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REPORT
116–514

MATERNAL HEALTH QUALITY IMPROVEMENT ACT OF 2019

SEPTEMBER 17, 2020.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PALLONE, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 4995]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4995) to amend the Public Health Service Act to improve obstetric care and maternal health outcomes, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Maternal Health Quality Improvement Act of 2019".

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—IMPROVING OBSTETRIC CARE IN RURAL AREAS

SEC. 101. IMPROVING RURAL MATERNAL AND OBSTETRIC CARE DATA.

(a) MATERNAL MORTALITY AND MORBIDITY ACTIVITIES.—Section 301 of the Public Health Service Act (42 U.S.C. 241) is amended—

(1) by redesignating subsections (e) through (h) as subsections (f) through (i), respectively; and

(2) by inserting after subsection (d), the following:

"(e) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand, intensify, and coordinate the activities of the Centers for Disease Control and Prevention with respect to maternal mortality and morbidity.".

(b) OFFICE OF WOMEN'S HEALTH.—Section 310A(b)(1) of the Public Health Service Act (42 U.S.C. 242s(b)(1)) is amended by inserting "sociocultural, including among American Indians and Alaska Natives, as such terms are defined in section 4 of the Indian Health Care Improvement Act, geographic," after "biological,".

(c) SAFE MOTHERHOOD.—Section 317K of the Public Health Service Act (42 U.S.C. 247b–12) is amended—

(1) in subsection (a)(2)(A), by inserting before the period at the end the following: ", including improving collection of data on race, ethnicity, and other demographic information"; and

(2) in subsection (b)(2)—

(A) in subparagraph (L), by striking "and" at the end;

(B) by redesignating subparagraph (M) as subparagraph (N); and

(C) by inserting after subparagraph (L), the following:

"(M) an examination of the relationship between maternal and obstetric services in rural areas and outcomes in delivery and postpartum care; and".

(d) OFFICE OF RESEARCH ON WOMEN'S HEALTH.—Section 486 of the Public Health Service Act (42 U.S.C. 287d) is amended—

(1) in subsection (b), by amending paragraph (3) to read as follows:

"(3) carry out paragraphs (1) and (2) with respect to—

"(A) the aging process in women, with priority given to menopause; and

"(B) pregnancy, with priority given to deaths related to pregnancy;"; and

(2) in subsection (d)(4)(A)(iv), by inserting ", including maternal mortality and other maternal morbidity outcomes" before the semicolon.

SEC. 102. RURAL OBSTETRIC NETWORK GRANTS.

The Public Health Service Act is amended by inserting after section 330A–1 of such Act (42 U.S.C. 254c–1a) the following:

"SEC. 330A–2. RURAL OBSTETRIC NETWORK GRANTS.

"(a) PROGRAM ESTABLISHED.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to establish collaborative improvement and innovation networks (referred to in this section as 'rural obstetric networks') to improve birth outcomes and reduce maternal morbidity and mortality by improving maternity care and access to care in rural areas, frontier areas, maternity care health professional target areas, and Indian country and with Indian Tribes and tribal organizations.

"(b) USE OF FUNDS.—Rural obstetric networks receiving funds pursuant to this section may use such funds to—

"(1) assist pregnant women and individuals in areas and within populations referenced in subsection (a) with accessing and utilizing maternal and obstetric care, including preconception, pregnancy, labor and delivery, postpartum, and interconception services to improve outcomes in birth and maternal mortality and morbidity;

"(2) identify successful delivery models for maternal and obstetric care (including preconception, pregnancy, labor and delivery, postpartum, and interconception services) for individuals in areas and within populations referenced by subsection (a), including evidence-based home visiting programs and successful, culturally competent models with positive maternal health outcomes that advance health equity;

"(3) develop a model for collaboration between health facilities that have an obstetric care unit and health facilities that do not have an obstetric care unit to improve access to and the delivery of obstetric services in communities lacking these services;

"(4) provide training and guidance on obstetric care for health facilities that do not have obstetric care units;

"(5) collaborate with academic institutions that can provide regional expertise and research on access, outcomes, needs assessments, and other identified data and measurement activities needed to inform rural obstetric network efforts to improve obstetric care; and

"(6) measure and address inequities in birth outcomes among rural residents, with an emphasis on racial and ethnic minorities and underserved populations.

"(c) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITIES.—The term 'eligible entities' means entities providing obstetric, gynecologic, and other maternal health care services in rural areas, frontier areas, or medically underserved areas, or to medically underserved populations or Native Americans, including Indian tribes or tribal organizations.

"(2) FRONTIER AREA.—The term 'frontier area' means a frontier county, as defined in section 1886(d)(3)(E)(iii)(III) of the Social Security Act.

"(3) INDIAN COUNTRY.—The term 'Indian country' has the meaning given such term in section 1151 of title 18, United States Code.

"(4) MATERNITY CARE HEALTH PROFESSIONAL TARGET AREA.—The term 'maternity care health professional target area' has the meaning of such term as used in section 332(k)(2).

"(5) RURAL AREA.—The term 'rural area' has the meaning given that term in section 1886(d)(2) of the Social Security Act.

"(6) INDIAN TRIBES; TRIBAL ORGANIZATION.—The terms 'Indian Tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $3,000,000 for each of fiscal years 2020 through 2024.".

SEC. 103. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

Section 330I of the Public Health Service Act (42 U.S.C. 254c–14) is amended—

(1) in subsection (f)(1)(B)(iii), by adding at the end the following:

"(XIII) Providers of maternal, including prenatal, labor and birth, and postpartum care services and entities operating obstetric care units."; and

(2) in subsection (i)(1)(B), by inserting "labor and birth, postpartum," before "or prenatal".

SEC. 104. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.

Subpart 1 of part E of title VII of the Public Health Service Act is amended by inserting after section 760 (42 U.S.C. 294n et seq.), as amended by section 202, is amended by adding at the end the following:

"SEC. 764. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.

"(a) IN GENERAL.—The Secretary shall establish a training demonstration program to award grants to eligible entities to support—

"(1) training for physicians, medical residents, including family medicine and obstetrics and gynecology residents, and fellows to practice maternal and obstetric medicine in rural community-based settings;

"(2) training for nurse practitioners, physician assistants, nurses, certified nurse midwives, home visiting nurses and non-clinical home visiting workforce professionals and paraprofessionals, or non-clinical professionals, who meet ap-

plicable State training and licensing requirements, to provide maternal care services in rural community-based settings; and

"(3) establishing, maintaining, or improving academic units or programs that—

"(A) provide training for students or faculty, including through clinical experiences and research, to improve maternal care in rural areas; or

"(B) develop evidence-based practices or recommendations for the design of the units or programs described in subparagraph (A), including curriculum content standards.

"(b) ACTIVITIES.—

"(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—A recipient of a grant under subsection (a)(1)—

"(A) shall use the grant funds—

"(i) to plan, develop, and operate a training program to provide obstetric care in rural areas for family practice or obstetrics and gynecology residents and fellows; or

"(ii) to train new family practice or obstetrics and gynecology residents and fellows in maternal and obstetric health care to provide and expand access to maternal and obstetric health care in rural areas; and

"(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such training.

"(2) TRAINING FOR OTHER PROVIDERS.—A recipient of a grant under subsection (a)(2)—

"(A) shall use the grant funds to plan, develop, or operate a training program to provide maternal health care services in rural, community-based settings; and

"(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such program.

"(3) TRAINING PROGRAM REQUIREMENTS.—The recipient of a grant under subsection (a)(1) or (a)(2) shall ensure that training programs carried out under the grant are evidence-based and include instruction on—

"(A) maternal mental health, including perinatal depression and anxiety;

"(B) maternal substance use disorder;

"(C) social determinants of health that impact individuals living in rural communities, including poverty, social isolation, access to nutrition, education, transportation, and housing; and

"(D) implicit bias.

"(c) ELIGIBLE ENTITIES.—

"(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—To be eligible to receive a grant under subsection (a)(1), an entity shall—

"(A) be a consortium consisting of—

"(i) at least one teaching health center; or

"(ii) the sponsoring institution (or parent institution of the sponsoring institution) of—

"(I) an obstetrics and gynecology or family medicine residency program that is accredited by the Accreditation Council of Graduate Medical Education (or the parent institution of such a program); or

"(II) a fellowship in maternal or obstetric medicine, as determined appropriate by the Secretary; or

"(B) be an entity described in subparagraph (A)(ii) that provides opportunities for medical residents or fellows to train in rural community-based settings.

"(2) TRAINING FOR OTHER PROVIDERS.—To be eligible to receive a grant under subsection (a)(2), an entity shall be—

"(A) a teaching health center (as defined in section 749A(f));

"(B) a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act);

"(C) a community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act);

"(D) a rural health clinic (as defined in section 1861(aa) of the Social Security Act);

"(E) a freestanding birth center (as defined in section 1905(l)(3) of the Social Security Act); or

"(F) an Indian Health Program or a Native Hawaiian health care system (as such terms are defined in section 4 of the Indian Health Care Improvement Act and section 12 of the Native Hawaiian Health Care Improvement Act, respectively).

"(3) ACADEMIC UNITS OR PROGRAMS.—To be eligible to receive a grant under subsection (a)(3), an entity shall be a school of medicine, a school of osteopathic medicine, a school of nursing (as defined in section 801), a physician assistant education program, an accredited public or nonprofit private hospital, an accredited medical residency training program, a school accredited by the Midwifery Education and Accreditation Council, by the Accreditation Commission for Midwifery Education, or by the American Midwifery Certification Board, or a public or private nonprofit educational entity which the Secretary has determined is capable of carrying out such grant.

"(4) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an estimate of the amount to be expended to conduct training activities under the grant (including ancillary and administrative costs).

"(d) STUDY AND REPORT.—

"(1) STUDY.—

"(A) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct a study on the results of the demonstration program under this section.

"(B) DATA SUBMISSION.—Not later than 90 days after the completion of the first year of the training program, and each subsequent year for the duration of the grant, that the program is in effect, each recipient of a grant under subsection (a) shall submit to the Secretary such data as the Secretary may require for analysis for the report described in paragraph (2).

"(2) REPORT TO CONGRESS.—Not later than 1 year after receipt of the data described in paragraph (1)(B), the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that includes—

"(A) an analysis of the effect of the demonstration program under this section on the quality, quantity, and distribution of maternal (including prenatal, labor and birth, and postpartum) care services and the demographics of the recipients of those services;

"(B) an analysis of maternal and infant health outcomes (including quality of care, morbidity, and mortality) before and after implementation of the program in the communities served by entities participating in the demonstration; and

"(C) recommendations on whether the demonstration program should be expanded.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2020 through 2024.".

SEC. 105. GAO REPORT.

Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on maternal care in rural areas, including prenatal, labor and birth, and postpartum care in rural areas. Such report shall include the following:

(1) Trends in data that may identify potential gaps in maternal and obstetric clinicians and health professionals, including non-clinical professionals.

(2) Trends in the number of facilities able to provide maternal care, including prenatal, labor and birth, and postpartum care, in rural areas, including care for high-risk pregnancies.

(3) The gaps in data on maternal mortality and morbidity and recommendations to standardize the format on collecting data related to maternal mortality and morbidity.

(4) The gaps in maternal health outcomes by race and ethnicity in rural communities, with a focus on racial inequities for residents who are racial and ethnic minorities or members of underserved populations.

(5) An examination of—

(A) activities which the Secretary of Health and Human Services plans to conduct to improve maternal care in rural areas, including prenatal, labor and birth, and postpartum care; and

(B) the extent to which the Secretary has a plan for completing these activities, has identified the lead agency responsible for each activity, has

identified any needed coordination among agencies, and has developed a budget for conducting such activities.

