

111TH CONGRESS
2^D SESSION

H. R. 6437

To amend title XIX 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, identifying payment mechanism improvements, and identifying essential evidence-based maternity care services.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 18, 2010

Mr. ENGEL (for himself and Mrs. MYRICK) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title XIX 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, identifying payment mechanism improvements, and identifying essential evidence-based maternity care services.

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.**

4 This Act may be cited as the “Partnering to Improve
5 Maternity Care Quality Act of 2010”.

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

3 Title XIX of the Social Security Act is amended by
4 inserting after section 1139B the following new section:

5 **“SEC. 1139C. MATERNITY CARE QUALITY MEASUREMENT.**

6 “(a) IN GENERAL.—The Secretary shall develop a
7 maternity care quality measurement program for care pro-
8 vided to childbearing women and newborns for use by—

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

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

17 “(3) providers of items and services (including
18 accountable care organizations) with respect to items
19 and services provided under such plans.

20 “(b) IDENTIFICATION OF AN INITIAL SET OF MATER-
21 NITY CARE QUALITY MEASURES.—

22 “(1) IN GENERAL.—Not later than January 1,
23 2013, the Secretary shall identify, and publish, from
24 maternity care quality measures endorsed under sec-
25 tion 1890(b)(2), an initial core set of maternity care

1 quality measures for use in data collection and re-
2 porting by—

3 “(A) a State in administering a State plan
4 under title XIX or a State Child Health Plan
5 under title XXI;

6 “(B) health insurance issuers (as such
7 term is defined in section 2791 of the Public
8 Health Service Act (42 U.S.C. 300gg–91)) and
9 managed care entities that enter into contracts
10 with States for the purpose of administering
11 such plans; and

12 “(C) providers of items and services (in-
13 cluding accountable care organizations) with re-
14 spect to items and services provided under such
15 plans.

16 “(2) CONSULTATION AND PUBLIC COMMENT.—
17 Not later than January 1, 2012, 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 “(c) DEVELOPMENT OF ADDITIONAL QUALITY
25 MEASURES.—

1 “(1) CONTRACTS WITH QUALIFIED ENTITIES.—
2 Not later than the end of the 6-month period begin-
3 ning on the date the Secretary publishes the initial
4 measures under subsection (b)(1), the Secretary,
5 acting through the Agency for Healthcare Research
6 and Quality, in consultation with the Centers for
7 Medicare & Medicaid Services, shall enter into
8 grants, contracts, or intergovernmental agreements
9 with qualified measure development entities for the
10 purpose of developing, testing, and validating mater-
11 nity care quality measures in areas that are not ade-
12 quately covered by the measures identified under
13 subsection (b)(1).

14 “(2) QUALIFIED MEASURE DEVELOPMENT EN-
15 TITY DEFINED.—For purposes of this subsection,
16 the term ‘qualified measure development entity’
17 means an entity that—

18 “(A) has demonstrated expertise and ca-
19 pacity in the development and testing of quality
20 measures;

21 “(B) has adopted procedures for quality
22 measure development that ensure the inclusion
23 of—

24 “(i) the views of the individuals and
25 entities who are identified in subsection

1 (d)(2)(E) and whose performance will be
2 assessed by the measures; and

3 “(ii) the views of other individuals
4 and entities (including patients, con-
5 sumers, and health care purchasers) who
6 will use the data generated as a result of
7 the use of the quality measures;

8 “(C) for the purpose of ensuring that the
9 quality measures developed under this sub-
10 section meet the requirements to be considered
11 for endorsement under section 1890(b)(2), has
12 provided assurances to the Secretary that the
13 measure development entity will collaborate
14 with—

15 “(i) the Secretary;

16 “(ii) the consensus-based entity with a
17 contract under section 1890(a)(1); and

18 “(iii) stakeholders (including those
19 stakeholders identified in subsection
20 (i)(1)), as practicable;

21 “(D) has transparent policies regarding
22 governance and conflicts of interest; and

23 “(E) submits an application to the Sec-
24 retary at such time, and in such form and man-
25 ner, as the Secretary may require.

