118TH CONGRESS
1ST SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Mr. BOOKER introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Black Maternal Health Momnibus Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

SEC. 3. DEFINITIONS.

In this Act:

(1) CULTURALLY AND LINGUISTICALLY CONGRUENT.—The term ''culturally and linguistically congruent'', with respect to care or maternity care,

means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(2) MATERNAL MORTALITY.—The term ''maternal mortality'' means a death occurring during or within a 1-year period after pregnancy, caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(3) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, a physician assistant, a midwife who meets, at a minimum, the international definition of a midwife and global standards for midwifery education as established by the International Confederation of Midwives, an advanced practice registered nurse, or a lactation consultant certified by the International Board of Lactation Consultant Examiners; and

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

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a nonclinical health worker focused on maternal or perinatal health, such as a doula, community health worker, peer supporter, lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, patient navigator or coordinator, or language interpreter.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

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

(7) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related death'' means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events

initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

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

(9) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(10) SOCIAL DETERMINANTS OF MATERNAL HEALTH DEFINED.—The term ''social determinants of maternal health'' means nonclinical factors that impact maternal health outcomes.

SEC. 4. SENSE OF CONGRESS.

It is the sense of Congress that—

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

(2) regardless of race, ethnicity, gender identity, sexual orientation, religion, marital status, pri-

mary language, familial status, socioeconomic status, immigration status, incarceration status, or disability, all deserve dignity.

TITLE I—SOCIAL DETERMINANTS FOR MOMS

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

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

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

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

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

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

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

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

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

(7) The Assistant Secretary for the Administration for Children and Families (or a designee thereof).

(8) The Administrator of the Centers for Medicare & Medicaid Services (or a designee thereof).

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

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

(11) The Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development (or a designee thereof).

(12) The Administrator of the Health Resources and Services Administration (or a designee thereof).

(13) The Deputy Assistant Secretary for Minority Health of the Department of Health and Human Services (or a designee thereof).

(14) The Deputy Assistant Secretary for Women's Health of the Department of Health and Human Services (or a designee thereof).

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

(16) The Director of the Office on Violence Against Women at the Department of Justice (or a designee thereof).

(c) APPOINTED MEMBERS.—In addition to the ex officio members of the Task Force, the Secretary of Health and Human Services may appoint the following members of the Task Force:

(1) Representatives of patients, to include—

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

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

(2) Leaders of community-based organizations that address maternal mortality, severe maternal morbidity, and maternal health with a specific focus on racial and ethnic disparities. In appointing such leaders under this paragraph, the Secretary of Health and Human Services shall give priority to individuals who are leaders of organizations led by in-

dividuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

(3) Perinatal health workers.

(4) A professionally and geographically diverse panel of maternity care providers.

(5) Other maternal health stakeholders outside of the Federal Government with expertise in maternal health, including social determinants of maternal health.

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

(e) TOPICS.—In developing strategies coordinating efforts between Federal agencies and other stakeholders to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States under this section, the Task Force may address topics such as—

(1) addressing barriers that prevent individuals from attending prenatal and postpartum appointments, accessing maternal health care services, or accessing services and resources related to social determinants of maternal health;

(2) increasing access to safe, stable, affordable, and adequate housing for pregnant and postpartum individuals and their families;

(3) delivering healthy food, infant formula, clean water, diapers, or other perinatal necessities to pregnant and postpartum individuals located in areas that are food deserts;

(4) addressing the impacts of water and air quality, exposure to extreme temperatures, environmental chemicals, environmental risks in the workplace and the home, and pollution levels, on maternal and infant health outcomes;

(5) offering free and accessible drop-in childcare services during prenatal and postpartum appointments;

(6) addressing the clinical and nonclinical needs of postpartum individuals and their families for the duration of the postpartum period;

(7) engaging with nongovernmental entities to address social determinants of maternal health, including through public-private partnerships;

(8) addressing the impact of domestic or intimate partner violence on maternal health outcomes; and

(9) other topics determined by the chair of the Task Force.

(f) REPORT.—Not later than 2 years after the date of enactment of this Act, and every year thereafter, the Task Force shall submit to Congress and make publicly available on the website of the Department of Health and Human Services a report—

(1) describing the Task Force's efforts to develop strategies and coordinate efforts between Federal agencies and other stakeholders to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States;

(2) providing an overview of actions taken by each member of the Task Force listed under subsection (b) to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States;

(3) providing recommendations on Federal funding amounts and authorities needed to implement strategies developed by the Task Force to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States;

(4) providing recommendations on actions that stakeholders outside of the Federal Government can take to eliminate preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States; and

(5) addressing other topics as determined by the chair of the Task Force.

(g) TERMINATION.—Section 1013 of title 5, United States Code, shall not apply to the Task Force with respect to termination.

SEC. 102. SUSTAINED FUNDING TO ADDRESS SOCIAL DETERMINANTS OF MATERNAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants to eligible entities to address social determinants of maternal health to eliminate maternal mortality, severe maternal morbidity, and maternal health disparities.

(b) ELIGIBLE ENTITIES.—In this section, the term ''eligible entity'' means—

(1) a community-based organization, Indian Tribe or Tribal organization, or Urban Indian organization;

(2) a public health department or nonprofit organization working with an entity listed in paragraph (1); or

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

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

(d) PRIORITIZATION.—In awarding grants under subsection (a), the Secretary shall give priority to an eligible entity that is operating in an area with—

(1) high rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes; and

(2) a high poverty rate.

(e) ACTIVITIES.—An eligible entity that receives a grant under this section may use the grant to address social determinants of maternal health such as—

(1) housing;

(2) transportation;

(3) nutrition;

(4) employment, workplace conditions, and other economic factors;

(5) environmental conditions;

(6) intimate partner violence; and

(7) other nonclinical factors that impact maternal health outcomes.

(f) TECHNICAL ASSISTANCE.—The Secretary shall provide to grant recipients under this section technical assistance to plan for sustaining programs to address social determinants of maternal health after the period of the grant.

(g) REPORTING.—

(1) GRANTEES.—Not later than 1 year after an eligible entity first receives a grant under this section, and annually thereafter, an eligible entity shall submit to the Secretary, and make publicly available, a report on the status of activities conducted using the grant. Each such report shall include data on the effects of such activities, disaggregated by race, ethnicity, gender, primary language, geography, socioeconomic status, and other relevant factors.

(2) SECRETARY.—Not later than the end of fiscal year 2028, the Secretary shall submit to Congress a report that includes—

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

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

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

TITLE II—EXTENDING WIC FOR NEW MOMS

SEC. 201. EXTENDING WIC ELIGIBILITY FOR NEW MOMS.

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

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

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

(1) maternal and infant health outcomes, including racial and ethnic disparities with respect to such outcomes;

(2) breastfeeding rates among postpartum individuals;

(3) qualitative evaluations of family experiences under the special supplemental nutrition program under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

(4) other relevant information as determined by the Secretary.

TITLE III—HONORING KIRA JOHNSON

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

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants to eligible entities to establish or expand programs to advance maternal health equity.

(b) TIMING.—Following the 1-year period described in subsection (d), the Secretary shall commence awarding the grants authorized by subsection (a).

(c) ELIGIBLE ENTITIES.—To be eligible to seek a grant under this section, an entity shall be a community-

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

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

(1) conduct outreach to encourage eligible entities to apply for grants under this section; and

(2) provide technical assistance to eligible entities on best practices for applying for grants under this section.

(e) SPECIAL CONSIDERATION.—

(1) OUTREACH.—In conducting outreach under subsection (d), the Secretary shall give special consideration to eligible entities that—

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

(B) are led by individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes; and

(C) offer programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

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

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

(B) offer programs and resources designed in consultation with and intended for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(C) offer programs and resources in the communities in which the respective eligible entities are located that—

(i) promote maternal mental health and maternal substance use disorder treatments and supports that are aligned with evidence-based practices for improving maternal mental and behavioral health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(ii) address social determinants of maternal health;

(iii) promote evidence-based health literacy and pregnancy, childbirth, and parenting education;

(iv) provide support from perinatal health workers;

(v) provide culturally and linguistically congruent training to perinatal health workers;

(vi) conduct or support research on maternal health issues disproportionately

impacting individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(vii) offer group prenatal care or group postpartum care;

(viii) coordinate mutual aid efforts during infant formula shortages, including community milk depots, donor human milk banks and exchanges, and forums for community outreach and education;

(ix) provide support to individuals or family members of individuals who suffered a pregnancy loss, pregnancy-associated death, or pregnancy-related death; or

(x) operate midwifery practices that provide culturally and linguistically congruent maternal health care and support, including for the purposes of—

(I) supporting additional education, training, and certification programs, including support for distance learning;

(II) providing financial support to current and future midwives to address education costs, debts, and other needs;

(III) clinical site investments;

(IV) supporting preceptor development trainings;

(V) expanding the midwifery practice; or

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

(D) have developed other programs and resources that address community-specific needs for pregnant and postpartum individuals and are aligned with evidence-based practices for improving maternal health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

(f) TECHNICAL ASSISTANCE.—The Secretary shall provide to grant recipients under this section technical assistance on—

(1) capacity building to establish or expand programs to advance maternal health equity;

(2) best practices in data collection, measurement, evaluation, and reporting; and

(3) planning for sustaining programs to advance maternal health equity after the period of the grant.

(g) EVALUATION.—Not later than the end of fiscal year 2028, the Secretary shall submit to the Congress an evaluation of the grant program under this section that—

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

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

(3) assesses the effectiveness of programs funded by grants under this section in improving maternal health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes, to the extent practicable; and

(4) makes recommendations for future Department of Health and Human Services grant programs and funding opportunities that deliver funding to community-based organizations that provide programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

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

SEC. 302. RESPECTFUL MATERNITY CARE TRAINING FOR ALL EMPLOYEES IN MATERNITY CARE SETTINGS.

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

"SEC. 742. RESPECTFUL MATERNITY CARE TRAINING FOR ALL EMPLOYEES IN MATERNITY CARE SETTINGS.

''(a) GRANTS.—The Secretary shall award grants for programs to reduce and prevent bias, racism, and discrimination in maternity care settings and to advance re-

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

''(b) SPECIAL CONSIDERATION.—In awarding grants under subsection (a), the Secretary shall give special consideration to applications for programs that would—

''(1) apply to all maternity care providers and any employees who interact with pregnant and postpartum individuals in the provider setting, including front desk employees, sonographers, schedulers, health care professionals, hospital or health system administrators, security staff, and other employees;

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

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

''(4) be delivered in ongoing education settings for providers maintaining their licenses, with a preference for trainings that provide continuing education units;

''(5) include trauma-informed care best practices and an emphasis on shared decision making between providers and patients;

''(6) include antiracism training and programs;

''(7) be delivered in undergraduate programs that funnel into health professions schools;

''(8) be delivered in settings that apply to providers of the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966;

''(9) integrate bias training in obstetric emergency simulation trainings or related trainings;

''(10) include training for emergency department employees and emergency medical technicians on recognizing warning signs for severe pregnancy-related complications;

''(11) offer training to all maternity care providers on the value of racially, ethnically, and professionally diverse maternity care teams to provide culturally and linguistically congruent care; or

''(12) be based on one or more programs designed by a historically Black college or university or other minority-serving institution.

