SENATE DOCKET, NO. 2401 FILED ON: 1/20/2023

SENATE . . . . . No. 1415

The Commonwealth of Massachusetts

PRESENTED BY:

Liz Miranda

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to birthing justice in the Commonwealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Liz Miranda	*Second Suffolk*	
Lindsay N. Sabadosa	*1st Hampshire*	*1/30/2023*
Paul W. Mark	*Berkshire, Hampden, Franklin and Hampshire*	*1/30/2023*
Tram T. Nguyen	*18th Essex*	*1/30/2023*
David M. Rogers	*24th Middlesex*	*1/30/2023*
Christine P. Barber	*34th Middlesex*	*1/30/2023*
Carmine Lawrence Gentile	*13th Middlesex*	*1/30/2023*
Rebecca L. Rausch	*Norfolk, Worcester and Middlesex*	*2/7/2023*
Samantha Montaño	*15th Suffolk*	*2/7/2023*
Ruth B. Balser	*12th Middlesex*	*2/7/2023*
Jack Patrick Lewis	*7th Middlesex*	*2/8/2023*
David Henry Argosky LeBoeuf	*17th Worcester*	*2/8/2023*
Jason M. Lewis	*Fifth Middlesex*	*2/8/2023*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*2/8/2023*
Steven Owens	*29th Middlesex*	*2/8/2023*
David Paul Linsky	*5th Middlesex*	*2/8/2023*
Lydia Edwards	*Third Suffolk*	*2/8/2023*

Patricia A. Duffy	*5th Hampden*	*2/8/2023*
Antonio F. D. Cabral	*13th Bristol*	*2/8/2023*
Anne M. Gobi	*Worcester and Hampshire*	*2/8/2023*
Thomas M. Stanley	*9th Middlesex*	*2/8/2023*
Sal N. DiDomenico	*Middlesex and Suffolk*	*2/8/2023*
Sean Garballey	*23rd Middlesex*	*2/8/2023*
James C. Arena-DeRosa	*8th Middlesex*	*2/14/2023*
Jacob R. Oliveira	*Hampden, Hampshire and Worcester*	*2/14/2023*
Michael O. Moore	*Second Worcester*	*2/21/2023*
Adrianne Pusateri Ramos	*14th Essex*	*2/21/2023*
Daniel Cahill	*10th Essex*	*2/21/2023*
James B. Eldridge	*Middlesex and Worcester*	*2/21/2023*
Natalie M. Higgins	*4th Worcester*	*3/2/2023*
Christopher Richard Flanagan	*1st Barnstable*	*3/2/2023*
Michael P. Kushmerek	*3rd Worcester*	*3/2/2023*
James J. O'Day	*14th Worcester*	*3/2/2023*
Patricia D. Jehlen	*Second Middlesex*	*3/2/2023*
Paul R. Feeney	*Bristol and Norfolk*	*3/6/2023*

SENATE DOCKET, NO. 2401 FILED ON: 1/20/2023

SENATE . . . . . No. 1415

By Ms. Miranda, a petition (accompanied by bill, Senate, No. 1415) of Liz Miranda, Lindsay N. Sabadosa, Paul W. Mark, Tram T. Nguyen and other members of the General Court for legislation relative to birthing justice in the Commonwealth. Public Health.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act relative to birthing justice in the Commonwealth.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 118E of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after Section 10L the following: -

Section 10M. The division shall provide coverage of screenings by pediatricians for postpartum depression in mothers of newly born children during any visit to a pediatrician's office taking place for up to one year from the date of the child's birth.

SECTION 2. Chapter 38 of the general laws is hereby amended by inserting after section 2A the following section: --

Section 2B. As used in this section, the term below shall have the following meaning: -

"Authorized local health agency", shall mean a health board, department, or other governmental entity that is authorized by the department of public health to receive timely data

relative to fetal and infant deaths for assessing, planning, improving and monitoring the service systems and community resources that support child and maternal health.

The department of public health shall establish a process for designating authorized local health agencies. This process may include reasonable criteria regarding the level of expertise, workforce capacity, or organizational capacity. Authorized local health agencies shall be authorized to conduct in-depth fetal infant mortality review of each individual infant and fetal death occurring within their jurisdiction, in order to identify local factors associated with fetal and infant deaths and inform public health policy programs.

For each case of fetal or infant death to be reviewed, authorized local health agencies are hereby authorized to collect relevant data from a variety of sources, which may include physician and hospital records in addition to relevant community program records. Authorized local health agencies are authorized to collect, and the department is authorized to provide, timely access to vital records and other data reasonably necessary for fetal and infant mortality review.

The department may issue additional guidance through policy or regulation, consistent with this section, regarding the process for conducting fetal infant mortality reviews by authorized local health agencies, which may include guidance from the National Fetal and Infant Mortality Review Program.

SECTION 3. Section 9 of chapter 13 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting, in line 7, after the word “counselors” the following words:- , the board of registration in midwifery.

SECTION 4. Said chapter 13, as so appearing, is hereby further amended by adding the following section:-

Section 110. (a) There shall be within the department of public health a board of registration in midwifery. The board shall consist of 8 members to be appointed by the governor, 5 of whom shall be midwives with not less than 5 years of experience in the practice of midwifery and who shall be licensed under sections 276 to 289, inclusive, of chapter 112, 1 of whom shall be a physician licensed to practice medicine under section 2 of said chapter 112 with experience working with midwives, 1 of whom shall be a certified nurse-midwife licensed to practice midwifery under section 80B of said chapter 112 and 1 of whom shall be a member of the public. Four of the members of the board of registration in midwifery shall have experience working on the issue of racial disparities in maternal health or be a member of a population that is underrepresented in the midwifery profession. When making the appointments, the governor shall consider the recommendations of organizations representing certified professional midwives in the commonwealth. The appointed members shall serve for terms of 3 years. Upon the expiration of a term of office, a member shall continue to serve until a successor has been appointed and qualified. A member shall not serve for more than 2 consecutive terms; provided, however, that a person who is chosen to fill a vacancy in an unexpired term of a prior board member may serve for 2 consecutive terms in addition to the remainder of that unexpired term. A member may be removed by the governor for neglect of duty, misconduct, malfeasance or misfeasance in the office after a written notice of the charges against the member and sufficient opportunity to be heard thereon. Upon the death or removal for cause of a member of the board, the governor shall fill the vacancy for the remainder of that member’s term after considering suggestions from a list of nominees provided by organizations representing certified professional midwives in the commonwealth. For the initial appointment of the board, the 5 members required to be licensed midwives shall be persons with at least 5 years of experience in the

practice of midwifery who meet the eligibility requirements set forth in subsection (a) of section 281 of chapter 112. Members of the board shall be residents of the commonwealth.

(b) Annually, the board shall elect from its membership a chair and a secretary who shall serve until their successors have been elected and qualified. The board shall meet not less than 4 times annually and may hold additional meetings at the call of the chair or upon the request of not less than 4 members. A quorum for the conduct of official business shall be a majority of those appointed. Board members shall serve without compensation but shall be reimbursed for actual and reasonable expenses incurred in the performance of their duties. The members shall be public employees for the purposes of chapter 258 for all acts or omissions within the scope of their duties as board members.

SECTION 5. Section 1E of chapter 46 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Physician" the following definition:-

"Licensed midwife," a midwife licensed to practice by the board of registration in midwifery as provided in sections 276 to 289 of chapter 112.

SECTION 6. Section 3B of said chapter 46, as so appearing, is hereby amended by inserting after the word "physician", in line 1, the following words:- or licensed midwife.

SECTION 7. Section 1 of chapter 94C of the general laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Isomer" the following definition:-

"Licensed midwife," a midwife licensed to practice by the board of registration in midwifery as provided in sections 276 to 289 of chapter 112.

SECTION 8. Section 7 of said chapter 94C, as so appearing, is hereby amended by adding the following new subsection:-

(j) The commissioner shall promulgate regulations which provide for the automatic registration of licensed midwives, upon the receipt of the fee as herein provided, to issue written prescriptions in accordance with the provisions of sections 279 of chapter 112 and the regulations issued by the board of registration in midwifery under said section 279 of chapter 112, unless the registration of such licensed midwife has been suspended or revoked pursuant to the provisions of section 13 or section 14 or unless such registration is denied for cause by the commissioner pursuant to the provisions of chapter 30A. Prior to promulgating such regulations, the commissioner shall consult with the board of registration in midwifery.

SECTION 9. Section 9 of said chapter 94C, as so appearing, is hereby amended by inserting in paragraph (a), after the words "certified nurse midwife as provided in section 80C of said chapter 112" the following words:- , licensed midwife as limited by subsection (j) of said section 7 and section 279 of said chapter 112.

SECTION 10. Section 9 of said chapter 94C, as so appearing, is hereby further amended in paragraph (b), by inserting after the words "midwife" in each place that they appear, the following words:- , licensed midwife.

SECTION 11. Said section 9 of said chapter 94C, as so appearing, is hereby further amended in paragraph (b), by inserting after the words "nurse-midwifery" in each place that they appear, the following words:- , midwifery.

SECTION 12. Section 9 of said chapter 94C is further amended in paragraph (c), by inserting after the words “certified nurse midwife” in each place that they appear, the following words:- , licensed midwife.

SECTION 13. The definition of “medical peer review committee” in section 1 of chapter 111 of the General Laws, as appearing in the 2020 official edition, is hereby amended by adding the following sentence:- “Medical peer review committee” shall include a committee or association that is authorized by a midwifery society or association to evaluate the quality of midwifery services or the competence of midwives and suggest improvements in midwifery practices to improve patient care.

SECTION 14. Section 202 of said chapter 111, as so appearing, is hereby amended by inserting, in the second and third paragraphs, after the word “attendance”, in each instance, the following words:- or midwife in attendance.

SECTION 15. Said section 202, as so appearing, is hereby further amended by inserting, in the fourth paragraph, after the word “attendance” the following words:- or without the attendance of a midwife,.

