Additional Questions for the Record

The Honorable Representative G.K. Butterfield

1. **Ms. Schwartz, thank you for your testimony on the importance of the Quality Care for Moms and Babies Act. I am especially interested in the expansion of the collaborative activities related to maternity and infant care quality. The Perinatal Quality Collaborative of North Carolina is currently a partner of the Centers for Disease Control on a wide number of initiatives related to postpartum health. Can you describe the impact of partnerships like that on public health in our country?**

   The Centers for Disease Control and Prevention (CDC) currently fund six states (California, New York, Ohio, Illinois, Massachusetts, and North Carolina) under the state-based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement. The funding is designed to assist the collaboratives in improving the quality of perinatal care in their states. These efforts are targeted at reducing maternal morbidity and mortality, reducing scheduled births without a medical indication, improving breastfeeding rates, and reducing hospital-acquired neonatal infections and neonatal morbidity.

   The Commission has not specifically evaluated the PQCs. However, our June 2013 report to Congress (https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/) provides an examination of eligibility and coverage for pregnant women in Medicaid and the State Children's Health Insurance Program (CHIP), and describes some of the efforts in states targeting maternal and child health. A copy of the chapter is attached. Commission staff would be happy to brief you or your staff on this work.

2. **Can you highlight some of the innovations which have come about through existing perinatal collaborations?**

   As described in the Commission's June 2013 report to Congress (https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/), collaborative quality improvement initiatives generally establish health care processes and procedures to discourage elective inductions and cesarean deliveries, with many initiatives focused primarily on deliveries before 39 weeks of gestation. (See Table 1-6 in the report for details.) Common elements of these initiatives include internal audit and feedback procedures, patient and provider education, policies limiting circumstances under which elective deliveries prior to 39 weeks can take place (for example, only when medically indicated or after peer review), and changes in scheduling processes for labor and delivery.

   Quality improvement initiatives have been implemented by statewide collaboratives, state agencies (including Medicaid), and health systems. Some of these collaboratives are supported by state legislation or occur within a learning network, where hospitals or other organizations learn from their peers while implementing systems changes at the same time. The Louisiana Institute for Healthcare Improvement, for example, is working with 28 of the state's 58 maternity hospitals to engage providers in quality improvement programs.

   At the federal level, the Strong Start for Mothers and Newborns Initiative is a joint effort between the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration, and the Administration on Children and Families. It aims to reduce

preterm births and improve outcomes for both newborns and pregnant women. The initiative is made up of two strategies – a public-private partnership and awareness campaign to reduce early elective deliveries and a funding opportunity to improve prenatal care among women enrolled in Medicaid and CHIP with the goal of reducing premature births.

3. **Can you describe how the provisions of the Quality Care for Moms and Babies Act will expand those partnerships and how that expansion would benefit millions of people across the country?**

   The Quality Care for Moms and Babies Act requires development of a core set of health care quality measures for maternal and infant health, and would facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures. Regarding expanded perinatal collaborative partnerships, the legislation would authorize the Secretary of Health and Human Services to make grants to eligible entities to support the development of new state and regional maternity and infant care quality collaboratives, expand activities of existing collaboratives, and expand maternity and infant care initiatives within established collaboratives that are not focused exclusively on maternity care.

   Entities that will be eligible for the grants include state Medicaid agencies, state departments of health, health insurance issuers, provider organizations, entities seeking to establish a maternity and infant care quality collaborative, and existing quality collaboratives that focus entirely or in part on maternity and infant care initiatives.

   Funding could also be used to support other activities including developing quality collaborative infrastructure; providing technical assistance; developing, implementing, and evaluating protocols to foster evidence-based practice; developing, implementing, and evaluating programs that translate into recommendations for clinicians; facilitating performance data collection and feedback reports; and developing access to and analyzing blinded liability claims data to improve practice.

   The bill would authorize $15 million for such grants. An additional $16 million would be authorized to develop and implement the core set of health care quality measures for maternal and infant health. The Congressional Budget Office (CBO) estimates that implementing the legislation would cost the amount appropriated ($31 million) over the 2016-2020 period, and would not affect direct spending or revenues (CBO 2015).