''(c) APPLICATION.—To seek a grant under subsection (a), an entity shall submit an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) REPORTING.—Each recipient of a grant under this section shall annually submit to the Secretary a report

on the status of activities conducted using the grant, including, as applicable, a description of the impact of training provided through the grant on patient outcomes and patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

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

''(1) shall produce an annual report on the findings resulting from programs funded through this section;

''(2) shall disseminate such report to all recipients of grants under this section and to the public; and

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

''(f) DEFINITIONS.—In this section:

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

''(2) The term 'culturally and linguistically congruent' means in agreement with the preferred cul-

tural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

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

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2024 through 2028.''.

SEC. 303. STUDY ON REDUCING AND PREVENTING BIAS, RACISM, AND DISCRIMINATION IN MATERNITY CARE SETTINGS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an agreement, not later than 90 days after the date of enactment of this Act, with the National Academies of Sciences, Engineering, and Medicine (referred to in this section as the ''National Academies'') under which the National Academies agree to—

(1) conduct a study on the design and implementation of programs to reduce and prevent bias, racism, and discrimination in maternity care settings and to advance respectful, culturally and linguistically congruent, trauma-informed care; and

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

(A) complete the study; and

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

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

(1) The development of a scorecard or other evaluation standards for programs designed to reduce and prevent bias, racism, and discrimination in maternity care settings to assess the effectiveness of such programs in improving patient outcomes and patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

(2) Determination of the types and frequency of training to reduce and prevent bias, racism, and discrimination in maternity care settings that are demonstrated to improve patient outcomes or patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

SEC. 304. RESPECTFUL MATERNITY CARE COMPLIANCE PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to accredited hospitals, health systems, and other maternity care settings to establish as an integral part of quality implementation initiatives within one or more hospitals or other birth settings a respectful maternity care compliance program.

(b) PROGRAM REQUIREMENTS.—A respectful maternity care compliance program funded through a grant under this section shall—

(1) institutionalize mechanisms to allow patients receiving maternity care services, the families of such patients, or perinatal health workers supporting such patients to report instances of racism or evidence of bias on the basis of race, ethnicity, or another protected class;

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

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

tected class in the delivery of maternity care that includes—

(A) information on the training programs to reduce and prevent bias, racism, and discrimination on the basis of race, ethnicity, or another protected class for all employees in maternity care settings;

(B) information on the number of cases reported to the compliance program; and

(C) the development of methods to routinely assess the extent to which bias, racism, or discrimination on the basis of race, ethnicity, or another protected class is present in the delivery of maternity care to patients from racial and ethnic minority groups;

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

(5) provide annual reports to the Secretary with information about each case reported to the compliance program over the course of the year containing such information as the Secretary may require, such as—

(A) deidentified demographic information on the patient in the case, such as race, ethnicity, gender identity, and primary language;

(B) the content of the report from the patient or the family of the patient to the compliance program;

(C) the response from the compliance program; and

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

(c) SECRETARY REQUIREMENTS.—

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

(A) disseminating best practices for establishing and implementing a respectful maternity care compliance program within a hospital or other birth setting;

(B) promoting coordination and collaboration between hospitals, health systems, and other maternity care delivery settings on the establishment and implementation of respectful maternity care compliance programs; and

(C) evaluating the effectiveness of respectful maternity care compliance programs on ma-

ternal health outcomes and patient and family experiences, especially for patients from racial and ethnic minority groups and their families.

(2) STUDY.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall, through a contract with an independent research organization, conduct a study on strategies to address—

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

(ii) successful implementation of respectful care initiatives.

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

(i) An assessment of the reports submitted to the Secretary from the respectful maternity care compliance programs pursuant to subsection (b)(5).

(ii) Based on such assessment, recommendations for potential accountability mechanisms related to cases of racism or bias on the basis of race, ethnicity, or another protected class in the delivery of ma-

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

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

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

SEC. 305. GAO REPORT.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and annually thereafter, the Comptroller General of the United States shall submit to the Congress and make publicly available a report on the establishment of respectful maternity care compliance programs within hospitals, health systems, and other maternity care settings.

(b) MATTERS INCLUDED.—The report under subsection (a) shall include the following:

(1) Information regarding the extent to which hospitals, health systems, and other maternity care settings have elected to establish respectful maternity care compliance programs, including—

(A) which hospitals and other birth settings elect to establish compliance programs and when such programs are established;

(B) to the extent practicable, impacts of the establishment of such programs on maternal health outcomes and patient and family experiences in the hospitals and other birth settings that have established such programs, especially for patients from racial and ethnic minority groups and their families;

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

(D) recommendations for establishing respectful maternity care compliance programs in geographic areas, and types of hospitals or other birth settings, where such programs are not being established.

(2) Whether the funding made available to carry out this section has been sufficient and, if applicable, recommendations for additional appropriations to carry out this section.

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

TITLE IV—MATERNAL HEALTH FOR VETERANS

SEC. 401. SUPPORT FOR MATERNITY HEALTH CARE AND COORDINATION PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter until September 30, 2028, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives, and make publicly available, a report that contains the following:

(1) A summary of the activities carried out under the programs of the Department of Veterans Affairs relating to maternity health care or coordination.

(2) Data on maternal health outcomes of veterans who receive care furnished by the Secretary of

Veterans Affairs, including pursuant to such programs.

(3) Recommendations by the Secretary of Veterans Affairs to improve the maternal health outcomes of veterans, with a particular focus on veterans from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to the Secretary of Veterans Affairs $15,000,000 for each of fiscal years 2024, 2025, 2026, 2027, and 2028, for the programs of the Department of Veterans Affairs relating to maternity care coordination and related programs, including the maternity care coordination program described in Veterans Health Administration Directive 1330.03.

(2) SUPPLEMENT NOT SUPPLANT.—Amounts authorized under paragraph (1) are authorized in addition to any other amounts authorized for maternity health care and coordination for the Department of Veterans Affairs.

TITLE V—PERINATAL WORKFORCE

SEC. 501. HHS AGENCY DIRECTIVES.

(a) GUIDANCE TO STATES.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall issue and disseminate guidance to States to educate providers, managed care entities, and other insurers about the value and process of delivering respectful maternal health care through diverse and multidisciplinary care provider models.

(2) CONTENTS.—The guidance required by paragraph (1) shall address how States can encourage and incentivize hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers—

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

(i) from racially, ethnically, and linguistically diverse backgrounds;

(ii) with experience practicing in racially and ethnically diverse communities; and

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

(B) to incorporate into maternity care teams—

(i) midwives who meet, at a minimum, the international definition of a midwife and global standards for midwifery education as established by the International Confederation of Midwives;

(ii) perinatal health workers;

(iii) physician assistants;

(iv) advanced practice registered nurses; and

(v) lactation consultants certified by the International Board of Lactation Consultant Examiners;

(C) to provide collaborative, culturally and linguistically congruent care; and

(D) to provide opportunities for individuals enrolled in accredited midwifery education pro-

grams to participate in job shadowing with maternity care teams in hospitals, health systems, midwifery practices, and freestanding birth centers.

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

(1) STUDY.—The Secretary of Health and Human Services acting through the Director of the National Institutes of Health (in this subsection referred to as the ''Secretary'') shall conduct a study on best practices in respectful and culturally and linguistically congruent maternity care.

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

(A) complete the study required by paragraph (1);

(B) submit to the Congress and make publicly available a report on the results of such study; and

(C) include in such report—

(i) a compendium of examples of hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers that are delivering

respectful and culturally and linguistically congruent maternal health care;

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

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

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

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

"SEC. 758. PERINATAL WORKFORCE GRANTS.

"(a) IN GENERAL.—The Secretary shall award grants to entities to establish or expand programs described in subsection (b) to grow and diversify the perinatal workforce.

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

"(1) establishing accredited schools or programs that provide education and training to individuals seeking appropriate licensing and certification as—

"(A) physician assistants who will complete clinical training in the field of maternal and perinatal health;

"(B) perinatal health workers; or

"(C) midwives who meet, at a minimum, the international definition of a midwife and global standards for midwifery education as established by the International Confederation of Midwives; and

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

dents (including students from racially, ethnically, and linguistically diverse backgrounds).

''(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to a school or program described in subsection (b) that—

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

''(2) has developed a strategy to recruit and retain a diverse pool of students into the school or program described in subsection (b) that is supported by funds received through the grant, particularly from racial and ethnic minority groups and other underserved populations;

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

''(4) has developed a strategy to recruit and retain students who plan to practice in an area with significant racial and ethnic disparities in maternal health outcomes, to the extent practicable; and

''(5) includes in the standard curriculum for all students within the school or program described in subsection (b) a bias, racism, or discrimination

training program that includes training on implicit bias and racism.

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

''(1) the number and demographics of students participating in the school or program;

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

''(A) health professional shortage areas designated under section 332; and

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

''(3) whether the school or program has included in the standard curriculum for all students a bias, racism, or discrimination training program that includes explicit and implicit bias, and if so the effectiveness of such training program.

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

''(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to entities seeking or receiving a grant under this section on the development, use, evaluation, and postgrant period sustainability of the school or program described in subsection (b) that is proposed to be, or is being, established or expanded through the grant.

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

''(1) recruiting students from racial and ethnic minority groups;

''(2) increasing the number of health professionals described in subparagraphs (A), (B), and (C) of subsection (b)(1) from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of such health professionals working in health professional shortage areas designated under section 332; and

''(4) increasing the number of such health professionals working in areas with significant racial and ethnic disparities in maternal health outcomes, to the extent such data are available.

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

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2024 through 2028.''.

SEC. 503. GRANTS TO GROW AND DIVERSIFY THE NURSING WORKFORCE IN MATERNAL AND PERINATAL HEALTH.

Title VIII of the Public Health Service Act is amended by inserting after section 811 of that Act (42 U.S.C. 296j) the following:

''SEC. 812. PERINATAL NURSING WORKFORCE GRANTS.

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

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

''(1) nurse practitioners whose education includes a focus on maternal and perinatal health;

''(2) certified nurse-midwives; or

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

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

''(1) has developed a strategy to recruit and retain a diverse pool of students seeking to enter careers focused on maternal and perinatal health, particularly students from racial and ethnic minority groups and other underserved populations;

''(2) has developed a partnership with a practice setting in a health professional shortage area designated under section 332 for the clinical placements of the school's students;

''(3) has developed a strategy to recruit and retain students who plan to practice in an area with significant racial and ethnic disparities in maternal health outcomes, to the extent practicable; and

''(4) includes in the standard curriculum for all students seeking to enter careers focused on maternal and perinatal health a bias, racism, or discrimination training program that includes education on implicit bias and racism.

