DATA AND**
16 **QUALITY MEASURES.**

17 (a) ESTABLISHMENT.—Not later than 180 days after
18 the date of enactment of this Act, the Secretary of Health
19 and Human Services shall establish a task force, to be
20 known as the Task Force on Maternal Health Data and
21 Quality Measures (in this section referred to as the “Task
22 Force”).

23 (b) DUTIES OF TASK FORCE.—

24 (1) IN GENERAL.—The Task Force shall use all
25 available relevant information, including information

1 from State-level sources, to prepare and submit a re-
2 port containing the following:

3 (A) An evaluation of current State and
4 Tribal practices for maternal health, maternal
5 mortality, and severe maternal morbidity data
6 collection and dissemination, including consider-
7 ation of—

8 (i) the timeliness of processes for
9 amending a death certificate when new in-
10 formation pertaining to the death becomes
11 available to reflect whether the death was
12 a pregnancy-related death;

13 (ii) maternal health data collected
14 with electronic health records, including
15 data on race and ethnicity;

16 (iii) the barriers preventing States
17 from correlating maternal outcome data
18 with race and ethnicity data;

19 (iv) processes for determining the
20 cause of a pregnancy-associated death in
21 States that do not have a maternal mor-
22 tality review committee;

23 (v) whether maternal mortality review
24 committees include multidisciplinary and
25 diverse membership (as described in sec-

1 tion 317K(d)(1)(A) of the Public Health
2 Service Act (42 U.S.C. 247b–12(d)(1)(A));

3 (vi) whether members of maternal
4 mortality review committees participate in
5 trainings on bias, racism, or discrimina-
6 tion, and the quality of such trainings;

7 (vii) the extent to which States have
8 implemented systematic processes of listen-
9 ing to the stories of pregnant and postpar-
10 tum women and their family members,
11 with a particular focus on minority women
12 and their family members, to fully under-
13 stand the causes of, and inform potential
14 solutions to, the maternal mortality and se-
15 vere maternal morbidity crisis within their
16 respective States;

17 (viii) the consideration of social deter-
18 minants of health by maternal mortality
19 review committees when examining the
20 causes of pregnancy-associated and preg-
21 nancy-related deaths;

22 (ix) the legal barriers preventing the
23 collation of State maternity care data;

24 (x) the effectiveness of data collection
25 and reporting processes in separating preg-

1 nancy-associated deaths from pregnancy-
2 related deaths; and

3 (xi) the current Federal, State, local,
4 and Tribal funding support for the activi-
5 ties referred to in clauses (i) through (x).

6 (B) An assessment of whether the funding
7 referred to in subparagraph (A)(xi) is adequate
8 for States to carry out optimal data collection
9 and dissemination processes with respect to ma-
10 ternal health, maternal mortality, and severe
11 maternal morbidity.

12 (C) An evaluation of current quality meas-
13 ures for maternity care, including prenatal
14 measures, labor and delivery measures, and
15 postpartum measures up to one year postpar-
16 tum. Such evaluation shall be conducted in con-
17 sultation with the National Quality Forum and
18 shall include consideration of—

19 (i) effective quality measures for ma-
20 ternity care used by hospitals, health sys-
21 tems, birth centers, health plans, and other
22 relevant entities;

23 (ii) the sufficiency of current outcome
24 measures used to evaluate maternity care
25 for testing and validating new maternal

1 health care payment and service delivery
2 models;

3 (iii) quality measures for the child-
4 birth experiences of women that other
5 countries effectively use;

6 (iv) current maternity care quality
7 measures that may be eliminated because
8 they are not achieving their intended ef-
9 fect;

10 (v) barriers preventing maternity care
11 providers from implementing quality meas-
12 ures that are aligned from best practices;

13 (vi) the frequency with which mater-
14 nity care quality measures are reviewed
15 and revised;

16 (vii) the strengths and weaknesses of
17 the Prenatal and Postpartum Care meas-
18 ures of the Health Plan Employer Data
19 and Information Set measures established
20 by the National Committee for Quality As-
21 surance;

22 (viii) the strengths and weaknesses of
23 maternity care quality measures under the
24 Medicaid program under title XIX of the
25 Social Security Act (42 U.S.C. 1396 et

1 seq.) and the Children’s Health Insurance
2 Program under title XXI of such Act (42
3 U.S.C. 1397 et seq.), including the extent
4 to which States voluntarily report relevant
5 measures;

6 (ix) the extent to which maternity
7 care quality measures are informed by pa-
8 tient experiences that include subjective
9 measures of patient-reported experience of
10 care;

11 (x) the current processes for collecting
12 stratified data on the race and ethnicity of
13 pregnant and postpartum women in hos-
14 pitals, health systems, and birth centers,
15 and for incorporating such racially and
16 ethnically stratified data in maternity care
17 quality measures;

18 (xi) the extent to which maternity
19 care quality measures account for the
20 unique experiences of minority women and
21 their families; and

22 (xii) the extent to which hospitals,
23 health systems, and birth centers are im-
24 plementing existing maternity care quality
25 measures.

1 (D) Recommendations on authorizing addi-
2 tional funds to improve maternal mortality re-
3 view committees and relevant maternal health
4 initiatives by the agencies and organizations
5 within the Department of Health and Human
6 Services.

7 (E) Recommendations for new authorities
8 that may be granted to maternal mortality re-
9 view committees to be able to—

10 (i) access records from other Federal
11 and State agencies and departments that
12 may be necessary to identify causes of
13 pregnancy-associated deaths that are
14 unique to women from specific populations,
15 such as women veterans and women who
16 are incarcerated; and

17 (ii) work with relevant experts who
18 are not members of the maternal mortality
19 review committee to assist in the review of
20 pregnancy-associated deaths of women
21 from specific populations, such as women
22 veterans and women who are incarcerated.

23 (F) Recommendations to improve current
24 quality measures for maternity care, including
25 recommendations on updating the Pregnancy &

1 Delivery Care measures on the Hospital Com-
2 pare website of the Centers for Medicare &
3 Medicaid Services or any successor website,
4 with a particular focus on racial and ethnic dis-
5 parities in maternal health outcomes.

6 (G) Recommendations to improve the co-
7 ordination by the Department of Health and
8 Human Services of the efforts undertaken by
9 the agencies and organizations within the De-
10 partment related to maternal health data and
11 quality measures.

12 (2) PUBLIC COMMENT.—Not later than 60 days
13 after the date on which a majority of the members
14 of the Task Force have been appointed, the Task
15 Force shall publish in the Federal Register a notice
16 for public comment period of 90 days, beginning on
17 the date of publication, on the duties and activities
18 of the Task Force.

19 (c) MEMBERSHIP.—

20 (1) IN GENERAL.—The Task Force shall be
21 composed of 18 members appointed by the Secretary
22 of Health and Human Services. The Secretary shall
23 give special consideration to individuals who are rep-
24 resentative of populations most affected by maternal
25 mortality and severe maternal morbidity.

1 (2) MEMBER CRITERIA.—To be eligible to be
2 appointed as a member of the Task Force, an indi-
3 vidual shall be—

4 (A) a woman who has experienced severe
5 maternal morbidity;

6 (B) a family member of a woman who had
7 a pregnancy-related death;

8 (C) an individual who provides non-clinical
9 support to women from pregnancy through the
10 postpartum period, such as a doula, community
11 health worker, peer supporter, certified lacta-
12 tion consultant, nutritionist or dietitian, social
13 worker, home visitor, or a patient navigator;

14 (D) a leader of a community-based organi-
15 zation that addresses adverse maternal health
16 outcomes with a specific focus on racial and
17 ethnic disparities;

18 (E) an academic researcher in a field or
19 policy area related to the duties of the Task
20 Force;

21 (F) a maternal health care provider;

22 (G) an elected or duly appointed leader
23 from an Indian Tribe;

24 (H) an expert in a field or policy area re-
25 lated to the duties of the Task Force; or

1 (I) an individual who has experience with
2 Federal or State government programs related
3 to the duties of the Task Force.

4 (3) APPOINTMENT TIMING.—Appointments to
5 the Task Force shall be made not later than 180
6 days after the date of enactment of this Act.

7 (4) DURATION.—Each member shall be ap-
8 pointed for the life of the Task Force.

9 (5) CO-CHAIR SELECTION.—Not later than 30
10 days after the date on which a majority of the mem-
11 bers of the Task Force have been appointed, the
12 Secretary shall select two of the members of the
13 Task Force to serve as co-chairs of the Task Force.

14 (6) VACANCIES.—

15 (A) IN GENERAL.—A vacancy in the Task
16 Force—

17 (i) shall not affect the powers of the
18 Task Force; and

19 (ii) shall be filled in the same manner
20 as the original appointment.

21 (B) CO-CHAIR VACANCY.—In the event of
22 a vacancy of a co-chair of the Task Force, a re-
23 placement co-chair shall be selected in the same
24 manner as the original selection.

1 (7) COMPENSATION.—Except as provided in
2 paragraph (8), members of the Task Force shall
3 serve without pay.

4 (8) TRAVEL EXPENSES.—Members of the Task
5 Force shall be allowed travel expenses, including per
6 diem in lieu of subsistence, at rates authorized for
7 employees of agencies under subchapter I of chapter
8 57 of title 5, United States Code, while away from
9 their homes or regular places of business in the per-
10 formance of service for the Task Force.

