

119TH CONGRESS
1ST SESSION

S. 2289

To amend titles XIX and XXI of the Social Security Act to improve maternal health coverage under Medicaid and CHIP, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 15, 2025

Mr. GRASSLEY (for himself and Ms. HASSAN) introduced the following bill;
which was read twice and referred to the Committee on Finance

A BILL

To amend titles XIX and XXI of the Social Security Act to improve maternal health coverage under Medicaid and CHIP, 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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Healthy Moms and Babies Act”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Definitions.

Sec. 3. Mandatory reporting by State Medicaid programs on adult health care quality measures of maternal and perinatal health.

- Sec. 4. Medicaid quality improvement initiatives to reduce rates of cesarean sections; Medicare requirement for hospitals to report on data on cesarean births.
- Sec. 5. State option to provide coordinated care through a health home for pregnant and postpartum women.
- Sec. 6. Guidance on care coordination to support maternal health.
- Sec. 7. National reskilling of the maternity care workforce.
- Sec. 8. MACPAC study on doulas and community health workers; guidance on increasing access to doula services under Medicaid.
- Sec. 9. Demonstration projects to improve the delivery of maternal health care through telehealth.
- Sec. 10. CMS report on coverage of remote physiologic monitoring devices and impact on maternal and child health outcomes under Medicaid.
- Sec. 11. Guidance on community-based maternal health programs.
- Sec. 12. Developing guidance on maternal mortality and severe morbidity reduction for maternal care providers receiving payment under the Medicaid program.
- Sec. 13. Program related to reducing cesarean births and increasing rates of vaginal birth after cesarean.
- Sec. 14. Collection of information related to social determinants of the health of Medicaid and CHIP beneficiaries.
- Sec. 15. Report on payment methodologies for transferring pregnant women between facilities before, during, and after childbirth.
- Sec. 16. Medicaid guidance on State options to address social determinants of health for pregnant and postpartum women.
- Sec. 17. Payment error rate measurement (PERM) audit and improvement requirements.

1 **SEC. 2. DEFINITIONS.**

2 In this Act:

3 (1) CHIP.—The term “CHIP” means the Chil-
 4 dren’s Health Insurance Program established under
 5 title XXI of the Social Security Act (42 U.S.C.
 6 1397aa et seq.).

7 (2) COMPTROLLER GENERAL.—The term
 8 “Comptroller General” means the Comptroller Gen-
 9 eral of the United States.

10 (3) GROUP HEALTH PLAN; HEALTH INSURANCE
 11 ISSUER, ETC.—The terms “group health plan”,
 12 “health insurance coverage”, “health insurance
 13 issuer”, “group health insurance coverage”, and “in-

dividual health insurance coverage” have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(4) MEDICAID.—The term “Medicaid” means the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) MEDICAID MANAGED CARE ORGANIZATION.—The term “medicaid managed care organization” has the meaning given that term in section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. 1396b(m)(1)(A)).

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

(7) STATE.—The term “State” has the meaning given that term for purposes of titles V, XIX, and XXI of the Social Security Act (42 U.S.C. 701 et seq., 1396 et seq., 1397aa et seq.).

SEC. 3. MANDATORY REPORTING BY STATE MEDICAID PROGRAMS ON ADULT HEALTH CARE QUALITY MEASURES OF MATERNAL AND PERINATAL HEALTH.

Section 1139B of the Social Security Act (42 U.S.C. 1320b–9b) is amended—

(1) in subsection (b)—

(A) in paragraph (3)(B)—

1 (i) in the subparagraph heading, by
 2 inserting “AND MATERNAL AND
 3 PERINATAL HEALTH” after “BEHAVIORAL
 4 HEALTH”;

5 (ii) by striking “all behavioral health”
 6 and inserting “all behavioral health and
 7 maternal and perinatal health”; and

8 (iii) by inserting “and of maternal
 9 and perinatal health care for Medicaid eli-
 10 gible adults” after “Medicaid eligible
 11 adults”; and

12 (B) in paragraph (5)(C)—

13 (i) in the subparagraph heading, by
 14 inserting “AND MATERNAL AND
 15 PERINATAL HEALTH” after “BEHAVIORAL
 16 HEALTH”; and

17 (ii) by inserting “and, with respect to
 18 Medicaid eligible adults, maternal and
 19 perinatal health measures” after “behav-
 20 ioral health measures”; and

21 (2) in subsection (d)(1)(A), by inserting “and
 22 maternal and perinatal health” after “behavioral
 23 health”.

1 **SEC. 4. MEDICAID QUALITY IMPROVEMENT INITIATIVES TO**
2 **REDUCE RATES OF CESAREAN SECTIONS;**
3 **MEDICARE REQUIREMENT FOR HOSPITALS**
4 **TO REPORT ON DATA ON CESAREAN BIRTHS.**

5 (a) MEDICAID STATE PLAN AMENDMENT.—Section
6 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))
7 is amended—

8 (1) in paragraph (86), by striking “and” after
9 the semicolon;

10 (2) in paragraph (87), by striking the period at
11 the end and inserting “; and”; and

12 (3) by inserting after paragraph (87) the fol-
13 lowing:

14 “(88) provide that, not later than January 1,
15 2027, and annually thereafter through January 1,
16 2037, the State shall submit a report to the Sec-
17 retary, that shall be made publicly available, which
18 contains with respect to the preceding calendar
19 year—

20 “(A) the rate of low-risk cesarean delivery,
21 as defined by the Secretary in consultation with
22 relevant stakeholders, for pregnant women eligi-
23 ble for medical assistance under the State plan
24 or a waiver of such plan in the State, as com-
25 pared to the overall rate of cesarean delivery in
26 the State;

“(B) a description of the State’s quality improvement activities to safely reduce the rate of low-risk cesarean delivery (as so defined) for pregnant women eligible for medical assistance under the State plan or a waiver of such plan in the State reported under subparagraph (A), including initiatives aimed at reducing racial and ethnic health disparities, hospital-level quality improvement initiatives, taking into account hospital type and the patient population served, and, if applicable, partnerships with State or regional perinatal quality collaboratives;

“(C) for each report submitted after January 1, 2027, the percentage change (if any) in the rate of low-risk cesarean delivery (as so defined) for pregnant women eligible for medical assistance under the State plan or a waiver of such plan in the State reported under subparagraph (A) from the rate reported for the most recent previous report; and

“(D) such other relevant data and information as determined by the Secretary, and in consultation with relevant stakeholders, such as State initiatives and evaluations of quality im-

1 provement activities, cesarean delivery rates,
2 and health outcomes.”.

3 (b) GAO STUDY REGARDING MEDICAID PAYMENT
4 RATES CESAREAN BIRTHS.—

5 (1) STUDY.—The Comptroller General shall
6 conduct a study regarding payment rates for cesar-
7 ean births and vaginal births under State Medicaid
8 programs. To the extent feasible and data are avail-
9 able, the study shall include analyses of the fol-
10 lowing:

11 (A) Payment rates for cesarean births and
12 vaginal births paid by fee-for-service Medicaid
13 programs and by Medicaid programs that con-
14 tract with Medicaid managed care organizations
15 to furnish medical assistance under such pro-
16 grams;

17 (B) What is known about how Medicaid
18 payment rates have changed over time;

19 (C) What is known about how payment
20 rates for cesarean and vaginal births by Med-
21 icaid programs compare with the payment rates
22 for such births by other sources of insurance
23 coverage; and

24 (D) Such other factors related to payment
25 rates for cesarean and vaginal births under

1 Medicaid as the Comptroller General deter-
2 mines appropriate.

3 (2) REPORT.—Not later than 18 months after
4 the date of enactment of this Act, the Comptroller
5 General shall submit to Congress a report containing
6 the results of the study conducted under paragraph
7 (1), together with recommendations for such legisla-
8 tion and administrative action as the Comptroller
9 General determines appropriate.

10 (c) GAO STUDY ON RACIAL DISPARITIES IN CESAR-
11 EAN BIRTHS.—

12 (1) IN GENERAL.—The Comptroller General
13 shall conduct a study on racial disparities in the fre-
14 quency of cesarean births. To the extent feasible and
15 data are available, the study shall compare such in-
16 formation on low- and high-risk cesarean births, dif-
17 ferences by payer (such as Medicaid and private
18 payers), and hospital characteristics (such as loca-
19 tion or hospital type). Such study may consider
20 other factors related to racial disparities in maternal
21 health as the Comptroller General deems appro-
22 priate.

23 (2) REPORT.—Not later than 2 years after the
24 date of enactment of this Act, the Comptroller Gen-
25 eral shall submit to Congress a report containing the

1 results of the study conducted under paragraph (1),
 2 together with recommendations for such legislation
 3 and administrative action as the Comptroller Gen-
 4 eral determines appropriate.

5 (d) MEDICARE REQUIREMENT FOR HOSPITALS TO
 6 REPORT DATA ON CESAREAN BIRTHS.—

7 (1) REQUIREMENT.—Section 1866(a)(1) of the
 8 Social Security Act (42 U.S.C. 1395cc(a)(1)) is
 9 amended—

10 (A) by moving the indentation of subpara-
 11 graph (W) 2 ems to the left;

12 (B) in subparagraph (X)—

13 (i) by moving the indentation 2 ems
 14 to the left; and

15 (ii) by striking “and” at the end;

16 (C) in subparagraph (Y), by striking the
 17 period at the end and inserting “; and”; and

18 (D) by inserting after subparagraph (Y)
 19 the following new subparagraph:

20 “(Z) in the case of a hospital, to submit, in a
 21 form and manner, and at a time, specified by the
 22 Secretary, data on the Nulliparous, Term, Singleton,
 23 Vertex Cesarean section (NTSV C-section) rate with
 24 respect to the hospital for the preceding year.”.