''(d) REPORTING.—As a condition on receipt of a grant under this section, a school of nursing shall agree to submit to the Secretary an annual report on the activities conducted through the grant, including, to the extent practicable—

''(1) the number and demographics of students in the school of nursing seeking to enter careers focused on maternal and perinatal health;

''(2) the extent to which such students are preparing to enter careers in—

''(A) health professional shortage areas designated under section 332; and

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

''(3) whether the standard curriculum for all students seeking to enter careers focused on maternal and perinatal health includes a bias, racism, or

discrimination training program that includes education on implicit bias and racism.

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

''(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to schools of nursing seeking or receiving a grant under this section on the processes of awarding and evaluating scholarships through the grant.

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

''(1) recruiting students from racial and ethnic minority groups and other underserved populations;

''(2) increasing the number of advanced practice registered nurses entering careers focused on

maternal and perinatal health from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of advanced practice registered nurses entering careers focused on maternal and perinatal health working in health professional shortage areas designated under section 332; and

''(4) increasing the number of advanced practice registered nurses entering careers focused on maternal and perinatal health working in areas with significant racial and ethnic disparities in maternal health outcomes, to the extent such data are available.

''(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2024 through 2028.''.

SEC. 504. GAO REPORT.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and every 5 years thereafter, the Comptroller General of the United States shall submit to Congress a report on barriers to maternal health education and access to care in the United States. Such report shall include the information and recommendations described in subsection (b).

(b) CONTENT OF REPORT.—The report under subsection (a) shall include—

(1) an assessment of current barriers to entering and successfully completing accredited midwifery education programs, and recommendations for addressing such barriers, particularly for low-income women and women from racial and ethnic minority groups;

(2) an assessment of current barriers to entering and successfully completing accredited education programs for other health professional careers related to maternity care, including maternity care providers, mental and behavioral health care providers acting in accordance with State law, and registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2)), particularly for low-income women and women from racial and ethnic minority groups;

(3) an assessment of current barriers that prevent midwives from meeting the international definition of a midwife and global standards for midwifery education as established by the International Confederation of Midwives, and recommendations for addressing such barriers, particularly for low-income

women and women from racial and ethnic minority groups;

(4) an assessment of disparities in access to maternity care providers, mental or behavioral health care providers acting in accordance with State law, and registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2))), and perinatal health workers, stratified by race, ethnicity, gender identity, primary language, geographic location, and insurance type and recommendations to promote greater access equity; and

(5) recommendations to promote greater equity in compensation for perinatal health workers under public and private insurers, particularly for such individuals from racially and ethnically diverse backgrounds.

SEC. 505. DEFINITIONS.

In this title:

(1) CULTURALLY AND LINGUISTICALLY CONGRUENT.—The term ''culturally and linguistically congruent'', with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and

practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of a midwife and global standards for midwifery education as established by the International Confederation of Midwives, advanced practice registered nurse, or a lactation consultant certified by the International Board of Lactation Consultant Examiners; and

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

(3) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a nonclinical health worker focused on maternal or perinatal health, such as a doula, community health worker, peer supporter, lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, patient navigator or coordinator, or language interpreter.

(4) POSTPARTUM.—The term ''postpartum'' refers to the 1-year period beginning on the last day of the pregnancy of an individual.

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

TITLE VI—DATA TO SAVE MOMS

SEC. 601. FUNDING FOR MATERNAL MORTALITY REVIEW COMMITTEES TO PROMOTE REPRESENTATIVE COMMUNITY ENGAGEMENT.

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

''(9) GRANTS TO PROMOTE REPRESENTATIVE COMMUNITY ENGAGEMENT IN MATERNAL MORTALITY REVIEW COMMITTEES.—

''(A) IN GENERAL.—The Secretary may, using funds made available pursuant to subparagraph (C), provide assistance to an applicable maternal mortality review committee of a State, Indian tribe, tribal organization, or Urban Indian organization (as such term is de-

fined in section 4 of the Indian Health Care Improvement Act)—

"(i) to select for inclusion in the membership of such a committee community members from the State, Indian tribe, tribal organization, or Urban Indian organization by—

"(I) prioritizing community members who can increase the diversity of the committee's membership with respect to race and ethnicity, location, personal or family experiences of maternal mortality or severe maternal morbidity, and professional background, including members with nonclinical experiences; and

"(II) to the extent applicable, using funds reserved under subsection (f), to address barriers to maternal mortality review committee participation for community members, including required training, transportation barriers, compensation, and other supports as may be necessary;

''(ii) to establish initiatives to conduct outreach and community engagement efforts within communities throughout the State or Indian tribe to seek input from community members on the work of such maternal mortality review committee, with a particular focus on outreach to women from racial and ethnic minority groups (as such term is defined in section 1707(g)(1)); and

''(iii) to release public reports assessing—

''(I) the pregnancy-related death and pregnancy-associated death review processes of the maternal mortality review committee, with a particular focus on the maternal mortality review committee's sensitivity to the unique circumstances of pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1)) who have suffered pregnancy-related deaths; and

"(II) the impact of the use of funds made available pursuant to subparagraph (C) on increasing the diversity of the maternal mortality review committee membership and promoting community engagement efforts throughout the State or Indian tribe.

"(B) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly through the Department of Health and Human Services or by contract) technical assistance to any maternal mortality review committee receiving a grant under this paragraph on best practices for increasing the diversity of the maternal mortality review committee's membership and for conducting effective community engagement throughout the State or Indian tribe.

"(C) AUTHORIZATION OF APPROPRIATIONS.—In addition to any funds made available under subsection (f), there is authorized to be appropriated to carry out this paragraph $10,000,000 for each of fiscal years 2024 through 2028.".

(b) RESERVATION OF FUNDS.—Section 317K(f) of the Public Health Service Act (42 U.S.C. 247b–12(f)) is

amended by adding at the end the following: ''Of the amount made available under the preceding sentence for a fiscal year, not less than $1,500,000 shall be reserved for grants to Indian tribes, tribal organizations, or Urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act)''.

SEC. 602. DATA COLLECTION AND REVIEW.

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

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

(2) by inserting after subclause (I) the following:

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

''(III) to the extent practicable, reviewing deaths during pregnancy or up to 1 year after the end of a pregnancy from suicide, overdose, or other death from a mental health condition or substance use disorder attributed to or aggravated by pregnancy or childbirth complications;

''(IV) to the extent practicable, consulting with local community-based organizations representing pregnant and postpartum individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes to ensure that, in addition to clinical factors, nonclinical factors that might have contributed to a pregnancy-related death are appropriately considered;''.

SEC. 603. REVIEW OF MATERNAL HEALTH DATA COLLECTION PROCESSES AND QUALITY MEASURES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality (referred to in this section as the ''Secretary''), shall consult with relevant stakeholders—

(1) to review existing maternal health data collection processes and quality measures; and

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

(b) COLLABORATION.—In carrying out this section, the Secretary shall consult with a diverse group of maternal health stakeholders, which may include—

(1) pregnant and postpartum individuals and their family members, and nonprofit organizations representing such individuals, with a particular focus on patients from racial and ethnic minority groups;

(2) community-based organizations that provide support for pregnant and postpartum individuals, with a particular focus on patients from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(3) membership organizations for maternity care providers;

(4) organizations representing perinatal health workers;

(5) organizations that focus on maternal mental or behavioral health;

(6) organizations that focus on intimate partner violence;

(7) institutions of higher education, with a particular focus on minority-serving institutions;

(8) licensed and accredited hospitals, birth centers, midwifery practices, or other facilities that provide maternal health care services;

(9) relevant State and local public agencies, including State maternal mortality review committees; and

(10) the National Quality Forum, or such other standard-setting organizations specified by the Secretary.

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

(1) Current State and Tribal practices for maternal health, maternal mortality, and severe maternal morbidity data collection and dissemination, including consideration of—

(A) the timeliness of processes for amending a death certificate when new information pertaining to the death becomes available to re-

flect whether the death was a pregnancy-related death;

(B) relevant data collected with electronic health records, including data on race, ethnicity, primary language, socioeconomic status, geography, insurance type, and other relevant demographic information;

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

(D) the barriers preventing States from correlating maternal outcome data with data on race, ethnicity, and other demographic characteristics;

(E) processes for determining the cause of a pregnancy-associated death in States that do not have a maternal mortality review committee;

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

(G) whether members of maternal mortality review committees participate in trainings

on bias, racism, or discrimination, and the quality of such trainings;

(H) the extent to which States have implemented systematic processes of listening to the stories of pregnant and postpartum individuals and their family members, with a particular focus on pregnant and postpartum individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes, and their family members, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective States;

(I) the extent to which maternal mortality review committees are considering social determinants of maternal health when examining the causes of pregnancy-associated and pregnancy-related deaths;

(J) the extent to which maternal mortality review committees are making actionable recommendations based on their reviews of adverse maternal health outcomes and the extent to

which such recommendations are being implemented by appropriate stakeholders;

(K) the legal and administrative barriers preventing the collection, collation, and dissemination of State maternity care data;

(L) the effectiveness of data collection and reporting processes in separating pregnancy-associated deaths from pregnancy-related deaths; and

(M) the current Federal, State, local, and Tribal funding support for the activities referred to in subparagraphs (A) through (L).

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

(3) Current quality measures for maternity care, including prenatal measures, labor and delivery measures, and postpartum measures, including topics such as—

(A) effective quality measures for maternity care used by hospitals, health systems, midwifery practices, birth centers, health plans, and other relevant entities;

(B) the sufficiency of current outcome measures used to evaluate maternity care for driving improved care, experiences, and outcomes in maternity care payment and delivery system models;

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

(D) validated measures that have been used for research purposes that could be tested, refined, and submitted for national endorsement;

(E) barriers preventing maternity care providers and insurers from implementing quality measures that are aligned with best practices;

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

(G) the strengths and weaknesses of the Prenatal and Postpartum Care measures of the Health Plan Employer Data and Information Set measures established by the National Committee for Quality Assurance;

(H) the strengths and weaknesses of maternity care quality measures under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the

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

(I) the extent to which maternity care quality measures are informed by patient experiences that include measures of patient-reported experience of care;

(J) the current processes for collecting and making publicly available, to the extent practicable, stratified data on race, ethnicity, and other demographic characteristics of pregnant and postpartum individuals in hospitals, health systems, midwifery practices, and birth centers, and for incorporating such demographically stratified data in maternity care quality measures;

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

(L) the extent to which hospitals, health systems, midwifery practices, and birth centers are implementing existing maternity care quality measures.

