II

119TH CONGRESS
1ST SESSION

S. 2289

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

IN THE SENATE OF THE UNITED STATES

JULY 15, 2025

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

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Healthy Moms and Babies Act''.

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

SEC. 2. DEFINITIONS.

In this Act:

(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.).

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

(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-

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

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

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

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

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

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

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

(1) in subsection (b)—

(A) in paragraph (3)(B)—

(i) in the subparagraph heading, by inserting ''AND MATERNAL AND PERINATAL HEALTH'' after ''BEHAVIORAL HEALTH'';

(ii) by striking ''all behavioral health'' and inserting ''all behavioral health and maternal and perinatal health''; and

(iii) by inserting ''and of maternal and perinatal health care for Medicaid eligible adults'' after ''Medicaid eligible adults''; and

(B) in paragraph (5)(C)—

(i) in the subparagraph heading, by inserting ''AND MATERNAL AND PERINATAL HEALTH'' after ''BEHAVIORAL HEALTH''; and

(ii) by inserting ''and, with respect to Medicaid eligible adults, maternal and perinatal health measures'' after ''behavioral health measures''; and

(2) in subsection (d)(1)(A), by inserting ''and maternal and perinatal health'' after ''behavioral health''.

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

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

(1) in paragraph (86), by striking ''and'' after the semicolon;

(2) in paragraph (87), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (87) the following:

''(88) provide that, not later than January 1, 2027, and annually thereafter through January 1, 2037, the State shall submit a report to the Secretary, that shall be made publicly available, which contains with respect to the preceding calendar year—

''(A) the rate of low-risk cesarean delivery, as defined by the Secretary in consultation with relevant stakeholders, for pregnant women eligible for medical assistance under the State plan or a waiver of such plan in the State, as compared to the overall rate of cesarean delivery in the State;

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

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

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

provement activities, cesarean delivery rates, and health outcomes.''.

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

(1) STUDY.—The Comptroller General shall conduct a study regarding payment rates for cesarean births and vaginal births under State Medicaid programs. To the extent feasible and data are available, the study shall include analyses of the following:

(A) Payment rates for cesarean births and vaginal births paid by fee-for-service Medicaid programs and by Medicaid programs that contract with Medicaid managed care organizations to furnish medical assistance under such programs;

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

(C) What is known about how payment rates for cesarean and vaginal births by Medicaid programs compare with the payment rates for such births by other sources of insurance coverage; and

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

Medicaid as the Comptroller General determines appropriate.

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

(c) GAO STUDY ON RACIAL DISPARITIES IN CESAREAN BIRTHS.—

(1) IN GENERAL.—The Comptroller General shall conduct a study on racial disparities in the frequency of cesarean births. To the extent feasible and data are available, the study shall compare such information on low- and high-risk cesarean births, differences by payer (such as Medicaid and private payers), and hospital characteristics (such as location or hospital type). Such study may consider other factors related to racial disparities in maternal health as the Comptroller General deems appropriate.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the

results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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

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

(A) by moving the indentation of subparagraph (W) 2 ems to the left;

(B) in subparagraph (X)—

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

(ii) by striking ''and'' at the end;

(C) in subparagraph (Y), by striking the period at the end and inserting ''; and''; and

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

''(Z) in the case of a hospital, to submit, in a form and manner, and at a time, specified by the Secretary, data on the Nulliparous, Term, Singleton, Vertex Cesarean section (NTSV C-section) rate with 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)).''.

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

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

"SEC. 1945B. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR PREGNANT AND POSTPARTUM WOMEN.

''(a) STATE OPTION.—

''(1) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), beginning April 1, 2028, a State, at its option as a State plan amendment, may provide for medical assistance under this title to an eligible woman who chooses to—

''(A) enroll in a maternity health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the woman's maternity health home for purposes of providing the woman with pregnancy and postpartum coordinated care services; or

''(B) receive such services from a designated provider, a team of health care profes-

sionals operating with such a provider, or a health team that has voluntarily opted to participate in a maternity health home for eligible women under this section.

''(2) ELIGIBLE WOMAN DEFINED.—In this section, the term 'eligible woman' means an individual—

''(A) who is eligible for medical assistance under the State plan (or under a waiver of such plan) for all items and services covered under the State plan (or waiver) that are not less in amount, duration, or scope, or are determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in subsection (a)(10)(A)(i); and

''(B) who—

''(i) is pregnant; or

''(ii) had a pregnancy end within the last 365 days.

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

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

''(1) Coordinate prompt care and access to necessary maternity care services, including services provided by specialists, and programs for an eligible woman during her pregnancy and the 365-day period beginning on the last day of her pregnancy.

''(2) Develop an individualized, comprehensive, patient-centered care plan for each eligible woman that accommodates patient preferences and, if applicable, reflects adjustments to the payment methodology described in subsection (c)(2)(B).

''(3) Develop and incorporate into each eligible woman's care plan, in a culturally and linguistically appropriate manner consistent with the needs of the eligible woman, ongoing home care, community-based primary care, inpatient care, social support services, health-related social needs services, behavioral health services, local hospital emergency care, and, in the event of a change in income that would

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

''(4) Coordinate with pediatric care providers, as appropriate.

''(5) Collect and report information under subsection (f)(1).

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of pregnancy and postpartum coordinated care services, to each eligible woman that selects such provider, team of health care professionals, or health team as the woman's maternity health home or care provider. Payments made to a maternity health home or care provider for such services shall be treated as medical assistance for purposes of section 1903(a).

