

117TH CONGRESS
2D SESSION

S. _____

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

Mr. GRASSLEY introduced the following bill; which was read twice and referred to the Committee on _____

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 caesarean sections.
- 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. MACPAC study on doulas and community health workers.
- Sec. 8. Demonstration projects to improve the delivery of maternal health care through telehealth.
- Sec. 9. CMS report on coverage of remote physiologic monitoring devices and impact on maternal and child health outcomes under Medicaid.
- Sec. 10. Guidance on community-based maternal health programs.
- Sec. 11. Developing guidance on maternal mortality and severe morbidity reduction for maternal care providers receiving payment under the Medicaid program.
- Sec. 12. Collection of information related to social determinants of the health of Medicaid and CHIP beneficiaries.
- Sec. 13. Report on payment methodologies for transferring pregnant women between facilities before, during, and after childbirth.
- Sec. 14. Medicaid guidance on State options to address social determinants of health for pregnant and postpartum women.
- Sec. 15. 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-
 14 dividual health insurance coverage” have the mean-

1 ings given such terms in section 2791 of the Public
2 Health Service Act (42 U.S.C. 300gg–91).

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

6 (5) MEDICAID MANAGED CARE ORGANIZA-
7 TION.—The term “medicaid managed care organiza-
8 tion” has the meaning given that term in section
9 1903(m)(1)(A) of the Social Security Act (42 U.S.C.
10 1396b(m)(1)(A)).

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

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

17 **SEC. 3. MANDATORY REPORTING BY STATE MEDICAID PRO-**
18 **GRAMS ON ADULT HEALTH CARE QUALITY**
19 **MEASURES OF MATERNAL AND PERINATAL**
20 **HEALTH.**

21 Section 1139B of the Social Security Act (42 U.S.C.
22 1320b–9b) is amended—

23 (1) in subsection (b)—

24 (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 CAESAREAN SECTIONS.**

3 (a) MEDICAID STATE PLAN AMENDMENT.—Section
4 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))
5 is amended—

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

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

10 (3) by inserting after paragraph (87) the fol-
11 lowing:

12 “(88) provide that, not later than January 1,
13 2024, and annually thereafter through January 1,
14 2034, the State shall submit a report to the Sec-
15 retary, that shall be made publicly available, which
16 contains with respect to the preceding calendar
17 year—

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

25 “(B) a description of the State’s quality
26 improvement activities to safely reduce the rate

1 of low-risk cesarean delivery (as so defined) for
2 pregnant women eligible for medical assistance
3 under the State plan or a waiver of such plan
4 in the State reported under subparagraph (A),
5 including initiatives aimed at reducing racial
6 and ethnic health disparities, hospital-level
7 quality improvement initiatives, taking into ac-
8 count hospital type and the patient population
9 served, and, if applicable, partnerships with
10 State or regional perinatal quality
11 collaboratives;

12 “(C) for each report submitted after Janu-
13 ary 1, 2024, the percentage change (if any) in
14 the rate of low-risk cesarean delivery (as so de-
15 fined) for pregnant women eligible for medical
16 assistance under the State plan or a waiver of
17 such plan in the State reported under subpara-
18 graph (A) from the rate reported for the most
19 recent previous report; and

20 “(D) such other relevant data and infor-
21 mation as determined by the Secretary, and in
22 consultation with relevant stakeholders, such as
23 State initiatives and evaluations of quality im-
24 provement activities, cesarean delivery rates,
25 and health outcomes.”.

1 (b) GAO STUDY REGARDING MEDICAID CAESAREAN
2 BIRTHS.—

3 (1) STUDY.—The Comptroller General shall
4 conduct a study regarding caesarean births under
5 State Medicaid programs. The study shall include
6 analyses of the following:

7 (A) Changes in Medicaid payment rates for
8 caesarean births and vaginal births over time,
9 disaggregated by rates paid by fee-for-service
10 Medicaid programs and by Medicaid programs
11 that contract with medicaid managed care orga-
12 nizations and other specified entities to furnish
13 medical assistance under such programs.

14 (B) The frequency of primary and repeat
15 caesarean births, as well as vaginal births after
16 a caesarean, under Medicaid programs and a
17 comparison of such frequency with the fre-
18 quency of such births when paid for under a
19 group health plan or by a health insurance
20 issuer offering group or individual health insur-
21 ance coverage. To the extent feasible, this infor-
22 mation should be disaggregated according to
23 race and ethnicity.

24 (C) Comparisons of payment rates for cae-
25 sarean and vaginal births under Medicaid pro-

1 grams with the payment rates for such births
2 under a group health plan or by a health insur-
3 ance issuer offering group or individual health
4 insurance coverage.

5 (D) Such other factors related to payment
6 rates for caesarean and vaginal births under
7 Medicaid as the Comptroller General deter-
8 mines appropriate.

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

16 (c) GAO STUDY ON RACIAL DISPARITIES IN CAE-
17 SAREAN BIRTHS.—

18 (1) IN GENERAL.—The Comptroller General
19 shall conduct a study on racial disparities in the fre-
20 quency of low- and high-risk caesarean births across
21 hospitals of different settings (rural, urban, and sub-
22 urban), volumes, and types (such as teaching, pri-
23 vate, public, and not-for-profit) in a selection of 10
24 States. The study shall compare such information
25 with respect to Medicaid and private payers and

1 compare total charges, if feasible. The study shall
2 also investigate, to the extent practicable, the day of
3 the week and time of day that such births occur at
4 a subset of hospitals in the selected States. Such
5 study may consider other factors related to racial
6 disparities in maternal health as the Comptroller
7 General deems appropriate.

8 (2) REPORT.—Not later than 2 years after the
9 date of enactment of this Act, the Comptroller Gen-
10 eral shall submit to Congress a report containing the
11 results of the study conducted under paragraph (1),
12 together with recommendations for such legislation
13 and administrative action as the Comptroller Gen-
14 eral determines appropriate.

15 **SEC. 5. STATE OPTION TO PROVIDE COORDINATED CARE**
16 **THROUGH A HEALTH HOME FOR PREGNANT**
17 **AND POSTPARTUM WOMEN.**

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

21 **“SEC. 1945B. STATE OPTION TO PROVIDE COORDINATED**
22 **CARE THROUGH A HEALTH HOME FOR PREG-**
23 **NANT AND POSTPARTUM WOMEN.**

24 “(a) STATE OPTION.—

1 “(1) IN GENERAL.—Notwithstanding section
2 1902(a)(1) (relating to statewideness) and section
3 1902(a)(10)(B) (relating to comparability), begin-
4 ning April 1, 2025, a State, at its option as a State
5 plan amendment, may provide for medical assistance
6 under this title to an eligible woman who chooses
7 to—

8 “(A) enroll in a maternity health home
9 under this section by selecting a designated pro-
10 vider, a team of health care professionals oper-
11 ating with such a provider, or a health team as
12 the woman’s maternity health home for pur-
13 poses of providing the woman with pregnancy
14 and postpartum coordinated care services; or

15 “(B) receive such services from a des-
16 ignated provider, a team of health care profes-
17 sionals operating with such a provider, or a
18 health team that has voluntarily opted to par-
19 ticipate in a maternity health home for eligible
20 women under this section.

