

112TH CONGRESS
1ST SESSION

H. R. 2141

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 3, 2011

Ms. ROYBAL-ALLARD 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,*

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

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

7 (b) TABLE OF CONTENTS.—The table of contents for
8 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.

1 SEC. 2. FINDINGS.

2 Congress finds the following:

3 (1) Maternity expenditures in the United States
 4 surpass all other developed countries, but childbirth
 5 continues to carry significant risks for mothers in
 6 the United States, as demonstrated by the following:

7 (A) More than two women die every day in
 8 the United States from pregnancy-related
 9 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) Severe complications that result in
7 women nearly dying, known as a “near miss”
8 or severe morbidity, increased by 25 percent be-
9 tween 1998 and 2005, to approximately 34,000
10 cases a year.

11 (D) African-American women have nearly
12 a four times greater risk of dying from preg-
13 nancy-related complications than White women,
14 and these disparities have not improved in 50
15 years.

16 (2) In spite of the considerable investment of
17 the United States in maternity care, the United
18 States is failing to ensure that all infants have a
19 healthy start in life, as demonstrated by the fol-
20 lowing:

21 (A) The national rate of pre-term birth in-
22 creased by 36 percent in the quarter-century
23 from 1981 to 2006. Despite a very modest re-
24 duction in pre-term births between 2006 and

1 2008, rates remain 31 percent higher than in
2 1981.

3 (B) The proportion of low birth weight ba-
4 bies increased by 21 percent between 1981 and
5 2008.

6 (C) Non-Hispanic Black infants continue
7 to experience significantly higher rates of both
8 pre-term birth and low birthweight, two of the
9 leading causes of infant mortality in this coun-
10 try.

11 (3) Despite shortcomings in the United States
12 statewide data collections systems, which make
13 international comparisons more challenging, inter-
14 national health organizations have ranked the
15 United States far behind almost all developed coun-
16 tries in important perinatal and maternal outcomes,
17 as demonstrated by the following:

18 (A) The World Health Organization identi-
19 fied 49 nations with lower rates of maternal
20 deaths than the United States in 2008.

21 (B) In the World Health Report 2005, the
22 World Health Organization identified 35 na-
23 tions with lower early neonatal mortality rates
24 (4/1,000 live births) and 33 with lower neonatal

1 mortality rates (5/1,000 live births) than the
2 United States.

3 (C) According to data from the
4 Organisation for Economic Co-operation and
5 Development (OECD), 26 countries (out of 29
6 reporting) had low birthweight rates lower than
7 that of the United States.

8 (D) 21 OECD countries (out of 27 report-
9 ing) had lower cesarean section rates than the
10 United States.

11 (4) Maternity care is a major component of the
12 escalating health care costs in the United States, as
13 demonstrated by the following:

14 (A) With 4,000,000 deliveries yearly, the
15 vast majority of which occur in hospitals, ma-
16 ternity care for mothers and their newborns is
17 the number one reason for hospitalization in the
18 United States, exceeding such prevalent condi-
19 tions as pneumonia, cancer, fracture, and heart
20 disease. Of those discharged from hospitals in
21 the United States in 2008, nearly one in four
22 were childbearing women and newborns.

23 (B) Combined mother and baby charges
24 for hospitalization, which was \$98,000,000,000

1 in 2008, far exceeded charges for any other
2 hospital condition in the United States.

3 (5) Maternity care also accounts for a signifi-
4 cant proportion of expenditures under the Medicaid
5 program, which covers 42 percent of births in this
6 country, as demonstrated by the following:

7 (A) In 2008, 26 percent of all hospital
8 charges for which payment was made under the
9 Medicaid program (totaling \$41,000,000,000)
10 was for birthing women and newborns.

11 (B) The two most common conditions for
12 which payments were made under the Medicaid
13 program in 2007 were pregnancy and childbirth
14 (constituting 28 percent of such payments) and
15 newborns (constituting 26 percent of such pay-
16 ments), which together accounted for 53 per-
17 cent of hospital discharges billed to Medicaid.

18 (C) The two most costly conditions for
19 which payment was made under the Medicaid
20 program in 2008 were “mother’s pregnancy and
21 delivery” and care for “newborn infants”, which
22 together accounted for 26 percent of all Med-
23 icaid expenditures.

24 (6) Maternity care facility charges vary signifi-
25 cantly by setting and type of birth. Part of the

1 charge differentials between facilities are attrib-
2 utable to high overhead of hospitals—

3 (A) in 2008, the average charge for a hos-
4 pital cesarean birth with complications was
5 \$20,080, and without complications was
6 \$14,900;

7 (B) in 2008, the average charge for a hos-
8 pital vaginal birth with complications was
9 \$11,410, and without complications was
10 \$8,920; and

11 (C) in 2010, the average charge for a birth
12 center vaginal birth was \$2,277.

