



January 21, 2013

Marilyn Tavenner,  
Administrator  
Centers for Medicare and Medicaid Services  
Attn: CMS-3288-NC  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: CMS-3288-NC: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology**

Dear Administrator Tavenner:

We are writing on behalf of the Coalition for Quality Maternity Care (CQMC), a group of national professional, consumer, and human rights organizations that promote high quality maternity care for all women and newborns regarding a request for comments from the Centers for Medicare and Medicaid Services (CMS) entitled, “CMS-3288-NC: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology,” published in the Federal Register on November 19, 2013.<sup>1</sup>

The CQMC strongly supports CMS’ work to implement the statutory requirement to develop a Quality Rating System (QRS) to assist consumers as they make decisions regarding their coverage. We appreciate the agency offering an opportunity to submit comments on specific quality measures being considered for use under the QRS and we hope that our comments below prove helpful in that respect.

**Number of Measures**

CQMC appreciates that CMS has identified maternity care as an area which merits distinct measurement. However, among the set of 42 measures CMS proposes for use in the QRS, only one measure (that rates two factors) is associated with maternity care. We believe that maternity care’s status as the most common reason for hospitalization deserves the use of more than two

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<sup>1</sup> 78 FR 69418

<sup>2</sup> Joyce A. Martin, M.P.H.; Brady E. Hamilton, Ph.D.; Stephanie J. Ventura, M.A.; Michelle J.K. Osterman, M.H.S.; and T.J. Mathews, M.S., Division of Vital Statistics “Births: Final Data for 2011,” National Vital Statistics Report vol. 62, no. 1., June 28, 2013, available at: [http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62\\_01.pdf#table01](http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf#table01)

measures.

There were nearly 4 million births in the US in 2011.<sup>2</sup> Childbirth is the leading reason for hospitalization in the US, exceeding conditions such as pneumonia, cancer, heart failure, bone fracture and stroke.<sup>3</sup> Costs for hospital maternity care, exclusive of professional fees, approached \$12 billion in 2009.<sup>4</sup> Given the place of maternity care within the health system in terms of both number of procedures and cost, we believe the use of only two measures related to this aspect of care, as CMS has proposed in its Notice, is insufficient and we strongly urge CMS to consider including additional maternity care measures within the QRS.

We note that the population of individuals expected to enroll under plans offered through the Marketplaces includes a significant number of women of childbearing age.<sup>5</sup> We believe that this group of women and their partners will be very interested in information regarding the quality of maternity care provided through the plans available to them. Below we have identified specific recommendations for maternity care measures that we believe should be included. We have divided them into “priority measures” and “additional measures” to provide CMS with guidance regarding those we believe are most important to include in the QRS.

We further note that because women may choose to obtain care from a variety of provider types (e.g., OB/GYNs, Family Practice physicians, Certified Nurse Midwives/Certified Midwives, Certified Professional Midwives), and in different settings (e.g., hospitals, birth centers and residences) it would be helpful if to the extent measure specifications and reported data allow, plans report this data broken down by provider type and place of service. Consumers would thus have access to more specific and useful information to guide them in their enrollment choices.

### **Priority Measures**

#### **NQF 0480 PC-05 Exclusive Breast Milk Feeding**

This measure examines the number of newborns exclusively fed breast milk during the newborn’s entire hospitalization and a subset of this group of newborns, those whose mothers chose to exclusively feed breast milk. Breastfeeding has been proven to foster a host of positive outcomes for both mothers and babies. Breastfed babies:

- score higher on cognitive and IQ tests at school age and on tests of visual acuity;<sup>6</sup>

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<sup>2</sup> Joyce A. Martin, M.P.H.; Brady E. Hamilton, Ph.D.; Stephanie J. Ventura, M.A.; Michelle J.K. Osterman, M.H.S.; and T.J. Mathews, M.S., Division of Vital Statistics “Births: Final Data for 2011,” National Vital Statistics Report vol. 62, no. 1., June 28, 2013, available at: [http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62\\_01.pdf#table01](http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf#table01)

<sup>3</sup> M.J. Hall, DeFrances CJ, Williams SN, Golosinskiy A, Schwartzman A. National Hospital Discharge Survey: 2007 summary. Natl Health Stat Rep. 2010;29:1-20, 24. - See more at: <http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/trends-in-hospital-based-childbirth-care-the-role-of-health-insurance/4#sthash.VZW9jPes.dpuf> and Kozak, L.J., C.J. DeFrances, and M.J. Hall. 2006 National Hospital Discharge Survey: 2004 Annual Summary with Detailed Diagnosis and Procedure Data. National Center for Health Statistics. *Vital and Health Statistics* 13(162). Available at [http://www.cdc.gov/nchs/data/series/sr\\_13/sr13\\_162.pdf](http://www.cdc.gov/nchs/data/series/sr_13/sr13_162.pdf).

