

111TH CONGRESS
2^D SESSION

H. R. 5807

To promote optimal maternity outcomes by making evidence-based maternity care a national priority, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 21, 2010

Ms. ROYBAL-ALLARD (for herself, Ms. BALDWIN, Mrs. CAPPS, Ms. CASTOR of Florida, Mrs. CHRISTENSEN, Mr. COHEN, Mr. CONYERS, Mrs. DAVIS of California, Ms. DEGETTE, Ms. DELAURO, Mr. ENGEL, Mr. HINOJOSA, Ms. LEE of California, Ms. ZOE LOFGREN of California, Mrs. LOWEY, Mr. MCGOVERN, Mrs. MALONEY, Mr. MICHAUD, Ms. MOORE of Wisconsin, Mrs. NAPOLITANO, Ms. NORTON, Mr. REYES, Ms. VELÁZQUEZ, Ms. WASSERMAN SCHULTZ, Ms. WOOLSEY, and Ms. SCHAKOWSKY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To promote optimal maternity outcomes by making evidence-based maternity care a national priority, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the
 3 “Maximizing Optimal Maternity Services for the 21st
 4 Century” or the “MOMS for the 21st Century Act”.

5 (b) **TABLE OF CONTENTS.**—The table of contents for
 6 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

**TITLE I—HHS FOCUS ON THE PROMOTION OF OPTIMAL
 MATERNITY CARE**

Sec. 101. Additional focus area for the Office on Women’s Health.

Sec. 102. Interagency Coordinating Committee on the Promotion of Optimal
 Maternity Outcomes.

“Sec. 229A. Interagency Coordinating Committee on the Promotion of Op-
 timal Maternity Outcomes.

Sec. 103. Consumer education campaign.

Sec. 104. Bibliographic database of systematic reviews for care of childbearing
 women and newborns.

**TITLE II—RESEARCH AND DATA COLLECTION ON MATERNITY
 CARE**

Sec. 201. Maternity care health professional shortage areas.

Sec. 202. Expansion of CDC Prevention Research Centers program to include
 Centers on Optimal Maternity Outcomes.

Sec. 203. Expanding models to be tested by Center for Medicare and Medicaid
 Innovation to include maternity care models.

**TITLE III—ENHANCEMENT OF A GEOGRAPHICALLY, RACIALLY,
 AND ETHNICALLY DIVERSE INTERDISCIPLINARY MATERNITY
 WORKFORCE**

Sec. 301. Development of interdisciplinary maternity care provider core cur-
 ricula.

Sec. 302. Interdisciplinary training of medical students, residents, and student
 midwives in academic health centers.

Sec. 303. Loan repayments for maternal care professionals.

Sec. 304. Grants to professional organizations to increase diversity in maternity
 care professionals.

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

9 (1) The United States spends more than double
 10 per capita on health care than other industrialized

1 countries, but ranks far behind almost all developed
2 countries in important perinatal outcomes. In the
3 World Health Report 2005—

4 (A) the World Health Organization identi-
5 fied 29 nations with lower estimated maternal
6 mortality ratios than the United States (14/
7 100,000 live births);

8 (B) the World Health Organization identi-
9 fied 35 nations with lower early neonatal mor-
10 tality rates (5/1,000 live births) and 33 with
11 lower neonatal mortality rates (5/1,000 live
12 births) than the United States;

13 (C) 23 countries (out of 30 reporting) had
14 superior low birth weight rates than the United
15 States; and

16 (D) 19 member countries (out of 23 re-
17 porting) had lower cesarean section rates than
18 the United States.

19 (2) Despite maternity expenditures in the
20 United States, childbirth continues to carry signifi-
21 cant risks for mothers in this country, as dem-
22 onstrated by the following:

23 (A) More than two women die every day in
24 the United States from pregnancy-related
25 causes.

1 (B) More than one-third of all women who
2 give birth in the United States (1,700,000
3 women each year) experience some type of com-
4 plication that has an adverse effect on their
5 health.

6 (C) African-American women having nearly
7 a four times greater risk of dying from preg-
8 nancy-related complications than White women,
9 and these disparities have not improved in 20
10 years.

11 (3) In spite of the Nation's considerable invest-
12 ment in maternity care, the United States is failing
13 to ensure that all infants have a healthy start in life,
14 as demonstrated by the following:

15 (A) The national rate of pre-term birth in-
16 creased by 36 percent in the quarter-century
17 from 1981 to 2006.

18 (B) The proportion of low birth weight ba-
19 bies increased by 22 percent between 1981 and
20 2006.

21 (C) Non-Hispanic Black infants continue
22 to experience significantly higher rates of both
23 pre-term birth and low birth weight, two of the
24 leading causes of infant mortality in this coun-
25 try.