1 (2) INCORPORATION INTO HOSPITAL QUALITY
2 REPORTING.—Section 1886(b)(3)(B)(viii) of the So-
3 cial Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii))
4 is amended by adding at the end the following new
5 subclause:

6 “(XIII) Effective for payments beginning with fiscal
7 year 2027, in expanding the number of measures under
8 subclause (III), the Secretary shall adopt a measure relat-
9 ing to the Nulliparous, Term, Singleton, Vertex Cesarean
10 section (NTSV C-section) rate for hospitals in inpatient
11 settings. Not later than 2027, the Secretary shall incor-
12 porate such measure into the designation of maternity
13 care quality hospitals, as described in the final rule enti-
14 tled ‘Medicare Program; Hospital Inpatient Prospective
15 Payment Systems for Acute Care Hospitals and the Long
16 Term Care Hospital Prospective Payment System and
17 Policy Changes and Fiscal Year 2023 Rates; Quality Pro-
18 grams and Medicare Promoting Interoperability Program
19 Requirements for Eligible Hospitals and Critical Access
20 Hospitals; Costs Incurred for Qualified and Non-Qualified
21 Deferred Compensation Plans; and Changes to Hospital
22 and Critical Access Hospital Conditions of Participation’
23 (87 Fed. Reg. 48780 (August 10, 2022)).”.

1 **SEC. 5. STATE OPTION TO PROVIDE COORDINATED CARE**
 2 **THROUGH A HEALTH HOME FOR PREGNANT**
 3 **AND POSTPARTUM WOMEN.**

4 Title XIX of the Social Security Act (42 U.S.C. 1396
 5 et seq.) is amended by inserting after section 1945A the
 6 following new section:

7 **“SEC. 1945B. STATE OPTION TO PROVIDE COORDINATED**
 8 **CARE THROUGH A HEALTH HOME FOR PREG-**
 9 **NANT AND POSTPARTUM WOMEN.**

10 “(a) STATE OPTION.—

11 “(1) IN GENERAL.—Notwithstanding section
 12 1902(a)(1) (relating to statewideness) and section
 13 1902(a)(10)(B) (relating to comparability), begin-
 14 ning April 1, 2028, a State, at its option as a State
 15 plan amendment, may provide for medical assistance
 16 under this title to an eligible woman who chooses
 17 to—

18 “(A) enroll in a maternity health home
 19 under this section by selecting a designated pro-
 20 vider, a team of health care professionals oper-
 21 ating with such a provider, or a health team as
 22 the woman’s maternity health home for pur-
 23 poses of providing the woman with pregnancy
 24 and postpartum coordinated care services; or

25 “(B) receive such services from a des-
 26 ignated provider, a team of health care profes-

1 sionals operating with such a provider, or a
 2 health team that has voluntarily opted to par-
 3 ticipate in a maternity health home for eligible
 4 women under this section.

5 “(2) ELIGIBLE WOMAN DEFINED.—In this sec-
 6 tion, the term ‘eligible woman’ means an indi-
 7 vidual—

8 “(A) who is eligible for medical assistance
 9 under the State plan (or under a waiver of such
 10 plan) for all items and services covered under
 11 the State plan (or waiver) that are not less in
 12 amount, duration, or scope, or are determined
 13 by the Secretary to be substantially equivalent,
 14 to the medical assistance available for an indi-
 15 vidual described in subsection (a)(10)(A)(i); and

16 “(B) who—

17 “(i) is pregnant; or

18 “(ii) had a pregnancy end within the
 19 last 365 days.

20 “(b) QUALIFICATION STANDARDS.—The Secretary
 21 shall establish standards for qualification as a maternity
 22 health home or as a designated provider, team of health
 23 care professionals operating with such a provider, or a
 24 health team eligible for participation in a maternity health
 25 home for purposes of this section. In establishing such

1 standards, the Secretary shall consider best practices and
2 models of care used by recipients of grants under section
3 330P of the Public Health Service Act. Such standards
4 shall include requiring designated providers, teams of
5 health care professionals operating with such providers,
6 and health teams (designated as a maternity health home)
7 to demonstrate to the State the ability to do the following:

8 “(1) Coordinate prompt care and access to nec-
9 essary maternity care services, including services
10 provided by specialists, and programs for an eligible
11 woman during her pregnancy and the 365-day pe-
12 riod beginning on the last day of her pregnancy.

13 “(2) Develop an individualized, comprehensive,
14 patient-centered care plan for each eligible woman
15 that accommodates patient preferences and, if appli-
16 cable, reflects adjustments to the payment method-
17 ology described in subsection (c)(2)(B).

18 “(3) Develop and incorporate into each eligible
19 woman’s care plan, in a culturally and linguistically
20 appropriate manner consistent with the needs of the
21 eligible woman, ongoing home care, community-
22 based primary care, inpatient care, social support
23 services, health-related social needs services, behav-
24 ioral health services, local hospital emergency care,
25 and, in the event of a change in income that would

1 result in the eligible woman losing eligibility for
2 medical assistance under the State plan or waiver,
3 care management and planning related to a change
4 in the eligible woman's health insurance coverage.

5 “(4) Coordinate with pediatric care providers,
6 as appropriate.

7 “(5) Collect and report information under sub-
8 section (f)(1).

9 “(c) PAYMENTS.—

10 “(1) IN GENERAL.—A State shall provide a des-
11 ignated provider, a team of health care professionals
12 operating with such a provider, or a health team
13 with payments for the provision of pregnancy and
14 postpartum coordinated care services, to each eligi-
15 ble woman that selects such provider, team of health
16 care professionals, or health team as the woman's
17 maternity health home or care provider. Payments
18 made to a maternity health home or care provider
19 for such services shall be treated as medical assist-
20 ance for purposes of section 1903(a).

21 “(2) METHODOLOGY.—The State shall specify
22 in the State plan amendment the methodology the
23 State will use for determining payment for the provi-
24 sion of pregnancy and postpartum coordinated care
25 services or treatment during an eligible woman's

1 pregnancy and the 365-day period beginning on the
2 last day of her pregnancy. Such methodology for de-
3 termining payment—

4 “(A) may be based on—

5 “(i) a per-member per-month basis for
6 each eligible woman enrolled in the mater-
7 nity health home;

8 “(ii) a prospective payment model, in
9 the case of payments to Federally qualified
10 health centers or a rural health clinics; or

11 “(iii) an alternate model of payment
12 (which may include a model developed
13 under a waiver under section 1115) pro-
14 posed by the State and approved by the
15 Secretary;

16 “(B) may be adjusted to reflect, with re-
17 spect to each eligible woman—

18 “(i) the severity of the risks associ-
19 ated with the woman’s pregnancy;

20 “(ii) the severity of the risks associ-
21 ated with the woman’s postpartum health
22 care needs; and

23 “(iii) the level or amount of time of
24 care coordination required with respect to
25 the woman; and

1 “(C) shall be established consistent with
2 section 1902(a)(30)(A).

3 “(d) COORDINATING CARE.—

4 “(1) HOSPITAL NOTIFICATION.—A State with a
5 State plan amendment approved under this section
6 shall require each hospital that is a participating
7 provider under the State plan (or under a waiver of
8 such plan) to establish procedures in the case of an
9 eligible woman who seeks treatment in the emer-
10 gency department of such hospital for—

11 “(A) providing the woman with culturally
12 and linguistically appropriate information on
13 the respective treatment models and opportuni-
14 ties for the woman to access a maternity health
15 home and its associated benefits; and

16 “(B) notifying the maternity health home
17 in which the woman is enrolled, or the des-
18 ignated provider, team of health care profes-
19 sionals operating with such a provider, or
20 health team treating the woman, of the wom-
21 an’s treatment in the emergency department
22 and of the protocols for the maternity health
23 home, designated provider, or team to be in-
24 volved in the woman’s emergency care or post-
25 discharge care.

1 “(2) EDUCATION WITH RESPECT TO AVAIL-
2 ABILITY OF A MATERNITY HEALTH HOME.—

3 “(A) IN GENERAL.—In order for a State
4 plan amendment to be approved under this sec-
5 tion, a State shall include in the State plan
6 amendment a description of the State’s process
7 for—

8 “(i) educating providers participating
9 in the State plan (or a waiver of such
10 plan) on the availability of maternity
11 health homes for eligible women, including
12 the process by which such providers can
13 participate in or refer eligible women to an
14 approved maternity health home or a des-
15 ignated provider, team of health care pro-
16 fessionals operating such a provider, or
17 health team; and

18 “(ii) educating eligible women, in a
19 culturally and linguistically appropriate
20 manner, on the availability of maternity
21 health homes.

22 “(B) OUTREACH.—The process established
23 by the State under subparagraph (A) shall in-
24 clude the participation of entities or other pub-
25 lic or private organizations or entities that pro-

1 vide outreach and information on the avail-
2 ability of health care items and services to fami-
3 lies of individuals eligible to receive medical as-
4 sistance under the State plan (or a waiver of
5 such plan).

6 “(3) MENTAL HEALTH COORDINATION.—A
7 State with a State plan amendment approved under
8 this section shall consult and coordinate, as appro-
9 priate, with the Secretary in addressing issues re-
10 garding the prevention, identification, and treatment
11 of mental health conditions and substance use dis-
12 orders among eligible women.

13 “(4) SOCIAL AND SUPPORT SERVICES.—A State
14 with a State plan amendment approved under this
15 section shall consult and coordinate, as appropriate,
16 with the Secretary in establishing means to connect
17 eligible women receiving pregnancy and postpartum
18 coordinated care services under this section with so-
19 cial and support services, including services made
20 available under maternal, infant, and early childhood
21 home visiting programs established under section
22 511, and services made available under section
23 330H or title X of the Public Health Service Act.

24 “(e) MONITORING.—A State shall include in the
25 State plan amendment—

1 “(1) a methodology for tracking reductions in
2 inpatient days and reductions in the total cost of
3 care resulting from improved care coordination and
4 management under this section;

5 “(2) a proposal for use of health information
6 technology in providing an eligible woman with preg-
7 nancy and postpartum coordinated care services as
8 specified under this section and improving service
9 delivery and coordination across the care continuum;
10 and

11 “(3) a methodology for tracking prompt and
12 timely access to medically necessary care for eligible
13 women from out-of-State providers.

14 “(f) DATA COLLECTION.—

15 “(1) PROVIDER REPORTING REQUIREMENTS.—
16 In order to receive payments from a State under
17 subsection (c), a maternity health home, or a des-
18 ignated provider, a team of health care professionals
19 operating with such a provider, or a health team,
20 shall report to the State, at such time and in such
21 form and manner as may be required by the State,
22 including through a health information exchange or
23 other public health data sharing entity, the following
24 information:

1 “(A) With respect to each such designated
 2 provider, team of health care professionals oper-
 3 ating with such a provider, and health team
 4 (designated as a maternity health home), the
 5 name, National Provider Identification number,
 6 address, and specific health care services of-
 7 fered to be provided to eligible women who have
 8 selected such provider, team of health care pro-
 9 fessionals, or health team as the women’s ma-
 10 ternity health home.

