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111TH CONGRESS
2D SESSION

H. R. 6437

To amend title XIX of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing a maternity care quality measurement program, identifying payment mechanism improvements, and identifying essential evidence-based maternity care services.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 18, 2010

Mr. ENGEL (for himself and Mrs. MYRICK) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XIX of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing a maternity care quality measurement program, identifying payment mechanism improvements, and identifying essential evidence-based maternity care services.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Partnering to Improve Maternity Care Quality Act of 2010''.

SEC. 2. QUALITY MEASURES FOR MATERNITY CARE UNDER MEDICAID AND CHIP.

Title XIX of the Social Security Act is amended by inserting after section 1139B the following new section:

"SEC. 1139C. MATERNITY CARE QUALITY MEASUREMENT.

"(a) IN GENERAL.—The Secretary shall develop a maternity care quality measurement program for care provided to childbearing women and newborns for use by—

"(1) a State in administering a State plan under title XIX or a State Child Health Plan under title XXI;

"(2) health insurance issuers (as such term is defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) and managed care entities that enter into contracts with States for the purpose of administering such plans; and

"(3) providers of items and services (including accountable care organizations) with respect to items and services provided under such plans.

"(b) IDENTIFICATION OF AN INITIAL SET OF MATERNITY CARE QUALITY MEASURES.—

"(1) IN GENERAL.—Not later than January 1, 2013, the Secretary shall identify, and publish, from maternity care quality measures endorsed under section 1890(b)(2), an initial core set of maternity care

quality measures for use in data collection and reporting by—

"(A) a State in administering a State plan under title XIX or a State Child Health Plan under title XXI;

"(B) health insurance issuers (as such term is defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) and managed care entities that enter into contracts with States for the purpose of administering such plans; and

"(C) providers of items and services (including accountable care organizations) with respect to items and services provided under such plans.

"(2) CONSULTATION AND PUBLIC COMMENT.—Not later than January 1, 2012, the Secretary shall—

"(A) solicit public comment on a recommended initial core set of maternity care quality measures; and

"(B) consult with stakeholders identified in subsection (i)(1) regarding such measures.

"(c) DEVELOPMENT OF ADDITIONAL QUALITY MEASURES.—

''(1) CONTRACTS WITH QUALIFIED ENTITIES.—Not later than the end of the 6-month period beginning on the date the Secretary publishes the initial measures under subsection (b)(1), the Secretary, acting through the Agency for Healthcare Research and Quality, in consultation with the Centers for Medicare & Medicaid Services, shall enter into grants, contracts, or intergovernmental agreements with qualified measure development entities for the purpose of developing, testing, and validating maternity care quality measures in areas that are not adequately covered by the measures identified under subsection (b)(1).

''(2) QUALIFIED MEASURE DEVELOPMENT ENTITY DEFINED.—For purposes of this subsection, the term 'qualified measure development entity' means an entity that—

''(A) has demonstrated expertise and capacity in the development and testing of quality measures;

''(B) has adopted procedures for quality measure development that ensure the inclusion of—

''(i) the views of the individuals and entities who are identified in subsection

(d)(2)(E) and whose performance will be assessed by the measures; and

''(ii) the views of other individuals and entities (including patients, consumers, and health care purchasers) who will use the data generated as a result of the use of the quality measures;

''(C) for the purpose of ensuring that the quality measures developed under this subsection meet the requirements to be considered for endorsement under section 1890(b)(2), has provided assurances to the Secretary that the measure development entity will collaborate with—

''(i) the Secretary;

''(ii) the consensus-based entity with a contract under section 1890(a)(1); and

''(iii) stakeholders (including those stakeholders identified in subsection (i)(1)), as practicable;

''(D) has transparent policies regarding governance and conflicts of interest; and

''(E) submits an application to the Secretary at such time, and in such form and manner, as the Secretary may require.

''(3) EMEASURES.—

''(A) IN GENERAL.—A qualified measure development entity with a grant, contract, or intergovernmental agreement under paragraph (1), in developing quality measures, shall use the measure-authoring tool of the consensus-based entity with a contract under section 1890(a)(1) to create eMeasures that make use of and build upon the quality dataset developed under subsection (g).

''(B) EMEASURE DEFINED.—For purposes of this paragraph, the term 'eMeasure' means a measure for which measurement data (including clinical data) will be collected electronically, including through the use of electronic health records and other electronic data sources.

''(4) ENDORSEMENT.—Any maternity care quality measures developed under this subsection by a qualified measure development entity shall be submitted by the qualified measure development entity to the consensus-based entity with a contract under section 1890(a)(1) to be considered for endorsement under section 1890(b)(2).