1 (4) Maternity Care is a major component of the
2 escalating health care costs in this country, as dem-
3 onstrated by the following:

4 (A) Maternity care for mothers and their
5 newborns is the number one reason for hos-
6 pitalization in the United States, exceeding
7 such prevalent conditions as pneumonia, cancer,
8 fracture, and heart disease. Of those discharged
9 from hospitals in the United States in 2007, 25
10 percent were childbearing women and newborns.

11 (B) Combined mother and baby charges
12 for hospitalization, which was \$86,000,000,000
13 in 2006, far exceeded charges for any other
14 hospital condition in the United States.

15 (5) Maternity care also accounts for a signifi-
16 cant proportion of expenditures under the Medicaid
17 program, as demonstrated by the following:

18 (A) In 2006, 29 percent of all hospital
19 charges under Medicaid (\$39,000,000,000)
20 were for birthing women and children.

21 (B) Six of the 10 most common procedures
22 reimbursed under the Medicaid program were
23 maternity related, making “mother’s pregnancy
24 and delivery” the most costly Medicaid expendi-
25 ture.

1 (6) Maternity care charges vary significantly by
2 setting and type of birth. In 2005—

3 (A) the average charge for a hospital ce-
4 sarean birth with complications was \$15,900,
5 and without complications was \$12,500;

6 (B) the average charge for a hospital vag-
7 inal birth with complications was \$8,960, and
8 without complications was \$6,970; and

9 (C) the average charge for a birth center
10 vaginal birth was \$1,600.

11 (7) The procedure-intensity of birth-related hos-
12 pital stays helps to explain their high costs. In 2005,
13 6 of the 15 most commonly performed hospital pro-
14 cedures for all patients with all diagnoses involved
15 childbirth. Cesarean section was the most common
16 operating room procedure for Medicaid, for private
17 payers, and for all payers combined.

18 (8) There is a vast body of knowledge regarding
19 best evidence-based practices in maternity care, but
20 current practice is not following the research, as
21 demonstrated by the following:

22 (A) A recent analysis of American College
23 of Obstetrics and Gynecology obstetrical prac-
24 tice bulletins 1998 through 2004 found that
25 only 23 percent of their practice recommenda-

1 tions were based on good, consistent scientific
2 evidence, while 42 percent of recommendations
3 were based on consensus and opinion.

4 (B) There is widespread overuse of mater-
5 nity practices that have been shown to have
6 benefit only in limited situations, which can ex-
7 pose women, infants, or both to risk of harm if
8 used routinely and indiscriminately, including
9 continuous fetal monitoring, labor induction,
10 epidural anesthesia, elective primary cesarean
11 section, and repeat cesarean delivery.

12 (C) There are multiple non-invasive mater-
13 nity practices that have been associated with
14 considerable improvement in outcomes with no
15 detrimental side effects, and are significantly
16 underused in this country, including smoking
17 cessation programs in pregnancy, group model
18 prenatal care, continuous labor support, non-su-
19 pine positions for birth, and external version to
20 turn breech babies at term.

21 (9) The growing shortage of maternity health
22 care professionals and childbirth facilities is creating
23 a serious obstacle to timely and adequate maternity
24 health care for women, particularly in rural areas
25 and the inner cities.

1 (10) There are significant racial and ethnic dis-
2 parities across the maternity care workforce creating
3 additional access barriers to culturally and linguis-
4 tically competent maternity services.

5 (11) Although most women in the United
6 States are healthy and at low risk for complications,
7 Obstetrician-Gynecologist Surgeons are the lead
8 caregivers for about 79 percent of women during
9 pregnancy and labor, as compared to midwives who
10 care for 8 percent to 9 percent of women, and Fam-
11 ily Practice Physicians who care for 6 percent to 7
12 percent of women. Among developed nations, only
13 the United States and Canada rely to this degree on
14 specialists rather than midwives or family physicians
15 to provide care to healthy birthing women.

16 (12) There is a growing shortage of Obstetri-
17 cian-Gynecologists in the United States who provide
18 maternity services. Data from the 2006 American
19 College of Obstetricians and Gynecologists (ACOG)
20 Survey on Professional Liability showed a negative
21 trend in length of obstetrical practice, with the aver-
22 age age at which physicians stopped practicing ob-
23 stetrics being 48 years. At one point this was the
24 near midpoint of an Obstetrician-Gynecologist's pro-
25 fessional career.

1 (13) There is extensive research demonstrating
2 that certified nurse midwives, when compared to Ob-
3 stetrician-Gynecologists, provide high quality of care
4 with comparable or better outcomes, high levels of
5 patient satisfaction, and at lower costs due to fewer
6 unnecessary, invasive, and expensive technologic
7 interventions.

8 (14) Approximately 1 percent of births in the
9 United States take place in non-hospital settings. Of
10 such births, 27 percent occur in birth centers and 65
11 percent are home births. Hospitals remain the set-
12 ting of delivery for 99 percent of all births despite
13 the following findings:

14 (A) Multiple studies have demonstrated
15 that for women who meet criteria to be consid-
16 ered at low risk for obstetrical complications,
17 labor and delivery at a birth center can result
18 in higher patient satisfaction and equivalent or
19 better outcomes than in-hospital birth.

