

116TH CONGRESS
1ST SESSION

H. R. 1551

To amend title XI of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures and supporting maternity care quality collaboratives.

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 2019

Mr. ENGEL (for himself and Mr. STIVERS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XI of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures and supporting maternity care quality collaboratives.

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 “Quality Care for Moms and Babies Act”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Quality measures for maternal and infant health.

Sec. 3. Quality collaboratives.

Sec. 4. Facilitation of increased coordination and alignment between the public
 and private sector with respect to quality and efficiency meas-
 ures.

3 **SEC. 2. QUALITY MEASURES FOR MATERNAL AND INFANT**
 4 **HEALTH.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
 6 (42 U.S.C. 1301 et seq.) is amended by inserting after
 7 section 1139B the following new section:

8 **“SEC. 1139C. MATERNAL AND INFANT QUALITY MEASURES.**

9 “(a) DEVELOPMENT OF CORE SET OF HEALTH CARE
 10 QUALITY MEASURES FOR MATERNAL AND INFANT
 11 HEALTH.—

12 “(1) IN GENERAL.—The Secretary shall iden-
 13 tify and publish a recommended core set of maternal
 14 and infant health quality measures for women and
 15 children described in subparagraphs (A) and (B) of
 16 section 1902(l)(1) in the same manner as the Sec-
 17 retary identifies and publishes a core set of child
 18 health quality measures under section 1139A, in-
 19 cluding with respect to identifying and publishing
 20 existing maternal and infant health quality measures
 21 that are in use under public and privately sponsored
 22 health care coverage arrangements, or that are part

1 of reporting systems that measure both the presence
2 and duration of health insurance coverage over time,
3 that may be applicable to Medicaid and CHIP eligi-
4 ble mothers and infants.

5 “(2) ALIGNMENT WITH EXISTING CORE SETS.—
6 In identifying and publishing the recommended core
7 set of maternal and infant health quality measures
8 required under paragraph (1), the Secretary shall
9 ensure that, to the extent possible, such measures
10 align with and do not duplicate—

11 “(A) the core set of child health quality
12 measures identified, published, and revised
13 under section 1139A; or

14 “(B) the core set of adult health quality
15 measures identified, published, and revised
16 under section 1139B.

17 “(3) PROCESS FOR MATERNAL AND INFANT
18 QUALITY MEASURES PROGRAM.—In identifying gaps
19 in existing maternal and infant measures and estab-
20 lishing priorities for the development and advance-
21 ment of such measures, the Secretary shall consult
22 with—

23 “(A) States;

24 “(B) physicians, including physicians in
25 the fields of general obstetrics, maternal-fetal

1 medicine, family medicine, neonatology, and pe-
2 diatrics;

3 “(C) nurse practitioners and nurses;

4 “(D) certified nurse-midwives and certified
5 midwives;

6 “(E) health facilities and health systems;

7 “(F) national organizations representing
8 mothers and infants;

9 “(G) national organizations representing
10 consumers and purchasers of health care;

11 “(H) national organizations and individ-
12 uals with expertise in maternal and infant
13 health quality measurement; and

14 “(I) voluntary consensus standard-setting
15 organizations and other organizations involved
16 in the advancement of evidence-based measures
17 of health care.

18 “(b) DEADLINES.—

19 “(1) RECOMMENDED MEASURES.—Not later
20 than January 1, 2021, the Secretary shall identify
21 and publish for comment a recommended core set of
22 maternal and infant health quality measures that in-
23 cludes the following:

1 “(A) Measures of the process, experience,
2 efficiency, and outcomes of maternity care, in-
3 cluding postpartum outcomes.

4 “(B) Measures that apply to childbearing
5 women and newborns at healthy, low, and high
6 risk, including measures of low-intervention
7 birth.

8 “(C) Measures that apply to care during
9 pregnancy, the intrapartum period, and the
10 postpartum period.

11 “(D) Measures that apply to a variety of
12 settings and provider types, such as clinics, fa-
13 cilities, health plans, and accountable care orga-
14 nizations.

15 “(E) Measures that address disparities,
16 care coordination, and shared decisionmaking.