''(2) METHODOLOGY.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of pregnancy and postpartum coordinated care services or treatment during an eligible woman's

pregnancy and the 365-day period beginning on the last day of her pregnancy. Such methodology for determining payment—

"(A) may be based on—

"(i) a per-member per-month basis for each eligible woman enrolled in the maternity health home;

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

"(iii) an alternate model of payment (which may include a model developed under a waiver under section 1115) proposed by the State and approved by the Secretary;

"(B) may be adjusted to reflect, with respect to each eligible woman—

"(i) the severity of the risks associated with the woman's pregnancy;

"(ii) the severity of the risks associated with the woman's postpartum health care needs; and

"(iii) the level or amount of time of care coordination required with respect to the woman; and

"(C) shall be established consistent with section 1902(a)(30)(A).

"(d) COORDINATING CARE.—

"(1) HOSPITAL NOTIFICATION.—A State with a State plan amendment approved under this section shall require each hospital that is a participating provider under the State plan (or under a waiver of such plan) to establish procedures in the case of an eligible woman who seeks treatment in the emergency department of such hospital for—

"(A) providing the woman with culturally and linguistically appropriate information on the respective treatment models and opportunities for the woman to access a maternity health home and its associated benefits; and

"(B) notifying the maternity health home in which the woman is enrolled, or the designated provider, team of health care professionals operating with such a provider, or health team treating the woman, of the woman's treatment in the emergency department and of the protocols for the maternity health home, designated provider, or team to be involved in the woman's emergency care or post-discharge care.

''(2) EDUCATION WITH RESPECT TO AVAILABILITY OF A MATERNITY HEALTH HOME.—

''(A) IN GENERAL.—In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for—

''(i) educating providers participating in the State plan (or a waiver of such plan) on the availability of maternity health homes for eligible women, including the process by which such providers can participate in or refer eligible women to an approved maternity health home or a designated provider, team of health care professionals operating such a provider, or health team; and

''(ii) educating eligible women, in a culturally and linguistically appropriate manner, on the availability of maternity health homes.

''(B) OUTREACH.—The process established by the State under subparagraph (A) shall include the participation of entities or other public or private organizations or entities that pro-

vide outreach and information on the availability of health care items and services to families of individuals eligible to receive medical assistance under the State plan (or a waiver of such plan).

''(3) MENTAL HEALTH COORDINATION.—A State with a State plan amendment approved under this section shall consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention, identification, and treatment of mental health conditions and substance use disorders among eligible women.

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

''(e) MONITORING.—A State shall include in the State plan amendment—

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

''(2) a proposal for use of health information technology in providing an eligible woman with pregnancy and postpartum coordinated care services as specified under this section and improving service delivery and coordination across the care continuum; and

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

''(f) DATA COLLECTION.—

''(1) PROVIDER REPORTING REQUIREMENTS.—In order to receive payments from a State under subsection (c), a maternity health home, or a designated provider, a team of health care professionals operating with such a provider, or a health team, shall report to the State, at such time and in such form and manner as may be required by the State, including through a health information exchange or other public health data sharing entity, the following information:

''(A) With respect to each such designated provider, team of health care professionals operating with such a provider, and health team (designated as a maternity health home), the name, National Provider Identification number, address, and specific health care services offered to be provided to eligible women who have selected such provider, team of health care professionals, or health team as the women's maternity health home.

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

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

''(D) Such other information as the Secretary shall specify in guidance.

''(2) STATE REPORTING REQUIREMENTS.—

''(A) COMPREHENSIVE REPORT.—A State with a State plan amendment approved under

this section shall report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission), at such time, but at a minimum frequency of every 12 months, and in such form and manner determined by the Secretary to be reasonable and minimally burdensome, including through a health information exchange or other public health data sharing entity, the following information:

''(i) Information described in paragraph (1).

''(ii) The number and, to the extent available and while maintaining all relevant protecting privacy and confidentially protections, disaggregated demographic information of eligible women who have enrolled in a maternity health home pursuant to this section.

''(iii) The number of maternity health homes in the State.

''(iv) The medical conditions or factors that contribute to severe maternal morbidity among eligible women enrolled in maternity health homes in the State.

''(v) The extent to which such women receive health care items and services under the State plan before, during, and after the women's enrollment in such a maternity health home.

''(vi) Where applicable, mortality data and data for the associated causes of death for eligible women enrolled in a maternity health home under this section, in accordance with subsection (g). For deaths occurring postpartum, such data shall distinguish between deaths occurring up to 42 days postpartum and deaths occurring between 43 days to up to 1 year postpartum. Where applicable, data reported under this clause shall be reported alongside comparable data from a State's maternal mortality review committee, as established in accordance with section 317K(d) of the Public Health Service Act, for purposes of further identifying and comparing statewide trends in maternal mortality among populations participating in the maternity health home under this section.

''(B) IMPLEMENTATION REPORT.—Not later than 18 months after a State has a State plan amendment approved under this section, the State shall submit to the Secretary, and make publicly available on the appropriate State website, a report on how the State is implementing the option established under this section, including through any best practices adopted by the State.