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

24 “(A) who is eligible for medical assistance
25 under the State plan (or under a waiver of such

1 plan) for all items and services covered under
2 the State plan (or waiver) that are not less in
3 amount, duration, or scope, or are determined
4 by the Secretary to be substantially equivalent,
5 to the medical assistance available for an indi-
6 vidual described in subsection (a)(10)(A)(i); and

7 “(B) who—

8 “(i) is pregnant; or

9 “(ii) had a pregnancy end within the
10 last 365 days.

11 “(b) QUALIFICATION STANDARDS.—The Secretary
12 shall establish standards for qualification as a maternity
13 health home or as a designated provider, team of health
14 care professionals operating with such a provider, or a
15 health team eligible for participation in a maternity health
16 home for purposes of this section. Such standards shall
17 include requiring designated providers, teams of health
18 care professionals operating with such providers, and
19 health teams (designated as a maternity health home) to
20 demonstrate to the State the ability to do the following:

21 “(1) Coordinate prompt care and access to nec-
22 essary maternity care services, including services
23 provided by specialists, and programs for an eligible
24 woman during her pregnancy and the 365-day pe-
25 riod beginning on the last day of her pregnancy.

1 “(2) Develop an individualized, comprehensive,
2 patient-centered care plan for each eligible woman
3 that accommodates patient preferences and , if ap-
4 plicable, reflects adjustments to the payment meth-
5 odology described in subsection (c)(2)(B).

6 “(3) Develop and incorporate into each eligible
7 woman’s care plan, in a culturally and linguistically
8 appropriate manner consistent with the needs of the
9 eligible woman, ongoing home care, community-
10 based primary care, inpatient care, social support
11 services, behavioral health services, local hospital
12 emergency care, and, in the event of a change in in-
13 come that would result in the eligible woman losing
14 eligibility for medical assistance under the State
15 plan or waiver, care management and planning re-
16 lated to a change in the eligible woman’s health in-
17 surance coverage.

18 “(4) Coordinate with pediatric care providers,
19 as appropriate.

20 “(5) Collect and report information under sub-
21 section (f)(1).

22 “(c) PAYMENTS.—

23 “(1) IN GENERAL.—A State shall provide a des-
24 ignated provider, a team of health care professionals
25 operating with such a provider, or a health team

1 with payments for the provision of pregnancy and
2 postpartum coordinated care services, to each eligi-
3 ble woman that selects such provider, team of health
4 care professionals, or health team as the woman's
5 maternity health home or care provider. Payments
6 made to a maternity health home or care provider
7 for such services shall be treated as medical assist-
8 ance for purposes of section 1903(a).

9 “(2) METHODOLOGY.—The State shall specify
10 in the State plan amendment the methodology the
11 State will use for determining payment for the provi-
12 sion of pregnancy and postpartum coordinated care
13 services or treatment during an eligible woman's
14 pregnancy and the 365-day period beginning on the
15 last day of her pregnancy. Such methodology for de-
16 termining payment—

17 “(A) may be based on—

18 “(i) a per-member per-month basis for
19 each eligible woman enrolled in the mater-
20 nity health home;

21 “(ii) a prospective payment model, in
22 the case of payments to Federally qualified
23 health centers or a rural health clinics; or

24 “(iii) an alternate model of payment
25 (which may include a model developed

1 under a waiver under section 1115) pro-
2 posed by the State and approved by the
3 Secretary;

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

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

8 “(ii) the severity of the risks associ-
9 ated with the woman’s postpartum health
10 care needs; and

11 “(iii) the level or amount of time of
12 care coordination required with respect to
13 the woman; and

14 “(C) shall be established consistent with
15 section 1902(a)(30)(A).

16 “(d) COORDINATING CARE.—

17 “(1) HOSPITAL NOTIFICATION.—A State with a
18 State plan amendment approved under this section
19 shall require each hospital that is a participating
20 provider under the State plan (or under a waiver of
21 such plan) to establish procedures in the case of an
22 eligible woman who seeks treatment in the emer-
23 gency department of such hospital for—

24 “(A) providing the woman with culturally
25 and linguistically appropriate information on

1 the respective treatment models and opportuni-
2 ties for the woman to access a maternity health
3 home and its associated benefits; and

4 “(B) notifying the maternity health home
5 in which the woman is enrolled, or the des-
6 ignated provider, team of health care profes-
7 sionals operating with such a provider, or
8 health team treating the woman, of the wom-
9 an’s treatment in the emergency department
10 and of the protocols for the maternity health
11 home, designated provider, or team to be in-
12 volved in the woman’s emergency care or post-
13 discharge care.

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

16 “(A) IN GENERAL.—In order for a State
17 plan amendment to be approved under this sec-
18 tion, a State shall include in the State plan
19 amendment a description of the State’s process
20 for—

21 “(i) educating providers participating
22 in the State plan (or a waiver of such
23 plan) on the availability of maternity
24 health homes for eligible women, including
25 the process by which such providers can

1 participate in or refer eligible women to an
2 approved maternity health home or a des-
3 ignated provider, team of health care pro-
4 fessionals operating such a provider, or
5 health team; and

6 “(ii) educating eligible women, in a
7 culturally and linguistically appropriate
8 manner, on the availability of maternity
9 health homes.

10 “(B) OUTREACH.—The process established
11 by the State under subparagraph (A) shall in-
12 clude the participation of entities or other pub-
13 lic or private organizations or entities that pro-
14 vide outreach and information on the avail-
15 ability of health care items and services to fami-
16 lies of individuals eligible to receive medical as-
17 sistance under the State plan (or a waiver of
18 such plan).

19 “(3) MENTAL HEALTH COORDINATION.—A
20 State with a State plan amendment approved under
21 this section shall consult and coordinate, as appro-
22 priate, with the Secretary in addressing issues re-
23 garding the prevention, identification, and treatment
24 of mental health conditions and substance use dis-
25 orders among eligible women.