13 (7) The procedure-intensity of birth-related hos-
14 pital stays also helps to explain the high costs of
15 such hospital stays. In 2008, 6 of the 10 most com-
16 monly performed hospital procedures for all patients
17 with all diagnoses involved childbirth and newborn
18 care. Cesarean section was the most common oper-
19 ating room procedure.

20 (8) Two non-invasive maternity practices, smok-
21 ing cessation programs in pregnancy and external
22 version to turn breech babies at term, have strong
23 proven correlation with considerable improvement in
24 outcomes with no detrimental side effects, but are
25 significantly underused in the United States. Other

1 non-invasive practices which are underused in cur-
2 rent practice and may be associated with improved
3 outcomes include group model prenatal care, contin-
4 uous labor support, and non-supine positions for
5 birth.

6 (9) The growing shortage of maternity health
7 care professionals and childbirth facilities is creating
8 a serious obstacle to timely and adequate maternity
9 health care for women, particularly in rural areas
10 and the inner cities.

11 (10) There are significant racial and ethnic dis-
12 parities across the maternity care workforce creating
13 additional access barriers to culturally and linguis-
14 tically competent maternity services.

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 care professional associations and organiza-
17 tions, reflecting racially, ethnically, demographically, and
18 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 (including the Medicare program
25 under title XVIII of the Social Security Act and

1 the Medicaid program under title XIX of such
2 Act) designed to promote optimal maternity
3 care, focusing particularly on programs and
4 policies that support the adoption of evidence
5 based maternity care, as defined by timely, sci-
6 entifically sound systematic reviews;

7 “(B) all programs and policies of Federal
8 agencies (including the Medicare program
9 under title XVIII of the Social Security Act and
10 the Medicaid program under title XIX of such
11 Act) designed to address the problems of mater-
12 nal mortality and infant mortality, prematurity,
13 and low birth weight;

14 “(C) the extent of progress in reducing
15 maternal mortality and infant mortality, low
16 birth weight, and prematurity at State and na-
17 tional levels; and

18 “(D) such other information regarding op-
19 timal maternity care as the Secretary deter-
20 mines to be appropriate.

21 The information specified in subparagraph (C) shall
22 be included in each such report in a manner that
23 disaggregates such information by race, ethnicity,
24 and indigenous status in order to determine the ex-

1 tent of progress in reducing racial and ethnic dis-
2 parities and disparities related to indigenous status.

3 “(2) CERTAIN INFORMATION.—Each report
4 under paragraph (1) shall include information
5 (disaggregated by race, ethnicity, and indigenous
6 status, as applicable) on the following rates and
7 costs by State:

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

10 “(B) The rate of vaginal births after cesar-
11 ean.

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

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

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

15 “(F) The rate of planned and unplanned
16 home birth.

17 “(G) The rate of attended births by pro-
18 vider, including by an obstetrician-gynecologist,
19 family practice physician, obstetrician-gyne-
20 cologist physician assistant, certified nurse-mid-
21 wife, certified midwife, and certified profes-
22 sional midwife.

23 “(H) The cost of maternity care
24 disaggregated by place of birth and provider of
25 care, including—

- 1 “(i) uncomplicated vaginal birth;
2 “(ii) complicated vaginal birth;
3 “(iii) uncomplicated cesarean birth;
4 and
5 “(iv) complicated cesarean birth.

6 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated, in addition to such
8 amounts authorized to be appropriated under section
9 229(e), to carry out this section \$1,000,000 for each of
10 the fiscal years 2012 through 2016.”.

11 (b) CONFORMING AMENDMENTS.—

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

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

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

20 (C) by adding at the end the following new
21 paragraph:

22 “(9) establish the Interagency Coordinating
23 Committee on the Promotion of Optimal Maternity
24 Outcomes in accordance with section 229A.”.

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

5 **SEC. 103. CONSUMER EDUCATION CAMPAIGN.**

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

9 (1) in subsection (b)—

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

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

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

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

1 “(A) highlights the importance of pro-
2 tecting, promoting, and supporting the innate
3 capacities of childbearing women and their
4 newborns for childbirth, breast-feeding, and at-
5 tachment;

6 “(B) promotes understanding of the impor-
7 tance of using obstetric interventions when
8 medically necessary and when supported by
9 strong, high-quality evidence;

10 “(C) highlights the widespread overuse of
11 maternity practices that have been shown to
12 have benefit when used appropriately in situa-
13 tions of medical necessity, but which can expose
14 women, infants, or both to risk of harm if used
15 routinely and indiscriminately, including contin-
16 uous fetal monitoring, labor induction, epidural
17 anesthesia, elective primary cesarean section,
18 and repeat cesarean delivery;

