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117TH CONGRESS
1ST SESSION

H. R. 1350

To require the Secretary of Health and Human Services to publish guidance for States on strategies for maternal care providers participating in the Medicaid program to reduce maternal mortality and severe morbidity with respect to individuals receiving medical assistance under such program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 2021

Ms. KELLY of Illinois (for herself and Mr. LATTA) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To require the Secretary of Health and Human Services to publish guidance for States on strategies for maternal care providers participating in the Medicaid program to reduce maternal mortality and severe morbidity with respect to individuals receiving medical assistance under such program.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Supporting Best Practices for Healthy Moms Act''.

SEC. 2. DEVELOPING GUIDANCE ON MATERNAL MORTALITY AND SEVERE MORBIDITY REDUCTION FOR MATERNAL CARE PROVIDERS RECEIVING PAYMENT UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Subject to the availability of appropriations, not later than 36 months after the date of enactment of this Act, the Secretary shall publish on a public website of the Centers for Medicare & Medicaid Services guidance for States on resources and strategies for hospitals, freestanding birth centers (as defined in section 1905(l)(3)(B) of the Social Security Act (42 U.S.C. 1396d(l)(3)(B))), and other maternal care providers as determined by the Secretary for reducing maternal mortality and severe morbidity in individuals who are eligible for and receiving medical assistance under Medicaid or CHIP.

(b) UPDATES.—The Secretary shall update the guidance and resources described in subsection (a) at least once every 3 years.

(c) CONSULTATION WITH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Subject to the availability of appropriations, not later than 18 months after the date of enactment of this Act, the Secretary shall establish an advisory committee to be known as the ''National Advisory Committee on Re-

ducing Maternal Deaths'' (referred to in this section as the ''Advisory Committee'').

(2) DUTIES.—The Advisory Committee shall provide consensus advice and guidance to the Secretary on the development and compilation of the guidance described in subsection (a) (and any updates to such guidance).

(3) MEMBERSHIP.—

(A) IN GENERAL.—The Secretary, in consultation with such other heads of agencies, as the Secretary deems appropriate and in accordance with this paragraph, shall appoint not more than 35 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that—

(i) the total number of members of the Advisory Committee is an odd number; and

(ii) the total number of voting members who are not Federal officials does not exceed the total number of voting Federal members who are Federal officials.

(B) REQUIRED MEMBERS.—

(i) FEDERAL OFFICIALS.—The Advisory Committee shall include as voting

members the following Federal officials, or their designees:

(I) The Secretary.

(II) The Administrator of the Centers for Medicare & Medicaid Services.

(III) The Director of the Centers for Disease Control and Prevention.

(IV) The Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration.

(V) The Director of the Agency for Healthcare Research and Quality.

(VI) The National Coordinator for Health Information Technology.

(VII) The Director of the National Institutes of Health.

(VIII) The Secretary of Veterans Affairs.

(IX) The Director of the Indian Health Service.

(X) The Deputy Assistant Secretary for Minority Health.

(XI) The Administrator of the Substance Abuse and Mental Health Services Administration.

(XII) The Deputy Assistant Secretary for Women's Health.

(XIII) Such other Federal officials or their designees as the Secretary determines appropriate.

(ii) NON-FEDERAL OFFICIALS.—

(I) IN GENERAL.—The Advisory Committee shall include the following as voting members:

(aa) At least 1 representative from a professional organization representing hospitals and health systems.

(bb) At least 1 representative from a medical professional organization representing primary care providers.

(cc) At least 1 representative from a medical professional organization representing general obstetrician-gynecologists.

(dd) At least 1 representative from a medical professional organization representing certified nurse-midwives.

(ee) At least 1 representative from a medical professional organization representing other maternal fetal medicine providers.

(ff) At least 1 representative from a medical professional organization representing anesthesiologists.

(gg) At least 1 representative from a medical professional organization representing emergency medicine physicians and urgent care providers.

(hh) At least 1 representative from a medical professional organization representing nurses.

(ii) At least 1 representative from a professional organization representing community health workers.

