

119TH CONGRESS
2D SESSION

S. 4187

To amend the Public Health Service Act to improve maternal health data collection processes and quality measures, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 25, 2026

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

A BILL

To amend the Public Health Service Act to improve maternal health data collection processes and quality measures, 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”.

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 terms are
 16 defined in section 4 of the Indian Health Care
 17 Improvement Act)—

18 “(i) to select for inclusion in the mem-
 19 bership of such a committee community
 20 members from the State, Indian Tribe,
 21 Tribal organization, or Urban Indian orga-
 22 nization 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 personal or family experiences of ma-
2 ternal mortality or severe maternal
3 morbidity, and professional back-
4 ground, including members with non-
5 clinical experiences; and

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

14 “(ii) to establish initiatives to conduct
15 outreach and community engagement ef-
16 forts within communities throughout the
17 State or Tribe to seek input from commu-
18 nity members on the work of such mater-
19 nal mortality review committee, with a par-
20 ticular focus on outreach to women from
21 racial and ethnic minority groups (as such
22 term is defined in section 1707(g)(1)); and

23 “(iii) to release public reports assess-
24 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 is authorized to be appropriated to carry out this paragraph \$10,000,000 for each of fiscal years 2027 through 2031.”.

(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)”.

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

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

3 “(II) to the extent practicable,
4 reviewing cases of severe maternal
5 morbidity, according to the most up-
6 to-date indicators;

7 “(III) to the extent practicable,
8 reviewing deaths during pregnancy or
9 up to 1 year after the end of a preg-
10 nancy from suicide, overdose, or other
11 death from a mental health condition
12 or substance use disorder attributed
13 to or aggravated by pregnancy or
14 childbirth complications;

15 “(IV) to the extent practicable,
16 consulting with local community-based
17 organizations representing pregnant
18 and postpartum individuals from de-
19 mographic groups with elevated rates
20 of maternal mortality, severe maternal
21 morbidity, maternal health disparities,
22 or other adverse perinatal or child-
23 birth outcomes to ensure that, in ad-
24 dition to clinical factors, nonclinical
25 factors that might have contributed to

1 a pregnancy-related death are appro-
2 priately considered;”.

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

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services, acting through the Administrator of the
7 Centers for Medicare & Medicaid Services and the Direc-
8 tor of the Agency for Healthcare Research and Quality,
9 shall consult with relevant stakeholders—

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

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

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

18 (1) pregnant and postpartum individuals and
19 their family members, and nonprofit organizations
20 representing such individuals, with a particular focus
21 on patients from racial and ethnic minority groups;

22 (2) community-based organizations that provide
23 support for pregnant and postpartum individuals,
24 with a particular focus on patients from demo-
25 graphic groups with elevated rates of maternal mor-

1 tality, severe maternal morbidity, maternal health
 2 disparities, or other adverse perinatal or childbirth
 3 outcomes;

4 (3) membership organizations for maternity
 5 care providers;

6 (4) organizations representing perinatal health
 7 workers;

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

10 (6) organizations that focus on intimate partner
 11 violence;

12 (7) institutions of higher education, with a par-
 13 ticular focus on minority-serving institutions;

14 (8) licensed and accredited hospitals, birth cen-
 15 ters, midwifery practices, or other facilities that pro-
 16 vide maternal health care services;

17 (9) relevant State and local public agencies, in-
 18 cluding State maternal mortality review committees;
 19 and

20 (10) the National Quality Forum, or such other
 21 standard-setting organizations specified by the Sec-
 22 retary.