19 “(D) emphasizes the non-invasive mater-
20 nity practices that have strong proven correla-
21 tion or may be associated with considerable im-
22 provement in outcomes with no detrimental side
23 effects, and are significantly underused in the
24 United States, including smoking cessation pro-
25 grams in pregnancy, group model prenatal care,

1 continuous labor support, non-supine positions
 2 for birth, and external version to turn breech
 3 babies at term;

4 “(E) educates consumers about the quali-
 5 fications of licensed providers of maternity care
 6 and the best evidence about their safety, satis-
 7 faction, outcomes, and costs;

8 “(F) informs consumers about the best
 9 available research comparing birth center
 10 births, planned home births, and hospital
 11 births, including information about each set-
 12 ting’s safety, satisfaction, outcomes, and costs;

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

15 “(H) is pilot tested for consumer com-
 16 prehension, cultural sensitivity, and acceptance
 17 of the messages across geographically, racially,
 18 ethnically, and linguistically diverse popu-
 19 lations.”.

20 **SEC. 104. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
 21 **VIEWS FOR CARE OF CHILDBEARING WOMEN**
 22 **AND NEWBORNS.**

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

1 (1) make publicly available an online biblio-
2 graphic database identifying systematic reviews, in-
3 cluding an explanation of the level and quality of
4 evidence, for care of childbearing women and
5 newborns; and

6 (2) initiate regular updates that incorporate
7 newly issued and updated systematic reviews.

8 (b) SOURCES.—To aim for a comprehensive inventory
9 of systematic reviews relevant to maternal and newborn
10 care, the database shall identify reviews from diverse
11 sources, including—

12 (1) scientific peer-reviewed journals;

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

16 (3) Internet Web sites of agencies and organi-
17 zations throughout the world that produce such sys-
18 tematic reviews.

19 (c) FEATURES.—The database shall—

20 (1) provide bibliographic citations for each
21 record within the database;

22 (2) include abstracts, as available;

23 (3) provide reference to companion documents
24 as may exist for each review, such as evidence tables

1 and guidelines or consumer educational materials de-
2 veloped from the review;

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

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

7 (6) be searchable by intervention or other topic
8 of the review, reported outcomes, author, title, and
9 source; and

10 (7) offer to users periodic electronic notification
11 of database updates relating to users' topics of inter-
12 est.

13 (d) OUTREACH.—Not later than the first date the
14 database is made publicly available and periodically there-
15 after, the Secretary of Health and Human Services shall
16 publicize the availability, features, and uses of the data-
17 base under this section to the stakeholders described in
18 subsection (e).

19 (e) CONSULTATION.—For purposes of developing the
20 database under this section and maintaining and updating
21 such database, the Secretary of Health and Human Serv-
22 ices shall convene and consult with an advisory committee
23 composed of relevant stakeholders, including—

24 (1) Federal Medicaid administrators and State
25 agencies administering State plans under title XIX

1 of the Social Security Act pursuant to section
2 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

3 (2) providers of maternity and newborn care
4 from both academic and community-based settings,
5 including obstetrician-gynecologists, family physi-
6 cians, midwives, physician assistants, perinatal
7 nurses, pediatricians, and nurse practitioners;

8 (3) maternal-fetal medicine specialists;

9 (4) neonatologists;

10 (5) childbearing women and their advocates
11 representing communities that are diverse in terms
12 of race, ethnicity, indigenous status, and geographic
13 area;

14 (6) employers and purchasers;

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

17 (8) journalists; and

18 (9) bibliographic informatics specialists.

19 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated \$2,500,000 for each of the
21 fiscal years 2012 through 2014 for the purpose of devel-
22 oping the database and such sums as may be necessary
23 for each subsequent fiscal year for updating the database
24 and providing outreach and notification to users, as de-
25 scribed in this section.

1 **TITLE II—RESEARCH AND DATA**
2 **COLLECTION ON MATERNITY**
3 **CARE**

4 **SEC. 201. MATERNITY CARE HEALTH PROFESSIONAL**
5 **SHORTAGE AREAS.**

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

9 “(k)(1) The Secretary, acting through the Adminis-
10 trator of the Health Resources and Services Administra-
11 tion, shall designate maternity care health professional
12 shortage areas in the States, publish a descriptive list of
13 the area’s population groups, medical facilities, and other
14 public facilities so designated, and at least annually review
15 and, as necessary, revise such designations.

16 “(2) For purposes of paragraph (1), a complete de-
17 scriptive list shall be published in the Federal Register not
18 later than July 1 of 2012 and each subsequent year.

