I

112TH CONGRESS
1ST SESSION

H. R. 3620

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 a maternity care quality measurement program, evaluating maternity care home models, and supporting maternity care quality collaboratives.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 8, 2011

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 a maternity care quality measurement program, evaluating maternity care home models, and supporting maternity care quality collaboratives.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 "Quality Care for Moms and Babies Act".

1 (b) TABLE OF CONTENTS.—The table of contents of
2 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.
Sec. 4. Woman- and family-centered maternity care home demonstration program.

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

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 is amended by inserting after section 1139B (42 U.S.C.
7 1320b–9b) the following new section:

8 **"SEC. 1139C. MATERNITY CARE QUALITY MEASUREMENT.**

9 "(a) IN GENERAL.—The Secretary shall develop a
10 maternity care quality measurement program for care pro-
11 vided to childbearing women and newborns for voluntary
12 use by—

13 "(1) a State in administering a State plan
14 under title XIX or a State child health plan under
15 title XXI;

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

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

1 "(b) COORDINATION WITH OTHER QUALITY MEAS-
2 URES.—
3 "(1) MEDICAID QUALITY MEASUREMENT PRO-
4 GRAM.—The maternity care quality measurement
5 program under subsection (a) shall be developed, ad-
6 ministered, and evaluated on an ongoing basis as
7 part of, and in coordination with, the Medicaid
8 Quality Measurement Program established under
9 section 1139B(b)(5)(A) and the pediatric quality
10 measures program established under section
11 1139A(b). In coordination with the publication re-
12 quirements under section 1139A(b)(5) and
13 1139B(b)(5)(B), the Secretary annually shall pub-
14 lish recommended changes to the core set of mater-
15 nity care quality measures published under sub-
16 section (c) that shall reflect the development, test-
17 ing, validation, and consensus process described in
18 subsection (d).
19 "(2) IDENTIFICATION OF MEASUREMENT
20 GAPS.—The maternity care quality measurement
21 program under subsection (a) shall include proce-
22 dures for identifying quality measure gaps and es-
23 tablishing priorities for the development and ad-
24 vancement of new or modified quality measures
25 under the maternity care quality measurement pro-

1 gram, the Medicaid Quality Measurement Program
2 established under section 1139B(b)(5)(A) and the
3 pediatric quality measures program established
4 under section 1139A(b).

5 "(3) REPORTS TO CONGRESS AND MACPAC.—
6 Not later than January 1, 2017, and every 3 years
7 thereafter, the Secretary shall include in the reports
8 required under sections 1139A(a)(6) and
9 1139B(b)(4) to Congress and the Medicaid and
10 CHIP Payment and Access Commission information
11 similar to the information required under such sec-
12 tions with respect to the measures established under
13 this section.

14 "(c) IDENTIFICATION OF AN INITIAL SET OF MATER-
15 NITY CARE QUALITY MEASURES.—

16 "(1) CONSULTATION AND PUBLIC COMMENT.—
17 Not later than January 1, 2014, the Secretary
18 shall—

19 "(A) solicit public comment on a rec-
20 ommended initial core set of maternity care
21 quality measures; and

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

24 "(2) PUBLICATION.—Not later than January 1,
25 2015, the Secretary shall identify, and publish, from

1 maternity care quality measures endorsed under sec-
2 tion 1890(b)(2), an initial core set of maternity care
3 quality measures.

4 "(3) STANDARDIZED REPORTING.—The Sec-
5 retary shall develop a standardized format for re-
6 porting information based on the initial core set of
7 maternity care quality measure for voluntary use in
8 data collection and reporting by—

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

12 "(B) health insurance issuers and man-
13 aged care entities that enter into contracts with
14 States for the purpose of administering such
15 plans; and

16 "(C) providers of items and services (in-
17 cluding accountable care organizations) with re-
18 spect to items and services provided under such
19 plans.

20 "(d) DEVELOPMENT OF ADDITIONAL QUALITY
21 MEASURES.—

22 "(1) CONTRACTS WITH QUALIFIED ENTITIES.—
23 Not later than the end of the 6-month period begin-
24 ning on the date the Secretary publishes the initial
25 measures under subsection (c)(2), subject to sub-

1 section (b), the Secretary, acting through the Agen-
2 cy for Healthcare Research and Quality, in consulta-
3 tion with the Centers for Medicare & Medicaid Serv-
4 ices, shall enter into grants, contracts, or intergov-
5 ernmental agreements with qualified measure devel-
6 opment entities for the purpose of developing, test-
7 ing, and validating maternity care quality measures
8 in areas that are not adequately covered by the
9 measures so published.