11 “(B) Information on measures from the
 12 core sets of child health quality measures and
 13 adult health quality measures under sections
 14 1139A and 1139B that are identified by the
 15 Secretary as being relevant to maternal,
 16 perinatal, or infant health.

17 “(C) Information on all other applicable
 18 measures for determining the quality of services
 19 provided by such provider, team of health care
 20 professionals, or health team.

21 “(D) Such other information as the Sec-
 22 retary shall specify in guidance.

23 “(2) STATE REPORTING REQUIREMENTS.—

24 “(A) COMPREHENSIVE REPORT.—A State
 25 with a State plan amendment approved under

1 this section shall report to the Secretary (and,
2 upon request, to the Medicaid and CHIP Pay-
3 ment and Access Commission), at such time,
4 but at a minimum frequency of every 12
5 months, and in such form and manner deter-
6 mined by the Secretary to be reasonable and
7 minimally burdensome, including through a
8 health information exchange or other public
9 health data sharing entity, the following infor-
10 mation:

11 “(i) Information described in para-
12 graph (1).

13 “(ii) The number and, to the extent
14 available and while maintaining all relevant
15 protecting privacy and confidentially pro-
16 tections, disaggregated demographic infor-
17 mation of eligible women who have enrolled
18 in a maternity health home pursuant to
19 this section.

20 “(iii) The number of maternity health
21 homes in the State.

22 “(iv) The medical conditions or fac-
23 tors that contribute to severe maternal
24 morbidity among eligible women enrolled in
25 maternity health homes in the State.

1 “(v) The extent to which such women
2 receive health care items and services
3 under the State plan before, during, and
4 after the women’s enrollment in such a
5 maternity health home.

6 “(vi) Where applicable, mortality data
7 and data for the associated causes of death
8 for eligible women enrolled in a maternity
9 health home under this section, in accord-
10 ance with subsection (g). For deaths occur-
11 ring postpartum, such data shall distin-
12 guish between deaths occurring up to 42
13 days postpartum and deaths occurring be-
14 tween 43 days to up to 1 year postpartum.
15 Where applicable, data reported under this
16 clause shall be reported alongside com-
17 parable data from a State’s maternal mor-
18 tality review committee, as established in
19 accordance with section 317K(d) of the
20 Public Health Service Act, for purposes of
21 further identifying and comparing state-
22 wide trends in maternal mortality among
23 populations participating in the maternity
24 health home under this section.

1 “(B) IMPLEMENTATION REPORT.—Not
 2 later than 18 months after a State has a State
 3 plan amendment approved under this section,
 4 the State shall submit to the Secretary, and
 5 make publicly available on the appropriate
 6 State website, a report on how the State is im-
 7 plementing the option established under this
 8 section, including through any best practices
 9 adopted by the State.

10 “(g) CONFIDENTIALITY.—A State with a State plan
 11 amendment under this section shall establish confiden-
 12 tiality protections for the purposes of subsection (f)(2)(A)
 13 to ensure, at a minimum, that there is no disclosure by
 14 the State of any identifying information about any specific
 15 eligible woman enrolled in a maternity health home or any
 16 maternal mortality case, and that all relevant confiden-
 17 tiality and privacy protections, including the requirements
 18 under 1902(a)(7)(A), are maintained.

19 “(h) RULE OF CONSTRUCTION.—Nothing in this sec-
 20 tion shall be construed to require—

21 “(1) an eligible woman to enroll in a maternity
 22 health home under this section; or

23 “(2) a designated provider or health team to
 24 act as a maternity health home and provide services
 25 in accordance with this section if the provider or

1 health team does not voluntarily agree to act as a
2 maternity health home.

3 “(i) PLANNING GRANTS.—

4 “(1) IN GENERAL.—Beginning October 1,
5 2027, from the amount appropriated under para-
6 graph (2), the Secretary shall award planning grants
7 to States for purposes of developing and submitting
8 a State plan amendment under this section. The
9 Secretary shall award a grant to each State that ap-
10 plies for a grant under this subsection, but the Sec-
11 retary may determine the amount of the grant based
12 on the merits of the application and the goal of the
13 State to prioritize health outcomes for eligible
14 women. A planning grant awarded to a State under
15 this subsection shall remain available until expended.

16 “(2) APPROPRIATION.—There are authorized to
17 be appropriated to the Secretary \$50,000,000 for
18 the period of fiscal years 2026 through 2028, for the
19 purposes of making grants under this subsection, to
20 remain available until expended.

21 “(3) LIMITATION.—The total amount of pay-
22 ments made to States under this subsection shall not
23 exceed \$50,000,000.

24 “(j) ADDITIONAL DEFINITIONS.—In this section:

1 “(1) DESIGNATED PROVIDER.—The term ‘des-
2 ignated provider’ means a physician (including an
3 obstetrician-gynecologist), hospital, clinical practice
4 or clinical group practice, a medicaid managed care
5 organization, as defined in section 1903(m)(1)(A), a
6 prepaid inpatient health plan, as defined in section
7 438.2 of title 42, Code of Federal Regulations (or
8 any successor regulation), a prepaid ambulatory
9 health plan, as defined in such section (or any suc-
10 cessor regulation), rural clinic, community health
11 center, community mental health center, or any
12 other entity or provider that is determined by the
13 State and approved by the Secretary to be qualified
14 to be a maternity health home on the basis of docu-
15 mentation evidencing that the entity has the sys-
16 tems, expertise, and infrastructure in place to pro-
17 vide pregnancy and postpartum coordinated care
18 services. Such term may include providers who are
19 employed by, or affiliated with, a hospital.

20 “(2) MATERNITY HEALTH HOME.—The term
21 ‘maternity health home’ means a designated provider
22 (including a provider that operates in coordination
23 with a team of health care professionals) or a health
24 team is selected by an eligible woman to provide
25 pregnancy and postpartum coordinated care services.

1 “(3) HEALTH TEAM.—The term ‘health team’
2 has the meaning given such term for purposes of
3 section 3502 of Public Law 111–148.

4 “(4) PREGNANCY AND POSTPARTUM COORDI-
5 NATED CARE SERVICES.—

6 “(A) IN GENERAL.—The term ‘pregnancy
7 and postpartum coordinated care services’
8 means items and services related to the coordi-
9 nation of care for comprehensive and timely
10 high-quality, culturally and linguistically appro-
11 priate, services described in subparagraph (B)
12 that are provided by a designated provider, a
13 team of health care professionals operating with
14 such a provider, or a health team (designated
15 as a maternity health home).

16 “(B) SERVICES DESCRIBED.—

17 “(i) IN GENERAL.—The services de-
18 scribed in this subparagraph shall include
19 with respect to a State electing the State
20 plan amendment option under this section,
21 any medical assistance for items and serv-
22 ices for which payment is available under
23 the State plan or under a waiver of such
24 plan.

1 “(ii) OTHER ITEMS AND SERVICES.—

2 In addition to medical assistance described
3 in clause (i), the services described in this
4 subparagraph shall include the following:

5 “(I) Any item or service for
6 which medical assistance is otherwise
7 available under the State plan (or a
8 waiver of such plan) related to the
9 treatment of a woman during the
10 woman’s pregnancy and the 1-year pe-
11 riod beginning on the last day of her
12 pregnancy, including mental health
13 and substance use disorder services.

14 “(II) Comprehensive care man-
15 agement.

16 “(III) Care coordination (includ-
17 ing with pediatricians as appropriate),
18 health promotion, and providing ac-
19 cess to the full range of maternal, ob-
20 stetric, and gynecologic services, in-
21 cluding services from out-of-State pro-
22 viders.

23 “(IV) Comprehensive transitional
24 care, including appropriate follow-up,
25 from inpatient to other settings.

1 “(V) Patient and family support
2 (including authorized representatives).

3 “(VI) Referrals to community
4 and social support services, if rel-
5 evant.

6 “(VII) Use of health information
7 technology to link services, as feasible
8 and appropriate.

9 “(5) TEAM OF HEALTH CARE PROFES-
10 SIONALS.—The term ‘team of health care profes-
11 sionals’ means a team of health care professionals
12 (as described in the State plan amendment under
13 this section) that may—

14 “(A) include—

15 “(i) physicians, including gynecologist-
16 obstetricians, pediatricians, and other pro-
17 fessionals such as physicians assistants,
18 advance practice nurses, including certified
19 nurse midwives, nurses, nurse care coordi-
20 nators, dietitians, nutritionists, social
21 workers, behavioral health professionals,
22 physical counselors, physical therapists, oc-
23 cupational therapists, or any professionals
24 that assist in prenatal care, delivery, or
25 postpartum care for which medical assist-

1 ance is available under the State plan or a
2 waiver of such plan and determined to be
3 appropriate by the State and approved by
4 the Secretary;

5 “(ii) an entity or individual who is
6 designated to coordinate such care deliv-
7 ered by the team; and

8 “(iii) when appropriate and if other-
9 wise eligible to furnish items and services
10 that are reimbursable as medical assist-
11 ance under the State plan or under a waiv-
12 er of such plan, doulas, community health
13 workers, translators and interpreters, and
14 other individuals with culturally appro-
15 priate and trauma-informed expertise; and

16 “(B) provide care at a facility that is free-
17 standing, virtual, or based at a hospital, com-
18 munity health center, community mental health
19 center, rural clinic, clinical practice or clinical
20 group practice, academic health center, or any
21 entity determined to be appropriate by the
22 State and approved by the Secretary.”.

