The Quality Care for Moms and Babies Act: Improving Maternity Care for Women and Families

MARCH 2016

The Quality Care for Moms and Babies Act, S. 466, introduced by Senators Debbie Stabenow (D – Mich.) and Chuck Grassley (R – Iowa), and H.R. 4695, introduced in the House by Representatives Eliot Engel (D – New York) and Steve Stivers (R – Ohio), would improve the quality of maternity care for mothers and babies by ensuring that maternity care providers have the necessary tools to guarantee that women have access to services that optimize outcomes for both childbearing women and newborns. The bill would enhance progress toward a high-quality, cost-effective maternity care system by addressing performance measurement gaps in Medicaid and the Children's Health Insurance Program (CHIP) and by fostering maternity care quality collaboratives – groups of maternity care providers and other stakeholders working together to accelerate the adoption of best practices, such as eliminating elective births before 39 weeks, increasing breastfeeding rates, reducing cesarean sections and much more.

Supporting partners include:

American College of Nurse-Midwives

American Congress of Obstetricians and Gynecologists

Association of Maternal & Child Health Programs

Association of Women's Health, Obstetric and Neonatal Nurses

March of Dimes

National Partnership for Women & Families

Society for Maternal-Fetal Medicine

Room for Improvement

Despite vast improvements in maternity care and knowledge about best practices, certain key indicators of maternal and newborn health have stagnated. Our nation's infant and maternal mortality rates are high, and our rates of prematurity, low birthweight babies and exclusive breastfeeding are worse than those of other developed countries.

While great progress has been made in identifying maternity care best practices and developing associated quality measures, the quality of perinatal care can vary by provider and facility.[1] This is in part because numerous measures for maternal and newborn care are not widely adopted and reported**. The Quality Care for Moms and Babies Act would support the development and adoption of quality measures and strengthen multidisciplinary, health care provider-led regional, state and local efforts to promote best practices, including care in rural areas and small practices.** Best practices, including reducing early elective deliveries and increasing breastfeeding, can dramatically improve the health of women and babies and significantly reduce costs for consumers,

insurers and federal and state governments.

Quality Care for Moms and Babies

The Quality Care for Moms and Babies Act would improve the tools health care providers need to deliver high-quality maternity care through:

- **The identification of gaps in maternity care quality measures in Medicaid and CHIP.** The United States lacks a coordinated set of nationally standardized maternity care quality measures.[2] The Quality Care for Moms and Babies Act would direct the U.S. Department of Health and Human Services to work with relevant providers, specialty organizations, consumer organizations and other stakeholders to identify and publish a core set of maternity care quality measures for childbearing women and newborns. Multi-stakeholder groups would identify gaps in existing Medicaid and CHIP quality measurement programs. The bill would also support the creation of new measures by qualified measure developers to fill gaps. It would catalyze the use of measures, including by endorsement of the National Quality Forum (NQF), a national organization that evaluates health care delivery services and endorses standardized health care performance measures. The development and reporting of a core set of measures would establish better benchmarking for the quality of care from pregnancy through the postpartum period. Such a measure set would inform providers of opportunities for improvement, support informed consumer choice of services and reduce costs.
- **The development and use of maternity Consumer Assessment of Healthcare Providers and Systems (CAHPS) Maternity surveys.** CAHPS provider, facility and health plan surveys are standardized surveys that allow people to evaluate their experience of care.[3] These generic surveys do not measure the experience of maternal and newborn care well and thus are not useful for fostering the improvement of maternal and newborn care and the informed choice of services by childbearing women and families. The Quality Care for Moms and Babies Act would direct the Agency for Healthcare Research and Quality (AHRQ) to adapt CAHPS facility, clinician and health plan surveys in consultation with relevant stakeholders to enable better measurement of the care experiences of childbearing women and newborns.[4] Childbearing women could provide feedback to those responsible for maternal and newborn care and share their experiences with other women choosing maternity services.
- **The expansion of maternity care quality collaboratives.** A quality collaborative is a group of stakeholders – such as physicians, nurses, nurse-midwives and purchasers within a region or state – working to improve the health care system and reduce costs.[5] Currently, national, multistate and state-level collaboratives are improving both overall health care and maternal and newborn care in particular.[6] The Quality Care for Moms and Babies Act would provide funding for the expansion or development of quality collaboratives that focus on maternal or perinatal care. Quality collaboratives benefit women and families and health care providers in many ways, including by:
    - Facilitating performance data collection and feedback reports to providers;
    - Developing, implementing and evaluating protocols and checklists to foster safe, evidence-based practice;
    - Providing technical assistance to providers and institutions to build quality improvement capacity;

