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S. 347

To improve the collection and review of maternal health data to address maternal mortality, severe maternal morbidity, and other adverse maternal health outcomes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 22, 2021

Ms. SMITH (for herself, Mr. BLUMENTHAL, Ms. KLOBUCHAR, and Mr. MARKEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To improve the collection and review of maternal health data to address maternal mortality, severe maternal morbidity, and other adverse maternal health outcomes.

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 “Data to Save Moms
5 Act”.

6 **SEC. 2. DEFINITIONS.**

7 In this Act:

1 (1) MATERNITY CARE PROVIDER.—The term
 2 “maternity care provider” means a health care pro-
 3 vider who—

4 (A) is a physician, physician assistant,
 5 midwife who meets at a minimum the inter-
 6 national definition of the midwife and global
 7 standards for midwifery education as estab-
 8 lished by the International Confederation of
 9 Midwives, nurse practitioner, or clinical nurse
 10 specialist; and

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

13 (2) MATERNAL MORTALITY.—The term “mater-
 14 nal mortality” means a death occurring during or
 15 within a one-year period after pregnancy, caused by
 16 pregnancy-related or childbirth complications, in-
 17 cluding a suicide, overdose, or other death resulting
 18 from a mental health or substance use disorder at-
 19 tributed to or aggravated by pregnancy-related or
 20 childbirth complications.

21 (3) PERINATAL HEALTH WORKER.—The term
 22 “perinatal health worker” means a doula, commu-
 23 nity health worker, peer supporter, breastfeeding
 24 and lactation educator or counselor, nutritionist or

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

(4) POSTPARTUM AND POSTPARTUM PERIOD.—

The terms “postpartum” and “postpartum period” refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(5) RACIAL AND ETHNIC MINORITY GROUP.—

The term “racial and ethnic minority group” has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(6) SEVERE MATERNAL MORBIDITY.—The term

“severe maternal morbidity” means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(7) SOCIAL DETERMINANTS OF MATERNAL

HEALTH.—The term “social determinants of maternal health” means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include

poverty, employment, food security, support for

1 and access to lactation and other infant feeding
2 options, housing stability, and related factors;

3 (B) neighborhood factors, which may in-
4 clude quality of housing, access to transpor-
5 tation, access to child care, availability of
6 healthy foods and nutrition counseling, avail-
7 ability of clean water, air and water quality,
8 ambient temperatures, neighborhood crime and
9 violence, access to broadband, and related fac-
10 tors;

11 (C) social and community factors, which
12 may include systemic racism, gender discrimi-
13 nation or discrimination based on other pro-
14 tected classes, workplace conditions, incarcer-
15 ation, and related factors;

16 (D) household factors, which may include
17 ability to conduct lead testing and abatement,
18 car seat installation, indoor air temperatures,
19 and related factors;

20 (E) education access and quality factors,
21 which may include educational attainment, lan-
22 guage and literacy, and related factors; and

23 (F) health care access factors, including
24 health insurance coverage, access to culturally
25 congruent health care services, providers, and

non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

SEC. 3. FUNDING FOR MATERNAL MORTALITY REVIEW COMMITTEES TO PROMOTE REPRESENTATIVE COMMUNITY ENGAGEMENT.

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

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

“(A) IN GENERAL.—The Secretary may, using funds made available pursuant to subparagraph (C), provide assistance to an applicable maternal mortality review committee of a State, Indian tribe, tribal organization, or urban Indian organization—

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

1 “(I) prioritizing community mem-
2 bers who can increase the diversity of
3 the committee’s membership with re-
4 spect to race and ethnicity, location,
5 and professional background, includ-
6 ing members with non-clinical experi-
7 ences; and

8 “(II) to the extent applicable,
9 using funds reserved under subsection
10 (f), to address barriers to maternal
11 mortality review committee participa-
12 tion for community members, includ-
13 ing required training, transportation
14 barriers, compensation, and other sup-
15 ports as may be necessary;

16 “(ii) to establish initiatives to conduct
17 outreach and community engagement ef-
18 forts within communities throughout the
19 State or Tribe to seek input from commu-
20 nity members on the work of such mater-
21 nal mortality review committee, with a par-
22 ticular focus on outreach to minority
23 women; and

24 “(iii) to release public reports assess-
25 ing—

1 “(I) the pregnancy-related death
2 and pregnancy-associated death review
3 processes of the maternal mortality
4 review committee, with a particular
5 focus on the maternal mortality re-
6 view committee’s sensitivity to the
7 unique circumstances of pregnant and
8 postpartum individuals from racial
9 and ethnic minority groups (as such
10 term is defined in section 1707(g)(1))
11 who have suffered pregnancy-related
12 deaths; and

13 “(II) the impact of the use of
14 funds made available pursuant to sub-
15 paragraph (C) on increasing the diver-
16 sity of the maternal mortality review
17 committee membership and promoting
18 community engagement efforts
19 throughout the State or Tribe.