1 **SEC. 6. GUIDANCE ON CARE COORDINATION TO SUPPORT**
2 **MATERNAL HEALTH.**

3 Not later than 2 years after the date of enactment
4 of this Act, the Secretary shall issue guidance for State
5 Medicaid programs on improved care coordination, con-
6 tinuity of care, and clinical integration to support the
7 needs of pregnant and postpartum women for services eli-
8 gible for Medicaid payment. Such guidance shall identify
9 best practices for care coordination for such women, both
10 with respect to fee-for-service State Medicaid programs
11 and State Medicaid programs that contract with Medicaid
12 managed care organizations or other specified entities to
13 furnish medical assistance for such women, and shall illus-
14 trate strategies for—

15 (1) enhancing primary care and maternity care
16 coordination with specialists, including cardiologists,
17 specialists in gestational diabetes, dentists, lactation
18 specialists, genetic counselors, and behavioral health
19 providers;

20 (2) integrating behavioral health providers to
21 provide screening, assessment, treatment, and refer-
22 ral for behavioral health needs, including substance
23 use disorders, maternal depression, anxiety, intimate
24 partner violence, and other trauma;

25 (3) integrating into care teams or coordinating
26 with nonclinical professionals, including (if licensed

1 or credentialed by a State or State-authorized orga-
 2 nization) doulas, peer support specialists, and com-
 3 munity health workers, and how these services pro-
 4 vided by such professionals may be eligible for Fed-
 5 eral financial participation under Medicaid;

6 (4) screening pregnant and postpartum women
 7 for social needs and coordinating related services
 8 during the prenatal and postpartum periods to en-
 9 sure social and physical supports are provided for
 10 such women during such periods and for their chil-
 11 dren;

12 (5) supporting women who have had a stillbirth;

13 (6) screening for maternal health, behavioral
 14 health, and social needs during well-child and pedi-
 15 atric care visits; and

16 (7) streamlining and reducing duplication in
 17 care coordination efforts across and among pro-
 18 viders, plans, and other entities for such women.

19 **SEC. 7. NATIONAL RESKILLING OF THE MATERNITY CARE**
 20 **WORKFORCE.**

21 Part B of title III of the Public Health Service Act
 22 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
 23 tion 317L–1 the following:

1 **“SEC. 317L-2. NATIONAL RESKILLING OF THE MATERNITY**
2 **CARE WORKFORCE.**

3 “(a) ESTABLISHMENT OF NATIONAL EXPERT
4 GROUP.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish a national expert group to evaluate national
7 education on, and practice of, best birthing prac-
8 tices.

9 “(2) MEMBERS.—

10 “(A) IN GENERAL.—The group established
11 under paragraph (1) shall be composed of such
12 members as the Secretary appoints, including—

13 “(i) obstetricians and gynecologists,
14 family medicine physicians, midwives, and
15 nursing leaders;

16 “(ii) hospital administrators;

17 “(iii) graduate medical education lead-
18 ers;

19 “(iv) doula leaders;

20 “(v) individuals with experience in
21 community birth settings;

22 “(vi) patients;

23 “(vii) high-risk birth experts; and

24 “(viii) quality improvement leaders.

25 “(B) GEOGRAPHIC DIVERSITY.—In ap-
26 pointing members under subparagraph (A), the

1 Secretary shall ensure a balance of members
2 representing rural areas and members rep-
3 resenting urban areas.

4 “(b) DUTIES.—The group established under sub-
5 section (a) shall—

6 “(1) examine evidence, trends, and differential
7 use or access by income, geographic area, and race
8 and ethnicity associated with birthing practices that
9 include—

10 “(A) cesarean sections, repeat cesarean,
11 and vaginal birth after cesarean;

12 “(B) electronic fetal monitoring and inter-
13 mittent auscultation;

14 “(C) birth positions, including upright po-
15 sitioning and ambulation;

16 “(D) labor with doula support;

17 “(E) evaluating indications for cesarean
18 delivery, including cervical dilation and duration
19 of pushing;

20 “(F) operative vaginal deliveries;

21 “(G) manual fetal rotation;

22 “(H) amniocentesis and scalp stimulation;

23 and

24 “(I) cervical ripening methods;

1 “(2) assess the role of the culture of care, ma-
 2 ternity care financing, and health education with re-
 3 spect to the trends under paragraph (1); and

4 “(3) identify case studies of the provision of ex-
 5 emplary birthing care.

6 “(c) RECOMMENDATIONS.—The group established
 7 under subsection (a) shall, not later than 1 year after such
 8 establishment, issue—

9 “(1) best practices for—

10 “(A) evaluating birthing skills;

11 “(B) improving curricula for health profes-
 12 sionals engaged in birthing; and

13 “(C) the incorporation of midwives and
 14 doulas into residency curricula for obstetricians;
 15 and

16 “(2) recommendations for policies and practices
 17 to improve maternity care overall.”.

18 **SEC. 8. MACPAC STUDY ON DOULAS AND COMMUNITY**
 19 **HEALTH WORKERS; GUIDANCE ON INCREAS-**
 20 **ING ACCESS TO DOULA SERVICES UNDER**
 21 **MEDICAID.**

22 (a) MACPAC STUDY ON DOULAS AND COMMUNITY
 23 HEALTH WORKERS.—

24 (1) IN GENERAL.—As part of the first report
 25 required under section 1900(b)(1) of the Social Se-

1 security Act (42 U.S.C. 1396(b)(1)) after the date
2 that is 1 year after the date of enactment of this
3 Act, the Medicaid and CHIP Payment and Access
4 Commission (referred to in this section as
5 “MACPAC”) shall include with such report a report
6 on the coverage of doula services and the role of
7 community health workers under State Medicaid
8 programs, which shall include the following:

9 (A) Information about coverage for doula
10 services and community health worker services
11 under State Medicaid programs that currently
12 provide coverage for such services, including the
13 type of doula services offered (such as prenatal,
14 labor and delivery, postpartum support, and
15 traditional doula services) and information on
16 the prevalence of doulas that care for individ-
17 uals in their own communities.

18 (B) An analysis of strategies to facilitate
19 the appropriate use of doula services in order to
20 provide better care and achieve better maternal
21 and infant health outcomes, including strategies
22 that States may use to assist with services for
23 which Federal financial participation is eligible
24 under a State Medicaid plan or a waiver of such
25 a plan by recruiting, training, and certifying a

1 diverse doula workforce, particularly from un-
 2 derserved communities, communities of color,
 3 and communities facing linguistic or cultural
 4 barriers.

5 (C) Provide examples of community health
 6 worker access in State Medicaid programs and
 7 strategies employed by States to encourage a
 8 broad care team to manage Medicaid patients.

9 (D) An assessment of the impact of the in-
 10 volvement of doulas and community health
 11 workers on maternal health outcomes.

12 (E) Recommendations, as MACPAC deems
 13 appropriate, for legislative and administrative
 14 actions to increase access to services that im-
 15 prove maternal health.

16 (2) STAKEHOLDER CONSULTATION.—In devel-
 17 oping the report required under paragraph (1),
 18 MACPAC shall consult with relevant stakeholders.

19 (b) GUIDANCE ON INCREASING ACCESS TO DOULA
 20 SERVICES UNDER MEDICAID.—

21 (1) IN GENERAL.—Not later than 1 year after
 22 the date that MACPAC publishes the report re-
 23 quired under subsection (a), the Secretary shall
 24 issue guidance to States on increasing access to

1 doula services under Medicaid. Such guidance shall
2 at a minimum include—

3 (A) options for States to provide medical
4 assistance for doula services under State Med-
5 icaid programs;

6 (B) best practices for ensuring that doulas,
7 including community-based doulas, receive reim-
8 bursement for doula services provided under a
9 State Medicaid program, at a level that allows
10 doulas to earn a living wage that accounts for
11 their time and costs associated with providing
12 care and community-based doula program ad-
13 ministration; and

14 (C) best practices for increasing access to
15 doula services, including services provided by
16 community-based doulas, under State Medicaid
17 programs.

18 (2) STAKEHOLDER CONSULTATION.—In devel-
19 oping the report required under paragraph (1), the
20 Secretary shall consult with relevant stakeholders.

21 (c) RELEVANT STAKEHOLDERS.—For purposes of
22 subsections (a)(2) and (b)(2), relevant stakeholders shall
23 include—

24 (1) States;

1 (2) organizations representing consumers, in-
 2 cluding those that are disproportionately impacted
 3 by poor maternal health outcomes;

4 (3) organizations and individuals representing
 5 doula services providers and community health work-
 6 ers, including community-based doula programs and
 7 those who serve underserved communities, commu-
 8 nities of color and communities facing linguistic or
 9 cultural barriers; and

10 (4) organizations representing health care pro-
 11 viders.

12 **SEC. 9. DEMONSTRATION PROJECTS TO IMPROVE THE DE-**
 13 **LIVERY OF MATERNAL HEALTH CARE**
 14 **THROUGH TELEHEALTH.**

15 (a) IN GENERAL.—Not later than 18 months after
 16 the date of enactment of this Act, the Secretary shall
 17 award grants to States to conduct demonstration projects
 18 under this section that are designed to expand the use of
 19 telehealth in State Medicaid programs for the delivery of
 20 health care to eligible pregnant or postpartum women.

21 (b) ELIGIBLE PREGNANT OR POSTPARTUM WOMAN
 22 DEFINED.—

23 (1) IN GENERAL.—In this section, the term “el-
 24 igible pregnant or postpartum woman” means a
 25 woman who is eligible for and receiving medical as-

1 sistance under a State Medicaid plan (or waiver of
2 such plan) and who is or becomes pregnant.

3 (2) POSTPARTUM WOMEN.—Such term includes
4 a woman described in paragraph (1) through the
5 end of the month in which the 365-day period begin-
6 ning on the last day of the woman’s pregnancy ends,
7 without regard to any change in income of the fam-
8 ily of which she is a member.

9 (c) APPLICATION; SELECTION OF STATES; DURA-
10 TION.—

11 (1) APPLICATION.—

12 (A) IN GENERAL.—To conduct a dem-
13 onstration project under this section, a State
14 shall submit an application to the Secretary at
15 such time and in such manner as the Secretary
16 shall require. Under the demonstration project,
17 a State may include multiple proposed uses of
18 grant funds, and propose to focus on multiple
19 populations, as otherwise allowable under this
20 section, within a single application.

21 (B) REQUIRED INFORMATION.—A State
22 application to conduct a demonstration project
23 under this section shall include the following:

24 (i) The population (such as individ-
25 uals residing in rural or medically under-

1 served areas) that the demonstration
2 project will target.

3 (ii) A description of how the State
4 proposes to use funds awarded under this
5 section to conduct the demonstration
6 project to integrate or increase the integra-
7 tion of telehealth into the State Medicaid
8 program's existing delivery system for fur-
9 nishing medical assistance to and improv-
10 ing the health care outcomes of eligible
11 pregnant or postpartum women.