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

''(h) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require—

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

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

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

''(i) PLANNING GRANTS.—

''(1) IN GENERAL.—Beginning October 1, 2027, from the amount appropriated under paragraph (2), the Secretary shall award planning grants to States for purposes of developing and submitting a State plan amendment under this section. The Secretary shall award a grant to each State that applies for a grant under this subsection, but the Secretary may determine the amount of the grant based on the merits of the application and the goal of the State to prioritize health outcomes for eligible women. A planning grant awarded to a State under this subsection shall remain available until expended.

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

''(3) LIMITATION.—The total amount of payments made to States under this subsection shall not exceed $50,000,000.

''(j) ADDITIONAL DEFINITIONS.—In this section:

''(1) DESIGNATED PROVIDER.—The term 'designated provider' means a physician (including an obstetrician-gynecologist), hospital, clinical practice or clinical group practice, a medicaid managed care organization, as defined in section 1903(m)(1)(A), a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation), a prepaid ambulatory health plan, as defined in such section (or any successor regulation), rural clinic, community health center, community mental health center, or any other entity or provider that is determined by the State and approved by the Secretary to be qualified to be a maternity health home on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide pregnancy and postpartum coordinated care services. Such term may include providers who are employed by, or affiliated with, a hospital.

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

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

''(4) PREGNANCY AND POSTPARTUM COORDINATED CARE SERVICES.—

''(A) IN GENERAL.—The term 'pregnancy and postpartum coordinated care services' means items and services related to the coordination of care for comprehensive and timely high-quality, culturally and linguistically appropriate, services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team (designated as a maternity health home).

''(B) SERVICES DESCRIBED.—

''(i) IN GENERAL.—The services described in this subparagraph shall include with respect to a State electing the State plan amendment option under this section, any medical assistance for items and services for which payment is available under the State plan or under a waiver of such plan.

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

"(I) Any item or service for which medical assistance is otherwise available under the State plan (or a waiver of such plan) related to the treatment of a woman during the woman's pregnancy and the 1-year period beginning on the last day of her pregnancy, including mental health and substance use disorder services.

"(II) Comprehensive care management.

"(III) Care coordination (including with pediatricians as appropriate), health promotion, and providing access to the full range of maternal, obstetric, and gynecologic services, including services from out-of-State providers.

"(IV) Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings.

''(V) Patient and family support (including authorized representatives).

''(VI) Referrals to community and social support services, if relevant.

''(VII) Use of health information technology to link services, as feasible and appropriate.

''(5) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health care professionals (as described in the State plan amendment under this section) that may—

''(A) include—

''(i) physicians, including gynecologist-obstetricians, pediatricians, and other professionals such as physicians assistants, advance practice nurses, including certified nurse midwives, nurses, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical counselors, physical therapists, occupational therapists, or any professionals that assist in prenatal care, delivery, or postpartum care for which medical assist-

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

''(ii) an entity or individual who is designated to coordinate such care delivered by the team; and

''(iii) when appropriate and if otherwise eligible to furnish items and services that are reimbursable as medical assistance under the State plan or under a waiver of such plan, doulas, community health workers, translators and interpreters, and other individuals with culturally appropriate and trauma-informed expertise; and

''(B) provide care at a facility that is freestanding, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.''.

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

Not later than 2 years after the date of enactment of this Act, the Secretary shall issue guidance for State Medicaid programs on improved care coordination, continuity of care, and clinical integration to support the needs of pregnant and postpartum women for services eligible for Medicaid payment. Such guidance shall identify best practices for care coordination for such women, both with respect to fee-for-service State Medicaid programs and State Medicaid programs that contract with Medicaid managed care organizations or other specified entities to furnish medical assistance for such women, and shall illustrate strategies for—

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

(2) integrating behavioral health providers to provide screening, assessment, treatment, and referral for behavioral health needs, including substance use disorders, maternal depression, anxiety, intimate partner violence, and other trauma;

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

or credentialed by a State or State-authorized organization) doulas, peer support specialists, and community health workers, and how these services provided by such professionals may be eligible for Federal financial participation under Medicaid;

(4) screening pregnant and postpartum women for social needs and coordinating related services during the prenatal and postpartum periods to ensure social and physical supports are provided for such women during such periods and for their children;

(5) supporting women who have had a stillbirth;

(6) screening for maternal health, behavioral health, and social needs during well-child and pediatric care visits; and

(7) streamlining and reducing duplication in care coordination efforts across and among providers, plans, and other entities for such women.

SEC. 7. NATIONAL RESKILLING OF THE MATERNITY CARE WORKFORCE.

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

"SEC. 317L–2. NATIONAL RESKILLING OF THE MATERNITY CARE WORKFORCE.

''(a) ESTABLISHMENT OF NATIONAL EXPERT GROUP.—

''(1) IN GENERAL.—The Secretary shall establish a national expert group to evaluate national education on, and practice of, best birthing practices.

''(2) MEMBERS.—

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

''(i) obstetricians and gynecologists, family medicine physicians, midwifes, and nursing leaders;

''(ii) hospital administrators;

''(iii) graduate medical education leaders;

''(iv) doula leaders;

''(v) individuals with experience in community birth settings;

''(vi) patients;

''(vii) high-risk birth experts; and

''(viii) quality improvement leaders.

''(B) GEOGRAPHIC DIVERSITY.—In appointing members under subparagraph (A), the

Secretary shall ensure a balance of members representing rural areas and members representing urban areas.