11 (d) MEETINGS.—

12 (1) IN GENERAL.—The Task Force shall meet
13 at the call of the co-chairs of the Task Force.

14 (2) QUORUM.—A majority of the members of
15 the Task Force shall constitute a quorum.

16 (3) INITIAL MEETING.—The Task Force shall
17 meet not later than 60 days after the date on which
18 a majority of the members of the Task Force have
19 been appointed.

20 (e) STAFF OF TASK FORCE.—

21 (1) ADDITIONAL STAFF.—The co-chairs of the
22 Task Force may appoint and fix the pay of addi-
23 tional staff to the Task Force as the co-chairs con-
24 sider appropriate.

1 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
2 LAWS.—The staff of the Task Force may be ap-
3 pointed without regard to the provisions of title 5,
4 United States Code, governing appointments in the
5 competitive service, and may be paid without regard
6 to the provisions of chapter 51 and subchapter III
7 of chapter 53 of that title relating to classification
8 and General Schedule pay rates.

9 (3) DETAILEES.—Any Federal Government em-
10 ployee may be detailed to the Task Force without re-
11 imbursement from the Task Force, and the detailee
12 shall retain the rights, status, and privileges of his
13 or her regular employment without interruption.

14 (f) POWERS OF TASK FORCE.—

15 (1) TESTIMONY AND EVIDENCE.—The Task
16 Force may take such testimony and receive such evi-
17 dence as the Task Force considers advisable to carry
18 out this section.

19 (2) OBTAINING OFFICIAL DATA.—The Task
20 Force may secure directly from any Federal depart-
21 ment or agency information necessary to carry out
22 its duties under this section. On request of the co-
23 chairs of the Task Force, the head of that depart-
24 ment or agency shall furnish such information to the
25 Task Force.

1 (3) **POSTAL SERVICES.**—The Task Force may
2 use the United States mails in the same manner and
3 under the same conditions as other Federal depart-
4 ments and agencies.

5 (g) **REPORT.**—Not later than 2 years after the date
6 on which the initial 18 members of the Task Force are
7 appointed under subsection (c)(1), the Task Force shall
8 submit to the Committee on Energy and Commerce, the
9 Committee on Education and Labor, and the Committee
10 on Ways and Means of the House of Representatives and
11 the Committee on Finance and the Committee on Health,
12 Education, Labor, and Pensions of the Senate, and make
13 publicly available, a report that—

14 (1) contains the information, evaluations, and
15 recommendations described in subsection (b); and

16 (2) is signed by more than half of the members
17 of the Task Force.

18 (h) **TERMINATION.**—Section 14 of the Federal Advi-
19 sory Committee Act (5 U.S.C. App.) shall not apply to
20 the Task Force.

21 (i) **DEFINITIONS.**—In this section:

22 (1) **MATERNAL HEALTH CARE PROVIDER.**—The
23 term “maternal health care provider” means an indi-
24 vidual who is an obstetrician-gynecologist, family
25 physician, midwife who meets at a minimum the

1 international definition of the midwife and global
2 standards for midwifery education as established by
3 the International Confederation of Midwives, nurse
4 practitioner, or clinical nurse specialist.

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

11 (3) PREGNANCY-ASSOCIATED DEATH.—The
12 term “pregnancy-associated death” means a death of
13 a woman, by any cause, that occurs during, or with-
14 in 1 year following, her pregnancy, regardless of the
15 outcome, duration, or site of the pregnancy.

16 (4) PREGNANCY-RELATED DEATH.—The term
17 “pregnancy-related death” means a death of a
18 woman that occurs during, or within 1 year fol-
19 lowing, her pregnancy, regardless of the outcome,
20 duration, or site of the pregnancy—

21 (A) from any cause related to, or aggra-
22 vated by, the pregnancy or its management;
23 and

24 (B) not from accidental or incidental
25 causes.

1 (j) 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 2021
4 through 2024.

5 **SEC. 504. INDIAN HEALTH SERVICE STUDY ON MATERNAL**
6 **MORTALITY.**

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

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

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

23 (b) PARTICIPATING ENTITIES.—The entities de-
24 scribed in this subsection shall consist of 12 members, se-
25 lected by the Director from among individuals nominated

1 by Indian tribes and tribal organizations (as such terms
2 are defined in section 4 of the Indian Self-Determination
3 and Education Assistance Act (25 U.S.C. 5304)), and
4 urban Indian organizations (as such term is defined in
5 section 4 of the Indian Health Care Improvement Act (25
6 U.S.C. 1603)). In selecting such members, the Director
7 shall ensure that each of the 12 service areas of the Indian
8 Health Service is represented.

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

11 (1) examine the causes of maternal mortality
12 and severe maternal morbidity that are unique to
13 American Indian and Alaska Native women;

14 (2) include a systematic process of listening to
15 the stories of American Indian and Alaska Native
16 women to fully understand the causes of, and inform
17 potential solutions to, the maternal mortality and se-
18 vere maternal morbidity crisis within their respective
19 communities;

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

1 (A) facilities operated by the Indian
2 Health Service;

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

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

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

23 (5) review current data collection and quality
24 measurement processes and practices;

1 (6) consider social determinants of health, in-
2 cluding poverty, lack of health insurance, unemploy-
3 ment, sexual violence, and environmental conditions
4 in Tribal areas;

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

9 (8) consider how current funding of the Indian
10 Health Service affects the ability of the Service to
11 deliver quality maternity care;

12 (9) consider the extent to which the delivery of
13 maternity care services is culturally appropriate for
14 American Indian and Alaska Native women;

15 (10) make recommendations to reduce misclas-
16 sification of American Indian and Alaska Native
17 women, including consideration of best practices in
18 training for maternal mortality review committee
19 members to be able to correctly classify American
20 Indian and Alaska Native women; and

21 (11) make recommendations informed by the
22 stories shared by American Indian and Alaska Na-
23 tive women in paragraph (2) to improve maternal
24 health outcomes for such women.

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

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section
10 \$2,000,000 for each of fiscal years 2021 through 2023.

11 **SEC. 505. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
12 **STUDY MATERNAL MORTALITY, SEVERE MA-**
13 **TERNAL MORBIDITY, AND OTHER ADVERSE**
14 **MATERNAL HEALTH OUTCOMES.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall establish a program under which
17 the Secretary shall award grants to research centers and
18 other entities at minority-serving institutions to study spe-
19 cific aspects of the maternal health crisis among minority
20 women. Such research may—

21 (1) include the development and implementation
22 of systematic processes of listening to the stories of
23 minority women to fully understand the causes of,
24 and inform potential solutions to, the maternal mor-

1 tality and severe maternal morbidity crisis within
2 their respective communities; and

3 (2) assess the potential causes of low rates of
4 maternal mortality among Hispanic women, includ-
5 ing potential racial misclassification and other data
6 collection and reporting issues that might be mis-
7 representing maternal mortality rates among His-
8 panic women in the United States.

9 (b) APPLICATION.—To be eligible to receive a grant
10 under subsection (a), an entity described in such sub-
11 section shall submit to the Secretary an application at
12 such time, in such manner, and containing such informa-
13 tion as the Secretary may require.

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

17 (1) to conduct outreach to Minority-Serving In-
18 stitutions to raise awareness of the availability of
19 grants under this subsection (a);

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

22 (3) to promote capacity building as needed to
23 enable entities described in such subsection to sub-
24 mit such an application.

1 (d) REPORTING REQUIREMENT.—Each entity award-
2 ed a grant under this section shall periodically submit to
3 the Secretary a report on the status of activities conducted
4 using the grant.

5 (e) EVALUATION.—Beginning one year after the date
6 on which the first grant is awarded under this section,
7 the Secretary shall submit to Congress an annual report
8 summarizing the findings of research conducted using
9 funds made available under this section.

10 (f) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 \$10,000,000 for each of fiscal years 2021 through 2025.

13 (g) MINORITY-SERVING INSTITUTIONS DEFINED.—
14 In this section, the term “minority-serving institution”
15 has the meaning given the term in section 371(a) of the
16 Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

17 **TITLE VI—MOMS MATTER**

18 **SEC. 601. INNOVATIVE MODELS TO REDUCE MATERNAL** 19 **MORTALITY.**

20 Title III of the Public Health Service Act (42 U.S.C.
21 241 et seq.) is amended by adding at the end the following
22 new part:

1 **“PART W—INNOVATIVE MODELS TO REDUCE MA-**
2 **TERNAL MORTALITY AND SEVERE MATER-**
3 **NAL MORBIDITY**

4 **“SEC. 39900. DEFINITIONS.**

5 “In this part:

6 “(1) The terms ‘postpartum’ and ‘postpartum
7 period’ refer to the 1-year period beginning on the
8 last day of the pregnancy.

9 “(2) The term ‘Secretary’ means the Secretary
10 of Health and Human Services.

11 “(3) The term ‘Task Force’ means the Mater-
12 nal Mental and Behavioral Health Task Force estab-
13 lished pursuant to section 39900–1.

14 “(4) The term ‘behavioral health’ includes sub-
15 stance use disorder and other behavioral health con-
16 ditions.

17 **“SEC. 39900–1. MATERNAL MENTAL AND BEHAVIORAL**
18 **HEALTH TASK FORCE.**

19 “(a) ESTABLISHMENT.—The Secretary shall estab-
20 lish a task force, to be known as the Maternal Mental and
21 Behavioral Health Task Force, to improve maternal men-
22 tal and behavioral health outcomes with a particular focus
23 on outcomes for minority women.

