I

116TH CONGRESS
2D SESSION

H. R. 6165

To amend the Public Health Service Act to improve data collection with respect to maternal mortality and severe maternal morbidity, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 10, 2020

Ms. DAVIDS of Kansas (for herself, Ms. UNDERWOOD, Ms. ADAMS, Mr. CLAY, Ms. SCANLON, Ms. NORTON, Ms. SEWELL of Alabama, Mr. KHANNA, Ms. MOORE, Mr. LAWSON of Florida, Ms. PRESSLEY, and Ms. HAALAND) 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

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A BILL

To amend the Public Health Service Act to improve data collection with respect to maternal mortality and severe maternal morbidity, 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 ''Data to Save Moms
5 Act of 2020''.

1 **SEC. 2. FUNDING FOR MATERNAL MORTALITY REVIEW**
2 **COMMITTEES TO PROMOTE REPRESENTA-**
3 **TIVE COMMUNITY ENGAGEMENT.**

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

7 "(9) GRANTS TO PROMOTE REPRESENTATIVE
8 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
9 TALITY REVIEW COMMITTEES.—

10 "(A) IN GENERAL.—The Secretary may,
11 using funds made available pursuant to sub-
12 paragraph (C), provide assistance to an applica-
13 ble maternal mortality review committee of a
14 State, Indian tribe, tribal organization, or
15 urban Indian organization (as such term is de-
16 fined in section 4 of the Indian Health Care
17 Improvement Act (25 U.S.C. 1603))—

18 "(i) to select for inclusion in the mem-
19 bership of such a committee community
20 members from the State, Indian tribe, trib-
21 al organization, or urban Indian organiza-
22 tion by—

23 "(I) prioritizing community mem-
24 bers who can increase the diversity of
25 the committee's membership with re-
26 spect to race and ethnicity, location,

1 and professional background, includ-
2 ing members with non-clinical experi-
3 ences; and
4 “(II) to the extent applicable,
5 using funds reserved under subsection
6 (f) to address barriers to maternal
7 mortality review committee participa-
8 tion for community members, includ-
9 ing required training, transportation
10 barriers, compensation, and other sup-
11 ports as may be necessary;
12 “(ii) to establish initiatives to conduct
13 outreach and community engagement ef-
14 forts within communities throughout the
15 State or Tribe to seek input from commu-
16 nity members on the work of such mater-
17 nal mortality review committee, with a par-
18 ticular focus on outreach to minority
19 women; and
20 “(iii) to release public reports assess-
21 ing—
22 “(I) the pregnancy-related death
23 and pregnancy-associated death review
24 processes of the maternal mortality
25 review committee, with a particular

focus on the maternal mortality review committee's sensitivity to the unique circumstances of minority women 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

1 to be appropriated to carry out this paragraph
2 $10,000,000 for each of fiscal years 2021
3 through 2025.''.
4 (b) RESERVATION OF FUNDS.—Section 317K(f) of
5 the Public Health Service Act (42 U.S.C. 247b–12(f)) is
6 amended by adding at the end the following: ''Of the
7 amount made available under the preceding sentence for
8 a fiscal year, not less than $1,500,000 shall be reserved
9 for grants to Indian tribes, tribal organizations, or urban
10 Indian organizations (as such term is defined in section
11 4 of the Indian Health Care Improvement Act (25 U.S.C.
12 1603))''.

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

14 (a) IN GENERAL.—Section 317K(d)(3)(A)(i) of the
15 Public Health Service Act (42 U.S.C. 247b–
16 12(d)(3)(A)(i)) is amended—
17 (1) by redesignating subclauses (II) and (III)
18 as subclauses (V) and (VI), respectively; and
19 (2) by inserting after subclause (I) the fol-
20 lowing:
21 ''(II) to the extent practicable,
22 reviewing cases of severe maternal
23 morbidity in which the patient re-
24 ceived a transfusion of four or more

units of blood and was admitted to an intensive care unit;

"(III) to the extent practicable, consulting with local community-based organizations representing women 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;".

