

119TH CONGRESS  
1ST 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 (for himself and Ms. HASSAN) 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 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 Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

7 (2) COMPTROLLER GENERAL.—The term “Comptroller General” means the Comptroller General of the United States.

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

1 individual health insurance coverage” have the mean-  
2 ings given such terms in section 2791 of the Public  
3 Health Service Act (42 U.S.C. 300gg-91).

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

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

22 Section 1139B of the Social Security Act (42 U.S.C.  
23 1320b-9b) is amended—

24 (1) in subsection (b)—

25 (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

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;

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

14                   “(C) for each report submitted after Janu-  
15                  ary 1, 2027, the percentage change (if any) in  
16                  the rate of low-risk cesarean delivery (as so de-  
17                  fined) for pregnant women eligible for medical  
18                  assistance under the State plan or a waiver of  
19                  such plan in the State reported under subpara-  
20                  graph (A) from the rate reported for the most  
21                  recent previous report; and

22                   “(D) such other relevant data and infor-  
23                  mation as determined by the Secretary, and in  
24                  consultation with relevant stakeholders, such as  
25                  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;

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.”.

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

“(XIII) Effective for payments beginning with fiscal year 2027, in expanding the number of measures under subclause (III), the Secretary shall adopt a measure relating to the Nulliparous, Term, Singleton, Vertex Cesarean section (NTSV C-section) rate for hospitals in inpatient settings. Not later than 2027, the Secretary shall incorporate such measure into the designation of maternity care quality hospitals, as described in the final rule entitled ‘Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation’ (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.

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

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 PROFE-  
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 gynecologists,  
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   **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 establish  
6               a national expert group to evaluate national  
7               education on, and practice of, best birthing practices.

## 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 leaders;  
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) amnioinfusion 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 Medi-  
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;

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.

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.—

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.

(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 racial or ethnic disparities in access or utilization.

(vi) Qualitative information on beneficiary experience.

(vii) Challenges faced and lessons learned by the State in integrating (or increasing the integration of) telehealth into the delivery system for furnishing medical assistance to eligible pregnant or postpartum women in the areas targeted under the demonstration project.

(2) REPORTS TO CONGRESS.—

(A) INITIAL REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a report to Congress summarizing the information reported by States 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 Medi-  
19 caid 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 Appropriations Act, 2023 (Public Law 117–328), publish on a public  
3 website of the Centers for Medicare & Medicaid Services  
4 guidance for States on resources and strategies for hos-  
5 pitals, freestanding birth centers (as defined in section  
6 1905(l)(3)(B) of the Social Security Act (42 U.S.C.  
7 1396d(l)(3)(B))), and other maternal care providers as de-  
8 termined by the Secretary for reducing maternal mortality  
9 and severe morbidity in individuals who are eligible for  
10 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 Appropriations Act, 2023 (Public Law 117–328), update the guid-  
17 ance and resources described in subsection (a) at least  
18 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

### 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 representative  
2 from a medical professional  
3 organization representing certified  
4 nurse-midwives.

5 (ee) At least 1 representative  
6 from a medical professional  
7 organization representing other  
8 maternal fetal medicine providers.

9  
10 (ff) At least 1 representative  
11 from a medical professional organization  
12 representing anesthesiologists.

13  
14 (gg) At least 1 representative  
15 from a medical professional organization  
16 representing emergency medicine physicians and  
17 urgent care providers.

18  
19 (hh) At least 1 representative  
20 from a medical professional organization  
21 representing nurses.

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

(II) Medical providers who care for women and infants during pregnancy and the postpartum period, such as family practice physicians, cardiologists, pulmonology critical care specialists, endocrinologists, pediatricians, 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-

grams, pre-natal care, and other evidence-based maternal mortality or severe morbidity reduction 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;

(H) risk appropriate transfer protocols during pregnancy, childbirth, and the 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.

(A) explains the risks associated with pregnancy, birth, and the postpartum period (including the risks of hemorrhage, preterm birth, sepsis, eclampsia, obstructed labor), chronic conditions (including high blood pressure, diabetes, heart disease, depression, and obesity) correlated with adverse pregnancy outcomes, risks associated with advanced maternal age, and the importance of adhering to a personalized 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;

(D) information about data sharing techniques 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

(H) any other information determined appropriate 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—

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 ICD-  
20                    10 codes (or successor codes) may be used to  
21                    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

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

(B) implementation considerations for capturing such information, including whether program or system changes would be required, whether additional steps would be needed to 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 Medi-  
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 subparagraph  
5           (B), the requirement for a State to collect  
6           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 information  
16           in accordance with the method made  
17           available under paragraph (1) shall not apply to  
18           the State before the date specified in such action  
19           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 provisions  
23           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:

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 minister 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.