20 (B) Studies have consistently found that
21 for low-risk mothers, planned home birth had
22 the same outcomes as hospital births for similar
23 risk women, but with fewer costly and often
24 preventable interventions.

1 (C) In a nationwide comparison of birth
2 center costs to hospital costs, it is estimated
3 that if 100,000 births were attended in birth
4 centers, access to care would be greatly im-
5 proved, and annual savings would total more
6 than \$314,000,000.

7 (15) Midwives serve as faculty at many of the
8 Nation’s most prominent academic health centers,
9 however, the time they spend training medical stu-
10 dents, residents, and midwifery students is not reim-
11 bursed as it is for physicians. As a result, medical
12 students, residents, and midwifery students often
13 fail to benefit from the practice experience and phys-
14 iologic birth expertise of midwives.

15 **TITLE I—HHS FOCUS ON THE**
16 **PROMOTION OF OPTIMAL MA-**
17 **TERNITY CARE**

18 **SEC. 101. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
19 **WOMEN’S HEALTH.**

20 Section 229(b) of the Public Health Service Act (42
21 U.S.C. 237a(b)) is amended—

22 (1) in paragraph (6), at the end, by striking
23 “and”;

24 (2) in paragraph (7), at the end, by striking the
25 period and inserting “; and”; and

1 (3) by adding at the end the following new
2 paragraph:

3 “(8) facilitate policy makers, health system
4 leaders and providers, consumers, and other stake-
5 holders in their understanding optimal maternity
6 care and support for the provision of such care, in-
7 cluding the priorities of—

8 “(A) protecting, promoting, and supporting
9 the innate capacities of childbearing women and
10 their newborns for childbirth, breast-feeding,
11 and attachment;

12 “(B) using obstetric interventions only
13 when such interventions are supported by
14 strong, high-quality evidence, and minimizing
15 overuse of maternity practices that have been
16 shown to have benefit in limited situations and
17 that can expose women, infants, or both to risk
18 of harm if used routinely and indiscriminately,
19 including continuous electronic fetal monitoring,
20 labor induction, epidural analgesia, primary ce-
21 sarian section, and routine repeat cesarean
22 birth;

23 “(C) reliably providing beneficial practices
24 with no or minimal evidence of harm that are
25 underused, including smoking cessation pro-

1 grams in pregnancy, group model prenatal care,
2 continuous labor support, non-supine positions
3 for birth, and external version to turn breech
4 babies at term;

5 “(D) a shared understanding of the quali-
6 fications of licensed providers of maternity care
7 and the best evidence about the safety, satisfac-
8 tion, outcomes, and costs of their care, and ap-
9 propriate deployment of such caregivers within
10 the maternity care workforce to address the
11 needs of childbearing women and newborns and
12 the growing shortage of maternity caregivers;

13 “(E) a shared understanding of the results
14 of the best available research comparing hos-
15 pital, birth center, and planned home births, in-
16 cluding information about each setting’s safety,
17 satisfaction, outcomes, and costs; and

18 “(F) informed decisionmaking by child-
19 bearing women.”.

20 **SEC. 102. INTERAGENCY COORDINATING COMMITTEE ON**
21 **THE PROMOTION OF OPTIMAL MATERNITY**
22 **OUTCOMES.**

23 (a) IN GENERAL.—Part B of title II of the Public
24 Health Service Act is amended by adding at the end the
25 following new section:

1 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
2 **THE PROMOTION OF OPTIMAL MATERNITY**
3 **OUTCOMES.**

4 “(a) IN GENERAL.—The Secretary of Health and
5 Human Services, acting through the Deputy Assistant
6 Secretary for Women’s Health under section 229 and in
7 collaboration with the Federal officials specified in sub-
8 section (b), shall establish the Interagency Coordinating
9 Committee on the Promotion of Optimal Maternity Out-
10 comes (referred to in this subsection as the ‘ICCPOM’).

11 “(b) OTHER AGENCIES.—The officials specified in
12 this subsection are the Secretary of Labor, the Secretary
13 of Defense, the Secretary of Veterans Affairs, the Surgeon
14 General, the Director of the Centers for Disease Control
15 and Prevention, the Administrator of the Health Re-
16 sources and Services Agency, the Administrator of the
17 Centers for Medicare & Medicaid Services, the Director
18 of the Indian Health Service, the Administrator of the
19 Substance Abuse and Mental Health Services Administra-
20 tion, the Director of the National Institute on Child
21 Health and Development, the Director of the Agency for
22 Healthcare Research and Quality, the Assistant Secretary
23 for Children and Families, the Deputy Assistant Secretary
24 for Minority Health, the Director of the Office of Per-
25 sonnel Management, and such other Federal officials as

1 the Secretary of Health and Human Services determines
2 to be appropriate.