23 (c) TOPICS.—The review of maternal health data col-
 24 lection processes and recommendations to improve such
 25 processes and measures required under subsection (a)

1 shall assess all available relevant information, including
2 information from State-level sources, and shall consider at
3 least the following:

4 (1) Current State and Tribal practices for ma-
5 ternal health, maternal mortality, and severe mater-
6 nal morbidity data collection and dissemination, in-
7 cluding consideration of—

8 (A) the timeliness of processes for amend-
9 ing a death certificate when new information
10 pertaining to the death becomes available to re-
11 flect whether the death was a pregnancy-related
12 death;

13 (B) relevant data collected with electronic
14 health records, including data on race, eth-
15 nicity, primary language, socioeconomic status,
16 geography, insurance type, and other relevant
17 demographic information;

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

21 (D) the barriers preventing States from
22 correlating maternal outcome data with data on
23 race, ethnicity, and other demographic charac-
24 teristics;

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

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

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

14 (H) the extent to which States have imple-
15 mented systematic processes of listening to the
16 stories of pregnant and postpartum individuals
17 and their family members, with a particular
18 focus on pregnant and postpartum individuals
19 from demographic groups with elevated rates of
20 maternal mortality, severe maternal morbidity,
21 maternal health disparities, or other adverse
22 perinatal or childbirth outcomes, and their fam-
23 ily members, to fully understand the causes of,
24 and inform potential solutions to, the maternal

1 mortality and severe maternal morbidity crisis
2 within their respective States;

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

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

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

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

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

24 (2) Whether the funding support referred to in
25 paragraph (1)(M) is adequate for States to carry out

1 optimal data collection and dissemination processes
2 with respect to maternal health, maternal mortality,
3 and severe maternal morbidity.

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

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

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

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

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

23 (E) barriers preventing maternity care pro-
24 viders and insurers from implementing quality
25 measures that are aligned with best practices;

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

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

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

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

20 (J) the current processes for collecting and
21 making publicly available, to the extent prac-
22 ticable, stratified data on race, ethnicity, and
23 other demographic characteristics of pregnant
24 and postpartum individuals in hospitals, health
25 systems, midwifery practices, and birth centers,

1 and for incorporating such demographically
2 stratified data in maternity care quality meas-
3 ures;

4 (K) the extent to which maternity care
5 quality measures account for the unique experi-
6 ences of pregnant and postpartum individuals
7 from racial and ethnic minority groups; and

8 (L) the extent to which hospitals, health
9 systems, midwifery practices, and birth centers
10 are implementing existing maternity care qual-
11 ity measures.

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

17 (5) Recommendations for new authorities that
18 may be granted to maternal mortality review com-
19 mittees to be able to—

20 (A) access records from other Federal and
21 State agencies and departments that may be
22 necessary to identify causes of pregnancy-asso-
23 ciated and pregnancy-related deaths that are
24 unique to pregnant and postpartum individuals

1 from specific populations, such as veterans and
2 individuals who are incarcerated; and

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

9 (6) Recommendations to improve and stand-
10 ardize current quality measures for maternity care,
11 with a particular focus on maternal health dispari-
12 ties.

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

18 (d) REPORT.—Not later than 1 year after the enact-
19 ment of this Act, the Secretary shall submit to the Con-
20 gress and make publicly available a report on the results
21 of the review of maternal health data collection processes
22 and quality measures and recommendations to improve
23 such processes and measures required under subsection
24 (a).

1 (e) DEFINITION.—In this section, the term “maternal
2 mortality review committee” means a maternal mortality
3 review committee duly authorized by a State and receiving
4 funding under section 317K(a)(2)(D) of the Public Health
5 Service Act (42 U.S.C. 247b–12(a)(2)(D)).

6 (f) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated such sums as may be
8 necessary to carry out this section for fiscal years 2027
9 through 2030.

10 **SEC. 5. STUDY ON MATERNAL HEALTH AMONG AMERICAN**
11 **INDIAN AND ALASKA NATIVE INDIVIDUALS.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services (referred to in this section as the “Sec-
14 retary”) shall, in coordination with entities described in
15 subsection (b)—

16 (1) not later than 90 days after the enactment
17 of this Act, enter into a contract with an inde-
18 pendent research organization or Tribal Epidemi-
19 ology Center to conduct a comprehensive study on
20 maternal mortality, severe maternal morbidity, and
21 other adverse perinatal or childbirth outcomes in the
22 populations of American Indian and Alaska Native
23 individuals; and

24 (2) not later than 3 years after the date of the
25 enactment of this Act, submit to Congress a report

1 on such study that contains recommendations for
2 policies and practices that can be adopted to im-
3 prove maternal health outcomes for American Indian
4 and Alaska Native individuals.