1 “(4) SOCIAL AND SUPPORT SERVICES.—A State
2 with a State plan amendment approved under this
3 section shall consult and coordinate, as appropriate,
4 with the Secretary in establishing means to connect
5 eligible women receiving pregnancy and postpartum
6 coordinated care services under this section with so-
7 cial and support services, including services made
8 available under maternal, infant, and early childhood
9 home visiting programs established under section
10 511, and services made available under section
11 330H or title X of the Public Health Service Act.

12 “(e) MONITORING.—A State shall include in the
13 State plan amendment—

14 “(1) a methodology for tracking reductions in
15 inpatient days and reductions in the total cost of
16 care resulting from improved care coordination and
17 management under this section;

18 “(2) a proposal for use of health information
19 technology in providing an eligible woman with preg-
20 nancy and postpartum coordinated care services as
21 specified under this section and improving service
22 delivery and coordination across the care continuum;
23 and

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

4 “(f) DATA COLLECTION.—

5 “(1) PROVIDER REPORTING REQUIREMENTS.—

6 In order to receive payments from a State under
7 subsection (c), a maternity health home, or a des-
8 ignated provider, a team of health care professionals
9 operating with such a provider, or a health team,
10 shall report to the State, at such time and in such
11 form and manner as may be required by the State,
12 including through a health information exchange or
13 other public health data sharing entity, the following
14 information:

15 “(A) With respect to each such designated
16 provider, team of health care professionals oper-
17 ating with such a provider, and health team
18 (designated as a maternity health home), the
19 name, National Provider Identification number,
20 address, and specific health care services of-
21 fered to be provided to eligible women who have
22 selected such provider, team of health care pro-
23 fessionals, or health team as the women’s ma-
24 ternity health home.

1 “(B) Information on all applicable meas-
2 ures for determining the quality of services pro-
3 vided by such provider, team of health care pro-
4 fessionals, or health team.

5 “(C) Such other information as the Sec-
6 retary shall specify in guidance.

7 “(2) STATE REPORTING REQUIREMENTS.—

8 “(A) COMPREHENSIVE REPORT.—A State
9 with a State plan amendment approved under
10 this section shall report to the Secretary (and,
11 upon request, to the Medicaid and CHIP Pay-
12 ment and Access Commission), at such time,
13 but at a minimum frequency of every 12
14 months, and in such form and manner deter-
15 mined by the Secretary to be reasonable and
16 minimally burdensome, including through a
17 health information exchange or other public
18 health data sharing entity, the following infor-
19 mation:

20 “(i) Information described in para-
21 graph (1).

22 “(ii) The number and, to the extent
23 available and while maintaining all relevant
24 protecting privacy and confidentially pro-
25 tections, disaggregated demographic infor-

1 mation of eligible women who have enrolled
2 in a maternity health home pursuant to
3 this section.

4 “(iii) The number of maternity health
5 homes in the State.

6 “(iv) The medical conditions or fac-
7 tors that contribute to severe maternal
8 morbidity among eligible women enrolled in
9 maternity health homes in the State.

10 “(v) The extent to which such women
11 receive health care items and services
12 under the State plan before, during, and
13 after the women’s enrollment in such a
14 maternity health home.

15 “(vi) Where applicable, mortality data
16 and data for the associated causes of death
17 for eligible women enrolled in a maternity
18 health home under this section, in accord-
19 ance with subsection (g). For deaths occur-
20 ring postpartum, such data shall distin-
21 guish between deaths occurring up to 42
22 days postpartum and deaths occurring be-
23 tween 43 days to up to 1 year postpartum.
24 Where applicable, data reported under this
25 clause shall be reported alongside com-

1 parable data from a State’s maternal mor-
2 tality review committee, as established in
3 accordance with section 317K(d) of the
4 Public Health Service Act, for purposes of
5 further identifying and comparing state-
6 wide trends in maternal mortality among
7 populations participating in the maternity
8 health home under this section.

9 “(B) IMPLEMENTATION REPORT.—Not
10 later than 18 months after a State has a State
11 plan amendment approved under this section,
12 the State shall submit to the Secretary, and
13 make publicly available on the appropriate
14 State website, a report on how the State is im-
15 plementing the option established under this
16 section, including through any best practices
17 adopted by the State.

18 “(g) CONFIDENTIALITY.—A State with a State plan
19 amendment under this section shall establish confiden-
20 tiality protections for the purposes of subsection (f)(2)(A)
21 to ensure, at a minimum, that there is no disclosure by
22 the State of any identifying information about any specific
23 eligible woman enrolled in a maternity health home or any
24 maternal mortality case, and that all relevant confiden-

1 tiality and privacy protections, including the requirements
2 under 1902(a)(7)(A), are maintained.

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

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

7 “(2) a designated provider or health team to
8 act as a maternity health home and provide services
9 in accordance with this section if the provider or
10 health team does not voluntarily agree to act as a
11 maternity health home.

12 “(i) PLANNING GRANTS.—

13 “(1) IN GENERAL.—Beginning October 1,
14 2024, from the amount appropriated under para-
15 graph (2), the Secretary shall award planning grants
16 to States for purposes of developing and submitting
17 a State plan amendment under this section. The
18 Secretary shall award a grant to each State that ap-
19 plies for a grant under this subsection, but the Sec-
20 retary may determine the amount of the grant based
21 on the merits of the application and the goal of the
22 State to prioritize health outcomes for eligible
23 women. A planning grant awarded to a State under
24 this subsection shall remain available until expended.

1 “(2) APPROPRIATION.—There are authorized to
2 be appropriated to the Secretary \$50,000,000 for
3 the period of fiscal years 2023 through 2025, for the
4 purposes of making grants under this subsection, to
5 remain available until expended.

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

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

10 “(1) DESIGNATED PROVIDER.—The term ‘des-
11 ignated provider’ means a physician (including an
12 obstetrician-gynecologist), hospital, clinical practice
13 or clinical group practice, a medicaid managed care
14 organization, as defined in section 1903(m)(1)(A), a
15 prepaid inpatient health plan, as defined in section
16 438.2 of title 42, Code of Federal Regulations (or
17 any successor regulation), a prepaid ambulatory
18 health plan, as defined in such section (or any suc-
19 cessor regulation), rural clinic, community health
20 center, community mental health center, or any
21 other entity or provider that is determined by the
22 State and approved by the Secretary to be qualified
23 to be a maternity health home on the basis of docu-
24 mentation evidencing that the entity has the sys-
25 tems, expertise, and infrastructure in place to pro-

1 vide pregnancy and postpartum coordinated care
2 services. Such term may include providers who are
3 employed by, or affiliated with, a hospital.

4 “(2) MATERNITY HEALTH HOME.—The term
5 ‘maternity health home’ means a designated provider
6 (including a provider that operates in coordination
7 with a team of health care professionals) or a health
8 team is selected by an eligible woman to provide
9 pregnancy and postpartum coordinated care services.