3 “(c) CHAIR.—The Deputy Assistant Secretary for
4 Women’s Health shall serve as the chair of the ICCPOM.

5 “(d) DUTIES.—The ICCPOM shall guide policy and
6 program development across the Federal Government with
7 respect to promotion of optimal maternity care, provided,
8 however, that nothing in this section shall be construed
9 as transferring regulatory or program authority from an
10 Agency to the Coordinating Committee.

11 “(e) CONSULTATIONS.—The ICCPOM shall actively
12 seek the input of, and shall consult with, all appropriate
13 and interested stakeholders, including State Health De-
14 partments, public health research and interest groups,
15 foundations, childbearing women and their advocates, and
16 maternity focused primary care professional associations
17 and organizations, reflecting racially, ethnically, demo-
18 graphically, and geographically diverse communities.

19 “(f) ANNUAL REPORT.—

20 “(1) IN GENERAL.—The Secretary, on behalf of
21 the ICCPOM, shall annually submit to Congress a
22 report that summarizes—

23 “(A) all programs and policies of Federal
24 agencies designed to promote optimal maternity
25 care, focusing particularly on programs and

1 policies that support the adoption of evidence
2 based maternity care, as defined by timely, sci-
3 entifically sound systematic reviews;

4 “(B) all programs and policies of Federal
5 agencies designed to address the problems of
6 maternal mortality and infant mortality, pre-
7 maturity, and low birth weight;

8 “(C) the extent of progress in reducing
9 maternal mortality and infant mortality, low
10 birth weight, and prematurity at State and na-
11 tional levels; and

12 “(D) such other information regarding op-
13 timal maternity care as the Secretary deter-
14 mines to be appropriate.

15 The information specified in subparagraph (C) shall
16 be included in each such report in a manner that
17 disaggregates such information by race, ethnicity,
18 and indigenous status in order to determine the ex-
19 tent of progress in reducing racial and ethnic dis-
20 parities and disparities related to indigenous status.

21 “(2) CERTAIN INFORMATION.—Each report
22 under paragraph (1) shall include information
23 (disaggregated by race, ethnicity, and indigenous
24 status, as applicable) on the following rates and
25 costs by State:

1 “(A) The rate of primary cesarean deliv-
2 eries and repeat cesarean deliveries.

3 “(B) The rate of vaginal births after cesar-
4 ean.

5 “(C) The rate of vaginal breech births.

6 “(D) The rate of induction of labor.

7 “(E) The rate of birthing center births.

8 “(F) The rate of planned and unplanned
9 home birth.

10 “(G) The rate of attended births by pro-
11 vider, including by an obstetrician-gynecologist,
12 family practice physician, obstetrician-gyne-
13 cologist physician assistant, certified nurse-mid-
14 wife, certified midwife, and certified profes-
15 sional midwife.

16 “(H) The cost of maternity care
17 disaggregated by place of birth and provider of
18 care, including—

19 “(i) uncomplicated vaginal birth;

20 “(ii) complicated vaginal birth;

21 “(iii) uncomplicated cesarean birth;

22 and

23 “(iv) complicated cesarean birth.

24 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated, in addition to such

1 amounts authorized to be appropriated under section
2 229(e), to carry out this section \$1,000,000 for each of
3 the fiscal years 2011 through 2015.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) INCLUSION AS DUTY OF HHS OFFICE ON
6 WOMEN’S HEALTH.—Section 229(b) of such Act (42
7 U.S.C. 237a(b)), as amended by section 101, is
8 amended—

9 (A) in paragraph (7), at the end, by strik-
10 ing “and”;

11 (B) in paragraph (8), at the end, by strik-
12 ing the period and inserting “; and”; and

13 (C) by adding at the end the following new
14 paragraph:

15 “(9) establish the Interagency Coordinating
16 Committee on the Promotion of Optimal Maternity
17 Outcomes in accordance with section 229A.”.

18 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
19 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
20 amended by inserting “(other than under subsection
21 (b)(9))” after “under this section”.

22 **SEC. 103. CONSUMER EDUCATION CAMPAIGN.**

23 Section 229 of the Public Health Service Act (42
24 U.S.C. 237a), as amended by sections 101 and 102, is
25 further amended—

1 (1) in subsection (b)—

2 (A) in paragraph (8), at the end, by strik-
3 ing “and”;

4 (B) in paragraph (9), at the end, by strik-
5 ing the period and inserting “; and”; and

6 (C) by adding at the end the following new
7 paragraph:

8 “(10) not later than one year after the date of
9 the enactment of the MOMS for the 21st Century
10 Act, develop and implement a 4-year culturally and
11 linguistically appropriate multi-media consumer edu-
12 cation campaign to promote understanding and ac-
13 ceptance of evidence based maternity practices and
14 models of care for optimal maternity outcomes
15 among women of childbearing ages and families of
16 such women and that—