20 “(B) TECHNICAL ASSISTANCE.—The Sec-
21 retary shall provide (either directly through the
22 Department of Health and Human Services or
23 by contract) technical assistance to any mater-
24 nal mortality review committee receiving a
25 grant under this paragraph on best practices

for increasing the diversity of the maternal mortality review committee’s membership and for conducting effective community engagement throughout the State or Tribe.

“(C) AUTHORIZATION OF APPROPRIATIONS.—In addition to any funds made available under subsection (f), there are authorized to be appropriated to carry out this paragraph \$10,000,000 for each of fiscal years 2022 through 2026.”.

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

(1) in paragraph (2), by striking “and” at the end;

(2) in paragraph (3)(B), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(4) the term ‘urban Indian organization’ has the meaning given such term in section 4 of the Indian Health Care Improvement Act.”.

(c) RESERVATION OF FUNDS.—Section 317K(f) of the Public Health Service Act (42 U.S.C. 247b–12(f)) is amended by adding at the end the following: “Of the amount made available under the preceding sentence for a fiscal year, not less than \$1,500,000 shall be reserved

1 for grants to Indian tribes, tribal organizations, or urban
 2 Indian organizations.”.

3 **SEC. 4. DATA COLLECTION AND REVIEW.**

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

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

8 (2) by inserting after subclause (I) the fol-
 9 lowing:

10 “(II) to the extent practicable,
 11 reviewing cases of severe maternal
 12 morbidity, according to the most up-
 13 to-date indicators;

14 “(III) to the extent practicable,
 15 reviewing deaths during pregnancy or
 16 up to 1 year after the end of a preg-
 17 nancy from suicide, overdose, or other
 18 death from a mental health condition
 19 or substance use disorder attributed
 20 to or aggravated by pregnancy or
 21 childbirth complications;

22 “(IV) to the extent practicable,
 23 consulting with local community-based
 24 organizations representing pregnant
 25 and postpartum individuals from de-

1 mographic groups disproportionately
 2 impacted by poor maternal health out-
 3 comes to ensure that, in addition to
 4 clinical factors, non-clinical factors
 5 that might have contributed to a preg-
 6 nancy-related death are appropriately
 7 considered;”.

8 **SEC. 5. REVIEW OF MATERNAL HEALTH DATA COLLECTION**
 9 **PROCESSES AND QUALITY MEASURES.**

10 (a) IN GENERAL.—The Secretary of Health and
 11 Human Services, acting through the Administrator for
 12 Centers for Medicare & Medicaid Services and the Director
 13 of the Agency for Healthcare Research and Quality, shall
 14 consult with relevant stakeholders—

15 (1) to review existing maternal health data col-
 16 lection processes and quality measures; and

17 (2) make recommendations to improve such
 18 processes and measures, including topics described
 19 in subsection (c).

20 (b) COLLABORATION.—In carrying out this section,
 21 the Secretary shall consult with a diverse group of mater-
 22 nal health stakeholders, which may include—

23 (1) pregnant and postpartum individuals and
 24 their family members, and nonprofit organizations

- 1 representing such individuals, with a particular focus
2 on patients from racial and ethnic minority groups;
- 3 (2) community-based organizations that provide
4 support for pregnant and postpartum individuals,
5 with a particular focus on patients from racial and
6 ethnic minority groups;
- 7 (3) membership organizations for maternity
8 care providers;
- 9 (4) organizations representing perinatal health
10 workers;
- 11 (5) organizations that focus on maternal mental
12 or behavioral health;
- 13 (6) organizations that focus on intimate partner
14 violence;
- 15 (7) institutions of higher education, with a par-
16 ticular focus on minority-serving institutions;
- 17 (8) licensed and accredited hospitals, birth cen-
18 ters, midwifery practices, or other medical practices
19 that provide maternal health care services to preg-
20 nant and postpartum patients;
- 21 (9) relevant State and local public agencies, in-
22 cluding State maternal mortality review committees;
23 and

1 (10) the National Quality Forum, or such other
2 standard-setting organizations specified by the Sec-
3 retary.