24 “(b) MEMBERSHIP.—

1 “(1) COMPOSITION.—The Task Force shall be
2 composed of no fewer than 20 members, to be ap-
3 pointed by the Secretary.

4 “(2) CO-CHAIRS.—The Secretary shall des-
5 ignate 2 members of the Task Force to serve as the
6 Co-Chairs of the Task Force.

7 “(3) MEMBERS.—The Task Force shall include
8 the following:

9 “(A) Maternal mental and behavioral
10 health care specialists; maternity care providers;
11 and researchers, government officials, and pol-
12 icy experts who specialize in women’s health,
13 maternal mental and behavioral health, mater-
14 nal substance use disorder, or maternal mor-
15 tality and severe maternal morbidity. In select-
16 ing such members of the Task Force, the Sec-
17 retary shall give special consideration to individ-
18 uals from diverse racial and ethnic backgrounds
19 or individuals with experience providing cul-
20 turally congruent maternity care in diverse
21 communities.

22 “(B) One or more patients who have suf-
23 fered from a diagnosed mental or behavioral
24 health condition during the prenatal or

1 postpartum period, or a spouse or family mem-
2 ber of such patient.

3 “(C) One or more representatives of a
4 community-based organization that addresses
5 adverse maternal health outcomes with a spe-
6 cific focus on racial and ethnic disparities in
7 maternal health outcomes. In selecting such
8 representatives, the Secretary shall give special
9 consideration to organizations from commu-
10 nities with significant minority populations.

11 “(D) One or more perinatal health workers
12 who provide non-clinical support to pregnant
13 and postpartum women, such as a doula, com-
14 munity health worker, peer supporter, certified
15 lactation consultant, nutritionist or dietitian,
16 social worker, home visitor, or navigator. In se-
17 lecting such perinatal health workers, the Sec-
18 retary shall give special consideration to individ-
19 uals with experience working in communities
20 with significant minority populations.

21 “(E) One or more representatives of rel-
22 evant patient advocacy organizations, with a
23 particular focus on organizations that address
24 racial and ethnic disparities in maternal health
25 outcomes.

1 “(F) One or more representatives of rel-
2 evant health care provider organizations, with a
3 particular focus on organizations that address
4 racial and ethnic disparities in maternal health
5 outcomes.

6 “(G) One or more leaders of a Federally-
7 qualified health center or rural health clinic (as
8 such terms are defined in section 1861 of the
9 Social Security Act).

10 “(H) One or more representatives of health
11 insurers.

12 “(4) TIMING OF APPOINTMENTS.—Not later
13 than 180 days after the date of enactment of this
14 part, the Secretary shall appoint all members of the
15 Task Force.

16 “(5) PERIOD OF APPOINTMENT; VACANCIES.—

17 “(A) IN GENERAL.—Each member of the
18 Task Force shall be appointed for the life of the
19 Task Force.

20 “(B) VACANCIES.—Any vacancy in the
21 Task Force—

22 “(i) shall not affect the powers of the
23 Task Force; and

24 “(ii) shall be filled in the same man-
25 ner as the original appointment.

1 “(6) NO PAY.—Members of the Task Force
2 (other than officers or employees of the United
3 States) shall serve without pay. Members of the
4 Task Force who are full-time officers or employees
5 of the United States may not receive additional pay,
6 allowances, or benefits by reason of their service on
7 the Task Force.

8 “(7) TRAVEL EXPENSES.—Members of the
9 Task Force may be allowed travel expenses, includ-
10 ing per diem in lieu of subsistence, at rates author-
11 ized for employees of agencies under subchapter I of
12 chapter 57 of title 5, United States Code, while
13 away from their homes or regular places of business
14 in the performance of services for the Task Force.

15 “(c) STAFF.—The Co-Chairs of the Task Force may
16 appoint and fix the pay of staff to the Task Force.

17 “(d) DETAILEES.—Any Federal Government em-
18 ployee may be detailed to the Task Force without reim-
19 bursement from the Task Force, and the detailee shall re-
20 tain the rights, status, and privileges of his or her regular
21 employment without interruption.

22 “(e) MEETINGS.—

23 “(1) IN GENERAL.—Subject to paragraph (2),
24 the Task Force shall meet at the call of the Co-
25 Chairs of the Task Force.

1 “(2) INITIAL MEETING.—The Task Force shall
2 meet not later than 30 days after the date on which
3 all members of the Task Force have been appointed.

4 “(3) QUORUM.—A majority of the members of
5 the Task Force shall constitute a quorum.

6 “(f) INFORMATION FROM FEDERAL AGENCIES.—

7 “(1) IN GENERAL.—The Task Force may se-
8 cure directly from any Federal department or agency
9 such information as may be relevant to carrying out
10 this part.

11 “(2) FURNISHING INFORMATION.—On request
12 of the Co-Chairs of the Task Force pursuant to
13 paragraph (1), the head of a Federal department or
14 agency shall, not later than 60 days after the date
15 of receiving such request, furnish to the Task Force
16 the information so requested.

17 “(g) TERMINATION.—Termination under section 14
18 of the Federal Advisory Committee Act (5 U.S.C. App.)
19 shall not apply to the Task Force.

20 “(h) DUTIES.—

21 “(1) NATIONAL STRATEGY.—The Task Force
22 shall make recommendations for a national strategy
23 to improve maternal mental and behavioral health
24 outcomes with a particular focus on outcomes for
25 minority women. Such strategy shall—

1 “(A) define collaborative maternity care;

2 “(B) make recommendations to the Sec-
3 retary and the Assistant Secretary for Mental
4 Health and Substance Use on how to imple-
5 ment collaborative maternity care models to im-
6 prove maternal mental and behavioral health
7 with a particular focus on such outcomes for
8 minority women;

9 “(C) identify barriers to the implementa-
10 tion of collaborative maternity care models to
11 improve maternal mental and behavioral health
12 with a particular focus on such outcomes for
13 minority women, and make recommendations to
14 address such barriers;

15 “(D) take into consideration as models ex-
16 isting State and other programs that have dem-
17 onstrated effectiveness in improving maternal
18 mental and behavioral health during the pre-
19 natal and postpartum periods;

20 “(E) promote treatment options and re-
21 duce stigma for pregnant and postpartum
22 women with a substance use disorder;

23 “(F) assess the extent to which insurers
24 are providing coverage for evidence-based men-
25 tal and behavioral health screenings and serv-

1 ices that adhere to existing prenatal and
2 postpartum guidelines;

3 “(G) assess the extent to which existing
4 guidelines and processes are culturally con-
5 gruent for minority women, specifically—

6 “(i) guidelines for identifying mater-
7 nal mental and behavioral health condi-
8 tions, including substance use disorders;

9 “(ii) guidelines for screening and, as
10 needed, follow-up referrals, evaluations,
11 and treatments after positive screens for—

12 “(I) depression;

13 “(II) anxiety;

14 “(III) trauma;

15 “(IV) substance use disorders;

16 and

17 “(V) other mental or behavioral
18 health conditions at the discretion of
19 the Task Force;

20 “(iii) processes for incorporating men-
21 tal and behavioral health screenings into
22 the current timeline of standard screening
23 practices for pregnant and postpartum
24 women, with distinctions for postpartum

1 screening timelines for uncomplicated and
2 complicated births; and

3 “(iv) processes for referring women
4 with positive screens for substance use dis-
5 order to addiction treatment centers offer-
6 ing—

7 “(I) on-site wraparound treat-
8 ment or networks for referrals;

9 “(II) multidisciplinary staff;

10 “(III) psychotherapy;

11 “(IV) contingency management;

12 “(V) access to all evidence-based
13 medication-assisted treatment; and

14 “(VI) evidence-based recovery
15 supports;

16 “(H) propose to the Secretary a multi-
17 lingual public awareness campaign for maternal
18 mental health and substance use disorder, with
19 a particular focus on minority women, that in-
20 cludes information on—

21 “(i) symptoms, triggers, risk factors,
22 and treatment options for maternal mental
23 and behavioral health conditions;

24 “(ii) using the website developed
25 under paragraph (3);

1 “(iii) the physiological process of re-
2 covery after birth;

3 “(iv) the frequency of occurrences for
4 common conditions such as postpartum
5 hemorrhage, preeclampsia and eclampsia,
6 infection, and thromboembolism;

7 “(v) best practices in patient report-
8 ing of health concerns to their maternity
9 care providers in the prenatal and postpar-
10 tum periods;

11 “(vi) addressing stigma around mater-
12 nal mental and behavioral health condi-
13 tions;

14 “(vii) how to seek treatment for sub-
15 stance use disorder during pregnancy and
16 in the postpartum period; and

17 “(viii) infant feeding options; and

18 “(I) disseminate to all State Medicaid pro-
19 grams under title XIX of the Social Security
20 Act and State child health plans under title
21 XXI of the Social Security Act an assessment
22 of the extent to which States are providing cov-
23 erage of evidence-based prenatal and
24 postpartum mental and behavioral health
25 screenings through such programs and plans,

1 and an assessment of the benefits of such cov-
2 erage.

3 “(2) GRANT PROGRAMS.—The Task Force shall
4 evaluate and advise on the grant programs under
5 section 39900–2.