SECTION 16. Section 204 of said chapter 111, as so appearing, is hereby amended by inserting, in lines 7, 12 and 28, after the word “medicine”, in each instance, the following word:- , midwifery.

SECTION 17. Chapter 112 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding the following new sections:-

Section 276. As used in sections 276 to 288, inclusive, of this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:

“Board”, the board of registration in midwifery, established under section 110 of chapter 13.

“Certified nurse-midwife”, a nurse with advanced training and who has obtained certification by the American Midwifery Certification Board.

“Certified professional midwife”, a professional independent midwifery practitioner who has obtained certification by the NARM."

“Client”, a person under the care of a licensed midwife, as described by a written statement pursuant to section 284 of this chapter.

“Licensed midwife”, a person registered by the board to practice midwifery in the commonwealth under sections 276 to 288, inclusive, of this chapter.

“MBC”, the midwifery bridge certificate issued by the NARM or its successor credential.

“MEAC”, the Midwifery Education Accreditation Council or its successor organization.

“Midwifery”, the practice of providing primary care to a client and newborn during the preconception, antepartum, intrapartum and postpartum periods.

“NARM”, the North American Registry of Midwives or its successor organization.

Section 277. Nothing in sections 276 to 288, inclusive, of this chapter shall limit or regulate the practice of a licensed physician, certified nurse-midwife, or licensed basic or

advanced emergency medical technician. The practice of midwifery shall not constitute the practice of medicine, certified nurse-midwifery or emergency medical care.

Section 278. (a) The board shall:

(i) adopt rules and promulgate regulations governing licensed midwives and the practice of midwifery to promote public health, welfare and safety, consistent with the essential competencies identified by the NARM;

(ii) administer the licensing process, including, but not limited to:

(A) receiving, reviewing, approving, rejecting and issuing applications for licensure;

(B) renewing, suspending, revoking and reinstating licenses;

(C) investigating complaints against persons licensed under sections 276 to 288, inclusive, of this chapter;

(D) holding hearings and ordering the disciplinary sanction of a person who violates sections 276 to 288, inclusive, of this chapter or a regulation of the board;

(iii) establish administrative procedures for processing applications and renewals;

(iv) have the authority to adopt and provide a uniform, proctored examination for applicants to measure the qualifications necessary for licensure;

(v) develop practice standards for licensed midwives that shall include, but not be limited to:

(A) adoption of ethical standards for licensed midwives and apprentice midwives;

(B) maintenance of records of care, including client charts;

(C) participation in peer review; and

(D) development of standardized informed consent, reporting and written emergency transport plan forms;

(vi) establish and maintain records of its actions and proceedings in accordance with public records laws; and

(vii) adopt professional continuing education requirements for licensed midwives seeking renewal consistent with those maintained by the NARM.

(b) Nothing in this section shall limit the board's authority to impose sanctions that are considered reasonable and appropriate by the board. A person subject to any disciplinary action taken by the board under this section or taken due to a violation of any other law, rule or regulation may file a petition for judicial review pursuant to section 64 of this chapter.

(c) A licensed midwife shall accept and provide care to clients only in accordance with the scope and standards of practice identified in the rules adopted pursuant to this section.

(d) Notwithstanding any other provision in this section, the board shall not issue any regulations that require a licensed midwife to practice under the supervision of or in collaboration with another healthcare provider or to enter into an agreement, written or otherwise, with another healthcare provider.

Section 279. A licensed midwife duly registered to issue written prescriptions in accordance with the provisions of subsection (j) of section 7 of chapter 94C may order, possess, purchase, and administer pharmaceutical agents consistent with the scope of midwifery practice,

including without limitation antihemorrhagic agents including but not limited to oxytocin, misoprostol and methergine; intravenous fluids for stabilization; vitamin K; eye prophylaxes; oxygen; antibiotics for Group B Streptococcal antibiotic prophylaxes; Rho (D) immune globulin; local anesthetic; epinephrine; and other pharmaceutical agents identified by the board, however, that nothing in this section shall be construed to permit a licensed midwife's use of pharmaceutical agents which are (a) controlled substances as described by Title 21 U.S.C. Section 812 or in chapter 94C, except for those listed in schedule VI; or (b) not identified by rules and regulations promulgated by the board of registration in midwifery as consistent with the scope of midwifery practice.

Section 280. A person who desires to be licensed and registered as a licensed midwife shall apply to the board in writing on an application form prescribed and furnished by the board. The applicant shall include in the application statements under oath satisfactory to the board showing that the applicant possesses the qualifications described under section 281 prior to any examination which may be required under section 278. The secretary of administration and finance, pursuant to section 3B of chapter 7, shall establish a license application fee, a license renewal fee and any other fee applicable under sections 276 to 288, inclusive, of this chapter; provided, however, that such license applicant and license renewal fees shall not exceed $200 biennially. The board, in consultation with the secretary of administration and finance, shall institute a process for applicants to apply for a financial hardship waiver, which may reduce or fully exempt an applicant from paying the fee pursuant to this section. Fees collected by the board shall be deposited into the Quality in Health Professions Trust Fund pursuant to section 35X of chapter 10 to support board operations and administration and to reimburse board members for actual and necessary expenses incurred in the performance of their official duties.

Section 281. (a) To be eligible for registration and licensure by the board as a licensed midwife, an applicant shall: (i) be of good moral character; (ii) be a graduate of a high school or its equivalent; and (iii) possess a valid certified professional midwife credential from the NARM.

(b) An applicant for a license to practice midwifery as a certified professional midwife shall submit to the board proof of successful completion of a formal midwifery education and training program as follows:

(i) a certificate of completion or equivalent from an educational program or institution accredited by the MEAC; or

(ii) an MBC, provided that an applicant: (1) is certified as a certified professional midwife within 5 years after the effective date of this section and completed a midwifery education and training program from an educational program or institution that is not accredited by the MEAC; or (2) is licensed as a professional midwife in a state that does not require completion of a midwifery education and training program from an educational program or institution that is accredited by the MEAC.

Section 282.

The board may license in a like manner, without examination, any midwife who has been licensed in another state under laws which, in the opinion of the board, require qualifications and maintain standards substantially the same as those of this commonwealth for licensed midwives, provided, however, that such midwife applies and remits fees as provided for in section 279.

Section 283. (a) The board may, after a hearing pursuant to chapter 30A, revoke, suspend or cancel the license of a licensed midwife, or reprimand or censure a licensed midwife, for any of the reasons set forth in section 61.

(b) No person filing a complaint or reporting information pursuant to this section or assisting the board at its request in any manner in discharging its duties and functions shall be liable in any cause of action arising out of providing such information or assistance; provided, however, that the person making the complaint or reporting or providing such information or assistance does so in good faith and without malice.

Section 284. When accepting a client for care, a licensed midwife shall obtain the client's informed consent, which shall be evidenced by a written statement in a form prescribed by the board and signed by both the licensed midwife and the client.

Section 285. A licensed midwife shall prepare, in a form prescribed by the board, a written plan for the appropriate delivery of emergency care. The plan shall include, but not be limited to: (i) consultation with other health care providers; (ii) emergency transfer; and (iii) access to neonatal intensive care units and obstetrical units or other patient care areas.

Section 286. A health care provider that consults with or accepts a transport, transfer or referral from a licensed midwife, or that provides care to a client of a licensed midwife or such client's newborn, shall not be liable in a civil action for personal injury or death resulting from an act or omission by the licensed midwife, unless the professional negligence or malpractice of the health care provider was a proximate cause of the injury or death.

Section 287. (a) The board may petition any court of competent jurisdiction for an injunction against any person practicing midwifery or any branch thereof without a license

granted pursuant to sections 276 to 288, inclusive, of this chapter. Proof of damage or harm sustained by any person shall not be required for issuance of such injunction. Nothing in this section shall relieve a person from criminal prosecution for practicing without a license.

(b) Nothing in this section shall prevent or restrict the practice, service or activities of:

(i) a person licensed in the commonwealth from engaging in activities within the scope of practice of the profession or occupation for which such person is licensed; provided, however, that such person does not represent to the public, directly or indirectly, that such person is licensed under sections 276 to 289, inclusive, and that such person does not use any name, title or designation indicating that such person is licensed under said sections 276 to 289, inclusive; or

(ii) a person employed as a midwife by the federal government or an agency thereof if that person provides midwifery services solely under the direction and control of the organization by which such person is employed;

(iii) a traditional birth attendant who provides midwifery services if no fee is contemplated, charged or received, and such person has cultural or religious traditions that have historically included the attendance of traditional birth attendants at birth, and the birth attendant serves only individuals and families in that distinct cultural or religious group;

(iv) persons who are members of Native American communities and provide traditional midwife services to their communities; or

(v) any person rendering aid in an emergency.

Section 288. A licensed midwife, registered by the board of registration in midwifery pursuant to sections 276 to 288, inclusive, of this chapter, who provides services to any person or

beneficiary covered by Title XIX of the Social Security Act or MassHealth pursuant to section 9A of chapter 118E, may accept the Medicaid or MassHealth approved rate as payment in full for such services; provided, that a licensed midwife who accepts the Medicaid or MassHealth approved rate pursuant to this section shall be reimbursed at said rate for such services

SECTION 18. Chapter 118E of the General Laws, as appearing in the 2020 Official Edition, is hereby amended in section 10A by adding the words “licensed midwife,” after the word “physician,” in line 15 and after the word “pediatrician,” in line 20, and by inserting at the end of the section the following sentence:- The division shall provide coverage for midwifery services including prenatal care, childbirth and postpartum care provided by a licensed midwife regardless of the site of services.

SECTION 19. The board established pursuant to section 110 of chapter 13 of the General Laws shall adopt rules and promulgate regulations pursuant to this act within 1 year from the effective date of this act.

SECTION 20. The board established pursuant to section 110 of chapter 13 of the General Laws shall promulgate regulations for the licensure of individuals practicing midwifery prior to the date on which the board commences issuing licenses; provided, however, that individuals practicing midwifery in the commonwealth as of the date on which the board commences issuing licenses shall have 2 years from that date to complete the requirements necessary for licensure.