(b) SEVERE MATERNAL MORBIDITY DEFINED.—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), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(4) the term 'severe maternal morbidity' means one or more unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman's health.".

1 **SEC. 4. TASK FORCE ON MATERNAL HEALTH DATA AND**
2 **QUALITY MEASURES.**

3 (a) ESTABLISHMENT.—Not later than 180 days after
4 the date of enactment of this Act, the Secretary of Health
5 and Human Services shall establish a task force to be
6 known as the "Task Force on Maternal Health Data and
7 Quality Measures" (in this section referred to as the
8 "Task Force").

9 (b) DUTIES OF TASK FORCE.—

10 (1) IN GENERAL.—The Task Force shall use all
11 available relevant information, including information
12 from State-level sources, to prepare and submit a re-
13 port containing the following:

14 (A) An evaluation of current State and
15 Tribal practices for maternal health, maternal
16 mortality, and severe maternal morbidity data
17 collection and dissemination, including consider-
18 ation of—

19 (i) the timeliness of processes for
20 amending a death certificate when new in-
21 formation pertaining to the death becomes
22 available to reflect whether the death was
23 a pregnancy-related death;

24 (ii) maternal health data collected
25 with electronic health records, including
26 data on race and ethnicity;

1 (iii) the barriers preventing States
2 from correlating maternal outcome data
3 with race and ethnicity data;
4 (iv) processes for determining the
5 cause of a pregnancy-associated death in
6 States that do not have a maternal mor-
7 tality review committee;
8 (v) whether maternal mortality review
9 committees include multidisciplinary and
10 diverse membership (as described in sec-
11 tion 317K(d)(1)(A) of the Public Health
12 Service Act (42 U.S.C. 247b–12(d)(1)(A));
13 (vi) whether members of maternal
14 mortality review committees participate in
15 trainings on bias, racism, or discrimina-
16 tion, and the quality of such trainings;
17 (vii) the extent to which States have
18 implemented systematic processes of listen-
19 ing to the stories of pregnant and postpar-
20 tum women and their family members,
21 with a particular focus on minority women
22 and their family members, to fully under-
23 stand the causes of, and inform potential
24 solutions to, the maternal mortality and se-

1 vere maternal morbidity crisis within their
2 respective States;
3 (viii) the consideration of social deter-
4 minants of health by maternal mortality
5 review committees when examining the
6 causes of pregnancy-associated and preg-
7 nancy-related deaths;
8 (ix) the legal barriers preventing the
9 collation of State maternity care data;
10 (x) the effectiveness of data collection
11 and reporting processes in separating preg-
12 nancy-associated deaths from pregnancy-
13 related deaths; and
14 (xi) the current Federal, State, local,
15 and Tribal funding support for the activi-
16 ties referred to in clauses (i) through (x).
17 (B) An assessment of whether the funding
18 referred to in subparagraph (A)(xi) is adequate
19 for States to carry out optimal data collection
20 and dissemination processes with respect to ma-
21 ternal health, maternal mortality, and severe
22 maternal morbidity.
23 (C) An evaluation of current quality meas-
24 ures for maternity care, including prenatal
25 measures, labor and delivery measures, and

1 postpartum measures up to one year postpar-
2 tum. Such evaluation shall be conducted in con-
3 sultation with the National Quality Forum and
4 shall include consideration of—
5 (i) effective quality measures for ma-
6 ternity care used by hospitals, health sys-
7 tems, birth centers, health plans, and other
8 relevant entities;
9 (ii) the sufficiency of current outcome
10 measures used to evaluate maternity care
11 for testing and validating new maternal
12 health care payment and service delivery
13 models;
14 (iii) quality measures for the child-
15 birth experiences of women that other
16 countries effectively use;
17 (iv) current maternity care quality
18 measures that may be eliminated because
19 they are not achieving their intended ef-
20 fect;
21 (v) barriers preventing maternity care
22 providers from implementing quality meas-
23 ures that are aligned from best practices;