<sup>4</sup> Health Care Cost and Utilization Project, Agency for Health Care Research and Quality, available at: [http://www.hcup-us.ahrq.gov/reports/factsandfigures/2009/exhibit4\\_1.jsp](http://www.hcup-us.ahrq.gov/reports/factsandfigures/2009/exhibit4_1.jsp)

<sup>5</sup> See for example: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8147.pdf> and

<sup>6</sup> Anderson JW, Johnstone BM, Remley DT. Breastfeeding and cognitive development: a meta-analysis. *Am J Clin Nutr* 1999; 70: 525–535. Drane DL, Logemann JA. A critical evaluation of the evidence on the association between type of infant feeding and cognitive development. *Pediatr Epidemiol* 2000; 14: 349–356. Lykke Mortensen E, Fleischer Michaelsen K, Sanders SA, Reinisch JM. The association between duration of breastfeeding and adult intelligence. *JAMA* 2002; 287: 2365–2371.

- are less likely to suffer from infectious illnesses and their symptoms (e.g., diarrhea, ear infections, respiratory tract infections, meningitis);<sup>7</sup>
- have a lower risk of the two most common inflammatory bowel diseases (Crohn's disease, ulcerative colitis);<sup>8</sup>
- suffer less often from some forms of cancer (e.g., Hodgkin's disease, childhood leukemia);<sup>9</sup>
- have a lower risk of juvenile onset diabetes, if they have a family history of the disease and are breastfed exclusively for at least 4 months;<sup>10</sup>
- are significantly protected against asthma and eczema, if at risk for allergic disorders and exclusively breastfed for at least 4 months; and<sup>11</sup>
- may have a lower risk of obesity in childhood and in adolescence.<sup>12</sup>

For mothers, the impact of breastfeeding is also significant.

- Women who have breastfed are less likely to develop ovarian and premenopausal breast cancers. The more months a woman has spent breastfeeding, the greater the beneficial effect.<sup>13</sup>
- Breastfeeding mothers enjoy a quicker recovery after childbirth, with reduced risk of postpartum bleeding.<sup>14</sup>
- Mothers who breastfeed are more likely to return to their prepregnancy weight than mothers who formula feed. Breastfeeding reduces the risk for long-term obesity.<sup>15</sup>
- Exclusive breastfeeding may reduce the risk of anemia by delaying the return of the menstrual cycle for 20 to 30 weeks.<sup>16</sup>
- Exclusive breastfeeding for the first 6 months postpartum, in the absence of menses, is 98 percent effective in preventing pregnancy.<sup>17</sup>
- Breastfeeding mothers are reported to be more confident and less anxious than bottle-feeding mothers.<sup>18</sup>

In addition to these positive health related effects, breastfeeding is significantly less costly than alternative forms of feeding. Unfortunately, breastfeeding is never initiated for approximately

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<sup>7</sup> Heinig MJ. Host defense benefits of breastfeeding for the infant: effect of breastfeeding duration and exclusivity. *Pediatr Clin North Am*, 2001; 48: 105–123. Uhari M, Matysaari K, Niemela M. A meta-analytic review of the risk factors for acute otitis media. *Clin Infect Dis* 1996; 22: 1079–1083.

<sup>8</sup> Heinig MJ, Dewey KG. Health advantages of breastfeeding for infants: a critical review. *Nutr Res Rev* 1996; 9: 89–110.

<sup>9</sup> Davis MK. Review of the evidence for an association between infant feeding and childhood cancer. *In J Cancer Suppl* 1998; 11: 29–33.

<sup>10</sup> Heinig MJ, Dewey KG. Health advantages of breastfeeding for infants: a critical review.

<sup>11</sup> Gdalevich M, Mimouni D, David M, Mimouni M. Breast-feeding and the onset of atopic dermatitis in childhood: a systematic review and meta-analysis of prospective studies. *J Am Acad Dermatol* 2001; 45:520–527. Gdalevich M, Mimouni D, Mimouni M. Breast-feeding and the risk of bronchial asthma in childhood: a systematic review with meta-analysis of prospective studies. *J Pediatr* 2001; 139: 261–266.