(6) Other information that the Comptroller General determines appropriate.

TITLE II—OTHER IMPROVEMENTS TO MATERNAL CARE

SEC. 201. INNOVATION FOR MATERNAL HEALTH.

The Public Health Service Act is amended—

(1) in the section designation of section 330M (42 U.S.C. 254c–19) by inserting a period after "330M"; and

(2) by inserting after such section 330M the following:

"SEC. 330N. INNOVATION FOR MATERNAL HEALTH.

"(a) IN GENERAL.—The Secretary, in consultation with experts representing a variety of clinical specialties, State, tribal, or local public health officials, researchers, epidemiologists, statisticians, and community organizations, shall establish or continue a program to award competitive grants to eligible entities for the purpose of—

"(1) identifying, developing, or disseminating best practices to improve maternal health care quality and outcomes, eliminate preventable maternal mortality and severe maternal morbidity, and improve infant health outcomes, which may include—

"(A) information on evidence-based practices to improve the quality and safety of maternal health care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

"(B) best practices for improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care; and

"(C) information on addressing determinants of health that impact maternal health outcomes for women before, during, and after pregnancy;

"(2) collaborating with State maternal mortality review committees to identify issues for the development and implementation of evidence-based practices to improve maternal health outcomes and reduce preventable maternal mortality and severe maternal morbidity;

"(3) providing technical assistance and supporting the implementation of best practices identified in paragraph (1) to entities providing health care services to pregnant and postpartum women; and

"(4) identifying, developing, and evaluating new models of care that improve maternal and infant health outcomes, which may include the integration of community-based services and clinical care.

"(b) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (a), an entity shall—

"(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

"(2) demonstrate in such application that the entity is capable of carrying out data-driven maternal safety and quality improvement initiatives in the areas of obstetrics and gynecology or maternal health.

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2020 through 2024.".

SEC. 202. TRAINING FOR HEALTH CARE PROVIDERS.

Title VII of the Public Health Service Act is amended by striking section 763 (42 U.S.C. 294p) and inserting the following:

"SEC. 763. TRAINING FOR HEALTH CARE PROVIDERS.

"(a) GRANT PROGRAM.—The Secretary shall establish a program to award grants to accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

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

"(c) REPORTING REQUIREMENT.—Each entity awarded a grant under this section shall periodically submit to the Secretary a report on the status of activities conducted using the grant, including a description of the impact of such training on patient outcomes, as applicable.

"(d) BEST PRACTICES.—The Secretary may identify and disseminate best practices for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2020 through 2024.".

SEC. 203. STUDY ON TRAINING TO REDUCE AND PREVENT DISCRIMINATION.

Not later than 2 years after date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the "Secretary") shall, through a contract with an independent research organization, conduct a study and make recommendations for accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs, on best practices related to training to reduce and prevent discrimination, including training related to implicit and explicit biases, in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

SEC. 204. PERINATAL QUALITY COLLABORATIVES.

(a) GRANTS.—Section 317K(a)(2) of the Public Health Service Act (42 U.S.C. 247b–12(a)(2)) is amended by adding at the end the following:

"(E)(i) The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall establish or continue a competitive grant program for the establishment or support of perinatal quality collaboratives to improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants. A State, Indian Tribe, or tribal organization may use funds received through such grant to—

"(I) support the use of evidence-based or evidence-informed practices to improve outcomes for maternal and infant health;

"(II) work with clinical teams; experts; State, local, and, as appropriate, tribal public health officials; and stakeholders, including patients and families, to identify, develop, or disseminate best practices to improve perinatal care and outcomes; and

"(III) employ strategies that provide opportunities for health care professionals and clinical teams to collaborate across health care settings and disciplines, including primary care and mental health, as appropriate, to improve maternal and infant health outcomes, which may include the use of data to provide timely feedback across hospital and clinical teams to inform responses, and to provide support and training to hospital and clinical teams for quality improvement, as appropriate.

"(ii) To be eligible for a grant under clause (i), an entity shall submit to the Secretary an application in such form and manner and containing such information as the Secretary may require.".

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 317K(f) of the Public Health Service Act (42 U.S.C. 247b–12(f)) is amended by striking "$58,000,000 for each of fiscal years 2019 through 2023" and inserting "$65,000,000 for each of fiscal years 2020 through 2024".

SEC. 205. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

(a) GRANTS.—The Public Health Service Act is amended by inserting after section 330N of such Act, as added by section 201, the following:

"SEC. 330O. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

"(a) IN GENERAL.—The Secretary may award grants for the purpose of establishing or operating evidence-based or innovative, evidence-informed programs to deliver integrated health care services to pregnant and postpartum women to optimize the health of women and their infants, including—

"(1) to reduce adverse maternal health outcomes, pregnancy-related deaths, and related health disparities (including such disparities associated with racial and ethnic minority populations); and

"(2) as appropriate, by addressing issues researched under section 317K(b)(2).

"(b) INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

"(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State, Indian Tribe, or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act) shall work with relevant stakeholders that coordinate care (including coordinating re-

sources and referrals for health care and social services) to develop and carry out the program, including—

"(A) State, Tribal, and local agencies responsible for Medicaid, public health, social services, mental health, and substance use disorder treatment and services;

"(B) health care providers who serve pregnant and postpartum women; and

"(C) community-based health organizations and health workers, including providers of home visiting services and individuals representing communities with disproportionately high rates of maternal mortality and severe maternal morbidity, and including those representing racial and ethnicity minority populations.

"(2) TERMS.—

"(A) PERIOD.—A grant awarded under subsection (a) shall be made for a period of 5 years. Any supplemental award made to a grantee under subsection (a) may be made for a period of less than 5 years.

"(B) PREFERENCE.—In awarding grants under subsection (a), the Secretary shall—

"(i) give preference to States, Indian Tribes, and tribal organizations that have the highest rates of maternal mortality and severe maternal morbidity relative to other such States, Indian Tribes, or tribal organizations, respectively; and

"(ii) shall consider health disparities related to maternal mortality and severe maternal morbidity, including such disparities associated with racial and ethnic minority populations.

"(C) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applications from up to 15 entities described in subparagraph (B)(i).

"(D) EVALUATION.—The Secretary shall require grantees to evaluate the outcomes of the programs supported under the grant.

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2020 through 2024.".

(b) REPORT ON GRANT OUTCOMES AND DISSEMINATION OF BEST PRACTICES.—

(1) REPORT.—Not later than February 1, 2026, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that describes—

(A) the outcomes of the activities supported by the grants awarded under the amendments made by this section on maternal and child health;

(B) best practices and models of care used by recipients of grants under such amendments; and

(C) obstacles identified by recipients of grants under such amendments, and strategies used by such recipients to deliver care, improve maternal and child health, and reduce health disparities.

(2) DISSEMINATION OF BEST PRACTICES.—Not later than August 1, 2026, the Secretary of Health and Human Services shall disseminate information on best practices and models of care used by recipients of grants under section 330O of the Public Health Service Act (as added by this section) (including best practices and models of care relating to the reduction of health disparities, including such disparities associated with racial and ethnic minority populations, in rates of maternal mortality and severe maternal morbidity) to relevant stakeholders, which may include health providers, medical schools, nursing schools, relevant State, tribal, and local agencies, and the general public.

I. PURPOSE AND SUMMARY

H.R. 4995, the "Maternal Health Quality Improvement Act of 2019", was introduced on November 8, 2019, by Representatives Eliot L. Engel (D–NY), Larry Bucshon (R–IN), Xochitl Torres Small (D–NM), Robert E. Latta (R–OH), Alma S. Adams (D–NC), and Steve Stivers (R–OH). H.R. 4995 authorizes public health programs designed to improve maternal health outcomes, including initiatives that: enhance data collection and coordination of health services in rural areas; expand the use of telehealth services for maternal health care; train health providers in rural areas; provide innovation in maternal health grants; train providers on how to reduce

racial disparities in maternal health outcomes; provide grants for perinatal quality collaboratives; and integrate services for pregnant and postpartum women to reduce adverse maternal health outcomes.

II. Background and Need for Legislation

According to the Centers for Disease Control and Prevention (CDC), women in the United States are more likely to die from childbirth or pregnancy-related causes than other women in the developed world, with about 700 women dying every year from pregnancy-related complications.[1] [2] More details are needed to better understand the actual causes of death, but research suggests that approximately three in every five pregnancy-related deaths are preventable.[3] The deaths are roughly evenly split between those that occur during pregnancy (31 percent of deaths), during delivery or in the week after delivery (36 percent of deaths), and between one week and one year postpartum (33 percent of deaths).[4]

Causes of pregnancy-related deaths differ throughout pregnancy and after delivery. Heart disease and stroke cause the most deaths overall, while obstetric emergencies, such as severe bleeding and amniotic fluid embolism cause the most deaths at delivery.[5] Severe bleeding, high blood pressure, and infection are the leading causes of death in the week after delivery, and weakened heart muscle is the leading cause of deaths one week to one year postpartum.[6] Observers have also noted postpartum depression as a common condition in postpartum women, with suicide among the leading causes of death in postpartum women.[7]

In addition to high rates of maternal mortality, rates of severe maternal morbidity (SMM) are on the rise. SMM is defined as a condition that includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. As tracked by the CDC, the rate of overall SMM rose nearly 200 percent between 1993 and 2014, with most women with a SMM requiring blood transfusion, but others requiring hysterectomy and ventilation or a temporary tracheostomy.[8]

Across nearly all causes of maternal mortality and morbidity, there are significant and pervasive racial disparities. Though literature has not fully explained all of the factors contributing to racial disparities in maternal health outcomes, statistics show non-Hispanic black and American Indian/Alaska Native women are about three times more likely to die from pregnancy-related causes than White women.[9] For women over the age of 30, pregnancy-related mortality for Black and American Indian/Alaska Native

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[1] Centers for Disease Control and Prevention, *Vital Signs: Pregnancy-related Deaths: Saving Women's Lives, Before, During and After Delivery* (https://www.cdc.gov/vitalsigns/maternal-deaths/index.html) (May 7, 2019).

[2] Centers for Disease Control and Prevention, *Pregnancy Related Deaths* (https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm) (Feb. 26, 2019).

[3] Centers for Disease Control and Prevention, *Vital Signs: Pregnancy-related Deaths: Saving Women's Lives, Before, During and After Delivery* (https://www.cdc.gov/vitalsigns/maternal-deaths/index.html) (May 7, 2019).

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] Dorothy Sit et al., *Suicidal Ideation in Depressed Postpartum Women: Associations with Childhood Trauma, Sleep Disturbance and Anxiety,* 66 J. Psychiatric Research 95 (2015).

[8] *Id.*

[9] *Id.*

women is four to five times higher than it is for White women.[10] These disparities persist despite education level and socioeconomic status.[11] For example, the data show that pregnancy-related deaths for Black and American Indian/Alaska Native women with some college education were higher than those for all other racial/ethnic groups with less than a high school diploma.[12] To address these disparities, CDC has recommended that hospitals and health care systems implement standardized protocols in quality improvement initiatives, especially among facilities that serve disproportionately affected communities. CDC has also encouraged hospitals and health systems to identify and address implicit biases in health care in order to improve patient-provider interactions, health communication, and health outcomes.[13]

Pregnant women in rural areas also face higher negative health outcomes. While the maternal mortality rate in urban areas was 18.2 maternal deaths per 100,000 live births in 2015, very rural areas had a maternal death rate of 29.4 per 100,000 live births.[14] Almost half of rural counties in the United States do not have a hospital with obstetric services, which means that most rural women do not have access to perinatal services within a 30-minute drive, and more than ten percent of women must drive 100 miles or more for perinatal services.[15] Providers of maternal health care are sparse throughout rural areas; nearly half of all counties do not have a single OB–GYN or certified nurse midwife.[16] While telehealth and telemedicine have been recognized as methods of providing health care in rural areas, its adoption has been limited for various reasons, such as limited access to broadband in rural areas and cost of equipment or technologies.[17] These barriers to care have been shown to increase rates of maternal mortality, SMM, and postpartum depression.[18]

Legislation is necessary to authorize Federally-supported initiatives that will further improve access to maternal health services, develop the maternal health care workforce, continue to develop and deploy best practices in maternal health care, and establish innovative evidence-informed programs that integrate services for pregnant and postpartum women.