SECTION 21. Nothing in this act shall preclude a person who was practicing midwifery before the effective date of this act from practicing midwifery in the commonwealth until the board establishes procedures for the licensure of midwives pursuant to this act.

SECTION 22. The department of public health shall promulgate regulations within 1 year from the effective date of this act, governing birth centers, consistent with standards set forth by the American Association of Birth Centers, including without limitation authorizing licensed professional midwives to practice in birth centers as primary birth attendants, director of birth centers, and director of clinical affairs. Licensed professional midwives practicing in licensed birth centers shall not be required to enter into any agreement for supervision or collaboration with any other healthcare provider or hospital.

SECTION 23. Chapter 118E of the General Laws is hereby amended by inserting after section 10N the following section:-

Section 10O: Medicaid Coverage for Doula Services.

(A) For purposes of this section, the term “doula services” shall have the following meaning:

“Doula Services” are physical, emotional, and informational support, but not medical care, provided by trained doulas to individuals and families during and after pregnancy, labor, childbirth, miscarriage, stillbirth or pregnancy loss. Doula services include but are not limited to:

(1) continuous labor support;

(2) prenatal, postpartum, and bereavement home or in-person visits throughout the perinatal period, lasting until 1 year after birth, pregnancy loss, stillbirth, or miscarriage;

(3) accompanying pregnant individuals to health care and social services appointments;

(4) providing support to individuals for loss of pregnancy or infant from conception

through one year postpartum;

(5) connecting individuals to community-based and state- and federally-funded resources, including those which address social determinants of health;

(6) making oneself available (being on-call) around the time of birth or loss as well as providing support for any concerns of pregnant individuals throughout pregnancy and until one year after birth, pregnancy loss, stillbirth, or miscarriage.

(7) providing support for other individuals providing care for a birthing parent, including a birthing parent's partner and family members.

(B) Coverage of Doula Services:

(1) The Division shall provide coverage of doula services to pregnant individuals and postpartum individuals up to 12 months following the end of the pregnancy who are eligible for medical assistance under this chapter and/or through Title XIX or Title XXI of the Social Security Act. The Division shall provide the same coverage of doula services to pregnant and postpartum individuals who are not otherwise eligible for medical assistance under this chapter or Titles XIX or XXI of the Social Security Act solely because of their immigration status.

(2) The Division must cover continuous support through labor and childbirth, and at least up to six doula visits across the prenatal and one year postpartum period, including at least two postpartum visits, without the need for prior authorization. The Division must also establish a procedure to cover additional doula visits as needed.

(C) Creation of Doula Advisory Committee: There is hereby created a Doula Advisory Committee.

(1) The committee shall consist of 10-12 members to be appointed by the commissioner of public health, or designee.

(a) All but 2 of the members must be practicing doulas from the community; the remaining 2 members must be individuals from the community who have experienced pregnancy as a MassHealth member and are not practicing doulas.

(b) Among the members described in (a) above:

(i) at least 1 member must be a person who identifies as belonging to the LGBTQIA+ community;

(iii) at least 1 member must be a person who has experienced a severe maternal morbidity, a perinatal mental health or mood disorder, or a near-death experience while pregnant or in maternity care;

(iv) at least 1 member must be a person who identifies as a person with disabilities or disabled person;

(c) The members of the committee shall represent a diverse range of experience levels- from doulas new to the practice to more experienced doulas.

(d) The members of the committee shall be from areas within the Commonwealth where maternal and infant outcomes are worse than the state average, as evidenced by the MA Department of Public Health's most current perinatal data available at the time the member is appointed.

(e) The members of the committee shall represent an equitable geographic distribution from across the Commonwealth.

(2) The committee must be convened within six months of passage of this law.

(3) Of the initial appointments to the Doula Advisory Committee, half shall be appointed to a term of 2 years and half shall be appointed to a term of 18 months. Thereafter, all terms shall be 2 years. The commissioner of public health, or designee, shall fill vacancies as soon as practicable.

(4) At least once every 8 weeks, the Division must meet with the Doula Advisory Committee to consult about at least the following:

(a) the scope of doula services covered by MassHealth;

(b) doula competencies required for reimbursement by MassHealth, and standards of proof or demonstration of those competencies;

(c) the recruitment of a diverse workforce of doulas to provide services to MassHealth members;

(d) the development of comprehensive and high quality continuing education and training that is free or low-cost to doulas committed to providing services to MassHealth members, as well as the development of mentorship and career growth opportunities for doulas providing services to MassHealth members;

(e) the performance of any third party administrators of MassHealth's doula coverage program, and standards and processes around billing for and prompt reimbursement of doula services;

(f) establishing grievance procedures for doulas, MassHealth members, and health care providers about MassHealth's coverage of doula services and/or the provision of doula services to MassHealth members;

(g) outreach to the public and stakeholders about how to access doula care for MassHealth members, and about the availability of and advantages of doula care;

(h) the evaluation and collection of data on the provision of, outcomes of, access to, and satisfaction with doula care services provided to MassHealth members;

(i) maintaining a reimbursement rate for doula services that incentivizes and supports a diverse workforce representative of the communities served, and establishing a recurring timeframe to review that rate in light of inflation and changing costs of living in the commonwealth;

(j) how to ensure that MassHealth's doula reimbursement program is directed towards the goal of reducing inequities in maternal and birth outcomes among racial, ethnic, and cultural populations who reside in all areas within the commonwealth, as evidenced by the most current perinatal data supplied by the department of public health.

(5) Each year, the Doula Advisory Committee must, by a majority vote of a quorum of its members, select an individual to serve as its chairperson for a one year term. The Doula Advisory Committee may replace the chairperson in the same manner mid-term.

(6) The Doula Advisory Committee may, by a majority vote of a quorum of its members, reduce the frequency of meetings with MassHealth to less than once every 8 weeks.

(7) The division and the Department of Public Health shall seek resources to offer reasonable compensation to members of the Doula Advisory Committee for fulfilling their duties, and must reimburse members for actual and necessary expenses incurred while fulfilling their duties.

(8) The division, in partnership with the Doula Advisory Committee, shall conduct at least 1 public hearing or forum each year until three years after passage of this law. The purposes of these hearings or forums shall be to gather feedback from the public and to inform the public about MassHealth's coverage of doula care.

SECTION 24. Chapter 29 of the Massachusetts General Laws is hereby amended by inserting after section 2QQQQQ the following section:-

Section 2RRRRR. (a) There shall be established and set up on the books of the commonwealth a separate fund known as the Doula Workforce Development Trust Fund, hereinafter called the fund. The fund shall be administered by the department of career services which shall contract with the Commonwealth Corporation to administer the fund. The fund shall be credited with: (i) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; (ii) interest earned on such revenues; and (iii) funds from public and private sources; and other gifts, grants and donations for the growth, training and continuous support of the doula workforce. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

(b) The Commonwealth Corporation shall make expenditures from the fund for the purposes of:

(i) the development and expansion of comprehensive doula training available across the commonwealth. including the development of doula training focused on meeting the needs of MassHealth members;

(ii) ensuring that doulas committed to serving MassHealth members have access to high quality doula training at no- or low-cost to them;

(iii) the recruitment and retention of doulas from communities with high concentrations of MassHealth members, as well as areas within the commonwealth where maternal and infant outcomes are worse than the state average, as evidenced by the MA Department of Public Health's perinatal data.

(iv) expanding doula mentoring opportunities across the state, which provide new doulas the opportunity to attend births and incentivize experienced practicing doulas to take on mentees.

(v) leveraging funds to secure future federal funding to support doula workforce development in the commonwealth.

(c) The director of career services shall annually, not later than December 31, report to the secretary of administration and finance, the house and senate committees on ways and means and the joint committee on labor and workforce development on the efforts undertaken in support of section (b) above; the number of doulas recruited and trained as a result of activities taken in support of (b) above, including but not limited to sex, gender identity, race, and ethnicity of such doulas; the amount of grants and identities of grantees awarded in support of section (b) above; and the availability of doula training at no- or low-cost to doulas committed to serving MassHealth members.

SECTION 25. Chapter 111 of the General Laws is hereby amended by inserting in section 70E after “Every patient or resident of a facility shall have the right:”:

(p) to have their birth doula’s continuous presence during labor and delivery. Facilities shall not place an undue burden on a patient’s doula’s access to clinical labor and delivery settings, and shall not arbitrarily exclude a patient’s doula from such settings.

SECTION 26. Notwithstanding any general or special law to the contrary the commissioner of the department of development services shall include neonatal abstinence syndrome under the definition of Closely Related Development Conditions as defined under 115 CMR 2 and 115 CMR 6.06(1).

SECTION 27. Chapter 123B, section 2 is hereby amended by inserting after the first paragraph the following paragraph:-

The department of developmental services shall promulgate regulations to facilitate interagency coordination with agencies including, but not limited to, the department of public health, the department of mental health, and the department of early and secondary education and continuation of care during and in the transition provision of Children’s Supports to support access to health care and other services to improve social determinants of health.

SECTION 28. Chapter 111 of the General Laws is hereby amended by inserting after section 110H the following sections:-

Section 110I: Required Newborn Screening for Congenital Cytomegalovirus

For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Birthing facility", an inpatient or ambulatory health care facility licensed by the department of public health that provides birthing and newborn care services.

"Congenital Cytomegalovirus (hereinafter referred to as cCMV) screening", the identification of a newborn who may have congenital CMV infection or has cCMV confirmed through the use of a saliva or urine test.

"Department", the department of public health.

"Newborn," any liveborn infant who has not yet attained the age of 21 days from a birth occurring in the commonwealth or from a birth prior to transfer to a hospital in the commonwealth.

The department, in consultation with the perinatal advisory committee, shall develop regulations for all hospitals and birthing facilities requiring cCMV screening within one year of the passage of this legislation. These regulations shall consider evidence-based guidance.