<sup>12</sup> Butte NF. The role of breastfeeding in obesity. *Pediatric Clinics of North America* 2001; 48: 189–198. Gillman MW, Rifas-Shiman SL, Camargo CA Jr, Berkey CS, Frazier AL, Rockett HR, Field AE, Colditz GA. Risk of overweight among adolescents who were breastfed as infants. *JAMA* 2001; 285: 2461–2467.

<sup>13</sup> Heinig MJ, Dewey KG. Health advantages of breastfeeding for mothers: a critical review. *Nutr Res Rev* 1997; 10: 35–56. Labbok MH. Effects of breastfeeding on the mother. *Pediatr Clin North America* 2001; 48: 143–158.

<sup>14</sup> Heinig MJ, Dewey KG. Health advantages of breastfeeding for mothers: a critical review

<sup>15</sup> Ibid.

<sup>16</sup> Labbok MH. Effects of breastfeeding on the mother. *Pediatr Clin North America* 2001; 48: 143–158.

<sup>17</sup> Ibid.

<sup>18</sup> Lawrence RA, Lawrence RM. *Breastfeeding: a guide for the medical profession*. 5th edition. Mosby, St. Louis, 1999.

one quarter of newborns, just over 44 percent are receiving any breast milk at six months and approximately 15 percent are being exclusively breastfed at six months of age.<sup>19</sup> There is also significant variation by facility type in the encouragement provided for mothers to breastfeed their newborns.<sup>20</sup>

Hospitals and professionals who provide maternity care therein are in an excellent position to encourage breastfeeding. Plans can take steps to reward providers for encouraging the initiation of breastfeeding through reimbursement mechanisms or educational programs. These steps could have a significant impact on the health of literally millions of mothers and children. Furthermore, the ACA has mandated coverage for breastfeeding supplies, equipment and counseling and it would be very helpful to track the implementation of this relatively new benefit.<sup>21</sup> We therefore strongly recommend that CMS use this measure in the QRS.

#### NQF 0741 PC-02 Cesarean Section

This measure examines the rate of low-risk women who give birth via cesarean section. In 2011, the cesarean section birth rate in the United States stood at 32.8 percent.<sup>22</sup> In 1985 the World Health Organization (WHO) stated: "There is no justification for any region to have CS rates higher than 10-15%".<sup>23</sup> Furthermore, the variation in cesarean section rates between hospitals in the United States is dramatic, with one recent study finding a range of from 7.1% to 69.9%.<sup>24</sup> Even when risk-adjusted, the cesarean section rate varies widely among physicians and hospitals.<sup>25</sup> Numerous studies have documented both short and long-term negative outcomes associated with cesarean sections. Cesarean sections are significantly more costly than normal vaginal birth. In 2011, hospital facility charges alone (not including professional charges) for an uncomplicated vaginal birth averaged \$10,657. Hospital charges for an uncomplicated cesarean section birth cost were \$17,859 and charges for a cesarean section with complications averaged \$23,923.<sup>26</sup> We believe that if CMS begins collecting and reporting these data on a national scale and using the outcomes of such measurement in reporting mechanisms such as the QRS, consumers will be empowered to make more informed choices and plans and providers will take action to lower what is an unacceptable rate of unnecessary, costly and risk-laden major surgery.

#### NQF 1517 Prenatal and Postpartum Care

This measure assesses the timeliness of prenatal care and the occurrence of a postpartum visit within a specified timeframe. This NQF measure is the only one related to maternity care included by CMS in its Notice. Studies have shown that prenatal care positively impacts birth outcomes. For example, it is associated with fewer preterm births in the presence, as well as

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<sup>19</sup> See the CDC's "Breastfeeding Report Card – 2012, United States" available online at:

<http://www.cdc.gov/breastfeeding/data/reportcard/reportcard2012.htm>

<sup>20</sup> The CDC's "Maternity Care Practices Survey" data show variation in support for breastfeeding mothers by state, facility type, facility birth size, NICU level and region, available online at: <http://www.cdc.gov/breastfeeding/data/mpinc/results-tables.htm>

<sup>21</sup> See guidance issued by HRSA at: <http://www.hrsa.gov/womensguidelines/>

<sup>22</sup> See: <http://www.cdc.gov/nchs/fastats/delivery.htm>

<sup>23</sup> World Health Organization. Appropriate technology for birth. *Lancet* 1985; 2 (8452): 436-7

<sup>24</sup> Katy Backes Kozhimannil, Michael R. Law, and Beth A. Virnig, "Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality and Cost issues," in *Health Affairs*, vol. 32, no. 3, March 2013, pp. 527-535.

<sup>25</sup> See, for example, risk adjusted c-section data on individual OB/Gyns and hospitals in Virginia, available at [www.vhi.org](http://www.vhi.org).