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

10 (1) Current State and Tribal practices for ma-
11 ternal health, maternal mortality, and severe mater-
12 nal morbidity data collection and dissemination, in-
13 cluding consideration of—

14 (A) the timeliness of processes for amend-
15 ing a death certificate when new information
16 pertaining to the death becomes available to re-
17 flect whether the death was a pregnancy-related
18 death;

19 (B) relevant data collected with electronic
20 health records, including data on race, eth-
21 nicity, socioeconomic status, insurance type,
22 and other relevant demographic information;

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

1 (D) the barriers preventing States from
2 correlating maternal outcome data with race
3 and ethnicity data;

4 (E) processes for determining the cause of
5 a pregnancy-associated death in States that do
6 not have a maternal mortality review com-
7 mittee;

8 (F) whether maternal mortality review
9 committees include multidisciplinary and di-
10 verse membership (as described in section
11 317K(d)(1)(A) of the Public Health Service Act
12 (42 U.S.C. 247b–12(d)(1)(A));

13 (G) whether members of maternal mor-
14 tality review committees participate in trainings
15 on bias, racism, or discrimination, and the qual-
16 ity of such trainings;

17 (H) the extent to which States have imple-
18 mented systematic processes of listening to the
19 stories of pregnant and postpartum individuals
20 and their family members, with a particular
21 focus on pregnant and postpartum individuals
22 from racial and ethnic minority groups (as such
23 term is defined in section 1707(g)(1) of the
24 Public Health Service Act (42 U.S.C. 300u–
25 6(g)(1))) and their family members, to fully un-

1 derstand the causes of, and inform potential so-
2 lutions to, the maternal mortality and severe
3 maternal morbidity crisis within their respective
4 States;

5 (I) the extent to which maternal mortality
6 review committees are considering social deter-
7 minants of maternal health when examining the
8 causes of pregnancy-associated and pregnancy-
9 related deaths;

10 (J) the extent to which maternal mortality
11 review committees are making actionable rec-
12 ommendations based on their reviews of adverse
13 maternal health outcomes and the extent to
14 which such recommendations are being imple-
15 mented by appropriate stakeholders;

16 (K) the legal and administrative barriers
17 preventing the collection, collation, and dissemi-
18 nation of State maternity care data;

19 (L) the effectiveness of data collection and
20 reporting processes in separating pregnancy-as-
21 sociated deaths from pregnancy-related deaths;

22 (M) the current Federal, State, local, and
23 Tribal funding support for the activities re-
24 ferred to in subparagraphs (A) through (L).

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

6 (3) Current quality measures for maternity
7 care, including prenatal measures, labor and delivery
8 measures, and postpartum measures, including top-
9 ics such as—

10 (A) effective quality measures for mater-
11 nity care used by hospitals, health systems,
12 midwifery practices, birth centers, health plans,
13 and other relevant entities;

14 (B) the sufficiency of current outcome
15 measures used to evaluate maternity care for
16 driving improved care, experiences, and out-
17 comes in maternity care payment and delivery
18 system models;

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

21 (D) validated measures that have been
22 used for research purposes that could be tested,
23 refined, and submitted for national endorse-
24 ment;

1 (E) barriers preventing maternity care pro-
 2 viders and insurers from implementing quality
 3 measures that are aligned with best practices;

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

6 (G) the strengths and weaknesses of the
 7 Prenatal and Postpartum Care measures of the
 8 Health Plan Employer Data and Information
 9 Set measures established by the National Com-
 10 mittee for Quality Assurance;

11 (H) the strengths and weaknesses of ma-
 12 ternity care quality measures under the Med-
 13 icaid program under title XIX of the Social Se-
 14 curity Act (42 U.S.C. 1396 et seq.) and the
 15 Children's Health Insurance Program under
 16 title XXI of such Act (42 U.S.C. 1397 et seq.),
 17 including the extent to which States voluntarily
 18 report relevant measures;