Title I—Improving Obstetric Care in Rural Areas

Title I establishes Rural Obstetric Network Grants to improve maternal health care in rural areas. Through these grants, care providers in rural areas, frontier areas, medically underserved

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[10] Centers for Disease Control and Prevention, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html) (Sept. 5, 2019).

[11] Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018).

[12] Emely E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016*, 68 MORBIDITY AND MORTALITY WEEKLY REPORT 762 (available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w) (Sept. 6, 2019).

[13] *See* note 9.

[14] Dina Fine Maron, *Maternal Health Care is Disappearing in Rural America,* SCIENTIFIC AMERICAN (https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/) (Feb. 15, 2017).

[15] Centers for Medicare and Medicaid Services, *Improving Access to Maternal Health Care in Rural Communities* (https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf) (June 2019).

[16] *Id.*

[17] *Id.*

[18] *Id.*

areas, and others, will be able to provide greater access to health services, improve training and awareness on providing care in rural areas, and allow for collaboration between health facilities that have obstetric care units and those that do not. This collaboration will foster better implementation of best practices to help women at risk of maternal mortality and SMM in hospital settings, including those facing severe hemorrhage and hypertension. Title I also ensures telehealth grants will be available for maternal health care and creates a new training demonstration grant program to improve and expand training in maternal mental health, substance use disorder, social determinants of health, and implicit bias for new health care providers in rural areas. This title also requires the Government Accountability Office (GAO) to report on maternal care in rural areas, including an examination of gaps in data on maternal mortality, morbidity and maternal health outcomes by race and ethnicity in rural communities, with a focus on inequities for residents who are racial and ethnic minorities or members of underserved populations.

Title II—Other Improvements to Maternal Health

Title II authorizes the Alliance for Innovation on Maternal Health, or AIM Program at the Department of Health and Human Services, which works to improve maternal health care standards across all settings, through patient safety bundles, grants, and other tools for the purposes of: identifying, developing, or disseminating best practices to improve maternal health care quality and outcomes and eliminate preventable maternal mortality and SMM; providing technical assistance to implement best practices; and implementing new models of care that improve maternal and infant health outcomes. H.R. 4995 authorizes $10 million in annual appropriations to help expand and improve on this program.

For the purposes of addressing the stark racial disparities in maternal health outcomes, title II authorizes $5 million in grants to medical and nursing schools, as well as other health professional programs, to help reduce and prevent discrimination, through training related to implicit and explicit biases in providing prenatal care, labor care, birthing, and postpartum care. Title II also requires the Secretary to enter into a contract with an independent research organization to study and make recommendations for medical schools, nursing schools, and other health professional training programs on best practices related to training to reduce and prevent discrimination and implicit and explicit biases.

Title II also supports States' work to improve maternal health outcomes by authorizing and expanding grants for perinatal quality collaboratives (PQCs) through CDC's National Network of Perinatal Quality Collaboratives, which currently helps States coordinate to share data and best practices. PQCs are State or multi-State networks working to improve the quality of care for women and newborns. PQCs may include health care providers, hospitals, and public health officials, and may focus exclusively on maternal health or neonatal health, or both, depending on the needs of the States. State PQCs generally develop relationships to improve the collection of data and implementation of best practice in the State.

To further improve care delivery, title II authorizes $15 million for grants to establish or operate evidence-based or innovative, evi-

dence-informed programs to deliver integrated health care services to pregnant and postpartum women to optimize their health and the health of their infants. To receive grants, States, Indian tribes, and tribal organizations are required to work with relevant stakeholders to coordinate care, including agencies responsible for Medicaid, public health, social service, mental health, substance use disorder treatment and services, providers of home visiting services, and others. These grants may be used to support delivery of care to improve health outcomes to States, Indian Tribes, and tribal organizations that face the highest rates of maternal mortality and SMM, as well as areas where there are health disparities associated with racial and ethnic minority populations.

Finally, title II requires the Secretary to produce a report no later than February 2026 describing the outcomes of activities supported by grants, best practices and models of care used by recipients of grants, and any obstacles identified by grant recipients. The Secretary will also be required to disseminate information on best practices and models of care used by recipients of grants to relevant stakeholders, which may include health providers, medical schools, nursing schools, relevant State, tribal, and local agencies, and the general public.

III. COMMITTEE HEARINGS

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearing was used to develop or consider H.R. 4995:

The Subcommittee on Health held a legislative hearing on September 10, 2019, entitled "Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care" to review related legislation, including H.R. 1897, the "Mothers and Offspring Mortality and Morbidity Awareness Act"; H.R. 1551, the "Quality Care for Moms and Babies Act"; H.R. 2902, the "Maternal Care Access and Reducing Emergencies Act"; and H.R. 2602, the "Healthy MOMMIES Act". The Subcommittee received testimony from the following witnesses:

- Wanda Irving, Mother of Dr. Shalon Irving
- Patrice Harris, M.D., President, Board of Trustees, American Medical Association
- Elizabeth Howell, M.D., M.P.P., Director, Blavatnik Family Women's Health Research Institute, Icahn School of Medicine at Mount Sinai
- David Nelson, M.D., Chief of Obstetrics, Parkland Health and Hospital System
- Usha Ranji, Associate Director, Women's Health Policy, Kaiser Family Foundation.

IV. COMMITTEE CONSIDERATION

Representatives Engel (D–NY), Bucshon (R–IN), Torres Small (D–MN), Latta (R–OH), Adams (D–NC), and Stivers (R–OH) introduced H.R. 4995, the "Maternal Health Quality Improvement Act of 2019", on November 8, 2019, and the bill was referred to the Committee on Energy and Commerce. Subsequently, the bill was referred to the Subcommittee on Health on November 12, 2019.

On November 13, 2019, the Subcommittee on Health met in open markup session, pursuant to notice, to consider H.R. 4995. No amendments were offered during consideration of the bill. The Subcommittee on Health then agreed to a motion by Ms. Eshoo, Chairwoman of the subcommittee, to forward favorably H.R. 4995, without amendment, to the full Committee on Energy and Commerce by a voice vote.

On November 19, 2019, the full Committee met in open markup session, pursuant to notice, to consider the bill H.R. 4995. During consideration of the bill, an amendment offered by Mr. Cárdenas of California was agreed to by a voice vote. At the conclusion of the markup of the bill, Mr. Pallone, Chairman of the committee, moved that H.R. 4995 be ordered reported favorably to the House, amended. The full Committee agreed to the Pallone motion on final passage by a voice vote, a quorum being present.

V. COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee advises that there were no record votes taken on H.R. 4995, including the motion for final passage of the bill.

VI. OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

VII. NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

VIII. CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, February 12, 2020.

Hon. FRANK PALLONE, JR.,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4995, the Maternal Health Quality Improvement Act of 2019.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Philippa Haven.

Sincerely,

PHILLIP L. SWAGEL,
Director.

Enclosure.

H.R. 4995, Maternal Health Quality Improvement Act of 2019
As ordered reported by the House Committee on Energy and Commerce on November 19, 2019

By Fiscal Year, Millions of Dollars	2020	2020-2025	2020-2030
Direct Spending (Outlays)	0	0	0
Revenues	0	0	0
Increase or Decrease (-) in the Deficit	0	0	0
Spending Subject to Appropriation (Outlays)	*	233	not estimated

Statutory pay-as-you-go procedures apply?	No	Mandate Effects	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2031?	No	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

* = between zero and $500,000.

H.R. 4995 would require the Health Resources and Services Administration or the Centers for Disease Control and Prevention to establish five new grant programs and one new demonstration program. Specifically:

- Section 102 would establish a new grant program for rural obstetric collaborative networks and would authorize $3 million each year from 2020 through 2024 to support those activities.
- Section 104 would establish a demonstration program to improve training for providers of maternal care in rural areas and would authorize $5 million each year from 2020 through 2024 to support those activities.
- Section 201 would establish a competitive grant program to identify, develop, or disseminate for best practices for improving maternal health care and infant health outcomes and would authorize $10 million each year from 2020 through 2024 to support those activities.
- Section 202 would establish a grant program for the training of health professionals to reduce and prevent discrimination in the provision of maternal care and would authorize $5 million each year from 2020 through 2024 to support those activities.
- Section 204 would establish a grant program to improve perinatal care and health outcomes and would authorize $65 million each year from 2020 through 2024 to support those activities. Under current law, $58 million is authorized for those activities each year through 2023. As a result, the bill would increase authorized amounts by $7 million annually for the 2020–2023 period.
- Section 205 would establish a grant program for states, Indian tribes, or tribal organizations to establish or operate programs that optimize the health of women and their infants through integrated care and would authorize $15 million each year from 2020 through 2024 to support those activities.

Based on historical spending for similar programs, CBO estimates that, in total, the grant programs would cost $230 million over the 2020–2025 period.

In addition, the bill would require two reports. Section 105 would require the Government Accountability Office to publish a report on maternal care in rural areas. Section 203 would require the Department of Health and Human Services to contract with an independent research organization to study and recommend best practices for training to reduce and prevent discrimination in the provision of prenatal labor, birthing, and postpartum care.

Based on historical spending for similar activates, CBO estimates that preparing those two reports would cost about $3 million over the 2020–2025 period.

In total and assuming appropriation of the necessary amounts, CBO estimates that implementing H.R. 4995 would cost $233 million over the 2020–2025 period. The costs of the legislation, detailed in Table I, fall within budget function 550 (health).

TABLE 1.—ESTIMATED INCREASES IN SPENDING SUBJECT TO APPROPRIATION UNDER H.R. 4995

	By fiscal year, millions of dollars—						
	2020	2021	2022	2023	2024	2025	2020–2025
Estimated Authorization	46	46	46	45	103	0	286
Estimated Outlays	*	6	31	56	70	70	233

* = between zero and $500,000.

The CBO staff contacts for this estimate are Alice Burns (Health Resources and Services Administration) and Philippa Haven (Centers for Disease Control and Prevention, Health and Human Services, and National Institutes of Health). The estimate was reviewed by Leo Lex, Deputy Director of Budget Analysis.

IX. Federal Mandates Statement

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

X. Statement of General Performance Goals and Objectives

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to improve obstetric care and maternal health outcomes across health care settings by increasing resources, improving standards of care, and addressing health inequities.

XI. Duplication of Federal Programs

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 4995 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

XII. Committee Cost Estimate

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

XIII. Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 4995 contains no earmarks, limited tax benefits, or limited tariff benefits.

XIV. Advisory Committee Statement

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

XV. Applicability to Legislative Branch

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

XVI. Section-by-Section Analysis of the Legislation

Section 1. Short title

Section 1 designates that the short title of this Act may be cited as the "Maternal Health Quality Improvement Act of 2019".