- Developing the capability to access and link data sources for better evaluation of the quality of care delivered in particular settings; and
- Providing a venue to share best practices and lessons learned with other providers and hospitals.

These activities improve maternal and newborn outcomes by reducing early elective deliveries, cesarean births, length of hospital stays and visits to neonatal intensive care units.

Bending the Maternity Care Cost Curve

Medicaid covered about 45 percent of births in the United States in 2010.[7] The "national bill" to Medicaid for maternal and newborn hospital care alone was over $58 billion that year.[8] Reducing the rates of unnecessary childbirth interventions and improving the quality of care to achieve better health outcomes are critical to improving care and experiences of childbearing women and newborns and saving Medicaid, and taxpayers, money.

For example, $75 million could be saved in Medicaid spending if the United States reduced elective inductions before 39 weeks of gestation by 10 percent.[9] Inducing labor prior to 39 weeks for non-medical reasons increases cesarean birth rates and risks premature birth.[10] In fact, Medicaid spends about $20,000 on the first year of medical care for preterm babies but only about $2,100 on full-term babies within the same time frame.[11] The quality improvement strategies supported by the Quality Care for Moms and Babies Act would facilitate real change in the delivery of maternity care to reduce rates of early elective inductions and other unnecessary interventions, improve the health of mothers and babies and truly bend the maternity care cost curve.

"With the federal government paying for 40 percent of births in the United States and the incredible expense and risk of complicated deliveries, improving maternity outcome quality makes sense for moms, babies and taxpayers."

— Senator Chuck Grassley (R – Iowa)

1 Childbirth Connection. (2013, March). *What's Wrong With The Status Quo?* Retrieved 12 May 2015, from http://transform.childbirthconnection.org/vision/status-quo/

2 Childbirth Connection. (2013, March). *Performance Measurement and Leveraging of Results: Problems and System Goals*. Retrieved 12 May 2015, from http://transform.childbirthconnection.org/blueprint/performancemeasurement/problemsgoals/

3 American College of Surgeons, Division of Advocacy and Health Policy. (2012, August 23). *About CAHPS*. Retrieved 12 May 2015, from http://www.facs.org/ahp/cahps/about-cahps.html

4 Ibid, p. 2.

5 Childbirth Connection. (2013, March). *Maternal and Perinatal Care Quality Collaboratives*. Retrieved 12 May 2015, from http://transform.childbirthconnection.org/resources/collaboratives/

6 Ibid, p. 5.

7 Markus, A.R., Andres, E., West, K.D., Garro, N., & Pellegrini, C. (2013). Medicaid covered births, 2008 through 2010, in context of the implementation of health reform. *Women's Health Issues, 23*(6), e411. Retrieved 2 November 2015, from http://www.ncbi.nlm.nih.gov/pubmed/23993475

8 U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. *HCUPnet*. Retrieved 12 May 2015, from http://hcupnet.ahrq.gov/HCUPnet.jsp

9 U.S. Department of Health and Human Services. (2012, February 8). *HHS launches Strong Start initiative to increase healthy deliveries and reduce preterm births* [Press Release]. Retrieved 12 May 2015, from http://www.hhs.gov/news/press/2012pres/02/20120208a.html

10 Association of Women's Health, Obstetric and Neonatal Nurses. (2011, December). *40 Reasons to Go the Full 40 Weeks*. Retrieved 12 May 2015, from http://www.health4mom.org/a/40_reasons_121611

11 Ibid, p. 9.