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

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

15 “(A) IN GENERAL.—The term ‘pregnancy
16 and postpartum coordinated care services’
17 means items and services related to the coordi-
18 nation of care for comprehensive and timely
19 high-quality, culturally and linguistically appro-
20 priate, services described in subparagraph (B)
21 that are provided by a designated provider, a
22 team of health care professionals operating with
23 such a provider, or a health team (designated
24 as a maternity health home).

25 “(B) SERVICES DESCRIBED.—

1 “(i) IN GENERAL.—The services de-
2 scribed in this subparagraph shall include
3 with respect to a State electing the State
4 plan amendment option under this section,
5 any medical assistance for items and serv-
6 ices for which payment is available under
7 the State plan or under a waiver of such
8 plan.

9 “(ii) OTHER ITEMS AND SERVICES.—
10 In addition to medical assistance described
11 in clause (i), the services described in this
12 subparagraph shall include the following:

13 “(I) Any item or service for
14 which medical assistance is otherwise
15 available under the State plan (or a
16 waiver of such plan) related to the
17 treatment of a woman during the
18 woman’s pregnancy and the 1-year pe-
19 riod beginning on the last day of her
20 pregnancy, including mental health
21 and substance use disorder services.

22 “(II) Comprehensive care man-
23 agement.

24 “(III) Care coordination (includ-
25 ing with pediatricians as appropriate),

1 health promotion, and providing ac-
2 cess to the full range of maternal, ob-
3 stetric, and gynecologic services, in-
4 cluding services from out-of-State pro-
5 viders.

6 “(IV) Comprehensive transitional
7 care, including appropriate follow-up,
8 from inpatient to other settings.

9 “(V) Patient and family support
10 (including authorized representatives).

11 “(VI) Referrals to community
12 and social support services, if rel-
13 evant.

14 “(VII) Use of health information
15 technology to link services, as feasible
16 and appropriate.

17 “(5) TEAM OF HEALTH CARE PROFES-
18 SIONALS.—The term ‘team of health care profes-
19 sionals’ means a team of health care professionals
20 (as described in the State plan amendment under
21 this section) that may—

22 “(A) include—

23 “(i) physicians, including gynecologist-
24 obstetricians, pediatricians, and other pro-
25 fessionals such as physicians assistants,

1 advance practice nurses, including certified
2 nurse midwives, nurses, nurse care coordi-
3 nators, dietitians, nutritionists, social
4 workers, behavioral health professionals,
5 physical counselors, physical therapists, oc-
6 cupational therapists, or any professionals
7 that assist in prenatal care, delivery, or
8 postpartum care for which medical assist-
9 ance is available under the State plan or a
10 waiver of such plan and determined to be
11 appropriate by the State and approved by
12 the Secretary;

13 “(ii) an entity or individual who is
14 designated to coordinate such care deliv-
15 ered by the team; and

16 “(iii) when appropriate and if other-
17 wise eligible to furnish items and services
18 that are reimbursable as medical assist-
19 ance under the State plan or under a waiv-
20 er of such plan, doulas, community health
21 workers, translators and interpreters, and
22 other individuals with culturally appro-
23 priate and trauma-informed expertise; and

24 “(B) provide care at a facility that is free-
25 standing, virtual, or based at a hospital, com-

1 community health center, community mental health
2 center, rural clinic, clinical practice or clinical
3 group practice, academic health center, or any
4 entity determined to be appropriate by the
5 State and approved by the Secretary.”.

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

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

20 (1) enhancing primary care and maternity care
21 coordination with specialists, including cardiologists,
22 specialists in gestational diabetes, dentists, lactation
23 specialists, genetic counselors, and behavioral health
24 providers;

1 (2) integrating behavioral health providers to
2 provide screening, assessment, treatment, and refer-
3 ral for behavioral health needs, including substance
4 use disorders, maternal depression, anxiety, intimate
5 partner violence, and other trauma;

6 (3) integrating into care teams or coordinating
7 with nonclinical professionals, including (if licensed
8 or credentialed by a State or State-authorized orga-
9 nization) doulas, peer support specialists, and com-
10 munity health workers, and how these services pro-
11 vided by such professionals may be eligible for Fed-
12 eral financial participation under Medicaid;

13 (4) screening pregnant and postpartum women
14 for social needs and coordinating related services
15 during the prenatal and postpartum periods to en-
16 sure social and physical supports are provided for
17 such women during such periods and for their chil-
18 dren;

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

20 (6) screening for maternal health, behavioral
21 health, and social needs during well-child and pedi-
22 atric care visits; and

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

1 **SEC. 7. MACPAC STUDY ON DOULAS AND COMMUNITY**
2 **HEALTH WORKERS.**

3 (a) IN GENERAL.—As part of the first report re-
4 quired under section 1900(b)(1) of the Social Security Act
5 (42 U.S.C. 1396(b)(1)) after the date that is 1 year after
6 the date of enactment of this Act, the Medicaid and CHIP
7 Payment and Access Commission (referred to in this sec-
8 tion as “MACPAC”) shall include with such report a re-
9 port on the coverage of doula services and the role of com-
10 munity health workers under State Medicaid programs,
11 which shall include the following:

12 (1) Information about coverage for doula serv-
13 ices and community health worker services under
14 State Medicaid programs that currently provide cov-
15 erage for such services, including the type of doula
16 services offered (such as prenatal, labor and deliv-
17 ery, postpartum support, and traditional doula serv-
18 ices) and information on the prevalence of doulas
19 that care for individuals in their own communities.

20 (2) An analysis of strategies to facilitate the ap-
21 propriate use of doula services in order to provide
22 better care and achieve better maternal and infant
23 health outcomes, including strategies that States
24 may use to assist with services for which Federal fi-
25 nancial participation is eligible under a State Med-
26 icaid plan or a waiver of such a plan by recruiting,

1 training, and certifying a diverse doula workforce,
2 particularly from underserved communities, commu-
3 nities of color, and communities facing linguistic or
4 cultural barriers.

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

9 (4) An assessment of the impact of the involve-
10 ment of doulas and community health workers on
11 maternal health outcomes.

12 (5) Recommendations, as MACPAC deems ap-
13 propriate, for legislative and administrative actions
14 to increase access to services that improve maternal
15 health.

16 (b) STAKEHOLDER CONSULTATION.—In developing
17 the report required under subsection (a), MACPAC shall
18 consult with relevant stakeholders, including—

19 (1) States;

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

23 (3) organizations and individuals representing
24 doula services providers and community health work-
25 ers, including community-based doula programs and

1 those who serve underserved communities, commu-
2 nities of color and communities facing linguistic or
3 cultural barriers; and

4 (4) organizations representing health care pro-
5 viders.

