

113TH CONGRESS
1ST SESSION

H. R. 896

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

FEBRUARY 28, 2013

Mr. ENGEL introduced the following bill; which was referred to the Committee on Energy and Commerce

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”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Quality measures for maternity care under Medicaid and CHIP.

Sec. 3. Quality collaboratives.

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

3 (a) IN GENERAL.—Section 1139A of the Social Secu-
 4 rity Act (42 U.S.C. 1320b–9a) is amended by adding at
 5 the end the following new subsection:

6 “(j) MOTHER AND INFANT CARE (MIC) QUALITY
 7 MEASURES.—

8 “(1) IN GENERAL.—As part of the pediatric
 9 quality measures program established under sub-
 10 section (b) and the Medicaid Quality Measurement
 11 Program established under section 1139B(b)(5)(A),
 12 the Secretary shall—

13 “(A) review quality measures endorsed
 14 under section 1890(b)(2) that relate to the care
 15 of childbearing women and newborns, particu-
 16 larly with respect to the application of such
 17 measures to the Medicaid and CHIP programs
 18 under titles XIX and XXI, and identify omis-
 19 sions and deficiencies in the application of those
 20 measures to such programs;

21 “(B) develop and publish a set of mater-
 22 nity care quality measures for the Medicaid and
 23 CHIP programs under titles XIX and XXI (in
 24 this subsection referred to as the ‘Mother and

1 Infant Care (MIC) quality measures’) in ac-
2 cordance with the requirements of paragraphs
3 (2) and (3); and

4 “(C) on an ongoing basis, review the MIC
5 quality measures and develop and publish any
6 modifications of, or additions or deletions to,
7 such measures that reflect the development,
8 testing, validation, and consensus process de-
9 scribed in paragraph (4).

10 “(2) PROCESS FOR INITIAL REVIEW AND PUBLI-
11 CATION.—

12 “(A) CONSULTATION AND PUBLIC COM-
13 MENT.—Not later than January 1, 2016, the
14 Secretary shall—

15 “(i) solicit public comment on the pro-
16 posed MIC quality measures; and

17 “(ii) consult with the stakeholders
18 identified in paragraph (6)(A) regarding
19 such measures.

20 “(B) PUBLICATION OF INITIAL SET OF
21 MEASURES.—Not later than January 1, 2017,
22 the Secretary shall identify and publish the ini-
23 tial MIC quality measures.

24 “(3) REQUIREMENTS.—

1 “(A) IN GENERAL.—The MIC quality
2 measures shall—

3 “(i) be evidence-based;

4 “(ii) utilize risk adjustment or risk
5 stratification methodologies, if appropriate;

6 “(iii) utilize attribution methods to
7 specify the clinicians, facilities, and other
8 entities that the measures are applicable
9 to;

10 “(iv) be pilot-tested with regard to
11 scientific validity, feasibility, and attribu-
12 tion method; and

13 “(v) include a balance of each of the
14 types of measures listed in subparagraph
15 (B).

16 “(B) LIST OF TYPES OF MEASURES.—The
17 measures listed in this subparagraph are the
18 following:

19 “(i) Measures of the process, experi-
20 ence, efficiency, and outcomes of maternity
21 care, including postpartum outcomes.

22 “(ii) Measures that apply to—

23 “(I) women and newborns who
24 are healthy and at low risk, including
25 measures of appropriately low-inter-

1 vention, physiologic birth in low-risk
2 women; and

3 “(II) women and newborns at
4 higher risk.

5 “(iii) Measures that apply to—

6 “(I) childbearing women; and

7 “(II) newborns.

8 “(iv) Measures that apply to care dur-
9 ing—

10 “(I) pregnancy;

11 “(II) intrapartum period; and

12 “(III) the postpartum period.

13 “(v) Measures that apply to—

14 “(I) clinicians and clinician
15 groups;

16 “(II) facilities;

17 “(III) health plans; and

18 “(IV) accountable care organiza-
19 tions.

20 “(vi) Measurement of—

21 “(I) disparities;

22 “(II) care coordination; and

23 “(III) shared decisionmaking.

24 “(C) PHYSIOLOGIC DEFINED.—For pur-
25 poses of this paragraph, the term ‘physiologic’

1 means characteristic of or conforming to the
2 normal functioning or state of the body or a tis-
3 sue or organ, normal, and not pathologic.

