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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

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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.

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 ''Quality Care for Moms and Babies Act''.

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

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

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

''(j) MOTHER AND INFANT CARE (MIC) QUALITY MEASURES.—

''(1) IN GENERAL.—As part of the pediatric quality measures program established under subsection (b) and the Medicaid Quality Measurement Program established under section 1139B(b)(5)(A), the Secretary shall—

''(A) review quality measures endorsed under section 1890(b)(2) that relate to the care of childbearing women and newborns, particularly with respect to the application of such measures to the Medicaid and CHIP programs under titles XIX and XXI, and identify omissions and deficiencies in the application of those measures to such programs;

''(B) develop and publish a set of maternity care quality measures for the Medicaid and CHIP programs under titles XIX and XXI (in this subsection referred to as the 'Mother and

Infant Care (MIC) quality measures') in accordance with the requirements of paragraphs (2) and (3); and

"(C) on an ongoing basis, review the MIC quality measures and develop and publish any modifications of, or additions or deletions to, such measures that reflect the development, testing, validation, and consensus process described in paragraph (4).

"(2) PROCESS FOR INITIAL REVIEW AND PUBLICATION.—

"(A) CONSULTATION AND PUBLIC COMMENT.—Not later than January 1, 2016, the Secretary shall—

"(i) solicit public comment on the proposed MIC quality measures; and

"(ii) consult with the stakeholders identified in paragraph (6)(A) regarding such measures.

"(B) PUBLICATION OF INITIAL SET OF MEASURES.—Not later than January 1, 2017, the Secretary shall identify and publish the initial MIC quality measures.

"(3) REQUIREMENTS.—

"(A) IN GENERAL.—The MIC quality measures shall—

"(i) be evidence-based;

"(ii) utilize risk adjustment or risk stratification methodologies, if appropriate;

"(iii) utilize attribution methods to specify the clinicians, facilities, and other entities that the measures are applicable to;

"(iv) be pilot-tested with regard to scientific validity, feasibility, and attribution method; and

"(v) include a balance of each of the types of measures listed in subparagraph (B).

"(B) LIST OF TYPES OF MEASURES.—The measures listed in this subparagraph are the following:

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

"(ii) Measures that apply to—

"(I) women and newborns who are healthy and at low risk, including measures of appropriately low-inter-

vention, physiologic birth in low-risk women; and

"(II) women and newborns at higher risk.

"(iii) Measures that apply to—

"(I) childbearing women; and

"(II) newborns.

"(iv) Measures that apply to care during—

"(I) pregnancy;

"(II) intrapartum period; and

"(III) the postpartum period.

"(v) Measures that apply to—

"(I) clinicians and clinician groups;

"(II) facilities;

"(III) health plans; and

"(IV) accountable care organizations.

"(vi) Measurement of—

"(I) disparities;

"(II) care coordination; and

"(III) shared decisionmaking.

"(C) PHYSIOLOGIC DEFINED.—For purposes of this paragraph, the term 'physiologic'

means characteristic of or conforming to the normal functioning or state of the body or a tissue or organ, normal, and not pathologic.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in any way limiting available services.

''(4) ONGOING REVIEW OF THE MIC MEASURES; eMEASURES.—

''(A) CONTRACTS WITH QUALIFIED ENTITIES.—Not later than June 30, 2017, 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 identifying quality of care issues that are not adequately addressed by the MIC quality measures and developing, testing, and validating modifications of, or additions or deletions to, the MIC quality measures, and creating

eMeasures for data collection related to the MIC quality measures.

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

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

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

''(I) the views of the individuals and entities referred to in paragraph (3)(B)(v) 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;

''(iii) for the purpose of ensuring that the MIC quality measures meet the requirements to be considered for endorse-

ment 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 paragraph (6)(A)), as practicable;

"(iv) has transparent policies regarding governance and conflicts of interest; and

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

"(C) eMEASURES.—

"(i) IN GENERAL.—A qualified measure development entity with a grant, contract, or intergovernmental agreement under subparagraph (A) shall consult with the voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-

based measures of health care that the Secretary consults with under subsection (b)(3)(H) and section 1139B(b)(5)(A) to create, as part of the MIC quality measures, eMeasures that are aligned with the measures developed under the pediatric quality measures program established under subsection (b) and the Medicaid Quality Measurement Program established under section 1139B(b)(5)(A).

''(ii) eMEASURE DEFINED.—For purposes of this subparagraph, 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.

''(D) ENDORSEMENT.—Any modifications of, or additions or deletions to, the MIC quality measures 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).

''(5) MATERNITY CONSUMER ASSESSMENT OF HEALTH CARE PROVIDERS AND SYSTEMS SURVEYS.—

''(A) ADAPTION OF SURVEYS.—Not later than January 1, 2018, 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—

''(i) providers;

''(ii) facilities; and

''(iii) health plans.

