I

117TH CONGRESS
1ST SESSION

H. R. 925

To amend the Public Health Service Act (42 U.S.C. 201 et seq.) to authorize funding for maternal mortality review committees to promote representative community engagement, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2021

Ms. DAVIDS of Kansas (for herself, Ms. UNDERWOOD, Ms. ADAMS, Mr. KHANNA, Ms. VELÁZQUEZ, Mrs. MCBATH, Mr. SMITH of Washington, Ms. SCANLON, Mr. LAWSON of Florida, Mrs. HAYES, Mr. BUTTERFIELD, Ms. MOORE of Wisconsin, Ms. STRICKLAND, Mr. RYAN, Mr. SCHIFF, Mr. JOHNSON of Georgia, Mr. HORSFORD, Ms. WASSERMAN SCHULTZ, Ms. BARRAGÁN, Mr. DEUTCH, Mr. PAYNE, Mr. BLUMENAUER, Mr. MOULTON, Mr. SOTO, Mr. NADLER, Mr. TRONE, Ms. CLARKE of New York, Ms. SCHAKOWSKY, Ms. BASS, Ms. PRESSLEY, Mr. EVANS, Ms. BLUNT ROCHESTER, Ms. CASTOR of Florida, Ms. SEWELL, and Ms. WILLIAMS of Georgia) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend the Public Health Service Act (42 U.S.C. 201 et seq.) to authorize funding for maternal mortality review committees to promote representative community engagement, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Data to Save Moms Act''.

SEC. 2. 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 (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603))—

''(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—

''(I) prioritizing community members who can increase the diversity of the committee's membership with respect to race and ethnicity, location, and professional background, including members with non-clinical experiences; and

''(II) to the extent applicable, using funds reserved under subsection (f), to address barriers to maternal mortality review committee participation for community members, including required training, transportation barriers, compensation, and other supports as may be necessary;

''(ii) to establish initiatives to conduct outreach and community engagement efforts within communities throughout the State or Tribe to seek input from community members on the work of such maternal mortality review committee, with a particular focus on outreach to minority women; and

''(iii) to release public reports assessing—

''(I) the pregnancy-related death and pregnancy-associated death review processes of the maternal mortality review committee, with a particular focus on the maternal mortality review committee's sensitivity to the unique circumstances of pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1)) who have suffered pregnancy-related deaths; and

''(II) the impact of the use of funds made available pursuant to paragraph (C) on increasing the diversity of the maternal mortality review committee membership and promoting community engagement efforts throughout the State or Tribe.

''(B) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly through the Department of Health and Human Services or by contract) technical assistance to any maternal mortality review committee receiving a 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) 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 for grants to Indian tribes, tribal organizations, or urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603))''.

SEC. 3. DATA COLLECTION AND REVIEW.

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

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

(2) by inserting after subclause (I) the following:

"(II) to the extent practicable, reviewing cases of severe maternal morbidity, according to the most up-to-date indicators;

"(III) to the extent practicable, reviewing deaths during pregnancy or up to 1 year after the end of a pregnancy from suicide, overdose, or other death from a mental health condition or substance use disorder attributed to or aggravated by pregnancy or childbirth complications;

"(IV) to the extent practicable, consulting with local community-based organizations representing pregnant and postpartum individuals from demographic groups disproportionately impacted by poor maternal health outcomes to ensure that, in addition to clinical factors, non-clinical factors that might have contributed to a pregnancy-related death are appropriately considered;".

SEC. 4. REVIEW OF MATERNAL HEALTH DATA COLLECTION PROCESSES AND QUALITY MEASURES.

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

(1) to review existing maternal health data collection processes and quality measures; and

(2) make recommendations to improve such processes and measures, including topics described under subsection (c).

(b) COLLABORATION.—In carrying out this section, the Secretary shall consult with a diverse group of maternal health stakeholders, which may include—

(1) pregnant and postpartum individuals and their family members, and non-profit organizations representing such individuals, with a particular focus on patients from racial and ethnic minority groups;

(2) community-based organizations that provide support for pregnant and postpartum individuals, with a particular focus on patients from racial and ethnic minority groups;

(3) membership organizations for maternity care providers;

(4) organizations representing perinatal health workers;

(5) organizations that focus on maternal mental or behavioral health;

(6) organizations that focus on intimate partner violence;

(7) institutions of higher education, with a particular focus on minority-serving institutions;

(8) licensed and accredited hospitals, birth centers, midwifery practices, or other medical practices that provide maternal health care services to pregnant and postpartum patients;

(9) relevant State and local public agencies, including State maternal mortality review committees; and

(10) the National Quality Forum, or such other standard-setting organizations specified by the Secretary.