The cCMV screening shall be performed using a saliva PCR test unless one is unavailable in which case a urine PCR test may be used. If positive, a saliva PCR test would require a confirmatory urine PCR test. The department may approve another test to conduct cCMV screening; provided, however, that the test shall be, at the discretion of the department, at least as accurate, widely available and cost-effective as a saliva or urine PCR test. A screening shall be performed within 21 days from the date of birth and before the newborn infant is discharged from the birthing facility to the care of the parent or guardian; provided, however, that the screening shall not be performed if the parent or guardian of the newborn infant objects to the screening based upon a sincerely held religious belief of the parent or guardian. The

cCMV educational materials outlined in section 70I(b) shall be provided to the parent or guardian of the infant at the time of cCMV screening.

A hospital that provides birthing and newborn services or a birthing facility shall adopt protocols for cCMV screening using a saliva or urine PCR test or another test approved by the department under this section for all newborns prior to discharge, and not to exceed 21 days from the date of birth, based on the department's regulations, on or before January 1, 2023.

The cost of providing the newborn cCMV screening shall be a covered benefit reimbursable by all health insurers, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, Medicare supplement or other supplemental policies. In the absence of a third-party payer, the charges for the newborn cCMV screening shall be paid by the Commonwealth.

A hospital or birthing facility shall report annually to the department data including, but not limited to, the number of cCMV tests administered and the outcomes of said tests. The hospital or birthing facility shall inform, orally and in writing, a parent or guardian of the newborn infant the result of the cCMV screening test regardless of its outcome. This information shall also be provided in writing to the newborn infant's primary care physician and to the department through its electronic birth certificate system or such mechanism as specified by the department.

The department shall review the protocols required under this section and the implementation of these protocols as part of its birthing facility licensure review processes.

The department shall promulgate regulations to implement the cCMV screening program.

Nothing in this statute shall preclude newborns born at home from obtaining said cCMV screening.

Section 110J: Advisory Committee for CMV Screening Program

There is hereby established an advisory committee for the purpose of implementing the provisions of Section 110I. The advisory committee shall consist of the following members to be appointed by the commissioner of the department: a representative of the hospital industry; a primary care pediatrician or family practitioner; an otolaryngologist; a neonatologist; an infectious disease specialist; a clinician representing newborn nurseries; an audiologist; an ophthalmologist; an obstetrician-gynecologist; a representative of the commonwealth's early intervention program; 2 parents and/or guardians of a child impacted by cCMV; 2 medical professionals; a developer of preventative and/or therapeutic interventions for cCMV; a teacher of the deaf; and a representative of the department.

The advisory committee shall advise the department regarding the validity and cost of proposed cCMV regulations and/or cCMV screening, and shall recommend standards for performing and interpreting screening tests based on the most current technological methods, for documenting test results and follow-up, and for facilitating interaction between professionals and agencies that participate in follow-up care. Members of the advisory committee shall serve without compensation. The advisory committee shall be provided support services by the department.

SECTION 29. Chapter 111 of the General Laws is hereby further amended by inserting after Section 70H the following section:-

Section 70I: Congenital cytomegalovirus; public information program; annual report

(a) The commissioner of the department shall establish, promote, and maintain a public information program regarding congenital cytomegalovirus, hereinafter referred to as cCMV. Such program shall be conducted throughout the commonwealth, and under said program, a hospital or birthing facility as defined in section 70E or any healthcare provider, physician assistant, nurse or midwife who renders prenatal or postnatal care shall give expectant or new parents or guardians information provided by the department under subsection (b). Such information shall be made available at the first prenatal appointment or at a preconception visit if applicable, whichever is earliest.

(b) The department shall make available to any healthcare provider, physician assistant, nurse or midwife who renders prenatal or postnatal care or offers fertility counseling or care to a parent or guardian the following: (i) up-to-date evidence-based, written information about cCMV and universal cCMV screening that has been vetted by an appropriate group of medical experts as determined by the department in conjunction with the advisory committee as established in section 110J of said Chapter 111; provided, however, that the written information provided shall include preventative measures that can be taken throughout pregnancy, and (ii) contact or other referral information for additional educational and support resources. The department may also make such information available to any other person who seeks information about cCMV infections.

SECTION 30. Section 17C of chapter 32A of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “coverage for”, in line 3, the following words:- abortion and abortion-related care,.

SECTION 31. Said section 17C of said chapter 32A, as so appearing, is hereby further amended by inserting after the second paragraph the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee's covered spouse and covered dependents.

The commission shall ensure plan compliance with this chapter.

SECTION 32. Section 10A of chapter 118E of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words "coverage for", in line 1, the following words:- abortion and abortion-related care,.

SECTION 33. Said section 10A of said chapter 118E, as so appearing, is hereby further amended by adding the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee's covered spouse and covered dependents.

Nothing in this section shall be construed to deny or restrict the division's authority to ensure its contracted health insurers, health plans, health maintenance organizations, behavioral

health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan are in compliance with this chapter.

SECTION 34. Section 47F of chapter 175 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “for the expense of”, in line 20, the following words:- abortion and abortion-related care,.

SECTION 35. Said section 47F of said chapter 175, as so appearing, is hereby further amended by inserting after the third paragraph the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee’s covered spouse and covered dependents.

A policy of accident and sickness insurance that is purchased by an employer that is a church or qualified church-controlled organization, as defined in section 47W of this chapter, shall be exempt from covering abortion and abortion-related care at the request of the employer. An employer that invokes the exemption under this section shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the health care methods and services for which the employer will not provide coverage for religious reasons.

SECTION 36. Section 8H of Chapter 176A of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “expense for”, in line 8, the following words:- abortion and abortion-related care,.

SECTION 37. Said section 8H of said chapter 176A, as so appearing, is hereby further amended by striking out, in lines 9 and 10, the words “to the same extent that benefits are provided for medical conditions not related to pregnancy”.

SECTION 38. Said section 8H of said chapter 176A, as so appearing, is hereby further amended by inserting after the third paragraph the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee’s covered spouse and covered dependents.

A policy of accident and sickness insurance that is purchased by an employer that is a church or qualified church-controlled organization, as defined in section 8W of this chapter, shall be exempt from covering abortion and abortion-related care at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the health care methods and services for which the employer will not provide coverage for religious reasons.

SECTION 39. Section 4H of chapter 176B of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “expense for”, in lines 7 and 8, the following words:- abortion and abortion-related care,.

SECTION 40. Said section 4H of said chapter 176B, as so appearing, is hereby further amended by striking out, in lines 8 to 10, inclusive, the words “to the same extent that benefits are provided for medical conditions not related to pregnancy”.

SECTION 41. Said section 4H of said chapter 176B, as so appearing, is hereby further amended by inserting after the third paragraph the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee’s covered spouse and covered dependents.

A policy of accident and sickness insurance that is purchased by an employer that is a church or qualified church-controlled organization, as defined in section 4W of this chapter, shall be exempt from covering abortion and abortion-related care at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the health care methods and services for which the employer will not provide coverage for religious reasons.

SECTION 42. Section 4I of chapter 176G of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “coverage for”, in lines 1 and 2, the following words:- abortion and abortion-related care,.

SECTION 43. Said section 4I of said chapter 176G, as so appearing, is hereby further amended by inserting after the second paragraph the following paragraphs:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

Benefits for an enrollee under this section shall be the same for the enrollee's covered spouse and covered dependents.

A health maintenance contract that is purchased by an employer that is a church or qualified church-controlled organization, as defined in section 40 of this chapter, shall be exempt from covering abortion and abortion-related care at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the health care methods and services for which the employer will not provide coverage for religious reasons.

SECTION 44. Sections 1 to 14, inclusive, shall apply to all policies, contracts and certificates of health insurance subject to chapters 32A, 118E, 175, 176A, 176B and 176G of the General Laws that are delivered, issued or renewed 6 months from the effective date of this act.

SECTION 45. Section 47C of chapter 175 is hereby amended by striking out the word "annually" and inserting in place thereof the following words:- once per calendar year.

SECTION 46. Chapter 111 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting, after section 2J, the following new section:-

Section 2K. (a) As used in this section, the following words shall have the following meanings unless context clearly requires otherwise:

"Commissioner," the commissioner of the department of public health.

"Department," the department of public health.

"Fund," the diaper benefits trust fund.

"Organization," an entity, including but not limited to, that acts in whole or in part as a diaper bank, diaper distribution organization, food bank or food pantry.

"Pilot program," an organization or organizations receiving funds from the department to provide diapers to low-income families with diaper-wearing infants and/or children. Organizations may collaborate to maximize distribution in their respective regions.

(b) There shall be established and set up on the books of the commonwealth a fund to address diaper insufficiency that shall be administered by the commissioner. The fund shall be credited with: (i) revenue from appropriations or other money authorized by the general court and specifically designated to the fund; (ii) interest earned on such revenues; and (iii) funds from public and private sources such as gifts, grants and donations to further the pilot program. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of the fiscal year shall not revert to the General Fund.

(c) The department shall distribute resources from the fund by issuing a request for proposal through which an organization or organizations may apply. Funds received shall be used for one or more of the following purposes: (i) acquiring diapers, (ii) storing diapers, (iii) distributing diapers, (iv) organizing diaper drives, or (v) marketing the pilot program.

The department shall grant funds based on the demonstrated capacity and need of the applicant. The department shall fund up to 12 applicants no more than 2 of which shall be from the western region of the commonwealth; no more than 2 of which shall be from the central

region of the commonwealth; no more than 2 of which shall be from the eastern region of the commonwealth; no more than 2 of which shall be from the southeastern region of the commonwealth; no more than 2 of which shall be from Cape Cod or the Islands; and no more than 2 of which shall be from the Merrimack valley.

Amounts received from private sources shall be approved by the commissioner of the department and subject to review before being deposited in the fund to ensure that pledged funds are not accompanied by conditions, explicit or implicit, on distributing diapers.