17 “(A) highlights the importance of pro-
18 tecting, promoting, and supporting the innate
19 capacities of childbearing women and their
20 newborns for childbirth, breast-feeding, and at-
21 tachment;

22 “(B) promotes understanding of the impor-
23 tance of using obstetric interventions only when
24 supported by strong, high-quality evidence;

1 “(C) highlights the widespread overuse of
2 maternity practices that have been shown to
3 have benefit only in limited situations, and
4 which can expose women, infants, or both to
5 risk of harm if used routinely and indiscrimi-
6 nately, including continuous fetal monitoring,
7 labor induction, epidural anesthesia, elective
8 primary cesarean section, and repeat cesarean
9 delivery;

10 “(D) emphasizes the multiple non-invasive
11 maternity practices that have been associated
12 with considerable improvement in outcomes
13 with no detrimental side effects, and are signifi-
14 cantly underused in the United States, includ-
15 ing smoking cessation programs in pregnancy,
16 group model prenatal care, continuous labor
17 support, non-supine positions for birth, and ex-
18 ternal version to turn breech babies at term;

19 “(E) educates consumers about the quali-
20 fications of licensed providers of maternity care
21 and the best evidence about their safety, satis-
22 faction, outcomes, and costs;

23 “(F) informs consumers about the best
24 available research comparing birth center births
25 and planned home births with hospital births,

1 including information about each setting’s safe-
2 ty, satisfaction, outcomes, and costs;

3 “(G) fosters involvement in informed deci-
4 sionmaking among childbirth consumers; and

5 “(H) is pilot tested for consumer com-
6 prehension, cultural sensitivity, and acceptance
7 of the messages across geographically, racially,
8 ethnically, and linguistically diverse popu-
9 lations.”.

10 **SEC. 104. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
11 **VIEWS FOR CARE OF CHILDBEARING WOMEN**
12 **AND NEWBORNS.**

13 (a) IN GENERAL.—Not later than January 1, 2014,
14 the Secretary of Health and Human Services, through the
15 Agency for Healthcare Research and Quality, shall—

16 (1) make publicly available an online biblio-
17 graphic database identifying systematic reviews for
18 care of childbearing women and newborns; and

19 (2) initiate regular updates that incorporate
20 newly issued and updated systematic reviews.

21 (b) SOURCES.—To aim for a comprehensive inventory
22 of systematic reviews relevant to maternal and newborn
23 care, the database shall identify reviews from diverse
24 sources, including—

25 (1) scientific journals;

1 (2) databases, including Cochrane Database of
2 Systematic Reviews, Clinical Evidence, and Data-
3 base of Abstracts of Reviews of Effects; and

4 (3) Internet Web sites of agencies and organi-
5 zations throughout the world that produce such sys-
6 tematic reviews.

7 (c) FEATURES.—The database shall—

8 (1) provide bibliographic citations for each
9 record within the database;

10 (2) include abstracts, as available;

11 (3) provide reference to companion documents
12 as may exist for each review, such as evidence tables
13 and guidelines or consumer educational materials de-
14 veloped from the review;

15 (4) provide links to the source of the full review
16 and to any companion documents;

17 (5) provide links to the source of a previous
18 version or update of the review;

19 (6) be searchable by intervention or other topic
20 of the review, reported outcomes, author, title, and
21 source; and

22 (7) offer to users periodic electronic notification
23 of database updates relating to users' topics of inter-
24 est.

1 (d) OUTREACH.—Not later than the first date the
2 database is made publicly available and periodically there-
3 after, the Secretary of Health and Human Services shall
4 publicize the availability, features, and uses of the data-
5 base under this section to the stakeholders described in
6 subsection (e).

7 (e) CONSULTATION.—For purposes of developing the
8 database under this section and maintaining and updating
9 such database, the Secretary of Health and Human Serv-
10 ices shall convene and consult with an advisory committee
11 composed of relevant stakeholders, including—

12 (1) Federal Medicaid administrators and State
13 agencies administering State plans under title XIX
14 of the Social Security Act pursuant to section
15 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

16 (2) providers of maternity and newborn care
17 from both academic and community-based settings,
18 including obstetrician-gynecologists, family physi-
19 cians, midwives, physician assistants, perinatal
20 nurses, pediatricians, and nurse practitioners;

21 (3) maternal-fetal medicine specialists;

22 (4) neonatologists;

23 (5) childbearing women and their advocates
24 representing communities that are diverse in terms

1 of race, ethnicity, indigenous status, and geographic
2 area;

3 (6) employers and purchasers;

4 (7) health facility and system leaders, including
5 both hospital and birth center facilities;

6 (8) journalists; and

7 (9) bibliographic informatics specialists.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated \$2,500,000 for each of the
10 fiscal years 2011 through 2013 for the purpose of devel-
11 oping the database and such sums as may be necessary
12 for each subsequent fiscal year for updating the database
13 and providing outreach and notification to users, as de-
14 scribed in this section.