6 **SEC. 8. DEMONSTRATION PROJECTS TO IMPROVE THE DE-**
7 **LIVERY OF MATERNAL HEALTH CARE**
8 **THROUGH TELEHEALTH.**

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

15 (b) ELIGIBLE PREGNANT OR POSTPARTUM WOMAN
16 DEFINED.—

17 (1) IN GENERAL.—In this section, the term “el-
18 igible pregnant or postpartum woman” means a
19 woman who is eligible for and receiving medical as-
20 sistance under a State Medicaid plan (or waiver of
21 such plan) and who is or becomes pregnant.

22 (2) POSTPARTUM WOMEN.—Such term includes
23 a woman described in paragraph (1) through the
24 end of the month in which the 365-day period begin-
25 ning on the last day of the woman’s pregnancy ends,

1 without regard to any change in income of the fam-
2 ily of which she is a member.

3 (c) APPLICATION; SELECTION OF STATES; DURA-
4 TION.—

5 (1) APPLICATION.—

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

15 (B) REQUIRED INFORMATION.—A State
16 application to conduct a demonstration project
17 under this section shall include the following:

18 (i) The population (such as individ-
19 uals residing in rural or medically under-
20 served areas) that the demonstration
21 project will target.

22 (ii) A description of how the State
23 proposes to use funds awarded under this
24 section to conduct the demonstration
25 project to integrate or increase the integra-

1 tion of telehealth into the State Medicaid
2 program's existing delivery system for fur-
3 nishing medical assistance to and improv-
4 ing the health care outcomes of eligible
5 pregnant or postpartum women.

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

17 (iv) A certification that the applica-
18 tion meets the requirements of subpara-
19 graph (C).

20 (v) Such other information as the Sec-
21 retary shall require.

22 (C) CONSULTATION WITH HEALTH CARE
23 STAKEHOLDERS.—Prior to the submission of an
24 application to conduct a demonstration project
25 under this section, a State shall consult with

1 health care systems and providers, health plans
2 (if relevant), consumer organizations and bene-
3 ficiary advocates, and community-based organi-
4 zations or other stakeholders in the area that
5 the demonstration project will target to ensure
6 that the proposed project addresses the health
7 care needs of eligible pregnant or postpartum
8 women in such area.

9 (2) SELECTION OF STATES AND DURATION OF
10 PROJECTS.—

11 (A) IN GENERAL.—The Secretary shall
12 award grants to States that apply and meet the
13 application requirements to conduct 4-year
14 demonstration projects under this section. A
15 State may request, and the Secretary shall de-
16 termine the appropriateness of, an application
17 of up to \$10,000,000.

18 (B) SELECTION OF PROJECTS.—In select-
19 ing a State to conduct a demonstration project
20 under this section, the Secretary shall ensure
21 that the State is aware of the 4-year duration
22 of the project and shall determine the State has
23 satisfied the application requirements.

24 (3) WAIVER OF STATEWIDENESS AND COM-
25 PARABILITY REQUIREMENT.—The Secretary shall

1 waive compliance with section 1902(a)(1) of the So-
2 cial Security Act (42 U.S.C. 1396a(a)(1)) (relating
3 to statewideness) and section 1902(a)(10)(B) of
4 such Act (42 U.S.C. 1396a(a)(10)(B)) (relating to
5 comparability) to the extent necessary to allow se-
6 lected States to conduct demonstration projects
7 under this section.

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

- 12 (1) primary and maternity care providers;
 - 13 (2) health care specialists;
 - 14 (3) behavioral health providers; and
 - 15 (4) other categories of health care providers
- 16 identified by the Secretary.

17 (e) REPORTS.—

18 (1) STATE REPORTS.—Each State that is
19 awarded a grant to conduct a demonstration project
20 under this section shall submit the following reports
21 to the Secretary:

22 (A) INITIAL REPORT.—An initial report on
23 the first 18 months during which the dem-
24 onstration project is conducted, not later than
25 the last day of the 19th month of the dem-

1 onstration project, as described in subpara-
2 graph (B).

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

(i) The number of eligible pregnant or postpartum women served under the demonstration project.

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

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

(iv) A description of the types of models or programs developed under the demonstration project.

(v) How such models or programs impacted access to, and utilization of, telehealth services by eligible pregnant or postpartum women, including a description of how such models or programs addressed

1 racial or ethnic disparities in access or uti-
2 lization.

3 (vi) Qualitative information on bene-
4 ficiary experience.

5 (vii) Challenges faced and lessons
6 learned by the State in integrating (or in-
7 creasing the integration of) telehealth into
8 the delivery system for furnishing medical
9 assistance to eligible pregnant or
10 postpartum women in the areas targeted
11 under the demonstration project.

12 (2) REPORTS TO CONGRESS.—

13 (A) INITIAL REPORT.—Not later than 2
14 years after the date of enactment of this Act,
15 the Secretary shall submit a report to Congress
16 summarizing the information reported by States
17 under paragraph (1)(A).

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

1 **SEC. 9. CMS REPORT ON COVERAGE OF REMOTE PHYSIO-**
2 **LOGIC MONITORING DEVICES AND IMPACT**
3 **ON MATERNAL AND CHILD HEALTH OUT-**
4 **COMES UNDER MEDICAID.**

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

19 (b) STATE RESOURCES.—Not later than 6 months
20 after the submission of the report required by subsection
21 (a), the Secretary shall update resources for State Med-
22 icaid programs, such as State Medicaid telehealth toolkits,
23 to be consistent with the recommendations provided in
24 such report.

1 **SEC. 10. GUIDANCE ON COMMUNITY-BASED MATERNAL**
2 **HEALTH PROGRAMS.**

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

12 **SEC. 11. DEVELOPING GUIDANCE ON MATERNAL MOR-**
13 **TALITY AND SEVERE MORBIDITY REDUCTION**
14 **FOR MATERNAL CARE PROVIDERS RECEIV-**
15 **ING PAYMENT UNDER THE MEDICAID PRO-**
16 **GRAM.**

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 publish on a
20 public website of the Centers for Medicare & Medicaid
21 Services guidance for States on resources and strategies
22 for hospitals, freestanding birth centers (as defined in sec-
23 tion 1905(l)(3)(B) of the Social Security Act (42 U.S.C.
24 1396d(l)(3)(B))), and other maternal care providers as de-
25 termined by the Secretary for reducing maternal mortality

1 and severe morbidity in individuals who are eligible for
2 and receiving medical assistance under Medicaid or CHIP.

3 (b) UPDATES.—The Secretary shall update the guid-
4 ance and resources described in subsection (a) at least
5 once every 3 years.