5 (b) PARTICIPATING ENTITIES.—The entities de-
6 scribed in this subsection shall consist of 12 members, se-
7 lected by the Secretary from among individuals nominated
8 by Indian Tribes and Tribal organizations (as such terms
9 are defined in section 4 of the Indian Self-Determination
10 and Education Assistance Act (25 U.S.C. 5304)), and
11 Urban Indian organizations (as such term is defined in
12 section 4 of the Indian Health Care Improvement Act (25
13 U.S.C. 1603)). In selecting such members, the Secretary
14 shall ensure that each of the 12 service areas of the Indian
15 Health Service is represented.

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

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

21 (2) include a systematic process of listening to
22 the stories of American Indian and Alaska Native
23 individuals to fully understand the causes of, and in-
24 form potential solutions to, the maternal health cri-
25 sis within their respective communities;

1 (3) distinguish between the causes of, landscape
2 of maternity care at, and recommendations to im-
3 prove maternal health outcomes within, the different
4 settings in which American Indian and Alaska Na-
5 tive individuals receive maternity care, such as—

6 (A) facilities operated by the Indian
7 Health Service;

8 (B) an Indian health program operated by
9 an Indian Tribe or Tribal organization pursu-
10 ant to a contract, grant, cooperative agreement,
11 or compact with the Indian Health Service pur-
12 suant to the Indian Self-Determination Act;

13 (C) an urban Indian health program oper-
14 ated by an Urban Indian organization pursuant
15 to a grant or contract with the Indian Health
16 Service pursuant to title V of the Indian Health
17 Care Improvement Act; and

18 (D) facilities outside of the Indian Health
19 Service in which American Indian and Alaska
20 Native individuals receive maternity care serv-
21 ices;

22 (4) review processes for coordinating programs
23 of the Indian Health Service with social services pro-
24 vided through other programs administered by the
25 Secretary of Health and Human Services (other

1 than the Medicare Program under title XVIII of the
2 Social Security Act (42 U.S.C. 1395 et seq.), the
3 Medicaid Program under title XIX of such Act (42
4 U.S.C. 1396 et seq.), and the Children’s Health In-
5 surance Program under title XXI of such Act (42
6 U.S.C. 1397 et seq.));

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

9 (6) assess causes and frequency of maternal
10 mental health conditions and substance use dis-
11 orders;

12 (7) consider social determinants of health, in-
13 cluding poverty, lack of health insurance, unemploy-
14 ment, sexual and domestic violence, and environ-
15 mental conditions in Tribal areas;

16 (8) consider the role that historical mistreat-
17 ment of American Indian and Alaska Native women
18 has played in causing currently elevated rates of ma-
19 ternal mortality, severe maternal morbidity, and
20 other adverse perinatal or childbirth outcomes;

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

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

4 (11) make recommendations to reduce
5 misclassification of American Indian and Alaska Na-
6 tive individuals, including consideration of best prac-
7 tices in training for maternal mortality review com-
8 mittee members to be able to correctly classify
9 American Indian and Alaska Native individuals; and

10 (12) make recommendations informed by the
11 stories shared by American Indian and Alaska Na-
12 tive individuals referred to in paragraph (2) to im-
13 prove maternal health outcomes for such individuals.

14 (d) REPORT.—The agreement entered into under
15 subsection (a) with an independent research organization
16 or Tribal Epidemiology Center shall require that the orga-
17 nization or Center transmit to Congress a report on the
18 results of the study conducted pursuant to that agreement
19 not later than 36 months after the date of the enactment
20 of this Act.

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section
23 \$2,000,000 for each of fiscal years 2027 through 2029.