15 **TITLE II—RESEARCH AND DATA**
16 **COLLECTION ON MATERNITY**
17 **CARE**

18 **SEC. 201. MATERNITY CARE HEALTH PROFESSIONAL**
19 **SHORTAGE AREAS.**

20 Section 332 of the Public Health Service Act (42
21 U.S.C. 254e) is amended by adding at the end the fol-
22 lowing new subsection:

23 “(k)(1) The Secretary, acting through the Adminis-
24 trator of the Health Resources and Services Administra-
25 tion, shall designate maternity care health professional

1 shortage areas in the States, publish a descriptive list of
2 the area’s population groups, medical facilities, and other
3 public facilities so designated, and at least annually review
4 and, as necessary, revise such designations.

5 “(2) For purposes of paragraph (1), a complete de-
6 scriptive list shall be published in the Federal Register not
7 later than July 1 of 2011 and each subsequent year.

8 “(3) The provisions of subsections (b), (c), (e), (f),
9 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
10 shall apply to the designation of a maternity care health
11 professional shortage area in a similar manner and extent
12 as such provisions apply to the designation of health pro-
13 fessional shortage areas, except in applying subsection
14 (b)(3), the reference in such subsection to ‘physicians’
15 shall be deemed to be a reference to ‘physicians, obstetri-
16 cians, family practice physicians who practice full-scope
17 maternity care, certified nurse-midwives, certified mid-
18 wives, and certified professional midwives’.

19 “(4) For purposes of this subsection, the term ‘ma-
20 ternity care health professional shortage area’ means—

21 “(A) an area in an urban or rural area (which
22 need not conform to the geographic boundaries of a
23 political subdivision and which is a rational area for
24 the delivery of health services) which the Secretary
25 determines has a shortage of providers of maternity

1 care health services, including obstetricians, family
2 practice physicians who practice full-scope maternity
3 care, certified nurse-midwives, certified midwives,
4 and certified professional midwives, and shall also
5 include urban or rural areas that have lost a signifi-
6 cant number of local hospital labor and delivery
7 units;

8 “(B) an area in an urban or rural area (which
9 need not conform to the geographic boundaries of a
10 political subdivision and which is a rational area for
11 the delivery of health services) which the Secretary
12 determines has a shortage of hospital or birth center
13 labor and delivery units, or areas that lost a signifi-
14 cant number of these units in during the 10-year pe-
15 riod beginning with 2000; or

16 “(C) a population group which the Secretary
17 determines has such a shortage of providers or fa-
18 cilities.”.

19 **SEC. 202. EXPANSION OF CDC PREVENTION RESEARCH**
20 **CENTERS PROGRAM TO INCLUDE CENTERS**
21 **ON OPTIMAL MATERNITY OUTCOMES.**

22 (a) IN GENERAL.—Not later than one year after the
23 date of the enactment of this Act, the Secretary of Health
24 and Human Services, shall support the establishment of
25 2 additional Prevention Research Centers under the Pre-

1 vention Research Center Program administered by the
2 Centers for Disease Control and Prevention. Such addi-
3 tional centers shall each be known as a Center for Excel-
4 lence on Optimal Maternity Outcomes.

5 (b) RESEARCH.—Each Center for Excellence on Opti-
6 mal Maternity Outcomes shall—

7 (1) conduct at least one focused program of re-
8 search to improve maternity outcomes, including the
9 reduction of cesarean birth rates, prematurity rates,
10 and low birth weight rates within an underserved
11 population that has a disproportionately large bur-
12 den of suboptimal maternity outcomes, including
13 maternal mortality and morbidity, cesarean section
14 rates, infant mortality, prematurity, or low birth
15 weight;

16 (2) work with partners on special interest
17 projects, as specified by the Centers for Disease
18 Control and Prevention and other relevant agencies
19 within the Department of Health and Human Serv-
20 ices, and on projects funded by other sources; and

21 (3) involve a minimum of two distinct birth set-
22 ting models, such as a hospital labor and delivery
23 model and birth center model; or a hospital labor
24 and delivery model and planned home birth model.

1 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude the following interdisciplinary providers of maternity
4 care:

5 (1) Obstetrician-gynecologists.

6 (2) Certified nurse midwives or certified mid-
7 wives.

8 (3) At least two of the following providers:

9 (A) Family practice physicians.

10 (B) Women’s health nurse practitioners.

11 (C) Obstetrician-gynecologists physician
12 assistants.

13 (D) Certified professional midwives.

14 (d) SERVICES.—Research conducted by each Center
15 for Excellence on Optimal Maternity Outcomes shall in-
16 clude at least 2 (and preferably more) of the following sup-
17 portive provider services:

18 (1) Mental health.

19 (2) Doula labor support.

20 (3) Nutrition education.

21 (4) Childbirth education.

22 (5) Social work.

23 (6) Physical therapy or occupation therapy.