(d) Not later than one year after the implementation of each pilot program said department shall provide a report to the joint committee on children, families and persons with disabilities and to the house and senate committees on ways and means. The report shall include, but not be limited to: (i) the number of children receiving diapers through the pilot program; (ii) the number of households receiving diapers through the pilot program; (iii) the number of diapers distributed through the pilot program to families in each region; (iv) an explanation of the organization's distribution process and allocation determination; (v) the sources and the amounts remaining in the fund; (vi) if and how the pilot program was able to leverage additional support; (vii) the amounts distributed and the purpose of expenditures from the fund; and (viii) the advisability of expanding the pilot program.

SECTION 47. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 31. The commission shall provide to any active or retired employee of the commonwealth insured under the group insurance commission coverage for services rendered by a certified nurse midwife designated to engage in the practice of nurse-midwifery by the board of

registration in nursing pursuant to section 80C of chapter 112; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified nurse midwife's authorization to practice by the board of registration in nursing; (2) the policy or contract currently provides benefits for identical services rendered by a health care provider licensed by the commonwealth; and (3) the reimbursement for the services provided shall be in the same amount as the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician to achieve compliance with this section.

SECTION 48. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 80. The division shall provide coverage for services rendered by a certified nurse midwife designated to engage in the practice of nurse-midwifery by the board of registration in nursing pursuant to section 80C of chapter 112; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified nurse midwife's authorization to practice by the board of registration in nursing; (2) the policy or contract currently provides benefits for identical services rendered by a health care provider licensed by the commonwealth; and (3) the reimbursement for the services provided shall be in the same amount as the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician to achieve compliance with this section.

SECTION 49. Section 47E of Chapter 175 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following sentences:- The reimbursement for

the services provided pursuant to this section shall be in the same amount as the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician in order to comply with this section.

SECTION 50. Chapter 176A of the General Laws is hereby amended by inserting after section 8OO the following section:-

Section 8PP. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed in the commonwealth shall provide as a benefit to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth for services rendered by a certified nurse midwife designated to engage in the practice of nurse-midwifery by the board of registration in nursing pursuant to section 80C of chapter 112; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified nurse midwife's authorization to practice by the board of registration in nursing; (2) the policy or contract currently provides benefits for identical services rendered by a health care provider licensed by the commonwealth; and (3) the reimbursement for the services provided shall be in the same amount as the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician in order to comply with this section.

SECTION 51. Section 4G of Chapter 176B of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following sentences:- The reimbursement for the services provided pursuant to this section shall be in the same amount as

the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician in order to comply with this section.

SECTION 52. Section 4 of Chapter 176G is of the General Laws, as so appearing, is hereby amended by adding the following subsection:-

(g) services rendered by a certified nurse midwife designated to engage in the practice of nurse-midwifery by the board of registration in nursing pursuant to section 80C of chapter 112, subject to the terms of a negotiated agreement between the health maintenance organization and the provider of health care services. The reimbursement for the services provided shall be in the same amount as the reimbursement paid under the policy to a licensed physician performing the service in the area served. An insurer may not reduce the reimbursement paid to a licensed physician in order to comply with this section.

SECTION 53. Chapter 94C, as appearing in the 2018 Official Edition, is hereby amended by inserting, after section 19D, the following section:-

Section 19E. A registered pharmacist may prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to a person who is:

(a) At least 18 years of age, regardless of whether the person has evidence of a previous prescription from a primary care practitioner or women’s health care practitioner for a hormonal contraceptive patch or self-administered oral hormonal contraceptive; or

(b) Under 18 years of age, only if the person has evidence of a previous prescription from a primary care practitioner or women's health care practitioner for a hormonal contraceptive patch or self-administered oral hormonal contraceptive.

The board shall adopt rules to establish, in consultation with the Massachusetts Medical Board, the Massachusetts State Board of Nursing and the MassHealth, and in consideration of guidelines established by the American Congress of Obstetricians and Gynecologists, standard procedures for the prescribing of hormonal contraceptive patches and self-administered oral hormonal contraceptives by pharmacists. The rules adopted under this subsection must require a pharmacist to:

(a) Complete a training program approved by the State Board of Pharmacy that is related to prescribing hormonal contraceptive patches and self-administered oral hormonal contraceptives;

(b) Provide a self-screening risk assessment tool that the patient must use prior to the pharmacist's prescribing the hormonal contraceptive patch or self-administered oral hormonal contraceptive;

(c) Refer the patient to the patient's primary care practitioner or women's health care practitioner upon prescribing and dispensing the hormonal contraceptive patch or self-administered oral hormonal contraceptive;

(d) Provide the patient with a written record of the hormonal contraceptive patch or self-administered oral hormonal contraceptive prescribed and dispensed and advise the patient to consult with a primary care practitioner or women's health care practitioner; and

(e) Dispense the hormonal contraceptive patch or self-administered oral hormonal contraceptive to the patient as soon as practicable after the pharmacist issues the prescription.

The rules adopted must prohibit a pharmacist from:

(a) Requiring a patient to schedule an appointment with the pharmacist for the prescribing or dispensing of a hormonal contraceptive patch or self-administered oral hormonal contraceptive; and

(b) Prescribing and dispensing a hormonal contraceptive patch or self-administered oral hormonal contraceptive to a patient who does not have evidence of a clinical visit for women's health within the three years immediately following the initial prescription and dispensation of a hormonal contraceptive patch or self-administered oral hormonal contraceptive by a pharmacist to the patient.

SECTION 54. Section 51A of chapter 119 of the general laws is hereby amended in subsection (a) in the first paragraph by striking out the words:-

(iii) physical dependence upon an addictive drug at birth,

SECTION 55. Said section 51A is hereby further amended by inserting in subsection (a) after the second paragraph a new subsection:

(a ½) Separate from the reporting requirements under subsection (a), health care providers involved in the delivery or care of infants affected by in-utero substance exposure or a Fetal Alcohol Spectrum disorder, shall notify the Department of such condition in such infants as required under 42 U.S.C. § 1506a(b)(2)(B)(ii). Such notification shall not include the names or

identifying information of the parents or the infant, shall not constitute a report that any parent has abused or neglected a child, and shall not trigger or require prosecution for any illegal action.

SECTION 56. Chapter 111 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking subsection (4) of section 51G and inserting in place thereof the following section:

(4) (a) A hospital shall notify the department of a proposed closure at least one calendar year in advance of the date of the proposed closure or discontinuance of an essential health service.

(b) At least 30 days prior to notifying the department of the proposed closure or discontinuance of an essential health service, the hospital shall inform either electronically or in writing the Department and the following parties of its intent to submit notice: (a) The hospital's patient and family council; (b) Each staff member of the hospital; (c) Every labor organization that represents the hospital's workforce during the period of the essential services closure; (d) The members of the General Court who represent the city or town in which the hospital is located; and; (e) A representative of the local officials of the city or town in which the hospital is located. The department shall define essential services according to 105 CMR 130.

(c) At least 30 days prior to notifying the department of the proposed closure of an essential health service, a detailed account of any community engagement and planning which has occurred prior to such filing, and such other information as the Commissioner may require shall be presented to the department. With respect to the proposed closure of an essential health service, the hospital shall also send a copy of the notice that it submits to the Department to the Health Policy Commission, Office of the Attorney General, Center for Health Information and

Analysis, and Executive Office of Labor and Workforce Development as well as each of the health care coalitions and community groups identified by the hospital in its notice to the department.

(d) The hospital proposing the discontinuance shall provide, with their initial notice to the department, evidence of support or non-opposition to the proposed change from each municipality to which it provides the service as a health care resource, as determined pursuant to section 16T of chapter 6A of the General Laws, or, if a statement of non-opposition cannot be obtained, evidence of having given notice and allowed an opportunity for comment from said municipalities. Any notice given without meeting the requirements of this paragraph shall not constitute notice to the department for the purpose of establishing the earliest date on which the hospital may close or discontinue an essential health service.

(e) The department shall, in the event that a hospital proposes to discontinue an essential health service or services, determine whether any such discontinued services are necessary for preserving access and health status in the hospital's service area, require the hospital to submit a plan for assuring access to such necessary services following the hospital's closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. This plan shall include the creation of a community oversight committee comprised of a representative from each municipality to which the hospital provides the service as a health care resource as well as non-managerial employees, including registered nurses and ancillary staff, from the hospital, and a representative from a local interfaith organization to ensure that any plan approved by the department is followed. The community oversight group shall inform the department in the event the plan is not executed and followed by the hospital. If the hospital's plan for assuring

continued access to a necessary service relies upon the availability of similar services at another hospital or health facility with which it does not share common ownership, the department shall require the hospital to submit with said plan a statement from each other hospital or health facility listed in the plan, affirming their capacity to provide continued access as described in the plan. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital. No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicants existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital. The department may waive this requirement, in whole or in part, at the request of the applicant which has provided or at the time the application is filed, is providing, substantial primary and preventive health care services and community contributions in its service area.

(f) If a hospital executes a plan to discontinue an essential health service, said plan not having been approved by the department pursuant to this section, the Attorney General shall seek an injunction to require that the essential health service be maintained for the duration of the notice period outlined in subsection (a). Additionally, that hospital shall not be eligible to have an application approved pursuant to section 25C for a period of three years from the date the service is discontinued, or until the essential health service is restored, or until such time as the department is satisfied that a plan is in place that, at the time of the discontinuance, would have met the requirements of paragraph (c).

SECTION 57. Section 51 of chapter 111 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding after the word “Gynecologists,” in line 106, the following words:- , American College of Nurse Midwives, American Association of Birth Centers.

SECTION 58. (a) The department of public health shall promulgate revised regulations under the Code of Massachusetts Regulations 105 CMR 140.000 and 142.000 governing the facility and operation of licensed birth centers in consultation with Seven Sisters Birth Center, Neighborhood Birth Center, American College of Nurse Midwives Massachusetts Affiliate, and other entities operating or planning to open birth centers in Massachusetts to bring the regulations in accordance with chapter 111 of the General Laws and the standards of the American Association of Birth Centers or any successor organization, and to ensure safe, equitable and accessible birth options for birth center clients.