Sec. 2. Table of Contents

Section 2 provides the Table of Contents for H.R. 4995, including Title I—Improving Obstetric Care in Rural Areas and Title II—Other Improvements to Maternal Care.

TITLE I—IMPROVING OBSTETRIC CARE IN RURAL AREAS

Sec. 101. Improving rural maternal and obstetric care data

Section 101, as reported, improves data collection on maternal and obstetric care in rural areas across the Department of Health and Human Services (HHS), by requiring CDC to expand, intensify, and coordinate activities with respect to maternal mortality and morbidity; requiring the CDC Office of Women's Health to report on women's health across all geographic areas and among American Indians and Alaska Natives; expanding research activities to improve data collection on race, ethnicity, and other demographic information; examining the relationship between maternal and obstetric services in rural areas and outcomes in delivery and postpartum care; and expanding activities within the Office of Research on Women's Health at the National Institutes of Health (NIH) to include maternal mortality and other maternal morbidity outcomes.

Sec. 102. Rural Obstetric Network Grants

Section 102 creates Rural Obstetric Network Grants at the Health Resources and Services Administration (HRSA) to improve birth outcomes and reduce maternal morbidity and mortality by improving maternity care and access to care in rural areas, frontier areas, maternity care health professional target areas, and Indian country, and with Indian Tribes and tribal organizations. To do so, the Administrator is authorized to award grants to eligible entities to establish collaborative improvement and innovation networks.

These grants can be used to assist pregnant women with accessing and utilizing maternal and obstetric care, including preconception, pregnancy, labor and delivery, postpartum, and interconception services to improve outcomes in birth and maternal mortality and morbidity. Grant funds may also be used for the identification of successful delivery models for maternal and obstetric care in applicable areas, the development of collaborative models between health facilities that have an obstetric care unit and health facilities that do not have an obstetric care unit, as well as for training and guidance on obstetric care for health facilities that do not have obstetric care units. Grantees may also collaborate with academic institutions for regional expertise and research and dedicate funds to measuring and addressing inequities in birth outcomes among rural residents, with an emphasis on racial and ethnic minorities and underserved populations. Section 102 authorizes $3 million annually to carry out these activities.

Sec. 103. Telehealth network and telehealth resource centers grant program

This section adds providers of maternal care to the list of eligible entities who may receive telehealth network and telehealth resource center grants and ensures applicants who provide care for labor and birth and postpartum care are prioritized for receiving such grants.

Sec. 104. Rural maternal and obstetric care training demonstration

Section 104 establishes a training demonstration program to award grants to support training for physicians, medical residents (including family medicine and obstetrics and gynecology residents), fellows, nurse practitioners, physician assistants, nurses, certified nurse midwives, home visiting nurses, and non-clinical professionals to practice maternal and obstetric medicine in rural community-based settings. Those receiving grants for these purposes are required to include instruction on maternal mental health and substance use disorder, social determinants of health that affect individuals living in rural communities, and on the reduction of implicit bias.

Section 104 also authorizes grants for medical schools, nursing schools, physician assistant education programs, accredited public and private nonprofit hospitals, accredited medical residency training programs, accredited midwifery schools to support establishing, maintaining, or improving academic units or programs that provide training for students or faculty to improve maternal care in rural areas and develop evidence-based practices or recommendations for the design of such units or programs.

Section 104 requires HRSA to submit a report to the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor, and Pensions on the outcomes of the demonstration program, including an analysis of the effect of the program on the quality, quantity, and distribution of maternal health care services, an analysis of maternal and infant health outcomes in communities served by entities participating in the demonstration program, and recommendations on whether the program should be expanded.

Section 104 authorizes $5 million annually to carry out these activities.

Sec. 105. GAO Report

Section 105 requires the Comptroller General to issue a report no later than 18 months after the date of enactment identifying potential gaps in maternal and obstetric clinicians and health professionals, trends in the number of facilities able to provide maternal care, gaps in maternal mortality and morbidity data along with recommendations to standardize the data collection related to maternal mortality and morbidity, gaps in maternal health outcomes by race and ethnicity in rural communities, activities which HHS plans to conduct to improve maternal care in rural areas, and the extent to which the Secretary has a plan for completing these activities, in addition to any other information that the Comptroller General determines appropriate.

TITLE II—OTHER IMPROVEMENTS TO MATERNAL CARE

Sec. 201. Innovation for maternal health

Section 201 requires the Secretary, in consultation with experts representing a variety of clinical specialties, State, tribal, or local public health officials, researchers, epidemiologists, statisticians, and community organizations, to establish or continue competitive grants for the purposes of identifying, developing, or disseminating best practices to improve maternal health care quality and outcomes, eliminating preventable maternal mortality and SMM, and facilitating better health outcomes. Such best practices may be on improving the quality and safety of maternal health care in hospitals and other care settings; improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care; and addressing determinants of health that impact maternal health outcomes. Additionally, the grantees may use grant funds to collaborate with maternal mortality review committees to identify issues that will inform the development and implementation of evidence-based practices to improve maternal health outcomes; provide technical assistance and support for the implementation of evidence-based practices; and identify, develop, and evaluate new models of care that improve maternal and infant health outcomes, which may include the integration of community-based services and clinical care. Section 201 authorizes $10 million annually to carry out this grant program.

Sec. 202. Training for health care providers

Section 202 requires the Secretary to establish a program to award grants to accredited schools of allopathic medicine, osteopathic medicine, nursing, and other health professional training programs for the purpose of reducing and preventing discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care. Each entity awarded a grant under this program will be required to report on activities conducted under the grant, including a description of patient out-

comes. This section also authorizes the Secretary to identify and disseminate best practices for the training of health professionals to reduce and prevent discrimination. Section 202 authorizes $5 million annually to carry out these activities.

Sec. 203. Study on Training To Reduce and Prevent Discrimination

Section 203 requires the Secretary to contract with an independent research organization to conduct a study and make recommendations for schools of allopathic medicine, osteopathic medicine, nursing, and other health professional training programs on best practices for health practitioner training on reducing and preventing discrimination, along with implicit and explicit biases related to the provision of health services in prenatal care, labor care, birthing, and postpartum care.

Sec. 204. Perinatal Quality Collaboratives

Section 204 amends the Public Health Service Act to require the Secretary, acting through the CDC Director, to establish or continue grants for PQCs, which are used to improve perinatal care and perinatal health outcomes for pregnant or postpartum women and their infants. These grants may be used to support the identification, development, and dissemination of evidence-based or evidence-informed best practices to improve outcomes for maternal and infant health, and employ strategies or provide opportunities for health care professionals and clinical teams to collaborate across health care settings and disciplines to improve care. Section 204 increases CDC's authorization for safe motherhood programs by $7 million annually, to $65 million, to fund this grant program.

Sec. 205. Integrated services for pregnant and postpartum women

Section 205 authorizes the Secretary to award grants to establish or operate evidence-based or innovative evidence-informed programs to deliver integrated health care services to pregnant and postpartum women in order to optimize their health and the health of their infants. Programs supported by the grants would include initiatives that reduce adverse maternal health outcomes, pregnancy-related deaths, and related disparities, including disparities associated with racial and ethnic minority populations. Grantees are required to work with stakeholders, including health care providers, relevant Medicaid, public health, social services, mental health, and substance use disorder treatment and services agencies, and community-based health organizations to develop and carry out the program. Grants under the program would be awarded for five-year periods, and supplemental grants could be made for less than five years. In awarding grants, the Secretary is required to give preference to states, Tribes, and tribal organizations with the highest rates of maternal mortality and SMM, giving priority to up to 15 of these applications. The Secretary is also required to consider health disparities related to maternal mortality and SMM in awarding grants, including those disparities associated with racial and ethnic minority populations. Section 205 authorizes $15 million annually to carry out these activities.

In addition, Section 205 would require the Secretary to submit a report to the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor, and Pensions de-

scribing the outcomes of activities supported by the grants in this section, along with best practices, models of care, and strategies used by grantees to deliver care, improve health, and reduce health disparities, and obstacles identified by grantees in conducting those activities. Furthermore, Section 205 would require the Secretary to disseminate information on best practices and models of care to relevant stakeholders not later than August 1, 2026.

XVII. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

PART A—RESEARCH AND INVESTIGATION

IN GENERAL

SEC. 301. (a) The Secretary shall conduct in the Service, and encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man, including water purification, sewage treatment, and pollution of lakes and streams. In carrying out the foregoing the Secretary is authorized to—

(1) collect and make available through publications and other appropriate means, information as to, and the practical application of, such research and other activities;

(2) make available research facilities of the Service to appropriate public authorities, and to health officials and scientists engaged in special study;

(3) make grants-in-aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals for such research projects as are recommended by the advisory council to the entity of the Department supporting such projects and make, upon recommendation of the advisory council to the appropriate entity of the Department, grants-in-aid to public or nonprofit universities, hospitals, laboratories, and other institutions for the general support of their research;

(4) secure from time to time and for such periods as he deems advisable, the assistance and advice of experts, scholars, and consultants from the United States or abroad;

(5) for purposes of study, admit and treat at institutions, hospitals, and stations of the Service, persons not otherwise eligible for such treatment;

(6) make available, to health officials, scientists, and appropriate public and other nonprofit institutions and organizations, technical advice and assistance on the application of statistical methods to experiments, studies, and surveys in health and medical fields;

(7) enter into contracts, including contracts for research in accordance with and subject to the provisions of law applicable to contracts entered into by the military departments under title 10, United States Code, sections 2353 and 2354, except that determination, approval, and certification required thereby shall be by the Secretary of Health, Education, and Welfare; and

(8) adopt, upon recommendations of the advisory councils to the appropriate entities of the Department or, with respect to mental health, the National Advisory Mental Health Council, such additional means as the Secretary considers necessary or appropriate to carry out the purposes of this section.

(b)(1) The Secretary shall conduct and may support through grants and contracts studies and testing of substances for carcinogenicity, teratogenicity, mutagenicity, and other harmful biological effects. In carrying out this paragraph, the Secretary shall consult with entities of the Federal Government, outside of the Department of Health, Education, and Welfare, engaged in comparable activities. The Secretary, upon request of such an entity and under appropriate arrangements for the payment of expenses, may conduct for such entity studies and testing of substances for carcinogenicity, teratogenicity, mutagenicity, and other harmful biological effects.

(2)(A) The Secretary shall establish a comprehensive program of research into the biological effects of low-level ionizing radiation under which program the Secretary shall conduct such research and may support such research by others through grants and contracts.

(B) The Secretary shall conduct a comprehensive review of Federal programs of research on the biological effects of ionizing radiation.

(3) The Secretary shall conduct and may support through grants and contracts research and studies on human nutrition, with particular emphasis on the role of nutrition in the prevention and treatment of disease and on the maintenance and promotion of health, and programs for the dissemination of information respecting human nutrition to health professionals and the public. In carrying out activities under this paragraph, the Secretary shall provide for the coordination of such of these activities as are performed by the different divisions within the Department of Health, Education, and Welfare and shall consult with entities of the Federal Government, outside of the Department of Health, Education, and Welfare, engaged in comparable activities. The Secretary, upon request of such an entity and under appropriate arrangements for the payment of expenses, may conduct and support such activities for such entity.