6 “(3) CENTRALIZED WEBSITE.—The Task Force
7 shall facilitate a coordinated effort between the Sub-
8 stance Abuse and Mental Health Services Adminis-
9 tration and State departments of health to develop,
10 either directly or through a contract, a centralized
11 website with information on finding local mental and
12 behavioral health providers who treat prenatal and
13 postpartum mental and behavioral health conditions,
14 including substance use disorder.

15 “(4) REPORT.—Not later than 18 months after
16 the date of enactment of the Black Maternal Health
17 Momnibus Act of 2020, and every year thereafter,
18 the Task Force shall submit to the Congress, the
19 Centers for Medicare & Medicaid Services, and the
20 Center for Medicare and Medicaid Innovation, and
21 make publicly available, a report that—

22 “(A) describes the activities of the Task
23 Force and the results of such activities, with
24 data in such results stratified racially, eth-
25 nically, and geographically; and

1 “(B) includes the strategy developed under
2 paragraph (1).

3 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there are authorized to be appro-
5 priated such sums as may be necessary for fiscal years
6 2021 through 2025.

7 **“SEC. 39900-2. INNOVATION IN MATERNITY CARE TO**
8 **CLOSE RACIAL AND ETHNIC MATERNAL**
9 **HEALTH DISPARITIES GRANTS.**

10 “(a) IN GENERAL.—The Secretary shall award
11 grants to eligible entities to establish, implement, evaluate,
12 or expand innovative models in maternity care that are
13 designed to reduce racial and ethnic disparities in mater-
14 nal health outcomes.

15 “(b) USE OF FUNDS.—An eligible entity receiving a
16 grant under this section may use the grant to establish,
17 implement, evaluate, or expand innovative models de-
18 scribed in subsection (a) including—

19 “(1) collaborative maternity care models to im-
20 prove maternal mental health, treat maternal sub-
21 stance use disorders, and reduce maternal mortality
22 and severe maternal morbidity, especially for minor-
23 ity women, consistent with the national strategy de-
24 veloped by the Task Force under section 39900—

1 1(h)(1) and other recommendations of the Task
2 Force;

3 “(2) evidence-based programming at clinics
4 that—

5 “(A) provide wraparound services for
6 women with substance use disorders in the pre-
7 natal and postpartum periods that may include
8 multidisciplinary staff, access to all evidence-
9 based medication-assisted treatment, psycho-
10 therapy, contingency management, and recovery
11 supports; or

12 “(B) make referrals for any such services
13 that are not provided within the clinic;

14 “(3) evidence-based programs at freestanding
15 birth centers that provide culturally congruent ma-
16 ternal mental and behavioral health care education,
17 treatments, and services, and other wraparound sup-
18 ports for women throughout the prenatal and
19 postpartum period; and

20 “(4) the development and implementation of
21 evidence-based programs, including toll-free tele-
22 phone hotlines, that connect maternity care pro-
23 viders with women’s mental health clinicians to pro-
24 vide maternity care providers with guidance on ad-

1 dressing maternal mental and behavioral health con-
2 ditions identified in patients.

3 “(c) SPECIAL CONSIDERATION.—In awarding grants
4 under this section, the Secretary shall give special consid-
5 eration to applications for models that will—

6 “(1) operate in—

7 “(A) areas with high rates of adverse ma-
8 ternal health outcomes;

9 “(B) areas with significant racial and eth-
10 nic disparities in maternal health outcomes; or

11 “(C) health professional shortage areas
12 designated under section 332;

13 “(2) be led by minority women from demo-
14 graphic groups with disproportionate rates of ad-
15 verse maternal health outcomes; or

16 “(3) be implemented with a culturally con-
17 gruent approach that is focused on improving out-
18 comes for demographic groups experiencing dis-
19 proportionate rates of adverse maternal health out-
20 comes.

21 “(d) EVALUATION.—As a condition on receipt of a
22 grant under this section, an eligible entity shall agree to
23 provide annual evaluations of the activities funded through
24 the grant to the Secretary and the Task Force. Such eval-
25 uations may address—

1 “(1) the effects of such activities on maternal
2 health outcomes and subjective assessments of pa-
3 tient and family experiences, especially for minority
4 women from demographic groups with dispropor-
5 tionate rates of adverse maternal health outcomes;
6 and

7 “(2) the cost-effectiveness of such activities.

8 “(e) DEFINITIONS.—In this section:

9 “(1) The term ‘eligible entity’ means any public
10 or private entity.

11 “(2) The term ‘collaborative maternity care’
12 means an integrated care model that includes the
13 delivery of maternal mental and behavioral health
14 care services in primary clinics or other care settings
15 familiar to pregnant and postpartum patients.

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

20 “(4) The term ‘freestanding birth center’ has
21 the meaning given that term under section
22 1905(l)(3)(A) of the Social Security Act.

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

1 priated \$15,000,000 for each of fiscal years 2021 through
2 2025.

3 **“SEC. 39900–3. GROUP PRENATAL AND POSTPARTUM CARE**
4 **MODELS.**

5 “(a) IN GENERAL.—The Secretary shall award
6 grants to eligible entities to establish, implement, evaluate,
7 or expand culturally congruent group prenatal care models
8 or group postpartum care models that are designed to re-
9 duce racial and ethnic disparities in maternal and infant
10 health outcomes.

11 “(b) USE OF FUNDS.—An eligible entity receiving a
12 grant under this section may use the grant for—

13 “(1) programming;

14 “(2) capital investments required to improve ex-
15 isting physical infrastructure for group prenatal care
16 and group postpartum care programming, such as
17 building space needed to implement such models;
18 and

19 “(3) evaluations of group prenatal care and
20 group postpartum care programming, with a par-
21 ticular focus on the impacts of such programming on
22 minority women.

23 “(c) SPECIAL CONSIDERATION.—In awarding grants
24 under this section, the Secretary shall give special consid-
25 eration to applicants that will—

1 “(1) operate in—

2 “(A) areas with high rates of adverse ma-
3 ternal health outcomes;

4 “(B) areas with significant racial and eth-
5 nic disparities in maternal health outcomes; or

6 “(C) health professional shortage areas
7 designated under section 332;

8 “(2) be led by minority women from demo-
9 graphic groups with disproportionate rates of ad-
10 verse maternal health outcomes; or

11 “(3) be implemented with a culturally con-
12 gruent approach that is focused on improving out-
13 comes for demographic groups experiencing dis-
14 proportionate rates of adverse maternal health out-
15 comes.

16 “(d) EVALUATION.—As a condition on receipt of a
17 grant under this section, an eligible entity shall agree to
18 provide annual evaluations of the activities funded through
19 the grant to the Secretary and the Task Force and ad-
20 dress in each such evaluation—

21 “(1) the effects of such activities on maternal
22 health outcomes with a particular focus on the ef-
23 fects of such activities on minority women, including
24 measures such as—

25 “(A) avoidable emergency room visits;

1 “(B) postpartum care visits after delivery;

2 “(C) rates of preterm birth;

3 “(D) rates of breastfeeding initiation;

4 “(E) psychological outcomes; and

5 “(F) subjective measures of patient-re-
6 ported experience of care; and

7 “(2) the cost-effectiveness of such activities.

8 “(e) DEFINITIONS.—In this section:

9 “(1) The term ‘eligible entity’ means any public
10 or private entity.

11 “(2) The term ‘culturally congruent’ means
12 care that is in agreement with the preferred cultural
13 values, beliefs, worldview, language, and practices of
14 the health care consumer and other stakeholders.

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there is authorized to be appro-
17 priated \$10,000,000 for each of fiscal years 2021 through
18 2025.”.

19 **TITLE VII—JUSTICE FOR** 20 **INCARCERATED MOMS**

21 **SEC. 701. SENSE OF CONGRESS.**

22 It is the sense of Congress that the respect and prop-
23 er care that mothers deserve is inclusive, and whether the
24 mothers are transgender, cisgender, or gender noncon-
25 forming, all deserve dignity.

1 **SEC. 702. ENDING THE SHACKLING OF PREGNANT INDIVID-**
2 **UALS.**

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

18 (b) **REALLOCATION.**—Amounts not allocated to a
19 State for failure to comply with subsection (a) shall be
20 reallocated in accordance with subpart 1 of part E of title
21 I of the Omnibus Crime Control and Safe Streets Act of
22 1968 (34 U.S.C. 10151 et seq.) to States that have com-
23 plied with such subsection.

1 **SEC. 703. CREATING MODEL PROGRAMS FOR THE CARE OF**
2 **INCARCERATED INDIVIDUALS IN THE PRE-**
3 **NATAL AND POSTPARTUM PERIODS.**

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

12 (1) relevant community-based organizations,
13 particularly organizations that represent incarcer-
14 ated and formerly incarcerated individuals and orga-
15 nizations that seek to improve maternal health out-
16 comes for minority women;

17 (2) relevant organizations representing patients,
18 with a particular focus on minority patients;

19 (3) relevant organizations representing mater-
20 nal health care providers;

21 (4) nonclinical perinatal health workers such as
22 doulas, community health workers, peer supporters,
23 certified lactation consultants, nutritionists and di-
24 etitians, social workers, home visitors, and naviga-
25 tors; and

1 (5) researchers and policy experts in fields re-
2 lated to women’s health care for incarcerated indi-
3 viduals.