''(b) DUTIES.—The group established under subsection (a) shall—

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

''(A) cesarean sections, repeat cesarean, and vaginal birth after cesarean;

''(B) electronic fetal monitoring and intermittent auscultation;

''(C) birth positions, including upright positioning and ambulation;

''(D) labor with doula support;

''(E) evaluating indications for cesarean delivery, including cervical dilation and duration of pushing;

''(F) operative vaginal deliveries;

''(G) manual fetal rotation;

''(H) amnioinfusion and scalp stimulation; and

''(I) cervical ripening methods;

''(2) assess the role of the culture of care, maternity care financing, and health education with respect to the trends under paragraph (1); and

''(3) identify case studies of the provision of exemplary birthing care.

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

''(1) best practices for—

''(A) evaluating birthing skills;

''(B) improving curricula for health professionals engaged in birthing; and

''(C) the incorporation of midwives and doulas into residency curricula for obstetricians; and

''(2) recommendations for policies and practices to improve maternity care overall.''.

SEC. 8. MACPAC STUDY ON DOULAS AND COMMUNITY HEALTH WORKERS; GUIDANCE ON INCREASING ACCESS TO DOULA SERVICES UNDER MEDICAID.

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

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

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

(A) Information about coverage for doula services and community health worker services under State Medicaid programs that currently provide coverage for such services, including the type of doula services offered (such as prenatal, labor and delivery, postpartum support, and traditional doula services) and information on the prevalence of doulas that care for individuals in their own communities.

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

diverse doula workforce, particularly from underserved communities, communities of color, and communities facing linguistic or cultural barriers.

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

(D) An assessment of the impact of the involvement of doulas and community health workers on maternal health outcomes.

(E) Recommendations, as MACPAC deems appropriate, for legislative and administrative actions to increase access to services that improve maternal health.

(2) STAKEHOLDER CONSULTATION.—In developing the report required under paragraph (1), MACPAC shall consult with relevant stakeholders.

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

(1) IN GENERAL.—Not later than 1 year after the date that MACPAC publishes the report required under subsection (a), the Secretary shall issue guidance to States on increasing access to

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

(A) options for States to provide medical assistance for doula services under State Medicaid programs;

(B) best practices for ensuring that doulas, including community-based doulas, receive reimbursement for doula services provided under a State Medicaid program, at a level that allows doulas to earn a living wage that accounts for their time and costs associated with providing care and community-based doula program administration; and

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

(2) STAKEHOLDER CONSULTATION.—In developing the report required under paragraph (1), the Secretary shall consult with relevant stakeholders.

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

(1) States;

(2) organizations representing consumers, including those that are disproportionately impacted by poor maternal health outcomes;

(3) organizations and individuals representing doula services providers and community health workers, including community-based doula programs and those who serve underserved communities, communities of color and communities facing linguistic or cultural barriers; and

(4) organizations representing health care providers.

SEC. 9. DEMONSTRATION PROJECTS TO IMPROVE THE DELIVERY OF MATERNAL HEALTH CARE THROUGH TELEHEALTH.

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

(b) ELIGIBLE PREGNANT OR POSTPARTUM WOMAN DEFINED.—

(1) IN GENERAL.—In this section, the term ''eligible pregnant or postpartum woman'' means a woman who is eligible for and receiving medical as-

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

(2) POSTPARTUM WOMEN.—Such term includes a woman described in paragraph (1) through the end of the month in which the 365-day period beginning on the last day of the woman's pregnancy ends, without regard to any change in income of the family of which she is a member.

(c) APPLICATION; SELECTION OF STATES; DURATION.—

(1) APPLICATION.—

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

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

(i) The population (such as individuals residing in rural or medically under-

served areas) that the demonstration project will target.

(ii) A description of how the State proposes to use funds awarded under this section to conduct the demonstration project to integrate or increase the integration of telehealth into the State Medicaid program's existing delivery system for furnishing medical assistance to and improving the health care outcomes of eligible pregnant or postpartum women.

(iii) A description of how the State will use funds to address racial or ethnic disparities in access to maternal health services or maternal health outcomes, barriers to care, including in rural or medically underserved communities, other barriers to using telehealth, such as those experienced by individuals with disabilities and individuals with limited English proficiency, and as applicable, barriers to the use of telehealth in tribal communities.

(iv) A certification that the application meets the requirements of subparagraph (C).

(v) Such other information as the Secretary shall require.

(C) CONSULTATION WITH HEALTH CARE STAKEHOLDERS.—Prior to the submission of an application to conduct a demonstration project under this section, a State shall consult with health care systems and providers, health plans (if relevant), consumer organizations and beneficiary advocates, and community-based organizations or other stakeholders in the area that the demonstration project will target to ensure that the proposed project addresses the health care needs of eligible pregnant or postpartum women in such area.

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

(A) IN GENERAL.—The Secretary shall award grants to States that apply and meet the application requirements to conduct 4-year demonstration projects under this section. A State may request, and the Secretary shall determine the appropriateness of, an application of up to $10,000,000.

(B) SELECTION OF PROJECTS.—In selecting a State to conduct a demonstration project

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

(3) WAIVER OF STATEWIDENESS AND COMPARABILITY REQUIREMENT.—The Secretary shall waive compliance with section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) and section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) (relating to comparability) to the extent necessary to allow selected States to conduct demonstration projects under this section.

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

(1) primary and maternity care providers;

(2) health care specialists;

(3) behavioral health providers; and

(4) other categories of health care providers identified by the Secretary.

(e) REPORTS.—

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

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

(A) INITIAL REPORT.—An initial report on the first 18 months during which the demonstration project is conducted, not later than the last day of the 19th month of the demonstration project, as described in subparagraph (B).