17 “(2) DISSEMINATION.—Not later than January
18 1, 2022, the Secretary shall publish an initial core
19 set of maternal and infant health quality measures
20 that are applicable to Medicaid and CHIP eligible
21 mothers and infants.

22 “(3) STANDARDIZED REPORTING.—Not later
23 than January 1, 2023, the Secretary, in consultation
24 with States, shall develop a standardized format for
25 reporting information based on the initial core set of

1 maternal and infant health quality measures and
2 create procedures to encourage States to use such
3 measures to voluntarily report information regarding
4 the quality of health care for Medicaid and CHIP el-
5 igible mothers and infants.

6 “(4) REPORTS TO CONGRESS.—Not later than
7 January 1, 2024, and every 3 years thereafter, the
8 Secretary shall include in the report to Congress re-
9 quired under section 1139A(a)(6) information simi-
10 lar to the information required under that section
11 with respect to the measures established under this
12 section.

13 “(5) ESTABLISHMENT OF MATERNAL AND IN-
14 FANT QUALITY MEASUREMENT PROGRAM.—

15 “(A) IN GENERAL.—Not later than 12
16 months after the release of the recommended
17 core set of maternal and infant health quality
18 measures under paragraph (1), the Secretary
19 shall establish a Maternal and Infant Quality
20 Measurement Program in the same manner as
21 the Secretary established the pediatric quality
22 measures program under section 1139A(b).

23 “(B) REVISING, STRENGTHENING, AND IM-
24 PROVING INITIAL CORE MEASURES.—Beginning
25 not later than 24 months after the establish-

1 ment of the Maternal and Infant Quality Meas-
2 urement Program, and annually thereafter, the
3 Secretary shall publish recommended changes
4 to the initial core set of maternal and infant
5 health quality measures that shall reflect the
6 results of the testing, validation, and consensus
7 process for the development of maternal and in-
8 fant health quality measures.

9 “(C) EMEASURES.—

10 “(i) IN GENERAL.—An entity awarded
11 a grant or contract by the Secretary to de-
12 velop emerging and innovative evidence-
13 based measures under the Maternal and
14 Infant Quality Measurement Program shall
15 work to advance eMeasures that are
16 aligned with the measures developed under
17 the Pediatric Quality Measures Program
18 established under section 1139A(b) and
19 the Medicaid Quality Measurement Pro-
20 gram established under section
21 1139B(b)(5).

22 “(ii) DEFINITION.—For purposes of
23 this subparagraph, the term ‘eMeasure’
24 means an electronic measure for which
25 measurement data (including clinical data)

1 will be collected electronically, including
2 through the use of electronic health
3 records and other electronic data sources.

4 “(D) AMOUNT AVAILABLE FOR GRANTS
5 AND CONTRACTS.—The aggregate amount of
6 funds that may be awarded as grants and con-
7 tracts under the Maternal and Infant Quality
8 Measurement Program for the development,
9 testing, and validation of emerging and innova-
10 tive evidence-based measures shall not exceed
11 the aggregate amount of funds awarded as
12 grants and contracts under section
13 1139A(b)(4)(A).

14 “(c) CONSTRUCTION.—Nothing in this section shall
15 be construed as supporting the restriction of coverage,
16 under title XIX or XXI or otherwise, to only those services
17 that are evidence based, or in any way limiting available
18 services.

19 “(d) MATERNITY CONSUMER ASSESSMENT OF
20 HEALTH CARE PROVIDERS AND SYSTEMS SURVEYS.—

21 “(1) ADAPTION OF SURVEYS.—Not later than
22 January 1, 2022, for the purpose of measuring the
23 care experiences of childbearing women and
24 newborns, where appropriate, the Agency for
25 Healthcare Research and Quality shall adapt Con-

1 consumer Assessment of Healthcare Providers and Sys-
2 tems program surveys of—

3 “(A) providers;

4 “(B) facilities; and

5 “(C) health plans.