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

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

9 (1) the number of pregnant and postpartum in-
10 dividuals incarcerated in such facility and, among
11 such individuals, the number of pregnant and post-
12 partum minority individuals; and

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

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

19 (e) **PROGRAMS.**—Bureau of Prisons facilities selected
20 by the Director shall establish programs for pregnant and
21 postpartum incarcerated individuals, and such programs
22 may—

23 (1) provide access to doulas and other perinatal
24 health workers from pregnancy through the
25 postpartum period;

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

4 (3) train correctional officers and medical per-
5 sonnel to ensure that pregnant incarcerated individ-
6 uals receive trauma-informed, culturally congruent
7 care that promotes the health and safety of the
8 pregnant individuals;

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

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

14 (B) domestic violence;

15 (C) human immunodeficiency virus;

16 (D) sexual abuse;

17 (E) pregnancy or infant loss; or

18 (F) chronic conditions, including heart dis-
19 ease, diabetes, osteoporosis and osteopenia, hy-
20 pertension, asthma, liver disease, and bleeding
21 disorders;

22 (5) provide pregnancy and childbirth education,
23 parenting support, and other relevant forms of
24 health literacy;

1 (6) 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 (7) provide reentry assistance, particularly to—

7 (A) ensure continuity of health insurance
8 coverage if an incarcerated individual exits the
9 criminal justice system during such individual's
10 pregnancy or in the postpartum period; and

11 (B) connect individuals exiting the criminal
12 justice system during pregnancy or in the
13 postpartum period to community-based re-
14 sources, such as referrals to health care pro-
15 viders and social services that address social de-
16 terminants of health like housing, employment
17 opportunities, transportation, and nutrition; or

18 (8) establish partnerships with local public enti-
19 ties, private community entities, community-based
20 organizations, Indian Tribes and tribal organizations
21 (as such terms are defined in section 4 of the Indian
22 Self-Determination and Education Assistance Act
23 (25 U.S.C. 5304)), and urban Indian organizations
24 (as such term is defined in section 4 of the Indian
25 Health Care Improvement Act (25 U.S.C. 1603)) to

1 establish or expand pretrial diversion programs as
2 an alternative to incarceration for pregnant and
3 postpartum individuals. Such programs may in-
4 clude—

5 (A) parenting classes;

6 (B) prenatal health coordination;

7 (C) family and individual counseling;

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

12 (E) family case management services;

13 (F) domestic violence education and pre-
14 vention;

15 (G) physical and sexual abuse counseling;

16 and

17 (H) programs to address social deter-
18 minants of health such as employment, housing,
19 education, transportation, and nutrition.

20 (f) IMPLEMENTATION AND REPORTING.—A selected
21 facility shall be responsible for—

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

24 (2) not later than 3 years after the date of en-
25 actment of this Act, and not 6 years after the date

1 of enactment of this Act, reporting results of the
2 programs to the Director, including information de-
3 scribing—

4 (A) relevant quantitative indicators of suc-
5 cess in improving the standard of care and
6 health outcomes for pregnant and postpartum
7 incarcerated individuals who participated in
8 such programs, including data stratified by
9 race, ethnicity, sex, age, geography, disability
10 status, the category of the criminal charge
11 against such individual, rates of pregnancy-re-
12 lated deaths, pregnancy-associated deaths, cases
13 of infant mortality, cases of severe maternal
14 morbidity, cases of violence against pregnant or
15 postpartum individuals, diagnoses of maternal
16 mental or behavioral health conditions, and
17 other such information as appropriate;

18 (B) relevant qualitative evaluations from
19 pregnant and postpartum incarcerated individ-
20 uals who participated in such programs, includ-
21 ing subjective measures of patient-reported ex-
22 perience of care;

23 (C) evaluations of cost effectiveness; and

24 (D) strategies to sustain such programs
25 beyond 2026.

1 (g) REPORT.—Not later than 7 years after the date
2 of enactment of this Act, the Director shall submit to the
3 Attorney General and to the Committee on the Judiciary
4 of the House of Representatives and the Senate a report
5 describing the results of the programs funded under this
6 section.

7 (h) OVERSIGHT.—Not later than 1 year after the
8 date of enactment of this Act, the Attorney General shall
9 award a contract to an independent organization or inde-
10 pendent organizations to conduct oversight of the pro-
11 grams described in subsection (e).

12 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to carry out this section
14 \$10,000,000 for each of fiscal years 2021 through 2025.

15 **SEC. 704. GRANT PROGRAM TO IMPROVE MATERNAL**
16 **HEALTH OUTCOMES FOR INDIVIDUALS IN**
17 **STATE AND LOCAL PRISONS AND JAILS.**

18 (a) ESTABLISHMENT.—Not later than 1 year after
19 the date of enactment of this Act, the Attorney General,
20 acting through the Director of the Bureau of Justice As-
21 sistance, shall award Justice for Incarcerated Moms
22 grants to States to establish or expand programs in State
23 and local prisons and jails for pregnant and postpartum
24 incarcerated individuals. The Attorney General shall

1 award such grants in consultation with stakeholders such
2 as—

3 (1) relevant community-based organizations,
4 particularly organizations that represent incarcerated
5 ated and formerly incarcerated individuals and orga-
6 nizations that seek to improve maternal health out-
7 comes for minority women;

8 (2) relevant organizations representing patients,
9 with a particular focus on minority patients;

10 (3) relevant organizations representing mater-
11 nal health care providers;

12 (4) nonclinical perinatal health workers such as
13 doulas, community health workers, peer supporters,
14 certified lactation consultants, nutritionists and di-
15 etitians, social workers, home visitors, and naviga-
16 tors; and

17 (5) researchers and policy experts in fields re-
18 lated to women’s health care for incarcerated indi-
19 viduals.

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

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

5 (1) provide access to doulas and other perinatal
6 health workers from pregnancy through the postpar-
7 tum period;

8 (2) provide access to healthy foods and coun-
9 seling on nutrition, recommended activity levels, and
10 safety measures throughout pregnancy;

11 (3) train correctional officers and medical per-
12 sonnel to ensure that pregnant incarcerated individ-
13 uals receive trauma-informed, culturally congruent
14 care that promotes the health and safety of the
15 pregnant individuals;

16 (4) provide counseling and treatment for indi-
17 viduals who have suffered from—

18 (A) diagnosed mental or behavioral health
19 conditions, including trauma and substance use
20 disorders;

21 (B) domestic violence;

22 (C) human immunodeficiency virus;

23 (D) sexual abuse;

24 (E) pregnancy or infant loss; or

1 (F) chronic conditions, including heart dis-
2 ease, diabetes, osteoporosis and osteopenia, hy-
3 pertension, asthma, liver disease, and bleeding
4 disorders;

5 (5) provide pregnancy and childbirth education,
6 parenting support, and other relevant forms of
7 health literacy;

8 (6) offer opportunities for postpartum individ-
9 uals to maintain contact with the individual's new-
10 born child to promote bonding, including enhanced
11 visitation policies, access to prison nursery pro-
12 grams, or breastfeeding support;

13 (7) provide reentry assistance, particularly to—

14 (A) ensure continuity of health insurance
15 coverage if an incarcerated individual exits the
16 criminal justice system during such individual's
17 pregnancy or in the postpartum period; and

18 (B) connect individuals exiting the criminal
19 justice system during pregnancy or in the
20 postpartum period to community-based re-
21 sources, such as referrals to health care pro-
22 viders and social services that address social de-
23 terminants of health like housing, employment
24 opportunities, transportation, and nutrition; or

1 (8) establish partnerships with local public enti-
2 ties, private community entities, community-based
3 organizations, Indian Tribes and tribal organizations
4 (as such terms are defined in section 4 of the Indian
5 Self-Determination and Education Assistance Act
6 (25 U.S.C. 5304)), and urban Indian organizations
7 (as such term is defined in section 4 of the Indian
8 Health Care Improvement Act (25 U.S.C. 1603)) to
9 establish or expand pretrial diversion programs as
10 an alternative to incarceration for pregnant and
11 postpartum individuals. Such programs may in-
12 clude—

13 (A) parenting classes;

14 (B) prenatal health coordination;

15 (C) family and individual counseling;

16 (D) evidence-based screenings, education,
17 and, as needed, treatment for mental and be-
18 havioral health conditions, including drug and
19 alcohol treatments;

20 (E) family case management services;

21 (F) domestic violence education and pre-
22 vention;

23 (G) physical and sexual abuse counseling;

24 and

1 (H) programs to address social deter-
2 minants of health such as employment, housing,
3 education, transportation, and nutrition.

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

7 (1) the number of pregnant and postpartum in-
8 dividuals incarcerated in the State and, among such
9 individuals, the number of pregnant and postpartum
10 minority individuals; and

11 (2) the extent to which the State has dem-
12 onstrated a commitment to developing exemplary
13 programs for pregnant and postpartum individuals
14 incarcerated in the prisons and jails in the State.

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

17 (f) IMPLEMENTING AND REPORTING.—A State that
18 receives a grant under this section shall be responsible
19 for—

20 (1) implementing the program funded by the
21 grant; and

22 (2) not later than 3 years after the date of en-
23 actment of this Act, and 6 years after the date of
24 enactment of this Act, reporting results of such pro-

1 gram to the Attorney General, including information
2 describing—

3 (A) relevant quantitative indicators of the
4 program's success in improving the standard of
5 care and health outcomes for pregnant and
6 postpartum incarcerated individuals who par-
7 ticipated in such program, including data strati-
8 fied by race, ethnicity, sex, age, geography, dis-
9 ability status, category of the criminal charge
10 against such individual, incidence rates of preg-
11 nancy-related deaths, pregnancy-associated
12 deaths, cases of infant mortality, cases of severe
13 maternal morbidity, cases of violence against
14 pregnant or postpartum individuals, diagnoses
15 of maternal mental or behavioral health condi-
16 tions, and other such information as appro-
17 priate;

18 (B) relevant qualitative evaluations from
19 pregnant and postpartum incarcerated individ-
20 uals who participated in such programs, includ-
21 ing subjective measures of patient-reported ex-
22 perience of care;

23 (C) evaluations of cost effectiveness; and

24 (D) strategies to sustain such programs
25 beyond the duration of the grant.