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

(1) Current State and Tribal practices for maternal health, maternal mortality, and severe maternal morbidity data collection and dissemination, including consideration of—

(A) the timeliness of processes for amending a death certificate when new information pertaining to the death becomes available to reflect whether the death was a pregnancy-related death;

(B) relevant data collected with electronic health records, including data on race, ethnicity, socioeconomic status, insurance type, and other relevant demographic information;

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

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

(E) processes for determining the cause of a pregnancy-associated death in States that do not have a maternal mortality review committee;

(F) whether maternal mortality review committees include multidisciplinary and di-

verse membership (as described in section 317K(d)(1)(A) of the Public Health Service Act (42 U.S.C. 247b–12(d)(1)(A)));

(G) whether members of maternal mortality review committees participate in trainings on bias, racism, or discrimination, and the quality of such trainings;

(H) the extent to which States have implemented systematic processes of listening to the stories of pregnant and postpartum individuals and their family members, with a particular focus on pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1))) and their family members, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective States;

(I) the extent to which maternal mortality review committees are considering social determinants of maternal health when examining the causes of pregnancy-associated and pregnancy-related deaths;

(J) the extent to which maternal mortality review committees are making actionable recommendations based on their reviews of adverse maternal health outcomes and the extent to which such recommendations are being implemented by appropriate stakeholders;

(K) the legal and administrative barriers preventing the collection, collation, and dissemination of State maternity care data;

(L) the effectiveness of data collection and reporting processes in separating pregnancy-associated deaths from pregnancy-related deaths;

(M) the current Federal, State, local, and Tribal funding support for the activities referred to in subparagraphs (A) through (L).

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

(3) Current quality measures for maternity care, including prenatal measures, labor and delivery measures, and postpartum measures, including topics such as—

(A) effective quality measures for maternity care used by hospitals, health systems, midwifery practices, birth centers, health plans, and other relevant entities;

(B) the sufficiency of current outcome measures used to evaluate maternity care for driving improved care, experiences, and outcomes in maternity care payment and delivery system models;

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

(D) validated measures that have been used for research purposes that could be tested, refined, and submitted for national endorsement;

(E) barriers preventing maternity care providers and insurers from implementing quality measures that are aligned with best practices;

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

(G) the strengths and weaknesses of the Prenatal and Postpartum Care measures of the Health Plan Employer Data and Information Set measures established by the National Committee for Quality Assurance;

(H) the strengths and weaknesses of maternity care quality measures under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397 et seq.), including the extent to which States voluntarily report relevant measures;

(I) the extent to which maternity care quality measures are informed by patient experiences that include measures of patient-reported experience of care;

(J) the current processes for collecting stratified data on the race and ethnicity of pregnant and postpartum individuals in hospitals, health systems, midwifery practices, and birth centers, and for incorporating such racially and ethnically stratified data in maternity care quality measures;

(K) the extent to which maternity care quality measures account for the unique experiences of pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1) of the

Public Health Service Act (42 U.S.C. 300u–6(g)(1))); and

(L) the extent to which hospitals, health systems, midwifery practices, and birth centers are implementing existing maternity care quality measures.

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

(5) Recommendations for new authorities that may be granted to maternal mortality review committees to be able to—

(A) access records from other Federal and State agencies and departments that may be necessary to identify causes of pregnancy-associated and pregnancy-related deaths that are unique to pregnant and postpartum individuals from specific populations, such as veterans and individuals who are incarcerated; and

(B) work with relevant experts who are not members of the maternal mortality review committee to assist in the review of pregnancy-associated deaths of pregnant and postpartum indi-

viduals from specific populations, such as veterans and individuals who are incarcerated.

(6) Recommendations to improve and standardize current quality measures for maternity care, with a particular focus on racial and ethnic disparities in maternal health outcomes.

(7) Recommendations to improve the coordination by the Department of Health and Human Services of the efforts undertaken by the agencies and organizations within the Department related to maternal health data and quality measures.

(d) REPORT.—Not later than 1 year after the enactment of this Act, the Secretary shall submit to the Congress and make publicly available a report on the results of the review of maternal health data collection processes and quality measures and recommendations to improve such processes and measures required under subsection (a).

(e) DEFINITIONS.—In this section:

(1) MATERNAL MORTALITY REVIEW COMMITTEE.—The term ''maternal mortality review committee'' means a maternal mortality review committee duly authorized by a State and receiving funding under section 317k(a)(2)(D) of the Public Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

(2) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated'', with respect to a death, means a death of a pregnant or postpartum individual, by any cause, that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(3) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related'', with respect to a death, means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

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

SEC. 5. INDIAN HEALTH SERVICE STUDY ON MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY.