6 (c) CONSULTATION WITH ADVISORY COMMITTEE.—

7 (1) ESTABLISHMENT.—Subject to the avail-
8 ability of appropriations, not later than 18 months
9 after the date of enactment of this Act, the Sec-
10 retary shall establish an advisory committee to be
11 known as the “National Advisory Committee on Re-
12 ducing Maternal Deaths” (referred to in this section
13 as the “Advisory Committee”).

14 (2) DUTIES.—The Advisory Committee shall
15 provide consensus advice and guidance to the Sec-
16 retary on the development and compilation of the
17 guidance described in subsection (a) (and any up-
18 dates to such guidance).

19 (3) MEMBERSHIP.—

20 (A) IN GENERAL.—The Secretary, in con-
21 sultation with such other heads of agencies, as
22 the Secretary deems appropriate and in accord-
23 ance with this paragraph, shall appoint not
24 more than 41 members to the Advisory Com-

1 mittee. In appointing such members, the Sec-
2 retary shall ensure that—

3 (i) the total number of members of
4 the Advisory Committee is an odd number;
5 and

6 (ii) the total number of voting mem-
7 bers who are not Federal officials does not
8 exceed the total number of voting Federal
9 members who are Federal officials.

10 (B) REQUIRED MEMBERS.—

11 (i) FEDERAL OFFICIALS.—The Advi-
12 sory Committee shall include as voting
13 members the following Federal officials, or
14 their designees:

15 (I) The Secretary.

16 (II) The Administrator of the
17 Centers for Medicare & Medicaid
18 Services.

19 (III) The Director of the Centers
20 for Disease Control and Prevention.

21 (IV) The Associate Administrator
22 of the Maternal and Child Health Bu-
23 reau of the Health Resources and
24 Services Administration.

1 (V) The Director of the Agency
2 for Healthcare Research and Quality.

3 (VI) The National Coordinator
4 for Health Information Technology.

5 (VII) The Director of the Na-
6 tional Institutes of Health.

7 (VIII) The Secretary of Veterans
8 Affairs.

9 (IX) The Director of the Indian
10 Health Service.

11 (X) The Deputy Assistant Sec-
12 retary for Minority Health.

13 (XI) The Administrator of the
14 Substance Abuse and Mental Health
15 Services Administration.

16 (XII) The Deputy Assistant Sec-
17 retary for Women's Health.

18 (XIII) Such other Federal offi-
19 cials or their designees as the Sec-
20 retary determines appropriate.

21 (ii) NON-FEDERAL OFFICIALS.—

22 (I) IN GENERAL.—The Advisory
23 Committee shall include the following
24 as voting members:

1 (aa) At least 1 representa-
2 tive from a professional organiza-
3 tion representing hospitals and
4 health systems.

5 (bb) At least 1 representa-
6 tive from a medical professional
7 organization representing pri-
8 mary care providers.

9 (cc) At least 1 representa-
10 tive from a medical professional
11 organization representing general
12 obstetrician-gynecologists.

13 (dd) At least 1 representa-
14 tive from a medical professional
15 organization representing cer-
16 tified nurse-midwives.

17 (ee) At least 1 representa-
18 tive from a medical professional
19 organization representing other
20 maternal fetal medicine pro-
21 viders.

22 (ff) At least 1 representative
23 from a medical professional orga-
24 nization representing anesthesiol-
25 ogists.

1 (gg) At least 1 representa-
2 tive from a medical professional
3 organization representing emer-
4 gency medicine physicians and
5 urgent care providers.

6 (hh) At least 1 representa-
7 tive from a medical professional
8 organization representing nurses.

9 (ii) At least 1 representative
10 from a professional organization
11 representing community health
12 workers.

13 (jj) At least 1 representative
14 from a professional organization
15 representing doulas.

16 (kk) At least 1 representa-
17 tive from a professional organiza-
18 tion representing perinatal psy-
19 chiatrists.

20 (ll) At least 1 representative
21 from State-affiliated programs or
22 existing collaboratives with dem-
23 onstrated expertise or success in
24 improving maternal health.

1 (mm) At least 1 director of
2 a State Medicaid agency that has
3 had demonstrated success in im-
4 proving maternal health.

5 (nn) At least 1 representa-
6 tive from an accrediting organi-
7 zation for maternal health quality
8 and safety standards.

9 (oo) At least 1 representa-
10 tive from a maternal patient ad-
11 vocacy organization with lived ex-
12 perience of severe maternal mor-
13 bidity.

14 (II) REQUIREMENTS.—Each in-
15 dividual selected to be a member
16 under this clause shall—

17 (aa) have expertise in mater-
18 nal health;

19 (bb) not be a Federal offi-
20 cial; and

21 (cc) have experience working
22 with populations that are at
23 higher risk for maternal mor-
24 tality or severe morbidity, such
25 as populations that experience

1 racial, ethnic, and geographic
2 health disparities, pregnant and
3 postpartum women experiencing
4 a mental health disorder, or
5 pregnant or postpartum women
6 with other comorbidities such as
7 substance use disorders, hyper-
8 tension, thyroid disorders, and
9 sickle cell disease.

10 (C) ADDITIONAL MEMBERS.—

11 (i) IN GENERAL.—In addition to the
12 members required to be appointed under
13 subparagraph (B), the Secretary may ap-
14 point as non-voting members to the Advi-
15 sory Committee such other individuals with
16 relevant expertise or experience as the Sec-
17 retary shall determine appropriate, which
18 may include, but is not limited to, individ-
19 uals described in clause (ii).

20 (ii) SUGGESTED ADDITIONAL MEM-
21 BERS.—The individuals described in this
22 clause are the following:

23 (I) Representatives from State
24 maternal mortality review committees
25 and perinatal quality collaboratives.

1 (II) Medical providers who care
2 for women and infants during preg-
3 nancy and the postpartum period,
4 such as family practice physicians,
5 cardiologists, pulmonology critical
6 care specialists, endocrinologists, pedi-
7 atricians, and neonatologists.

8 (III) Representatives from State
9 and local public health departments,
10 including State Medicaid Agencies.

11 (IV) Subject matter experts in
12 conducting outreach to women who
13 are African American or belong to an-
14 other minority group.

15 (V) Directors of State agencies
16 responsible for administering a State's
17 maternal and child health services
18 program under title V of the Social
19 Security Act (42 U.S.C. 701 et seq.).

20 (VI) Experts in medical edu-
21 cation or physician training.

22 (VII) Representatives from med-
23 icaid managed care organizations.

1 (4) APPLICABILITY OF FACA.—The Federal Ad-
2 visory Committee Act (5 U.S.C. App.) shall apply to
3 the committee established under this subsection.