12 (iii) A description of how the State
13 will use funds to address racial or ethnic
14 disparities in access to maternal health
15 services or maternal health outcomes, bar-
16 riers to care, including in rural or medi-
17 cally underserved communities, other bar-
18 riers to using telehealth, such as those ex-
19 perienceed by individuals with disabilities
20 and individuals with limited English pro-
21 ficiency, and as applicable, barriers to the
22 use of telehealth in tribal communities.

23 (iv) A certification that the applica-
24 tion meets the requirements of subpara-
25 graph (C).

1 (v) Such other information as the Sec-
2 retary shall require.

3 (C) CONSULTATION WITH HEALTH CARE
4 STAKEHOLDERS.—Prior to the submission of an
5 application to conduct a demonstration project
6 under this section, a State shall consult with
7 health care systems and providers, health plans
8 (if relevant), consumer organizations and bene-
9 ficiary advocates, and community-based organi-
10 zations or other stakeholders in the area that
11 the demonstration project will target to ensure
12 that the proposed project addresses the health
13 care needs of eligible pregnant or postpartum
14 women in such area.

15 (2) SELECTION OF STATES AND DURATION OF
16 PROJECTS.—

17 (A) IN GENERAL.—The Secretary shall
18 award grants to States that apply and meet the
19 application requirements to conduct 4-year
20 demonstration projects under this section. A
21 State may request, and the Secretary shall de-
22 termine the appropriateness of, an application
23 of up to \$10,000,000.

24 (B) SELECTION OF PROJECTS.—In select-
25 ing a State to conduct a demonstration project

1 under this section, the Secretary shall ensure
 2 that the State is aware of the 4-year duration
 3 of the project and shall determine the State has
 4 satisfied the application requirements.

5 (3) WAIVER OF STATEWIDENESS AND COM-
 6 PARABILITY REQUIREMENT.—The Secretary shall
 7 waive compliance with section 1902(a)(1) of the So-
 8 cial Security Act (42 U.S.C. 1396a(a)(1)) (relating
 9 to statewideness) and section 1902(a)(10)(B) of
 10 such Act (42 U.S.C. 1396a(a)(10)(B)) (relating to
 11 comparability) to the extent necessary to allow se-
 12 lected States to conduct demonstration projects
 13 under this section.

14 (d) USE OF GRANT FUNDS.—A State may use funds
 15 from a grant awarded under this section to connect eligible
 16 pregnant or postpartum women to telehealth services de-
 17 livered via telehealth that are furnished by—

- 18 (1) primary and maternity care providers;
 - 19 (2) health care specialists;
 - 20 (3) behavioral health providers; and
 - 21 (4) other categories of health care providers
- 22 identified by the Secretary.

23 (e) REPORTS.—

- 24 (1) STATE REPORTS.—Each State that is
- 25 awarded a grant to conduct a demonstration project

1 under this section shall submit the following reports
2 to the Secretary:

3 (A) INITIAL REPORT.—An initial report on
4 the first 18 months during which the dem-
5 onstration project is conducted, not later than
6 the last day of the 19th month of the dem-
7 onstration project, as described in subpara-
8 graph (B).

9 (B) FINAL REPORT.—Not later than 6
10 months after the date on which the State's
11 demonstration project ends, a final report that
12 includes the following:

13 (i) The number of eligible pregnant or
14 postpartum women served under the dem-
15 onstration project.

16 (ii) The activities and services funded
17 under the demonstration project, including
18 the providers that received funds under the
19 demonstration project.

20 (iii) Demographic information about
21 the eligible pregnant or postpartum women
22 served under the demonstration project, if
23 available.

1 (iv) A description of the types of mod-
 2 els or programs developed under the dem-
 3 onstration project.

4 (v) How such models or programs im-
 5 pacted access to, and utilization of, tele-
 6 health services by eligible pregnant or
 7 postpartum women, including a description
 8 of how such models or programs addressed
 9 racial or ethnic disparities in access or uti-
 10 lization.

11 (vi) Qualitative information on bene-
 12 ficiary experience.

13 (vii) Challenges faced and lessons
 14 learned by the State in integrating (or in-
 15 creasing the integration of) telehealth into
 16 the delivery system for furnishing medical
 17 assistance to eligible pregnant or
 18 postpartum women in the areas targeted
 19 under the demonstration project.

20 (2) REPORTS TO CONGRESS.—

21 (A) INITIAL REPORT.—Not later than 2
 22 years after the date of enactment of this Act,
 23 the Secretary shall submit a report to Congress
 24 summarizing the information reported by States
 25 under paragraph (1)(A).

1 (B) FINAL REPORT.—Not later than 5
 2 years after the date of enactment of this Act,
 3 the Secretary shall submit a report to Congress
 4 summarizing the information reported by States
 5 under paragraph (1)(B).

6 **SEC. 10. CMS REPORT ON COVERAGE OF REMOTE PHYSIO-**
 7 **LOGIC MONITORING DEVICES AND IMPACT**
 8 **ON MATERNAL AND CHILD HEALTH OUT-**
 9 **COMES UNDER MEDICAID.**

10 (a) IN GENERAL.—Not later than 18 months after
 11 the date of enactment of this Act, the Secretary shall sub-
 12 mit to Congress a report containing information on au-
 13 thorities and State practices for covering remote physio-
 14 logical monitoring devices, including limitations and bar-
 15 riers to such coverage and the impact on maternal health
 16 outcomes, and to the extent appropriate, recommendations
 17 on how to address such limitations or barriers related to
 18 coverage of remote physiologic devices under State Med-
 19 icaid programs, including, but not limited to, pulse
 20 oximeters, blood pressure cuffs, scales, and blood glucose
 21 monitors, with the goal of improving maternal and child
 22 health outcomes for pregnant and postpartum women en-
 23 rolled in State Medicaid programs.

24 (b) STATE RESOURCES.—Not later than 6 months
 25 after the submission of the report required by subsection

1 (a), the Secretary shall update resources for State Med-
2 icaid programs, such as State Medicaid telehealth toolkits,
3 to be consistent with the recommendations provided in
4 such report.

5 **SEC. 11. GUIDANCE ON COMMUNITY-BASED MATERNAL**
6 **HEALTH PROGRAMS.**

7 Not later than 3 years after the date of enactment
8 of this Act, the Secretary shall issue guidance to State
9 Medicaid programs to support the use of evidence-based
10 community-based maternal health programs, including
11 programs that offer group prenatal care, home visiting
12 services, childbirth and parenting education, peer sup-
13 ports, stillbirth prevention activities, and substance use
14 disorder and recovery supports, under such programs, and
15 any other programs as determined by the Secretary.

16 **SEC. 12. DEVELOPING GUIDANCE ON MATERNAL MOR-**
17 **TALITY AND SEVERE MORBIDITY REDUCTION**
18 **FOR MATERNAL CARE PROVIDERS RECEIV-**
19 **ING PAYMENT UNDER THE MEDICAID PRO-**
20 **GRAM.**

21 (a) IN GENERAL.—Subject to the availability of ap-
22 propriations, not later than 36 months after the date of
23 enactment of this Act, the Secretary shall, in consultation
24 with the Advisory Committee on Reducing Maternal
25 Deaths established under subsection (c) and the Task

1 Force on Maternal Mental Health established under sec-
 2 tion 1113 of division FF of the Consolidated Appropria-
 3 tions Act, 2023 (Public Law 117–328), publish on a public
 4 website of the Centers for Medicare & Medicaid Services
 5 guidance for States on resources and strategies for hos-
 6 pitals, freestanding birth centers (as defined in section
 7 1905(l)(3)(B) of the Social Security Act (42 U.S.C.
 8 1396d(l)(3)(B))), and other maternal care providers as de-
 9 termined by the Secretary for reducing maternal mortality
 10 and severe morbidity in individuals who are eligible for
 11 and receiving medical assistance under Medicaid or CHIP.

12 (b) UPDATES.—The Secretary shall, in consultation
 13 with the Advisory Committee on Reducing Maternal
 14 Deaths established under subsection (c) and the Task
 15 Force on Maternal Mental Health established under sec-
 16 tion 1113 of division FF of the Consolidated Appropria-
 17 tions Act, 2023 (Public Law 117–328), update the guid-
 18 ance and resources described in subsection (a) at least
 19 once every 3 years.

20 (c) CONSULTATION WITH ADVISORY COMMITTEE.—

21 (1) ESTABLISHMENT.—Subject to the avail-
 22 ability of appropriations, not later than 18 months
 23 after the date of enactment of this Act, the Sec-
 24 retary shall establish an advisory committee to be
 25 known as the “National Advisory Committee on Re-

1 ducing Maternal Deaths” (referred to in this section
2 as the “Advisory Committee”).

3 (2) DUTIES.—The Advisory Committee shall
4 provide consensus advice and guidance to the Sec-
5 retary on the development and compilation of the
6 guidance described in subsection (a) (and any up-
7 dates to such guidance).

8 (3) MEMBERSHIP.—

9 (A) IN GENERAL.—The Secretary, in con-
10 sultation with such other heads of agencies, as
11 the Secretary deems appropriate and in accord-
12 ance with this paragraph, shall appoint not
13 more than 41 members to the Advisory Com-
14 mittee. In appointing such members, the Sec-
15 retary shall ensure that—

16 (i) the total number of members of
17 the Advisory Committee is an odd number;
18 and

19 (ii) the total number of voting mem-
20 bers who are not Federal officials does not
21 exceed the total number of voting Federal
22 members who are Federal officials.

23 (B) REQUIRED MEMBERS.—

24 (i) FEDERAL OFFICIALS.—The Advi-
25 sory Committee shall include as voting

1 members the following Federal officials, or
2 their designees:

3 (I) The Secretary.

4 (II) The Administrator of the
5 Centers for Medicare & Medicaid
6 Services.

7 (III) The Director of the Centers
8 for Disease Control and Prevention.

9 (IV) The Associate Administrator
10 of the Maternal and Child Health Bu-
11 reau of the Health Resources and
12 Services Administration.

13 (V) The Director of the Agency
14 for Healthcare Research and Quality.

15 (VI) The National Coordinator
16 for Health Information Technology.

17 (VII) The Director of the Na-
18 tional Institutes of Health.

19 (VIII) The Secretary of Veterans
20 Affairs.

21 (IX) The Director of the Indian
22 Health Service.

23 (X) The Deputy Assistant Sec-
24 retary for Minority Health.