<sup>26</sup> See: <http://transform.childbirthconnection.org/resources/datacenter/chargeschart/>

absence of high-risk conditions, as well as fewer neonatal deaths.<sup>27</sup> Postnatal care is an ideal time for providers to identify issues related to postpartum depression, to discuss family planning and promote breastfeeding.<sup>28</sup> CQMC supports the use of this measure within the QRS and we appreciate the fact that CMS included it in the initial list.

### **Additional Measures**

#### **NQF 0649 PC-01 Elective Delivery**

This measure assesses patients with elective vaginal deliveries or elective cesarean sections between 37 and 39 weeks of gestation. The American College of Obstetricians and Gynecologists (ACOG) recommends that no elective delivery should be performed before the gestational age of 39 weeks. Notwithstanding this recommendation, studies report elective delivery rates of 28-35.8% occurring before 39 weeks. Elective deliveries are tied to increased rates of late-preterm births, increased neonatal morbidity, neonatal intensive care unit admissions, and associated hospital costs compared to deliveries occurring at 39-40 weeks.<sup>29</sup> Notably, efforts to reduce elective deliveries have been shown to be effective.<sup>30</sup> CMS has recognized the importance of reducing the rate of early elective deliveries and has developed both the Strong Start for Mothers and Newborns and the Neonatal Outcomes Improvement Project to further that goal.<sup>31</sup> We believe that CMS can help to promote similar efforts by plans offered through the Marketplaces by incorporating into the QRS a measure of their rate of early elective delivery. These efforts will help reduce the exorbitant immediate and long-term costs associated with caring for low birth weight babies. More importantly, these efforts have the potential to greatly improve newborn outcomes of care. Finally, providers have a very clear, direct ability to influence this practice, and a measure of their performance on this indicator can be used as a barometer of their commitment to evidence based care. Plans are in an excellent position to support providers in this work by modifying payment to reward appropriate behavior, or putting barriers in place to prevent elective deliveries when there is no medical justification.

#### **NQF 0716 Healthy Term Newborn**

This measure examines the percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care. Clearly, it is important to recognize not only when problems occur, but when they do NOT occur. Many interventions commonly used during birth carry with them risks. Unfortunately, it has become common practice to employ such interventions for

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<sup>27</sup> See, for example, Anthony Vintzeleos, et. al., "The impact of prenatal care in the United States on preterm births in the presence and absence of antenatal high-risk conditions," *AJOG*, vol. 187, issue 5, pp. 1254-57, November 2002. See also, Anthony Vintzeleos, et., al., "The impact of prenatal care on neonatal deaths in the presence and absence of antenatal high-risk conditions," *AJOG*, vol. 186, issue 5, pp. 1011-16, May 2002.

<sup>28</sup> Ching Yu-Cheng, et. al., "Post Partum Maternal Health Care in the United States: A Critical Review," in *The Journal of Perinatal Education*, vol. 15, no. 3, pp. 34-42, Summer 2002.

<sup>29</sup> D.M. Ashton "Elective Deliveries at Less than 39 Weeks," in *Current Opinion in Obstetrics and Gynecology*, 2010 Dec; 22(6): 506-510.

<sup>30</sup> One maternity hospital lowered its NICU admission rate by 50 percent by putting in place mechanisms to control early elective deliveries. See: <http://www.newswise.com/articles/early-elective-deliveries-reduction-halves-nicu-admissions>

<sup>31</sup> See a CMS paper entitled "Reducing Early Elective Deliveries in Medicaid and CHIP," available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf>

reasons that may not be based on rigorous evidence.<sup>32</sup> A recent examination of evidence-based maternity care notes that “support for physiologic labor is the safest care for healthy women experiencing normal labor.”<sup>33</sup> Unfortunately, under typical fee-for-service environments, interventions are rewarded financially, which may contribute to their inappropriate occurrence.<sup>34</sup> Plans are well positioned to address this by modifying their reimbursement methodologies to recognize providers who generate better outcomes by *doing less*. Women and their partners preparing for birth or anticipating pregnancy will be very interested in identifying providers who promote normal physiologic birth (and plans who contract with them). For these reasons, we recommend that CMS include this measure in the QRS.

