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2^D SESSION

S. 4550

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

IN THE SENATE OF THE UNITED STATES

MAY 18, 2026

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Maternal Health Pan-
5 demic Response Act”.

1 **SEC. 2. FUNDING FOR DATA COLLECTION, SURVEILLANCE,**
2 **AND RESEARCH ON MATERNAL HEALTH OUT-**
3 **COMES DURING PUBLIC HEALTH EMER-**
4 **GENCIES.**

5 To conduct or support data collection, surveillance,
6 and research on maternal health as a result of public
7 health emergencies and infectious diseases that pose a risk
8 to maternal and infant health, including support to assist
9 in the capacity building for State, Tribal, territorial, and
10 local public health departments to collect and transmit ra-
11 cial, ethnic, and other demographic data related to mater-
12 nal health, there are authorized to be appropriated—

13 (1) \$100,000,000 for the Surveillance for
14 Emerging Threats to Mothers and Babies program
15 of the Centers for Disease Control and Prevention,
16 to support the Centers for Disease Control and Pre-
17 vention in its efforts to—

18 (A) work with public health, clinical, and
19 community-based organizations to provide time-
20 ly, continually updated guidance to families and
21 health care providers on ways to reduce risk to
22 pregnant and postpartum individuals and their
23 newborns and tailor interventions to improve
24 their long-term health;

25 (B) partner with more State, Tribal, terri-
26 torial, and local public health programs in the

1 collection and analysis of clinical data on the
2 impact of public health emergencies and infec-
3 tious diseases that pose a risk to maternal and
4 infant health on pregnant and postpartum pa-
5 tients and their newborns, particularly among
6 patients from racial and ethnic minority groups;
7 and

8 (C) establish regionally based centers of
9 excellence to offer medical, public health, and
10 other knowledge to ensure communities can
11 help pregnant and postpartum individuals and
12 newborns get the care and support they need,
13 particularly in areas with large populations of
14 individuals from demographic groups with ele-
15 vated rates of maternal mortality, severe mater-
16 nal morbidity, maternal health disparities, or
17 other adverse perinatal or childbirth outcomes;

18 (2) \$30,000,000 for the Enhancing Reviews
19 and Surveillance to Eliminate Maternal Mortality
20 program (commonly known as the “ERASE MM
21 program”) of the Centers for Disease Control and
22 Prevention, to support the Centers for Disease Con-
23 trol and Prevention in expanding its partnerships
24 with States and Indian Tribes and provide technical

1 assistance to existing Maternal Mortality Review
2 Committees;

3 (3) \$45,000,000 for the Pregnancy Risk As-
4 sessment Monitoring System (commonly known as
5 the “PRAMS”) of the Centers for Disease Control
6 and Prevention, to support the Centers for Disease
7 Control and Prevention in its efforts to—

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

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

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

21 (4) \$15,000,000 for the National Institute of
22 Child Health and Human Development, to conduct
23 or support research for interventions to mitigate the
24 effects of public health emergencies and infectious
25 diseases that pose a risk to maternal and infant

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

6 **SEC. 3. PUBLIC HEALTH EMERGENCY MATERNAL HEALTH**
7 **DATA COLLECTION AND DISCLOSURE.**

8 (a) AVAILABILITY OF COLLECTED DATA.—The Sec-
9 retary, acting through the Director of the Centers for Dis-
10 ease Control and Prevention and the Administrator of the
11 Centers for Medicare & Medicaid Services, shall make pub-
12 licly available on the website of the Centers for Disease
13 Control and Prevention data described in subsection (b).

14 (b) DATA DESCRIBED.—The data described in this
15 subsection are data collected through Federal surveillance
16 systems under the Centers for Disease Control and Pre-
17 vention with respect to public health emergencies and indi-
18 viduals who are pregnant or in a postpartum period. Such
19 data shall include the following:

20 (1) Diagnostic testing, confirmed cases, hos-
21 pitalizations, deaths, and other health outcomes re-
22 lated to an infectious disease outbreak among preg-
23 nant and postpartum individuals.

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

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

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

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

15 (1) at least on a monthly basis; and

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

18 (f) PRIVACY.—In carrying out subsection (a), the
19 Secretary shall—

20 (1) take steps to protect the privacy of individ-
21 uals pursuant to regulations promulgated under sec-
22 tion 264(c) of the Health Insurance Portability and
23 Accountability Act of 1996 (42 U.S.C. 1320d-2
24 note); and

25 (2) ensure that—

1 (A) all data collected is deidentified;

2 (B) at a minimum, there is no disclosure
3 of any individually identifying or potentially
4 identifying information regarding a patient or a
5 patient's health care provider; and

6 (C) all data is collected in a manner that
7 is consistent with applicable Federal and State
8 privacy law.