(b) The regulations shall include, but not be limited to, the following provisions:

(i) a licensed free-standing birth center shall have a detailed and written plan on the premises for transfer of a client to a nearby hospital providing obstetrical and newborn services as needed for emergency treatment beyond that provided by the birth center;

(ii) a licensed free-standing birth center shall develop policies and procedures to ensure coordination of ongoing care and transfer when complications occur which render the patient ineligible for birth center care during the antepartum, intrapartum or postpartum period;

(iii) the department shall not require a licensed free-standing birth center or the directors and providers on staff to practice under the supervision of a hospital or another health care

provider or to enter into an agreement, written or otherwise, with another hospital or health care provider, or maintain privileges at a hospital;

(iv) a licensed free-standing birth center shall have an administrative director responsible for implementing and overseeing the operational policies of the birth center;

(v) a licensed free-standing birth center shall have a director of clinical affairs on staff who shall be a nurse midwife or physician licensed and in good standing in Massachusetts whose professional scope of practice includes preconception, prenatal, labor, birth, and postpartum care and early care of the newborn and who may be the primary attendants during the perinatal period in accordance with chapter 112 of the General Laws; and

(vi) birth attendants at licensed free-standing birth centers shall be midwives, physicians, or other providers licensed and in good standing in Massachusetts whose professional scope of practice includes preconception, prenatal, labor, birth, and postpartum care and early care of the newborn and who may be the primary attendants in accordance with chapter 112 of the General Laws.

SECTION 59. The department shall issue the revised regulations under section 2 of this act no later than 180 days after the effective date of this act.

SECTION 60. Chapter 118E of the General Laws is hereby amended by inserting after section 10N the following section:-

Section 10O: Medicaid Coverage for Doula Services.

(A) For purposes of this section, the term “doula services” shall have the following meaning:

"Doula Services" are physical, emotional, and informational support, but not medical care, provided by trained doulas to individuals and families during and after pregnancy, labor, childbirth, miscarriage, stillbirth or pregnancy loss. Doula services include but are not limited to:

(1) continuous labor support;

(2) prenatal, postpartum, and bereavement home or in-person visits throughout the perinatal period, lasting until 1 year after birth, pregnancy loss, stillbirth, or miscarriage;

(3) accompanying pregnant individuals to health care and social services appointments;

(4) providing support to individuals for loss of pregnancy or infant from conception through one year postpartum;

(5) connecting individuals to community-based and state- and federally-funded resources, including those which address social determinants of health;

(6) making oneself available (being on-call) around the time of birth or loss as well as providing support for any concerns of pregnant individuals throughout pregnancy and until one year after birth, pregnancy loss, stillbirth, or miscarriage.

(7) providing support for other individuals providing care for a birthing parent, including a birthing parent's partner and family members.

(B) Coverage of Doula Services:

(1) The Division shall provide coverage of doula services to pregnant individuals and postpartum individuals up to 12 months following the end of the pregnancy who are eligible for medical assistance under this chapter and/or through Title XIX or Title XXI of the Social

Security Act. The Division shall provide the same coverage of doula services to pregnant and postpartum individuals who are not otherwise eligible for medical assistance under this chapter or Titles XIX or XXI of the Social Security Act solely because of their immigration status.

(2) The Division must cover continuous support through labor and childbirth, and at least up to six doula visits across the prenatal and one year postpartum period, including at least two postpartum visits, without the need for prior authorization. The Division must also establish a procedure to cover additional doula visits as needed.

(C) Creation of Doula Advisory Committee: There is hereby created a Doula Advisory Committee.

(1) The committee shall consist of 10-12 members to be appointed by the commissioner of public health, or designee.

(a) All but 2 of the members must be practicing doulas from the community; the remaining 2 members must be individuals from the community who have experienced pregnancy as a MassHealth member and are not practicing doulas.

(b) Among the members described in (a) above:

(i) at least 1 member must be a person who identifies as belonging to the LGBTQIA+ community;

(iii) at least 1 member must be a person who has experienced a severe maternal morbidity, a perinatal mental health or mood disorder, or a near-death experience while pregnant or in maternity care;

(iv) at least 1 member must be a person who identifies as a person with disabilities or disabled person;

(c) The members of the committee shall represent a diverse range of experience levels- from doulas new to the practice to more experienced doulas.

(d) The members of the committee shall be from areas within the Commonwealth where maternal and infant outcomes are worse than the state average, as evidenced by the MA Department of Public Health's most current perinatal data available at the time the member is appointed.

(e) The members of the committee shall represent an equitable geographic distribution from across the Commonwealth.

(2) The committee must be convened within six months of passage of this law.

(3) Of the initial appointments to the Doula Advisory Committee, half shall be appointed to a term of 2 years and half shall be appointed to a term of 18 months. Thereafter, all terms shall be 2 years. The commissioner of public health, or designee, shall fill vacancies as soon as practicable.

(4) At least once every 8 weeks, the Division must meet with the Doula Advisory Committee to consult about at least the following:

(a) the scope of doula services covered by MassHealth;

(b) doula competencies required for reimbursement by MassHealth, and standards of proof or demonstration of those competencies;

(c) the recruitment of a diverse workforce of doulas to provide services to MassHealth members;

(d) the development of comprehensive and high quality continuing education and training that is free or low-cost to doulas committed to providing services to MassHealth members, as well as the development of mentorship and career growth opportunities for doulas providing services to MassHealth members;

(e) the performance of any third party administrators of MassHealth's doula coverage program, and standards and processes around billing for and prompt reimbursement of doula services;

(f) establishing grievance procedures for doulas, MassHealth members, and health care providers about MassHealth's coverage of doula services and/or the provision of doula services to MassHealth members;

(g) outreach to the public and stakeholders about how to access doula care for MassHealth members, and about the availability of and advantages of doula care;

(h) the evaluation and collection of data on the provision of, outcomes of, access to, and satisfaction with doula care services provided to MassHealth members;

(i) maintaining a reimbursement rate for doula services that incentivizes and supports a diverse workforce representative of the communities served, and establishing a recurring timeframe to review that rate in light of inflation and changing costs of living in the commonwealth;

(j) how to ensure that MassHealth's doula reimbursement program is directed towards the goal of reducing inequities in maternal and birth outcomes among racial, ethnic, and cultural populations who reside in all areas within the commonwealth, as evidenced by the most current perinatal data supplied by the department of public health.

(5) Each year, the Doula Advisory Committee must, by a majority vote of a quorum of its members, select an individual to serve as its chairperson for a one year term. The Doula Advisory Committee may replace the chairperson in the same manner mid-term.

(6) The Doula Advisory Committee may, by a majority vote of a quorum of its members, reduce the frequency of meetings with MassHealth to less than once every 8 weeks.

(7) The division and the Department of Public Health shall seek resources to offer reasonable compensation to members of the Doula Advisory Committee for fulfilling their duties, and must reimburse members for actual and necessary expenses incurred while fulfilling their duties.

(8) The division, in partnership with the Doula Advisory Committee, shall conduct at least 1 public hearing or forum each year until three years after passage of this law. The purposes of these hearings or forums shall be to gather feedback from the public and to inform the public about MassHealth's coverage of doula care.

SECTION 61. Chapter 32A of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after section 27 the following section:

Section 28. (a) Any coverage offered by the commission to any active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for all doula services as defined in Section XX.

(b) Nothing in this section shall be construed to deny or restrict in any way the group insurance commission's authority to ensure plan compliance with this chapter.

SECTION 3. Chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after section 10I the following section:

10J (a) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide coverage for all doula services as defined in Section XX.

(b) Nothing in this section shall be construed to deny or restrict in any way the group insurance commission's authority to ensure plan compliance with this chapter.

SECTION 62. Chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after section 47W(c) the following:

(d) An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense and any group blanket policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance, delivered, issued or renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, (hereinafter "policy") shall provide benefits

for residents of the Commonwealth and all group members having a principal place of employment within the Commonwealth coverage for all doula services as defined in Section XX.

(e) Nothing in this section shall be construed to deny or restrict in any way the division of insurance's authority to ensure compliance with this chapter.

SECTION 63. Chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after section 8W(c) the following:

(d) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the Commonwealth and that provides benefits for outpatient services shall provide to all individual subscribers and members within the Commonwealth and to all group members having a principal place of employment within the Commonwealth coverage for all doula services as defined in Section XX.

(e) Nothing in this section shall be construed to deny or restrict in any way the division of insurance's authority to ensure compliance with this chapter.

SECTION 64. Chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after section 4W(c) the following:

(d) Any subscription certificate under an individual or group medical service agreement that is delivered, issued or renewed within or without the Commonwealth and that provides benefits for outpatient services shall provide to all individual subscribers and members within the Commonwealth and to all group members having a principal place of employment within the Commonwealth coverage for all doula services as defined in Section XX.

(e) Nothing in this subsection shall be construed to deny or restrict in any way the division of insurance's authority to ensure medical service agreement compliance with this chapter.

SECTION 65. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after section 4O(c) the following:

(d) Any individual or group health maintenance contract that is issued, renewed or delivered within or without the Commonwealth and that provides benefits for outpatient prescription drugs or devices shall provide to residents of the Commonwealth and to persons having a principal place of employment within the Commonwealth coverage for all doula services as defined in Section XX.

(e) Nothing in this subsection shall be construed to deny or restrict in any way the division of insurance's authority to ensure health maintenance contract compliance with this chapter.

SECTION 66. Sections 1 through 6 of this act shall apply to all policies, contracts and certificates of health insurance subject to chapters 32A, chapter 118E, chapter 175, chapter 176A, chapter 176B, and chapter 176G which are delivered, issued or renewed on or after September 1, 2024.