''(d) TYPES OF MEASURES.—

''(1) IN GENERAL.—The maternity quality measures identified under subsection (b) and the measures developed under subsection (c) shall—

''(A) be evidence-based and, as appropriate, risk-adjusted; and

''(B) include a balance of each of the types of measures listed in paragraph (2).

''(2) LIST OF TYPES OF MEASURES.—The measures listed in this paragraph are the following:

''(A) Measures of the process, experience, efficiency, and outcomes of maternity care, including postpartum outcomes.

''(B) Measures that apply to—

''(i) women and newborns who are healthy and at low risk, including measures of appropriately low-intervention, physiologic birth in low-risk women; and

''(ii) women and newborns at higher risk.

''(C) Measures that apply to—

''(i) childbearing women; and

''(ii) newborns.

''(D) Measures that apply to care during—

''(i) pregnancy;

''(ii) intrapartum period; and

''(iii) the postpartum period.

''(E) Measures that apply to—

''(i) clinicians and clinician groups;

''(ii) facilities;

''(iii) health plans; and

''(iv) accountable care organizations.

''(F) Measurement of—

''(i) disparities;

''(ii) care coordination; and

''(iii) shared decision making.

''(e) MATERNITY CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS SURVEYS.—

''(1) ADAPTION OF SURVEYS.—Not later than January 1, 2014, for the purpose of measuring the care experiences of childbearing women and newborns, the Agency for Healthcare Research and Quality shall adapt the Consumer Assessment of Healthcare Providers and Systems program surveys of—

''(A) providers;

''(B) facilities; and

''(C) health plans.

''(2) SURVEYS MUST BE EFFECTIVE.—The Agency for Healthcare Research and Quality shall ensure that the surveys adapted under paragraph

(1) are effective in measuring aspects of care that childbearing women and newborns experience, including aspects related to—

"(A) various care settings;

"(B) various types of caregivers;

"(C) considerations relating to pain;

"(D) the use of medications;

"(E) shared decision making—

"(i) during pregnancy;

"(ii) in the intrapartum period; and

"(iii) in the postpartum period; and

"(F) the provision of information, emotional support, and comfort measures during the intrapartum period.

"(3) LANGUAGES.—The surveys adapted under paragraph (1) shall be available in English and Spanish.

"(4) ENDORSEMENT.—The Agency for Healthcare Research and Quality shall submit any Consumer Assessment of Healthcare Providers and Systems surveys adapted under this subsection to the consensus-based entity with a contract under section 1890(a)(1) to be considered for endorsement under section 1890(b)(2).

''(5) CONSULTATION.—The adaption of (and process for applying) the surveys under paragraph (1) shall be conducted in consultation with the stakeholders identified in subsection (i)(1).

''(f) MEASUREMENT REPORTING.—

''(1) VOLUNTARY REPORTING.—The Secretary shall encourage voluntary and standardized reporting to the Secretary, using the maternity care quality measures identified under subsection (b) and developed under subsection (c) and the surveys adapted under subsection (e), by—

''(A) clinicians (including physicians, midwives, and clinician groups);

''(B) facilities (including hospitals and freestanding birth centers);

''(C) accountable care organizations; and

''(D) health plans,

on the performance of such clinicians, facilities, accountable care organizations, or plans.

''(2) STANDARDIZED FORMAT AND PROCESS.—Not later than January 1, 2013, the Secretary, in consultation with the stakeholders identified under subsection (i)(1), shall—

''(A)(i) develop, validate, and test formats and processes for standardized reporting under paragraph (1)—

''(I) to the clinicians, facilities, accountable care organizations, health plans, and State agencies identified in paragraph (3); and

''(II) to the patients, policymakers, and payers identified in paragraph (4)(A); and

''(ii) update such formats and processes to incorporate any additional quality measures developed under subsection (c) and any surveys developed under subsection (e); and

''(B) reflect best practices for timely, accurate, effective communications for quality measures, and update such formats and processes as appropriate.

''(3) FEEDBACK REPORTS.—

''(A) CLINICIANS, FACILITIES, ACCOUNTABLE CARE ORGANIZATIONS, AND HEALTH PLANS.—If the Secretary receives a report from a clinician, facility, accountable care organization, or health plan under paragraph (1), the Secretary shall provide, annually, to such clini-

cian, facility, accountable care organization, or health plan a confidential feedback report that contains quality measure data collected through the report received under paragraph (1), and, if feasible, risk-adjusted benchmarks. Such feedback reports shall be designed and used for the purpose of quality improvement by such clinician, facility, accountable care organization, or plan.