9 (g) GUIDANCE.—

10 (1) IN GENERAL.—Not later than 30 days after
11 the declaration of a public health emergency, the
12 Secretary shall issue guidance to States and local
13 public health departments to ensure that—

14 (A) laboratories that test specimens for an
15 infectious disease receive all relevant demo-
16 graphic data on race, ethnicity, pregnancy sta-
17 tus, and other demographic data as determined
18 by the Secretary; and

19 (B) data described in subsection (b) are
20 disaggregated by race, ethnicity, gender, pri-
21 mary language, geography, socioeconomic sta-
22 tus, and other relevant factors.

23 (2) CONSULTATION.—In carrying out para-
24 graph (1), the Secretary shall consult with Indian
25 Tribes—

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

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

5 **SEC. 4. PUBLIC HEALTH COMMUNICATION REGARDING MA-**
6 **TERNAL CARE DURING PUBLIC HEALTH**
7 **EMERGENCIES.**

8 The Director of the Centers for Disease Control and
9 Prevention shall conduct public health education cam-
10 paigns during public health emergencies to ensure that
11 pregnant and postpartum individuals, their employers,
12 and their health care providers have accurate, evidence-
13 based information on maternal and infant health risks
14 during the public health emergency, with a particular
15 focus on reaching pregnant and postpartum individuals in
16 underserved communities.

17 **SEC. 5. TASK FORCE ON BIRTHING EXPERIENCE AND SAFE,**
18 **RESPECTFUL, RESPONSIVE, AND EMPOW-**
19 **ERING MATERNITY CARE DURING PUBLIC**
20 **HEALTH EMERGENCIES.**

21 (a) ESTABLISHMENT.—The Secretary, in consulta-
22 tion with the Director of the Centers for Disease Control
23 and Prevention and the Administrator of the Health Re-
24 sources and Services Administration, shall convene a task
25 force (in this section referred to as the “Task Force”) to

1 develop Federal recommendations regarding respectful, re-
2 sponsive, and empowering maternity care, including safe
3 birth care and postpartum care, during public health
4 emergencies.

5 (b) DUTIES.—The Task Force shall develop, publicly
6 post, and update Federal recommendations in multiple
7 languages to ensure high-quality, nondiscriminatory ma-
8 ternity care, promote positive birthing experiences, and
9 improve maternal health outcomes during public health
10 emergencies, with a particular focus on outcomes for indi-
11 viduals from demographic groups with elevated rates of
12 maternal mortality, severe maternal morbidity, maternal
13 health disparities, or other adverse perinatal or childbirth
14 outcomes. Such recommendations shall—

15 (1) address, with particular attention to ensur-
16 ing equitable treatment on the basis of race and eth-
17 nicity—

18 (A) measures to facilitate respectful, re-
19 sponsive, and empowering maternity care;

20 (B) measures to facilitate telehealth mater-
21 nity care for pregnant individuals who cannot
22 regularly access in-person care;

23 (C) strategies to increase access to special-
24 ized care for those with high-risk pregnancies

1 or pregnant individuals with elevated risk fac-
2 tors;

3 (D) diagnostic testing for pregnant and la-
4 boring patients;

5 (E) birthing without one's chosen compan-
6 ions, with one's chosen companions, and with
7 smartphone or other telehealth connection to
8 one's chosen companions;

9 (F) newborn separation after birth in rela-
10 tion to maternal infection status;

11 (G) breast milk feeding in relation to ma-
12 ternal infection status;

13 (H) licensure, training, scope of practice,
14 and Medicaid and other insurance reimburse-
15 ment for certified midwives, certified nurse-mid-
16 wives, and certified professional midwives, who
17 meet, at a minimum, the international defini-
18 tion of a midwife and global standards for mid-
19 wifery education, as established by the Inter-
20 national Confederation of Midwives, in a man-
21 ner that facilitates inclusion of midwives of
22 color and midwives from underserved commu-
23 nities;

24 (I) financial support and training for
25 perinatal health workers who provide nonclinical

1 support to individuals from pregnancy through
2 the postpartum period in a manner that facili-
3 tates inclusion from underserved communities;

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

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

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

15 (M) strategies to address hospital capacity
16 concerns in communities with a surge in infec-
17 tious disease cases and to provide childbearing
18 individuals with options that reduce the poten-
19 tial for cross-contamination and increase the
20 ability to implement their care preferences while
21 maintaining safety and quality, such as the use
22 of freestanding birth centers;

23 (N) provision of child care services during
24 prenatal and postpartum appointments for
25 mothers whose children are unable to attend as

1 a result of restrictions relating to the public
2 health emergencies;