   While MACPAC does not have estimates of how many people would benefit from quality collaborative grants authorized in the bill, the Centers for Disease Control and Prevention (CDC) reports that perinatal quality collaboratives currently exist or are being formed in 38 states, 6 of which are funded by the CDC (CDC 2015). Grants authorized by the Quality Care for Moms and Babies Act would likely support many of these existing programs, and may be the catalyst to create perinatal collaboratives in additional states.

4. **With nearly one out of every two births covered by Medicaid, it seems that the Quality Care for Moms and Babies act has an opportunity to benefit millions of people across the country. Can you describe some potential quality measures and how they would directly benefit beneficiaries?**

   MACPAC last examined the use of quality measures for prenatal and maternity services in its June 2013 report to Congress (https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/). There we found that while the use of quality measures in health care has expanded rapidly, there are still relatively few valid measures of labor and delivery care processes and outcomes. In addition, performance reporting on maternity care remains relatively limited and inconsistent across the country and among various entities, including health plans, health systems, and facilities. However, some notable efforts have been made in recent years to develop and promote reporting on measures of elective deliveries. (See Table 1-7 in the report.)

   For example, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required HHS to identify a set of core quality measures related to children's health which states can report on a voluntary basis. The 2015 core set of children's quality health measures for Medicaid/CHIP (also known as the child core set) includes six measures related to maternal and perinatal health. The core set includes the frequency and timeliness of ongoing prenatal and postpartum care (including a behavioral risk assessment), as well as the rates of cesarean sections, low-birthweight babies, and bloodstream infections among infants in intensive care.

   Additionally, the National Quality Forum (NQF) endorsed a set of 14 clinical quality measures related to perinatal care. Some of these measures have been adopted by the Joint Commission, the Leapfrog Group, and CMS (as part of the core set of 25 children's health care quality measures discussed above). In August of 2012, the American College of Obstetricians and Gynecologists (ACOG) convened the reVITALize conference to assist in clarifying existing data definitions and in streamlining measurement for obstetrical outcomes nationwide.

   MACPAC will continue to monitor quality measure development and update information and its impact on Medicaid and CHIP enrollees in future reports to Congress.

5. **Can you discuss how national evidence-based measures can benefit providers and potentially lead to better health outcomes for mothers and babies?**

   Highlighted as a success by the CDC, the California Maternal Quality Care Collaborative built a data center to establish rapid-cycle performance measures about maternity services and outcomes and has used the data center to reduce both maternal morbidity and non-medically indicated early deliveries.

   Specifically, the state used the California Maternal Data Center as a data source and reporting application for its Preeclampsia Collaborative, a statewide hospital-level learning and quality improvement initiative. From February 2013 through June 2014, 13 hospitals participating in the Preeclampsia Collaborative showed a 12 percent reduction in severe

complications among women with severe preeclampsia/eclampsia. When women who experienced hemorrhage or had a blood transfusion (which comprises the majority of the complications) were excluded, there was a more dramatic reduction of 36 percent in severe complications.

Non-medically indicated deliveries before 39 weeks gestation are also declining among hospitals actively enrolled in the California Maternal Data Center. Between January 2012 and May 2014, hospitals using the center's quality improvement tools demonstrated a 57 percent reduction in the percentage of non-medically indicated deliveries performed in the 37- and 38-week gestational period.

6. Can you describe the projected financial impact that quality measures would have for Medicaid and CHIP programs?

The Commission does not develop cost estimates for pending legislation. Like Congress, we rely on estimates of legislative proposals developed and made public by the CBO.

7. Would you agree that investing in this legislation will benefit patients and also reduce the likelihood of costly or potentially dangerous medical procedures?

The Commission has not specifically evaluated the impact of this bill on enrollees or the federal budget. As its published work on Medicaid and CHIP policies concerning maternity care and children's coverage issues highlights, the Commission is committed to learning from and sharing knowledge about program improvements that benefit enrollees.