24 (e) COORDINATION.—The programs of research at
25 each of the two Centers of Excellence on Optimal Mater-

1 nity Outcomes shall compliment and not replicate the
2 work of the other.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$2,000,000 for each of the fiscal years 2011 through
6 2015.

7 **SEC. 203. EXPANDING MODELS TO BE TESTED BY CENTER**
8 **FOR MEDICARE AND MEDICAID INNOVATION**
9 **TO INCLUDE MATERNITY CARE MODELS.**

10 Section 1115A(b)(2)(B) of the Social Security Act
11 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
12 end the following new clause:

13 “(xxi) Promoting evidence-based
14 group prenatal care models, doula support,
15 and out-of-hospital births, including births
16 at home or a birthing center.”.

17 **TITLE III—ENHANCEMENT OF A**
18 **GEOGRAPHICALLY, RACIALLY,**
19 **AND ETHNICALLY DIVERSE**
20 **INTERDISCIPLINARY**
21 **MATERNITY WORKFORCE**

22 **SEC. 301. DEVELOPMENT OF INTERDISCIPLINARY MATER-**
23 **NITY CARE PROVIDER CORE CURRICULA.**

24 (a) IN GENERAL.—Not later than 6 months after the
25 date of the enactment of this Act, the Secretary of Health

1 and Human Services, acting in conjunction with the Ad-
2 ministrator of Health Resources and Services Administra-
3 tion, shall convene, for a 1-year period, a Maternity Cur-
4 riculum Commission to discuss and make recommenda-
5 tions for—

6 (1) a shared core maternity care curriculum;

7 (2) strategies to integrate and coordinate edu-
8 cation across maternity care disciplines, including
9 suggestions for multi-disciplinary use of the shared
10 core curriculum; and

11 (3) pilot demonstrations of interdisciplinary
12 educational models.

13 (b) PARTICIPANTS.—The Commission shall include
14 maternity care educators, curriculum developers, service
15 leaders, certification leaders, and accreditation leaders
16 from the various professions that provide maternity care
17 in this country. Such professions shall include obstetri-
18 cian-gynecologists, certified nurse midwives, certified mid-
19 wives, family practice physicians, women’s health nurse
20 practitioners, obstetrician-gynecologists physician assist-
21 ants, certified professional midwives, and perinatal nurses.

22 (c) CURRICULUM.—The shared core maternity care
23 curriculum described in subsection (A) shall—

24 (1) have a public health focus with a foundation
25 in health promotion and disease prevention;

1 (1) in paragraph (6), by striking “; or” and in-
2 serting “, or in the case of services in a hospital or
3 osteopathic hospital by a student midwife or an in-
4 tern or resident-in-training under a teaching pro-
5 gram previously described in this paragraph who is
6 in the field of obstetrics and gynecology, if such stu-
7 dent midwife, intern, or resident-in-training is super-
8 vised by a certified nurse-midwife to the extent per-
9 mitted under applicable State law and as may be au-
10 thorized by the hospital;”;

11 (2) in paragraph (7), by striking the period at
12 the end and inserting “; or”; and

13 (3) by adding at the end the following new
14 paragraph:

15 “(8) a certified nurse-midwife where the hos-
16 pital has a teaching program approved as specified
17 in paragraph (6), if (A) the hospital elects to receive
18 any payment due under this title for reasonable
19 costs of such services, and (B) all certified nurse-
20 midwives in such hospital agree not to bill charges
21 for professional services rendered in such hospital to
22 individuals covered under the insurance program es-
23 tablished by this title.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to services furnished on or after
3 the date of the enactment of this Act.

4 **SEC. 303. LOAN REPAYMENTS FOR MATERNAL CARE PRO-**
5 **FESSIONALS.**

6 (a) PURPOSE.—It is the purpose of this section to
7 alleviate critical shortages of maternal care professionals.

8 (b) LOAN REPAYMENTS.—The Secretary of Health
9 and Human Services, acting through the Administrator of
10 the Health Resources and Services Administration, shall
11 establish a program of entering into contracts with eligible
12 individuals under which—

13 (1) the individual agrees to serve full-time—

14 (A) as a physician in the field of obstetrics
15 and gynecology; as a certified nurse midwife,
16 certified midwife or certified professional mid-
17 wife; or as a family practice physician who
18 agrees to practice full-scope maternity care; and

19 (B) in an area that is either a health pro-
20 fessional shortage area (as designated under
21 section 332 of the Public Health Service Act) or
22 a maternity care health professional shortage
23 area (as designated under subsection (k) of
24 such section, as added by section 201 of this
25 Act); and

1 (2) the Secretary agrees to pay, for each year
2 of such full-time service, not more than \$50,000 of
3 the principal and interest of the undergraduate or
4 graduate educational loans of the individual.

5 (c) SERVICE REQUIREMENT.—A contract entered
6 into under this section shall allow the individual receiving
7 the loan repayment to satisfy the service requirement de-
8 scribed in subsection (a)(1) through employment in a solo
9 or group practice, a clinic, a public or private nonprofit
10 hospital, a freestanding birth center, or any other appro-
11 priate health care entity.