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

8 (1) Best practices regarding evidence-based
9 screening and clinician education initiatives relating
10 to screening and treatment protocols for individuals
11 who are at risk of experiencing complications related
12 to pregnancy, with an emphasis on individuals with
13 preconditions directly linked to pregnancy complica-
14 tions and maternal mortality and severe morbidity,
15 including—

16 (A) methods to identify individuals who are
17 at risk of maternal mortality or severe mor-
18 bidity, including risk stratification;

19 (B) evidence-based risk factors associated
20 with maternal mortality or severe morbidity and
21 racial, ethnic, and geographic health disparities;

22 (C) evidence-based strategies to reduce risk
23 factors associated with maternal mortality or
24 severe morbidity through services which may be
25 covered under Medicaid or CHIP, including,

1 but not limited to, activities by community
2 health workers (as such term is defined in sec-
3 tion 2113 of the Social Security Act (42 U.S.C.
4 1397mm)) that are funded by a grant awarded
5 under such section;

6 (D) resources available to such individuals,
7 such as nutrition assistance and education,
8 home visitation, mental health and substance
9 use disorder services, smoking cessation pro-
10 grams, pre-natal care, and other evidence-based
11 maternal mortality or severe morbidity reduc-
12 tion programs;

13 (E) examples of educational materials used
14 by providers of obstetrics services;

15 (F) methods for improving community cen-
16 tralized care, including providing telehealth
17 services or home visits to increase and facilitate
18 access to and engagement in prenatal and
19 postpartum care and collaboration with home
20 health agencies, community health centers, local
21 public health departments, or clinics;

22 (G) guidance on medical record diagnosis
23 codes linked to maternal mortality and severe
24 morbidity, including, if applicable, codes related
25 to social risk factors, and methods for edu-

1 eating clinicians on the proper use of such
2 codes;

3 (H) risk appropriate transfer protocols
4 during pregnancy, childbirth, and the
5 postpartum period; and

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

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

12 (3) Best practices for such hospitals, free-
13 standing birth centers, and providers to make preg-
14 nant women aware of the complications related to
15 pregnancy.

16 (4) A fact sheet for providing pregnant women
17 who are receiving care on an outpatient basis with
18 a notice during the prenatal stage of pregnancy
19 that—

20 (A) explains the risks associated with preg-
21 nancy, birth, and the postpartum period (in-
22 cluding the risks of hemorrhage, preterm birth,
23 sepsis, eclampsia, obstructed labor), chronic
24 conditions (including high blood pressure, dia-
25 betes, heart disease, depression, and obesity)

1 correlated with adverse pregnancy outcomes,
2 risks associated with advanced maternal age,
3 and the importance of adhering to a personal-
4 ized plan of care;

5 (B) highlights multimodal and evidence-
6 based prevention and treatment techniques;

7 (C) highlights evidence-based programs
8 and activities to reduce the incidence of still-
9 birth (including tracking and awareness of fetal
10 movements, improvement of birth timing for
11 pregnancies with risk factors, initiatives that
12 encourage safe sleeping positions during preg-
13 nancy, screening and surveillance for fetal
14 growth restriction, efforts to achieve smoking
15 cessation during pregnancy, community-based
16 programs that provide home visits or other
17 types of support, and any other research or evi-
18 dence-based programming to prevent still-
19 births);

20 (D) provides for a method (through signa-
21 ture or otherwise) for such an individual, or a
22 person acting on such individual's behalf, to ac-
23 knowledge receipt of such fact sheet;

24 (E) is worded in an easily understandable
25 manner and made available in multiple lan-

1 guages and accessible formats determined ap-
2 propriate by the Secretary; and

3 (F) includes any other information deter-
4 mined appropriate by the Secretary.

5 (5) A template for a voluntary clinician check-
6 list that outlines the minimum responsibilities that
7 clinicians, such as physicians, certified nurse-mid-
8 wives, emergency room and urgent care providers,
9 nurses and others, are expected to meet in order to
10 promote quality and safety in the provision of ob-
11 stetric services.

12 (6) A template for a voluntary checklist that
13 outlines the minimum responsibilities that hospital
14 leadership responsible for direct patient care, such
15 as the institution's president, chief medical officer,
16 chief nursing officer, or other hospital leadership
17 that directly report to the president or chief execu-
18 tive officer of the institution, should meet to pro-
19 mote hospital-wide initiatives that improve quality
20 and safety in the provision of obstetric services.

21 (7) Information on multi-stakeholder quality
22 improvement initiatives, such as the Alliance for In-
23 novation on Maternal Health, State perinatal quality
24 improvement initiatives, and other similar initiatives

1 determined appropriate by the Secretary, includ-
2 ing—

3 (A) information about such improvement
4 initiatives and how to join;

5 (B) information about public maternal
6 data collection centers;

7 (C) information about quality metrics used
8 and outcomes achieved by such improvement
9 initiatives;

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

12 (E) information about data sources used
13 by such improvement initiatives to identify ma-
14 ternal mortality and severe morbidity risks;

15 (F) information about interventions used
16 by such improvement initiatives to mitigate
17 risks of maternal mortality and severe mor-
18 bidity;

19 (G) information about data collection tech-
20 niques on race, ethnicity, geography, age, in-
21 come, and other demographic information used
22 by such improvement initiatives; and

23 (H) any other information determined ap-
24 propriate by the Secretary.

1 (e) INCLUSION OF BEST PRACTICES.—Not later than
2 18 months after the date of the publication of the guid-
3 ance required under subsection (a), the Secretary shall up-
4 date such guidance to include best practices identified by
5 the Secretary for such hospitals, freestanding birth cen-
6 ters, and providers to track maternal mortality and severe
7 morbidity trends by clinicians at such hospitals, free-
8 standing birth centers, and providers including—

9 (1) ways to establish scoring systems, which
10 may include quality triggers and safety and quality
11 metrics to score case and patient outcome metrics,
12 for such clinicians;

13 (2) methods to identify, educate, and improve
14 such clinicians who may have higher rates of mater-
15 nal mortality or severe morbidity compared to their
16 regional or State peers (taking into account dif-
17 ferences in patient risk for adverse outcomes, which
18 may include social risk factors);

19 (3) methods for using such data and tracking
20 to enhance research efforts focused on maternal
21 health, while also improving patient outcomes, clini-
22 cian education and training, and coordination of
23 care; and

24 (4) any other information determined appro-
25 priate by the Secretary.

1 (f) CULTURAL AND LINGUISTIC APPROPRIATE-
2 NESS.—To the extent practicable, the Secretary should de-
3 velop the guidance, best practices, fact sheets, templates,
4 and other materials that are required under this section
5 in a trauma-informed, culturally and linguistically appro-
6 priate manner.