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

(5) Recommendations for new authorities that may be granted to maternal mortality review committees to be able to—

(A) access records from other Federal and State agencies and departments that may be necessary to identify causes of pregnancy-associated and pregnancy-related deaths that are unique to pregnant and postpartum individuals from specific populations, such as veterans and individuals who are incarcerated; and

(B) work with relevant experts who are not members of the maternal mortality review committee to assist in the review of pregnancy-associated deaths of pregnant and postpartum individuals from specific populations, such as veterans and individuals who are incarcerated.

(6) Recommendations to improve and standardize current quality measures for maternity care, with a particular focus on maternal health disparities.

(7) Recommendations to improve the coordination by the Department of Health and Human Services of the efforts undertaken by the agencies and organizations within the Department related to maternal health data and quality measures.

(d) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the Congress and make publicly available a report on the results of the review of maternal health data collection processes and quality measures and recommendations to improve such processes and measures required under subsection (a).

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

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

SEC. 604. STUDY ON MATERNAL HEALTH AMONG AMERICAN INDIAN AND ALASKA NATIVE INDIVIDUALS.

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

(1) not later than 90 days after the date of enactment of this Act, enter into a contract with an independent research organization or Tribal Epidemiology Center to conduct a comprehensive study on maternal mortality, severe maternal morbidity, and other adverse perinatal or childbirth outcomes in the populations of American Indian and Alaska Native individuals; and

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

(b) PARTICIPATING ENTITIES.—The entities described in this subsection shall consist of 12 members, selected by the Secretary from among individuals nominated by Indian Tribes and Tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination

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

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

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

(2) include a systematic process of listening to the stories of American Indian and Alaska Native individuals to fully understand the causes of, and inform potential solutions to, the maternal health crisis within their respective communities;

(3) distinguish between the causes of, landscape of maternity care at, and recommendations to improve maternal health outcomes within, the different settings in which American Indian and Alaska Native individuals receive maternity care, such as—

(A) facilities operated by the Indian Health Service;

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

ant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act;

(C) an urban Indian health program operated by an Urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act; and

(D) facilities outside of the Indian Health Service in which American Indian and Alaska Native individuals receive maternity care services;

(4) review processes for coordinating programs of the Indian Health Service with social services provided through other programs administered by the Secretary (other than the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid Program under title XIX of such Act (42 U.S.C. 1396 et seq.), and the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397 et seq.);

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

(6) assess causes and frequency of maternal mental health conditions and substance use disorders;

(7) consider social determinants of health, including poverty, lack of health insurance, unemployment, sexual and domestic violence, and environmental conditions in Tribal areas;

(8) consider the role that historical mistreatment of American Indian and Alaska Native women has played in causing currently elevated rates of maternal mortality, severe maternal morbidity, and other adverse perinatal or childbirth outcomes;

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

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

(11) make recommendations to reduce misclassification of American Indian and Alaska Native individuals, including consideration of best practices in training for maternal mortality review committee members to be able to correctly classify American Indian and Alaska Native individuals; and

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

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

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

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

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

dividuals from racial and ethnic minority groups. Such research may—

(1) include the development and implementation of systematic processes of listening to the stories of pregnant and postpartum individuals from racial and ethnic minority groups, and perinatal health workers supporting such individuals, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective communities;

(2) assess the potential causes of relatively low rates of maternal mortality among Hispanic individuals, including potential racial misclassification and other data collection and reporting issues that might be misrepresenting maternal mortality rates among Hispanic individuals in the United States;

(3) assess differences in rates of adverse maternal health outcomes among subgroups identifying as Hispanic, including disparities in access to early prenatal care; and

(4) include lactation education to promote racial and ethnic diversity within the workforce of health care professionals with breastfeeding and lactation expertise.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity described in such subsection shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

(1) to conduct outreach to minority-serving institutions to raise awareness of the availability of grants under subsection (a);

(2) to provide technical assistance in the application process for such a grant; and

(3) to promote capacity building as needed to enable entities described in such subsection to submit such an application.

(d) REPORTING REQUIREMENT.—Each entity awarded a grant under this section shall periodically submit to the Secretary a report on the status of activities conducted using the grant.

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

(f) MINORITY-SERVING INSTITUTIONS DEFINED.—In this section, the term ''minority-serving institution'' means an institution described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

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

TITLE VII—MOMS MATTER

SEC. 701. MATERNAL MENTAL HEALTH EQUITY GRANT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall establish a program to award grants to eligible entities to address maternal mental health conditions and substance use disorders, with a focus on demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

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

(c) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to an eligible entity that—

(1) is, or will partner with, a community-based organization to address maternal mental health conditions and substance use disorders described in subsection (a);

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

(3) is operating in a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(d) USE OF FUNDS.—An eligible entity that receives a grant under this section shall use the grant for the following:

(1) Establishing or expanding maternity care programs to improve the integration of maternal mental health and behavioral health care services into primary care settings where pregnant individuals regularly receive health care services.

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

(3) Expanding existing programs that improve maternal mental and behavioral health during the prenatal and postpartum periods, with a focus on individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

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

(5) Addressing stigma associated with maternal mental health conditions and substance use disorders, with a focus on individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

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

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

(7) Establishing or expanding programs to prevent suicide or self-harm among pregnant and postpartum individuals.

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

(9) Establishing or expanding programs to provide education and training to maternity care providers with respect to—

(A) identifying potential warning signs for maternal mental health conditions or substance use disorders in pregnant and postpartum individuals, with a focus on individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes; and

(B) in the case where such providers identify such warning signs, offering referrals to mental and behavioral health care professionals.

(10) Developing a website, or other source, that includes information on health care providers who treat maternal mental health conditions and substance use disorders.

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

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

(e) REPORTING.—

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

tative evaluations of such activities, including the experience of individuals who received health care through such grant.

(2) SECRETARY.—Not later than the end of fiscal year 2027, the Secretary shall submit to Congress a report that includes—

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

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

(C) recommendations with respect to expanding coverage of evidence-based screenings and treatments for maternal mental health conditions and substance use disorders; and

(D) recommendations with respect to ensuring activities described under subsection (d) continue after the end of a grant period.

(f) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(A) a community-based organization serving pregnant and postpartum individuals, including such organizations serving individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity,

maternal health disparities, or other adverse perinatal or childbirth outcomes;

(B) a nonprofit or patient advocacy organization with expertise in maternal mental and behavioral health;

(C) a maternity care provider;

(D) a mental or behavioral health care provider who treats maternal mental health conditions or substance use disorders;

(E) a State or local governmental entity, including a State or local public health department;

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

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

(2) FREESTANDING BIRTH CENTER.—The term ''freestanding birth center'' has the meaning given that term under section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

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

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

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

Title VII of the Public Health Service Act is amended by inserting after section 758 of such Act, as added by section 502 of this Act, the following new section:

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

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

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

''(1) establishing schools or programs that provide education and training to individuals seeking appropriate licensing or certification as mental or behavioral health care providers who will specialize

in maternal mental health conditions or substance use disorders; or

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

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

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

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

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

''(4) has developed a strategy to recruit and retain students who plan to practice in an area with

significant maternal health disparities, to the extent practicable; and

''(5) includes in the standard curriculum for all students within the maternal mental or behavioral health care workforce program or school a bias, racism, or discrimination training program that includes training on implicit bias and racism.

''(d) REPORTING.—As a condition on receipt of a grant under this section for a maternal mental or behavioral health care workforce program or school, an entity shall agree to submit to the Secretary an annual report on the activities conducted through the grant, including—

''(1) the number and demographics of students participating in the program or school;

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

''(A) health professional shortage areas designated under section 332; and

''(B) areas with significant maternal health disparities, to the extent such data are available; and

''(3) whether the program or school has included in the standard curriculum for all students a bias, racism, or discrimination training program that

includes training on implicit bias and racism, and if so the effectiveness of such training program.

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

''(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to entities seeking or receiving a grant under this section on the development, use, evaluation, and postgrant period sustainability of the maternal mental or behavioral health care workforce programs or schools proposed to be, or being, established or expanded through the grant.

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

''(1) recruiting students from racial and ethnic minority groups and other underserved populations;

''(2) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders working in health professional shortage areas designated under section 332; and

''(4) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders working in areas with significant maternal health disparities, to the extent such data are available.

''(i) DEFINITIONS.—In this section:

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

''(2) MENTAL OR BEHAVIORAL HEALTH CARE PROVIDER.—The term 'mental or behavioral health care provider' refers to a health care provider in the field of mental and behavioral health, including substance use disorders, acting in accordance with State law.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2024 through 2028.''.

TITLE VIII—JUSTICE FOR INCARCERATED MOMS

SEC. 801. ENDING THE SHACKLING OF PREGNANT INDIVIDUALS.

(a) IN GENERAL.—Beginning on the date that is 6 months after the date of enactment of this Act, and annually thereafter, in each State that receives a grant under subpart 1 of part E of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.) (commonly referred to as the ''Edward Byrne Memorial Justice Assistance Grant Program'') and that does not have in effect throughout the State for such fiscal year laws restricting the use of restraints on pregnant individuals in prison that are substantially similar to the rights, procedures, requirements, effects, and penalties set forth in section 4322 of title 18, United States Code, the amount of such grant that would otherwise be allocated to such State under such subpart for the fiscal year shall be decreased by 25 percent.

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

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

SEC. 802. CREATING MODEL PROGRAMS FOR THE CARE OF INCARCERATED INDIVIDUALS IN THE PRENATAL AND POSTPARTUM PERIODS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Attorney General, acting through the Director of the Bureau of Prisons, shall establish, in not fewer than 6 Bureau of Prisons facilities, programs to optimize maternal health outcomes for pregnant and postpartum individuals incarcerated in such facilities. The Attorney General shall establish such programs in consultation with stakeholders such as—

(1) relevant community-based organizations, particularly organizations that represent incarcerated and formerly incarcerated individuals and organizations that seek to improve maternal health outcomes for pregnant and postpartum individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(2) relevant organizations representing patients, with a particular focus on patients from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(3) organizations representing maternity care providers and maternal health care education programs;

(4) perinatal health workers; and

(5) researchers and policy experts in fields related to maternal health care for incarcerated individuals.