(4) The Secretary shall publish a biennial report which contains—

(A) a list of all substances (i) which either are known to be carcinogens or may reasonably be anticipated to be carcinogens

and (ii) to which a significant number of persons residing in the United States are exposed;

(B) information concerning the nature of such exposure and the estimated number of persons exposed to such substances;

(C) a statement identifying (i) each substance contained in the list under subparagraph (A) for which no effluent, ambient, or exposure standard has been established by a Federal agency, and (ii) for each effluent, ambient, or exposure standard established by a Federal agency with respect to a substance contained in the list under subparagraph (A), the extent to which, on the basis of available medical, scientific, or other data, such standard, and the implementation of such standard by the agency, decreases the risk to public health from exposure to the substance; and

(D) a description of (i) each request received during the year involved—

(I) from a Federal agency outside the Department of Health, Education, and Welfare for the Secretary, or

(II) from an entity within the Department of Health, Education, and Welfare to any other entity within the Department,

to conduct research into, or testing for, the carcinogenicity of substances or to provide information described in clause (ii) of subparagraph (C), and (ii) how the Secretary and each such other entity, respectively, have responded to each such request.

(5) The authority of the Secretary to enter into any contract for the conduct of any study, testing, program, research, or review, or assessment under this subsection shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in Appropriation Acts.

(c) The Secretary may conduct biomedical research, directly or through grants or contracts, for the identification, control, treatment, and prevention of diseases (including tropical diseases) which do not occur to a significant extent in the United States.

(d)(1)(A) If a person is engaged in biomedical, behavioral, clinical, or other research, in which identifiable, sensitive information is collected (including research on mental health and research on the use and effect of alcohol and other psychoactive drugs), the Secretary, in coordination with other agencies, as applicable—

(i) shall issue to such person a certificate of confidentiality to protect the privacy of individuals who are the subjects of such research if the research is funded wholly or in part by the Federal Government; and

(ii) may, upon application by a person engaged in research, issue to such person a certificate of confidentiality to protect the privacy of such individuals if the research is not so funded.

(B) Except as provided in subparagraph (C), any person to whom a certificate is issued under subparagraph (A) to protect the privacy of individuals described in such subparagraph shall not disclose or provide to any other person not connected with the research the name of such an individual or any information, document, or biospecimen that contains identifiable, sensitive information about such an individual and that was created or compiled for purposes of the research.

(C) The disclosure prohibition in subparagraph (B) shall not apply to disclosure or use that is—

(i) required by Federal, State, or local laws, excluding instances described in subparagraph (D);

(ii) necessary for the medical treatment of the individual to whom the information, document, or biospecimen pertains and made with the consent of such individual;

(iii) made with the consent of the individual to whom the information, document, or biospecimen pertains; or

(iv) made for the purposes of other scientific research that is in compliance with applicable Federal regulations governing the protection of human subjects in research.

(D) Any person to whom a certificate is issued under subparagraph (A) to protect the privacy of an individual described in such subparagraph shall not, in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding, disclose or provide the name of such individual or any such information, document, or biospecimen that contains identifiable, sensitive information about the individual and that was created or compiled for purposes of the research, except in the circumstance described in subparagraph (C)(iii).

(E) Identifiable, sensitive information protected under subparagraph (A), and all copies thereof, shall be immune from the legal process, and shall not, without the consent of the individual to whom the information pertains, be admissible as evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceeding.

(F) Identifiable, sensitive information collected by a person to whom a certificate has been issued under subparagraph (A), and all copies thereof, shall be subject to the protections afforded by this section for perpetuity.

(G) The Secretary shall take steps to minimize the burden to researchers, streamline the process, and reduce the time it takes to comply with the requirements of this subsection.

(2) The Secretary shall coordinate with the heads of other applicable Federal agencies to ensure that such departments have policies in place with respect to the issuance of a certificate of confidentiality pursuant to paragraph (1) and other requirements of this subsection.

(3) Nothing in this subsection shall be construed to limit the access of an individual who is a subject of research to information about himself or herself collected during such individual's participation in the research.

(4) For purposes of this subsection, the term "identifiable, sensitive information" means information that is about an individual and that is gathered or used during the course of research described in paragraph (1)(A) and—

(A) through which an individual is identified; or

(B) for which there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual.

(e) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand, intensify, and coordi-

nate the activities of the Centers for Disease Control and Prevention with respect to maternal mortality and morbidity.

[(e)**]** *(f)* The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand, intensify, and coordinate the activities of the Centers for Disease Control and Prevention with respect to preterm labor and delivery and infant mortality.

[(f)**]** *(g)*(1) The Secretary may exempt from disclosure under section 552(b)(3) of title 5, United States Code, biomedical information that is about an individual and that is gathered or used during the course of biomedical research if—

(A) an individual is identified; or

(B) there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, the request, and other available data sources could be used to deduce the identity of an individual.

(2)(A) Each determination of the Secretary under paragraph (1) to exempt information from disclosure shall be made in writing and accompanied by a statement of the basis for the determination.

(B) Each such determination and statement of basis shall be available to the public, upon request, through the Office of the Chief FOIA Officer of the Department of Health and Human Services.

(3) Nothing in this subsection shall be construed to limit a research participant's access to information about such participant collected during the participant's participation in the research.

[(g)**]** *(h)* Subchapter I of chapter 35 of title 44, United States Code, shall not apply to the voluntary collection of information during the conduct of research by the National Institutes of Health.

[(h)**]** *(i)*(1) The Secretary may make available to individuals and entities, for biomedical and behavioral research, substances and living organisms. Such substances and organisms shall be made available under such terms and conditions (including payment for them) as the Secretary determines appropriate.

(2) Where research substances and living organisms are made available under paragraph (1) through contractors, the Secretary may direct such contractors to collect payments on behalf of the Secretary for the costs incurred to make available such substances and organisms and to forward amounts so collected to the Secretary, in the time and manner specified by the Secretary.

(3) Amounts collected under paragraph (2) shall be credited to the appropriations accounts that incurred the costs to make available the research substances and living organisms involved, and shall remain available until expended for carrying out activities under such accounts.

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SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in

this section as the "Office"). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

(b) PURPOSE.—The Director of the Office shall—

(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, *sociocultural, including among American Indians and Alaska Natives, as such terms are defined in section 4 of the Indian Health Care Improvement Act, geographic,* and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

(3) identify projects in women's health that should be conducted or supported by the Centers;

(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

(c) DEFINITION.—As used in this section, the term "women's health conditions", with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

(1) unique to, significantly more serious for, or significantly more prevalent in women; and

(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

PART B—FEDERAL-STATE COOPERATION

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SAFE MOTHERHOOD

SEC. 317K. (a) SURVEILLANCE.—

(1) PURPOSE.—The purposes of this subsection are to establish or continue a Federal initiative to support State and tribal maternal mortality review committees, to improve data collection and reporting around maternal mortality, and to develop or support surveillance systems at the local, State, and national level to better understand the burden of maternal complications and mortality and to decrease the disparities among

populations at risk of death and severe complications from pregnancy.

(2) ACTIVITIES.—For the purpose described in paragraph (1), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may carry out the following activities:

(A) The Secretary may continue and improve activities related to a national maternal mortality data collection and surveillance program to identify and support the review of pregnancy-associated deaths and pregnancy-related deaths that occur during, or within 1 year following, pregnancy.

(B) The Secretary may expand the Pregnancy Risk Assessment Monitoring System to provide surveillance and collect data in each State.

(C) The Secretary may expand the Maternal and Child Health Epidemiology Program to provide technical support, financial assistance, or the time-limited assignment of senior epidemiologists to maternal and child health programs in each State.

(D) The Secretary may, in cooperation with States, Indian tribes, and tribal organizations, develop a program to support States, Indian tribes, and tribal organizations in establishing or operating maternal mortality review committees, in accordance with subsection (d).

(E)(i) The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall establish or continue a competitive grant program for the establishment or support of perinatal quality collaboratives to improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants. A State, Indian Tribe, or tribal organization may use funds received through such grant to—

(I) support the use of evidence-based or evidence-informed practices to improve outcomes for maternal and infant health;

(II) work with clinical teams; experts; State, local, and, as appropriate, tribal public health officials; and stakeholders, including patients and families, to identify, develop, or disseminate best practices to improve perinatal care and outcomes; and

(III) employ strategies that provide opportunities for health care professionals and clinical teams to collaborate across health care settings and disciplines, including primary care and mental health, as appropriate, to improve maternal and infant health outcomes, which may include the use of data to provide timely feedback across hospital and clinical teams to inform responses, and to provide support and training to hospital and clinical teams for quality improvement, as appropriate.

(ii) To be eligible for a grant under clause (i), an entity shall submit to the Secretary an application in such form and manner and containing such information as the Secretary may require.

(b) PREVENTION RESEARCH.—

(1) PURPOSE.—The purpose of this subsection is to provide the Secretary with the authority to further expand research concerning risk factors, prevention strategies, and the roles of the family, health care providers and the community in safe motherhood.

(2) RESEARCH.—The Secretary may carry out activities to expand research relating to—

(A) prepregnancy counseling, especially for at risk populations such as women with diabetes and women with substance use disorder;

(B) the identification of critical components of prenatal delivery and postpartum care;

(C) the identification of outreach and support services, such as folic acid education, that are available for pregnant women;

(D) the identification of women who are at high risk for complications;

(E) preventing preterm delivery;

(F) preventing urinary tract infections;

(G) preventing unnecessary caesarean sections;

(H) the identification of the determinants of disparities in maternal care, health risks, and health outcomes, including an examination of the higher rates of maternal mortality among African American women and other groups of women with disproportionately high rates of maternal mortality;

(I) activities to reduce disparities in maternity services and outcomes;

(J) an examination of the relationship between interpersonal violence and maternal complications and mortality;

(K) preventing and reducing adverse health consequences that may result from smokingand substance abuse and misuse before, during and after pregnancy;

(L) preventing infections that cause maternal and infant complications; [and]

(M) an examination of the relationship between maternal and obstetric services in rural areas and outcomes in delivery and postpartum care; and

[(M)] *(N)* other areas determined appropriate by the Secretary.

(c) PREVENTION PROGRAMS.—The Secretary may carry out activities to promote safe motherhood, including—

(1) public education campaigns on healthy pregnancies;

(2) education programs for physicians, nurses and other health care providers;

(3) activities to promote community support services for pregnant women; and

(4) activities to promote physical, mental, and behavioral health during, and up to 1 year following, pregnancy, with an emphasis on prevention of, and treatment for, mental health disorders and substance use disorder.

(d) MATERNAL MORTALITY REVIEW COMMITTEES.—

(1) IN GENERAL.—In order to participate in the program under subsection (a)(2)(D), the applicable maternal mortality review committee of the State, Indian tribe, or tribal organization shall—

(A) include multidisciplinary and diverse membership that represents a variety of clinical specialties, State, tribal, or local public health officials, epidemiologists, statisticians, community organizations, geographic regions within the area covered by such committee, and individuals or organizations that represent the populations in the area covered by such committee that are most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services; and

(B) demonstrate to the Centers for Disease Control and Prevention that such maternal mortality review committee's methods and processes for data collection and review, as required under paragraph (3), use best practices to reliably determine and include all pregnancy-associated deaths and pregnancy-related deaths, regardless of the outcome of the pregnancy.

(2) PROCESS FOR CONFIDENTIAL REPORTING.—States, Indian tribes, and tribal organizations that participate in the program described in this subsection shall, through the State maternal mortality review committee, develop a process that—

(A) provides for confidential case reporting of pregnancy-associated and pregnancy-related deaths to the appropriate State or tribal health agency, including such reporting by—

(i) health care professionals;

(ii) health care facilities;

(iii) any individual responsible for completing death records, including medical examiners and medical coroners; and

(iv) other appropriate individuals or entities; and

(B) provides for voluntary and confidential case reporting of pregnancy-associated deaths and pregnancy-related deaths to the appropriate State or tribal health agency by family members of the deceased, and other appropriate individuals, for purposes of review by the applicable maternal mortality review committee; and

(C) shall include—

(i) making publicly available contact information of the committee for use in such reporting; and

(ii) conducting outreach to local professional organizations, community organizations, and social services agencies regarding the availability of the review committee.