19 (I) the extent to which maternity care
 20 quality measures are informed by patient expe-
 21 riences that include measures of patient-re-
 22 ported experience of care;

23 (J) the current processes for collecting
 24 stratified data on the race and ethnicity of
 25 pregnant and postpartum individuals in hos-

1 pitals, health systems, midwifery practices, and
 2 birth centers, and for incorporating such ra-
 3 cially and ethnically stratified data in maternity
 4 care quality measures;

5 (K) the extent to which maternity care
 6 quality measures account for the unique experi-
 7 ences of pregnant and postpartum individuals
 8 from racial and ethnic minority groups (as such
 9 term is defined in section 1707(g)(1) of the
 10 Public Health Service Act (42 U.S.C. 300u-
 11 6(g)(1))); and

12 (L) the extent to which hospitals, health
 13 systems, midwifery practices, and birth centers
 14 are implementing existing maternity care qual-
 15 ity measures.

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

21 (5) Recommendations for new authorities that
 22 may be granted to maternal mortality review com-
 23 mittees to be able to—

24 (A) access records from other Federal and
 25 State agencies and departments that may be

1 necessary to identify causes of pregnancy-asso-
2 ciated and pregnancy-related deaths that are
3 unique to pregnant and postpartum individuals
4 from specific populations, such as veterans and
5 individuals who are incarcerated; and

6 (B) work with relevant experts who are not
7 members of the maternal mortality review com-
8 mittee to assist in the review of pregnancy-asso-
9 ciated deaths of pregnant and postpartum indi-
10 viduals from specific populations, such as vet-
11 erans and individuals who are incarcerated.

12 (6) Recommendations to improve and stand-
13 ardize current quality measures for maternity care,
14 with a particular focus on racial and ethnic dispari-
15 ties in maternal health outcomes.

16 (7) Recommendations to improve the coordina-
17 tion by the Department of Health and Human Serv-
18 ices of the efforts undertaken by the agencies and
19 organizations within the Department related to ma-
20 ternal health data and quality measures.

21 (d) REPORT.—Not later than 1 year after the date
22 of enactment of this Act, the Secretary shall submit to
23 Congress and make publicly available a report on the re-
24 sults of the review of maternal health data collection proc-
25 esses and quality measures and recommendations to im-

1 prove such processes and measures required under sub-
 2 section (a).

3 (e) DEFINITIONS.—In this section:

4 (1) MATERNAL MORTALITY REVIEW COM-
 5 MITTEE.—The term “maternal mortality review
 6 committee” means a maternal mortality review com-
 7 mittee duly authorized by a State and receiving
 8 funding under section 317K(a)(2)(D) of the Public
 9 Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

10 (2) PREGNANCY-ASSOCIATED DEATH.—The
 11 term “pregnancy-associated”, with respect to a
 12 death, means a death of a pregnant or postpartum
 13 individual, by any cause, that occurs during, or with-
 14 in 1 year following, the individual’s pregnancy, re-
 15 gardless of the outcome, duration, or site of the
 16 pregnancy.

17 (3) PREGNANCY-RELATED DEATH.—The term
 18 “pregnancy-related”, with respect to a death, means
 19 a death of a pregnant or postpartum individual that
 20 occurs during, or within 1 year following, the indi-
 21 vidual’s pregnancy, from a pregnancy complication,
 22 a chain of events initiated by pregnancy, or the ag-
 23 gravation of an unrelated condition by the physio-
 24 logic effects of pregnancy.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as may be
 3 necessary to carry out this section for fiscal years 2022
 4 through 2025.

5 **SEC. 6. INDIAN HEALTH SERVICE STUDY AND REPORT ON**
 6 **MATERNAL MORTALITY AND SEVERE MATER-**
 7 **NAL MORBIDITY.**

8 (a) DEFINITIONS.—In this section:

9 (1) DIRECTOR.—The term “Director” means
 10 the Director of the Indian Health Service.

11 (2) INDIAN TRIBE.—The term “Indian Tribe”
 12 has the meaning given the term in section 4 of the
 13 Indian Self-Determination and Education Assistance
 14 Act (25 U.S.C. 5304).