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

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

(1) the number of pregnant and postpartum individuals incarcerated in such facility and, among such individuals, the number of pregnant and postpartum individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes; and

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

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

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

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

(2) provide access to healthy foods and counseling on nutrition, recommended activity levels, and safety measures throughout pregnancy;

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

(4) train medical personnel to ensure that pregnant incarcerated individuals receive trauma-informed, culturally and linguistically congruent care that promotes the health and safety of the pregnant individuals;

(5) provide counseling and treatment for individuals who have suffered from—

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

(B) trauma or violence, including domestic violence;

(C) human immunodeficiency virus;

(D) sexual abuse;

(E) pregnancy or infant loss; or

(F) chronic conditions;

(6) provide evidence-based pregnancy and childbirth education, parenting support, and other relevant forms of health literacy;

(7) provide clinical education opportunities to maternity care providers in training to expand pathways into maternal health care careers serving incarcerated individuals;

(8) offer opportunities for postpartum individuals to maintain contact with the individual's newborn child to promote bonding, including enhanced visitation policies, access to prison nursery programs, or breastfeeding support;

(9) provide reentry assistance, particularly to—

(A) ensure access to health insurance coverage and transfer of health records to community providers if an incarcerated individual exits

the criminal justice system during such individual's pregnancy or in the postpartum period; and

(B) connect individuals exiting the criminal justice system during pregnancy or in the postpartum period to community-based resources, such as referrals to health care providers, substance use disorder treatments, and social services that address social determinants maternal of health; or

(10) establish partnerships with local public entities, private community entities, community-based organizations, Indian Tribes and Tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), and Urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) to establish or expand pretrial diversion programs as an alternative to incarceration for pregnant and postpartum individuals. Such programs may include—

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

(B) prenatal health coordination;

(C) family and individual counseling;

(D) evidence-based screenings, education, and, as needed, treatment for mental and behavioral health conditions, including drug and alcohol treatments;

(E) family case management services;

(F) domestic violence education and prevention;

(G) physical and sexual abuse counseling; and

(H) programs to address social determinants of health such as employment, housing, education, transportation, and nutrition.

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

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

(2) not later than 3 years after the date of enactment of this Act, and 6 years after the date of enactment of this Act, reporting results of the programs to the Director, including information describing—

(A) relevant quantitative indicators of success in improving the standard of care and health outcomes for pregnant and postpartum

incarcerated individuals in the facility, including data stratified by race, ethnicity, sex, gender, primary language, age, geography, disability status, the category of the criminal charge against such individual, rates of pregnancy-related deaths, pregnancy-associated deaths, cases of infant mortality and morbidity, rates of preterm births and low-birthweight births, cases of severe maternal morbidity, cases of violence against pregnant or postpartum individuals, diagnoses of maternal mental or behavioral health conditions, and other such information as appropriate;

(B) relevant qualitative and quantitative evaluations from pregnant and postpartum incarcerated individuals who participated in such programs, including measures of patient-reported experience of care; and

(C) strategies to sustain such programs after fiscal year 2028 and expand such programs to other facilities.

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

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

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

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

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

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

demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(2) relevant organizations representing patients, with a particular focus on patients from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(3) organizations representing maternity care providers and maternal health care education programs;

(4) perinatal health workers; and

(5) researchers and policy experts in fields related to maternal health care for incarcerated individuals.

(b) APPLICATIONS.—Each applicant for a grant under this section shall submit to the Director of the Bureau of Justice Assistance an application at such time, in such manner, and containing such information as the Director may require.

(c) USE OF FUNDS.—A State that is awarded a grant under this section shall use such grant to establish or ex-

pand programs for pregnant and postpartum incarcerated individuals, and such programs may—

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

(2) provide access to healthy foods and counseling on nutrition, recommended activity levels, and safety measures throughout pregnancy;

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

(4) train medical personnel to ensure that pregnant incarcerated individuals receive trauma-informed, culturally and linguistically congruent care that promotes the health and safety of the pregnant individuals;

(5) provide counseling and treatment for individuals who have suffered from—

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

(B) trauma or violence, including domestic violence;

(C) human immunodeficiency virus;

(D) sexual abuse;

(E) pregnancy or infant loss; or

(F) chronic conditions;

(6) provide evidence-based pregnancy and childbirth education, parenting support, and other relevant forms of health literacy;

(7) provide clinical education opportunities to maternity care providers in training to expand pathways into maternal health care careers serving incarcerated individuals;

(8) offer opportunities for postpartum individuals to maintain contact with the individual's newborn child to promote bonding, including enhanced visitation policies, access to prison nursery programs, or breastfeeding support;

(9) provide reentry assistance, particularly to—

(A) ensure access to health insurance coverage and transfer of health records to community providers if an incarcerated individual exits the criminal justice system during such individual's pregnancy or in the postpartum period; and

(B) connect individuals exiting the criminal justice system during pregnancy or in the postpartum period to community-based resources, such as referrals to health care providers, substance use disorder treatments, and

social services that address social determinants of maternal health; or

(10) establish partnerships with local public entities, private community entities, community-based organizations, Indian Tribes and Tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), and Urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) to establish or expand pretrial diversion programs as an alternative to incarceration for pregnant and postpartum individuals. Such programs may include—

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

(B) prenatal health coordination;

(C) family and individual counseling;

(D) evidence-based screenings, education, and, as needed, treatment for mental and behavioral health conditions, including drug and alcohol treatments;

(E) family case management services;

(F) domestic violence education and prevention;

(G) physical and sexual abuse counseling; and

(H) programs to address social determinants of health such as employment, housing, education, transportation, and nutrition.

(d) PRIORITY.—In awarding grants under this section, the Director of the Bureau of Justice Assistance shall give priority to applicants based on—

(1) the number of pregnant and postpartum individuals incarcerated in the State and, among such individuals, the number of pregnant and postpartum individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes; and

(2) the extent to which the State has demonstrated a commitment to developing exemplary programs for pregnant and postpartum individuals incarcerated in the prisons and jails in the State.

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

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

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

(2) not later than 3 years after the date of enactment of this Act, and 6 years after the date of enactment of this Act, reporting results of such program to the Attorney General, including information describing—

(A) relevant quantitative indicators of the program's success in improving the standard of care and health outcomes for pregnant and postpartum incarcerated individuals in the facility, including data stratified by race, ethnicity, sex, gender, primary language, age, geography, disability status, category of the criminal charge against such individual, incidence rates of pregnancy-related deaths, pregnancy-associated deaths, cases of infant mortality and morbidity, rates of preterm births and low-birthweight births, cases of severe maternal morbidity, cases of violence against pregnant or postpartum individuals, diagnoses of maternal mental or behavioral health conditions, and other such information as appropriate;

(B) relevant qualitative and quantitative evaluations from pregnant and postpartum in-

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

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

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

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

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

SEC. 804. GAO REPORT.

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

ties in maternal and infant health outcomes for incarcerated individuals.

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

(1) to the extent practicable—

(A) the number of pregnant individuals who are incarcerated in Bureau of Prisons facilities;

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

(C) the number of cases of severe maternal morbidity among incarcerated individuals, including those incarcerated in Federal, State, and local detention facilities, in the most recent 10 years of available data;

(D) the number of preterm and low-birthweight births of infants born to incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities, in the most recent 10 years of available data; and

(E) statistics on the racial and ethnic disparities in maternal and infant health outcomes and severe maternal morbidity rates among incarcerated individuals, including those incarcerated in Federal, State, and local detention facilities;

(2) in the case that the Comptroller General of the United States is unable determine the information required in subparagraphs (A) through (C) of paragraph (1), an assessment of the barriers to determining such information and recommendations for improvements in tracking maternal health outcomes among incarcerated individuals, including those incarcerated in Federal, State, and local detention facilities;

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

(A) the effects of such ineligibility on maternal health outcomes for pregnant and postpartum incarcerated individuals, with emphasis given to such effects for pregnant and

postpartum individuals from racial and ethnic minority groups; and

(B) potential implications on maternal health outcomes resulting from temporarily suspending, rather than permanently terminating, such eligibility when a pregnant or postpartum individual is incarcerated;

(4) the extent to which Federal, State, and local correctional facilities are holding pregnant and postpartum individuals who test positive for illicit drug use in detention with special conditions, such as additional bond requirements, due to the individual's drug use, and the effect of such detention policies on maternal and infant health outcomes.

(5) causes of adverse maternal health outcomes that are unique to incarcerated individuals, including those incarcerated in Federal, State, and local detention facilities;

(6) causes of adverse maternal health outcomes and severe maternal morbidity that are unique to incarcerated individuals from racial and ethnic minority groups;

(7) recommendations to reduce maternal mortality and severe maternal morbidity among incarcerated individuals and to address racial and ethnic

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

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

TITLE IX—TECH TO SAVE MOMS

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

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

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

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

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

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

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

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

''(1) in health professional shortage areas;

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

''(3) in rural and underserved areas;

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

''(5) for medically underserved populations and American Indians and Alaska Natives, including Indian Tribes, Tribal organizations, and Urban Indian organizations.

''(b) USE OF FUNDS.—

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

''(A) train maternal health care providers, students, and other similar professionals through models that include—

''(i) methods to increase safety and health care quality;

''(ii) implicit bias, racism, and discrimination;

''(iii) best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders;

''(iv) training on best practices in maternity care for pregnant and postpartum individuals during public health emergencies;

''(v) methods to screen for social determinants of maternal health risks in the prenatal and postpartum; and

"(vi) the use of remote patient monitoring tools for pregnancy-related complications described in section 1115A(b)(2)(B)(xxviii) of the Social Security Act;

"(B) evaluate and collect information on the effect of such models on—

"(i) access to and quality of care;

"(ii) outcomes with respect to the health of an individual; and

"(iii) the experience of individuals who receive pregnancy-related health care;

"(C) develop qualitative and quantitative measures to identify best practices for the expansion and use of such models;

"(D) study the effect of such models on patient outcomes and maternity care providers; and

"(E) conduct any other activity determined by the Secretary.

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

"(A) the use and expansion of technology-enabled collaborative learning and capacity

building models, including hardware and software that—

''(i) enables distance learning and technical support; and

''(ii) supports the secure exchange of electronic health information; and

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

''(c) APPLICATION.—

''(1) IN GENERAL.—An eligible entity seeking a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(2) ASSURANCE.—An application under paragraph (1) shall include an assurance that such entity shall collect information on and assess the effect of the use of technology-enabled collaborative learning and capacity building models, including with respect to—

''(A) maternal health outcomes;

''(B) access to maternal health care services;

''(C) quality of maternal health care; and

''(D) retention of maternity care providers serving areas and populations described in subsection (a).

''(d) LIMITATIONS.—

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

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

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

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

''(1) in health professional shortage areas;

''(2) in areas with high rates of maternal mortality and severe maternal morbidity or significant maternal health disparities;

''(3) in rural and underserved areas; and

''(4) for medically underserved populations or American Indians and Alaska Natives.

''(g) RESEARCH AND EVALUATION.—The Secretary, in consultation with experts, shall develop a strategic plan to research and evaluate the evidence for technology-enabled collaborative learning and capacity building models.

''(h) REPORTING.—

''(1) ELIGIBLE ENTITIES.—An eligible entity that receives a grant under subsection (a) shall submit to the Secretary a report, at such time, in such manner, and containing such information as the Secretary may require.