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

(vii) 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;

(viii) 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;

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

(x) the current processes for collecting stratified data on the race and ethnicity of

1 pregnant and postpartum women in hos-
2 pitals, health systems, and birth centers,
3 and for incorporating such racially and
4 ethnically stratified data in maternity care
5 quality measures;
6 (xi) the extent to which maternity
7 care quality measures account for the
8 unique experiences of minority women and
9 their families; and
10 (xii) the extent to which hospitals,
11 health systems, and birth centers are im-
12 plementing existing maternity care quality
13 measures.
14 (D) Recommendations on authorizing addi-
15 tional funds to improve maternal mortality re-
16 view committees and relevant maternal health
17 initiatives by the agencies and organizations
18 within the Department of Health and Human
19 Services.
20 (E) Recommendations for new authorities
21 that may be granted to maternal mortality re-
22 view committees to be able to—
23 (i) access records from other Federal
24 and State agencies and departments that
25 may be necessary to identify causes of

pregnancy-associated deaths that are unique to women from specific populations, such as women veterans and women who are incarcerated; and

(ii) work with relevant experts who are not members of the maternal mortality review committee to assist in the review of pregnancy-associated deaths of women from specific populations, such as women veterans and women who are incarcerated.

(F) Recommendations to improve current quality measures for maternity care, including recommendations on updating the Pregnancy & Delivery Care measures on the Hospital Compare website of the Centers for Medicare & Medicaid Services or any successor website, with a particular focus on racial and ethnic disparities in maternal health outcomes.

(G) 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.

1 (2) PUBLIC COMMENT.—Not later than 60 days
2 after the date on which a majority of the members
3 of the Task Force have been appointed, the Task
4 Force shall publish in the Federal Register a notice
5 for public comment period of 90 days, beginning on
6 the date of publication, on the duties and activities
7 of the Task Force.
8 (c) MEMBERSHIP.—
9 (1) IN GENERAL.—The Task Force shall be
10 composed of 18 members appointed by the Secretary
11 of Health and Human Services. The Secretary shall
12 give special consideration to individuals who are rep-
13 resentative of populations most affected by maternal
14 mortality and severe maternal morbidity.
15 (2) MEMBER CRITERIA.—To be eligible to be
16 appointed as a member of the Task Force, an indi-
17 vidual shall be—
18 (A) a woman who has experienced severe
19 maternal morbidity;
20 (B) a family member of a woman who had
21 a pregnancy-related death;
22 (C) an individual who provides non-clinical
23 support to women from pregnancy through the
24 postpartum period, such as a doula, community
25 health worker, peer supporter, certified lacta-

1 tion consultant, nutritionist or dietitian, social
2 worker, home visitor, or a patient navigator;
3 (D) a leader of a community-based organi-
4 zation that addresses adverse maternal health
5 outcomes with a specific focus on racial and
6 ethnic disparities;
7 (E) an academic researcher in a field or
8 policy area related to the duties of the Task
9 Force;
10 (F) a maternal health care provider;
11 (G) an elected or duly appointed leader
12 from an Indian Tribe;
13 (H) an expert in a field or policy area re-
14 lated to the duties of the Task Force; or
15 (I) an individual who has experience with
16 Federal or State government programs related
17 to the duties of the Task Force.
18 (3) APPOINTMENT TIMING.—Appointments to
19 the Task Force shall be made not later than 180
20 days after the date of enactment of this Act.
21 (4) DURATION.—Each member shall be ap-
22 pointed for the life of the Task Force.
23 (5) CO-CHAIR SELECTION.—Not later than 30
24 days after the date on which a majority of the mem-
25 bers of the Task Force have been appointed, the