1 **SEC. 6. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
2 **STUDY MATERNAL MORTALITY, SEVERE MA-**
3 **TERNAL MORBIDITY, AND OTHER ADVERSE**
4 **MATERNAL HEALTH OUTCOMES.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services shall establish a program under which
7 the Secretary shall award grants to research centers,
8 health professions schools and programs, and other enti-
9 ties at minority-serving institutions to study specific as-
10 pects of the maternal health crisis among pregnant and
11 postpartum individuals from racial and ethnic minority
12 groups. Such research may—

13 (1) include the development and implementation
14 of systematic processes of listening to the stories of
15 pregnant and postpartum individuals from racial
16 and ethnic minority groups, and perinatal health
17 workers supporting such individuals, to fully under-
18 stand the causes of, and inform potential solutions
19 to, the maternal mortality and severe maternal mor-
20 bidity crisis within their respective communities;

21 (2) assess the potential causes of relatively low
22 rates of maternal mortality among Hispanic individ-
23 uals, including potential racial misclassification and
24 other data collection and reporting issues that might
25 be misrepresenting maternal mortality rates among
26 Hispanic individuals in the United States;

1 (3) assess differences in rates of adverse mater-
2 nal health outcomes among subgroups identifying as
3 Hispanic, including disparities in access to early pre-
4 natal care; and

5 (4) include lactation education to promote ra-
6 cial and ethnic diversity within the workforce of
7 health care professionals with breastfeeding and lac-
8 tation expertise.

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

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

17 (1) to conduct outreach to minority-serving in-
18 stitutions to raise awareness of the availability of
19 grants under subsection (a);

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

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

1 (d) REPORTING REQUIREMENT.—Each entity award-
 2 ed a grant under this section shall periodically submit to
 3 the Secretary a report on the status of activities conducted
 4 using the grant.

5 (e) EVALUATION.—Beginning 1 year after the date
 6 on which the first grant is awarded under this section,
 7 the Secretary shall submit to Congress an annual report
 8 summarizing the findings of research conducted using
 9 funds made available under this section.

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

14 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
 15 authorized to be appropriated to carry out this section
 16 \$10,000,000 for each of fiscal years 2027 through 2031.

17 **SEC. 7. DEFINITIONS.**

18 In this Act:

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

22 (A) is a physician, a physician assistant, a
 23 midwife who meets, at a minimum, the inter-
 24 national definition of a midwife and global
 25 standards for midwifery education as estab-

lished by the International Confederation of
 Midwives, an advanced practice registered
 nurse, a doula accredited by a State to receive
 reimbursement for doula services under a State
 plan (or a waiver of such plan) under title XIX
 of the Social Security Act (42 U.S.C. 1396 et
 seq.), or a lactation consultant certified by the
 International Board of Lactation Consultant
 Examiners; and

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

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

(3) POSTPARTUM.—The term “postpartum” re-
 fers to the 1-year period beginning on the last day
 of the pregnancy of an individual.

(4) PREGNANCY-ASSOCIATED DEATH.—The
 term “pregnancy-associated death” means a death of
 a pregnant or postpartum individual, by any cause,

1 that occurs during, or within 1 year following, the
2 individual’s pregnancy, regardless of the outcome,
3 duration, or site of the pregnancy.

4 (5) PREGNANCY-RELATED DEATH.—The term
5 “pregnancy-related death” means a death of a preg-
6 nant or postpartum individual that occurs during, or
7 within 1 year following, the individual’s pregnancy,
8 from a pregnancy complication, a chain of events
9 initiated by pregnancy, or the aggravation of an un-
10 related condition by the physiologic effects of preg-
11 nancy.

12 (6) RACIAL AND ETHNIC MINORITY GROUP.—
13 The term “racial and ethnic minority group” has the
14 meaning given such term in section 1707(g)(1) of
15 the Public Health Service Act (42 U.S.C. 300u-
16 6(g)(1)).

17 (7) SEVERE MATERNAL MORBIDITY.—The term
18 “severe maternal morbidity” means a health condi-
19 tion, including mental health conditions and sub-
20 stance use disorders, attributed to or aggravated by
21 pregnancy or childbirth that results in significant
22 short-term or long-term consequences to the health
23 of the individual who was pregnant.

24 (8) SOCIAL DETERMINANTS OF MATERNAL
25 HEALTH.—The term “social determinants of mater-

- 1 nal health” means nonclinical factors that impact
- 2 maternal health outcomes.