1 (g) REPORT.—Not later than 7 years after the date
2 of enactment of this Act, the Attorney General shall sub-
3 mit to the Committee on the Judiciary of the House of
4 Representatives and the Senate a report describing the re-
5 sults of such grant programs.

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

11 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
12 authorized to be appropriated to carry out this section
13 \$10,000,000 for each of fiscal years 2021 through 2025.

14 **SEC. 705. GAO REPORT.**

15 (a) IN GENERAL.—Not later than 2 years after the
16 date of enactment of this Act, the Comptroller General
17 of the United States shall submit to Congress a report
18 on adverse maternal health outcomes among incarcerated
19 individuals, with a particular focus on racial and ethnic
20 disparities in maternal health outcomes for incarcerated
21 individuals.

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

24 (1) to the extent practicable—

1 (A) the number of incarcerated individuals,
2 including those incarcerated in Federal, State,
3 and local correctional facilities, who have expe-
4 rienced a pregnancy-related death or preg-
5 nancy-associated death in the most recent 10
6 years of available data;

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

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

18 (2) in the case that the Comptroller General of
19 the United States is unable determine the informa-
20 tion required in paragraphs (1) through (4), an as-
21 sessment of the barriers to determining such infor-
22 mation and recommendations for improvements in
23 tracking maternal health outcomes among incarcer-
24 ated individuals, including those incarcerated in
25 Federal, State, and local detention facilities;

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

5 (4) causes of adverse maternal health outcomes
6 and severe maternal morbidity that are unique to in-
7 carcerated individuals of color;

8 (5) recommendations to reduce maternal mor-
9 tality and severe maternal morbidity among incar-
10 cerated individuals and to address racial and ethnic
11 disparities in maternal health outcomes for incarcer-
12 ated individuals in Bureau of Prisons facilities and
13 State and local prisons and jails; and

14 (6) such other information as may be appro-
15 priate to reduce the occurrence of adverse maternal
16 health outcomes among incarcerated individuals and
17 to address racial and ethnic disparities in maternal
18 health outcomes for such individuals.

19 **SEC. 706. MACPAC REPORT.**

20 (a) IN GENERAL.—Not later than 2 years after the
21 date of enactment of this Act, the Medicaid and CHIP
22 Payment and Access Commission (referred to in this sec-
23 tion as “MACPAC”) shall publish a report on the implica-
24 tions of pregnant and postpartum incarcerated individuals
25 being ineligible for medical assistance under a State plan

1 under title XIX of the Social Security Act (42 U.S.C.
2 1396 et seq.).

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

5 (1) information on the effect of ineligibility for
6 medical assistance under a State plan under title
7 XIX of the Social Security Act (42 U.S.C. 1396 et
8 seq.) on maternal health outcomes for pregnant and
9 postpartum incarcerated individuals, concentrating
10 on the effects of such ineligibility for pregnant and
11 postpartum individuals of color; and

12 (2) the potential implications on maternal
13 health outcomes resulting from suspending eligibility
14 for medical assistance under a State plan under
15 such title of such Act when a pregnant or
16 postpartum individual is incarcerated.

17 **TITLE VIII—TECH TO SAVE**
18 **MOMS**

19 **SEC. 801. CMI MODELING OF INTEGRATED TELEHEALTH**
20 **MODELS IN MATERNITY CARE SERVICES.**

21 (a) IN GENERAL.—Section 1115A(b)(2)(B) of the
22 Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amend-
23 ed by adding at the end the following new clauses:

24 “(xxviii) Focusing on title XIX, pro-
25 viding for the adoption of and use of tele-

1 health tools that allow for screening and
2 treatment of common pregnancy-related
3 complications (including anxiety and de-
4 pression, substance use disorder, hemor-
5 rhage, infection, amniotic fluid embolism,
6 thrombotic pulmonary or other embolism,
7 hypertensive disorders of pregnancy, cere-
8 brovascular accidents, cardiomyopathy, and
9 other cardiovascular conditions) for a preg-
10 nant woman receiving medical assistance
11 under such title during her pregnancy and
12 for not more than a 1-year period begin-
13 ning on the last day of her pregnancy.”.

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

17 **SEC. 802. GRANTS TO EXPAND THE USE OF TECHNOLOGY-**
18 **ENABLED COLLABORATIVE LEARNING AND**
19 **CAPACITY MODELS THAT PROVIDE CARE TO**
20 **PREGNANT AND POSTPARTUM WOMEN.**

21 Title III of the Public Health Service Act is amended
22 by inserting after section 330M (42 U.S.C. 254c–19) the
23 following::

1 **“SEC. 330N. EXPANDING CAPACITY FOR MATERNAL**
2 **HEALTH OUTCOMES.**

3 “(a) PROGRAM ESTABLISHED.—Beginning not later
4 than 1 year after the date of enactment of this Act, the
5 Secretary of Health and Human Services shall, as appro-
6 priate, award grants to eligible entities to evaluate, de-
7 velop, and, as appropriate, expand the use of technology-
8 enabled collaborative learning and capacity building mod-
9 els, to improve maternal health outcomes in health profes-
10 sional shortage areas; areas with high rates of maternal
11 mortality and severe maternal morbidity, and significant
12 racial and ethnic disparities in maternal health outcomes;
13 and for medically underserved populations or American
14 Indians and Alaska Natives, including Indian tribes, tribal
15 organizations, and urban Indian organizations.

16 “(b) USE OF FUNDS.—

17 “(1) REQUIRED USES.—Grants awarded under
18 subsection (a) shall be used for—

19 “(A) the development and acquisition of
20 instructional programming, and the training of
21 maternal health care providers and other pro-
22 fessionals that provide or assist in the provision
23 of services through models such as—

24 “(i) training on adopting and effec-
25 tively implementing Alliance for Innovation
26 on Maternal Health (referred to in this

1 section as ‘AIM’) safety and quality im-
2 provement bundles;

3 “(ii) training on implicit and explicit
4 bias, racism, and discrimination for pro-
5 viders of maternity care;

6 “(iii) training on best practices in
7 screening for and, as needed, evaluating
8 and treating maternal mental health condi-
9 tions and substance use disorders;

10 “(iv) training on how to screen for so-
11 cial determinants of health risks in the
12 prenatal and postpartum periods such as
13 inadequate housing, lack of access to nutri-
14 tion, environmental risks, and transpor-
15 tation barriers; and

16 “(v) training on the use of remote pa-
17 tient monitoring tools for pregnancy-re-
18 lated complications described in section
19 1115A(b)(2)(B)(xxviii);

20 “(B) information collection and evaluation
21 activities to—

22 “(i) study the impact of such models
23 on—

24 “(I) access to and quality of care;

25 “(II) patient outcomes;

1 “(III) subjective measures of pa-
2 tient experience; and

3 “(IV) cost-effectiveness; and

4 “(ii) identify best practices for the ex-
5 pansion and use of such models;

6 “(C) information collection and evaluation
7 activities to study the impact of such models on
8 patient outcomes and maternal health care pro-
9 viders, and to identify best practices for the ex-
10 pansion and use of such models; and

11 “(D) any other activity consistent with
12 achieving the objectives of grants awarded
13 under this section, as determined by the Sec-
14 retary.

15 “(2) PERMISSIBLE USES.—In addition to any of
16 the uses under paragraph (1), grants awarded under
17 subsection (a) may be used for—

18 “(A) equipment to support the use and ex-
19 pansion of technology-enabled collaborative
20 learning and capacity building models, including
21 for hardware and software that enables distance
22 learning, maternal health care provider support,
23 and the secure exchange of electronic health in-
24 formation; and

1 “(B) support for maternal health care pro-
2 viders and other professionals that provide or
3 assist in the provision of maternity care services
4 through such models.

5 “(c) LIMITATIONS.—

6 “(1) NUMBER.—The Secretary may not award
7 more than 1 grant under this section to an eligible
8 entity.

9 “(2) DURATION.—Each grant under this sec-
10 tion shall be made for a period of up to 5 years.

11 “(3) AMOUNT.—The Secretary shall determine
12 the maximum amount of each grant under this sec-
13 tion.

14 “(d) GRANT REQUIREMENTS.—The Secretary shall
15 require entities awarded a grant under this section to col-
16 lect information on the effect of the use of technology-
17 enabled collaborative learning and capacity building mod-
18 els, such as on maternal health outcomes, access to mater-
19 nal health care services, quality of maternal health care,
20 and maternal health care provider retention in areas and
21 populations described in subsection (a). The Secretary
22 may award a grant or contract to assist in the coordina-
23 tion of such models, including to assess outcomes associ-
24 ated with the use of such models in grants awarded under

1 subsection (a), including for the purpose described in sub-
2 section (b)(1)(B).