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

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

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

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

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

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

(B) FINAL REPORT.—Not later than 5 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)(B).

SEC. 10. CMS REPORT ON COVERAGE OF REMOTE PHYSIOLOGIC MONITORING DEVICES AND IMPACT ON MATERNAL AND CHILD HEALTH OUTCOMES UNDER MEDICAID.

(a) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing information on authorities and State practices for covering remote physiological monitoring devices, including limitations and barriers to such coverage and the impact on maternal health outcomes, and to the extent appropriate, recommendations on how to address such limitations or barriers related to coverage of remote physiologic devices under State Medicaid programs, including, but not limited to, pulse oximeters, blood pressure cuffs, scales, and blood glucose monitors, with the goal of improving maternal and child health outcomes for pregnant and postpartum women enrolled in State Medicaid programs.

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

(a), the Secretary shall update resources for State Medicaid programs, such as State Medicaid telehealth toolkits, to be consistent with the recommendations provided in such report.

SEC. 11. GUIDANCE ON COMMUNITY-BASED MATERNAL HEALTH PROGRAMS.

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

SEC. 12. DEVELOPING GUIDANCE ON MATERNAL MORTALITY AND SEVERE MORBIDITY REDUCTION FOR MATERNAL CARE PROVIDERS RECEIVING PAYMENT UNDER THE MEDICAID PROGRAM.

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

Force on Maternal Mental Health established under section 1113 of division FF of the Consolidated Appropriations Act, 2023 (Public Law 117–328), publish on a public website of the Centers for Medicare & Medicaid Services guidance for States on resources and strategies for hospitals, freestanding birth centers (as defined in section 1905(l)(3)(B) of the Social Security Act (42 U.S.C. 1396d(l)(3)(B))), and other maternal care providers as determined by the Secretary for reducing maternal mortality and severe morbidity in individuals who are eligible for and receiving medical assistance under Medicaid or CHIP.

(b) UPDATES.—The Secretary shall, in consultation with the Advisory Committee on Reducing Maternal Deaths established under subsection (c) and the Task Force on Maternal Mental Health established under section 1113 of division FF of the Consolidated Appropriations Act, 2023 (Public Law 117–328), update the guidance and resources described in subsection (a) at least once every 3 years.

(c) CONSULTATION WITH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Subject to the availability of appropriations, not later than 18 months after the date of enactment of this Act, the Secretary shall establish an advisory committee to be known as the ''National Advisory Committee on Re-

ducing Maternal Deaths'' (referred to in this section as the ''Advisory Committee'').

(2) DUTIES.—The Advisory Committee shall provide consensus advice and guidance to the Secretary on the development and compilation of the guidance described in subsection (a) (and any updates to such guidance).

(3) MEMBERSHIP.—

(A) IN GENERAL.—The Secretary, in consultation with such other heads of agencies, as the Secretary deems appropriate and in accordance with this paragraph, shall appoint not more than 41 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that—

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

(ii) the total number of voting members who are not Federal officials does not exceed the total number of voting Federal members who are Federal officials.

(B) REQUIRED MEMBERS.—

(i) FEDERAL OFFICIALS.—The Advisory Committee shall include as voting

members the following Federal officials, or their designees:

(I) The Secretary.

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

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

(IV) The Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration.

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

(VI) The National Coordinator for Health Information Technology.

(VII) The Director of the National Institutes of Health.

(VIII) The Secretary of Veterans Affairs.

(IX) The Director of the Indian Health Service.

(X) The Deputy Assistant Secretary for Minority Health.

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

(XII) The Deputy Assistant Secretary for Women's Health.

(XIII) Such other Federal officials or their designees as the Secretary determines appropriate.

(ii) NON-FEDERAL OFFICIALS.—

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

(aa) At least 1 representative from a professional organization representing hospitals and health systems.

(bb) At least 1 representative from a medical professional organization representing primary care providers.

(cc) At least 1 representative from a medical professional organization representing general obstetrician-gynecologists.

(dd) At least 1 representative from a medical professional organization representing certified nurse-midwives.

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

(ff) At least 1 representative from a medical professional organization representing anesthesiologists.

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

(hh) At least 1 representative from a medical professional organization representing nurses.

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

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

(kk) At least 1 representative from a professional organization representing perinatal psychiatrists.

(ll) At least 1 representative from State-affiliated programs or existing collaboratives with demonstrated expertise or success in improving maternal health.

(mm) At least 1 director of a State Medicaid agency that has had demonstrated success in improving maternal health.

(nn) At least 1 representative from an accrediting organization for maternal health quality and safety standards.

(oo) At least 1 representative from a maternal patient advocacy organization with lived experience of severe maternal morbidity.

(pp) At least 1 medical professional who is an expert in the treatment of pregnant women with substance use disorder.

(II) REQUIREMENTS.—Each individual selected to be a member under this clause shall—

(aa) have expertise in maternal health;

(bb) not be a Federal official; and

(cc) have experience working with populations that are at higher risk for maternal mortality or severe morbidity, such as populations that experience racial, ethnic, and geographic health disparities, pregnant and postpartum women experiencing a mental health disorder, or pregnant or postpartum women with other comorbidities such as substance use disorders, hypertension, thyroid disorders, and sickle cell disease.