6 “(2) SURVEYS MUST BE EFFECTIVE.—The
7 Agency for Healthcare Research and Quality shall
8 ensure that the surveys adapted under paragraph
9 (1) are effective in measuring aspects of care that
10 childbearing women and newborns experience, which
11 may include—

12 “(A) various types of care settings;

13 “(B) various types of caregivers;

14 “(C) considerations relating to pain;

15 “(D) shared decisionmaking;

16 “(E) supportive care around the time of
17 birth; and

18 “(F) other topics relevant to the quality of
19 the experience of childbearing women and
20 newborns.

21 “(3) LANGUAGES.—The surveys adapted under
22 paragraph (1) shall be available in English and
23 Spanish.

24 “(4) ENDORSEMENT.—The Agency for Health-
25 care Research and Quality shall submit any Con-

1 consumer Assessment of Healthcare Providers and Sys-
2 tems surveys adapted under this paragraph to the
3 consensus-based entity with a contract under section
4 1890(a)(1) to be considered for endorsement under
5 section 1890(b)(2).

6 “(5) CONSULTATION.—The adaption of (and
7 process for applying) the surveys under paragraph
8 (1) shall be conducted in consultation with the
9 stakeholders identified in paragraph (6)(A).

10 “(6) STAKEHOLDERS.—

11 “(A) IN GENERAL.—The stakeholders
12 identified in this subparagraph are—

13 “(i) the various clinical disciplines and
14 specialties involved in providing maternity
15 care;

16 “(ii) State Medicaid administrators;

17 “(iii) maternity care consumers and
18 their advocates;

19 “(iv) technical experts in quality
20 measurement;

21 “(v) hospital, facility and health sys-
22 tem leaders;

23 “(vi) employers and purchasers; and

1 “(vii) other individuals who are in-
2 volved in the advancement of evidence-
3 based maternity care quality measures.

4 “(B) PROFESSIONAL ORGANIZATIONS.—
5 The stakeholders identified under subparagraph
6 (A) may include representatives from relevant
7 national medical specialty and professional or-
8 ganizations and specialty societies.

9 “(e) ANNUAL STATE REPORTS REGARDING STATE-
10 SPECIFIC MATERNAL AND INFANT QUALITY OF CARE
11 MEASURES APPLIED UNDER MEDICAID OR CHIP.—

12 “(1) IN GENERAL.—Each State with a plan or
13 waiver approved under title XIX or XXI shall annu-
14 ally report (separately or as part of the annual re-
15 port required under section 1139A(c)) to the Sec-
16 retary on—

17 “(A) the State-specific maternal and infant
18 health quality measures applied by the State
19 under such plan or waiver, including measures
20 described in subsection (b)(5)(B); and

21 “(B) the State-specific information on the
22 quality of health care furnished to Medicaid and
23 CHIP eligible mothers and infants under such
24 plan or waiver, including information collected
25 through external quality reviews of managed

1 care organizations under section 1932 and
2 benchmark plans under section 1937.

3 “(2) PUBLICATION.—Not later than September
4 30, 2024, and annually thereafter, the Secretary
5 shall collect, analyze, and make publicly available the
6 information reported by States under paragraph (1).

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated \$16,000,000 to carry
9 out this section. Funds appropriated under this subsection
10 shall remain available until expended.”.

11 (b) TECHNICAL AMENDMENT.—Section
12 1139B(d)(1)(A) of the Social Security Act (42 U.S.C.
13 1320b–9b(d)(1)(A)) is amended by striking “subsection
14 (a)(5)” and inserting “subsection (b)(5)”.

15 **SEC. 3. QUALITY COLLABORATIVES.**

16 (a) GRANTS.—The Secretary of Health and Human
17 Services (in this section referred to as the Secretary) may
18 make grants to eligible entities to support—

19 (1) the development of new State and regional
20 maternity and infant care quality collaboratives;

21 (2) expanded activities of existing maternity
22 and infant care quality collaboratives; and

23 (3) maternity and infant care initiatives within
24 established State and regional quality collaboratives
25 that are not focused exclusively on maternity care.

1 (b) ELIGIBLE ENTITY.—The following entities shall
2 be eligible for a grant under subsection (a):

3 (1) Quality collaboratives that focus entirely, or
4 in part, on maternity and infant care initiatives, to
5 the extent that such collaboratives use such grant
6 only for such initiatives.

7 (2) Entities seeking to establish a maternity
8 and infant care quality collaborative.