''(B) SURVEYS MUST BE EFFECTIVE.—The Agency for Healthcare Research and Quality shall ensure that the surveys adapted under subparagraph (A) are effective in measuring aspects of care that childbearing women and newborns experience, which may include—

''(i) various types of care settings;

''(ii) various types of caregivers;

''(iii) considerations relating to pain;

''(iv) shared decisionmaking;

''(v) supportive care around the time of birth; and

"(vi) other topics relevant to the quality of the experience of childbearing women and newborns.

"(C) LANGUAGES.—The surveys adapted under subparagraph (A) shall be available in English and Spanish.

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

"(E) CONSULTATION.—The adaption of (and process for applying) the surveys under subparagraph (A) shall be conducted in consultation with the stakeholders identified in paragraph (6)(A).

"(6) STAKEHOLDERS.—

"(A) IN GENERAL.—The stakeholders identified in this subparagraph are—

"(i) the various clinical disciplines and specialties involved in providing maternity care;

"(ii) State Medicaid administrators;

''(iii) maternity care consumers and their advocates;

''(iv) technical experts in quality measurement;

''(v) hospital, facility and health system leaders;

''(vi) employers and purchasers; and

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

''(B) PROFESSIONAL ORGANIZATIONS.—The stakeholders identified under subparagraph (A) may include representatives from relevant national medical specialty and professional organizations and specialty societies.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $16,000,000 to carry out this subsection. Funds appropriated under this paragraph shall remain available until expended.''.

(b) CONFORMING AMENDMENTS.—

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

(A) in subsection (a)(6), in the matter preceding subparagraph (A), by inserting ''and the

Medicaid and CHIP Payment and Access Commission'' after ''Congress''; and

(B) in subsection (i), by striking ''subsection (e)'' and inserting ''subsections (e) and (j)''.

(2) Section 1139B(b)(4) of such Act (42 U.S.C. 1320b–9b(b)(4)) is amended by inserting ''and the Medicaid and CHIP Payment and Access Commission'' after ''Congress''.

SEC. 3. QUALITY COLLABORATIVES.

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

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

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

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

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

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

that such collaboratives use such grant only for such initiatives.

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

(3) State Medicaid agencies.

(4) State departments of health.

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

(6) Provider organizations, including associations representing—

(A) health professionals; and

(B) hospitals.

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

(1) improving the appropriate use of cesarean section;

(2) reducing maternal and newborn morbidity rates;

(3) improving breast-feeding rates;

(4) reducing hospital readmission rates;

(5) identifying improvement priorities through shared peer review and third-party reviews of qualitative and quantitative data, and developing and carrying out projects or programs to address such priorities; or

(6) delivering risk-appropriate levels of care.

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

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

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

(3) Developing, implementing, and evaluating programs that translate into practice clinical recommendations supported by high-quality evidence in national guidelines, systematic reviews, or other well-conducted clinical studies.

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

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

ity and facilitate participation in collaborative activities.

(6) Developing the capability to access the following data sources:

(A) A mother's prenatal, intrapartum, and postpartum records.

(B) A mother's medical records.

(C) An infant's medical records since birth.

(D) Birth and death certificates.

(E) Any other relevant State-level generated data (such as data from the pregnancy risk assessment management system (PRAMS)).

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

(e) SPECIAL RULE FOR BIRTHS.—

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

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

State in which less than 25 percent of the health facilities in the State perform less than 1,000 births per year, the percentage of births in such facilities addressed by such project or program shall be commensurate with the Statewide percentage of births performed at such facilities.

(f) USE OF QUALITY MEASURES.—Projects and programs for which such a grant is made shall—

(1) include data collection with rapid analysis and feedback to participants with a focus on improving practice and health outcomes;

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

(3) identify and document evidence-based strategies that will be used to improve performance on quality measures and other metrics; and

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

(g) REPORTING ON QUALITY MEASURES.—Any reporting requirements established by a project or program funded under subsection (a) shall be designed to—

(1) minimize costs and administrative effort; and

(2) use existing data resources when feasible.

(h) CLEARINGHOUSE.—The Secretary shall establish an online, open-access clearinghouse to make protocols, procedures, reports, tools, and other resources of individual collaboratives available to collaboratives and other entities that are working to improve maternity care quality.

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

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

(2) publish its experiences and results in articles, technical reports, or other formats for the benefit of others working on maternity care quality improvement activities.

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

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

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

(3) The achievements of the collaborative or entity under the grant with respect to the quality, health outcomes, and value of maternity care.

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

Such reports shall be made available to the public.

(k) GOVERNANCE.—

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

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

(A) physicians, including physicians in the fields of general obstetrics, maternal-fetal medicine, family medicine, neonatology, and pediatrics;

(B) nurse-practitioners and nurses;

(C) certified nurse-midwives and certified midwives;

(D) health facilities and health systems;

(E) consumers;

(F) employers and other private purchasers;

(G) Medicaid programs; and

(H) other public health agencies and organizations, as appropriate.

Such committee also may include other individuals, such as individuals with expertise in health quality measurement and other types of expertise as recommended by the Secretary. Such committee also may be composed of a combination of general collaborative executive committee members and maternity specific project executive committee members.

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

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

(2) public and private health insurers; and

(3) regional and State organizations representing physicians, midwives, and nurses who provide maternity services.

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

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