1 (XI) The Administrator of the
2 Substance Abuse and Mental Health
3 Services Administration.

4 (XII) The Deputy Assistant Sec-
5 retary for Women's Health.

6 (XIII) Such other Federal offi-
7 cials or their designees as the Sec-
8 retary determines appropriate.

9 (ii) NON-FEDERAL OFFICIALS.—

10 (I) IN GENERAL.—The Advisory
11 Committee shall include the following
12 as voting members:

13 (aa) At least 1 representa-
14 tive from a professional organiza-
15 tion representing hospitals and
16 health systems.

17 (bb) At least 1 representa-
18 tive from a medical professional
19 organization representing pri-
20 mary care providers.

21 (cc) At least 1 representa-
22 tive from a medical professional
23 organization representing general
24 obstetrician-gynecologists.

1 (dd) At least 1 representa-
2 tive from a medical professional
3 organization representing cer-
4 tified nurse-midwives.

5 (ee) At least 1 representa-
6 tive from a medical professional
7 organization representing other
8 maternal fetal medicine pro-
9 viders.

10 (ff) At least 1 representative
11 from a medical professional orga-
12 nization representing anesthesiol-
13 ogists.

14 (gg) At least 1 representa-
15 tive from a medical professional
16 organization representing emer-
17 gency medicine physicians and
18 urgent care providers.

19 (hh) At least 1 representa-
20 tive from a medical professional
21 organization representing nurses.

22 (ii) At least 1 representative
23 from a professional organization
24 representing community health
25 workers.

1 (jj) At least 1 representative
2 from a professional organization
3 representing doulas.

4 (kk) At least 1 representa-
5 tive from a professional organiza-
6 tion representing perinatal psy-
7 chiatrists.

8 (ll) At least 1 representative
9 from State-affiliated programs or
10 existing collaboratives with dem-
11 onstrated expertise or success in
12 improving maternal health.

13 (mm) At least 1 director of
14 a State Medicaid agency that has
15 had demonstrated success in im-
16 proving maternal health.

17 (nn) At least 1 representa-
18 tive from an accrediting organi-
19 zation for maternal health quality
20 and safety standards.

21 (oo) At least 1 representa-
22 tive from a maternal patient ad-
23 vocacy organization with lived ex-
24 perience of severe maternal mor-
25 bidity.

1 (pp) At least 1 medical pro-
2 fessional who is an expert in the
3 treatment of pregnant women
4 with substance use disorder.

5 (II) REQUIREMENTS.—Each in-
6 dividual selected to be a member
7 under this clause shall—

8 (aa) have expertise in mater-
9 nal health;

10 (bb) not be a Federal offi-
11 cial; and

12 (cc) have experience working
13 with populations that are at
14 higher risk for maternal mor-
15 tality or severe morbidity, such
16 as populations that experience
17 racial, ethnic, and geographic
18 health disparities, pregnant and
19 postpartum women experiencing
20 a mental health disorder, or
21 pregnant or postpartum women
22 with other comorbidities such as
23 substance use disorders, hyper-
24 tension, thyroid disorders, and
25 sickle cell disease.

1 (C) ADDITIONAL MEMBERS.—

2 (i) IN GENERAL.—In addition to the
3 members required to be appointed under
4 subparagraph (B), the Secretary may ap-
5 point as non-voting members to the Advi-
6 sory Committee such other individuals with
7 relevant expertise or experience as the Sec-
8 retary shall determine appropriate, which
9 may include, but is not limited to, individ-
10 uals described in clause (ii).

11 (ii) SUGGESTED ADDITIONAL MEM-
12 BERS.—The individuals described in this
13 clause are the following:

14 (I) Representatives from State
15 maternal mortality review committees
16 and perinatal quality collaboratives.

17 (II) Medical providers who care
18 for women and infants during preg-
19 nancy and the postpartum period,
20 such as family practice physicians,
21 cardiologists, pulmonology critical
22 care specialists, endocrinologists, pedi-
23 atricians, and neonatologists.

1 (III) Representatives from State
2 and local public health departments,
3 including State Medicaid Agencies.

4 (IV) Subject matter experts in
5 conducting outreach to women who
6 are African-American or belong to an-
7 other minority group.

8 (V) Directors of State agencies
9 responsible for administering a State's
10 maternal and child health services
11 program under title V of the Social
12 Security Act (42 U.S.C. 701 et seq.).

13 (VI) Experts in medical edu-
14 cation or physician training.

15 (VII) Representatives from Med-
16 icaid managed care organizations.

17 (4) APPLICABILITY OF FACA.—Chapter 10 of
18 title 5, United States Code, shall apply to the com-
19 mittee established under this subsection.

20 (d) CONTENTS.—The guidance described in sub-
21 section (a) shall include, with respect to hospitals, free-
22 standing birth centers, and other maternal care providers,
23 the following:

24 (1) Best practices regarding evidence-based
25 screening and clinician education initiatives relating

1 to screening and treatment protocols for individuals
2 who are at risk of experiencing complications related
3 to pregnancy, with an emphasis on individuals with
4 preconditions directly linked to pregnancy complica-
5 tions and maternal mortality and severe morbidity,
6 including—

7 (A) methods to identify individuals who are
8 at risk of maternal mortality or severe mor-
9 bidity, including risk stratification;

10 (B) evidence-based risk factors associated
11 with maternal mortality or severe morbidity and
12 racial, ethnic, and geographic health disparities;

13 (C) evidence-based strategies to reduce risk
14 factors associated with maternal mortality or
15 severe morbidity through services which may be
16 covered under Medicaid or CHIP, including,
17 but not limited to, activities by community
18 health workers (as such term is defined in sec-
19 tion 2113 of the Social Security Act (42 U.S.C.
20 1397mm)) that are funded by a grant awarded
21 under such section;

22 (D) resources available to such individuals,
23 such as nutrition assistance and education,
24 home visitation, mental health and substance
25 use disorder services, smoking cessation pro-

1 grams, prenatal care, and other evidence-based
2 maternal mortality or severe morbidity reduc-
3 tion programs;

4 (E) examples of educational materials used
5 by providers of obstetrics services;

6 (F) methods for improving community cen-
7 tralized care, including providing telehealth
8 services or home visits to increase and facilitate
9 access to and engagement in prenatal and
10 postpartum care and collaboration with home
11 health agencies, community health centers, local
12 public health departments, or clinics;

13 (G) guidance on medical record diagnosis
14 codes linked to maternal mortality and severe
15 morbidity, including, if applicable, codes related
16 to social risk factors, and methods for edu-
17 cating clinicians on the proper use of such
18 codes;

19 (H) risk appropriate transfer protocols
20 during pregnancy, childbirth, and the
21 postpartum period; and

22 (I) any other information related to pre-
23 vention and treatment of at-risk individuals de-
24 termined appropriate by the Secretary.

1 (2) Guidance on monitoring programs for indi-
2 viduals who have been identified as at risk of com-
3 plications related to pregnancy.

4 (3) Best practices for such hospitals, free-
5 standing birth centers, and providers to make preg-
6 nant women aware of the complications related to
7 pregnancy.

8 (4) A fact sheet for providing pregnant women
9 who are receiving care on an outpatient basis with
10 a notice during the prenatal stage of pregnancy
11 that—

12 (A) explains the risks associated with preg-
13 nancy, birth, and the postpartum period (in-
14 cluding the risks of hemorrhage, preterm birth,
15 sepsis, eclampsia, obstructed labor), chronic
16 conditions (including high blood pressure, dia-
17 betes, heart disease, depression, and obesity)
18 correlated with adverse pregnancy outcomes,
19 risks associated with advanced maternal age,
20 and the importance of adhering to a personal-
21 ized plan of care;

22 (B) highlights multimodal and evidence-
23 based prevention and treatment techniques;

24 (C) highlights evidence-based programs
25 and activities to reduce the incidence of still-

1 birth (including tracking and awareness of fetal
2 movements, improvement of birth timing for
3 pregnancies with risk factors, initiatives that
4 encourage safe sleeping positions during preg-
5 nancy, screening and surveillance for fetal
6 growth restriction, efforts to achieve smoking
7 cessation during pregnancy, community-based
8 programs that provide home visits or other
9 types of support, and any other research or evi-
10 dence-based programming to prevent still-
11 births);

12 (D) provides for a method (through signa-
13 ture or otherwise) for such an individual, or a
14 person acting on such individual's behalf, to ac-
15 knowledge receipt of such fact sheet;

16 (E) is worded in an easily understandable
17 manner and made available in multiple lan-
18 guages and accessible formats determined ap-
19 propriate by the Secretary; and

20 (F) includes any other information deter-
21 mined appropriate by the Secretary.

22 (5) A template for a voluntary clinician check-
23 list that outlines the minimum responsibilities that
24 clinicians, such as physicians, certified nurse-mid-
25 wives, emergency room and urgent care providers,

1 nurses and others, are expected to meet in order to
2 promote quality and safety in the provision of ob-
3 stetric services.

4 (6) A template for a voluntary checklist that
5 outlines the minimum responsibilities that hospital
6 leadership responsible for direct patient care, such
7 as the institution's president, chief medical officer,
8 chief nursing officer, or other hospital leadership
9 that directly report to the president or chief execu-
10 tive officer of the institution, should meet to pro-
11 mote hospital-wide initiatives that improve quality
12 and safety in the provision of obstetric services.

13 (7) Information on multi-stakeholder quality
14 improvement initiatives, such as the Alliance for In-
15 novation on Maternal Health, State perinatal quality
16 improvement initiatives, and other similar initiatives
17 determined appropriate by the Secretary, includ-
18 ing—

19 (A) information about such improvement
20 initiatives and how to join;

21 (B) information about public maternal
22 data collection centers;

23 (C) information about quality metrics used
24 and outcomes achieved by such improvement
25 initiatives;

1 (D) information about data sharing tech-
2 niques used by such improvement initiatives;

3 (E) information about data sources used
4 by such improvement initiatives to identify ma-
5 ternal mortality and severe morbidity risks;

6 (F) information about interventions used
7 by such improvement initiatives to mitigate
8 risks of maternal mortality and severe mor-
9 bidity;

10 (G) information about data collection tech-
11 niques on race, ethnicity, geography, age, in-
12 come, and other demographic information used
13 by such improvement initiatives; and

14 (H) any other information determined ap-
15 propriate by the Secretary.