''(B) STATE AGENCIES.—The Secretary shall provide an annual report to the State agency administering or supervising the administration of a State plan under title XIX or a State Child Health plan under title XXI on the quality of care provided by clinicians, facilities, accountable care organizations, and health plans in such State.

''(4) PUBLIC AVAILABILITY OF DATA.—

''(A) IN GENERAL.—Subject to subparagraph (B), the data contained in the reports under paragraph (1) shall be made available to—

''(i) patients to use in maternity care decision making; and

"(ii) policymakers and purchasers to assess the quality of maternity care services provided under titles XIX and XXI.

"(B) ENDORSED AND VALID.—Data reported under this subsection may only be made available under this paragraph, or otherwise made public, if—

"(i) such data are received—

"(I) from a maternity care quality measure that is identified under subsection (b) or developed under subsection (c); or

"(II) through the use of a survey adapted under subsection (e);

"(ii) endorsed without time-limited qualification under section 1890(b)(2); and

"(iii) the clinician, facility, accountable care organization, or health plan that submitted such data has been given an opportunity to confirm the quality and accuracy of such data.

"(g) CONVERSION OF CURRENTLY ENDORSED MEASURES AND CREATION OF INITIAL QUALITY DATASET TO ENABLE ELECTRONIC HEALTH RECORDS TO MEASURE

THE CARE OF CHILDBEARING WOMEN AND NEWBORNS.—

''(1) IN GENERAL.—Not later than January 1, 2012, for the purpose of fostering automated patient-centered longitudinal quality measurement of maternity and newborn care using clinical data, the consensus-based entity with a contract under section 1890(b)(2) shall coordinate—

''(A) the conversion of endorsed measures for the care of childbearing women and newborns to eMeasures (as such term is defined in subsection (c)(3)(B)); and

''(B) the development of an initial quality dataset for use within electronic health records of childbearing women and newborns enrolled in a program administered by a State through State plans under title XIX and State Child Health plans under title XXI for purposes of such eMeasures.

''(2) REQUIREMENTS FOR EMEASURE CONVERSION AND DATASET CREATION.—The conversion to eMeasures and the dataset creation under paragraph (1) shall, for each quality measure of the care of childbearing women or newborns that the consensus-based entity with a contract under section

1890(b)(2) endorses, use the entity's measure authoring tool to—

"(A) specify standard data elements, quality data elements, and data flow connectors to electronic information;

"(B) specify quality measure logical statements;

"(C) test quality measure validity with an appropriate electronic health record test database;

"(D) finalize eMeasures for export to electronic health record systems; and

"(E) carry out this work in—

"(i) collaboration with the developer or sponsor of each endorsed measure, who is responsible, under an agreement with the entity that endorsed such measure, for updating such measure; and

"(ii) consultation with the stakeholders identified in subsection (i)(1).

"(h) MEASUREMENT PROGRAM REPORTING.—Not later than January 1, 2014, and every 2 years thereafter, the Secretary shall submit to the Congress and the Medicaid and CHIP Payment and Access Commission a report

on the status of the maternity care quality measurement program under this section, including—

"(1) the measured results in maternity care quality;

"(2) trends over time in maternity care quality;

"(3) the adequacy and use of the set of—

"(A) the quality measures identified under subsection (b);

"(B) the quality measures developed under subsection (c); and

"(C) the surveys adapted under subsection (e);

"(4) the adequacy and use of the reporting format under subsection (f)(2);

"(5) the adequacy of the quality dataset under subsection (g); and

"(6) any recommendations for programmatic and legislative changes needed to improve the quality of care provided to childbearing women and newborns under this title and title XXI, including recommendations for quality reporting by the States.

"(i) STAKEHOLDERS.—

"(1) IN GENERAL.—The stakeholders identified in this subsection are—

"(A) State Medicaid administrators;

"(B) maternal-fetal medicine specialists;

"(C) obstetrician-gynecologists;

"(D) family physicians;

"(E) certified nurse-midwives;

"(F) certified midwives;

"(G) nurse practitioners;

"(H) nurses;

"(I) neonatologists;

"(J) pediatricians;

"(K) consumers and their advocates;

"(L) health quality measurement experts;

"(M) health quality measure developers;

"(N) representatives from the consensus-based entity with a contract under section 1890(a) of the Social Security Act;

"(O) electronic health record developers and vendors;

"(P) employers and purchasers;

"(Q) health facility and health system leaders; and

"(R) other individuals who are involved in the advancement of evidence-based maternity care quality measures.