SECTION 67. Chapter 29 of the Massachusetts General Laws is hereby amended by inserting after section 2QQQQQ the following section:-

Section 2RRRRR. (a) There shall be established and set up on the books of the commonwealth a separate fund known as the Doula Workforce Development Trust Fund,

hereinafter called the fund. The fund shall be administered by the department of career services which shall contract with the Commonwealth Corporation to administer the fund. The fund shall be credited with: (i) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; (ii) interest earned on such revenues; and (iii) funds from public and private sources; and other gifts, grants and donations for the growth, training and continuous support of the doula workforce. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

(b) The Commonwealth Corporation shall make expenditures from the fund for the purposes of:

(i) the development and expansion of comprehensive doula training available across the commonwealth. including the development of doula training focused on meeting the needs of MassHealth members;

(ii) ensuring that doulas committed to serving MassHealth members have access to high quality doula training at no- or low-cost to them;

(iii) the recruitment and retention of doulas from communities with high concentrations of MassHealth members, as well as areas within the commonwealth where maternal and infant outcomes are worse than the state average, as evidenced by the MA Department of Public Health’s perinatal data.

(iv) expanding doula mentoring opportunities across the state, which provide new doulas the opportunity to attend births and incentivize experienced practicing doulas to take on mentees.

(v) leveraging funds to secure future federal funding to support doula workforce development in the commonwealth.

(c) The director of career services shall annually, not later than December 31, report to the secretary of administration and finance, the house and senate committees on ways and means and the joint committee on labor and workforce development on the efforts undertaken in support of section (b) above; the number of doulas recruited and trained as a result of activities taken in support of (b) above, including but not limited to sex, gender identity, race, and ethnicity of such doulas; the amount of grants and identities of grantees awarded in support of section (b) above; and the availability of doula training at no- or low-cost to doulas committed to serving MassHealth members.

SECTION 68. Chapter 111 of the General Laws is hereby amended by inserting in section 70E after “Every patient or resident of a facility shall have the right:”:

(p) to have their birth doula’s continuous presence during labor and delivery. Facilities shall not place an undue burden on a patient’s doula’s access to clinical labor and delivery settings, and shall not arbitrarily exclude a patient’s doula from such settings.

SECTION 69. Section 17C of chapter 32A of the General Laws, as most recently amended by section 8 of chapter 127 of the acts of 2022, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement; provided, however, that deductibles, coinsurance or copayments shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on

deductibles, coinsurance or copayments for these services. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

SECTION 70. Said section 17C of said chapter 32A, as most recently amended by section 8 of chapter 127, is hereby further amended by adding the following sentence:-

The commission shall ensure plan compliance with this section.

SECTION 71. Section 10A of chapter 118E of the General Laws, as most recently amended by section 19 of chapter 127 of the acts of 2022, is hereby amended by adding the following paragraphs:-

Nothing in this section shall be construed to deny or restrict the division's authority to ensure its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan are in compliance with this chapter.

The division shall ensure plan compliance with this chapter.

SECTION 72. Section 47F of chapter 175 of the General Laws, as most recently amended by section 22 of chapter 127 of the acts of 2022, is hereby amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement; provided, however, that deductibles, coinsurance or copayments shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on

deductibles, coinsurance or copayments for these services. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

SECTION 73. Said section 47F of said chapter 175, as recently amended by section 22 of chapter 127 of the acts of 2022, is hereby further amended by adding the following sentence:-

The commissioner shall ensure plan compliance with this section.

SECTION 74. Section 8H of chapter 176A of the General Laws, as most recently amended by section 26 of chapter 127 of the acts of 2022, is hereby amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement; provided, however, that deductibles, coinsurance or copayments shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on deductibles, coinsurance or copayments for these services. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

SECTION 75. Said section 8H of said chapter 176A, as most recently amended by section 26 of chapter 127 of the acts of 2022, is hereby further amended by adding the following sentence:-

The commissioner shall ensure plan compliance with this section.

SECTION 76. Section 4H of chapter 176B of the General Laws, as most recently amended by section 29 of chapter 127 of the acts of 2022, is hereby amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement; provided, however, that deductibles, coinsurance or copayments shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on deductibles, coinsurance or copayments for these services. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

SECTION 77. Said section 4H of said chapter 176B, as most recently amended by section 29 of chapter 127 of the acts of 2022, is hereby further amended by adding the following sentence:-

The commissioner shall ensure plan compliance with this section.

SECTION 78. Section 4I of chapter 176G of the General Laws, as most recently amended by section 31 of chapter 127 of the acts of 2022, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:-

Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement; provided, however, that deductibles, coinsurance or copayments shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on deductibles, coinsurance or copayments for these services. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage.

SECTION 79. Said section 4I of said chapter 176G, as most recently amended by section 31 of chapter 127 of the acts of 2022, is hereby amended by adding the following sentence:-

The commissioner shall ensure plan compliance with this section.

SECTION 80. Sections 1 to 11, inclusive, shall apply to all policies, contracts and certificates of health insurance subject to chapters 32A, 118E, 175, 176A, 176B and 176G of the General Laws that are delivered, issued or renewed 6 months from the effective date of this act.

SECTION 81. (A) There is hereby created in the department of job and family services the Massachusetts commission on fatherhood. The commission shall consist of the following members:

(1) (a) Four members of the house of representatives appointed by the speaker of the house, not more than two of whom are members of the same political party. Two of the members must be from legislative districts that include a county or part of a county that is among the one-third of counties in this state with the highest number per capita of households headed by females.

(b) Two members of the senate appointed by the president of the senate, each from a different political party. One of the members must be from a legislative district that includes a county or part of a county that is among the one-third of counties in this state with the highest number per capita of households headed by females.

(2) The governor, or the governor's designee;

(3) One representative of the judicial branch of government appointed by the chief justice of the supreme court;

(4) The directors of health, job and family services, rehabilitation and correction, and youth services and the superintendent of public instruction, or their designees;

(5) Two representative of the Massachusetts family and children first cabinet council created under section 121.37 of the Revised Code appointed by the chairperson of the council;

(6) Five representatives of the general public appointed by the governor. These members shall have extensive experience in issues related to fatherhood.

(B) The appointing authorities of the Massachusetts commission on fatherhood shall make initial appointments to the commission within thirty days after the effective date of this section. Of the initial appointments to the commission made pursuant to divisions (A)(3), (5), and (6) of this section, three of the members shall serve a term of one year and four shall serve a term of two years. Members so appointed subsequently shall serve two-year terms. A member appointed pursuant to division (A)(I) of this section shall serve on the commission until the end of the general assembly from which the member was appointed or until the member ceases to serve in the chamber of the general assembly in which the member serves at the time of appointment, whichever occurs first. The governor or the governor's designee shall serve on the commission until the governor ceases to be governor. The directors and superintendent or their designees shall serve on the commission until they cease, or the director or superintendent a designee represents ceases, to be director or superintendent. Each member shall serve on the commission from the date of appointment until the end of the term for which the member was appointed. Members may be reappointed.

Vacancies shall be filled in the manner provided for original appointments. Any member appointed to fill a vacancy occurring prior to the expiration date of the term for which the member's predecessor was appointed shall serve on the commission for the remainder of that term. A member shall continue to serve on the commission subsequent to the expiration date of

the member's term until the member's successor is appointed or until a period of sixty days has elapsed, whichever occurs first. Members shall serve without compensation but shall be reimbursed for necessary expenses

SECTION 82. Chapter 32A of the General Laws, is hereby amended by inserting after section 30 the following section:-

Section 31. The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for the universal postpartum home visiting program administered by the department of public health. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible.

SECTION 83. Chapter 111 is hereby amended by adding after Section 243 the following section:-

Section 244. (a) For the purposes of this section, the following words shall have the following meanings:-

“Department”, the department of public health.

“Provider”, an entity or individual that provides universal postpartum home visiting services.

“Programs”, entities or providers qualified by the department of public health to provide universal postpartum home visiting services.

“Universal postpartum home visiting services”, evidence-based, voluntary home or community-based services for birthing people and caregivers with newborns, regardless of age,

income, number of children, or other criteria. Services shall be delivered by a qualified health professional with maternal and child health training, as defined by the department of public health, during at least one visit in the family's home or a mutually agreed upon location within eight weeks postpartum, and one follow-up visit no later than three months after the first visit. Services shall include, but not be limited to, screenings for unmet health needs including reproductive health services, maternal and infant nutritional needs, substance use, emotional health including postpartum depression personal safety/domestic violence; clinical assessment of the birthing person and infant; brief intervention; education and support; referrals to community resources, such as breastfeeding supports; and follow up phone calls.

(b) The department shall establish and administer a statewide system of programs providing universal postpartum home visiting services. The department shall be the lead agency for the coordination of all government funding, both state and federal, for such programs. The department may contract with agencies, individuals or groups for the provision of such services, subject to appropriation. The department shall begin implementation of the universal newborn nurse home visiting program first in those communities with the greatest inequities in maternal health outcomes, as identified by the department. The department shall scale up the program to achieve universal, statewide access within six years of the passage of this act.

(c) In designing the program designed in subsection (b) of this section, the department shall consult, coordinate, and collaborate, as necessary, with insurers that offer health benefit plans in the commonwealth, MassHealth officials, hospitals, local public health departments, birthing centers, existing early childhood home visiting programs, community-based organizations, and social service providers.

(d) A provider of universal postpartum home visiting services shall determine whether any recipient for whom it provides said services are or may be eligible for coverage of said services through an alternative source. The department is the payer of last resort, and a provider shall request payment for services it provides from third-party payers pursuant to chapters 32A, 118E, 175, 176A, 176B, or 176G of the General Laws, before payment is requested from the department.

(e) The department shall collect and analyze data generated by the program to monitor and assess the effectiveness of universal postpartum home visiting services. The department shall work with other state agencies to develop protocols for sharing data, including the timely sharing of data with primary care providers of care to the families with newborns receiving the services. Programs which are in receipt of state or federal funding for said services shall report such information as requested by the department for the purpose of monitoring, assessing the effectiveness of such programs, initiating quality improvement, and reducing health disparities.