10 ‘‘(2) QUALIFIED MEASURE DEVELOPMENT EN-
11 TITY DEFINED.—For purposes of this subsection,
12 the term ‘qualified measure development entity’
13 means an entity that—

14 ‘‘(A) has demonstrated expertise and ca-
15 pacity in the development and testing of quality
16 measures;

17 ‘‘(B) has adopted procedures for quality
18 measure development that ensure the inclusion
19 of—

20 ‘‘(i) the views of the individuals and
21 entities referred to in subsection (e)(2)(E)
22 and whose performance will be assessed by
23 the measures; and

24 ‘‘(ii) the views of other individuals
25 and entities (including patients, con-

1 sumers, and health care purchasers) who
2 will use the data generated as a result of
3 the use of the quality measures;
4 "(C) for the purpose of ensuring that the
5 quality measures developed under this sub-
6 section meet the requirements to be considered
7 for endorsement under section 1890(b)(2), has
8 provided assurances to the Secretary that the
9 measure development entity will collaborate
10 with—
11 "(i) the Secretary;
12 "(ii) the consensus-based entity with a
13 contract under section 1890(a)(1); and
14 "(iii) stakeholders (including those
15 stakeholders identified in subsection
16 (i)(1)), as practicable;
17 "(D) has transparent policies regarding
18 governance and conflicts of interest; and
19 "(E) submits an application to the Sec-
20 retary at such time, and in such form and man-
21 ner, as the Secretary may require.
22 "(3) eMEASURES.—
23 "(A) IN GENERAL.—A qualified measure
24 development entity with a grant, contract, or
25 intergovernmental agreement under paragraph

1 (1), in developing quality measures, shall con-
2 sult with the voluntary consensus standards set-
3 ting organizations and other organizations in-
4 volved in the advancement of evidence-based
5 measures of health care as the Secretary
6 consults with under sections 1139A(b)(3)(H)
7 and 1139B(b)(5)(A) to create eMeasures that
8 are aligned with the measures developed under
9 the Medicaid Quality Measurement Program es-
10 tablished under section 1139B(b)(5)(A) and the
11 pediatric quality measures program established
12 under section 1139A(b).

13 "(B) eMEASURE DEFINED.—For purposes
14 of this section, the term 'eMeasure' means a
15 measure for which measurement data (including
16 clinical data) will be collected electronically, in-
17 cluding through the use of electronic health
18 records and other electronic data sources.

19 "(4) ENDORSEMENT.—Any maternity care
20 quality measures developed under this subsection by
21 a qualified measure development entity shall be sub-
22 mitted by the qualified measure development entity
23 to the consensus-based entity with a contract under
24 section 1890(a)(1) to be considered for endorsement
25 under section 1890(b)(2).

1 "(e) TYPES OF MEASURES.—
2 "(1) IN GENERAL.—The maternity quality
3 measures identified under subsection (c) and the
4 measures developed under subsection (d) shall—
5 "(A) be evidence-based;
6 "(B) utilize risk adjustment or risk strati-
7 fication methodologies, if appropriate;
8 "(C) utilize attribution methods to specify
9 the clinicians, facilities, and other entities that
10 the measures are applicable to;
11 "(D) be pilot-tested with regards to sci-
12 entific validity, feasibility, and attribution meth-
13 od; and
14 "(E) include a balance of each of the types
15 of measures listed in paragraph (2).
16 "(2) LIST OF TYPES OF MEASURES.—The
17 measures listed in this paragraph are the following:
18 "(A) Measures of the process, experience,
19 efficiency, and outcomes of maternity care, in-
20 cluding postpartum outcomes.
21 "(B) Measures that apply to—
22 "(i) women and newborns who are
23 healthy and at low risk, including meas-
24 ures of appropriately low-intervention,
25 physiologic birth in low-risk women; and

1 "(ii) women and newborns at higher
2 risk.
3 "(C) Measures that apply to—
4 "(i) childbearing women; and
5 "(ii) newborns.
6 "(D) Measures that apply to care during—
7 "(i) pregnancy;
8 "(ii) intrapartum period; and
9 "(iii) the postpartum period.
10 "(E) Measures that apply to—
11 "(i) clinicians and clinician groups;
12 "(ii) facilities;
13 "(iii) health plans; and
14 "(iv) accountable care organizations.
15 "(F) Measurement of—
16 "(i) disparities;
17 "(ii) care coordination; and
18 "(iii) shared decisionmaking.
19 "(3) PHYSIOLOGIC DEFINED.—For purposes of
20 this subsection, the term 'physiologic' means char-
21 acteristic of or conforming to the normal functioning
22 or state of the body or a tissue or organ, normal,
23 and not pathologic.
24 "(4) CONSTRUCTION.—Nothing in this sub-
25 section shall be construed as supporting the restric-