1 “(3) EMEASURES.—

2 “(A) IN GENERAL.—A qualified measure
3 development entity with a grant, contract, or
4 intergovernmental agreement under paragraph
5 (1), in developing quality measures, shall use
6 the measure-authoring tool of the consensus-
7 based entity with a contract under section
8 1890(a)(1) to create eMeasures that make use
9 of and build upon the quality dataset developed
10 under subsection (g).

11 “(B) EMEASURE DEFINED.—For purposes
12 of this paragraph, the term ‘eMeasure’ means a
13 measure for which measurement data (including
14 clinical data) will be collected electronically, in-
15 cluding through the use of electronic health
16 records and other electronic data sources.

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

24 “(d) TYPES OF MEASURES.—

1 “(1) IN GENERAL.—The maternity quality
2 measures identified under subsection (b) and the
3 measures developed under subsection (c) shall—

4 “(A) be evidence-based and, as appro-
5 priate, risk-adjusted; and

6 “(B) include a balance of each of the types
7 of measures listed in paragraph (2).

8 “(2) LIST OF TYPES OF MEASURES.—The
9 measures listed in this paragraph are the following:

10 “(A) Measures of the process, experience,
11 efficiency, and outcomes of maternity care, in-
12 cluding postpartum outcomes.

13 “(B) Measures that apply to—

14 “(i) women and newborns who are
15 healthy and at low risk, including meas-
16 ures of appropriately low-intervention,
17 physiologic birth in low-risk women; and

18 “(ii) women and newborns at higher
19 risk.

20 “(C) Measures that apply to—

21 “(i) childbearing women; and

22 “(ii) newborns.

23 “(D) Measures that apply to care during—

24 “(i) pregnancy;

25 “(ii) intrapartum period; and

1 “(iii) the postpartum period.

2 “(E) Measures that apply to—

3 “(i) clinicians and clinician groups;

4 “(ii) facilities;

5 “(iii) health plans; and

6 “(iv) accountable care organizations.

7 “(F) Measurement of—

8 “(i) disparities;

9 “(ii) care coordination; and

10 “(iii) shared decision making.

11 “(e) MATERNITY CONSUMER ASSESSMENT OF
12 HEALTHCARE PROVIDERS AND SYSTEMS SURVEYS.—

13 “(1) ADAPTION OF SURVEYS.—Not later than
14 January 1, 2014, for the purpose of measuring the
15 care experiences of childbearing women and
16 newborns, the Agency for Healthcare Research and
17 Quality shall adapt the Consumer Assessment of
18 Healthcare Providers and Systems program surveys
19 of—

20 “(A) providers;

21 “(B) facilities; and

22 “(C) health plans.

23 “(2) SURVEYS MUST BE EFFECTIVE.—The
24 Agency for Healthcare Research and Quality shall
25 ensure that the surveys adapted under paragraph

1 (1) are effective in measuring aspects of care that
2 childbearing women and newborns experience, in-
3 cluding aspects related to—

4 “(A) various care settings;

5 “(B) various types of caregivers;

6 “(C) considerations relating to pain;

7 “(D) the use of medications;

8 “(E) shared decision making—

9 “(i) during pregnancy;

10 “(ii) in the intrapartum period; and

11 “(iii) in the postpartum period; and

12 “(F) the provision of information, emo-
13 tional support, and comfort measures during
14 the intrapartum period.

15 “(3) LANGUAGES.—The surveys adapted under
16 paragraph (1) shall be available in English and
17 Spanish.

18 “(4) ENDORSEMENT.—The Agency for
19 Healthcare Research and Quality shall submit any
20 Consumer Assessment of Healthcare Providers and
21 Systems surveys adapted under this subsection to
22 the consensus-based entity with a contract under
23 section 1890(a)(1) to be considered for endorsement
24 under section 1890(b)(2).