(jj) At least 1 representative from a professional organization representing doulas.

(kk) At least 1 representative from a professional organization representing perinatal psychiatrists.

(ll) At least 1 representative from State-affiliated programs or existing collaboratives with demonstrated expertise or success in improving maternal health.

(mm) At least 1 director of a State Medicaid agency that has had demonstrated success in improving maternal health.

(nn) At least 1 representative from an accrediting organization for maternal health quality and safety standards.

(oo) At least 1 representative from a maternal patient advocacy organization with lived experience of severe maternal morbidity.

(II) REQUIREMENTS.—Each individual selected to be a member under this clause shall—

(aa) have expertise in maternal health;

(bb) not be a Federal official; and

(cc) have experience working with populations that are at higher risk for maternal mortality or severe morbidity, such as populations that experience racial, ethnic, and geographic health disparities, pregnant and postpartum women experiencing a mental health disorder, or pregnant or postpartum women with other comorbidities such as substance use disorders, hypertension, thyroid disorders, and sickle cell disease.

(C) ADDITIONAL MEMBERS.—

(i) IN GENERAL.—In addition to the members required to be appointed under subparagraph (B), the Secretary may ap-

point to the Advisory Committee such other individuals with relevant expertise or experience as the Secretary shall determine appropriate, which may include individuals described in clause (ii).

(ii) SUGGESTED ADDITIONAL MEMBERS.—The individuals described in this clause are the following:

(I) Representatives from State maternal mortality review committees and perinatal quality collaboratives.

(II) Medical providers who care for women and infants during pregnancy and the postpartum period, such as family practice physicians, cardiologists, pulmonology critical care specialists, endocrinologists, pediatricians, and neonatologists.

(III) Representatives from State and local public health departments, including State Medicaid Agencies.

(IV) Subject matter experts in conducting outreach to women who are African American or belong to another minority group.

(V) Directors of State agencies responsible for administering a State's maternal and child health services program under title V of the Social Security Act (42 U.S.C. 701 et seq.).

(VI) Experts in medical education or physician training.

(VII) Representatives from Medicaid managed care organizations.

(4) APPLICABILITY OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the committee established under this subsection.

(d) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals, freestanding birth centers, and other maternal care providers, the following:

(1) Best practices regarding evidence-based screening and clinician education initiatives relating to screening and treatment protocols for individuals who are at risk of experiencing complications related to pregnancy, with an emphasis on individuals with preconditions directly linked to pregnancy complications and maternal mortality and severe morbidity, including—

(A) methods to identify individuals who are at risk of maternal mortality or severe morbidity, including risk stratification;

(B) evidence-based risk factors associated with maternal mortality or severe morbidity and racial, ethnic, and geographic health disparities;

(C) evidence-based strategies to reduce risk factors associated with maternal mortality or severe morbidity through services which may be covered under Medicaid or CHIP, including, but not limited to, activities by community health workers (as such term is defined in section 2113(f)(4) of the Social Security Act (42 U.S.C. 1397mm(f)(4))) that are funded by a grant awarded under such section;

(D) resources available to such individuals, such as nutrition assistance and education, home visitation, mental health and substance use disorder services, smoking cessation programs, pre-natal care, and other evidence-based maternal mortality or severe morbidity reduction programs;

(E) examples of educational materials used by providers of obstetrics services;

(F) methods for improving community centralized care, including providing telehealth services or home visits to increase and facilitate access to and engagement in prenatal and postpartum care and collaboration with home health agencies, community health centers, local public health departments, or clinics;

(G) guidance on medical record diagnosis codes linked to maternal mortality and severe morbidity, including, if applicable, codes related to social risk factors, and methods for educating clinicians on the proper use of such codes;

(H) risk appropriate transfer protocols during pregnancy, childbirth, and the postpartum period; and

(I) any other information related to prevention and treatment of at-risk individuals determined appropriate by the Secretary.

(2) Guidance on monitoring programs for individuals who have been identified as at risk of complications related to pregnancy.

(3) Best practices for such hospitals, freestanding birth centers, and providers to make preg-

nant women aware of the complications related to pregnancy.