1 tion of coverage, under title XIX or XXI or other-
2 wise, to only those services that are evidence-based,
3 or in anyway limiting available services.
4 "(f) MATERNITY CONSUMER ASSESSMENT OF
5 HEALTHCARE PROVIDERS AND SYSTEMS SURVEYS.—
6 "(1) ADAPTION OF SURVEYS.—Not later than
7 January 1, 2016, for the purpose of measuring the
8 care experiences of childbearing women and
9 newborns, the Agency for Healthcare Research and
10 Quality shall adapt the Consumer Assessment of
11 Healthcare Providers and Systems program surveys
12 of—
13 "(A) providers;
14 "(B) facilities; and
15 "(C) health plans.
16 "(2) SURVEYS MUST BE EFFECTIVE.—The
17 Agency for Healthcare Research and Quality shall
18 ensure that the surveys adapted under paragraph
19 (1) are effective in measuring aspects of care that
20 childbearing women and newborns experience, which
21 may include—
22 "(A) various types of care settings;
23 "(B) various types of caregivers;
24 "(C) considerations relating to pain;
25 "(D) shared decisionmaking;

1 ''(E) supportive care around the time of
2 birth; and
3 ''(F) other topics relevant to the quality of
4 the experience of childbearing women and
5 newborns.
6 ''(3) LANGUAGES.—The surveys adapted under
7 paragraph (1) shall be available in English and
8 Spanish.
9 ''(4) ENDORSEMENT.—The Agency for
10 Healthcare Research and Quality shall submit any
11 Consumer Assessment of Healthcare Providers and
12 Systems surveys adapted under this subsection to
13 the consensus-based entity with a contract under
14 section 1890(a)(1) to be considered for endorsement
15 under section 1890(b)(2).
16 ''(5) CONSULTATION.—The adaption of (and
17 process for applying) the surveys under paragraph
18 (1) shall be conducted in consultation with the
19 stakeholders identified in subsection (i)(1).
20 ''(g) ANNUAL STATE REPORTS REGARDING STATE-
21 SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER
22 MEDICAID.—
23 ''(1) ANNUAL STATE REPORTS.—Each State
24 with a State plan or waiver approved under title
25 XIX shall annually report (separately or as part of

1 an annual report required under section 1139A(c) or
2 section 1139B(d)), to the Secretary on the—
3 ''(A) State-specific maternity health qual-
4 ity measures applied by the State under the
5 such plan; and
6 ''(B) State-specific information on the
7 quality of maternity care furnished to Medicaid
8 eligible individuals under such plan, including
9 information collected through external quality
10 reviews of managed care organizations under
11 section 1932 and benchmark plans under sec-
12 tion 1937.
13 ''(2) PUBLICATION.—Not later than September
14 30, 2015, and annually thereafter, the Secretary
15 shall collect, analyze, and make publicly available the
16 information reported by States under subparagraph
17 (A).
18 ''(h) CONVERSION OF CURRENTLY ENDORSED MEAS-
19 URES AND CREATION OF INITIAL QUALITY DATA MODEL
20 TO ENABLE ELECTRONIC HEALTH RECORDS TO MEAS-
21 URE THE CARE OF CHILDBEARING WOMEN AND
22 NEWBORNS.—
23 ''(1) IN GENERAL.—Not later than January 1,
24 2015, for the purpose of fostering automated pa-
25 tient-centered longitudinal quality measurement of

1 maternal and newborn care using clinical data, the
2 consensus-based entity with a contract under section
3 1890(b)(2) shall coordinate—
4 ‘‘(A) the conversion of endorsed measures
5 for the care of childbearing women and
6 newborns to eMeasures (as such term is defined
7 in subsection (d)(3)(B)); and
8 ‘‘(B) the development of an initial quality
9 data model for use within electronic health
10 records of childbearing women and newborns
11 enrolled in a program administered by a State
12 through State plans under title XIX and State
13 Child Health plans under title XXI for pur-
14 poses of such eMeasures.
15 ‘‘(2) REQUIREMENTS FOR EMEASURE CONVER-
16 SION AND QUALITY DATA MODEL CREATION.—The
17 conversion to eMeasures and the quality data model
18 creation under paragraph (1) shall, for each quality
19 measure of the care of childbearing women or
20 newborns that the consensus-based entity with a
21 contract under section 1890(b)(2) has endorsed, use
22 the entity's measure authoring tool to—
23 ‘‘(A) specify standard data elements, qual-
24 ity data elements, and data flow connectors to
25 electronic information;