(C) ADDITIONAL MEMBERS.—

(i) IN GENERAL.—In addition to the members required to be appointed under subparagraph (B), the Secretary may appoint as non-voting members to the Advisory Committee such other individuals with relevant expertise or experience as the Secretary shall determine appropriate, which may include, but is not limited to, individuals described in clause (ii).

(ii) SUGGESTED ADDITIONAL MEMBERS.—The individuals described in this clause are the following:

(I) Representatives from State maternal mortality review committees 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.

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

(IV) Subject matter experts in conducting outreach to women who are African-American or belong to another minority group.

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

(VI) Experts in medical education or physician training.

(VII) Representatives from Medicaid managed care organizations.

(4) APPLICABILITY OF FACA.—Chapter 10 of title 5, United States Code, shall apply to the committee established under this subsection.

(d) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals, freestanding birth centers, and other maternal care providers, the following:

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

to screening and treatment protocols for individuals who are at risk of experiencing complications related to pregnancy, with an emphasis on individuals with preconditions directly linked to pregnancy complications and maternal mortality and severe morbidity, including—

(A) methods to identify individuals who are at risk of maternal mortality or severe morbidity, including risk stratification;

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

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

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

grams, prenatal care, and other evidence-based maternal mortality or severe morbidity reduction programs;

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

(F) methods for improving community centralized care, including providing telehealth services or home visits to increase and facilitate access to and engagement in prenatal and postpartum care and collaboration with home health agencies, community health centers, local public health departments, or clinics;

(G) guidance on medical record diagnosis codes linked to maternal mortality and severe morbidity, including, if applicable, codes related to social risk factors, and methods for educating clinicians on the proper use of such codes;

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

(I) any other information related to prevention and treatment of at-risk individuals determined appropriate by the Secretary.

(2) Guidance on monitoring programs for individuals who have been identified as at risk of complications related to pregnancy.

(3) Best practices for such hospitals, freestanding birth centers, and providers to make pregnant women aware of the complications related to pregnancy.

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

(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;

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

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

birth (including tracking and awareness of fetal movements, improvement of birth timing for pregnancies with risk factors, initiatives that encourage safe sleeping positions during pregnancy, screening and surveillance for fetal growth restriction, efforts to achieve smoking cessation during pregnancy, community-based programs that provide home visits or other types of support, and any other research or evidence-based programming to prevent stillbirths);

(D) provides for a method (through signature or otherwise) for such an individual, or a person acting on such individual's behalf, to acknowledge receipt of such fact sheet;

(E) is worded in an easily understandable manner and made available in multiple languages and accessible formats determined appropriate by the Secretary; and

(F) includes any other information determined appropriate by the Secretary.

(5) A template for a voluntary clinician checklist that outlines the minimum responsibilities that clinicians, such as physicians, certified nurse-midwives, emergency room and urgent care providers,

nurses and others, are expected to meet in order to promote quality and safety in the provision of obstetric services.

(6) A template for a voluntary checklist that outlines the minimum responsibilities that hospital leadership responsible for direct patient care, such as the institution's president, chief medical officer, chief nursing officer, or other hospital leadership that directly report to the president or chief executive officer of the institution, should meet to promote hospital-wide initiatives that improve quality and safety in the provision of obstetric services.

(7) Information on multi-stakeholder quality improvement initiatives, such as the Alliance for Innovation on Maternal Health, State perinatal quality improvement initiatives, and other similar initiatives determined appropriate by the Secretary, including—

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

(B) information about public maternal data collection centers;

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

(D) information about data sharing techniques used by such improvement initiatives;

(E) information about data sources used by such improvement initiatives to identify maternal mortality and severe morbidity risks;

(F) information about interventions used by such improvement initiatives to mitigate risks of maternal mortality and severe morbidity;

(G) information about data collection techniques on race, ethnicity, geography, age, income, and other demographic information used by such improvement initiatives; and

(H) any other information determined appropriate by the Secretary.

(e) INCLUSION OF BEST PRACTICES.—Not later than 18 months after the date of the publication of the guidance required under subsection (a), the Secretary shall update such guidance to include best practices identified by the Secretary for such hospitals, freestanding birth centers, and providers to track maternal mortality and severe morbidity trends by clinicians at such hospitals, freestanding birth centers, and providers including—

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

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

(2) methods to identify, educate, and improve such clinicians who may have higher rates of maternal mortality or severe morbidity compared to their regional or State peers (taking into account differences in patient risk for adverse outcomes, which may include social risk factors);

(3) methods for using such data and tracking to enhance research efforts focused on maternal health, while also improving patient outcomes, clinician education and training, and coordination of care; and

(4) any other information determined appropriate by the Secretary.

(f) CULTURAL AND LINGUISTIC APPROPRIATENESS.—To the extent practicable, the Secretary should develop the guidance, best practices, fact sheets, templates, and other materials that are required under this section in a trauma-informed, culturally and linguistically appropriate manner.