1 Secretary shall select 2 of the members of the Task
2 Force to serve as co-chairs of the Task Force.
3 (6) VACANCIES.—
4 (A) IN GENERAL.—A vacancy in the Task
5 Force—
6 (i) shall not affect the powers of the
7 Task Force; and
8 (ii) shall be filled in the same manner
9 as the original appointment.
10 (B) CO-CHAIR VACANCY.—In the event of
11 a vacancy of a co-chair of the Task Force, a re-
12 placement co-chair shall be selected in the same
13 manner as the original selection.
14 (7) COMPENSATION.—Except as provided in
15 paragraph (8), members of the Task Force shall
16 serve without pay.
17 (8) TRAVEL EXPENSES.—Members of the Task
18 Force shall be allowed travel expenses, including per
19 diem in lieu of subsistence, at rates authorized for
20 employees of agencies under subchapter I of chapter
21 57 of title 5, United States Code, while away from
22 their homes or regular places of business in the per-
23 formance of service for the Task Force.
24 (d) MEETINGS.—

1 (1) IN GENERAL.—The Task Force shall meet
2 at the call of the co-chairs of the Task Force.
3 (2) QUORUM.—A majority of the members of
4 the Task Force shall constitute a quorum.
5 (3) INITIAL MEETING.—The Task Force shall
6 meet not later than 60 days after the date on which
7 a majority of the members of the Task Force have
8 been appointed.
9 (e) STAFF OF TASK FORCE.—
10 (1) ADDITIONAL STAFF.—The co-chairs of the
11 Task Force may appoint and fix the pay of addi-
12 tional staff to the Task Force as the co-chairs con-
13 sider appropriate.
14 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
15 LAWS.—The staff of the Task Force may be ap-
16 pointed without regard to the provisions of title 5,
17 United States Code, governing appointments in the
18 competitive service, and may be paid without regard
19 to the provisions of chapter 51 and subchapter III
20 of chapter 53 of that title relating to classification
21 and General Schedule pay rates.
22 (3) DETAILEES.—Any Federal Government em-
23 ployee may be detailed to the Task Force without re-
24 imbursement from the Task Force, and the detailee

1 shall retain the rights, status, and privileges of his
2 or her regular employment without interruption.
3 (f) POWERS OF TASK FORCE.—
4 (1) TESTIMONY AND EVIDENCE.—The Task
5 Force may take such testimony and receive such evi-
6 dence as the Task Force considers advisable to carry
7 out this section.
8 (2) OBTAINING OFFICIAL DATA.—The Task
9 Force may secure directly from any Federal depart-
10 ment or agency information necessary to carry out
11 its duties under this section. On request of the co-
12 chairs of the Task Force, the head of that depart-
13 ment or agency shall furnish such information to the
14 Task Force.
15 (3) POSTAL SERVICES.—The Task Force may
16 use the United States mails in the same manner and
17 under the same conditions as other Federal depart-
18 ments and agencies.
19 (g) REPORT.—Not later than 2 years after the date
20 on which the initial 18 members of the Task Force are
21 appointed under subsection (c)(1), the Task Force shall
22 submit to the Committee on Energy and Commerce, the
23 Committee on Education and Labor, and the Committee
24 on Ways and Means of the House of Representatives and
25 the Committee on Finance and the Committee on Health,

1 Education, Labor and Pensions of the Senate, and make
2 publicly available, a report that—
3 (1) contains the information, evaluations, and
4 recommendations described in subsection (b); and
5 (2) is signed by more than half of the members
6 of the Task Force.
7 (h) TERMINATION.—Section 14 of the Federal Advi-
8 sory Committee Act (5 U.S.C. App.) shall not apply to
9 the Task Force.
10 (i) DEFINITIONS.—In this section:
11 (1) MATERNAL HEALTH CARE PROVIDER.—The
12 term ''maternal health care provider'' means an indi-
13 vidual who is an obstetrician-gynecologist, family
14 physician, midwife who meets at a minimum the
15 international definition of the midwife and global
16 standards for midwifery education as established by
17 the International Confederation of Midwives, nurse
18 practitioner, or clinical nurse specialist.
19 (2) MATERNAL MORTALITY.—The term ''mater-
20 nal mortality'' means deaths occurring during, or
21 within 12 months after, pregnancy from complica-
22 tions of pregnancy or childbirth.
23 (3) MATERNAL MORTALITY REVIEW COM-
24 MITTEE.—The term ''maternal mortality review
25 committee'' means a maternal mortality review com-