1 “(5) CONSULTATION.—The adaptation of (and
2 process for applying) the surveys under paragraph
3 (1) shall be conducted in consultation with the
4 stakeholders identified in subsection (i)(1).

5 “(f) MEASUREMENT REPORTING.—

6 “(1) VOLUNTARY REPORTING.—The Secretary
7 shall encourage voluntary and standardized report-
8 ing to the Secretary, using the maternity care qual-
9 ity measures identified under subsection (b) and de-
10 veloped under subsection (c) and the surveys adapt-
11 ed under subsection (e), by—

12 “(A) clinicians (including physicians, mid-
13 wives, and clinician groups);

14 “(B) facilities (including hospitals and
15 freestanding birth centers);

16 “(C) accountable care organizations; and

17 “(D) health plans,

18 on the performance of such clinicians, facilities, ac-
19 countable care organizations, or plans.

20 “(2) STANDARDIZED FORMAT AND PROCESS.—

21 Not later than January 1, 2013, the Secretary, in
22 consultation with the stakeholders identified under
23 subsection (i)(1), shall—

1 “(A)(i) develop, validate, and test formats
2 and processes for standardized reporting under
3 paragraph (1)—

4 “(I) to the clinicians, facilities, ac-
5 countable care organizations, health plans,
6 and State agencies identified in paragraph
7 (3); and

8 “(II) to the patients, policymakers,
9 and payers identified in paragraph (4)(A);
10 and

11 “(ii) update such formats and processes to
12 incorporate any additional quality measures de-
13 veloped under subsection (c) and any surveys
14 developed under subsection (e); and

15 “(B) reflect best practices for timely, accu-
16 rate, effective communications for quality meas-
17 ures, and update such formats and processes as
18 appropriate.

19 “(3) FEEDBACK REPORTS.—

20 “(A) CLINICIANS, FACILITIES, ACCOUNT-
21 ABLE CARE ORGANIZATIONS, AND HEALTH
22 PLANS.—If the Secretary receives a report from
23 a clinician, facility, accountable care organiza-
24 tion, or health plan under paragraph (1), the
25 Secretary shall provide, annually, to such clini-

1 cian, facility, accountable care organization, or
2 health plan a confidential feedback report that
3 contains quality measure data collected through
4 the report received under paragraph (1), and, if
5 feasible, risk-adjusted benchmarks. Such feed-
6 back reports shall be designed and used for the
7 purpose of quality improvement by such clini-
8 cian, facility, accountable care organization, or
9 plan.

10 “(B) STATE AGENCIES.—The Secretary
11 shall provide an annual report to the State
12 agency administering or supervising the admin-
13 istration of a State plan under title XIX or a
14 State Child Health plan under title XXI on the
15 quality of care provided by clinicians, facilities,
16 accountable care organizations, and health
17 plans in such State.

18 “(4) PUBLIC AVAILABILITY OF DATA.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (B), the data contained in the reports
21 under paragraph (1) shall be made available
22 to—

23 “(i) patients to use in maternity care
24 decision making; and

1 “(ii) policymakers and purchasers to
2 assess the quality of maternity care serv-
3 ices provided under titles XIX and XXI.

4 “(B) ENDORSED AND VALID.—Data re-
5 ported under this subsection may only be made
6 available under this paragraph, or otherwise
7 made public, if—

8 “(i) such data are received—

9 “(I) from a maternity care qual-
10 ity measure that is identified under
11 subsection (b) or developed under sub-
12 section (c); or

13 “(II) through the use of a survey
14 adapted under subsection (e);

15 “(ii) endorsed without time-limited
16 qualification under section 1890(b)(2); and

17 “(iii) the clinician, facility, account-
18 able care organization, or health plan that
19 submitted such data has been given an op-
20 portunity to confirm the quality and accu-
21 racy of such data.