15 (3) MATERNAL MORTALITY REVIEW COM-
 16 MITTEE.—The term “maternal mortality review
 17 committee” means a maternal mortality review com-
 18 mittee duly authorized by a State and receiving
 19 funding under section 317k(a)(2)(D) of the Public
 20 Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

21 (4) TRIBAL EPIDEMIOLOGY CENTER.—The term
 22 “Tribal epidemiology center” means a Tribal epide-
 23 miology center established under section 214 of the
 24 Indian Health Care Improvement Act (25 U.S.C.
 25 1621m).

1 (5) TRIBAL ORGANIZATION.—The term “tribal
2 organization” has the meaning given the term in
3 section 4 of the Indian Self-Determination and Edu-
4 cation Assistance Act (25 U.S.C. 5304).

5 (6) URBAN INDIAN ORGANIZATION.—The term
6 “urban Indian organization” has the meaning given
7 the term in section 4 of the Indian Health Care Im-
8 provement Act (25 U.S.C. 1603).

9 (b) STUDY AND REPORT.—

10 (1) STUDY.—

11 (A) IN GENERAL.—Not later than 90 days
12 after the date of enactment of this Act, the Di-
13 rector, in coordination with the individuals se-
14 lected under subsection (c), shall enter into an
15 agreement with an independent research organi-
16 zation or a Tribal epidemiology center to con-
17 duct a comprehensive study on maternal mor-
18 tality and severe maternal morbidity in Indian
19 and Alaska Native populations.

20 (B) REPORT.—The agreement entered into
21 under subparagraph (A) shall require that the
22 independent research organization or Tribal ep-
23 idemiology center submit to the Director a re-
24 port describing the results of the study con-
25 ducted pursuant to that agreement by not later

1 than 2 years after the date of enactment of this
2 Act.

3 (2) CONTENTS OF STUDY.—The study con-
4 ducted under paragraph (1) shall—

5 (A) examine the causes of maternal mor-
6 tality and severe maternal morbidity that are
7 unique to Indians and Alaska Natives;

8 (B) include a systematic process of listen-
9 ing to the stories of pregnant and postpartum
10 Indians and Alaska Natives to fully understand
11 the causes of, and inform potential solutions to,
12 the maternal mortality and severe maternal
13 morbidity crisis within the Indian and Alaska
14 Native communities;

15 (C) identify the different settings in which
16 pregnant and postpartum Indians and Alaska
17 Natives receive maternity care, such as—

18 (i) facilities operated by the Indian
19 Health Service;

20 (ii) an Indian health program oper-
21 ated by an Indian Tribe or tribal organiza-
22 tion pursuant to a grant from, or contract,
23 cooperative agreement, or compact with,
24 the Indian Health Service pursuant to the
25 Indian Self-Determination and Education

1 Assistance Act (25 U.S.C. 5301 et seq.);

2 and

3 (iii) an urban Indian health program
4 operated by an urban Indian organization
5 pursuant to a grant from or contract with
6 the Indian Health Service pursuant to title
7 V of the Indian Health Care Improvement
8 Act (25 U.S.C. 1651 et seq.);

9 (D) determine the different landscapes of
10 maternity care received by pregnant and
11 postpartum Indians and Alaska Natives at the
12 different settings identified under subparagraph
13 (C);

14 (E) review processes for coordinating pro-
15 grams of the Indian Health Service with social
16 services provided through other programs ad-
17 ministered by the Secretary of Health and
18 Human Services (other than the Medicare pro-
19 gram under title XVIII of the Social Security
20 Act (42 U.S.C. 1395 et seq.), the Medicaid pro-
21 gram under title XIX of that Act (42 U.S.C.
22 1396 et seq.), and the State Children's Health
23 Insurance Program established under title XXI
24 of that Act (42 U.S.C. 1397aa et seq.));

1 (F) review current data collection and
2 quality measurement processes and practices
3 with respect to pregnant and postpartum Indi-
4 ans and Alaska Natives;

5 (G) assess causes and frequency of mater-
6 nal mental health conditions and substance use
7 disorders with respect to Indians and Alaska
8 Natives;

9 (H) consider social determinants of health,
10 including poverty, lack of health insurance, un-
11 employment, sexual violence, and environmental
12 conditions in Tribal areas;

13 (I) consider the role that historical mis-
14 treatment of Indian and Alaska Native women
15 has played in causing currently high rates of
16 maternal mortality and severe maternal mor-
17 bidity;

18 (J) consider how current funding of the
19 Indian Health Service affects the ability of the
20 Indian Health Service to deliver quality mater-
21 nity care; and

22 (K) consider the extent to which the deliv-
23 ery of maternity care services is culturally ap-
24 propriate for pregnant and postpartum Indians
25 and Alaska Natives.