7 **SEC. 12. COLLECTION OF INFORMATION RELATED TO SO-**
8 **CIAL DETERMINANTS OF THE HEALTH OF**
9 **MEDICAID AND CHIP BENEFICIARIES.**

10 (a) IMPLEMENTATION ASSESSMENT REPORT TO
11 CONGRESS.—

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

22 (A) a description of whether and how ICD-
23 10 codes (or successor codes) may be used to
24 identify social determinants of health in pro-
25 grams such as Medicaid and CHIP, and wheth-

1 er other claims file or demographic information
2 may be employed; and

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

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

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

23 (B) implementation considerations for cap-
24 turing such information, including whether pro-
25 gram or system changes would be required,

1 whether additional steps would be needed to
2 maintain privacy and confidentiality as required
3 under relevant laws and regulations, and the re-
4 sources and timeframes at that would be needed
5 to make such changes.

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

15 (4) ACTION PLAN REPORT.—

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

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

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

18 (5) AUTHORIZATION OF APPROPRIATIONS.—

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

1 or child health assistance or pregnancy-related
2 assistance under CHIP.

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

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

16 “(d) COLLECTION OF INFORMATION RELATED TO
17 SOCIAL DETERMINANTS OF HEALTH.—

18 “(1) DEVELOPMENT OF COLLECTION METH-
19 ODS.—

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

1 title and beneficiaries under title XXI which the
2 States, notwithstanding section 1902(a)(7) and
3 as a condition for meeting the requirements of
4 section 1902(a)(6) and section 2107(b)(1), shall
5 use to annually report such information:

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

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

22 “(iii) A model uniform form to be
23 adapted for inclusion in the Medicaid and
24 CHIP Scorecard developed by the Centers
25 for Medicare & Medicaid Services, for pur-

1 poses of the Secretary collecting such in-
2 formation.

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

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

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

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

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

1 spect to the information collected under
2 such method;

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

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

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

1 tives of the Office of Disease Prevention and Health
2 Promotion of the Department of Health and Human
3 Services, or any other standardized set of definitions
4 for social determinants of health identified by the
5 Secretary. Such definitions shall incorporate meas-
6 ures for quantifying the relative severity of any such
7 social determinant of health need identified in an in-
8 dividual.

9 “(3) FEDERAL PRIVACY REQUIREMENTS.—
10 Nothing in this subsection shall be construed to su-
11 persede any Federal privacy or confidentiality re-
12 quirement, including the regulations promulgated
13 under section 264(c) of the Health Insurance Port-
14 ability and Accountability Act of 1996 and section
15 543 of the Public Health Service Act and any regu-
16 lations promulgated thereunder .

17 “(4) APPLICATION TO TERRITORIES.—

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

1 “(B) TERRITORIES SPECIFIED.—The
2 States specified in this subparagraph are Puer-
3 to Rico, the Virgin Islands, Guam, American
4 Samoa, and the Northern Mariana Islands.

5 “(5) APPLICATION.—

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

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

22 “(6) APPROPRIATION.—There is appropriated
23 to the Secretary for fiscal year 2023 and each fiscal
24 year thereafter \$1,000,000 to carry out the provi-
25 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 “(U) Section 1946 (relating to addressing
12 health care disparities).”.

13 **SEC. 13. 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. 14. MEDICAID GUIDANCE ON STATE OPTIONS TO AD-**
6 **DRESS SOCIAL DETERMINANTS OF HEALTH**
7 **FOR PREGNANT AND POSTPARTUM WOMEN.**

8 Not later than 1 year after the date of enactment
9 of this Act, the Secretary shall issue guidance to States
10 regarding options States may employ to address social de-
11 terminants of health, as defined by the Healthy People
12 2030 and related initiatives of the Office of Disease Pre-
13 vention and Health Promotion of the Department of
14 Health and Human Services, including for pregnant and
15 postpartum women. Such guidance shall, at a minimum,
16 describe the authorities that States may leverage to sup-
17 port addressing the social determinants of health for preg-
18 nant and postpartum women and outline best practices for
19 such efforts.

20 **SEC. 15. PAYMENT ERROR RATE MEASUREMENT (PERM)**
21 **AUDIT AND IMPROVEMENT REQUIREMENTS.**

22 (a) BIENNIAL PERM AUDIT REQUIREMENT.—Be-
23 ginning with fiscal year 2024, the Administrator shall con-
24 duct payment error rate measurement (“PERM”) audits
25 of each State Medicaid program on a biennial basis.

1 (b) PERM ERROR RATE REDUCTION PLAN RE-
2 QUIREMENT.—Beginning with fiscal year 2025, any State
3 with an overall PERM error rate exceeding 15 percent in
4 a PERM audit conducted with respect to the State in the
5 previous fiscal year shall publish a plan, in coordination
6 with, and subject to the approval of, the Administrator,
7 for how the State will reduce its PERM error rate below
8 15 percent in the current fiscal year.

9 (c) NOTIFICATION; IDENTIFICATION OF SOURCES OF
10 IMPROPER PAYMENTS.—

11 (1) NOTIFICATION.—Not later than 6 months
12 after the date of enactment of this Act, the Adminis-
13 trator shall notify the contractor conducting PERM
14 audits of the Administrator’s intent to modify con-
15 tracts to require PERM audits not less than once
16 every other year in each State.

17 (2) IDENTIFICATION OF SOURCES OF IMPROPER
18 PAYMENTS.—The Administrator shall direct the con-
19 tractor conducting PERM audits of State Medicaid
20 programs to identify areas known to be sources of
21 improper payments under such programs to identify
22 program areas or components known to be sources
23 of high risk for improper payments under such pro-
24 grams.

1 (d) STATE MEDICAID DIRECTOR LETTER.—Not later
2 than 12 months after the date of enactment of this Act,
3 the Administrator shall issue a State Medicaid Director
4 letter regarding State requirements under Federal law and
5 regulations regarding avoiding and responding to im-
6 proper payments under State Medicaid programs.

7 (e) STATE IMPROPER PAYMENT MITIGATION
8 PLANS.—

9 (1) IN GENERAL.—Not later than January 1,
10 2023, each State Medicaid program shall submit to
11 the Administrator a plan, which shall include spe-
12 cific actions and timeframes for taking such actions
13 and achieving specified results, for mitigating im-
14 proper payments under such program.

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

18 (f) DEFINITIONS.—In this section:

19 (1) ADMINISTRATOR.—The term “Adminis-
20 trator” means the Administrator of the Centers for
21 Medicare & Medicaid Services.

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

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