3 (O) how to identify and address racism,
4 bias, and discrimination in the delivery of ma-
5 ternity care services to pregnant and
6 postpartum individuals, including evaluating the
7 value of training for hospital staff on implicit
8 bias and racism, respectful, responsive, and em-
9 powering maternity care, and demographic data
10 collection;

11 (P) how to address the needs of undocu-
12 mented pregnant individuals and new mothers
13 who may be afraid or unable to seek needed
14 care during the public health emergency;

15 (Q) how to address the needs of uninsured
16 and underinsured pregnant individuals who
17 have historically relied on emergency depart-
18 ments for care;

19 (R) how to identify pregnant and
20 postpartum individuals at risk for depression,
21 anxiety disorder, psychosis, obsessive-compul-
22 sive disorder, and other maternal mood dis-
23 orders before, during, and after pregnancy, and
24 how to treat those diagnosed with a prenatal or
25 postpartum mood disorder;

1 (S) how to effectively and compassionately
2 screen for substance use disorder during preg-
3 nancy and postpartum and help pregnant and
4 postpartum individuals find support and effec-
5 tive treatment;

6 (T) how to ensure access to infant nutri-
7 tion during public health emergencies; and

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

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

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

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

20 (c) MEMBERSHIP.—The Secretary shall appoint the
21 members of the Task Force. Such members shall be com-
22 prised of—

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

25 (A) the Secretary;

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

3 (C) the Administrator of the Health Re-
4 sources and Services Administration;

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

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

9 (F) the Commissioner of Food and Drugs;

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

12 (H) the Director of the Indian Health
13 Service;

14 (2) at least 3 State, local, or territorial public
15 health officials representing departments of public
16 health, who shall represent jurisdictions from dif-
17 ferent regions of the United States with relatively
18 high concentrations of historically marginalized pop-
19 ulations;

20 (3) at least 1 Tribal public health official rep-
21 resenting departments of public health;

22 (4) 1 or more representatives of community-
23 based organizations that address adverse maternal
24 health outcomes with a specific focus on racial and
25 ethnic inequities in maternal health outcomes, with

1 special consideration given to representatives of such
2 organizations that are led by a person of color or
3 from communities with significant minority popu-
4 lations;

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

7 (6) 1 or more patients who were pregnant or
8 gave birth during the COVID–19 public health
9 emergency or a subsequent public health emergency;

10 (7) 1 or more patients who have received sup-
11 port from a perinatal health worker; and

12 (8) racially and ethnically diverse representa-
13 tion from at least 3 independent experts with knowl-
14 edge or field experience with racial and ethnic dis-
15 parities in public health, women’s health, or mater-
16 nal mortality and severe maternal morbidity.

17 **SEC. 6. DEFINITIONS.**

18 In this Act:

19 (1) **CULTURALLY AND LINGUISTICALLY CON-**
20 **GRUENT.**—The term “culturally and linguistically
21 congruent”, with respect to care or maternity care,
22 means care that is in agreement with the preferred
23 cultural values, beliefs, worldview, language, and
24 practices of the health care consumer and other
25 stakeholders.

1 (2) MATERNAL MORTALITY.—The term “mater-
2 nal mortality” means a death occurring during or
3 within a 1-year period after pregnancy, caused by
4 pregnancy-related or childbirth complications, in-
5 cluding a suicide, overdose, or other death resulting
6 from a mental health or substance use disorder at-
7 tributed to or aggravated by pregnancy-related or
8 childbirth complications.

9 (3) PERINATAL HEALTH WORKER.—The term
10 “perinatal health worker” means a nonclinical health
11 worker focused on maternal or perinatal health, such
12 as a doula, community health worker, peer sup-
13 porter, lactation educator or counselor, nutritionist
14 or dietitian, childbirth educator, social worker, home
15 visitor, patient navigator or coordinator, or language
16 interpreter.

17 (4) POSTPARTUM AND POSTPARTUM PERIOD.—
18 The terms “postpartum” and “postpartum period”
19 refer to the 1-year period beginning on the last day
20 of the pregnancy of an individual.

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

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

6 (7) RESPECTFUL MATERNITY CARE.—The term
7 “respectful maternity care” refers to care organized
8 for, and provided to, pregnant and postpartum indi-
9 viduals in a manner that—

10 (A) is culturally and linguistically con-
11 gruent;

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

14 (C) ensures freedom from harm and mis-
15 treatment; and

16 (D) enables informed choice and contin-
17 uous support.

18 (8) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

20 (9) SEVERE MATERNAL MORBIDITY.—The term
21 “severe maternal morbidity” means a health condi-
22 tion, including mental health conditions and sub-
23 stance use disorders, attributed to or aggravated by
24 pregnancy or childbirth that results in significant

- 1 short-term or long-term consequences to the health
- 2 of the individual who was pregnant.