1 "(B) specify quality measure logical state-
2 ments;
3 "(C) test quality measure validity with an
4 appropriate electronic health record test data-
5 base;
6 "(D) finalize eMeasures for export to elec-
7 tronic health record systems; and
8 "(E) carry out this work in—
9 "(i) collaboration with the developer
10 or sponsor of each endorsed measure, who
11 is responsible, under an agreement with
12 the entity that endorsed such measure, for
13 updating such measure; and
14 "(ii) consultation with the stake-
15 holders identified in subsection (i)(1).
16 "(3) COORDINATION WITH HITECH ACT.—In
17 carrying out activities under this subsection, the
18 consensus-based entity with a contract under section
19 1890(b)(2) shall take into account, and to the extent
20 practicable, coordinate with, similar activities relat-
21 ing to the implementation of the Health Information
22 Technology for Economic and Clinical Health Act
23 established under title XIII of division A and title
24 IV of division B of Public Law 111–5.
25 "(i) STAKEHOLDERS.—

1 "(1) IN GENERAL.—The stakeholders identified
2 in this paragraph are—
3 "(A) the various clinical disciplines and
4 specialties involved in providing maternity care;
5 "(B) State Medicaid administrators;
6 "(C) maternity care consumers and their
7 advocates;
8 "(D) technical experts in quality measure-
9 ment;
10 "(E) hospital, facility and health system
11 leaders;
12 "(F) employers and purchasers; and
13 "(G) other individuals who are involved in
14 the advancement of evidence-based maternity
15 care quality measures.
16 "(2) PROFESSIONAL ORGANIZATIONS.—The
17 stakeholders identified under paragraph (1) may in-
18 clude representatives from relevant national medical
19 specialty and professional organizations and spe-
20 cialty societies.
21 "(j) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated $28,000,000 to carry
23 out this section. Funds appropriated under this subsection
24 shall remain available until expended.".
25 (b) CONFORMING AMENDMENTS.—

1 (1) Section 1139A(a)(6) of the Social Security
2 Act (42 U.S.C. 1320b–9a(a)(6)) is amended, in the
3 matter preceding subparagraph (A), by inserting
4 ''and the Medicaid and CHIP Payment and Access
5 Commission'' after ''Congress''.

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;

(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-

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

(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.

SEC. 4. WOMAN- AND FAMILY-CENTERED MATERNITY CARE HOME DEMONSTRATION PROGRAM.

(a) DEFINITIONS.—In this section:

1 (1) CHIP.—The term ''CHIP'' means the
2 State Children's Health Insurance Program estab-
3 lished under title XXI of the Social Security Act (42
4 U.S.C. 1397aa et seq.).
5 (2) ELIGIBLE INDIVIDUALS.—The term ''eligi-
6 ble individual'' means a childbearing woman who is
7 receiving assistance under Medicaid or CHIP.
8 (3) ELIGIBLE ENTITY.—The term ''eligible enti-
9 ty'' means a State, an entity or organization receiv-
10 ing payments under Medicaid or CHIP, a hospital,
11 a freestanding birth center (as defined in section
12 1905(l)(3)(B) of the Social Security Act (42 U.S.C.
13 1396d(l)(3)(B)), an entity or organization receiving
14 assistance under section 330 of the Public Health
15 Service Act (42 U.S.C. 254b), a federally qualified
16 health center (as defined in subsection (l)(2)(C) of
17 section 1905 of the Social Security Act (42 U.S.C.
18 1396d), a rural health clinic (as defined in sub-
19 section (l)(1) of such section), or an entity that re-
20 ceives assistance under title X or XX of the Public
21 Health Service Act (42 U.S.C. 300 et seq., 300z et
22 seq.), that submits an approved application to the
23 Secretary to conduct a demonstration project under
24 this section.

1 (4) MEDICAID.—The term ''Medicaid'' means
2 the Federal and State program for medical assist-
3 ance established under title XIX of the Social Secu-
4 rity Act (42 U.S.C. 1396 et seq.).
5 (5) PRINCIPAL MATERNITY CARE PROVIDER.—
6 The term ''principal maternity care provider''
7 means:
8 (A) A physician (as defined in section
9 1861(r)(1) of the Social Security Act (42
10 U.S.C. 1395x(r)(1)) who meets the following re-
11 quirements:
12 (i) The physician is a board certified
13 physician who specializes in women's
14 health issues, such as obstetrics and gyne-
15 cology, or family practice, and who pro-
16 vides continuous and comprehensive care
17 for individuals under the physician's care.
18 (ii) The physician has the staff and
19 resources to manage the comprehensive
20 and coordinated health care of each such
21 individual.
22 (iii) The physician practices in a prac-
23 tice, health or birth center, clinic, or hos-
24 pital recognized to be a maternity care
25 home.