''(2) SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall submit to the Congress, and make available on the website of the Department of Health and Human Services, a report that includes—

''(A) a description of grants awarded under subsection (a) and the purpose and amounts of such grants;

''(B) a summary of—

''(i) the evaluations conducted under subsection (b)(1)(B);

''(ii) any technical assistance provided under subsection (f); and

''(iii) the activities conducted under subsection (a); and

''(C) a description of any significant findings with respect to—

''(i) patient outcomes; and

''(ii) best practices for expanding, using, or evaluating technology-enabled collaborative learning and capacity building models.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $6,000,000 for each of fiscal years 2024 through 2028.

''(j) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—

''(A) IN GENERAL.—The term 'eligible entity' means an entity that provides, or supports the provision of, maternal health care services or other evidence-based services for pregnant and postpartum individuals—

''(i) in health professional shortage areas;

''(ii) in rural or underserved areas;

''(iii) in areas with high rates of adverse maternal health outcomes or signifi-

cant racial and ethnic disparities in maternal health outcomes; and

"(iv) who are—

"(I) members of medically underserved populations; or

"(II) American Indians and Alaska Natives, including Indian Tribes, Tribal organizations, and Urban Indian organizations.

"(B) INCLUSIONS.—An eligible entity may include entities that lead, or are capable of leading a technology-enabled collaborative learning and capacity building model.

"(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

"(3) INDIAN TRIBE.—The term 'Indian Tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

"(4) MATERNAL MORTALITY.—The term 'maternal mortality' means a death occurring during or within 1-year period after pregnancy caused by pregnancy-related or childbirth complications, including a

suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy or childbirth complications.

''(5) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given such term in section 330(b)(3).

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

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

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

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

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

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

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

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

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

and containing such information as the Secretary may require.

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

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

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

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

(d) LIMITATIONS.—

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

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

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

(f) REPORTING.—

(1) ELIGIBLE ENTITIES.—An eligible entity that receives a grant under subsection (a) shall submit to the Secretary a report, at such time, in such manner, and containing such information as the Secretary may require.

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

(A) an evaluation on the effectiveness of grants awarded under this section to improve maternal health outcomes, particularly for pregnant and postpartum individuals from racial and ethnic minority groups;

(B) recommendations on new grant programs that promote the use of technology to improve such maternal health outcomes; and

(C) recommendations with respect to—

(i) technology-based privacy and security safeguards in maternal health care;

(ii) reimbursement rates for maternal telehealth services;

(iii) the use of digital tools to analyze large data sets to identify potential pregnancy-related complications;

(iv) barriers that prevent maternity care providers from providing telehealth services across States;

(v) the use of consumer digital tools such as mobile phone applications, patient portals, and wearable technologies to improve maternal health outcomes;

(vi) barriers that prevent access to telehealth services, including a lack of access to reliable, high-speed internet or electronic devices;

(vii) barriers to data sharing between the Special Supplemental Nutrition Program for Women, Infants, and Children program and maternity care providers, and recommendations for addressing such barriers; and

(viii) lessons learned from expanded access to telehealth related to maternity care during the COVID–19 public health emergency.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $6,000,000 for each of fiscal years 2024 through 2028.

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

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

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

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

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

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

nology and patient monitoring devices in maternity care.

(4) Best practices in the use of innovative technology and patient monitoring devices for pregnant and postpartum individuals from racial and ethnic minority groups.

(5) Best practices with respect to privacy and security safeguards in such use.

(c) REPORT.—The agreement under subsection (a) shall direct the National Academies to complete the study under this section, and transmit to Congress a report on the results of the study, not later than 24 months after the date of enactment of this Act.

TITLE X—IMPACT TO SAVE MOMS

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

(a) IN GENERAL.—For the period of fiscal years 2024 through 2028, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish and implement, in accordance with the requirements of this section, a demonstration project, to be known as the Perinatal Care Alternative Payment Model Demonstration Project (re-

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

(b) COORDINATION.—In establishing the Demonstration Project, the Secretary shall coordinate with stakeholders such as—

(1) State Medicaid programs;

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

(3) relevant organizations representing patients, with a particular focus on patients from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(4) relevant community-based organizations, particularly organizations that seek to improve maternal health outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health

disparities, or other adverse perinatal or childbirth outcomes;

(5) perinatal health workers;

(6) relevant health insurance issuers;

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

(8) researchers and policy experts in fields related to maternity care payment models; and

(9) any other stakeholders as the Secretary determines appropriate, with a particular focus on stakeholders from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

(c) CONSIDERATIONS.—In establishing the Demonstration Project, the Secretary shall consider any alternative payment model that—

(1) is designed to improve maternal health outcomes for individuals from demographic groups with

elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

(2) includes methods for stratifying patients by pregnancy risk level and, as appropriate, adjusting payments under such model to take into account pregnancy risk level, including consideration of the appropriate transfer of patients by pregnancy risk level;

(3) establishes evidence-based quality metrics for such payments;

(4) includes consideration of nonhospital birth settings such as freestanding birth centers (as so defined);

(5) includes consideration of social determinants of maternal health;

(6) includes diverse maternity care teams that include—

(A) maternity care providers, mental and behavioral health care providers acting in accordance with State law, and registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2)))—

(i) from racially, ethnically, and professionally diverse backgrounds;

(ii) with experience practicing in racially and ethnically diverse communities; or

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

(B) perinatal health workers; or

(7) includes consideration of maternal mental health conditions and substance use disorders.

(d) ELIGIBILITY.—To be eligible to participate in the Demonstration Project, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(e) EVALUATION.—The Secretary shall conduct an evaluation of the Demonstration Project to determine the impact of the Demonstration Project on—

(1) maternal health outcomes, with data stratified by race, ethnicity, primary language, socioeconomic status, geography, insurance type, and other factors as the Secretary determines appropriate;

(2) spending on maternity care by States participating in the Demonstration Project;

(3) to the extent practicable, qualitative and quantitative measures of patient experience; and

(4) any other areas of assessment that the Secretary determines relevant.

(f) REPORT.—Not later than one year after the completion or termination date of the Demonstration Project, the Secretary shall submit to the Congress, and make publicly available, a report containing—

(1) the results of any evaluation conducted under subsection (e); and

(2) a recommendation regarding whether the Demonstration Project should be continued after fiscal year 2028 and expanded on a national basis.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) ALTERNATIVE PAYMENT MODEL.—The term ''alternative payment model'' has the meaning given such term in section 1833(z)(3)(C) of the Social Security Act (42 U.S.C. 1395l(z)(3)(C)).

(2) PERINATAL.—The term ''perinatal'' means the period beginning on the day an individual becomes pregnant and ending on the last day of the

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

TITLE XI—MATERNAL HEALTH PANDEMIC RESPONSE

SEC. 1101. DEFINITIONS.

In this title:

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

(A) is culturally and linguistically congruent;

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

(C) ensures freedom from harm and mistreatment; and

(D) enables informed choice and continuous support.

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

SEC. 1102. FUNDING FOR DATA COLLECTION, SURVEILLANCE, AND RESEARCH ON MATERNAL HEALTH OUTCOMES DURING PUBLIC HEALTH EMERGENCIES.

To conduct or support data collection, surveillance, and research on maternal health as a result of public health emergencies and infectious diseases that pose a risk to maternal and infant health, including support to assist in the capacity building for State, Tribal, territorial, and local public health departments to collect and transmit racial, ethnic, and other demographic data related to maternal health, there are authorized to be appropriated—

(1) $100,000,000 for the Surveillance for Emerging Threats to Mothers and Babies program of the Centers for Disease Control and Prevention, to support the Centers for Disease Control and Prevention in its efforts to—

(A) work with public health, clinical, and community-based organizations to provide timely, continually updated guidance to families and health care providers on ways to reduce risk to pregnant and postpartum individuals and their newborns and tailor interventions to improve their long-term health;

(B) partner with more State, Tribal, territorial, and local public health programs in the

collection and analysis of clinical data on the impact of public health emergencies and infectious diseases that pose a risk to maternal and infant health on pregnant and postpartum patients and their newborns, particularly among patients from racial and ethnic minority groups; and

(C) establish regionally based centers of excellence to offer medical, public health, and other knowledge to ensure communities can help pregnant and postpartum individuals and newborns get the care and support they need, particularly in areas with large populations of individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes;

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

assistance to existing Maternal Mortality Review Committees;

(3) $45,000,000 for the Pregnancy Risk Assessment Monitoring System (commonly known as the ''PRAMS'') of the Centers for Disease Control and Prevention, to support the Centers for Disease Control and Prevention in its efforts to—

(A) create a supplement to its PRAMS survey related to public health emergencies and infectious diseases that pose a risk to maternal and infant health;

(B) add questions around experiences of respectful maternity care in prenatal, intrapartum, and postpartum care; and

(C) work to transition such PRAMS survey to an electronic platform and expand such PRAMS survey to a larger population, with a special focus on reaching underrepresented communities, and other program improvements; and

(4) $15,000,000 for the National Institute of Child Health and Human Development, to conduct or support research for interventions to mitigate the effects of public health emergencies and infectious diseases that pose a risk to maternal and infant

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

SEC. 1103. PUBLIC HEALTH EMERGENCY MATERNAL HEALTH DATA COLLECTION AND DISCLOSURE.

(a) AVAILABILITY OF COLLECTED DATA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the Administrator of the Centers for Medicare & Medicaid Services, shall make publicly available on the website of the Centers for Disease Control and Prevention data described in subsection (b).

(b) DATA DESCRIBED.—The data described in this subsection are data collected through Federal surveillance systems under the Centers for Disease Control and Prevention with respect to public health emergencies and individuals who are pregnant or in a postpartum period. Such data shall include the following:

(1) Diagnostic testing, confirmed cases, hospitalizations, deaths, and other health outcomes related to an infectious disease outbreak among pregnant and postpartum individuals.

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

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

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

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

(1) at least on a monthly basis; and

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

(f) PRIVACY.—In carrying out subsection (a), the Secretary shall take steps to protect the privacy of individuals pursuant to regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(g) GUIDANCE.—

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

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

(A) laboratories that test specimens for an infectious disease receive all relevant demographic data on race, ethnicity, pregnancy status, and other demographic data as determined by the Secretary; and

(B) data described in subsection (b) are disaggregated by race, ethnicity, gender, primary language, geography, socioeconomic status, and other relevant factors.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall consult with Indian Tribes—

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

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

SEC. 1104. PUBLIC HEALTH COMMUNICATION REGARDING MATERNAL CARE DURING PUBLIC HEALTH EMERGENCIES.

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

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

SEC. 1105. TASK FORCE ON BIRTHING EXPERIENCE AND SAFE, RESPECTFUL, RESPONSIVE, AND EMPOWERING MATERNITY CARE DURING PUBLIC HEALTH EMERGENCIES.

(a) ESTABLISHMENT.—The Secretary, in consultation with the Director of the Centers for Disease Control and Prevention and the Administrator of the Health Resources and Services Administration, shall convene a task force (in this subsection referred to as the ''Task Force'') to develop Federal recommendations regarding respectful, responsive, and empowering maternity care, including safe birth care and postpartum care, during public health emergencies.