16 (e) INCLUSION OF BEST PRACTICES.—Not later than
17 18 months after the date of the publication of the guid-
18 ance required under subsection (a), the Secretary shall up-
19 date such guidance to include best practices identified by
20 the Secretary for such hospitals, freestanding birth cen-
21 ters, and providers to track maternal mortality and severe
22 morbidity trends by clinicians at such hospitals, free-
23 standing birth centers, and providers including—

24 (1) ways to establish scoring systems, which
25 may include quality triggers and safety and quality

1 metrics to score case and patient outcome metrics,
2 for such clinicians;

3 (2) methods to identify, educate, and improve
4 such clinicians who may have higher rates of mater-
5 nal mortality or severe morbidity compared to their
6 regional or State peers (taking into account dif-
7 ferences in patient risk for adverse outcomes, which
8 may include social risk factors);

9 (3) methods for using such data and tracking
10 to enhance research efforts focused on maternal
11 health, while also improving patient outcomes, clini-
12 cian education and training, and coordination of
13 care; and

14 (4) any other information determined appro-
15 priate by the Secretary.

16 (f) CULTURAL AND LINGUISTIC APPROPRIATE-
17 NESS.—To the extent practicable, the Secretary should de-
18 velop the guidance, best practices, fact sheets, templates,
19 and other materials that are required under this section
20 in a trauma-informed, culturally and linguistically appro-
21 priate manner.

1 **SEC. 13. PROGRAM RELATED TO REDUCING CESAREAN**
2 **BIRTHS AND INCREASING RATES OF VAGINAL**
3 **BIRTH AFTER CESAREAN.**

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

6 (1) in paragraph (1)—

7 (A) by striking “and to develop or sup-
8 port” and inserting “to develop or support”;
9 and

10 (B) by inserting “, and to establish a grant
11 program, or extend the Alliance for Innovation
12 on Maternal Health, for the establishment of
13 perinatal quality collaboratives to reduce cesar-
14 ean section rates and increase vaginal birth
15 after cesarean rates” before the period at the
16 end; and

17 (2) in paragraph (2), by adding at the end the
18 following:

19 “(E) The Secretary may establish a com-
20 petitive grant program, or extend existing pro-
21 grams, including the Alliance for Innovation on
22 Maternal Health, for the establishment or sup-
23 port of perinatal quality collaboratives, with a
24 focus on maternity care health professional tar-
25 get areas and other areas with limited birthing
26 resources, to reduce cesarean birth rates and

1 increase vaginal birth after cesarean rates, in-
2 cluding through—

3 “(i) coordination with hospitals, clin-
4 ical teams, obstetricians and gynecologists,
5 birthing centers and community-based ma-
6 ternal health organizations, public health
7 agencies, midwives, doulas, patients and
8 families, and other relevant entities;

9 “(ii) providing support and training to
10 hospital and clinical teams for quality im-
11 provement, as appropriate;

12 “(iii) employing strategies that pro-
13 vide opportunities for health care profes-
14 sionals and clinical teams to collaborate
15 across health care settings and disciplines,
16 including midwifery care, doula support,
17 the integration of primary care and mental
18 health, and blended case payment rates;

19 “(iv) using data, disaggregated by
20 race and ethnicity, to provide timely feed-
21 back across hospital and clinical teams,
22 document baseline cesarean and vaginal
23 birth rates, and measure progress; and

1 “(v) promotion of existing evidence on
 2 the best practices for the safe reduction of
 3 primary cesarean births.”.

4 **SEC. 14. COLLECTION OF INFORMATION RELATED TO SO-**
 5 **CIAL DETERMINANTS OF THE HEALTH OF**
 6 **MEDICAID AND CHIP BENEFICIARIES.**

7 (a) IMPLEMENTATION ASSESSMENT REPORT TO
 8 CONGRESS.—

9 (1) IN GENERAL.—Not later than 2 years after
 10 the date of enactment of this Act, the Secretary
 11 shall submit a report to Congress that includes a de-
 12 scription of whether and how information related to
 13 the social determinants of health for individuals eli-
 14 gible for medical assistance under Medicaid or child
 15 health assistance or pregnancy-related assistance
 16 under CHIP may be captured under the data sys-
 17 tems for such programs as in effect on the date such
 18 report is submitted, including—

19 (A) a description of whether and how
 20 ICD–10 codes (or successor codes) may be used
 21 to identify social determinants of health in pro-
 22 grams such as Medicaid and CHIP, and wheth-
 23 er other claims file or demographic information
 24 may be employed; and

1 (B) a description of whether existing data
2 systems under Medicaid and CHIP could be
3 employed to capture such information, whether
4 program or system changes would be required,
5 how privacy and confidentiality as required
6 under applicable law and regulations would be
7 maintained, and the resources and timeframes
8 at the Federal and State levels that would be
9 needed to make such changes.

10 (2) GUIDANCE FOR STATES.—The Secretary
11 shall issue detailed guidance for States concurrent
12 with the submission of the report to Congress under
13 paragraph (1). Such guidance shall address—

14 (A) whether and how information related
15 to the social determinants of health for individ-
16 uals eligible for medical assistance under Med-
17 icaid or child health assistance or pregnancy-re-
18 lated assistance under CHIP could be captured
19 employing existing systems under such pro-
20 grams; and

21 (B) implementation considerations for cap-
22 turing such information, including whether pro-
23 gram or system changes would be required,
24 whether additional steps would be needed to
25 maintain privacy and confidentiality as required

1 under relevant laws and regulations, and the re-
2 sources and timeframes at that would be needed
3 to make such changes.

4 (3) STAKEHOLDER INPUT.—The Secretary shall
5 develop the report required under paragraph (1) and
6 the guidance required under paragraph (2) with the
7 input of relevant stakeholders, such as State Med-
8 icaid directors, Medicaid managed care organiza-
9 tions, and other relevant Federal agencies such as
10 the Centers for Disease Control and Prevention, the
11 Health Resources Services Administration, and the
12 Agency for Healthcare Research and Quality.

13 (4) ACTION PLAN REPORT.—

14 (A) IN GENERAL.—If the Secretary deter-
15 mines in the report required under paragraph
16 (1) that information related to the social deter-
17 minants of health for individuals eligible for
18 medical assistance under Medicaid or child
19 health assistance or pregnancy-related assist-
20 ance under CHIP cannot be captured under the
21 data systems for such programs as in effect on
22 the date such report is submitted, then, not
23 later than 6 months after such date, the Sec-
24 retary shall submit a second report to Congress
25 that contains an action plan for implementing

1 the program or data systems changes needed in
2 order for such information to be collected while
3 maintaining privacy and confidentiality as re-
4 quired under relevant laws and regulations. The
5 action plan should be prepared so as to be im-
6 plemented by the Federal Government and
7 States not later than 2 years after the date on
8 which the report required under this paragraph
9 is submitted to Congress.

10 (B) REVISED GUIDANCE FOR STATES.—

11 The Secretary shall revise and reissue the guid-
12 ance for States required under paragraph (2) to
13 take into account the action plan included in
14 the report submitted to Congress under sub-
15 paragraph (A).

16 (5) AUTHORIZATION OF APPROPRIATIONS.—

17 (A) FEDERAL COSTS.—There are author-
18 ized to be appropriated to the Secretary,
19 \$40,000,000 for purposes of preparing the re-
20 ports required under this subsection and imple-
21 menting the collection of information related to
22 the social determinants of health for individuals
23 eligible for medical assistance under Medicaid
24 or child health assistance or pregnancy-related
25 assistance under CHIP.

1 (B) STATE COSTS.—There are authorized
 2 to be appropriated to the Secretary,
 3 \$50,000,000 for purposes of making payments
 4 to States in accordance with a methodology es-
 5 tablished by the Secretary for State expendi-
 6 tures attributable to planning for and imple-
 7 menting the collection of such information in
 8 accordance with subsection (d) of section 1946
 9 of the Social Security Act (42 U.S.C. 1396w-
 10 5) (as added by subsection (b)).

11 (b) APPLICATION TO STATES.—Section 1946 of the
 12 Social Security Act (42 U.S.C. 1396w-5) is amended by
 13 adding at the end the following:

14 “(d) COLLECTION OF INFORMATION RELATED TO
 15 SOCIAL DETERMINANTS OF HEALTH.—

16 “(1) DEVELOPMENT OF COLLECTION METH-
 17 ODS.—

18 “(A) IN GENERAL.—Subject to paragraph
 19 (5), the Secretary, in consultation with the
 20 States, shall develop a method for collecting
 21 standardized and aggregated State-level infor-
 22 mation related to social determinants that may
 23 factor into the health of beneficiaries under this
 24 title and beneficiaries under title XXI which the
 25 States, notwithstanding section 1902(a)(7) and

1 as a condition for meeting the requirements of
2 section 1902(a)(6) and section 2107(b)(1), shall
3 use to annually report such information:

4 “(i) A model uniform reporting field
5 through the transformed Medicaid Statis-
6 tical Information System (T-MSIS) (or a
7 successor system) or another appropriate
8 reporting platform, as approved by the
9 Secretary.

10 “(ii) A model uniform questionnaire
11 or survey (which may be included as part
12 of an existing survey, questionnaire, or
13 form administered by the Secretary), for
14 purposes of the State or the Secretary col-
15 lecting such information by administering
16 regularly but not less than annually a
17 questionnaire or survey of beneficiaries
18 under this title and beneficiaries under
19 title XXI.

20 “(iii) A model uniform form to be
21 adapted for inclusion in the Medicaid and
22 CHIP Scorecard developed by the Centers
23 for Medicare & Medicaid Services, for pur-
24 poses of the Secretary collecting such in-
25 formation.

1 “(iv) An alternative method identified
2 by the Secretary for collecting such infor-
3 mation.