(3) DATA COLLECTION AND REVIEW.—States, Indian tribes, and tribal organizations that participate in the program described in this subsection shall—

(A) annually identify pregnancy-associated deaths and pregnancy-related deaths—

(i) through the appropriate vital statistics unit by—

(I) matching each death record related to a pregnancy-associated death or pregnancy-related

death in the State or tribal area in the applicable year to a birth certificate of an infant or fetal death record, as applicable;

(II) to the extent practicable, identifying an underlying or contributing cause of each pregnancy-associated death and each pregnancy-related death in the State or tribal area in the applicable year; and

(III) collecting data from medical examiner and coroner reports, as appropriate;

(ii) using other appropriate methods or information to identify pregnancy-associated deaths and pregnancy-related deaths, including deaths from pregnancy outcomes not identified through clause (i)(I);

(B) through the maternal mortality review committee, review data and information to identify adverse outcomes that may contribute to pregnancy-associated death and pregnancy-related death, and to identify trends, patterns, and disparities in such adverse outcomes to allow the State, Indian tribe, or tribal organization to make recommendations to individuals and entities described in paragraph (2)(A), as appropriate, to improve maternal care and reduce pregnancy-associated death and pregnancy-related death;

(C) identify training available to the individuals and entities described in paragraph (2)(A) for accurate identification and reporting of pregnancy-associated and pregnancy-related deaths;

(D) ensure that, to the extent practicable, the data collected and reported under this paragraph is in a format that allows for analysis by the Centers for Disease Control and Prevention; and

(E) publicly identify the methods used to identify pregnancy-associated deaths and pregnancy-related deaths in accordance with this section.

(4) CONFIDENTIALITY.—States, Indian tribes, and tribal organizations participating in the program described in this subsection shall establish confidentiality protections to ensure, at a minimum, that—

(A) there is no disclosure by the maternal mortality review committee, including any individual members of the committee, to any person, including any government official, of any identifying information about any specific maternal mortality case; and

(B) no information from committee proceedings, including deliberation or records, is made public unless specifically authorized under State and Federal law.

(5) REPORTS TO CDC.—For fiscal year 2019, and each subsequent fiscal year, each maternal mortality review committee participating in the program described in this subsection shall submit to the Director of the Centers for Disease Control and Prevention a report that includes—

(A) data, findings, and any recommendations of such committee; and

(B) as applicable, information on the implementation during such year of any recommendations submitted by the committee in a previous year.

(6) STATE PARTNERSHIPS.—States may partner with one or more neighboring States to carry out the activities under this subparagraph. With respect to the States in such a partnership, any requirement under this subparagraph relating to the reporting of information related to such activities shall be deemed to be fulfilled by each such State if a single such report is submitted for the partnership.

(7) APPROPRIATE MECHANISMS FOR INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, in consultation with Indian tribes, shall identify and establish appropriate mechanisms for Indian tribes and tribal organizations to demonstrate, report data, and conduct the activities as required for participation in the program described in this subsection. Such mechanisms may include technical assistance with respect to grant application and submission procedures, and award management activities.

(8) RESEARCH AVAILABILITY.—The Secretary shall develop a process to ensure that data collected under paragraph (5) is made available, as appropriate and practicable, for research purposes, in a manner that protects individually identifiable or potentially identifiable information and that is consistent with State and Federal privacy law.

(e) DEFINITIONS.—In this section—

(1) the terms "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act;

(2) the term "pregnancy-associated death" means a death of a woman, by any cause, that occurs during, or within 1 year following, her pregnancy, regardless of the outcome, duration, or site of the pregnancy; and

(3) the term "pregnancy-related death" means a death of a woman that occurs during, or within 1 year following, her pregnancy, regardless of the outcome, duration, or site of the pregnancy—

(A) from any cause related to, or aggravated by, the pregnancy or its management; and

(B) not from accidental or incidental causes.

(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated **[**$58,000,000 for each of fiscal years 2019 through 2023**]** *$65,000,000 for each of fiscal years 2020 through 2024*.

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PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

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SEC. 330A–2. RURAL OBSTETRIC NETWORK GRANTS.

(a) PROGRAM ESTABLISHED.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to establish collaborative im-

provement and innovation networks (referred to in this section as "rural obstetric networks") to improve birth outcomes and reduce maternal morbidity and mortality by improving maternity care and access to care in rural areas, frontier areas, maternity care health professional target areas, and Indian country and with Indian Tribes and tribal organizations.

(b) USE OF FUNDS.—Rural obstetric networks receiving funds pursuant to this section may use such funds to—

(1) assist pregnant women and individuals in areas and within populations referenced in subsection (a) with accessing and utilizing maternal and obstetric care, including preconception, pregnancy, labor and delivery, postpartum, and interconception services to improve outcomes in birth and maternal mortality and morbidity;

(2) identify successful delivery models for maternal and obstetric care (including preconception, pregnancy, labor and delivery, postpartum, and interconception services) for individuals in areas and within populations referenced by subsection (a), including evidence-based home visiting programs and successful, culturally competent models with positive maternal health outcomes that advance health equity;

(3) develop a model for collaboration between health facilities that have an obstetric care unit and health facilities that do not have an obstetric care unit to improve access to and the delivery of obstetric services in communities lacking these services;

(4) provide training and guidance on obstetric care for health facilities that do not have obstetric care units;

(5) collaborate with academic institutions that can provide regional expertise and research on access, outcomes, needs assessments, and other identified data and measurement activities needed to inform rural obstetric network efforts to improve obstetric care; and

(6) measure and address inequities in birth outcomes among rural residents, with an emphasis on racial and ethnic minorities and underserved populations.

(c) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITIES.—The term "eligible entities" means entities providing obstetric, gynecologic, and other maternal health care services in rural areas, frontier areas, or medically underserved areas, or to medically underserved populations or Native Americans, including Indian tribes or tribal organizations.

(2) FRONTIER AREA.—The term "frontier area" means a frontier county, as defined in section 1886(d)(3)(E)(iii)(III) of the Social Security Act.

(3) INDIAN COUNTRY.—The term "Indian country" has the meaning given such term in section 1151 of title 18, United States Code.

(4) MATERNITY CARE HEALTH PROFESSIONAL TARGET AREA.—The term "maternity care health professional target area" has the meaning of such term as used in section 332(k)(2).

(5) RURAL AREA.—The term "rural area" has the meaning given that term in section 1886(d)(2) of the Social Security Act.

(6) INDIAN TRIBES; TRIBAL ORGANIZATION.—The terms "Indian Tribe" and "tribal organization" have the meaning given such

terms in section 4 of the Indian Self-Determination and Education Assistance Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $3,000,000 for each of fiscal years 2020 through 2024.

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SEC. 330I. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR; OFFICE.—The terms "Director" and "Office" mean the Director and Office specified in subsection (c).

(2) FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC.—The term "Federally qualified health center" and "rural health clinic" have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

(3) FRONTIER COMMUNITY.—The term "frontier community" shall have the meaning given the term in regulations issued under subsection (r).

(4) MEDICALLY UNDERSERVED AREA.—The term "medically underserved area" has the meaning given the term "medically underserved community" in section 799B(6).

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

(6) TELEHEALTH SERVICES.—The term "telehealth services" means services provided through telehealth technologies.

(7) TELEHEALTH TECHNOLOGIES.—The term "telehealth technologies" means technologies relating to the use of electronic information, and telecommunications technologies, to support and promote, at a distance, health care, patient and professional health-related education, health administration, and public health.

(b) PROGRAMS.—The Secretary shall establish, under section 301, telehealth network and telehealth resource centers grant programs.

(c) ADMINISTRATION.—

(1) ESTABLISHMENT.—There is established in the Health Resources and Services Administration an Office for the Advancement of Telehealth. The Office shall be headed by a Director.

(2) DUTIES.—The telehealth network and telehealth resource centers grant programs established under section 301 shall be administered by the Director, in consultation with the State offices of rural health, State offices concerning primary care, or other appropriate State government entities.

(d) GRANTS.—

(1) TELEHEALTH NETWORK GRANTS.—The Director may, in carrying out the telehealth network grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used through telehealth networks in rural areas, frontier communities, and medically underserved areas, and for medically underserved populations, to—

(A) expand access to, coordinate, and improve the quality of health care services;

(B) improve and expand the training of health care providers; and

(C) expand and improve the quality of health information available to health care providers, and patients and their families, for decisionmaking.

(2) TELEHEALTH RESOURCE CENTERS GRANTS.—The Director may, in carrying out the telehealth resource centers grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used in the areas and communities, and for the populations, described in paragraph (1), to establish telehealth resource centers.

(e) GRANT PERIODS.—The Director may award grants under this section for periods of not more than 4 years.

(f) ELIGIBLE ENTITIES.—

(1) TELEHEALTH NETWORK GRANTS.—

(A) GRANT RECIPIENT.—To be eligible to receive a grant under subsection (d)(1), an entity shall be a nonprofit entity.

(B) TELEHEALTH NETWORKS.—

(i) IN GENERAL.—To be eligible to receive a grant under subsection (d)(1), an entity shall demonstrate that the entity will provide services through a telehealth network.

(ii) NATURE OF ENTITIES.—Each entity participating in the telehealth network may be a nonprofit or forprofit entity.

(iii) COMPOSITION OF NETWORK.—The telehealth network shall include at least 2 of the following entities (at least 1 of which shall be a community-based health care provider):

(I) Community or migrant health centers or other Federally qualified health centers.

(II) Health care providers, including pharmacists, in private practice.

(III) Entities operating clinics, including rural health clinics.

(IV) Local health departments.

(V) Nonprofit hospitals, including community access hospitals.

(VI) Other publicly funded health or social service agencies.

(VII) Long-term care providers.

(VIII) Providers of health care services in the home.

(IX) Providers of outpatient mental health services and entities operating outpatient mental health facilities.

(X) Local or regional emergency health care providers.

(XI) Institutions of higher education.

(XII) Entities operating dental clinics.

(XIII) Providers of maternal, including prenatal, labor and birth, and postpartum care services and entities operating obstetric care units.

(2) TELEHEALTH RESOURCE CENTERS GRANTS.—To be eligible to receive a grant under subsection (d)(2), an entity shall be a nonprofit entity.

(g) APPLICATIONS.—To be eligible to receive a grant under subsection (d), an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the project that the eligible entity will carry out using the funds provided under the grant;

(2) a description of the manner in which the project funded under the grant will meet the health care needs of rural or other populations to be served through the project, or improve the access to services of, and the quality of the services received by, those populations;

(3) evidence of local support for the project, and a description of how the areas, communities, or populations to be served will be involved in the development and ongoing operations of the project;

(4) a plan for sustaining the project after Federal support for the project has ended;

(5) information on the source and amount of non-Federal funds that the entity will provide for the project;

(6) information demonstrating the long-term viability of the project, and other evidence of institutional commitment of the entity to the project;

(7) in the case of an application for a project involving a telehealth network, information demonstrating how the project will promote the integration of telehealth technologies into the operations of health care providers, to avoid redundancy, and improve access to and the quality of care; and

(8) other such information as the Secretary determines to be appropriate.

(h) TERMS; CONDITIONS; MAXIMUM AMOUNT OF ASSISTANCE.—The Secretary shall establish the terms and conditions of each grant program described in subsection (b) and the maximum amount of a grant to be awarded to an individual recipient for each fiscal year under this section. The Secretary shall publish, in a publication of the Health Resources and Services Administration, notice of the application requirements for each grant program described in subsection (b) for each fiscal year.