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

emergencies, with a particular focus on outcomes for individuals from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes. Such recommendations shall—

(1) address, with particular attention to ensuring equitable treatment on the basis of race and ethnicity—

(A) measures to facilitate respectful, responsive, and empowering maternity care;

(B) measures to facilitate telehealth maternity care for pregnant people who cannot regularly access in-person care;

(C) strategies to increase access to specialized care for those with high-risk pregnancies or pregnant individuals with elevated risk factors;

(D) diagnostic testing for pregnant and laboring patients;

(E) birthing without one's chosen companions, with one's chosen companions, and with smartphone or other telehealth connection to one's chosen companions;

(F) newborn separation after birth in relation to maternal infection status;

(G) breast milk feeding in relation to maternal infection status;

(H) licensure, training, scope of practice, and Medicaid and other insurance reimbursement for certified midwives, certified nurse-midwives, and certified professional midwives, in a manner that facilitates inclusion of midwives of color and midwives from underserved communities;

(I) financial support and training for perinatal health workers who provide nonclinical support to people from pregnancy through the postpartum period in a manner that facilitates inclusion from underserved communities;

(J) strategies to ensure and expand doula coverage under State Medicaid programs;

(K) how to identify, address, and treat prenatal and postpartum mental and behavioral health conditions, such as anxiety, substance use disorder, and depression, during public health emergencies;

(L) how to identify and address instances of intimate partner violence during pregnancy which may arise or intensify during public health emergencies;

(M) strategies to address hospital capacity concerns in communities with a surge in infectious disease cases and to provide childbearing people with options that reduce the potential for cross-contamination and increase the ability to implement their care preferences while maintaining safety and quality, such as the use of auxiliary maternity units and freestanding birth centers;

(N) provision of child care services during prenatal and postpartum appointments for mothers whose children are unable to attend as a result of restrictions relating to the public health emergencies;

(O) how to identify and address racism, bias, and discrimination in the delivery of maternity care services to pregnant and postpartum people, including evaluating the value of training for hospital staff on implicit bias and racism, respectful, responsive, and empowering maternity care, and demographic data collection;

(P) how to address the needs of undocumented pregnant individuals and new mothers who may be afraid or unable to seek needed

care during the COVID–19 public health emergency;

(Q) how to address the needs of uninsured pregnant individuals who have historically relied on emergency departments for care;

(R) how to identify pregnant and postpartum individuals at risk for depression, anxiety disorder, psychosis, obsessive-compulsive disorder, and other maternal mood disorders before, during, and after pregnancy, and how to treat those diagnosed with a postpartum mood disorder;

(S) how to effectively and compassionately screen for substance use disorder during pregnancy and postpartum and help pregnant and postpartum individuals find support and effective treatment;

(T) how to ensure access to infant nutrition during public health emergencies; and

(U) such other matters as the Task Force determines appropriate;

(2) identify barriers to the implementation of the recommendations;

(3) take into consideration existing State and other programs that have demonstrated effectiveness

in addressing pregnancy, birth, and postpartum care during public health emergencies; and

(4) identify policies specific to COVID–19 that should be discontinued when safely possible and those that should be continued as the public health emergency abates.

(c) MEMBERSHIP.—The Secretary shall appoint the members of the Task Force. Such members shall be comprised of—

(1) representatives of the Department of Health and Human Services, including representatives of—

(A) the Secretary;

(B) the Director of the Centers for Disease Control and Prevention;

(C) the Administrator of the Health Resources and Services Administration;

(D) the Administrator of the Centers for Medicare & Medicaid Services;

(E) the Director of the Agency for Healthcare Research and Quality;

(F) the Commissioner of Food and Drugs;

(G) the Assistant Secretary for Mental Health and Substance Use; and

(H) the Director of the Indian Health Service;

(2) at least 3 State, local, or territorial public health officials representing departments of public health, who shall represent jurisdictions from different regions of the United States with relatively high concentrations of historically marginalized populations;

(3) at least 1 Tribal public health official representing departments of public health;

(4) 1 or more representatives of community-based organizations that address adverse maternal health outcomes with a specific focus on racial and ethnic inequities in maternal health outcomes, with special consideration given to representatives of such organizations that are led by a person of color or from communities with significant minority populations;

(5) a professionally diverse panel of maternity care providers and perinatal health workers;

(6) 1 or more patients who were pregnant or gave birth during the COVID–19 public health emergency;

(7) 1 or more patients who contracted COVID–19 and later gave birth;

(8) 1 or more patients who have received support from a perinatal health worker; and

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

TITLE XII—PROTECTING MOMS AND BABIES AGAINST CLIMATE CHANGE

SEC. 1201. DEFINITIONS.

In this title, the following definitions apply:

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

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

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

(4) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the

meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

(5) RISKS ASSOCIATED WITH CLIMATE CHANGE.—The term ''risks associated with climate change'' includes risks associated with extreme heat, air pollution, extreme weather events, and other environmental issues associated with climate change that can result in adverse maternal and infant health outcomes.

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

(7) STAKEHOLDER ORGANIZATION.—The term ''stakeholder organization'' means—

(A) a community-based organization with expertise in providing assistance to vulnerable individuals;

(B) a nonprofit organization with expertise in—

(i) maternal or infant health; or

(ii) environmental or climate justice; and

(C) a patient advocacy organization representing vulnerable individuals.

(8) VULNERABLE INDIVIDUAL.—The term ''vulnerable individual'' means—

(A) an individual who is pregnant;

(B) an individual who was pregnant during any portion of the preceding 1-year period; and

(C) an individual under 3 years of age.

SEC. 1202. GRANT PROGRAM TO PROTECT VULNERABLE MOTHERS AND BABIES FROM CLIMATE CHANGE RISKS.

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

(b) GRANT AUTHORITY.—In carrying out the Program, the Secretary may award, on a competitive basis, grants to 10 covered entities.

(c) APPLICATIONS.—To be eligible for a grant under the Program, a covered entity shall submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require, which shall include, at a minimum, a description of the following:

(1) Plans for the use of grant funds awarded under the Program and how patients and stake-

holder organizations were involved in the development of such plans.

(2) How such grant funds will be targeted to geographic areas that have disproportionately high levels of risks associated with climate change for vulnerable individuals.

(3) How such grant funds will be used to address racial and ethnic disparities in—

(A) adverse maternal and infant health outcomes; and

(B) exposure to risks associated with climate change for vulnerable individuals.

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

(A) adverse environmental impacts;

(B) displacement of residents and businesses;

(C) rent and housing price increases; or

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

(d) SELECTION OF GRANT RECIPIENTS.—

(1) TIMING.—Not later than 270 days after the date of enactment of this Act, the Secretary shall select the recipients of grants under the Program.

(2) CONSULTATION.—In selecting covered entities for grants under the Program, the Secretary shall consult with—

(A) representatives of stakeholder organizations;

(B) the Administrator of the Environmental Protection Agency;

(C) the Administrator of the National Oceanic and Atmospheric Administration; and

(D) from the Department of Health and Human Services—

(i) the Deputy Assistant Secretary for Minority Health;

(ii) the Administrator of the Centers for Medicare & Medicaid Services;

(iii) the Administrator of the Health Resources and Services Administration;

(iv) the Director of the National Institutes of Health; and

(v) the Director of the Centers for Disease Control and Prevention.

(3) PRIORITY.—In selecting grantees under the Program, the Secretary shall give priority to covered entities that serve a county or locality—

(A) designated, or located in an area designated, as a nonattainment area pursuant to section 107 of the Clean Air Act (42 U.S.C. 7407) for any air pollutant for which air quality criteria have been issued under section 108(a) of such Act (42 U.S.C. 7408(a));

(B) with a level of vulnerability of moderate-to-high or higher, according to the Social Vulnerability Index of the Centers for Disease Control and Prevention, or a similar rating of social vulnerability according to related Federal mapping tools;

(C) with temperatures that pose a risk to human health, as determined by the Secretary, in consultation with the Administrator of the National Oceanic and Atmospheric Administration and the Chair of the United States Global Change Research Program, based on the best available science;

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

(E) with a rating of very high or relatively high risk according to the National Risk Index

for Natural Hazards of the Federal Emergency Management Agency; or

(F) with other climate-sensitive hazards with associations to adverse maternal or infant health outcomes, as determined by the Secretary.

(4) LIMITATION.—A recipient of grant funds under the Program may not use such grant funds to serve a county or locality that is served by any other recipient of a grant under the Program.

(e) USE OF FUNDS.—A covered entity awarded grant funds under the Program may only use such grant funds for the following:

(1) Initiatives to identify risks associated with climate change for vulnerable individuals and to provide services and support to such individuals that address such risks, which may include—

(A) training for health care providers, perinatal health workers, and other employees in hospitals, birth centers, midwifery practices, and other health care practices that provide prenatal or labor and delivery services to vulnerable individuals on the identification of, and patient counseling relating to, risks associated with climate change for vulnerable individuals;

(B) hiring, training, or providing resources to perinatal health workers who can help identify risks associated with climate change for vulnerable individuals, provide patient counseling about such risks, and carry out the distribution of relevant services and support;

(C) enhancing the monitoring of risks associated with climate change for vulnerable individuals, including by—

(i) collecting data on such risks in specific census tracts, neighborhoods, or other geographic areas; and

(ii) sharing such data with local health care providers, perinatal health workers, and other employees in hospitals, birth centers, midwifery practices, and other health care practices that provide prenatal or labor and delivery services to local vulnerable individuals; and

(D) providing vulnerable individuals—

(i) air conditioning units, residential weatherization support, filtration systems, household appliances, or related items;

(ii) direct financial assistance; and

(iii) services and support, including housing assistance, evacuation assistance, transportation assistance, access to cooling shelters, and mental health counseling, to prepare for or recover from extreme weather events, which may include floods, hurricanes, wildfires, droughts, and related events.

(2) Initiatives to mitigate levels of and exposure to risks associated with climate change for vulnerable individuals, which shall be based on the best available science and which may include initiatives to—

(A) develop, maintain, or expand urban or community forestry initiatives and tree canopy coverage initiatives;

(B) improve infrastructure, such as buildings and paved surfaces;

(C) develop or improve community outreach networks to provide culturally and linguistically appropriate information and notifications about risks associated with climate change for vulnerable individuals; and

(D) provide enhanced services to racial and ethnic minority groups and other underserved populations.

(f) LENGTH OF AWARD.—A grant under this section shall be disbursed over 4 fiscal years.

(g) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to a covered entity awarded a grant under the Program to support the development, implementation, and evaluation of activities funded with such grant.

(h) REPORTS TO SECRETARY.—

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

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

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

pregnancy status, and other relevant demographic information.