1 (iv) Such other requirements as are
2 defined by the Secretary.
3 (B) An advanced practice nurse, a certified
4 nurse-midwife (CNM) or certified midwife (CM)
5 certified by the American Midwifery Certifi-
6 cation Board, or physician assistant, who meets
7 the following requirements:
8 (i) The advanced practice nurse, mid-
9 wife, or physician assistant specializes in
10 women's health issues, such as obstetrics
11 and gynecology, and provides continuous
12 and comprehensive care for patients.
13 (ii) The advanced practice nurse, mid-
14 wife, or physician assistant has the staff
15 and resources to manage the comprehen-
16 sive and coordinated health care of each
17 such individual.
18 (iii) The advanced practice nurse,
19 midwife, or physician assistant practices in
20 a practice or health or birth center recog-
21 nized to be a maternity care home.
22 (iv) Such other requirements as are
23 defined by the Secretary.
24 (6) SECRETARY.—The term "Secretary" means
25 the Secretary of Health and Human Services.

1 (7) MATERNITY CARE HOME.—The term ''ma-
2 ternity care home'' means a physician-led practice,
3 or advanced practice nurse-, certified nurse-midwife-
4 , certified midwife, or physician assistant-led prac-
5 tice in those States in which State law does not re-
6 quire direct supervision of licensed advanced practice
7 nurses, certified nurse-midwives, certified midwives,
8 or physician assistants providing services in a hos-
9 pital, practice, health or birth center, or clinic par-
10 ticipating as maternity care home under the pro-
11 gram that uses practice innovations and coordina-
12 tion agreements with other providers to improve the
13 management and coordination of maternity care that
14 meets the following standards:
15 (A) The practice, health or birth center,
16 clinic, or hospital is able to provide or coordi-
17 nate maternity care for women, including pre-
18 conception care, prenatal care, family planning,
19 medical care, mental and behavioral health
20 care, and screening, that, at a minimum, in-
21 cludes at least 3 of the following, and may in-
22 clude all of the following:
23 (i) An initial health assessment and
24 development of a maternity care plan.

1 (ii) Pregnancy care to foster access of
2 all women to preventive services and sup-
3 port, including guidance about nutrition,
4 weight gain, exercise, stress management,
5 rest, and environmental exposures.
6 (iii) Pregnancy care to foster access of
7 women with special needs to such services
8 as help with smoking cessation; use of al-
9 cohol and other harmful substances; mood
10 disorders; and domestic violence.
11 (iv) Evaluation and development of a
12 plan for appropriate use of any continuing
13 and new prescription and over-the-counter
14 medications.
15 (v) Appropriate care for women who
16 are deemed at risk for premature birth.
17 (vi) Appropriate care for women who
18 are members of a minority population that
19 experiences pregnancy-related health dis-
20 parities.
21 (vii) Coordination with providers of
22 services for any ongoing or new medical
23 conditions.
24 (viii) Care to foster initiation and es-
25 tablishment of breast feeding through ef-

1 fective prenatal, intrapartum, and
2 postpartum services and practices.
3 (ix) Plan for childbirth that supports
4 utilization of evidence-based intrapartum
5 practices.
6 (x) Care of the newborn from birth
7 until transition to the baby's primary care
8 provider, including preventive practices
9 promoting optimal feeding and attachment.
10 (xi) Postpartum health services for
11 the first two months after birth, including
12 family planning, weight control, exercise,
13 nutrition, and other preventive services; as-
14 sessment and treatment for postpartum
15 depression and other mood disorders; as-
16 sessment and treatment of other new-onset
17 conditions that may include infection, pain,
18 and heavy bleeding; and any continuing
19 needs for help with smoking cessation, sub-
20 stance abuse, and other health risks.
21 (xii) At the conclusion of maternity
22 services and as needed in the course of ma-
23 ternity services, communication with the
24 primary care providers of the woman and
25 newborn about care processes, outcomes of

1 maternal and newborn care, and any con-
2 tinuing health care needs.
3 (xiii) Any other services specified by
4 the Secretary.
5 (B) The practice, health or birth center,
6 clinic, or hospital applies standards for access
7 to care and communication with eligible individ-
8 uals participating in the demonstration program
9 established under this section, including direct
10 and ongoing access to the principal maternity
11 care provider who accepts responsibility for pro-
12 viding continuous care, including coordination
13 for comprehensive maternity care to the whole
14 person, in collaboration with a team of other
15 health professionals, including other nurses, pri-
16 mary care and specialist physicians, and mental
17 health professionals, as needed and appropriate.
18 Care is patient and family centered, culturally
19 and linguistically appropriate, structured to en-
20 sure women receive complete and accurate
21 health information for shared decisionmaking,
22 and structured to assure confidentiality so that
23 teens and women may seek needed care in a
24 timely way.