1 mittee duly authorized by a State and receiving
2 funding under section 317k(a)(2)(D) of the Public
3 Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).
4 (4) PREGNANCY-ASSOCIATED DEATH.—The
5 term ''pregnancy-associated death'' means a death of
6 a woman, by any cause, that occurs during, or with-
7 in 1 year following, her pregnancy, regardless of the
8 outcome, duration, or site of the pregnancy.
9 (5) PREGNANCY-RELATED DEATH.—The term
10 ''pregnancy-related death'' means a death of a
11 woman that occurs during, or within 1 year fol-
12 lowing, her pregnancy, regardless of the outcome,
13 duration, or site of the pregnancy—
14 (A) from any cause related to, or aggra-
15 vated by, the pregnancy or its management;
16 and
17 (B) not from accidental or incidental
18 causes.
19 (6) SEVERE MATERNAL MORBIDITY.—The term
20 ''severe maternal morbidity'' means unexpected out-
21 comes of labor and delivery resulting in significant
22 short-term or long-term consequences to the health
23 of a woman.
24 (j) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated such sums as may be

1 necessary to carry out this section for fiscal years 2021
2 through 2024.

3 **SEC. 5. INDIAN HEALTH SERVICE STUDY ON MATERNAL**
4 **MORTALITY.**

5 (a) IN GENERAL.—The Director of the Indian Health
6 Service (referred to in this section as the ''Director'')
7 shall, in coordination with entities described in subsection
8 (b)—

9 (1) not later than 90 days after the enactment
10 of this Act, enter into a contract with an inde-
11 pendent research organization or Tribal Epidemi-
12 ology Center to conduct a comprehensive study on
13 maternal mortality and severe maternal morbidity in
14 the populations of American Indian and Alaska Na-
15 tive women; and

16 (2) not later than 3 years after the date of the
17 enactment of this Act, submit to Congress a report
18 on such study that contains recommendations for
19 policies and practices that can be adopted to im-
20 prove maternal health outcomes for such women.

21 (b) PARTICIPATING ENTITIES.—The entities de-
22 scribed in this subsection shall consist of 12 members, se-
23 lected by the Director from among individuals nominated
24 by Indian tribes and tribal organizations (as such terms
25 are defined in section 4 of the Indian Self-Determination

1 and Education Assistance Act (25 U.S.C. 5304)), and
2 urban Indian organizations (as such term is defined in
3 section 4 of the Indian Health Care Improvement Act (25
4 U.S.C. 1603)). In selecting such members, the Director
5 shall ensure that each of the 12 service areas of the Indian
6 Health Service is represented.

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

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

12 (2) include a systematic process of listening to
13 the stories of American Indian and Alaska Native
14 women to fully understand the causes of, and inform
15 potential solutions to, the maternal mortality and se-
16 vere maternal morbidity crisis within their respective
17 communities;

18 (3) distinguish between the causes of, landscape
19 of maternity care at, and recommendations to im-
20 prove maternal health outcomes within, the different
21 settings in which American Indian and Alaska Na-
22 tive women receive maternity care, such as—

23 (A) facilities operated by the Indian
24 Health Service;

