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[Report No. 114–100]

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 SENATE OF THE UNITED STATES

FEBRUARY 11, 2015

Ms. STABENOW (for herself, Mr. GRASSLEY, Mrs. BOXER, Mr. CASEY, Mr. HEINRICH, Mr. REED, Mr. SCHUMER, Mr. MENENDEZ, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Finance

JULY 30, 2015

Reported by Mr. HATCH, with an amendment

[Strike out all after the enacting clause and insert the part printed in italic]

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, 2018, 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, 2019, 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 regards 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-intervention, 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) the 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; cMEASURES.—

"(A) CONTRACTS WITH QUALIFIED ENTITIES.—Not later than June 30, 2019, the Secretary, acting through the Agency for Healthcare Research and Quality, in consulta-

tion 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 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 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, 2020, 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 rec-

~~ommendations 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 capacity 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.~~

~~(c) 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 medi-

cine, 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.~~

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 MATERNAL AND INFANT HEALTH.

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

"SEC. 1139C. MATERNAL AND INFANT QUALITY MEASURES.

"(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR MATERNAL AND INFANT HEALTH.—

"(1) IN GENERAL.—The Secretary shall identify and publish a recommended core set of maternal and infant health quality measures for women and children described in subparagraphs (A) and (B) of section 1902(l)(1) in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing maternal and infant health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid and CHIP eligible mothers and infants.

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

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

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

"(3) PROCESS FOR MATERNAL AND INFANT QUALITY MEASURES PROGRAM.—In identifying gaps in existing maternal and infant measures and establishing priorities for the development and advancement of such measures, the Secretary shall consult with—

"(A) States;

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

"(C) nurse practitioners and nurses;

"(D) certified nurse-midwives and certified midwives;

"(E) health facilities and health systems;

"(F) national organizations representing mothers and infants;

"(G) national organizations representing consumers and purchasers of health care;

"(H) national organizations and individuals with expertise in maternal and infant health quality measurement; and

"(I) voluntary consensus standard-setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

"(b) DEADLINES.—

"(1) RECOMMENDED MEASURES.—Not later than January 1, 2018, the Secretary shall identify and publish for comment a recommended core set of maternal and infant health quality measures that includes the following:

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

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

"(C) Measures that apply to care during pregnancy, the intrapartum period, and the postpartum period.

"(D) Measures that apply to a variety of settings and provider types, such as clinics, facilities, health plans, and accountable care organizations.

"(E) Measures that address disparities, care coordination, and shared decisionmaking.

"(2) DISSEMINATION.—Not later than January 1, 2019, the Secretary shall publish an initial core set of maternal and infant health quality measures that are applicable to Medicaid and CHIP eligible mothers and infants.

"(3) STANDARDIZED REPORTING.—Not later than January 1, 2020, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of maternal and infant health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid and CHIP eligible mothers and infants.

"(4) REPORTS TO CONGRESS.—Not later than January 1, 2021, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

"(5) ESTABLISHMENT OF MATERNAL AND INFANT QUALITY MEASUREMENT PROGRAM.—

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

"(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Maternal and Infant Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of maternal and infant health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of maternal and infant health quality measures.

"(C) EMEASURES.—

"(i) IN GENERAL.—An entity awarded a grant or contract by the Secretary to develop emerging and innovative evidence-based measures under the Maternal and Infant Quality Measurement Program shall

work to advance eMeasures that are aligned with the measures developed under the Pediatric Quality Measures Program established under section 1139A(b) and the Medicaid Quality Measurement Program established under section 1139B(b)(5).

"(ii) DEFINITION.—For purposes of this subparagraph, the term 'eMeasure' means an electronic 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) AMOUNT AVAILABLE FOR GRANTS AND CONTRACTS.—The aggregate amount of funds that may be awarded as grants and contracts under the Maternal and Infant Quality Measurement Program for the development, testing, and validation of emerging and innovative evidence-based measures shall not exceed the aggregate amount of funds awarded as grants and contracts under section 1139A(b)(4)(A).

"(c) CONSTRUCTION.—Nothing in this section 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.

"(d) MATERNITY CONSUMER ASSESSMENT OF HEALTH CARE PROVIDERS AND SYSTEMS SURVEYS.—

"(1) ADAPTION OF SURVEYS.—Not later than January 1, 2020, for the purpose of measuring the care experiences of childbearing women and newborns, where appropriate, the Agency for Healthcare Research and Quality shall adapt 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, which may include—

"(A) various types of care settings;

"(B) various types of caregivers;

"(C) considerations relating to pain;

"(D) shared decisionmaking;

"(E) supportive care around the time of birth; and

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

"(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 paragraph 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 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.

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

"(1) IN GENERAL.—Each State with a plan or waiver approved under title XIX or XXI shall annually report (separately or as part of the annual report required under section 1139A(c)) to the Secretary on the—

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

"(B) State-specific information on the quality of health care furnished to Medicaid and CHIP eligible mothers and infants under such plan or waiver, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

"(2) PUBLICATION.—Not later than September 30, 2021, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

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

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

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 and infant care quality collaboratives;

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

(3) maternity and infant 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 and infant care initiatives, to the extent that such collaboratives use such grant only for such initiatives.

(2) Entities seeking to establish a maternity and infant 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 capacity 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 and infant 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 and infant 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 and infant 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 and infant 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 and infant care quality collaborative or a maternity and infant 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 and infant 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 and infant 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.

SEC. 4. FACILITATION OF INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY AND EFFICIENCY MEASURES.

(a) IN GENERAL.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph:

"(4) FACILITATION OF INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY AND EFFICIENCY MEASURES.—

"(A) IN GENERAL.—The entity shall facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

"(B) ANNUAL REPORTS.—The entity shall prepare and make available to the public its findings under this paragraph in its annual report. Such public availability shall include posting each report on the Internet website of the entity.".

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

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114TH CONGRESS
1ST SESSION

S. 466

[Report No. 114–100]

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.

JULY 30, 2015

Reported with an amendment