4 “(B) IMPLEMENTATION.—In carrying out
5 the requirements of subparagraph (A), the Sec-
6 retary shall—

7 “(i) for purposes of the method de-
8 scribed in clause (i) of such subparagraph,
9 determine the appropriate providers and
10 frequency with which such providers shall
11 complete the reporting field identified and
12 report the information to the State;

13 “(ii) for purposes of the method de-
14 scribed in clause (ii) of such subparagraph,
15 identify the means and frequency (which
16 shall be no less frequent than once per
17 year) with which a questionnaire or survey
18 of beneficiaries is to be conducted;

19 “(iii) with respect to any method de-
20 scribed in such subparagraph, issue guid-
21 ance for ensuring compliance with applica-
22 ble laws regarding beneficiary informed
23 consent, privacy, and anonymity with re-
24 spect to the information collected under
25 such method;

1 “(iv) with respect to the collection of
2 information relating to beneficiaries who
3 are children, issue guidance on the collec-
4 tion of such information from a parent,
5 legal guardian, or any other person who is
6 legally authorized to share such informa-
7 tion on behalf of the child when the direct
8 collection of such information from chil-
9 dren may not otherwise be feasible or ap-
10 propriate; and

11 “(v) regularly evaluate the method
12 under such subparagraph and the informa-
13 tion reported using such method, and, as
14 needed, make updates to the method and
15 the information reported.

16 “(2) SOCIAL DETERMINANTS OF HEALTH.—The
17 information collected in accordance with the method
18 made available under paragraph (1) shall, to the ex-
19 tent practicable, include standardized definitions for
20 identifying social determinants of health needs iden-
21 tified in the ICD–10 diagnostic codes Z55 through
22 Z65 (or any such successor diagnostic codes), as de-
23 fined by the Healthy People 2020 and related initia-
24 tives of the Office of Disease Prevention and Health
25 Promotion of the Department of Health and Human

1 Services, or any other standardized set of definitions
 2 for social determinants of health identified by the
 3 Secretary. Such definitions shall incorporate meas-
 4 ures for quantifying the relative severity of any such
 5 social determinant of health need identified in an in-
 6 dividual.

7 “(3) FEDERAL PRIVACY REQUIREMENTS.—
 8 Nothing in this subsection shall be construed to su-
 9 persede any Federal privacy or confidentiality re-
 10 quirement, including the regulations promulgated
 11 under section 264(c) of the Health Insurance Port-
 12 ability and Accountability Act of 1996 and section
 13 543 of the Public Health Service Act and any regu-
 14 lations promulgated thereunder.

15 “(4) APPLICATION TO TERRITORIES.—

16 “(A) IN GENERAL.—To the extent that the
 17 Secretary determines that it is not practicable
 18 for a State specified in subparagraph (B) to re-
 19 port information in accordance with the method
 20 made available under paragraph (1), this sub-
 21 section shall not apply with respect to such
 22 State.

23 “(B) TERRITORIES SPECIFIED.—The
 24 States specified in this subparagraph are Puer-

1 to Rico, the Virgin Islands, Guam, American
2 Samoa, and the Northern Mariana Islands.

3 “(5) APPLICATION.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), the requirement for a State to col-
6 lect information in accordance with the method
7 made available under paragraph (1) shall not
8 apply to the State before the date that is 4
9 years after the date of enactment of this sub-
10 section.

11 “(B) ALTERNATIVE DATE.—If an action
12 plan is submitted to Congress under section
13 14(a)(4) of the Healthy Moms and Babies Act,
14 in lieu of the date described in subparagraph
15 (A), the requirement for a State to collect infor-
16 mation in accordance with the method made
17 available under paragraph (1) shall not apply to
18 the State before the date specified in such ac-
19 tion plan.

20 “(6) APPROPRIATION.—There is appropriated
21 to the Secretary for fiscal year 2026 and each fiscal
22 year thereafter \$1,000,000 to carry out the provi-
23 sions of this section and subsection (b)(2)(B).”.

1 (c) REPORT ON DATA ANALYSES.—Section
 2 1946(b)(2) of such Act (42 U.S.C. 1396w–5(b)(2)) is
 3 amended—

4 (1) by striking “Not later than” and inserting
 5 the following:

6 “(A) INITIAL REPORTS.—Not later than”;

7 and

8 (2) by adding at the end the following:

9 “(B) REPORTS ON COLLECTION OF INFOR-
 10 MATION RELATED TO SOCIAL DETERMINANTS
 11 OF HEALTH.—

12 “(i) IN GENERAL.—Not later than 5
 13 years after the date on which the require-
 14 ment to collect information under sub-
 15 section (d) is first applicable to States, the
 16 Secretary shall submit to Congress a re-
 17 port that includes aggregate findings and
 18 trends across respective beneficiary popu-
 19 lations for improving the identification of
 20 social determinants of health for bene-
 21 ficiaries under this title and beneficiaries
 22 under title XXI based on analyses of the
 23 data collected under subsection (d).

24 “(ii) INTERIM REPORT.—Not later
 25 than 3 years after the date of enactment

1 of this subparagraph, the Secretary shall
 2 submit to Congress an interim report on
 3 progress in developing, implementing, and
 4 utilizing the method selected by the Sec-
 5 retary under subsection (d)(1) along with
 6 any available, preliminary information that
 7 has been collected using such method.”.

8 (d) CONFORMING AMENDMENT.—Section 2107(e)(1)
 9 of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is
 10 amended by adding at the end the following:

11 “(V) Section 1946 (relating to addressing
 12 health care disparities).”.

13 **SEC. 15. REPORT ON PAYMENT METHODOLOGIES FOR**
 14 **TRANSFERRING PREGNANT WOMEN BE-**
 15 **TWEEN FACILITIES BEFORE, DURING, AND**
 16 **AFTER CHILDBIRTH.**

17 (a) IN GENERAL.—Subject to the availability of ap-
 18 propriations, not later than 36 months after the date of
 19 enactment of this Act, the Secretary shall submit to Con-
 20 gress a report on the payment methodologies under Med-
 21 icaid for the antepartum, intrapartum, and postpartum
 22 transfer of pregnant women from one health care facility
 23 to another, including any potential disincentives or regu-
 24 latory barriers to such transfers.

1 (b) CONSULTATION.—In developing the report re-
 2 quired under subsection (a), the Secretary shall consult
 3 with the advisory committee established under section
 4 12(c).

5 **SEC. 16. MEDICAID GUIDANCE ON STATE OPTIONS TO AD-**
 6 **DRESS SOCIAL DETERMINANTS OF HEALTH**
 7 **FOR PREGNANT AND POSTPARTUM WOMEN.**

8 (a) IN GENERAL.—Not later than 2 years after the
 9 date of enactment of this Act, the Secretary shall issue
 10 guidance to States and conduct one or more learning
 11 collaboratives to promote cross-state learning regarding
 12 options States may employ to address social determinants
 13 of health, as defined by the Healthy People 2030 and re-
 14 lated initiatives of the Office of Disease Prevention and
 15 Health Promotion of the Department of Health and
 16 Human Services, including for pregnant and postpartum
 17 women.

18 (b) GUIDANCE REQUIREMENTS.—The guidance re-
 19 quired under subsection (a) shall, at a minimum, describe
 20 the authorities that States may leverage to support ad-
 21 dressing the social determinants of health for pregnant
 22 and postpartum women and outline best practices for such
 23 efforts.

24 (c) LEARNING COLLABORATIVE REQUIREMENTS.—
 25 The learning collaboratives required under subsection (a)

1 shall, at a minimum, include opportunities for States and
 2 other stakeholders to share innovative practices and ap-
 3 proaches as they are being considered and developed,
 4 share solutions related to challenges that multiple urban
 5 and rural States face, and promote the uptake of ap-
 6 proved, effective interventions addressing social needs and
 7 determinants covered by the Medicaid program.

8 **SEC. 17. PAYMENT ERROR RATE MEASUREMENT (PERM)**
 9 **AUDIT AND IMPROVEMENT REQUIREMENTS.**

10 (a) BIENNIAL PERM AUDIT REQUIREMENT.—Be-
 11 ginning with fiscal year 2027, the Administrator shall con-
 12 duct payment error rate measurement (“PERM”) audits
 13 of each State Medicaid program on a biennial basis.

14 (b) PERM ERROR RATE REDUCTION PLAN RE-
 15 QUIREMENT.—Beginning with fiscal year 2027, any State
 16 with an overall PERM error rate exceeding 15 percent in
 17 a PERM audit conducted with respect to the State in the
 18 previous fiscal year shall publish a plan, in coordination
 19 with, and subject to the approval of, the Administrator,
 20 for how the State will reduce its PERM error rate below
 21 15 percent in the current fiscal year.

22 (c) NOTIFICATION; IDENTIFICATION OF SOURCES OF
 23 IMPROPER PAYMENTS.—

24 (1) NOTIFICATION.—Not later than 6 months
 25 after the date of enactment of this Act, the Adminis-

1 trator shall notify the contractor conducting PERM
2 audits of the Administrator's intent to modify con-
3 tracts to require PERM audits not less than once
4 every other year in each State.

5 (2) IDENTIFICATION OF SOURCES OF IMPROPER
6 PAYMENTS.—The Administrator shall direct the con-
7 tractor conducting PERM audits of State Medicaid
8 programs to identify areas known to be sources of
9 improper payments under such programs to identify
10 program areas or components known to be sources
11 of high risk for improper payments under such pro-
12 grams.

13 (d) STATE MEDICAID DIRECTOR LETTER.—Not later
14 than 12 months after the date of enactment of this Act,
15 the Administrator shall issue a State Medicaid Director
16 letter regarding State requirements under Federal law and
17 regulations regarding avoiding and responding to im-
18 proper payments under State Medicaid programs.

19 (e) STATE IMPROPER PAYMENT MITIGATION
20 PLANS.—

21 (1) IN GENERAL.—Not later than January 1,
22 2026, each State Medicaid program shall submit to
23 the Administrator a plan, which shall include spe-
24 cific actions and timeframes for taking such actions

1 and achieving specified results, for mitigating im-
2 proper payments under such program.

3 (2) PUBLICATION OF STATE PLANS.—The Ad-
4 ministrator shall make State plans submitted under
5 paragraph (1) available to the public.

6 (f) DEFINITIONS.—In this section:

7 (1) ADMINISTRATOR.—The term “Adminis-
8 trator” means the Administrator of the Centers for
9 Medicare & Medicaid Services.

10 (2) STATE.—The term “State” has the mean-
11 ing given such term for purposes of title XIX of the
12 Social Security Act (42 U.S.C. 1396 et seq.).

13 (3) STATE MEDICAID PROGRAM.—The term
14 “State Medicaid program” means a State plan
15 under title XIX of the Social Security Act (42
16 U.S.C. 1396 et seq.), and includes any waiver of
17 such a plan.

○