22 “(g) CONVERSION OF CURRENTLY ENDORSED MEAS-
23 URES AND CREATION OF INITIAL QUALITY DATASET TO
24 ENABLE ELECTRONIC HEALTH RECORDS TO MEASURE

1 THE CARE OF CHILDBEARING WOMEN AND
2 NEWBORNS.—

3 “(1) IN GENERAL.—Not later than January 1,
4 2012, for the purpose of fostering automated pa-
5 tient-centered longitudinal quality measurement of
6 maternity and newborn care using clinical data, the
7 consensus-based entity with a contract under section
8 1890(b)(2) shall coordinate—

9 “(A) the conversion of endorsed measures
10 for the care of childbearing women and
11 newborns to eMeasures (as such term is defined
12 in subsection (c)(3)(B)); and

13 “(B) the development of an initial quality
14 dataset for use within electronic health records
15 of childbearing women and newborns enrolled in
16 a program administered by a State through
17 State plans under title XIX and State Child
18 Health plans under title XXI for purposes of
19 such eMeasures.

20 “(2) REQUIREMENTS FOR EMEASURE CONVER-
21 SION AND DATASET CREATION.—The conversion to
22 eMeasures and the dataset creation under paragraph
23 (1) shall, for each quality measure of the care of
24 childbearing women or newborns that the consensus-
25 based entity with a contract under section

1 1890(b)(2) endorses, use the entity’s measure au-
2 thoring tool to—

3 “(A) specify standard data elements, qual-
4 ity data elements, and data flow connectors to
5 electronic information;

6 “(B) specify quality measure logical state-
7 ments;

8 “(C) test quality measure validity with an
9 appropriate electronic health record test data-
10 base;

11 “(D) finalize eMeasures for export to elec-
12 tronic health record systems; and

13 “(E) carry out this work in—

14 “(i) collaboration with the developer
15 or sponsor of each endorsed measure, who
16 is responsible, under an agreement with
17 the entity that endorsed such measure, for
18 updating such measure; and

19 “(ii) consultation with the stake-
20 holders identified in subsection (i)(1).

21 “(h) MEASUREMENT PROGRAM REPORTING.—Not
22 later than January 1, 2014, and every 2 years thereafter,
23 the Secretary shall submit to the Congress and the Med-
24 icaid and CHIP Payment and Access Commission a report

1 on the status of the maternity care quality measurement
2 program under this section, including—

3 “(1) the measured results in maternity care
4 quality;

5 “(2) trends over time in maternity care quality;

6 “(3) the adequacy and use of the set of—

7 “(A) the quality measures identified under
8 subsection (b);

9 “(B) the quality measures developed under
10 subsection (c); and

11 “(C) the surveys adapted under subsection
12 (e);

13 “(4) the adequacy and use of the reporting for-
14 mat under subsection (f)(2);

15 “(5) the adequacy of the quality dataset under
16 subsection (g); and

17 “(6) any recommendations for programmatic
18 and legislative changes needed to improve the quality
19 of care provided to childbearing women and
20 newborns under this title and title XXI, including
21 recommendations for quality reporting by the States.

22 “(i) STAKEHOLDERS.—

23 “(1) IN GENERAL.—The stakeholders identified
24 in this subsection are—

25 “(A) State Medicaid administrators;

- 1 “(B) maternal-fetal medicine specialists;
2 “(C) obstetrician-gynecologists;
3 “(D) family physicians;
4 “(E) certified nurse-midwives;
5 “(F) certified midwives;
6 “(G) nurse practitioners;
7 “(H) nurses;
8 “(I) neonatologists;
9 “(J) pediatricians;
10 “(K) consumers and their advocates;
11 “(L) health quality measurement experts;
12 “(M) health quality measure developers;
13 “(N) representatives from the consensus-
14 based entity with a contract under section
15 1890(a) of the Social Security Act;
16 “(O) electronic health record developers
17 and vendors;
18 “(P) employers and purchasers;
19 “(Q) health facility and health system
20 leaders; and
21 “(R) other individuals who are involved in
22 the advancement of evidence-based maternity
23 care quality measures.
- 24 “(2) PROFESSIONAL ORGANIZATIONS.—The
25 stakeholders identified under paragraph (1) may in-

1 include representatives from professional organizations
2 and specialty societies (such as the American College
3 of Obstetricians and Gynecologists, the American
4 Academy of Family Physicians, the American Col-
5 lege of Nurse-Midwives, the Society for Maternal
6 Fetal Medicine, and the Association of Women’s
7 Health, Obstetric, and Neonatal Nurses).