3 “(e) APPLICATION.—

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

9 “(2) MATTERS TO BE INCLUDED.—Such appli-
10 cation shall include plans to assess the effect of
11 technology-enabled collaborative learning and capac-
12 ity building models on indicators, including access to
13 and quality of care, patient outcomes, subjective
14 measures of patient experience, and cost-effective-
15 ness. Such indicators may focus on—

16 “(A) health professional shortage areas;

17 “(B) areas with high rates of maternal
18 mortality and severe maternal morbidity, and
19 significant racial and ethnic disparities in ma-
20 ternal health outcomes; and

21 “(C) medically underserved populations or
22 American Indians and Alaska Natives, includ-
23 ing Indian tribes, tribal organizations, and
24 urban Indian organizations.

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

6 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
7 provide (either directly through the Department of Health
8 and Human Services or by contract) technical assistance
9 to eligible entities, including recipients of grants under
10 subsection (a), on the development, use, and post-grant
11 sustainability of technology-enabled collaborative learning
12 and capacity building models in order to expand access
13 to maternal health care services provided by such entities,
14 including for health professional shortage areas and areas
15 with high rates of maternal mortality and severe maternal
16 morbidity, and significant racial and ethnic disparities in
17 maternal health outcomes, and to medically underserved
18 populations or American Indians and Alaska Natives, in-
19 cluding Indian tribes, tribal organizations, and urban In-
20 dian organizations.

21 “(h) RESEARCH AND EVALUATION.—The Secretary,
22 in consultation with stakeholders with appropriate exper-
23 tise in such models, shall develop a strategic plan to re-
24 search and evaluate the evidence for such models. The

1 Secretary shall use such plan to inform the activities car-
2 ried out under this section.

3 “(i) REPORTING.—

4 “(1) BY ELIGIBLE ENTITIES.—An eligible enti-
5 ty that receives a grant under subsection (a) shall
6 submit to the Secretary a report, at such time, in
7 such manner, and containing such information as
8 the Secretary may require.

9 “(2) BY THE SECRETARY.—Not later than 4
10 years after the date of enactment of this section, the
11 Secretary shall prepare and submit to the Congress,
12 and post on the internet website of the Department
13 of Health and Human Services, a report including,
14 at minimum—

15 “(A) a description of any new and con-
16 tinuing grants awarded under subsection (a)
17 and the specific purpose and amounts of such
18 grants;

19 “(B) an overview of—

20 “(i) the evaluations conducted under
21 subsection (b);

22 “(ii) technical assistance provided
23 under subsection (g); and

24 “(iii) activities conducted by entities
25 awarded grants under subsection (a); and

1 “(C) a description of any significant find-
2 ings related to patient outcomes or maternal
3 health care providers and best practices for eli-
4 gible entities expanding, using, or evaluating
5 technology-enabled collaborative learning and
6 capacity building models.

7 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
8 is authorized to be appropriated to carry out this section,
9 \$6,000,000 for each of fiscal years 2021 through 2025.

10 “(k) DEFINITIONS.—In this section:

11 “(1) ELIGIBLE ENTITY.—

12 “(A) IN GENERAL.—The term ‘eligible en-
13 tity’ means an entity that provides, or supports
14 the provision of, maternal health care services
15 or other evidence-based services for pregnant
16 and postpartum women—

17 “(i) in health professional shortage
18 areas;

19 “(ii) in areas with high rates of ad-
20 verse maternal health outcomes and sig-
21 nificant racial and ethnic disparities in ma-
22 ternal health outcomes; or

23 “(iii) medically underserved popu-
24 lations or American Indians and Alaska
25 Natives, including Indian tribes, tribal or-

1 ganizations, and urban Indian organiza-
2 tions.

3 “(B) INCLUSIONS.—An eligible entity may
4 include entities leading, or capable of leading, a
5 technology-enabled collaborative learning and
6 capacity building model or engaging in tech-
7 nology-enabled collaborative training of partici-
8 pants in such model.

9 “(2) HEALTH PROFESSIONAL SHORTAGE
10 AREA.—The term ‘health professional shortage area’
11 means a health professional shortage area des-
12 ignated under section 332.

13 “(3) INDIAN TRIBE.—The term ‘Indian tribe’
14 has the meaning given such term in section 4 of the
15 Indian Self-Determination and Education Assistance
16 Act.

17 “(4) MATERNAL MORTALITY.—The term ‘ma-
18 ternal mortality’ means a death occurring during or
19 within 1-year period after pregnancy caused by preg-
20 nancy or childbirth complications.

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 the pregnancy of a woman.

4 “(7) SEVERE MATERNAL MORBIDITY.—The
5 term ‘severe maternal morbidity’ means an unex-
6 pected outcome caused by labor and delivery of a
7 woman that results in significant short-term or long-
8 term consequences to the health of the woman.

9 “(8) TECHNOLOGY-ENABLED COLLABORATIVE
10 LEARNING AND CAPACITY BUILDING MODEL.—The
11 term ‘technology-enabled collaborative learning and
12 capacity building model’ means a distance health
13 education model that connects health care profes-
14 sionals, and particularly specialists, with multiple
15 other health care professionals through simultaneous
16 interactive videoconferencing for the purpose of fa-
17 cilitating case-based learning, disseminating best
18 practices, and evaluating outcomes in the context of
19 maternal health care.

20 “(9) TRIBAL ORGANIZATION.—The term ‘Tribal
21 organization’ has the meaning given such term in
22 section 4 of the Indian Self-Determination and Edu-
23 cation Assistance Act.

24 “(10) URBAN INDIAN ORGANIZATION.—The
25 term ‘urban Indian organization’ has the meaning

1 given such term in section 4 of the Indian Health
2 Care Improvement Act.”.

3 **SEC. 803. GRANTS TO PROMOTE EQUITY IN MATERNAL**
4 **HEALTH OUTCOMES BY INCREASING ACCESS**
5 **TO DIGITAL TOOLS.**

6 (a) IN GENERAL.—Beginning not later than 1 year
7 after the date of the enactment of this Act, the Secretary
8 of Health and Human Services shall carry out a program
9 (in this section referred to as “Investments in Digital
10 Tools to Promote Equity in Maternal Health Outcomes
11 Program” or “Program”) under which the Secretary
12 makes grants to eligible entities reduce racial and ethnic
13 disparities in maternal health outcomes by increasing ac-
14 cess to digital tools related to maternal health care.

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

20 (c) LIMITATIONS.—

21 (1) NUMBER.—The Secretary may not award
22 more than 1 grant under this section to an eligible
23 entity.

24 (2) DURATION.—Each grant under this section
25 shall be made for a period of not more than 5 years.

1 (3) AMOUNT.—The Secretary shall determine
2 the maximum amount of each grant under this sec-
3 tion.

4 (4) PRIORITIZATION.—In awarding grants
5 under this section, the Secretary shall prioritize the
6 selection of an eligible entity that—

7 (A) operates in an area with high rates of
8 adverse maternal health outcomes and signifi-
9 cant racial and ethnic disparities in maternal
10 health outcomes; and

11 (B) promotes technology that addresses ra-
12 cial and ethnic disparities in maternal health
13 outcomes.

14 (d) TECHNICAL ASSISTANCE.—The Secretary shall
15 provide technical assistance to an eligible entity on the de-
16 velopment, use, evaluation, and post-grant sustainability
17 of digital tools for purposes of promoting equity in mater-
18 nal health outcomes.

19 (e) REPORTING.—

20 (1) BY ELIGIBLE ENTITIES.—An eligible entity
21 that receives a grant under subsection (a) shall sub-
22 mit to the Secretary a report, at such time, in such
23 manner, and containing such information as the Sec-
24 retary may require.

1 (2) BY THE SECRETARY.—Not later than 4
2 years after the date of the enactment of this Act, the
3 Secretary shall submit to Congress a report that—

4 (A) evaluates the effectiveness of grants
5 awarded under this section in improving mater-
6 nal health outcomes for minority women;

7 (B) makes recommendations for future
8 grant programs that promote the use of tech-
9 nology to improve maternal health outcomes for
10 minority women; and

11 (C) makes recommendations that ad-
12 dress—

13 (i) privacy and security safeguards
14 that should be implemented in the use of
15 technology in maternal health care;

16 (ii) reimbursement rates for maternal
17 telehealth services;

18 (iii) the use of digital tools to analyze
19 large data sets for the purposes of identi-
20 fying potential pregnancy-related complica-
21 tions as early as possible;

22 (iv) barriers that prevent maternal
23 health care providers from providing tele-
24 health services across states and rec-
25 ommendations from the Centers for Medi-

1 care and Medicaid Services for addressing
2 such barriers in State Medicaid programs;

3 (v) the use of consumer digital tools
4 such as mobile phone applications, patient
5 portals, and wearable technologies to im-
6 prove maternal health outcomes;

7 (vi) barriers that prevent consumers
8 from accessing telehealth services or other
9 digital technologies to improve maternal
10 health outcomes, including a lack of access
11 to reliable, high-speed internet or lack of
12 access to electronic devices needed to use
13 such services and technologies; and

14 (vii) any other related issues as deter-
15 mined by the Secretary.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to carry out this section,
18 \$6,000,000 for each of fiscal years 2021 through 2025.

19 (g) ELIGIBLE ENTITY DEFINED.—In this section,
20 the term “eligible entity” is an entity that is described
21 in section 51a.3(a) of title 42, Code of Federal Regula-
22 tions, including domestic faith-based and community-
23 based organizations.