"(2) PROFESSIONAL ORGANIZATIONS.—The stakeholders identified under paragraph (1) may in-

clude representatives from professional organizations and specialty societies (such as the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Nurse-Midwives, the Society for Maternal Fetal Medicine, and the Association of Women's Health, Obstetric, and Neonatal Nurses).

''(j) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2011 through 2015, such sums as may be necessary for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 3. DEMONSTRATION PROJECT TO EVALUATE PAYMENT REFORM IN MATERNITY CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a demonstration project to evaluate the use of alternative payment methods under the Medicaid program under title XIX of the Social Security Act, for the purpose of—

(1) improving the quality, value, and outcomes of maternity care by reliably delivering effective care that contributes to improved outcomes; and

(2) reducing the costs of maternity care for beneficiaries under such program by—

(A) delivering effective care;

(B) avoiding overuse of care that may cause harm to the beneficiary or a waste of resources, without providing a benefit to the beneficiary; and

(C) discouraging the provision of care that lacks an evidence base and is contrary to strong recommendations supported by high quality evidence in clinical practice guidelines from nationally recognized specialty societies and professional organizations.

(b) PAYMENTS.—

(1) REQUIREMENTS.—Payments made under the demonstration project under subsection (a) for the provision of medical services shall be adjusted for the health conditions and other characteristics of Medicaid beneficiaries, as determined by the Secretary.

(2) ALLOWABLE PAYMENT STRUCTURES.—Under the demonstration project under subsection (a), the Secretary may evaluate alternative payment methods, including the following:

(A) Payments that are defined to cover services for a single episode of care for an individual woman and her newborn, including—

(i) all care from the prenatal through the postpartum period; or

(ii) all care received during the intrapartum period.

(B) Payments based on a condition-adjusted capitated rate for a population of women and newborns.

(C) Payments that cover multiple providers (such as hospitals, birth centers, physicians, midwives, and nurse practitioners) that would otherwise be paid separately.

(D) Payments in the form of ''virtual bundling'', in which providers are paid separately, but the amount of such payments are adjusted so that the total of the individual payments to each provider remains under a total payment budget for the episode of care.

(E) Payments to providers (including doulas, and other providers of continuous labor support) and for services (such as shared decision making, breast-feeding support programs, and doula services) that may not currently be eligible for direct reimbursement under title XIX of the Social Security Act.

(F) Payments that cover multiple services that would otherwise be paid for separately, or that allow greater flexibility as to the type of provider, location of service, or approach to care than would otherwise be permitted, to enable providers to improve outcomes or value.

(G) Other payment innovations that are likely to result in improved maternity care quality, outcomes, and value (such as payment of bonuses for improved outcomes or payments for care coordination).

(3) EVALUATION AND MONITORING.—The Secretary shall also make payments for the purpose of collecting data necessary for the evaluation and monitoring of the demonstration project under this section.

(c) SCOPE AND SELECTION OF STATES.—The demonstration project under subsection (a) shall be conducted in no more than 8 States, which shall be selected by the Secretary based on—

(1) an application that—

(A) is submitted by a entity or consortium that—

(i) includes the single State agency under section 1902(a)(5); and

(ii) may include managed care organizations, integrated health systems, and accountable care organizations providing maternity care to Medicaid and CHIP beneficiaries; and

(B) specifies the regions and populations in the State that will be served by the entity or consortium under the demonstration project;

(2) criteria designed to ensure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally; and

(3) criteria designed to ensure that multiple payment models are tested through the demonstration project.

(d) PROTECTIONS FOR BENEFICIARIES.—

(1) NO ADDITIONAL COST SHARING.—Under the demonstration project under subsection (a), a Medicaid beneficiary shall not be liable for any cost sharing in excess of the amount of cost sharing that such beneficiary would otherwise be liable for under title XIX of the Social Security Act.

(2) NO REDUCTION IN QUALITY.—A provider who provides services to a Medicaid beneficiary

under the demonstration project under subsection (a) shall provide services that the provider expects will result in a similar or improved health outcome for such beneficiary, compared with the services such beneficiary would receive under title XIX of the Social Security Act if the beneficiary was not receiving services under the demonstration project.

(3) NO DENIAL OF COVERED SERVICES.—In no case may a Medicaid beneficiary be denied maternity and nonmaternity items and services under the demonstration project under subsection (a) than such beneficiary would otherwise receive under title XIX of the Social Security Act.

(e) PERIOD.—The demonstration project under subsection (a) shall begin on January 1, 2012, and shall end on December 31, 2016.