4 “(D) CONSTRUCTION.—Nothing in this
5 paragraph shall be construed as supporting the
6 restriction of coverage, under title XIX or XXI
7 or otherwise, to only those services that are evi-
8 dence-based, or in any way limiting available
9 services.

10 “(4) ONGOING REVIEW OF THE MIC MEASURES;
11 eMEASURES.—

12 “(A) CONTRACTS WITH QUALIFIED ENTI-
13 TIES.—Not later than June 30, 2017, the Sec-
14 retary, acting through the Agency for
15 Healthcare Research and Quality, in consulta-
16 tion with the Centers for Medicare & Medicaid
17 Services, shall enter into grants, contracts, or
18 intergovernmental agreements with qualified
19 measure development entities for the purpose of
20 identifying quality of care issues that are not
21 adequately addressed by the MIC quality meas-
22 ures and developing, testing, and validating
23 modifications of, or additions or deletions to,
24 the MIC quality measures, and creating

1 eMeasures for data collection related to the
2 MIC quality measures.

3 “(B) QUALIFIED MEASURE DEVELOPMENT
4 ENTITY DEFINED.—For purposes of this para-
5 graph, the term ‘qualified measure development
6 entity’ means an entity that—

7 “(i) has demonstrated expertise and
8 capacity in the development and testing of
9 quality measures;

10 “(ii) has adopted procedures for qual-
11 ity measure development that ensure the
12 inclusion of—

13 “(I) the views of the individuals
14 and entities referred to in paragraph
15 (3)(B)(v) and whose performance will
16 be assessed by the measures; and

17 “(II) the views of other individ-
18 uals and entities (including patients,
19 consumers, and health care pur-
20 chasers) who will use the data gen-
21 erated as a result of the use of the
22 quality measures;

23 “(iii) for the purpose of ensuring that
24 the MIC quality measures meet the re-
25 quirements to be considered for endorse-

1 ment under section 1890(b)(2), has pro-
2 vided assurances to the Secretary that the
3 measure development entity will collaborate
4 with—

5 “(I) the Secretary;

6 “(II) the consensus-based entity
7 with a contract under section
8 1890(a)(1); and

9 “(III) stakeholders (including
10 those stakeholders identified in para-
11 graph (6)(A)), as practicable;

12 “(iv) has transparent policies regard-
13 ing governance and conflicts of interest;
14 and

15 “(v) submits an application to the
16 Secretary at such time, and in such form
17 and manner, as the Secretary may require.

18 “(C) eMEASURES.—

19 “(i) IN GENERAL.—A qualified meas-
20 ure development entity with a grant, con-
21 tract, or intergovernmental agreement
22 under subparagraph (A) shall consult with
23 the voluntary consensus standards setting
24 organizations and other organizations in-
25 volved in the advancement of evidence-

1 based measures of health care that the
2 Secretary consults with under subsection
3 (b)(3)(H) and section 1139B(b)(5)(A) to
4 create, as part of the MIC quality meas-
5 ures, eMeasures that are aligned with the
6 measures developed under the pediatric
7 quality measures program established
8 under subsection (b) and the Medicaid
9 Quality Measurement Program established
10 under section 1139B(b)(5)(A).

11 “(ii) eMEASURE DEFINED.—For pur-
12 poses of this subparagraph, the term
13 ‘eMeasure’ means a measure for which
14 measurement data (including clinical data)
15 will be collected electronically, including
16 through the use of electronic health
17 records and other electronic data sources.

18 “(D) ENDORSEMENT.—Any modifications
19 of, or additions or deletions to, the MIC quality
20 measures shall be submitted by the qualified
21 measure development entity to the consensus-
22 based entity with a contract under section
23 1890(a)(1) to be considered for endorsement
24 under section 1890(b)(2).

1 “(5) MATERNITY CONSUMER ASSESSMENT OF
2 HEALTH CARE PROVIDERS AND SYSTEMS SUR-
3 VEYS.—

4 “(A) ADAPTION OF SURVEYS.—Not later
5 than January 1, 2018, for the purpose of meas-
6 uring the care experiences of childbearing
7 women and newborns, the Agency for
8 Healthcare Research and Quality shall adapt
9 the Consumer Assessment of Healthcare Pro-
10 viders and Systems program surveys of—

11 “(i) providers;

12 “(ii) facilities; and

13 “(iii) health plans.