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

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

(1) in paragraph (1)—

(A) by striking ''and to develop or support'' and inserting ''to develop or support''; and

(B) by inserting '', and to establish a grant program, or extend the Alliance for Innovation on Maternal Health, for the establishment of perinatal quality collaboratives to reduce cesarean section rates and increase vaginal birth after cesarean rates'' before the period at the end; and

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

''(E) The Secretary may establish a competitive grant program, or extend existing programs, including the Alliance for Innovation on Maternal Health, for the establishment or support of perinatal quality collaboratives, with a focus on maternity care health professional target areas and other areas with limited birthing resources, to reduce cesarean birth rates and

increase vaginal birth after cesarean rates, including through—

"(i) coordination with hospitals, clinical teams, obstetricians and gynecologists, birthing centers and community-based maternal health organizations, public health agencies, midwives, doulas, patients and families, and other relevant entities;

"(ii) providing support and training to hospital and clinical teams for quality improvement, as appropriate;

"(iii) employing strategies that provide opportunities for health care professionals and clinical teams to collaborate across health care settings and disciplines, including midwifery care, doula support, the integration of primary care and mental health, and blended case payment rates;

"(iv) using data, disaggregated by race and ethnicity, to provide timely feedback across hospital and clinical teams, document baseline cesarean and vaginal birth rates, and measure progress; and

"(v) promotion of existing evidence on the best practices for the safe reduction of primary cesarean births.".

SEC. 14. COLLECTION OF INFORMATION RELATED TO SOCIAL DETERMINANTS OF THE HEALTH OF MEDICAID AND CHIP BENEFICIARIES.

(a) IMPLEMENTATION ASSESSMENT REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a report to Congress that includes a description of whether and how information related to the social determinants of health for individuals eligible for medical assistance under Medicaid or child health assistance or pregnancy-related assistance under CHIP may be captured under the data systems for such programs as in effect on the date such report is submitted, including—

(A) a description of whether and how ICD–10 codes (or successor codes) may be used to identify social determinants of health in programs such as Medicaid and CHIP, and whether other claims file or demographic information may be employed; and

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

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

(A) whether and how information related to the social determinants of health for individuals eligible for medical assistance under Medicaid or child health assistance or pregnancy-related assistance under CHIP could be captured employing existing systems under such programs; 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

under relevant laws and regulations, and the resources and timeframes at that would be needed to make such changes.

(3) STAKEHOLDER INPUT.—The Secretary shall develop the report required under paragraph (1) and the guidance required under paragraph (2) with the input of relevant stakeholders, such as State Medicaid directors, Medicaid managed care organizations, and other relevant Federal agencies such as the Centers for Disease Control and Prevention, the Health Resources Services Administration, and the Agency for Healthcare Research and Quality.

(4) ACTION PLAN REPORT.—

(A) IN GENERAL.—If the Secretary determines in the report required under paragraph (1) that information related to the social determinants of health for individuals eligible for medical assistance under Medicaid or child health assistance or pregnancy-related assistance under CHIP cannot be captured under the data systems for such programs as in effect on the date such report is submitted, then, not later than 6 months after such date, the Secretary shall submit a second report to Congress that contains an action plan for implementing

the program or data systems changes needed in order for such information to be collected while maintaining privacy and confidentiality as required under relevant laws and regulations. The action plan should be prepared so as to be implemented by the Federal Government and States not later than 2 years after the date on which the report required under this paragraph is submitted to Congress.

(B) REVISED GUIDANCE FOR STATES.—The Secretary shall revise and reissue the guidance for States required under paragraph (2) to take into account the action plan included in the report submitted to Congress under subparagraph (A).

(5) AUTHORIZATION OF APPROPRIATIONS.—

(A) FEDERAL COSTS.—There are authorized to be appropriated to the Secretary, $40,000,000 for purposes of preparing the reports required under this subsection and implementing the collection of information related to the social determinants of health for individuals eligible for medical assistance under Medicaid or child health assistance or pregnancy-related assistance under CHIP.

(B) STATE COSTS.—There are authorized to be appropriated to the Secretary, $50,000,000 for purposes of making payments to States in accordance with a methodology established by the Secretary for State expenditures attributable to planning for and implementing the collection of such information in accordance with subsection (d) of section 1946 of the Social Security Act (42 U.S.C. 1396w–5) (as added by subsection (b)).

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

''(d) COLLECTION OF INFORMATION RELATED TO SOCIAL DETERMINANTS OF HEALTH.—

''(1) DEVELOPMENT OF COLLECTION METHODS.—

''(A) IN GENERAL.—Subject to paragraph (5), the Secretary, in consultation with the States, shall develop a method for collecting standardized and aggregated State-level information related to social determinants that may factor into the health of beneficiaries under this title and beneficiaries under title XXI which the States, notwithstanding section 1902(a)(7) and

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

"(i) A model uniform reporting field through the transformed Medicaid Statistical Information System (T-MSIS) (or a successor system) or another appropriate reporting platform, as approved by the Secretary.

"(ii) A model uniform questionnaire or survey (which may be included as part of an existing survey, questionnaire, or form administered by the Secretary), for purposes of the State or the Secretary collecting such information by administering regularly but not less than annually a questionnaire or survey of beneficiaries under this title and beneficiaries under title XXI.

"(iii) A model uniform form to be adapted for inclusion in the Medicaid and CHIP Scorecard developed by the Centers for Medicare & Medicaid Services, for purposes of the Secretary collecting such information.

"(iv) An alternative method identified by the Secretary for collecting such information.

"(B) IMPLEMENTATION.—In carrying out the requirements of subparagraph (A), the Secretary shall—

"(i) for purposes of the method described in clause (i) of such subparagraph, determine the appropriate providers and frequency with which such providers shall complete the reporting field identified and report the information to the State;

"(ii) for purposes of the method described in clause (ii) of such subparagraph, identify the means and frequency (which shall be no less frequent than once per year) with which a questionnaire or survey of beneficiaries is to be conducted;

"(iii) with respect to any method described in such subparagraph, issue guidance for ensuring compliance with applicable laws regarding beneficiary informed consent, privacy, and anonymity with respect to the information collected under such method;

''(iv) with respect to the collection of information relating to beneficiaries who are children, issue guidance on the collection of such information from a parent, legal guardian, or any other person who is legally authorized to share such information on behalf of the child when the direct collection of such information from children may not otherwise be feasible or appropriate; and

''(v) regularly evaluate the method under such subparagraph and the information reported using such method, and, as needed, make updates to the method and the information reported.