8 “(j) APPROPRIATION.—Out of any funds in the
9 Treasury not otherwise appropriated, there are appro-
10 priated for each of fiscal years 2011 through 2015, such
11 sums as may be necessary for the purpose of carrying out
12 this section. Funds appropriated under this subsection
13 shall remain available until expended.”.

14 **SEC. 3. DEMONSTRATION PROJECT TO EVALUATE PAY-**
15 **MENT REFORM IN MATERNITY CARE.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services shall establish a demonstration project
18 to evaluate the use of alternative payment methods under
19 the Medicaid program under title XIX of the Social Secu-
20 rity Act, for the purpose of—

21 (1) improving the quality, value, and outcomes
22 of maternity care by reliably delivering effective care
23 that contributes to improved outcomes; and

24 (2) reducing the costs of maternity care for
25 beneficiaries under such program by—

1 (A) delivering effective care;

2 (B) avoiding overuse of care that may
3 cause harm to the beneficiary or a waste of re-
4 sources, without providing a benefit to the ben-
5 eficiary; and

6 (C) discouraging the provision of care that
7 lacks an evidence base and is contrary to strong
8 recommendations supported by high quality evi-
9 dence in clinical practice guidelines from na-
10 tionally recognized specialty societies and pro-
11 fessional organizations.

12 (b) PAYMENTS.—

13 (1) REQUIREMENTS.—Payments made under
14 the demonstration project under subsection (a) for
15 the provision of medical services shall be adjusted
16 for the health conditions and other characteristics of
17 Medicaid beneficiaries, as determined by the Sec-
18 retary.

19 (2) ALLOWABLE PAYMENT STRUCTURES.—
20 Under the demonstration project under subsection
21 (a), the Secretary may evaluate alternative payment
22 methods, including the following:

23 (A) Payments that are defined to cover
24 services for a single episode of care for an indi-
25 vidual woman and her newborn, including—

1 (i) all care from the prenatal through
2 the postpartum period; or

3 (ii) all care received during the
4 intrapartum period.

5 (B) Payments based on a condition-ad-
6 justed capitated rate for a population of women
7 and newborns.

8 (C) Payments that cover multiple providers
9 (such as hospitals, birth centers, physicians,
10 midwives, and nurse practitioners) that would
11 otherwise be paid separately.

12 (D) Payments in the form of “virtual bun-
13 dling”, in which providers are paid separately,
14 but the amount of such payments are adjusted
15 so that the total of the individual payments to
16 each provider remains under a total payment
17 budget for the episode of care.

18 (E) Payments to providers (including
19 doulas, and other providers of continuous labor
20 support) and for services (such as shared deci-
21 sion making, breast-feeding support programs,
22 and doula services) that may not currently be
23 eligible for direct reimbursement under title
24 XIX of the Social Security Act.

1 (F) Payments that cover multiple services
2 that would otherwise be paid for separately, or
3 that allow greater flexibility as to the type of
4 provider, location of service, or approach to care
5 than would otherwise be permitted, to enable
6 providers to improve outcomes or value.

7 (G) Other payment innovations that are
8 likely to result in improved maternity care qual-
9 ity, outcomes, and value (such as payment of
10 bonuses for improved outcomes or payments for
11 care coordination).

12 (3) EVALUATION AND MONITORING.—The Sec-
13 retary shall also make payments for the purpose of
14 collecting data necessary for the evaluation and
15 monitoring of the demonstration project under this
16 section.