1 (C) The practice, health or birth center,
2 clinic, or hospital has readily accessible, clini-
3 cally useful records on eligible individuals par-
4 ticipating in the demonstration program estab-
5 lished under this section, when feasible through
6 electronic health records available in ambula-
7 tory and inpatient settings, that enable the
8 practice to treat such individuals comprehen-
9 sively and systematically.

10 (D) The practice, health or birth center,
11 clinic or hospital maintains continuous relation-
12 ships with eligible individuals participating in
13 the demonstration program established under
14 this section by implementing clinical rec-
15 ommendations supported by high-quality evi-
16 dence in national guidelines, systematic reviews,
17 or other well-conducted clinical studies and ap-
18 plying them to the identified needs of such indi-
19 viduals over time and with the intensity needed
20 by such individuals.

21 (E) The practice, health or birth center,
22 clinic, or hospital supports eligible individuals in
23 self-care to pursue their goals and achieve opti-
24 mal health.

1 (F) The practice, health or birth center,
2 clinic, or hospital assesses and addresses bar-
3 riers to communication between health profes-
4 sions and eligible individuals.

5 (G) The practice, health or birth center,
6 clinic, or hospital has in place the resources and
7 processes necessary to achieve improvements in
8 the management and coordination of care for
9 eligible individuals participating in the dem-
10 onstration program established under this sec-
11 tion, including—

12 (i) providing training programs for
13 personnel involved in the coordination of
14 care;

15 (ii) utilizing information technology to
16 support optimal patient care, performance
17 measurement and use of the results to im-
18 prove practice, patient education, and en-
19 hanced communication; and

20 (iii) implementation of programs to
21 improve the quality of care.

22 (H) The practice, health or birth center,
23 clinic, or hospital meets the requirements im-
24 posed on a covered entity for purposes of apply-
25 ing part C of title XI of the Public Health

1 Service Act (42 U.S.C. 300b–1 et seq.) and all
2 regulatory provisions promulgated there under,
3 including regulations (relating to privacy)
4 adopted pursuant to the authority of the Sec-
5 retary under section 264(c) of the Health In-
6 surance Portability and Accountability Act of
7 1996 (42 U.S.C. 1320d–2 note).
8 (b) ESTABLISHMENT.—
9 (1) IN GENERAL.—Not later than 1 year after
10 the date of enactment of this Act, the Secretary
11 shall establish a maternity care home demonstration
12 program (in this section referred to as the ''pro-
13 gram'').
14 (2) DURATION; SCOPE.—The program shall be
15 conducted for a 3-year period (except that an eligible
16 individual participating in the program shall remain
17 eligible for items and services provided under the
18 program through 2 months postpartum regardless of
19 the termination of the program period) and shall in-
20 clude a nationally representative sample of physi-
21 cians, advanced practice nurses, certified nurse mid-
22 wives, certified midwives, and physician assistants
23 who specialize in women's health issues, such as ob-
24 stetrics and gynecology, or family practice, and who

1 serve urban, rural, and underserved areas in a total
2 of no more than 8 States.
3 (3) COMPREHENSIVENESS.—The Secretary
4 shall give priority under the program to demonstra-
5 tion projects that reflect a comprehensive inclusion
6 of the care components identified under subsection
7 (a)(7)(A).
8 (4) ENCOURAGING PARTICIPATION OF SMALL
9 PHYSICIAN PRACTICES.—The program shall be de-
10 signed to include the participation of maternity care
11 providers in practices with fewer than 4 full-time
12 equivalent clinicians, as well as maternity care pro-
13 viders in larger practices, particularly in rural and
14 underserved areas.
15 (5) PROGRAM GOALS.—The program shall be
16 designed in order to determine whether and to what
17 extent maternity care homes accomplish the fol-
18 lowing:
19 (A) Increase—
20 (i) cost efficiencies of maternity care
21 delivery;
22 (ii) the reliable provision of care sup-
23 ported by high-quality evidence in national
24 guidelines, systematic reviews, or other
25 well-conducted clinical studies;