1 (3) REPORT.—Not later than 3 years after the
2 date of enactment of this Act, the Director shall
3 submit to Congress a report describing the results of
4 the study conducted under paragraph (1), including
5 recommendations for policies and practices that can
6 be adopted to improve maternal health outcomes for
7 pregnant and postpartum Indians and Alaska Na-
8 tives, including recommendations—

9 (A) on how to improve maternal health
10 outcomes for Indians and Alaska Natives re-
11 ceiving care at the different settings identified
12 under paragraph (2)(C);

13 (B) on how to reduce misclassification of
14 pregnant and postpartum Indians and Alaska
15 Natives, including consideration of best prac-
16 tices in training for members of maternal mor-
17 tality review committees to be able to correctly
18 classify Indians and Alaska Natives; and

19 (C) informed by the stories shared by preg-
20 nant and postpartum Indians and Alaska Na-
21 tives under paragraph (2)(B) to improve mater-
22 nal health outcomes for those individuals.

23 (c) PARTICIPATING INDIVIDUALS.—

24 (1) IN GENERAL.—The Director shall select
25 from among individuals nominated by Indian Tribes,

1 tribal organizations, and urban Indian organizations
 2 12 individuals for participation in the study con-
 3 ducted under subsection (b)(1).

4 (2) REQUIREMENT.—In selecting members
 5 under paragraph (1), the Director shall ensure that
 6 each of the 12 service areas of the Indian Health
 7 Service is represented.

8 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
 9 authorized to be appropriated to carry out this section
 10 \$2,000,000 for each of fiscal years 2022 through 2024.

11 **SEC. 7. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
 12 **STUDY MATERNAL MORTALITY, SEVERE MA-**
 13 **TERNAL MORBIDITY, AND OTHER ADVERSE**
 14 **MATERNAL HEALTH OUTCOMES.**

15 (a) IN GENERAL.—The Secretary of Health and
 16 Human Services shall establish a program under which
 17 the Secretary shall award grants to research centers,
 18 health professions schools and programs, and other enti-
 19 ties at minority-serving institutions to study specific as-
 20 pects of the maternal health crisis among pregnant and
 21 postpartum individuals from racial and ethnic minority
 22 groups. Such research may—

23 (1) include the development and implementation
 24 of systematic processes of listening to the stories of
 25 pregnant and postpartum individuals from racial

1 and ethnic minority groups, and perinatal health
2 workers supporting such individuals, to fully under-
3 stand the causes of, and inform potential solutions
4 to, the maternal mortality and severe maternal mor-
5 bidity crisis within their respective communities;

6 (2) assess the potential causes of relatively low
7 rates of maternal mortality among Hispanic individ-
8 uals, including potential racial misclassification and
9 other data collection and reporting issues that might
10 be misrepresenting maternal mortality rates among
11 Hispanic individuals in the United States; and

12 (3) assess differences in rates of adverse mater-
13 nal health outcomes among subgroups identifying as
14 Hispanic.

15 (b) APPLICATION.—To be eligible to receive a grant
16 under subsection (a), an entity described in such sub-
17 section shall submit to the Secretary an application at
18 such time, in such manner, and containing such informa-
19 tion as the Secretary may require.

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

23 (1) to conduct outreach to minority-serving in-
24 stitutions to raise awareness of the availability of
25 grants under this subsection (a);

1 (2) to provide technical assistance in the appli-
2 cation process for such a grant; and

3 (3) to promote capacity building as needed to
4 enable entities described in such subsection to sub-
5 mit such an application.

6 (d) REPORTING REQUIREMENT.—Each entity award-
7 ed a grant under this section shall periodically submit to
8 the Secretary a report on the status of activities conducted
9 using the grant.

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

15 (f) MINORITY-SERVING INSTITUTIONS DEFINED.—In
16 this section, the term “minority-serving institution” has
17 the meaning given the term in section 371(a) of the High-
18 er Education Act of 1965 (20 U.S.C. 1067q(a)).

19 (g) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 \$10,000,000 for each of fiscal years 2022 through 2026.

○