12 (d) APPLICATION OF CERTAIN PROVISIONS.—The
13 provisions of subpart III of part D of title III of the Public
14 Health Service Act shall, except as inconsistent with this
15 section, apply to the program established in subsection (a)
16 in the same manner and to the same extent as such provi-
17 sions apply to the National Health Service Corps Scholar-
18 ship Program established in such subpart.

19 (e) DEFINITION.—In this section, the term “eligible
20 individual” means—

21 (1) a physician in the field of obstetrics and
22 gynecology; or

23 (2) a certified nurse-midwife or certified mid-
24 wife;

1 (3) a family practice physician who practices
2 full scope maternity care; or

3 (4) a certified professional midwife who has
4 graduated from an accredited midwifery education
5 program.

6 **SEC. 304. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
7 **INCREASE DIVERSITY IN MATERNITY CARE**
8 **PROFESSIONALS.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services, through the Administrator of the Health
11 Resources and Services Administration, shall carry out a
12 grant program under which the Secretary may make to
13 eligible health professional organizations—

14 (1) for fiscal year 2011, planning grants de-
15 scribed in subsection (b); and

16 (2) for the subsequent 4-year period, implemen-
17 tation grants described in subsection (c).

18 (b) PLANNING GRANTS.—

19 (1) IN GENERAL.—Planning grants described in
20 this subsection are grants for the following purposes:

21 (A) To collect data and identify any work-
22 force disparities, with respect to a health pro-
23 fession, at each of the following areas along the
24 health professional continuum:

1 (i) Pipeline availability with respect to
2 students at the high school and college or
3 university levels considering and working
4 toward entrance in the profession.

5 (ii) Entrance into the training pro-
6 gram for the profession.

7 (iii) Graduation from such training
8 program.

9 (iv) Entrance into practice.

10 (v) Retention in practice for more
11 than a 5-year period.

12 (B) To develop one or more strategies to
13 address the workforce disparities within the
14 health profession, as identified under (and in
15 response to the findings pursuant to) subpara-
16 graph (A).

17 (2) APPLICATION.—To be eligible to receive a
18 grant under this subsection, an eligible health pro-
19 fessional organization shall submit to the Secretary
20 of Health and Human Services an application in
21 such form and manner and containing such informa-
22 tion as specified by the Secretary.

23 (3) AMOUNT.—Each grant awarded under this
24 subsection shall be for an amount not to exceed
25 \$300,000.

1 (4) REPORT.—Each recipient of a grant under
2 this subsection shall submit to the Secretary of
3 Health and Human Services a report containing—

4 (A) information on the extent and distribu-
5 tion of workforce disparities identified through
6 the grant; and

7 (B) reasonable objectives and strategies
8 developed to address such disparities within a
9 5-, 10-, and 25-year period.

10 (c) IMPLEMENTATION GRANTS.—

11 (1) IN GENERAL.—Implementation grants de-
12 scribed in this subsection are grants to implement
13 one or more of the strategies developed pursuant to
14 a planning grant awarded under subsection (b).

15 (2) APPLICATION.—To be eligible to receive a
16 grant under this subsection, an eligible health pro-
17 fessional organization shall submit to the Secretary
18 of Health and Human Services an application in
19 such form and manner as specified by the Secretary.
20 Each such application shall contain information on
21 the capability of the organization to carry out a
22 strategy described in paragraph (1), involvement of
23 partners or coalitions, plans for developing sustain-
24 ability of the efforts after the culmination of the

1 grant cycle, and any other information specified by
2 the Secretary.

3 (3) AMOUNT.—Each grant awarded under this
4 subsection shall be for an amount not to exceed
5 \$500,000 each year during the 4-year period of the
6 grant.

7 (4) REPORTS.—For each of the first 3 years for
8 which an eligible health professional organization is
9 awarded a grant under this subsection, the organiza-
10 tion shall submit to the Secretary of Health and
11 Human Services a report on the activities carried
12 out by such organization through the grant during
13 such year and objectives for the subsequent year.
14 For the fourth year for which an eligible health pro-
15 fessional organization is awarded a grant under this
16 subsection, the organization shall submit to the Sec-
17 retary a report that includes an analysis of all the
18 activities carried out by the organization through the
19 grant and a detailed plan for continuation of out-
20 reach efforts.

21 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
22 TION DEFINED.—For purposes of this section, the term
23 “eligible health professional organization” means a profes-
24 sional organization representing obstetrician-gyne-
25 cologists, certified nurse midwives, certified midwives,

1 family practice physicians, women's health nurse practi-
2 tioners, obstetrician-gynecologist physician assistants, or
3 certified professional midwives.

4 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
5 authorized to be appropriated to carry out this section
6 \$2,000,000 for fiscal year 2011 and \$3,000,000 for each
7 of the fiscal years 2012 through 2015.

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