SECTION 84. Chapter 118E of the General Laws, is hereby amended by inserting after section 10N the following section:-

Section 10O. The division and its contracted managed care organizations, accountable care organizations, health plans, integrated care organizations, third-party administrators, or other entities contracting with the division to administer benefits, shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing.

SECTION 85. Chapter 175 of the General Laws, is hereby amended by inserting after section 47PP the following section:-

Section 47QQ. An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 86. Chapter 176A of the General Laws, is hereby amended by inserting after section 8KK the following section:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth

shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is

governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 87. Chapter 176B of the General Laws, is hereby amended by inserting after section 4KK the following section:-

Section 4LL. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 88. Chapter 176G of the General Laws, is hereby amended by inserting after section 4KK the following section:-

Section 4LL. Any individual or group health maintenance contract that is issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-

exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 89. Chapter 32A of the General Laws, is hereby amended by inserting after section 30 the following section:-

Section 31. The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for the universal postpartum home visiting program administered by the department of public health. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible.

SECTION 90. Chapter 111 is hereby amended by adding after Section 243 the following section:-

Section 244. (a) For the purposes of this section, the following words shall have the following meanings:-

"Department", the department of public health.

"Provider", an entity or individual that provides universal postpartum home visiting services.

"Programs", entities or providers qualified by the department of public health to provide universal postpartum home visiting services.

"Universal postpartum home visiting services", evidence-based, voluntary home or community-based services for birthing people and caregivers with newborns, regardless of age, income, number of children, or other criteria. Services shall be delivered by a qualified health

professional with maternal and child health training, as defined by the department of public health, during at least one visit in the family's home or a mutually agreed upon location within eight weeks postpartum, and one follow-up visit no later than three months after the first visit. Services shall include, but not be limited to, screenings for unmet health needs including reproductive health services, maternal and infant nutritional needs, substance use, emotional health including postpartum depression personal safety/domestic violence; clinical assessment of the birthing person and infant; brief intervention; education and support; referrals to community resources, such as breastfeeding supports; and follow up phone calls.

(b) The department shall establish and administer a statewide system of programs providing universal postpartum home visiting services. The department shall be the lead agency for the coordination of all government funding, both state and federal, for such programs. The department may contract with agencies, individuals or groups for the provision of such services, subject to appropriation. The department shall begin implementation of the universal newborn nurse home visiting program first in those communities with the greatest inequities in maternal health outcomes, as identified by the department. The department shall scale up the program to achieve universal, statewide access within six years of the passage of this act.

(c) In designing the program designed in subsection (b) of this section, the department shall consult, coordinate, and collaborate, as necessary, with insurers that offer health

benefit plans in the commonwealth, MassHealth officials, hospitals, local public health departments, birthing centers, existing early childhood home visiting programs, community-based organizations, and social service providers.

(d) A provider of universal postpartum home visiting services shall determine whether any recipient for whom it provides said services are or may be eligible for coverage of said services through an alternative source. The department is the payer of last resort, and a provider shall request payment for services it provides from third-party payers pursuant to chapters 32A, 118E, 175, 176A, 176B, or 176G of the General Laws, before payment is requested from the department.

(e) The department shall collect and analyze data generated by the program to monitor and assess the effectiveness of universal postpartum home visiting services. The department shall work with other state agencies to develop protocols for sharing data, including the timely sharing of data with primary care providers of care to the families with newborns receiving the services. Programs which are in receipt of state or federal funding for said services shall report such information as requested by the department for the purpose of monitoring, assessing the effectiveness of such programs, initiating quality improvement, and reducing health disparities.

SECTION 91. Chapter 118E of the General Laws, is hereby amended by inserting after section 10N the following section:-

Section 10O. The division and its contracted managed care organizations, accountable care organizations, health plans, integrated care organizations, third-party administrators, or other entities contracting with the division to administer benefits, shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing.

SECTION 92. Chapter 175 of the General Laws, is hereby amended by inserting after section 47PP the following section:-

Section 47QQ. An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 93. Chapter 176A of the General Laws, is hereby amended by inserting after section 8KK the following section:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth

shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is

governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 94. Chapter 176B of the General Laws, is hereby amended by inserting after section 4KK the following section:-

Section 4LL. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 95. Chapter 176G of the General Laws, is hereby amended by inserting after section 4KK the following section:-

Section 4LL. Any individual or group health maintenance contract that is issued or renewed within the commonwealth shall provide coverage for universal postpartum home visiting services, in accordance with operational standards set by the department of public health pursuant to section 244 of chapter 111 of the General Laws. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-

exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 96. Only free-standing and hospital-affiliated birth centers licensed pursuant to 105 CMR 140.000 and 105 CMR 142.000 shall use the terms birth center or birthing center in their clinic's name.

SECTION 97. (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 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.

SECTION 98. (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 racial and ethnic minority groups;

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

(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 racial and ethnic minority groups; 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 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, 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 2026 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 2022 through 2026.

SECTION 99. (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 racial and ethnic minority groups;

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

(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 expand programs for pregnant and postpartum incarcerated individuals, and such programs may—

(1) provide access to perinatal health workers from pregnancy through the post-partum 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 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 racial and ethnic minority groups; 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, 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 incarcerated 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 2022 through 2026.

SECTION 100. (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 disparities 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) causes of adverse maternal health outcomes that are unique to incarcerated individuals, including those incarcerated in Federal, State, and local detention facilities;

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

(5) 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

(6) 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.

SECTION 101. (a) In General.—Not later than 2 years after the date of enactment of this Act, the Medicaid and CHIP Payment and Access Commission (referred to in this section as "MACPAC") shall publish a report on 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.) that contains the information described in subsection.

(b) Information Described.—For purposes of subsection (a), the information described in this subsection includes—

(1) information on the effect of ineligibility for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on maternal health outcomes for pregnant and postpartum incarcerated individuals, concentrating on the effects of such ineligibility for pregnant and postpartum individuals from racial and ethnic minority groups; and

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

SECTION 102. In this title, the following definitions apply:

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

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

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

(4) RACIAL AND ETHNIC MINORITY GROUP.—The term "racial and ethnic minority group" has the meaning given such term in section 1707(g) 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) 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 maternal or infant health or environmental justice; and

(C) a patient advocacy organization representing vulnerable individuals.

(7) 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.

SECTION 103. (a) In General.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a grant program (in this section referred to as the "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 stakeholder 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 the 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 a covered entity to be awarded a grant under the Program, the Secretary shall give priority to covered entities that serve a county—

(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

(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.

(4) LIMITATION.—A recipient of grant funds under the Program may not use such grant funds to serve a county 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, doulas, 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 community health workers and 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, doulas, 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 and transportation assistance, 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, including 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, gender, and pregnancy status.

(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 5; and

(C) recommendations for additional funding.

(j) Covered Entity Defined.—In this section, the term "covered entity" means a consortium of organizations serving a county that—

(1) shall include a community-based organization; and

(2) may include—

(A) another stakeholder organization;

(B) the government of such county;

(C) the governments of one or more municipalities within such county;

(D) a State or local public health department or emergency management agency;

(E) 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;

(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));

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

(H) an institution of higher education.

(k) Authorization Of Appropriations.—There is authorized to be appropriated to carry out this section $100,000,000 for the period of fiscal years 2022 through 2025.

SECTION 104. (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 (in this section referred to as the “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 developing 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) Health Profession School Defined.—In this section, the term "health profession school" means an accredited—

(1) medical school;

(2) school of nursing;

(3) midwifery program;

(4) physician assistant education program;

(5) teaching hospital;

(6) residency or fellowship program; or

(7) other school or program determined appropriate by the Secretary.

(i) Authorization Of Appropriations.—There is authorized to be appropriated to carry out this section $5,000,000 for the period of fiscal years 2022 through 2025.

SECTION 105. (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; and

(E) 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 Nursing Research; and

(5) 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.

SECTION 106. (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.

SECTION 107. Create a temporary or permanent birthing justice steering committee that closely resembles the 2020 Health Equity Task Force formed by the legislature to address the impact of Covid 19. The tenants of that task force include: The Birthing Justice task force shall include:

- 4 members appointed by the Senate President, not more than 2 shall be members of the Senate
- 4 members Speaker of the house, not more than
- 2 of whom shall be members of the House of
- Representatives
- 1 member appointed by the minority leader of
- the Senate

- 1 member appointed by the minority leader of the House of Representatives
- The chair of the Massachusetts Asian-American
- Legislative Caucus or a designee
- The chair of the Massachusetts Black and Latino
- Legislative Caucus or a designee
- 2 Co-chairs of the Birthing Justice taskforce and the MA Women's Caucus
- 4 residents who are recommended that work in birthing and reproductive justice in the Commonwealth
- At least 2 members who have not been recommended by Senate President or Speaker that served in the 2021 Special Commission on Racial Inequities in Maternal Health
- Steering Committee membership shall reflect diverse representation in the commonwealth including, but not limited to, diverse cultures, races, ethnicities, languages, disabilities, gender identities, sexual orientations, geographic locations and ages.
- Appointees of the Senate President, Speaker of the House, Minority Leader of the Senate and Minority Leader of the House who are not members of the general court shall be knowledgeable in public health or healthcare. When making appointments, the Senate President, Speaker of the House, Minority Leader of the Senate and Minority Leader of the House shall give consideration to individuals who have experience addressing disparities in underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age or who work in the healthcare system

with a diverse patient population. Two members of the task force shall be elected by a majority of the task force membership to serve as co-chairs; provided, however, that neither member shall be a member of the general court.

- The Steering Committee should consult with the Massachusetts Department of Public Health (MDPH) to inform its work. MDPH shall provide requested information to the task force whenever possible.

- The Steering Committee shall hold at least 2 public conversations to share and accept public testimony regarding the birthing justice omnibus bill.