''(2) SOCIAL DETERMINANTS OF HEALTH.—The information collected in accordance with the method made available under paragraph (1) shall, to the extent practicable, include standardized definitions for identifying social determinants of health needs identified in the ICD–10 diagnostic codes Z55 through Z65 (or any such successor diagnostic codes), as defined by the Healthy People 2020 and related initiatives of the Office of Disease Prevention and Health Promotion of the Department of Health and Human

Services, or any other standardized set of definitions for social determinants of health identified by the Secretary. Such definitions shall incorporate measures for quantifying the relative severity of any such social determinant of health need identified in an individual.

''(3) FEDERAL PRIVACY REQUIREMENTS.—Nothing in this subsection shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and section 543 of the Public Health Service Act and any regulations promulgated thereunder.

''(4) APPLICATION TO TERRITORIES.—

''(A) IN GENERAL.—To the extent that the Secretary determines that it is not practicable for a State specified in subparagraph (B) to report information in accordance with the method made available under paragraph (1), this subsection shall not apply with respect to such State.

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

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

''(5) APPLICATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the requirement for a State to collect information in accordance with the method made available under paragraph (1) shall not apply to the State before the date that is 4 years after the date of enactment of this subsection.

''(B) ALTERNATIVE DATE.—If an action plan is submitted to Congress under section 14(a)(4) of the Healthy Moms and Babies Act, in lieu of the date described in subparagraph (A), the requirement for a State to collect information in accordance with the method made available under paragraph (1) shall not apply to the State before the date specified in such action plan.

''(6) APPROPRIATION.—There is appropriated to the Secretary for fiscal year 2026 and each fiscal year thereafter $1,000,000 to carry out the provisions of this section and subsection (b)(2)(B).''.

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

(1) by striking ''Not later than'' and inserting the following:

''(A) INITIAL REPORTS.—Not later than''; and

(2) by adding at the end the following:

''(B) REPORTS ON COLLECTION OF INFORMATION RELATED TO SOCIAL DETERMINANTS OF HEALTH.—

''(i) IN GENERAL.—Not later than 5 years after the date on which the requirement to collect information under subsection (d) is first applicable to States, the Secretary shall submit to Congress a report that includes aggregate findings and trends across respective beneficiary populations for improving the identification of social determinants of health for beneficiaries under this title and beneficiaries under title XXI based on analyses of the data collected under subsection (d).

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

of this subparagraph, the Secretary shall submit to Congress an interim report on progress in developing, implementing, and utilizing the method selected by the Secretary under subsection (d)(1) along with any available, preliminary information that has been collected using such method.''.

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

''(V) Section 1946 (relating to addressing health care disparities).''.

SEC. 15. REPORT ON PAYMENT METHODOLOGIES FOR TRANSFERRING PREGNANT WOMEN BETWEEN FACILITIES BEFORE, DURING, AND AFTER CHILDBIRTH.

(a) IN GENERAL.—Subject to the availability of appropriations, not later than 36 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the payment methodologies under Medicaid for the antepartum, intrapartum, and postpartum transfer of pregnant women from one health care facility to another, including any potential disincentives or regulatory barriers to such transfers.

(b) CONSULTATION.—In developing the report required under subsection (a), the Secretary shall consult with the advisory committee established under section 12(c).

SEC. 16. MEDICAID GUIDANCE ON STATE OPTIONS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH FOR PREGNANT AND POSTPARTUM WOMEN.

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

(b) GUIDANCE REQUIREMENTS.—The guidance required under subsection (a) shall, at a minimum, describe the authorities that States may leverage to support addressing the social determinants of health for pregnant and postpartum women and outline best practices for such efforts.

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

shall, at a minimum, include opportunities for States and other stakeholders to share innovative practices and approaches as they are being considered and developed, share solutions related to challenges that multiple urban and rural States face, and promote the uptake of approved, effective interventions addressing social needs and determinants covered by the Medicaid program.

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

(a) BIENNIAL PERM AUDIT REQUIREMENT.—Beginning with fiscal year 2027, the Administrator shall conduct payment error rate measurement (''PERM'') audits of each State Medicaid program on a biennial basis.

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

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

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

trator shall notify the contractor conducting PERM audits of the Administrator's intent to modify contracts to require PERM audits not less than once every other year in each State.

(2) IDENTIFICATION OF SOURCES OF IMPROPER PAYMENTS.—The Administrator shall direct the contractor conducting PERM audits of State Medicaid programs to identify areas known to be sources of improper payments under such programs to identify program areas or components known to be sources of high risk for improper payments under such programs.

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

(e) STATE IMPROPER PAYMENT MITIGATION PLANS.—

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

and achieving specified results, for mitigating improper payments under such program.

(2) PUBLICATION OF STATE PLANS.—The Administrator shall make State plans submitted under paragraph (1) available to the public.

(f) DEFINITIONS.—In this section:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Centers for Medicare & Medicaid Services.

(2) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

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

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