(i) PREFERENCES.—

(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for projects involving telehealth networks, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

(A) ORGANIZATION.—The eligible entity is a rural community-based organization or another community-based organization.

(B) SERVICES.—The eligible entity proposes to use Federal funds made available through such a grant to develop plans for, or to establish, telehealth networks that provide mental health, public health, long-term care, home care,

preventive, case management services, *labor and birth, postpartum,* or prenatal care for high-risk pregnancies.

(C) COORDINATION.—The eligible entity demonstrates how the project to be carried out under the grant will be coordinated with other relevant federally funded projects in the areas, communities, and populations to be served through the grant.

(D) NETWORK.—The eligible entity demonstrates that the project involves a telehealth network that includes an entity that—

(i) provides clinical health care services, or educational services for health care providers and for patients or their families; and

(ii) is—

(I) a public library;

(II) an institution of higher education; or

(III) a local government entity.

(E) CONNECTIVITY.—The eligible entity proposes a project that promotes local connectivity within areas, communities, or populations to be served through the project.

(F) INTEGRATION.—The eligible entity demonstrates that health care information has been integrated into the project.

(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

(A) PROVISION OF SERVICES.—The eligible entity has a record of success in the provision of telehealth services to medically underserved areas or medically underserved populations.

(B) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

(C) BROAD RANGE OF TELEHEALTH SERVICES.—The eligible entity has a record of providing a broad range of telehealth services, which may include—

(i) a variety of clinical specialty services;

(ii) patient or family education;

(iii) health care professional education; and

(iv) rural residency support programs.

(j) DISTRIBUTION OF FUNDS.—

(1) IN GENERAL.—In awarding grants under this section, the Director shall ensure, to the greatest extent possible, that such grants are equitably distributed among the geographical regions of the United States.

(2) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for a fiscal year, the Director shall ensure that—

(A) not less than 50 percent of the funds awarded shall be awarded for projects in rural areas; and

(B) the total amount of funds awarded for such projects for that fiscal year shall be not less than the total amount of funds awarded for such projects for fiscal year 2001 under section 330A (as in effect on the day before the date

of enactment of the Health Care Safety Net Amendments of 2002).

(k) USE OF FUNDS.—

(1) TELEHEALTH NETWORK PROGRAM.—The recipient of a grant under subsection (d)(1) may use funds received through such grant for salaries, equipment, and operating or other costs, including the cost of—

(A) developing and delivering clinical telehealth services that enhance access to community-based health care services in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations;

(B) developing and acquiring, through lease or purchase, computer hardware and software, audio and video equipment, computer network equipment, interactive equipment, data terminal equipment, and other equipment that furthers the objectives of the telehealth network grant program;

(C)(i) developing and providing distance education, in a manner that enhances access to care in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations; or

(ii) mentoring, precepting, or supervising health care providers and students seeking to become health care providers, in a manner that enhances access to care in the areas and communities, or for the populations, described in clause (i);

(D) developing and acquiring instructional programming;

(E)(i) providing for transmission of medical data, and maintenance of equipment; and

(ii) providing for compensation (including travel expenses) of specialists, and referring health care providers, who are providing telehealth services through the telehealth network, if no third party payment is available for the telehealth services delivered through the telehealth network;

(F) developing projects to use telehealth technology to facilitate collaboration between health care providers;

(G) collecting and analyzing usage statistics and data to document the cost-effectiveness of the telehealth services; and

(H) carrying out such other activities as are consistent with achieving the objectives of this section, as determined by the Secretary.

(2) TELEHEALTH RESOURCE CENTERS.—The recipient of a grant under subsection (d)(2) may use funds received through such grant for salaries, equipment, and operating or other costs for—

(A) providing technical assistance, training, and support, and providing for travel expenses, for health care providers and a range of health care entities that provide or will provide telehealth services;

(B) disseminating information and research findings related to telehealth services;

(C) promoting effective collaboration among telehealth resource centers and the Office;

(D) conducting evaluations to determine the best utilization of telehealth technologies to meet health care needs;

(E) promoting the integration of the technologies used in clinical information systems with other telehealth technologies;

(F) fostering the use of telehealth technologies to provide health care information and education for health care providers and consumers in a more effective manner; and

(G) implementing special projects or studies under the direction of the Office.

(l) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds made available through the grant—

(1) to acquire real property;

(2) for expenditures to purchase or lease equipment, to the extent that the expenditures would exceed 40 percent of the total grant funds;

(3) in the case of a project involving a telehealth network, to purchase or install transmission equipment (such as laying cable or telephone lines, or purchasing or installing microwave towers, satellite dishes, amplifiers, or digital switching equipment);

(4) to pay for any equipment or transmission costs not directly related to the purposes for which the grant is awarded;

(5) to purchase or install general purpose voice telephone systems;

(6) for construction; or

(7) for expenditures for indirect costs (as determined by the Secretary), to the extent that the expenditures would exceed 15 percent of the total grant funds.

(m) COLLABORATION.—In providing services under this section, an eligible entity shall collaborate, if feasible, with entities that—

(1)(A) are private or public organizations, that receive Federal or State assistance; or

(B) are public or private entities that operate centers, or carry out programs, that receive Federal or State assistance; and

(2) provide telehealth services or related activities.

(n) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in subsection (b), to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar programs, to maximize the effect of public dollars in funding meritorious proposals.

(o) OUTREACH ACTIVITIES.—The Secretary shall establish and implement procedures to carry out outreach activities to advise potential end users of telehealth services in rural areas, frontier communities, medically underserved areas, and medically underserved populations in each State about the grant programs described in subsection (b).

(p) TELEHEALTH.—It is the sense of Congress that, for purposes of this section, States should develop reciprocity agreements so that a provider of services under this section who is a licensed or otherwise authorized health care provider under the law of 1 or more States, and who, through telehealth technology, consults with a li-

censed or otherwise authorized health care provider in another State, is exempt, with respect to such consultation, from any State law of the other State that prohibits such consultation on the basis that the first health care provider is not a licensed or authorized health care provider under the law of that State.

(q) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsection (b).

(r) REGULATIONS.—The Secretary shall issue regulations specifying, for purposes of this section, a definition of the term "frontier area". The definition shall be based on factors that include population density, travel distance in miles to the nearest medical facility, travel time in minutes to the nearest medical facility, and such other factors as the Secretary determines to be appropriate. The Secretary shall develop the definition in consultation with the Director of the Bureau of the Census and the Administrator of the Economic Research Service of the Department of Agriculture.

(s) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) for grants under subsection (d)(1), $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006; and

(2) for grants under subsection (d)(2), $20,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

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SEC. 330M. PEDIATRIC MENTAL HEALTH CARE ACCESS GRANTS.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in coordination with other relevant Federal agencies, shall award grants to States, political subdivisions of States, and Indian tribes and tribal organizations (for purposes of this section, as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) to promote behavioral health integration in pediatric primary care by—

(1) supporting the development of statewide or regional pediatric mental health care telehealth access programs; and

(2) supporting the improvement of existing statewide or regional pediatric mental health care telehealth access programs.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—A pediatric mental health care telehealth access program referred to in subsection (a), with respect to which a grant under such subsection may be used, shall—

(A) be a statewide or regional network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;

(B) support and further develop organized State or regional networks of pediatric mental health teams to provide consultative support to pediatric primary care sites;

(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers' preferred mechanisms for receiving consultation, training, and technical assistance;

(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;

(E) provide rapid statewide or regional clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;

(G) provide information to pediatric providers about, and assist pediatric providers in accessing, pediatric mental health care providers, including child and adolescent psychiatrists, and licensed mental health professionals, such as psychologists, social workers, or mental health counselors and in scheduling and conducting technical assistance;

(H) assist with referrals to specialty care and community or behavioral health resources; and

(I) establish mechanisms for measuring and monitoring increased access to pediatric mental health care services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term "pediatric mental health team" means a team consisting of at least one case coordinator, at least one child and adolescent psychiatrist, and at least one licensed clinical mental health professional, such as a psychologist, social worker, or mental health counselor. Such a team may be regionally based.

(c) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the comprehensive evaluation of activities that are carried out with funds received under such grant.

(d) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under this section shall prepare and submit an evaluation of activities that are carried out with funds received under such grant to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including a process and outcome evaluation.

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

(f) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section unless the State, political subdivision of a State, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the State, political subdivision of a State, Indian tribe, or tribal organization in carrying out the purpose described in this section, to make available non-Federal

contributions (in cash or in kind) toward such costs in an amount that is not less than 20 percent of Federal funds provided in the grant.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated, $9,000,000 for the period of fiscal years 2018 through 2022.

SEC. 330N. INNOVATION FOR MATERNAL HEALTH.

(a) IN GENERAL.—The Secretary, in consultation with experts representing a variety of clinical specialties, State, tribal, or local public health officials, researchers, epidemiologists, statisticians, and community organizations, shall establish or continue a program to award competitive grants to eligible entities for the purpose of—

(1) identifying, developing, or disseminating best practices to improve maternal health care quality and outcomes, eliminate preventable maternal mortality and severe maternal morbidity, and improve infant health outcomes, which may include—

(A) information on evidence-based practices to improve the quality and safety of maternal health care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

(B) best practices for improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and post–partum care; and

(C) information on addressing determinants of health that impact maternal health outcomes for women before, during, and after pregnancy;

(2) collaborating with State maternal mortality review committees to identify issues for the development and implementation of evidence-based practices to improve maternal health outcomes and reduce preventable maternal mortality and severe maternal morbidity;

(3) providing technical assistance and supporting the implementation of best practices identified in paragraph (1) to entities providing health care services to pregnant and postpartum women; and

(4) identifying, developing, and evaluating new models of care that improve maternal and infant health outcomes, which may include the integration of community-based services and clinical care.

(b) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (a), an entity shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(2) demonstrate in such application that the entity is capable of carrying out data-driven maternal safety and quality improvement initiatives in the areas of obstetrics and gynecology or maternal health.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2020 through 2024.

SEC. 330O. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

(a) IN GENERAL.—The Secretary may award grants for the purpose of establishing or operating evidence-based or innovative, evidence-informed programs to deliver integrated health care services to pregnant and postpartum women to optimize the health of women and their infants, including—

(1) to reduce adverse maternal health outcomes, pregnancy-related deaths, and related health disparities (including such disparities associated with racial and ethnic minority populations); and

(2) as appropriate, by addressing issues researched under section 317K(b)(2).

(b) INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

(1) ELIGIBILITY To be eligible to receive a grant under subsection (a), a State, Indian Tribe, or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act) shall work with relevant stakeholders that coordinate care (including coordinating resources and referrals for health care and social services) to develop and carry out the program, including—

(A) State, Tribal, and local agencies responsible for Medicaid, public health, social services, mental health, and substance use disorder treatment and services;

(B) health care providers who serve pregnant and postpartum women; and

(C) community-based health organizations and health workers, including providers of home visiting services and individuals representing communities with disproportionately high rates of maternal mortality and severe maternal morbidity, and including those representing racial and ethnicity minority populations.

(2) TERMS

(A) PERIOD A grant awarded under subsection (a) shall be made for a period of 5 years. Any supplemental award made to a grantee under subsection (a) may be made for a period of less than 5 years.

(B) PREFERENCE In awarding grants under subsection (a), the Secretary shall—

(i) give preference to States, Indian Tribes, and tribal organizations that have the highest rates of maternal mortality and severe maternal morbidity relative to other such States, Indian Tribes, or tribal organizations, respectively; and

(ii) shall consider health disparities related to maternal mortality and severe maternal morbidity, including such disparities associated with racial and ethnic minority populations.