14 “(B) SURVEYS MUST BE EFFECTIVE.—The
15 Agency for Healthcare Research and Quality
16 shall ensure that the surveys adapted under
17 subparagraph (A) are effective in measuring as-
18 pects of care that childbearing women and
19 newborns experience, which may include—

20 “(i) various types of care settings;

21 “(ii) various types of caregivers;

22 “(iii) considerations relating to pain;

23 “(iv) shared decisionmaking;

24 “(v) supportive care around the time
25 of birth; and

1 “(vi) other topics relevant to the qual-
2 ity of the experience of childbearing women
3 and newborns.

4 “(C) LANGUAGES.—The surveys adapted
5 under subparagraph (A) shall be available in
6 English and Spanish.

7 “(D) ENDORSEMENT.—The Agency for
8 Healthcare Research and Quality shall submit
9 any Consumer Assessment of Healthcare Pro-
10 viders and Systems surveys adapted under this
11 paragraph to the consensus-based entity with a
12 contract under section 1890(a)(1) to be consid-
13 ered for endorsement under section 1890(b)(2).

14 “(E) CONSULTATION.—The adaption of
15 (and process for applying) the surveys under
16 subparagraph (A) shall be conducted in con-
17 sultation with the stakeholders identified in
18 paragraph (6)(A).

19 “(6) STAKEHOLDERS.—

20 “(A) IN GENERAL.—The stakeholders
21 identified in this subparagraph are—

22 “(i) the various clinical disciplines and
23 specialties involved in providing maternity
24 care;

25 “(ii) State Medicaid administrators;

1 “(iii) maternity care consumers and
2 their advocates;

3 “(iv) technical experts in quality
4 measurement;

5 “(v) hospital, facility and health sys-
6 tem leaders;

7 “(vi) employers and purchasers; and

8 “(vii) other individuals who are in-
9 volved in the advancement of evidence-
10 based maternity care quality measures.

11 “(B) PROFESSIONAL ORGANIZATIONS.—

12 The stakeholders identified under subparagraph
13 (A) may include representatives from relevant
14 national medical specialty and professional or-
15 ganizations and specialty societies.

16 “(7) AUTHORIZATION OF APPROPRIATIONS.—

17 There are authorized to be appropriated
18 \$16,000,000 to carry out this subsection. Funds ap-
19 propriated under this paragraph shall remain avail-
20 able until expended.”.

21 (b) CONFORMING AMENDMENTS.—

22 (1) Section 1139A of the Social Security Act
23 (42 U.S.C. 1320b–9a) is amended—

24 (A) in subsection (a)(6), in the matter pre-
25 ceding subparagraph (A), by inserting “and the

1 Medicaid and CHIP Payment and Access Com-
2 mission” after “Congress”; and

3 (B) in subsection (i), by striking “sub-
4 section (e)” and inserting “subsections (e) and
5 (j)”.

6 (2) Section 1139B(b)(4) of such Act (42 U.S.C.
7 1320b–9b(b)(4)) is amended by inserting “and the
8 Medicaid and CHIP Payment and Access Commis-
9 sion” after “Congress”.

10 **SEC. 3. QUALITY COLLABORATIVES.**

11 (a) GRANTS.—The Secretary of Health and Human
12 Services (in this section referred to as the “Secretary”)
13 may make grants to eligible entities to support—

14 (1) the development of new State and regional
15 maternity care quality collaboratives;

16 (2) expanded activities of existing maternity
17 care quality collaboratives; and

18 (3) maternity care initiatives within established
19 State and regional quality collaboratives that are not
20 focused exclusively on maternity care.

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

23 (1) Quality collaboratives that focus entirely, or
24 in part, on maternity care initiatives, to the extent

1 that such collaboratives use such grant only for such
2 initiatives.

3 (2) Entities seeking to establish a maternity
4 care quality collaborative.

5 (3) State Medicaid agencies.

6 (4) State departments of health.

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

10 (6) Provider organizations, including associa-
11 tions representing—

12 (A) health professionals; and

13 (B) hospitals.

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

19 (1) improving the appropriate use of cesarean
20 section;

21 (2) reducing maternal and newborn morbidity
22 rates;

23 (3) improving breast-feeding rates;

24 (4) reducing hospital readmission rates;

1 (5) identifying improvement priorities through
2 shared peer review and third-party reviews of quali-
3 tative and quantitative data, and developing and car-
4 rying out projects or programs to address such pri-
5 orities; or

6 (6) delivering risk-appropriate levels of care.

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

9 (1) Facilitating performance data collection and
10 feedback reports to providers with respect to their
11 performance, relative to peers and benchmarks, if
12 any.