(f) REPORTS.—

(1) STATE REPORTS.—Each entity or consortium with an application that is approved under subsection (c) that participates in the demonstration project under subsection (a) shall report to the Secretary, in a time, form, and manner specified by the Secretary, the data necessary to—

(A) monitor the—

(i) health outcomes of participating beneficiaries;

(ii) the costs of the project; and

(iii) the quality of maternity care provided under the project; and

(B) evaluate the rationale for the selection of the items and services included in any bundled payment made by the entity or consortium under the project.

(2) FINAL REPORT.—Not later than December 31, 2017, the Secretary shall submit to Congress a report containing—

(A) the results of the demonstration project under subsection (a);

(B) an assessment of the influence of medical liability on the results of such project; and

(C) recommendations for changes in Medicaid payment policies to enhance the quality, health outcomes, and value of maternity care provided through the Medicaid program.

SEC. 4. ESSENTIAL SERVICES FOR CHILDBEARING WOMEN AND NEWBORNS.

(a) REPORT ON EVIDENCE-BASED MATERNITY CARE SERVICES.—The Secretary of Health and Human Services is authorized to, and shall seek to, enter an agreement

with the Institute of Medicine of the National Academies to develop and, not later than January 1, 2013, publish a report that, on the basis of the best available evidence, identifies the following:

(1) ESSENTIAL SERVICES.—The following essential maternity care services:

(A) A package of evidence-based maternity care services that the Institute of Medicine identifies as essential for the majority of childbearing women and newborns who are healthy and at low risk for complications during pregnancy, birth, the postpartum period, and the newborn period (the 28-day period beginning on the date of birth).

(B) Any additional and differing maternity care services that the Institute of Medicine identifies as essential to women and newborns who are at higher risk than the individuals described under paragraph (1) for complications during pregnancy, birth, the postpartum period, and the newborn period.

(C) Any pre- and interconception care services that have been demonstrated to contribute to improved maternal and newborn outcomes.

(2) LIMITED VALUE AND UNDERSTUDIED SERVICES.—Maternity care services that are identified by the Institute of Medicine as—

(A) being of limited value (including use of a specific service for indications that are not supported); or

(B) requiring comparative effectiveness research to clarify the safety and effectiveness of such services.

(b) STRENGTH OF EVIDENCE.—In identifying the essential services under subsection (a)(1), the Institute of Medicine shall—

(1) give priority to maternal care services that are supported for use for specific indications or populations by systematic reviews with high- or moderate-quality evidence and strong recommendations, as determined by a valid assessment system, such as GRADE (Grading of Recommendations Assessment, Development and Evaluation); and

(2) clearly indicate if a service that is recommended as essential is based on lower quality evidence or weaker recommendations than the levels described under paragraph (1).

(c) CONSULTATIVE PROCESS.—

(1) IN GENERAL.—The Institute of Medicine shall develop the report under subsection (a) in consultation with a multistakeholder panel that includes representatives of—

(A) clinicians with expertise in—

(i) obstetrics;

(ii) family medicine;

(iii) pediatrics;

(iv) midwifery;

(v) nursing;

(vi) maternal fetal medicine;

(vii) genetics;

(viii) anesthesia;

(ix) substance abuse;

(x) reproductive endocrinology;

(xi) mental health;

(xii) infectious disease; and

(xiii) interconception care;

(B) consumers and their advocates;

(C) payers and purchasers; and

(D) research methodology experts.

(2) PROFESSIONAL ORGANIZATIONS.—The representatives under paragraph (1) may include representatives from professional organizations and specialty societies (such as the American College of Ob-

stetricians and Gynecologists, the American Academy of Family Physicians, the American College of Nurse-Midwives, the Society for Maternal Fetal Medicine, and the Association of Women's Health, Obstetric, and Neonatal Nurses).

(d) DEFINITION OF MATERNAL CARE SERVICES.—For purposes of the report under subsection (a), the term ''maternity care services'' shall include—

(1) services related to the confirmation of pregnancy and preconception, prenatal, intrapartum, postpartum, newborn, and interconception care;

(2) newborn care services that are incidental to interconception care;

(3) mental health and substance abuse services; and

(4) support services (such as language translation and care coordination).

(e) SENSE OF CONGRESS.—It is the sense of Congress that the Administrator of the Centers for Medicare & Medicaid Services and the directors of State Medicaid agencies should ensure that the services available to childbearing women and newborns under the Medicaid program in each State are well-aligned with the essential maternity care services identified in subsection (a)(1).

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