#### NQF 0477 Under 1500g Infant Not Delivered at Appropriate Level of Care

This measure examines the number per 1,000 live births of infants less than 1500 grams who are delivered at a hospital that is not appropriate for infants of that size; specifically, hospitals that do not contain a level III NICU. When a provider recognizes that risk factors exist that may entail preterm delivery, or when preterm labor begins, there is generally sufficient time to arrange transfer of the mother to a hospital with a NICU capable of caring for these children. One recent study found that preterm infants who were delivered at a hospital with a high-level NICU had significantly fewer in-hospital deaths than those who were delivered at hospitals without such a NICU.<sup>35</sup>

Unfortunately, payment systems and staffing protocols may provide financial incentives for providers to allow a known pre-term birth to occur at a facility that does not have such a NICU and then transfer the infant afterward. Plans have the capacity to financially reward appropriate transfer by taking steps to unbundle payment, allowing for partial payment when prenatal care and/or the initial stages of labor, prior to the birth, have been attended by a different provider than the one attending the actual delivery. Likewise, plans can institute payment mechanisms that encourage the occurrence of preterm birth in an appropriate facility. A measure of appropriateness of place of birth for preterm infants is a useful measure of plan quality. We believe that plans that take steps to protect these very vulnerable infants should be rewarded by having the outcomes included in the QRS and made available to the public.

#### NQF 0476 PC-03 Antenatal Steroids

This measure assesses patients at risk of preterm delivery at  $\geq 24$  and  $< 32$  weeks gestation receiving antenatal steroids prior to delivering preterm newborns. It has been known for some time that administration of antenatal steroids impacts the rate of premature births. For example, a Cochrane Review published in 1996 that looked at eighteen separate trials found that antenatal administration of steroids to women expected to give birth preterm

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<sup>32</sup> Carol Sakala and Maureen P. Corry, “Evidence-Based Maternity Care: What It Is and What It Can Achieve,” Childbirth Connection, Reforming States Group, Milbank Memorial Fund, 2008, p. 64. Available at:

<http://www.milbank.org/uploads/documents/0809MaternityCare/0809MaternityCare.html>

<sup>33</sup> Ibid.

<sup>34</sup> Janet Currie and Jonathan Gruber, “The Technology of Birth: Health Insurance, Medical Interventions, and Infant Health,” NBER Working Paper No. 5985, Issued in April 1997. Available at: <http://www.nber.org/papers/w5985>

<sup>35</sup> Lorch, Scott A., MD., et al., “The Differential Impact of Delivery Hospital on the Outcomes of Premature Infants,” in *Pediatrics*, July 9, 2012, available online at: <http://pediatrics.aappublications.org/content/early/2012/07/03/peds.2011-2820>



was associated with significant reductions in mortality, respiratory distress syndrome and intraventricular haemorrhage in preterm infants. These benefits extended to a broad range of gestational ages and were not limited by gender or race. No adverse consequences related to the steroids had been identified.<sup>36</sup> More recent studies have shown reductions in rates of death and neurodevelopmental impairment.<sup>37</sup> A 2013 Cochrane Review of 36 randomized controlled trials found that progesterone was given it had beneficial effects, including reducing the risk of the baby dying after birth, suffering complications such as requiring assisted ventilation, necrotising enterocolitis or requiring admission to neonatal intensive care, prolonging the pregnancy, and reducing the chance of neonatal intensive care admission.<sup>38</sup>

Clearly mitigation of the conditions impacted by administration of antenatal steroids will result not only in better health for newborns, but also in reduced costs. For this reason, the CQMC recommends that CMS include this measure in the QRS.

We appreciate the opportunity to comment on this important Notice. Should you have any questions related to our comments, please feel free to contact Jesse Bushman, Director of Advocacy and Government Affairs with the American College of Nurse Midwives at [jbushman@acnm.org](mailto:jbushman@acnm.org), or 240 485-1843.

Organizations signing onto this letter include:

American Association of Birth Centers  
American College of Nurse Midwives  
Association of Women's Health, Obstetric and Neonatal Nurses  
Midwives Alliance of North America  
National Association of Certified Professional Midwives  
National Women's Health Network  
United States Breastfeeding Committee

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<sup>36</sup> P. Crowley, "Prophylactic Corticosteroids for Preterm Birth," Cochrane Pregnancy and Childbirth Group, published online April 22, 1996. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000065/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

<sup>37</sup> Waldemar A. Carlo, MD, et. al., "Association of Antenatal Corticosteroids With Mortality and Neurodevelopmental Outcomes Among Infants Born at 22 to 25 Weeks' Gestation," *JAMA*, vol. 306, no. 21, December 7, 2011.

<sup>38</sup> JM Dodd, et. al., "Prenatal administration of progesterone for preventing preterm birth in women considered to be at risk of preterm birth (Review)," in *The Cochrane Library*, 2013, Issue 8. Available at: <http://www.update-software.com/BCP/WileyPDF/EN/CD004947.pdf>