17 (c) SCOPE AND SELECTION OF STATES.—The dem-
18 onstration project under subsection (a) shall be conducted
19 in no more than 8 States, which shall be selected by the
20 Secretary based on—

21 (1) an application that—

22 (A) is submitted by a entity or consortium
23 that—

24 (i) includes the single State agency
25 under section 1902(a)(5); and

1 (ii) may include managed care organi-
2 zations, integrated health systems, and ac-
3 countable care organizations providing ma-
4 ternity care to Medicaid and CHIP bene-
5 ficiaries; and

6 (B) specifies the regions and populations
7 in the State that will be served by the entity or
8 consortium under the demonstration project;

9 (2) criteria designed to ensure that, as a whole,
10 the demonstration project is, to the greatest extent
11 possible, representative of the demographic and geo-
12 graphic composition of Medicaid beneficiaries nation-
13 ally; and

14 (3) criteria designed to ensure that multiple
15 payment models are tested through the demonstra-
16 tion project.

17 (d) PROTECTIONS FOR BENEFICIARIES.—

18 (1) NO ADDITIONAL COST SHARING.—Under
19 the demonstration project under subsection (a), a
20 Medicaid beneficiary shall not be liable for any cost
21 sharing in excess of the amount of cost sharing that
22 such beneficiary would otherwise be liable for under
23 title XIX of the Social Security Act.

24 (2) NO REDUCTION IN QUALITY.—A provider
25 who provides services to a Medicaid beneficiary

1 under the demonstration project under subsection
2 (a) shall provide services that the provider expects
3 will result in a similar or improved health outcome
4 for such beneficiary, compared with the services such
5 beneficiary would receive under title XIX of the So-
6 cial Security Act if the beneficiary was not receiving
7 services under the demonstration project.

8 (3) NO DENIAL OF COVERED SERVICES.—In no
9 case may a Medicaid beneficiary be denied maternity
10 and nonmaternity items and services under the dem-
11 onstration project under subsection (a) than such
12 beneficiary would otherwise receive under title XIX
13 of the Social Security Act.

14 (e) PERIOD.—The demonstration project under sub-
15 section (a) shall begin on January 1, 2012, and shall end
16 on December 31, 2016.

17 (f) REPORTS.—

18 (1) STATE REPORTS.—Each entity or consor-
19 tium with an application that is approved under sub-
20 section (c) that participates in the demonstration
21 project under subsection (a) shall report to the Sec-
22 retary, in a time, form, and manner specified by the
23 Secretary, the data necessary to—

24 (A) monitor the—

1 (i) health outcomes of participating
2 beneficiaries;

3 (ii) the costs of the project; and

4 (iii) the quality of maternity care pro-
5 vided under the project; and

6 (B) evaluate the rationale for the selection
7 of the items and services included in any bun-
8 dled payment made by the entity or consortium
9 under the project.

10 (2) FINAL REPORT.—Not later than December
11 31, 2017, the Secretary shall submit to Congress a
12 report containing—

13 (A) the results of the demonstration
14 project under subsection (a);

15 (B) an assessment of the influence of med-
16 ical liability on the results of such project; and

17 (C) recommendations for changes in Med-
18 icaid payment policies to enhance the quality,
19 health outcomes, and value of maternity care
20 provided through the Medicaid program.

21 **SEC. 4. ESSENTIAL SERVICES FOR CHILDBEARING WOMEN**
22 **AND NEWBORNS.**

23 (a) REPORT ON EVIDENCE-BASED MATERNITY CARE
24 SERVICES.—The Secretary of Health and Human Services
25 is authorized to, and shall seek to, enter an agreement

1 with the Institute of Medicine of the National Academies
2 to develop and, not later than January 1, 2013, publish
3 a report that, on the basis of the best available evidence,
4 identifies the following:

5 (1) ESSENTIAL SERVICES.—The following es-
6 sential maternity care services:

7 (A) A package of evidence-based maternity
8 care services that the Institute of Medicine
9 identifies as essential for the majority of child-
10 bearing women and newborns who are healthy
11 and at low risk for complications during preg-
12 nancy, birth, the postpartum period, and the
13 newborn period (the 28-day period beginning on
14 the date of birth).