1 (B) an Indian health program operated by
2 an Indian tribe or tribal organization pursuant
3 to a contract, grant, cooperative agreement, or
4 compact with the Indian Health Service pursu-
5 ant to the Indian Self-Determination Act; and
6 (C) an urban Indian health program oper-
7 ated by an urban Indian organization pursuant
8 to a grant or contract with the Indian Health
9 Service pursuant to title V of the Indian Health
10 Care Improvement Act;
11 (4) review processes for coordinating programs
12 of the Indian Health Service with social services pro-
13 vided through other programs administered by the
14 Secretary of Health and Human Services (other
15 than the Medicare program under title XVIII of the
16 Social Security Act, the Medicaid program under
17 title XIX of such Act, and the Children's Health In-
18 surance Program under title XXI of such Act), in-
19 cluding coordination with the efforts of the Task
20 Force established under section 3;
21 (5) review current data collection and quality
22 measurement processes and practices;
23 (6) consider social determinants of health, in-
24 cluding poverty, lack of health insurance, unemploy-

1 ment, sexual violence, and environmental conditions
2 in Tribal areas;
3 (7) consider the role that historical mistreat-
4 ment of American Indian and Alaska Native women
5 has played in causing currently high rates of mater-
6 nal mortality and severe maternal morbidity;
7 (8) consider how current funding of the Indian
8 Health Service affects the ability of the Service to
9 deliver quality maternity care;
10 (9) consider the extent to which the delivery of
11 maternity care services is culturally appropriate for
12 American Indian and Alaska Native women;
13 (10) make recommendations to reduce misclas-
14 sification of American Indian and Alaska Native
15 women, including consideration of best practices in
16 training for maternal mortality review committee
17 members to be able to correctly classify American
18 Indian and Alaska Native women; and
19 (11) make recommendations informed by the
20 stories shared by American Indian and Alaska Na-
21 tive women in paragraph (2) to improve maternal
22 health outcomes for such women.
23 (d) REPORT.—The agreement entered into under
24 subsection (a) with an independent research organization
25 or Tribal Epidemiology Center shall require that the orga-

1 nization or center transmit to Congress a report on the
2 results of the study conducted pursuant to that agreement
3 not later than 36 months after the date of the enactment
4 of this Act.
5 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 $2,000,000 for each of fiscal years 2021 through 2023.
8 **SEC. 6. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
9 **STUDY MATERNAL MORTALITY, SEVERE MA-**
10 **TERNAL MORBIDITY, AND OTHER ADVERSE**
11 **MATERNAL HEALTH OUTCOMES.**
12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall establish a program under which
14 the Secretary shall award grants to research centers and
15 other entities at minority-serving institutions to study spe-
16 cific aspects of the maternal health crisis among minority
17 women. Such research may—
18 (1) include the development and implementation
19 of systematic processes of listening to the stories of
20 minority women to fully understand the causes of,
21 and inform potential solutions to, the maternal mor-
22 tality and severe maternal morbidity crisis within
23 their respective communities; and
24 (2) assess the potential causes of low rates of
25 maternal mortality among Hispanic women, includ-

1 ing potential racial misclassification and other data
2 collection and reporting issues that might be mis-
3 representing maternal mortality rates among His-
4 panic women in the United States.

5 (b) APPLICATION.—To be eligible to receive a grant
6 under subsection (a), an entity described in such sub-
7 section shall submit to the Secretary an application at
8 such time, in such manner, and containing such informa-
9 tion as the Secretary may require.

10 (c) TECHNICAL ASSISTANCE.—The Secretary may
11 use not more than 10 percent of the funds made available
12 under subsection (f)—

13 (1) to conduct outreach to Minority-Serving In-
14 stitutions to raise awareness of the availability of
15 grants under this subsection (a);

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

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

21 (d) REPORTING REQUIREMENT.—Each entity award-
22 ed a grant under this section shall periodically submit to
23 the Secretary a report on the status of activities conducted
24 using the grant.

1 (e) EVALUATION.—Beginning one year after the date
2 on which the first grant is awarded under this section,
3 the Secretary shall submit to Congress an annual report
4 summarizing the findings of research conducted using
5 funds made available under this section.
6 (f) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 $10,000,000 for each of fiscal years 2021 through 2025.
9 (g) MINORITY-SERVING INSTITUTIONS DEFINED.—
10 In this section, the term ''minority-serving institution''
11 has the meaning given the term in section 371(a) of the
12 Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

○