1 **SEC. 804. REPORT ON THE USE OF TECHNOLOGY TO RE-**
2 **DUCE MATERNAL MORTALITY AND SEVERE**
3 **MATERNAL MORBIDITY AND TO CLOSE RA-**
4 **CIAL AND ETHNIC DISPARITIES IN OUT-**
5 **COMES.**

6 (a) IN GENERAL.—Not later than 60 days after the
7 date of enactment of this Act, the Secretary of Health and
8 Human Services shall seek to enter an agreement with the
9 National Academies of Sciences, Engineering, and Medi-
10 cine (referred to in this Act as the “National Academies”)
11 under which the National Academies shall conduct a study
12 on the use of technology to reduce preventable maternal
13 mortality and severe maternal morbidity, and close racial
14 and ethnic disparities in maternal health outcomes in the
15 United States. The study shall assess current and future
16 uses of artificial intelligence in maternity care, including
17 issues such as—

18 (1) the extent to which artificial intelligence
19 technologies are currently being used in maternal
20 health care;

21 (2) the extent to which artificial intelligence
22 technologies have exacerbated racial or ethnic biases
23 in maternal health care;

24 (3) recommendations for reducing racial or eth-
25 nic biases in artificial intelligence technologies used
26 in maternal health care;

1 (4) recommendations for potential applications
2 of artificial intelligence technologies that could im-
3 prove maternal health outcomes, particularly for mi-
4 nority women; and

5 (5) recommendations for privacy and security
6 safeguards that should be implemented in the devel-
7 opment of artificial intelligence technologies in ma-
8 ternal health care.

9 (b) REPORT.—As a condition of any agreement under
10 subsection (a), the Administrator shall require that the
11 National Academies transmit to Congress a report on the
12 results of the study under subsection (a) not later than
13 24 months after the date of enactment of this Act.

14 **TITLE IX—IMPACT TO SAVE**
15 **MOMS**

16 **SEC. 901. PERINATAL CARE ALTERNATIVE PAYMENT**
17 **MODEL DEMONSTRATION PROJECT.**

18 (a) IN GENERAL.—For the period of fiscal years
19 2022 through 2026, the Secretary of Health and Human
20 Services (referred to in this section as the “Secretary”),
21 acting through the Administrator of the Centers for Medi-
22 care & Medicaid Services, shall establish and implement,
23 in accordance with the requirements of this section, a
24 demonstration project, to be known as the Perinatal Care
25 Alternative Payment Model Demonstration Project (re-

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

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

12 (1) State Medicaid programs;

13 (2) relevant organizations representing mater-
14 nal health care providers;

15 (3) relevant organizations representing patients,
16 with a particular focus on women from demographic
17 groups with disproportionate rates of adverse mater-
18 nal health outcomes;

19 (4) relevant community-based organizations,
20 particularly organizations that seek to improve ma-
21 ternal health outcomes for women from demographic
22 groups with disproportionate rates of adverse mater-
23 nal health outcomes;

24 (5) non-clinical perinatal health workers such as
25 doulas, community health workers, peer supporters,

1 certified lactation consultants, nutritionists and di-
2 eticians, social workers, home visitors, and naviga-
3 tors;

4 (6) relevant health insurance issuers;

5 (7) hospitals, health systems, freestanding birth
6 centers (as such term is defined in paragraph (3)(B)
7 of section 1905(l) of the Social Security Act (42
8 U.S.C. 1396d(l)), Federally-qualified health centers
9 (as such term is defined in paragraph (2)(B) of such
10 section), and rural health clinics (as such term is de-
11 fined in section 1861(aa) of such Act (42 U.S.C.
12 1395x(aa)));

13 (8) researchers and policy experts in fields re-
14 lated to maternity care payment models; and

15 (9) any other stakeholders as the Secretary de-
16 termines appropriate, with a particular focus on
17 stakeholders from demographic groups with dis-
18 proportionate rates of adverse maternal health out-
19 comes.

20 (c) CONSIDERATIONS.—In establishing the Dem-
21 onstration Project, the Secretary shall consider each of the
22 following:

23 (1) Findings from any evaluations of the
24 Strong Start for Mothers and Newborns initiative
25 carried out by the Centers for Medicare & Medicaid

1 Services, the Health Resources and Services Admin-
2 istration, and the Administration on Children and
3 Families.

4 (2) Any alternative payment model that—

5 (A) is designed to improve maternal health
6 outcomes for racial and ethnic groups with dis-
7 proportionate rates of adverse maternal health
8 outcomes;

9 (B) includes methods for stratifying pa-
10 tients by pregnancy risk level and, as appro-
11 priate, adjusting payments under such model to
12 take into account pregnancy risk level;

13 (C) establishes evidence-based quality
14 metrics for such payments;

15 (D) includes consideration of non-hospital
16 birth settings such as freestanding birth centers
17 (as so defined);

18 (E) includes consideration of social deter-
19 minants of health that are relevant to maternal
20 health outcomes such as housing, transpor-
21 tation, nutrition, and other non-clinical factors
22 that influence maternal health outcomes; or

23 (F) includes diverse maternity care teams
24 that include—

1 (i) maternity care providers, including
2 obstetrician-gynecologists, family physi-
3 cians, physician assistants, midwives who
4 meet, at a minimum, the international def-
5 inition of the term “midwife” and global
6 standards for midwifery education (as es-
7 tablished by the International Confed-
8 eration of Midwives), and nurse practi-
9 tioners—

10 (I) from racially, ethnically, and
11 professionally diverse backgrounds;

12 (II) with experience practicing in
13 racially and ethnically diverse commu-
14 nities; or

15 (III) who have undergone
16 trainings on racism, implicit bias, and
17 explicit bias; and

18 (ii) non-clinical perinatal health work-
19 ers such as doulas, community health
20 workers, peer supporters, certified lacta-
21 tion consultants, nutritionists and dieti-
22 cians, social workers, home visitors, and
23 navigators.

24 (d) ELIGIBILITY.—To be eligible to participate in the
25 Demonstration Project, a State shall submit an applica-

1 tion to the Secretary at such time, in such manner, and
2 containing such information as the Secretary may require.

3 (e) EVALUATION.—The Secretary shall conduct an
4 evaluation of the Demonstration Project to determine the
5 impact of the Demonstration Project on—

6 (1) maternal health outcomes, with data strati-
7 fied by race, ethnicity, socioeconomic indicators, and
8 any other factors as the Secretary determines appro-
9 priate;

10 (2) spending on maternity care by States par-
11 ticipating in the Demonstration Project;

12 (3) to the extent practicable, subjective meas-
13 ures of patient experience; and

14 (4) any other areas of assessment that the Sec-
15 retary determines relevant.

16 (f) REPORT.—Not later than one year after the com-
17 pletion or termination date of the Demonstration Project,
18 the Secretary shall submit to the Committee on Energy
19 and Commerce, the Committee on Ways and Means, and
20 the Committee on Education and Labor of the House of
21 Representatives and the Committee on Finance and the
22 Committee on Health, Education, Labor, and Pensions of
23 the Senate, and make publicly available, a report con-
24 taining—

1 (1) the results of any evaluation conducted
2 under subsection (e); and

3 (2) a recommendation regarding whether the
4 Demonstration Project should be continued after fis-
5 cal year 2026 and expanded on a national basis.

6 (g) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated such sums as are nec-
8 essary to carry out this section.

9 (h) DEFINITIONS.—In this section:

10 (1) ALTERNATIVE PAYMENT MODEL.—The
11 term “alternative payment model” has the meaning
12 given such term in section 1833(z)(3)(C) of the So-
13 cial Security Act (42 U.S.C. 1395l(z)(3)(C)).

14 (2) PERINATAL.—The term “perinatal” means
15 the period beginning on the day a woman becomes
16 pregnant and ending on the last day of the 1-year
17 period beginning on the last day of such woman’s
18 pregnancy.

19 **SEC. 902. MACPAC REPORT.**

20 Not later than two years after the date of the enact-
21 ment of this Act, the Medicaid and CHIP Payment and
22 Access Commission shall publish a report on issues relat-
23 ing to the continuity of coverage under State plans under
24 title XIX of the Social Security Act (42 U.S.C. 1396 et
25 seq.) and State child health plans under title XXI of such

1 Act (42 U.S.C. 1397aa et seq.) for pregnant and
2 postpartum women. Such report shall, at a minimum, in-
3 clude the following:

4 (1) An assessment of any existing policies
5 under such State plans and such State child health
6 plans regarding presumptive eligibility for pregnant
7 women while their application for enrollment in such
8 a State plan or such a State child health plan is
9 being processed.

10 (2) An assessment of any existing policies
11 under such State plans and such State child health
12 plans regarding measures to ensure continuity of
13 coverage under such a State plan or such a State
14 child health plan for pregnant and postpartum
15 women, including such women who need to change
16 their health insurance coverage during their preg-
17 nancy or the postpartum period following their preg-
18 nancy.

19 (3) An assessment of any existing policies
20 under such State plans and such State child health
21 plans regarding measures to automatically reenroll
22 women who are eligible to enroll under such a State
23 plan or such a State child health plan as a parent.

24 (4) If determined appropriate by the Commis-
25 sion, any recommendations for the Department of

1 Health and Human Services, or such State plans
2 and such State child health plans, to ensure con-
3 tinuity of coverage under such a State plan or such
4 a State child health plan for pregnant and
5 postpartum women.

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