15 (B) Any additional and differing maternity
16 care services that the Institute of Medicine
17 identifies as essential to women and newborns
18 who are at higher risk than the individuals de-
19 scribed under paragraph (1) for complications
20 during pregnancy, birth, the postpartum period,
21 and the newborn period.

22 (C) Any pre- and interconception care
23 services that have been demonstrated to con-
24 tribute to improved maternal and newborn out-
25 comes.

1 (2) LIMITED VALUE AND UNDERSTUDIED SERV-
2 ICES.—Maternity care services that are identified by
3 the Institute of Medicine as—

4 (A) being of limited value (including use of
5 a specific service for indications that are not
6 supported); or

7 (B) requiring comparative effectiveness re-
8 search to clarify the safety and effectiveness of
9 such services.

10 (b) STRENGTH OF EVIDENCE.—In identifying the es-
11 sential services under subsection (a)(1), the Institute of
12 Medicine shall—

13 (1) give priority to maternal care services that
14 are supported for use for specific indications or pop-
15 ulations by systematic reviews with high- or mod-
16 erate-quality evidence and strong recommendations,
17 as determined by a valid assessment system, such as
18 GRADE (Grading of Recommendations Assessment,
19 Development and Evaluation); and

20 (2) clearly indicate if a service that is rec-
21 ommended as essential is based on lower quality evi-
22 dence or weaker recommendations than the levels de-
23 scribed under paragraph (1).

24 (c) CONSULTATIVE PROCESS.—

1 (1) IN GENERAL.—The Institute of Medicine
2 shall develop the report under subsection (a) in con-
3 sultation with a multistakeholder panel that includes
4 representatives of—

5 (A) clinicians with expertise in—

6 (i) obstetrics;

7 (ii) family medicine;

8 (iii) pediatrics;

9 (iv) midwifery;

10 (v) nursing;

11 (vi) maternal fetal medicine;

12 (vii) genetics;

13 (viii) anesthesia;

14 (ix) substance abuse;

15 (x) reproductive endocrinology;

16 (xi) mental health;

17 (xii) infectious disease; and

18 (xiii) interconception care;

19 (B) consumers and their advocates;

20 (C) payers and purchasers; and

21 (D) research methodology experts.

22 (2) PROFESSIONAL ORGANIZATIONS.—The rep-
23 resentatives under paragraph (1) may include rep-
24 resentatives from professional organizations and spe-
25 cialty societies (such as the American College of Ob-

1 stetricians and Gynecologists, the American Acad-
2 emy of Family Physicians, the American College of
3 Nurse-Midwives, the Society for Maternal Fetal
4 Medicine, and the Association of Women’s Health,
5 Obstetric, and Neonatal Nurses).

6 (d) DEFINITION OF MATERNAL CARE SERVICES.—

7 For purposes of the report under subsection (a), the term
8 “maternity care services” shall include—

9 (1) services related to the confirmation of preg-
10 nancy and preconception, prenatal, intrapartum,
11 postpartum, newborn, and interconception care;

12 (2) newborn care services that are incidental to
13 interconception care;

14 (3) mental health and substance abuse services;
15 and

16 (4) support services (such as language trans-
17 lation and care coordination).

18 (e) SENSE OF CONGRESS.—It is the sense of Con-
19 gress that the Administrator of the Centers for Medicare
20 & Medicaid Services and the directors of State Medicaid
21 agencies should ensure that the services available to child-
22 bearing women and newborns under the Medicaid program
23 in each State are well-aligned with the essential maternity
24 care services identified in subsection (a)(1).

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