9 (3) State Medicaid agencies.

10 (4) State departments of health.

11 (5) Health insurance issuers (as such term is
12 defined in section 2791 of the Public Health Service
13 Act (42 U.S.C. 300gg–91)).

14 (6) Provider organizations, including associa-
15 tions representing—

16 (A) health professionals; and

17 (B) hospitals.

18 (c) ELIGIBLE PROJECTS AND PROGRAMS.—In order
19 for a project or program of an eligible entity to be eligible
20 for funding under subsection (a), the project or program
21 must have goals that are designed to improve the quality
22 of maternity care delivered, such as—

23 (1) improving the appropriate use of caesarean
24 section;

- 1 (2) reducing maternal and newborn morbidity
- 2 rates;
- 3 (3) improving breast-feeding rates;
- 4 (4) reducing hospital readmission rates;
- 5 (5) identifying improvement priorities through
- 6 shared peer review and third-party reviews of quali-
- 7 tative and quantitative data, and developing and car-
- 8 rying out projects or programs to address such pri-
- 9 orities; or
- 10 (6) delivering risk-appropriate levels of care.

11 (d) ACTIVITIES.—Activities that may be supported by
12 the funding under subsection (a) include the following:

- 13 (1) Facilitating performance data collection and
- 14 feedback reports to providers with respect to their
- 15 performance, relative to peers and benchmarks, if
- 16 any.
- 17 (2) Developing, implementing, and evaluating
- 18 protocols and checklists to foster safe, evidence-
- 19 based practice.
- 20 (3) Developing, implementing, and evaluating
- 21 programs that translate into practice clinical rec-
- 22 ommendations supported by high-quality evidence in
- 23 national guidelines, systematic reviews, or other well-
- 24 conducted clinical studies.

1 (4) Developing underlying infrastructure needed
2 to support quality collaborative activities under this
3 subsection.

4 (5) Providing technical assistance to providers
5 and institutions to build quality improvement capac-
6 ity and facilitate participation in collaborative activi-
7 ties.

8 (6) Developing the capability to access the fol-
9 lowing data sources:

10 (A) A mother’s prenatal, intrapartum, and
11 postpartum records.

12 (B) A mother’s medical records.

13 (C) An infant’s medical records since birth.

14 (D) Birth and death certificates.

15 (E) Any other relevant State-level gen-
16 erated data (such as data from the Pregnancy
17 Risk Assessment Monitoring System (PRAMS)).

18 (7) Developing access to blinded liability claims
19 data, analyzing the data, and using the results of
20 such analysis to improve practice.

21 (e) SPECIAL RULE FOR BIRTHS.—

22 (1) IN GENERAL.—Subject to paragraph (2), if
23 a grant under subsection (a) is for a project or pro-
24 gram that focuses on births, at least 25 percent of
25 the births addressed by such project or program

1 must occur in health facilities that perform fewer
2 than 1,000 births per year.

3 (2) EXCEPTION.—In the case of a grant under
4 subsection (a) for a project or program located in a
5 State in which less than 25 percent of the health fa-
6 cilities in the State perform less than 1,000 births
7 per year, the percentage of births in such facilities
8 addressed by such project or program shall be com-
9 mensurate with the Statewide percentage of births
10 performed at such facilities.

11 (f) USE OF QUALITY MEASURES.—Projects and pro-
12 grams for which such a grant is made shall—

13 (1) include data collection with rapid analysis
14 and feedback to participants with a focus on improv-
15 ing practice and health outcomes;

16 (2) develop a plan to identify and resolve data
17 collection problems;

18 (3) identify and document evidence-based strat-
19 egies that will be used to improve performance on
20 quality measures and other metrics; and

21 (4) exclude from quality measure collection and
22 reporting physicians and midwives who attend fewer
23 than 30 births per year.

1 (g) REPORTING ON QUALITY MEASURES.—Any re-
2 porting requirements established by a project or program
3 funded under subsection (a) shall be designed to—

- 4 (1) minimize costs and administrative effort;
5 and
6 (2) use existing data resources when feasible.