(C) PRIORITY In awarding grants under subsection (a), the Secretary shall give priority to applications from up to 15 entities described in subparagraph (B)(i).

(D) EVALUATION The Secretary shall require grantees to evaluate the outcomes of the programs supported under the grant.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2020 through 2024.

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TITLE IV—NATIONAL RESEARCH INSTITUTES

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PART F—RESEARCH ON WOMEN'S HEALTH

SEC. 486. OFFICE OF RESEARCH ON WOMEN'S HEALTH.

(a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Research on Women's Health (in this part referred to as the "Office"). The Office shall be headed by a director, who shall be appointed by the Director of NIH and who shall report directly to the Director.

(b) PURPOSE.—The Director of the Office shall—

(1) identify projects of research on women's health that should be conducted or supported by the national research institutes;

(2) identify multidisciplinary research relating to research on women's health that should be so conducted or supported;

[(3) carry out paragraphs (1) and (2) with respect to the aging process in women, with priority given to menopause;]

(3) carry out paragraphs (1) and (2) with respect to—

(A) the aging process in women, with priority given to menopause; and

(B) pregnancy, with priority given to deaths related to pregnancy;

(4) promote coordination and collaboration among entities conducting research identified under any of paragraphs (1) through (3);

(5) encourage the conduct of such research by entities receiving funds from the national research institutes;

(6) recommend an agenda for conducting and supporting such research;

(7) promote the sufficient allocation of the resources of the national research institutes for conducting and supporting such research;

(8) assist in the administration of section 492B with respect to the inclusion of women as subjects in clinical research; and

(9) prepare the report required in section 486B.

(c) COORDINATING COMMITTEE.—

(1) In carrying out subsection (b), the Director of the Office shall establish a committee to be known as the Coordinating Committee on Research on Women's Health (in this subsection referred to as the "Coordinating Committee").

(2) The Coordinating Committee shall be composed of the Directors of the national research institutes (or the senior-level staff designees of the Directors).

(3) The Director of the Office shall serve as the chair of the Coordinating Committee.

(4) With respect to research on women's health, the Coordinating Committee shall assist the Director of the Office in—

(A) identifying the need for such research, and making an estimate each fiscal year of the funds needed to adequately support the research;

(B) identifying needs regarding the coordination of research activities, including intramural and extramural multidisciplinary activities;

(C) supporting the development of methodologies to determine the circumstances in which obtaining data specific to women (including data relating to the age of women and the membership of women in ethnic or racial groups) is an appropriate function of clinical trials of treatments and therapies;

(D) supporting the development and expansion of clinical trials of treatments and therapies for which obtaining such data has been determined to be an appropriate function; and

(E) encouraging the national research institutes to conduct and support such research, including such clinical trials.

(d) ADVISORY COMMITTEE.—

(1) In carrying out subsection (b), the Director of the Office shall establish an advisory committee to be known as the Advisory Committee on Research on Women's Health (in this subsection referred to as the "Advisory Committee").

(2) The Advisory Committee shall be composed of no fewer than 12, and not more than 18 individuals, who are not officers or employees of the Federal Government. The Director of NIH shall make appointments to the Advisory Committee from among physicians, practitioners, scientists, and other health professionals, whose clinical practice, research specialization, or professional expertise includes a significant focus on research on women's health. A majority of the members of the Advisory Committee shall be women.

(3) The Director of the Office shall serve as the chair of the Advisory Committee.

(4) The Advisory Committee shall—

(A) advise the Director of the Office on appropriate research activities to be undertaken by the national research institutes with respect to—

(i) research on women's health;

(ii) research on gender differences in clinical drug trials, including responses to pharmacological drugs;

(iii) research on gender differences in disease etiology, course, and treatment;

(iv) research on obstetrical and gynecological health conditions, diseases, and treatments*, including maternal mortality and other maternal morbidity outcomes*; and

(v) research on women's health conditions which require a multidisciplinary approach;

(B) report to the Director of the Office on such research;

(C) provide recommendations to such Director regarding activities of the Office (including recommendations on the

development of the methodologies described in subsection (c)(4)(C) and recommendations on priorities in carrying out research described in subparagraph (A)); and

(D) assist in monitoring compliance with section 492B regarding the inclusion of women in clinical research.

(5)(A) The Advisory Committee shall prepare a biennial report describing the activities of the Committee, including findings made by the Committee regarding—

(i) compliance with section 492B;

(ii) the extent of expenditures made for research on women's health by the agencies of the National Institutes of Health; and

(iii) the level of funding needed for such research.

(B) The report required in subparagraph (A) shall be submitted to the Director of NIH for inclusion in the report required in section 403.

(e) REPRESENTATION OF WOMEN AMONG RESEARCHERS.—The Secretary, acting through the Assistant Secretary for Personnel and in collaboration with the Director of the Office, shall determine the extent to which women are represented among senior physicians and scientists of the national research institutes and among physicians and scientists conducting research with funds provided by such institutes, and as appropriate, carry out activities to increase the extent of such representation.

(f) DEFINITIONS.—For purposes of this part:

(1) The term "women's health conditions", with respect to women of all age, ethnic, and racial groups, means all diseases, disorders, and conditions (including with respect to mental health)—

(A) unique to, more serious, or more prevalent in women;

(B) for which the factors of medical risk or types of medical intervention are different for women, or for which it is unknown whether such factors or types are different for women; or

(C) with respect to which there has been insufficient clinical research involving women as subjects or insufficient clinical data on women.

(2) The term "research on women's health" means research on women's health conditions, including research on preventing such conditions.

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TITLE VII—HEALTH PROFESSIONS EDUCATION

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PART E—HEALTH PROFESSIONS AND PUBLIC HEALTH WORKFORCE

Subpart 1—Health Professions Workforce Information and Analysis

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[SEC. 763. PEDIATRIC RHEUMATOLOGY.

[(a) IN GENERAL.—The Secretary, acting through the appropriate agencies, shall evaluate whether the number of pediatric rheumatologists is sufficient to address the health care needs of children with arthritis and related conditions, and if the Secretary determines that the number is not sufficient, shall develop strategies to help address the shortfall.

[(b) REPORT TO CONGRESS.—Not later than October 1, 2001, the Secretary shall submit to the Congress a report describing the results of the evaluation under subsection (a), and as applicable, the strategies developed under such subsection.

[(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.**]**

SEC. 763. TRAINING FOR HEALTH CARE PROVIDERS.

(a) GRANT PROGRAM.—The Secretary shall establish a program to award grants to accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

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

(c) REPORTING REQUIREMENT.—Each entity awarded a grant under this section shall periodically submit to the Secretary a report on the status of activities conducted using the grant, including a description of the impact of such training on patient outcomes, as applicable.

(d) BEST PRACTICES.—The Secretary may identify and disseminate best practices for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2020 through 2024.

SEC. 764. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.

(a) IN GENERAL.—The Secretary shall establish a training demonstration program to award grants to eligible entities to support—

(1) training for physicians, medical residents, including family medicine and obstetrics and gynecology residents, and fel-

lows to practice maternal and obstetric medicine in rural community-based settings;

(2) training for nurse practitioners, physician assistants, nurses, certified nurse midwives, home visiting nurses and non-clinical home visiting workforce professionals and paraprofessionals, or non-clinical professionals, who meet applicable State training and licensing requirements, to provide maternal care services in rural community-based settings; and

(3) establishing, maintaining, or improving academic units or programs that—

(A) provide training for students or faculty, including through clinical experiences and research, to improve maternal care in rural areas; or

(B) develop evidence-based practices or recommendations for the design of the units or programs described in subparagraph (A), including curriculum content standards.

(b) ACTIVITIES.—

(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—A recipient of a grant under subsection (a)(1)—

(A) shall use the grant funds—

(i) to plan, develop, and operate a training program to provide obstetric care in rural areas for family practice or obstetrics and gynecology residents and fellows; or

(ii) to train new family practice or obstetrics and gynecology residents and fellows in maternal and obstetric health care to provide and expand access to maternal and obstetric health care in rural areas; and

(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such training.

(2) TRAINING FOR OTHER PROVIDERS.—A recipient of a grant under subsection (a)(2)—

(A) shall use the grant funds to plan, develop, or operate a training program to provide maternal health care services in rural, community-based settings; and

(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such program.

(3) TRAINING PROGRAM REQUIREMENTS.—The recipient of a grant under subsection (a)(1) or (a)(2) shall ensure that training programs carried out under the grant are evidence-based and include instruction on—

(A) maternal mental health, including perinatal depression and anxiety;

(B) maternal substance use disorder;

(C) social determinants of health that impact individuals living in rural communities, including poverty, social isolation, access to nutrition, education, transportation, and housing; and

(D) implicit bias.

(c) ELIGIBLE ENTITIES.—

(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—To be eligible to receive a grant under subsection (a)(1), an entity shall—

(A) be a consortium consisting of—

(i) at least one teaching health center; or

(ii) the sponsoring institution (or parent institution of the sponsoring institution) of—

(I) an obstetrics and gynecology or family medicine residency program that is accredited by the Accreditation Council of Graduate Medical Education (or the parent institution of such a program); or

(II) a fellowship in maternal or obstetric medicine, as determined appropriate by the Secretary; or

(B) be an entity described in subparagraph (A)(ii) that provides opportunities for medical residents or fellows to train in rural community-based settings.

(2) TRAINING FOR OTHER PROVIDERS.—To be eligible to receive a grant under subsection (a)(2), an entity shall be—

(A) a teaching health center (as defined in section 749A(f));

(B) a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act);

(C) a community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act);

(D) a rural health clinic (as defined in section 1861(aa) of the Social Security Act);

(E) a freestanding birth center (as defined in section 1905(l)(3) of the Social Security Act); or

(F) an Indian Health Program or a Native Hawaiian health care system (as such terms are defined in section 4 of the Indian Health Care Improvement Act and section 12 of the Native Hawaiian Health Care Improvement Act, respectively).

(3) ACADEMIC UNITS OR PROGRAMS.—To be eligible to receive a grant under subsection (a)(3), an entity shall be a school of medicine, a school of osteopathic medicine, a school of nursing (as defined in section 801), a physician assistant education program, an accredited public or nonprofit private hospital, an accredited medical residency training program, a school accredited by the Midwifery Education and Accreditation Council, by the Accreditation Commission for Midwifery Education, or by the American Midwifery Certification Board, or a public or private nonprofit educational entity which the Secretary has determined is capable of carrying out such grant.

(4) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an estimate of the amount to be expended to conduct training activities under the grant (including ancillary and administrative costs).

(d) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct a study on the results of the demonstration program under this section.

(B) DATA SUBMISSION.—Not later than 90 days after the completion of the first year of the training program, and each subsequent year for the duration of the grant, that the program is in effect, each recipient of a grant under subsection (a) shall submit to the Secretary such data as the Secretary may require for analysis for the report described in paragraph (2).

(2) REPORT TO CONGRESS.—Not later than 1 year after receipt of the data described in paragraph (1)(B), the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that includes—

(A) an analysis of the effect of the demonstration program under this section on the quality, quantity, and distribution of maternal (including prenatal, labor and birth, and postpartum) care services and the demographics of the recipients of those services;

(B) an analysis of maternal and infant health outcomes (including quality of care, morbidity, and mortality) before and after implementation of the program in the communities served by entities participating in the demonstration; and

(C) recommendations on whether the demonstration program should be expanded.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2020 through 2024.

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