1 (iii) communication among maternity
2 care providers, other health professionals,
3 facilities, and eligible individuals; and
4 (iv) the quality of maternity care serv-
5 ices provided, as based on nationally en-
6 dorsed quality measures.
7 (B) Decrease—
8 (i) inappropriate emergency room uti-
9 lization;
10 (ii) avoidable maternal and newborn
11 hospitalizations and admissions to inten-
12 sive care units;
13 (iii) duplication of health care services
14 provided; and
15 (iv) health disparities.
16 (C) Improve—
17 (i) the woman's experience of care and
18 the maternity care provider's experience of
19 providing care; and
20 (ii) health outcomes of women and
21 newborns, such as—
22 (I) decreased preterm and early
23 term birth, postpartum morbidities,
24 and untreated postpartum depression;
25 and

1 (II) increased vaginal birth and
2 initiation and duration of exclusive
3 breast feeding.
4 (6) ELIGIBLE INDIVIDUAL AND ELIGIBLE ENTI-
5 TY PARTICIPATION.—
6 (A) ELIGIBLE INDIVIDUALS.—The Sec-
7 retary shall establish a process under which—
8 (i) an eligible individual may elect to
9 participate in a maternity care home under
10 the program; and
11 (ii) no cost sharing shall be imposed
12 with respect to any service required under
13 to be provided to the individual under the
14 program.
15 (B) ASSURANCE OF PARTICIPATION OF EL-
16 IGIBLE ENTITIES THAT ARE NOT PARTICI-
17 PATING PROVIDERS OR ARE IN STATES WITH
18 MANAGED CARE.—The Secretary shall establish
19 a process to ensure that eligible entities that
20 are not participating providers under Medicaid
21 or CHIP in the State, or, in the case of a State
22 that contracts with a private entity to manage
23 parts of the Medicaid or CHIP in the State, do
24 not participate with that entity, are able to par-
25 ticipate in the program.

1 (7) STANDARD SETTING PROCESS.—In con-
2 sultation with the stakeholders specified in sub-
3 section (d), the Secretary shall—
4 (A) develop a maternity care home reim-
5 bursement methodology that takes into consid-
6 eration, to the maximum extent practicable—
7 (i) recognition of the value of mater-
8 nity care provider and clinical staff work
9 associated with patient care that falls out-
10 side the face-to-face visit, such as the time
11 and effort spent on educating family mem-
12 bers and arranging appropriate followup
13 services with other health care profes-
14 sionals;
15 (ii) reimbursement of services associ-
16 ated with coordination of care both within
17 a given practice and between consultants,
18 ancillary providers, and community re-
19 sources;
20 (iii) recognition of expenses that the
21 maternity care home practices will incur to
22 acquire and utilize health information tech-
23 nology, such as clinical decision support
24 tools, patient registries, or electronic med-
25 ical records;

1 (iv) reimbursement for separately
2 identifiable e-mail and telephonic consulta-
3 tions, either as separately billable services
4 or as part of a global management fee;
5 (v) recognition of the value of provider
6 work associated with remote monitoring of
7 clinical data using technology;
8 (vi) reimbursement for provision of
9 preventive services, health education, and
10 participation in shared decisionmaking;
11 (vii) recognition and sharing of sav-
12 ings with respect to reduction of proce-
13 dures and practices that are contrary to
14 high-quality evidence in national guide-
15 lines, systematic reviews, or other well-con-
16 ducted clinical studies and to reductions in
17 the occurrence of health and pregnancy
18 complications, hospitalization rates, med-
19 ical errors, adverse drug reactions, and
20 other occurrences;
21 (viii) allowance for additional pay-
22 ments for achieving measurable and con-
23 tinuous quality improvements, including
24 under a process established by the Sec-
25 retary for paying a performance-based

1 bonus to maternity care homes which meet
2 or achieve substantial improvements in
3 performance (as specified under clinical,
4 patient experience of care, and efficiency
5 benchmarks established by the Secretary);
6 (ix) recognition of the existing pay-
7 ment methodology for federally qualified
8 health centers when determining the most
9 appropriate mechanism for providing
10 bonus payments for maternity care home
11 services delivered at such centers; and
12 (x) such other innovative methods as
13 the Secretary finds appropriate;
14 (B) develop appropriate risk-adjustment
15 mechanisms to account for varying costs of ma-
16 ternity care homes based upon characteristics of
17 the eligible individuals participating in the pro-
18 gram;
19 (C) make allowance for additional pay-
20 ments for achieving measurable and continuous
21 quality improvements, including under a process
22 established by the Secretary for paying a per-
23 formance-based bonus to maternity care homes
24 which meet or achieve substantial improvements
25 in performance (as specified under clinical, pa-