7 (h) CLEARINGHOUSE.—The Secretary shall establish
8 an online, open-access clearinghouse to make protocols,
9 procedures, reports, tools, and other resources of indi-
10 vidual collaboratives available to collaboratives and other
11 entities that are working to improve maternity and infant
12 care quality.

13 (i) EVALUATION.—A quality collaborative (or other
14 entity receiving a grant under subsection (a)) shall—

- 15 (1) develop and carry out plans for evaluating
16 its maternity and infant care quality improvement
17 programs and projects; and

18 (2) publish its experiences and results in arti-
19 cles, technical reports, or other formats for the ben-
20 efit of others working on maternity and infant care
21 quality improvement activities.

22 (j) ANNUAL REPORTS TO SECRETARY.—A quality
23 collaborative or other eligible entity that receives a grant
24 under subsection (a) shall submit an annual report to the
25 Secretary containing the following:

1 (1) A description of the activities carried out
2 using the funding from such grant.

3 (2) A description of any barriers that limited
4 the ability of the collaborative or entity to achieve its
5 goals.

6 (3) The achievements of the collaborative or en-
7 tity under the grant with respect to the quality,
8 health outcomes, and value of maternity and infant
9 care.

10 (4) A list of lessons learned from the grant.

11 Such reports shall be made available to the public.

12 (k) GOVERNANCE.—

13 (1) IN GENERAL.—A maternity and infant care
14 quality collaborative or a maternity and infant care
15 program within a broader quality collaborative that
16 is supported under subsection (a) shall be governed
17 by a multi-stakeholder executive committee.

18 (2) COMPOSITION.—Such executive committee
19 shall include individuals who represent—

20 (A) physicians, including physicians in the
21 fields of general obstetrics, maternal-fetal medi-
22 cine, family medicine, neonatology, and pediat-
23 rics;

24 (B) nurse-practitioners and nurses;

- 1 (C) certified nurse-midwives and certified
2 midwives;
- 3 (D) health facilities and health systems;
- 4 (E) consumers;
- 5 (F) employers and other private pur-
6 chasers;
- 7 (G) Medicaid programs; and
- 8 (H) other public health agencies and orga-
9 nizations, as appropriate.

10 Such committee also may include other individuals,
11 such as individuals with expertise in health quality
12 measurement and other types of expertise as rec-
13 ommended by the Secretary. Such committee also
14 may be composed of a combination of general col-
15 laborative executive committee members and mater-
16 nity and infant specific project executive committee
17 members.

18 (I) CONSULTATION.—A quality collaborative or other
19 eligible entity that receives a grant under subsection (a)
20 shall engage in regular ongoing consultation with—

- 21 (1) regional and State public health agencies
22 and organizations;
- 23 (2) public and private health insurers; and

1 (3) regional and State organizations rep-
2 resenting physicians, midwives, and nurses who pro-
3 vide maternity and infant services.

4 (m) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated \$15,000,000 to carry
6 out this section. Funds appropriated under this subsection
7 shall remain available until expended.

8 **SEC. 4. FACILITATION OF INCREASED COORDINATION AND**
9 **ALIGNMENT BETWEEN THE PUBLIC AND PRI-**
10 **VATE SECTOR WITH RESPECT TO QUALITY**
11 **AND EFFICIENCY MEASURES.**

12 (a) IN GENERAL.—Section 1890(b) of the Social Se-
13 curity Act (42 U.S.C. 1395aaa(b)) is amended by insert-
14 ing after paragraph (3) the following new paragraph:

15 “(4) FACILITATION OF INCREASED COORDINA-
16 TION AND ALIGNMENT BETWEEN THE PUBLIC AND
17 PRIVATE SECTOR WITH RESPECT TO QUALITY AND
18 EFFICIENCY MEASURES.—

19 “(A) IN GENERAL.—The entity shall facili-
20 tate increased coordination and alignment be-
21 tween the public and private sector with respect
22 to quality and efficiency measures.

23 “(B) ANNUAL REPORTS.—The entity shall
24 prepare and make available to the public its
25 findings under this paragraph in its annual re-

1 port. Such public availability shall include post-
2 ing each report on the Internet website of the
3 entity.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall take effect on the date of enactment
6 of this Act.

○