13 (2) Developing, implementing, and evaluating
14 protocols and checklists to foster safe, evidence-
15 based practice.

16 (3) Developing, implementing, and evaluating
17 programs that translate into practice clinical rec-
18 ommendations supported by high-quality evidence in
19 national guidelines, systematic reviews, or other well-
20 conducted clinical studies.

21 (4) Developing underlying infrastructure needed
22 to support quality collaborative activities under this
23 subsection.

24 (5) Providing technical assistance to providers
25 and institutions to build quality improvement capac-

1 ity and facilitate participation in collaborative activi-
2 ties.

3 (6) Developing the capability to access the fol-
4 lowing data sources:

5 (A) A mother’s prenatal, intrapartum, and
6 postpartum records.

7 (B) A mother’s medical records.

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

9 (D) Birth and death certificates.

10 (E) Any other relevant State-level gen-
11 erated data (such as data from the pregnancy
12 risk assessment management system
13 (PRAMS)).

14 (7) Developing access to blinded liability claims
15 data, analyzing the data, and using the results of
16 such analysis to improve practice.

17 (e) SPECIAL RULE FOR BIRTHS.—

18 (1) IN GENERAL.—Subject to paragraph (2), if
19 a grant under subsection (a) is for a project or pro-
20 gram that focuses on births, at least 25 percent of
21 the births addressed by such project or program
22 must occur in health facilities that perform fewer
23 than 1,000 births per year.

24 (2) EXCEPTION.—In the case of a grant under
25 subsection (a) for a project or program located in a

1 State in which less than 25 percent of the health fa-
2 cilities in the State perform less than 1,000 births
3 per year, the percentage of births in such facilities
4 addressed by such project or program shall be com-
5 mensurate with the Statewide percentage of births
6 performed at such facilities.

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

9 (1) include data collection with rapid analysis
10 and feedback to participants with a focus on improv-
11 ing practice and health outcomes;

12 (2) develop a plan to identify and resolve data
13 collection problems;

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

17 (4) exclude from quality measure collection and
18 reporting physicians and midwives who attend fewer
19 than 30 births per year.

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

23 (1) minimize costs and administrative effort;
24 and

25 (2) use existing data resources when feasible.

1 (h) CLEARINGHOUSE.—The Secretary shall establish
2 an online, open-access clearinghouse to make protocols,
3 procedures, reports, tools, and other resources of indi-
4 vidual collaboratives available to collaboratives and other
5 entities that are working to improve maternity care qual-
6 ity.

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

9 (1) develop and carry out plans for evaluating
10 its maternity care quality improvement programs
11 and projects; and

12 (2) publish its experiences and results in arti-
13 cles, technical reports, or other formats for the ben-
14 efit of others working on maternity care quality im-
15 provement activities.

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

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

22 (2) A description of any barriers that limited
23 the ability of the collaborative or entity to achieve its
24 goals.

1 (3) The achievements of the collaborative or en-
2 tity under the grant with respect to the quality,
3 health outcomes, and value of maternity care.

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

5 Such reports shall be made available to the public.

6 (k) GOVERNANCE.—

7 (1) IN GENERAL.—A maternity care quality col-
8 laborative or a maternity care program within a
9 broader quality collaborative that is supported under
10 subsection (a) shall be governed by a multi-stake-
11 holder executive committee.

12 (2) COMPOSITION.—Such executive committee
13 shall include individuals who represent—

14 (A) physicians, including physicians in the
15 fields of general obstetrics, maternal-fetal medi-
16 cine, family medicine, neonatology, and pediat-
17 rics;

18 (B) nurse-practitioners and nurses;

19 (C) certified nurse-midwives and certified
20 midwives;

21 (D) health facilities and health systems;

22 (E) consumers;

23 (F) employers and other private pur-
24 chasers;

25 (G) Medicaid programs; and

1 (H) other public health agencies and orga-
2 nizations, as appropriate.

3 Such committee also may include other individuals,
4 such as individuals with expertise in health quality
5 measurement and other types of expertise as rec-
6 ommended by the Secretary. Such committee also
7 may be composed of a combination of general col-
8 laborative executive committee members and mater-
9 nity specific project executive committee members.

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

13 (1) regional and State public health agencies
14 and organizations;

15 (2) public and private health insurers; and

16 (3) regional and State organizations rep-
17 resenting physicians, midwives, and nurses who pro-
18 vide maternity services.

19 (m) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated \$15,000,000 to carry
21 out this section. Funds appropriated under this subsection
22 shall remain available until expended.

○