118TH CONGRESS
1ST SESSION

S. 1605

To authorize appropriations for data collection, surveillance, and research on maternal health outcomes during public health emergencies, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 15, 2023

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

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A BILL

To authorize appropriations for data collection, surveillance, and research on maternal health outcomes during public health emergencies, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Maternal Health Pandemic Response Act''.

SEC. 2. FUNDING FOR DATA COLLECTION, SURVEILLANCE, AND RESEARCH ON MATERNAL HEALTH OUTCOMES DURING PUBLIC HEALTH EMERGENCIES.

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

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

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

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

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

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

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

assistance to existing Maternal Mortality Review Committees;

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

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

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

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

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

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

SEC. 3. PUBLIC HEALTH EMERGENCY MATERNAL HEALTH DATA COLLECTION AND DISCLOSURE.

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

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

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

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

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

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

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

(1) at least on a monthly basis; and

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

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

(g) GUIDANCE.—

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

Secretary shall issue guidance to States and local public health departments to ensure that—

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

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

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

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

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

SEC. 4. PUBLIC HEALTH COMMUNICATION REGARDING MATERNAL CARE DURING PUBLIC HEALTH EMERGENCIES.

The Director of the Centers for Disease Control and Prevention shall conduct public health education campaigns during public health emergencies to ensure that pregnant and postpartum individuals, their employers,

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

SEC. 5. TASK FORCE ON BIRTHING EXPERIENCE AND SAFE, RESPECTFUL, RESPONSIVE, AND EMPOWERING MATERNITY CARE DURING PUBLIC HEALTH EMERGENCIES.

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

(b) DUTIES.—The Task Force shall develop, publicly post, and update Federal recommendations in multiple languages to ensure high-quality, nondiscriminatory maternity care, promote positive birthing experiences, and improve maternal health outcomes during public health emergencies, with a particular focus on outcomes for individuals from demographic groups with elevated rates of

maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes. Such recommendations shall—

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

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

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

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

(D) diagnostic testing for pregnant and laboring patients;

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

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

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

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

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

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

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

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

(M) strategies to address hospital capacity concerns in communities with a surge in infec-

tious disease cases and to provide childbearing people with options that reduce the potential for cross-contamination and increase the ability to implement their care preferences while maintaining safety and quality, such as the use of auxiliary maternity units and freestanding birth centers;

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

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

(P) how to address the needs of undocumented pregnant individuals and new mothers who may be afraid or unable to seek needed care during the public health emergency;

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

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

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

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

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

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

(3) take into consideration existing State and other programs that have demonstrated effectiveness in addressing pregnancy, birth, and postpartum care during public health emergencies; and

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

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

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

(A) the Secretary;

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

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

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

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

(F) the Commissioner of Food and Drugs;

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

(H) the Director of the Indian Health Service;

(2) at least 3 State, local, or territorial public health officials representing departments of public

health, who shall represent jurisdictions from different regions of the United States with relatively high concentrations of historically marginalized populations;

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

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

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

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

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

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

(9) racially and ethnically diverse representation from at least 3 independent experts with knowl-

edge or field experience with racial and ethnic disparities in public health, women's health, or maternal mortality and severe maternal morbidity.

SEC. 6. DEFINITIONS.

In this Act:

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

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

(3) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a nonclinical health worker focused on maternal or perinatal health, such as a doula, community health worker, peer supporter, lactation educator or counselor, nutritionist

or dietitian, childbirth educator, social worker, home visitor, patient navigator or coordinator, or language interpreter.

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

(5) PUBLIC HEALTH EMERGENCY.—The term ''public health emergency'' means a public health emergency declared under section 319 of the Public Health Service Act (42 U.S.C. 247d).

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

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

(A) is culturally and linguistically congruent;

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

(C) ensures freedom from harm and mistreatment; and

(D) enables informed choice and continuous support.

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

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

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