(4) A fact sheet for providing pregnant women who are receiving care on an outpatient basis with a notice during the prenatal stage of pregnancy that—

(A) explains the risks associated with pregnancy, birth, and the postpartum period (including the risks of hemorrhage, preterm birth, sepsis, eclampsia, obstructed labor), chronic conditions (including high blood pressure, diabetes, heart disease, depression, and obesity) correlated with adverse pregnancy outcomes, risks associated with advanced maternal age, and the importance of adhering to a personalized plan of care;

(B) highlights multimodal and evidence-based prevention and treatment techniques;

(C) provides for a method (through signature or otherwise) for such an individual, or a person acting on such individual's behalf, to acknowledge receipt of such fact sheet;

(D) is worded in an easily understandable manner and made available in multiple lan-

guages and accessible formats determined appropriate by the Secretary; and

(E) includes any other information determined appropriate by the Secretary.

(5) A template for a voluntary clinician checklist that outlines the minimum responsibilities that clinicians, such as physicians, certified nurse-midwives, emergency room and urgent care providers, nurses and others, are expected to meet in order to promote quality and safety in the provision of obstetric services.

(6) A template for a voluntary checklist that outlines the minimum responsibilities that hospital leadership responsible for direct patient care, such as the institution's president, chief medical officer, chief nursing officer, or other hospital leadership that directly report to the president or chief executive officer of the institution, should meet to promote hospital-wide initiatives that improve quality and safety in the provision of obstetric services.

(7) Information on multi-stakeholder quality improvement initiatives, such as the Alliance for Innovation on Maternal Health, State perinatal quality improvement initiatives, and other similar initiatives

determined appropriate by the Secretary, including—

(A) information about such improvement initiatives and how to join;

(B) information about public maternal data collection centers;

(C) information about quality metrics used and outcomes achieved by such improvement initiatives;

(D) information about data sharing techniques used by such improvement initiatives;

(E) information about data sources used by such improvement initiatives to identify maternal mortality and severe morbidity risks;

(F) information about interventions used by such improvement initiatives to mitigate risks of maternal mortality and severe morbidity;

(G) information about data collection techniques on race, ethnicity, geography, age, income, and other demographic information used by such improvement initiatives; and

(H) any other information determined appropriate by the Secretary.

(e) INCLUSION OF BEST PRACTICES.—Not later than 18 months after the date of the publication of the guidance required under subsection (a), the Secretary shall update such guidance to include best practices identified by the Secretary for such hospitals, freestanding birth centers, and providers to track maternal mortality and severe morbidity trends by clinicians at such hospitals, freestanding birth centers, and providers including—

(1) ways to establish scoring systems, which may include quality triggers and safety and quality metrics to score case and patient outcome metrics, for such clinicians;

(2) methods to identify, educate, and improve such clinicians who may have higher rates of maternal mortality or severe morbidity compared to their regional or State peers (taking into account differences in patient risk for adverse outcomes, which may include social risk factors);

(3) methods for using such data and tracking to enhance research efforts focused on maternal health, while also improving patient outcomes, clinician education and training, and coordination of care; and

(4) any other information determined appropriate by the Secretary.

(f) CULTURAL AND LINGUISTIC APPROPRIATENESS.—To the extent practicable, the Secretary should develop the guidance, best practices, fact sheets, templates, and other materials that are required under this section in a trauma-informed, culturally and linguistically appropriate manner.

SEC. 3. REPORT ON PAYMENT METHODOLOGIES FOR TRANSFERRING PREGNANT WOMEN BETWEEN FACILITIES BEFORE, DURING, AND AFTER CHILDBIRTH.

(a) IN GENERAL.—Subject to the availability of appropriations, not later than 36 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the payment methodologies under Medicaid for the antepartum, intrapartum, and postpartum transfer of pregnant women from one health care facility to another, including any potential disincentives or regulatory barriers to such transfers.

(b) CONSULTATION.—In developing the report required under subsection (a), the Secretary shall consult with the advisory committee established under section 2(c).

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