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

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

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

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

(i) adverse environmental impacts;

(ii) displacement of residents and businesses;

(iii) rent and housing price increases; and

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

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

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

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

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

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

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

(A) identifying risks associated with climate change for vulnerable individuals;

(B) providing services and support to such individuals;

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

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

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

(A) monitoring efforts or data collection that would be required to identify areas with high levels of risks associated with climate change for vulnerable individuals;

(B) how such areas could be identified using the strategy developed under section 1205; and

(C) recommendations for additional funding.

(j) DEFINITIONS.—In this section:

(1) The term ''covered entity'' means a consortium of organizations serving a county that—

(A) shall include a community-based organization; and

(B) may include—

(i) another stakeholder organization;

(ii) the government of such county;

(iii) the governments of one or more municipalities within such county;

(iv) a State or local public health department or emergency management agency;

(v) a local health care practice, which may include a licensed and accredited hospital, birth center, midwifery practice, or other health care practice that provides prenatal or labor and delivery services to vulnerable individuals;

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

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

(viii) an institution of higher education.

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

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

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

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a grant program to provide funds to health profession schools to support the development and integration of education and training programs for identifying and addressing risks associated with climate change for vulnerable individuals.

(b) GRANT AUTHORITY.—In carrying out the Program, the Secretary may award, on a competitive basis, grants to health profession schools.

(c) APPLICATION.—To be eligible for a grant under the Program, a health profession school shall submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require, which shall include, at a minimum, a description of the following:

(1) How such health profession school will engage with vulnerable individuals, and stakeholder organizations representing such individuals, in devel-

oping and implementing the education and training programs supported by grant funds awarded under the Program.

(2) How such health profession school will ensure that such education and training programs will address racial and ethnic disparities in exposure to, and the effects of, risks associated with climate change for vulnerable individuals.

(d) USE OF FUNDS.—A health profession school awarded a grant under the Program shall use the grant funds to develop, and integrate into the curriculum and continuing education of such health profession school, education and training on each of the following:

(1) Identifying risks associated with climate change for vulnerable individuals and individuals with the intent to become pregnant.

(2) How risks associated with climate change affect vulnerable individuals and individuals with the intent to become pregnant.

(3) Racial and ethnic disparities in exposure to, and the effects of, risks associated with climate change for vulnerable individuals and individuals with the intent to become pregnant.

(4) Patient counseling and mitigation strategies relating to risks associated with climate change for vulnerable individuals.

(5) Relevant services and support for vulnerable individuals relating to risks associated with climate change and strategies for ensuring vulnerable individuals have access to such services and support.

(6) Implicit and explicit bias, racism, and discrimination.

(7) Related topics identified by such health profession school based on the engagement of such health profession school with vulnerable individuals and stakeholder organizations representing such individuals.

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

(1) A State or local public health department.

(2) A health care professional membership organization.

(3) A stakeholder organization.

(4) A health profession school.

(5) An institution of higher education.

(f) REPORTS TO SECRETARY.—

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

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

(g) REPORT TO CONGRESS.—Not later than the date that is 6 years after the date on which the Program is established, the Secretary shall submit to Congress and publish on a public website of the Department of Health and Human Services a report that includes the following:

(1) A summary of the reports submitted under subsection (f).

(2) Recommendations to improve education and training programs at health profession schools with respect to identifying and addressing risks associated with climate change for vulnerable individuals.

(h) DEFINITIONS.—In this section:

(1) The term ''health profession school'' means an accredited—

(A) medical school;

(B) school of nursing;

(C) midwifery program;

(D) physician assistant education program;

(E) teaching hospital;

(F) residency or fellowship program; or

(G) other school or program determined appropriate by the Secretary.

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

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for the period of fiscal years 2024 through 2027.

SEC. 1204. NIH CONSORTIUM ON BIRTH AND CLIMATE CHANGE RESEARCH.

(a) ESTABLISHMENT.—Not later than one year after the date of the enactment of this Act, the Director of the National Institutes of Health shall establish the Consortium on Birth and Climate Change Research (in this section referred to as the ''Consortium'').

(b) DUTIES.—

(1) IN GENERAL.—The Consortium shall coordinate, across the institutes, centers, and offices of the National Institutes of Health, research on the risks associated with climate change for vulnerable individuals.

(2) REQUIRED ACTIVITIES.—In carrying out paragraph (1), the Consortium shall—

(A) establish research priorities, including by prioritizing research that—

(i) identifies the risks associated with climate change for vulnerable individuals with a particular focus on disparities in such risks among racial and ethnic minority groups and other underserved populations; and

(ii) identifies strategies to reduce levels of, and exposure to, such risks, with a particular focus on risks among racial and ethnic minority groups and other underserved populations;

(B) identify gaps in available data related to such risks;

(C) identify gaps in, and opportunities for, research collaborations;

(D) identify funding opportunities for community-based organizations and researchers from racially, ethnically, and geographically diverse backgrounds;

(E) identify opportunities to increase public awareness related to risks associated with climate change for vulnerable individuals; and

(F) publish annual reports on the work and findings of the Consortium on a public website of the National Institutes of Health.

(c) MEMBERSHIP.—The Director shall appoint to the Consortium representatives of such institutes, centers, and offices of the National Institutes of Health as the Director considers appropriate, including, at a minimum, representatives of—

(1) the National Institute of Environmental Health Sciences;

(2) the National Institute on Minority Health and Health Disparities;

(3) the Eunice Kennedy Shriver National Institute of Child Health and Human Development;

(4) the National Institute of Mental Health;

(5) the National Institute of Nursing Research; and

(6) the Office of Research on Women's Health.

(d) CHAIRPERSON.—The Chairperson of the Consortium shall be designated by the Director and selected from among the representatives appointed under subsection (c).

(e) CONSULTATION.—In carrying out the duties described in subsection (b), the Consortium shall consult with—

(1) the heads of relevant Federal agencies, including—

(A) the Environmental Protection Agency;

(B) the National Oceanic and Atmospheric Administration;

(C) the Occupational Safety and Health Administration; and

(D) from the Department of Health and Human Services—

(i) the Office of Minority Health in the Office of the Secretary;

(ii) the Centers for Medicare & Medicaid Services;

(iii) the Health Resources and Services Administration;

(iv) the Centers for Disease Control and Prevention;

(v) the Indian Health Service; and

(vi) the Administration for Children and Families; and

(2) representatives of—

(A) stakeholder organizations;

(B) health care providers and professional membership organizations with expertise in maternal health or environmental justice;

(C) State and local public health departments;

(D) licensed and accredited hospitals, birth centers, midwifery practices, or other health care practices that provide prenatal or labor and delivery services to vulnerable individuals; and

(E) institutions of higher education, including such institutions that are minority-serving institutions or have expertise in maternal health or environmental justice.

SEC. 1205. STRATEGY FOR IDENTIFYING CLIMATE CHANGE RISK ZONES FOR VULNERABLE MOTHERS AND BABIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall develop a strategy (in this section referred to as the ''Strategy'') for

designating areas that the Secretary determines to have a high risk of adverse maternal and infant health outcomes among vulnerable individuals as a result of risks associated with climate change.

(b) STRATEGY REQUIREMENTS.—

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

(A) the incidence of diseases associated with air pollution, extreme heat, and other environmental factors;

(B) the availability and accessibility of maternal and infant health care providers;

(C) English-language proficiency among women of reproductive age;

(D) the health insurance status of women of reproductive age;

(E) the number of women of reproductive age who are members of racial or ethnic groups with disproportionately high rates of adverse maternal and infant health outcomes;

(F) the socioeconomic status of women of reproductive age, including with respect to—

(i) poverty;

(ii) unemployment;

(iii) household income; and

(iv) educational attainment; and

(G) access to quality housing, transportation, and nutrition.

(2) RESOURCES.—In developing the Strategy, the Secretary shall identify, and incorporate a description of, the following:

(A) Existing mapping tools or Federal programs that identify—

(i) risks associated with climate change for vulnerable individuals; and

(ii) other factors that can influence maternal and infant health outcomes, including the factors described in paragraph (1).

(B) Environmental, health, socioeconomic, and demographic data relevant to identifying risks associated with climate change for vulnerable individuals.

(C) Existing monitoring networks that collect data described in subparagraph (B), and any gaps in such networks.

(D) Federal, State, and local stakeholders involved in maintaining monitoring networks identified under subparagraph (C), and how such stakeholders are coordinating their monitoring efforts.

(E) Additional monitoring networks, and enhancements to existing monitoring networks, that would be required to address gaps identified under subparagraph (C), including at the subcounty and census tract level.

(F) Funding amounts required to establish the monitoring networks identified under subparagraph (E) and recommendations for Federal, State, and local coordination with respect to such networks.

(G) Potential uses for data collected and generated as a result of the Strategy, including how such data may be used in determining recipients of grants under the program established by section 2 or other similar programs.

(H) Other information the Secretary considers relevant for the development of the Strategy.

(c) COORDINATION AND CONSULTATION.—In developing the Strategy, the Secretary shall—

(1) coordinate with the Administrator of the Environmental Protection Agency and the Administrator of the National Oceanic and Atmospheric Administration; and

(2) consult with—

(A) stakeholder organizations;

(B) health care providers and professional membership organizations with expertise in maternal health or environmental justice;

(C) State and local public health departments;

(D) licensed and accredited hospitals, birth centers, midwifery practices, or other health care providers that provide prenatal or labor and delivery services to vulnerable individuals; and

(E) institutions of higher education, including such institutions that are minority-serving institutions or have expertise in maternal health or environmental justice.

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

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

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

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

(1) the Strategy;

(2) the public comments received under subsection (d); and

(3) the responses of the Secretary to such public comments.

TITLE XIII—MATERNAL VACCINATIONS

SEC. 1301. MATERNAL VACCINATION AWARENESS AND EQUITY CAMPAIGN.

(a) CAMPAIGN.—Section 313 of the Public Health Service Act (42 U.S.C. 245) is amended—

(1) in subsection (a), by inserting ''and among pregnant and postpartum individuals,'' after ''low rates of vaccination,'';

(2) in subsection (c)(3), by striking ''prenatal and pediatric'' and inserting ''prenatal, obstetric, and pediatric'';

(3) in subsection (d)(4)(B), by inserting ''pregnant and postpartum individuals and'' after ''including''; and

(4) in subsection (g), by striking ''$15,000,000 for each of fiscal years 2021 through 2025'' and inserting ''$17,000,000 for each of fiscal years 2024 through 2028''.

(b) ADDITIONAL ACTIVITIES.—Section 317(k)(1)(E) of the Public Health Service Act (42 U.S.C. 247b(k)(1)(E)) is amended—

(1) in clause (v), by striking ''and'' at the end; and

(2) by adding at the end the following:

''(vii) increase vaccination rates of pregnant and postpartum individuals, including individuals from racial and ethnic minority groups, and their children; and''.