(a) IN GENERAL.—The Director of the Indian Health Service (referred to in this section as the ''Director'')

shall, in coordination with entities described in subsection (b)—

(1) not later than 90 days after the enactment of this Act, enter into a contract with an independent research organization or Tribal Epidemiology Center to conduct a comprehensive study on maternal mortality and severe maternal morbidity in the populations of American Indian and Alaska Native individuals; and

(2) not later than 3 years after the date of the enactment of this Act, submit to Congress a report on such study that contains recommendations for policies and practices that can be adopted to improve maternal health outcomes for pregnant and postpartum American Indian and Alaska Native individuals.

(b) PARTICIPATING ENTITIES.—The entities described in this subsection shall consist of 12 members, selected by the Director from among individuals nominated by Indian tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), and urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)). In selecting such members, the Director

shall ensure that each of the 12 service areas of the Indian Health Service is represented.

(c) CONTENTS OF STUDY.—The study conducted pursuant to subsection (a) shall—

(1) examine the causes of maternal mortality and severe maternal morbidity that are unique to American Indian and Alaska Native individuals;

(2) include a systematic process of listening to the stories of American Indian and Alaska Native pregnant and postpartum individuals to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective communities;

(3) distinguish between the causes of, landscape of maternity care at, and recommendations to improve maternal health outcomes within, the different settings in which American Indian and Alaska Native pregnant and postpartum individuals receive maternity care, such as—

(A) facilities operated by the Indian Health Service;

(B) an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or

compact with the Indian Health Service pursuant to the Indian Self-Determination Act; and

(C) an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act;

(4) review processes for coordinating programs of the Indian Health Service with social services provided through other programs administered by the Secretary of Health and Human Services (other than the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the Children's Health Insurance Program under title XXI of such Act);

(5) review current data collection and quality measurement processes and practices;

(6) assess causes and frequency of maternal mental health conditions and substance use disorders;

(7) consider social determinants of health, including poverty, lack of health insurance, unemployment, sexual violence, and environmental conditions in Tribal areas;

(8) consider the role that historical mistreatment of American Indian and Alaska Native women has played in causing currently high rates of maternal mortality and severe maternal morbidity;

(9) consider how current funding of the Indian Health Service affects the ability of the Service to deliver quality maternity care;

(10) consider the extent to which the delivery of maternity care services is culturally appropriate for American Indian and Alaska Native pregnant and postpartum individuals;

(11) make recommendations to reduce misclassification of American Indian and Alaska Native pregnant and postpartum individuals, including consideration of best practices in training for maternal mortality review committee members to be able to correctly classify American Indian and Alaska Native individuals; and

(12) make recommendations informed by the stories shared by American Indian and Alaska Native pregnant and postpartum individuals in paragraph (2) to improve maternal health outcomes for such individuals.

(d) REPORT.—The agreement entered into under subsection (a) with an independent research organization

or Tribal Epidemiology Center shall require that the organization or center transmit to Congress a report on the results of the study conducted pursuant to that agreement not later than 36 months after the date of the enactment of this Act.

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

SEC. 6. GRANTS TO MINORITY-SERVING INSTITUTIONS TO STUDY MATERNAL MORTALITY, SEVERE MATERNAL MORBIDITY, AND OTHER ADVERSE MATERNAL HEALTH OUTCOMES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a program under which the Secretary shall award grants to research centers, health professions schools and programs, and other entities at minority-serving institutions to study specific aspects of the maternal health crisis among pregnant and postpartum individuals from racial and ethnic minority groups. Such research may—

(1) include the development and implementation of systematic processes of listening to the stories of pregnant and postpartum individuals from racial and ethnic minority groups, and perinatal health workers supporting such individuals, to fully under-

stand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective communities;

(2) assess the potential causes of relatively low rates of maternal mortality among Hispanic individuals, including potential racial misclassification and other data collection and reporting issues that might be misrepresenting maternal mortality rates among Hispanic individuals in the United States; and

(3) assess differences in rates of adverse maternal health outcomes among subgroups identifying as Hispanic.

(b) APPLICATION.—To be eligible to receive 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) TECHNICAL ASSISTANCE.—The Secretary may use not more than 10 percent of the funds made available under subsection (f)—

(1) to conduct outreach to Minority-Serving Institutions to raise awareness of the availability of grants under this subsection (a);

(2) to provide technical assistance in the application process for such a grant; and

(3) to promote capacity building as needed to enable entities described in such subsection to submit such an application.

(d) 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.

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

(f) MINORITY-SERVING INSTITUTIONS DEFINED.—In this section, the term ''minority-serving institution'' has the meaning given the term in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

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

SEC. 7. DEFINITIONS.

In this Act:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language,

and practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

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

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

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, community health worker, peer supporter, breastfeeding

and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) 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.

(6) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated death'' means a death of a pregnant or postpartum individual, by any cause, that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(7) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related death'' means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(8) 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)).

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

(10) SOCIAL DETERMINANTS OF MATERNAL HEALTH DEFINED.—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 and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

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

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally 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.

○