1 tient experience, and efficiency benchmarks es-
2 tablished by the Secretary in consultation with
3 the stakeholders specified in subsection (d));
4 (D) recognize the existing payment meth-
5 odology for federally qualified health centers
6 when determining the most appropriate mecha-
7 nism for providing bonus payments for mater-
8 nity care home services delivered at such cen-
9 ters; and
10 (E) establish such other methods as the
11 Secretary, in consultation with the stakeholders
12 specified in subsection (d), finds appropriate.
13 (8) PLANNING OR IMPLEMENTATION GRANTS.—
14 The Secretary may award planning or implementa-
15 tion grants to eligible entities desiring or selected to
16 participate in the program.
17 (9) ONGOING OVERSIGHT AND PERFORMANCE
18 ASSESSMENT.—The Secretary shall establish proce-
19 dures to ensure that hospitals, practices, health or
20 birth centers, and clinics participating as maternity
21 care homes under the program, and the physicians,
22 advanced practice nurses, certified nurse-midwives,
23 certified midwives, and physician assistants pro-
24 viding services at such hospitals, practices, centers,
25 and clinics, have access to confidential feedback and

1 benchmarking reports as a function of the hospital's,
2 practice's, health or birth center's, or clinic's moni-
3 toring of its clinical process and performance (in-
4 cluding process and outcome measures).

5 (10) TECHNICAL ASSISTANCE.—The Secretary
6 shall establish mechanisms to provide technical as-
7 sistance to hospitals, practices, health or birth cen-
8 ters, and clinics participating as maternity care
9 homes under the program.

10 (11) PAYMENTS TO STATES.—The Secretary
11 shall pay each State participating in the program an
12 amount equal to 100 percent of the amounts ex-
13 pended by the State for services provided to an eligi-
14 ble individual under the program, including adminis-
15 trative expenses.

16 (12) AUTHORIZATION OF APPROPRIATIONS.—
17 There are authorized to be appropriated
18 $50,000,000 to carry out this section. Funds appro-
19 priated under this paragraph shall remain available
20 until expended.

21 (c) EVALUATIONS AND PROGRAM REPORTS.—

22 (1) ANNUAL INTERIM EVALUATIONS AND RE-
23 PORTS.—For each year of the program, the Sec-
24 retary shall provide for an interim evaluation of the
25 program and shall submit to Congress and the Med-

1 icaid and CHIP Payment and Access Commission
2 established under section 1900 of the Social Security
3 Act (42 U.S.C. 1396) (in this subsection referred to
4 as "MACPAC") reports on the results of such eval-
5 uations.

6 (2) FINAL EVALUATION AND REPORT.—The
7 Secretary shall provide for a final evaluation of the
8 program and shall submit to Congress and
9 MACPAC, not later than 1 year after completion of
10 the program, a final report on the program based on
11 the results of such evaluation. Such final report shall
12 include—

13 (A) an assessment of improvements in
14 quality and outcomes of childbearing women
15 and newborns identified under the program
16 goals specified in subsection (b)(4);

17 (B) an assessment of the women's experi-
18 ence of care and the maternity care providers'
19 satisfaction;

20 (C) an assessment of which women, based
21 on demographic factors, such as age, race, sex-
22 ual orientation, disability, ethnicity, and socio-
23 economic status, benefit the most from partici-
24 pating in a maternity care home;

(D) estimates of cost savings to Medicaid, CHIP, and other Federal programs resulting from the program; and

(E) recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(d) CONSULTATION WITH RELEVANT STAKEHOLDERS.—In carrying out the activities under this section, the Secretary shall consult with the following stakeholders on selection and evaluation of the program, setting of payment and incentives criteria, and other activities determined by the Secretary (in addition to the issues for which consultation with such stakeholders is required in other subsections of this section):

(1) States.

(2) National organizations and individuals representing obstetrician-gynecologists, family physicians, certified nurse-midwives and certified midwives, advanced practice nurses, registered nurses, and physician assistants.

(3) National organizations representing consumers.

(4) Health care providers that furnish care to women who live in urban and rural medically under-

1 served communities and are at heightened risk for
2 poor health outcomes.
3 (5) National organizations and individuals with
4 expertise in maternity health quality measurement
5 and coding and reimbursement related issues.
6 (6) National organizations and individuals that
7 provide social and medical services to pregnant
8 women, such as mental health professionals and so-
9 cial workers.

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