19 “(3) The provisions of subsections (b), (c), (e), (f),
20 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
21 shall apply to the designation of a maternity care health
22 professional shortage area in a similar manner and extent
23 as such provisions apply to the designation of health pro-
24 fessional shortage areas, except in applying subsection
25 (b)(3), the reference in such subsection to ‘physicians’

1 shall be deemed to be a reference to ‘physicians, obstetri-
2 cians, family practice physicians who practice full-scope
3 maternity care, certified nurse-midwives, certified mid-
4 wives, and certified professional midwives’.

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

7 “(A) an area in an urban or rural area (which
8 need not conform to the geographic boundaries of a
9 political subdivision and which is a rational area for
10 the delivery of health services) which the Secretary
11 determines has a shortage of providers of maternity
12 care health services, including obstetricians, family
13 practice physicians who practice full-scope maternity
14 care, certified nurse-midwives, certified midwives,
15 and certified professional midwives, and shall also
16 include urban or rural areas that have lost a signifi-
17 cant number of local hospital labor and delivery
18 units;

19 “(B) an area in an urban or rural area (which
20 need not conform to the geographic boundaries of a
21 political subdivision and which is a rational area for
22 the delivery of health services) which the Secretary
23 determines has a shortage of hospital or birth center
24 labor and delivery units, or areas that lost a signifi-

1 cant number of these units in during the 10-year pe-
2 riod beginning with 2000; or

3 “(C) a population group which the Secretary
4 determines has such a shortage of providers or fa-
5 cilities.”.

6 **SEC. 202. EXPANSION OF CDC PREVENTION RESEARCH**
7 **CENTERS PROGRAM TO INCLUDE CENTERS**
8 **ON OPTIMAL MATERNITY OUTCOMES.**

9 (a) IN GENERAL.—Not later than one year after the
10 date of the enactment of this Act, the Secretary of Health
11 and Human Services, shall support the establishment of
12 2 additional Prevention Research Centers under the Pre-
13 vention Research Center Program administered by the
14 Centers for Disease Control and Prevention. Such addi-
15 tional centers shall each be known as a Center for Excel-
16 lence on Optimal Maternity Outcomes.

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

19 (1) conduct at least one focused program of re-
20 search to improve maternity outcomes, including the
21 reduction of cesarean birth rates, elective inductions,
22 prematurity rates, and low birth weight rates within
23 an underserved population that has a disproportion-
24 ately large burden of suboptimal maternity out-

1 comes, including maternal mortality and morbidity,
2 infant mortality, prematurity, or low birth weight;

3 (2) work with partners on special interest
4 projects, as specified by the Centers for Disease
5 Control and Prevention and other relevant agencies
6 within the Department of Health and Human Serv-
7 ices, and on projects funded by other sources; and

8 (3) involve a minimum of two distinct birth set-
9 ting models, such as a hospital labor and delivery
10 model and birth center model; or a hospital labor
11 and delivery model and planned home birth model.

12 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
13 for Excellence on Optimal Maternity Outcomes shall in-
14 clude the following interdisciplinary providers of maternity
15 care:

16 (1) Obstetrician-gynecologists.

17 (2) Certified nurse midwives or certified mid-
18 wives.

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

20 (A) Family practice physicians.

21 (B) Women’s health nurse practitioners.

22 (C) Obstetrician-gynecologists physician
23 assistants.

24 (D) Certified professional midwives.

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

- 5 (1) Mental health.
- 6 (2) Doula labor support.
- 7 (3) Nutrition education.
- 8 (4) Childbirth education.
- 9 (5) Social work.
- 10 (6) Physical therapy or occupation therapy.
- 11 (7) Substance abuse services.
- 12 (8) Home visiting.

13 (e) COORDINATION.—The programs of research at
14 each of the two Centers of Excellence on Optimal Mater-
15 nity Outcomes shall compliment and not replicate the
16 work of the other.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated to carry out this section
19 \$2,000,000 for each of the fiscal years 2012 through
20 2016.

1 **SEC. 203. EXPANDING MODELS TO BE TESTED BY CENTER**
 2 **FOR MEDICARE AND MEDICAID INNOVATION**
 3 **TO INCLUDE MATERNITY CARE MODELS.**

4 Section 1115A(b)(2)(B) of the Social Security Act
 5 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
 6 end the following new clause:

7 “(xxi) Promoting evidence-based
 8 group prenatal care models, doula support,
 9 and out-of-hospital births, including births
 10 at home or a birthing center.”.

11 **TITLE III—ENHANCEMENT OF A**
 12 **GEOGRAPHICALLY, RACIALLY,**
 13 **ETHNICALLY DIVERSE INTERDISCIPLINARY**
 14 **MATERNITY WORKFORCE**

16 **SEC. 301. DEVELOPMENT OF INTERDISCIPLINARY MATERNITY CARE PROVIDER CORE CURRICULA.**

18 (a) IN GENERAL.—Not later than 6 months after the
 19 date of the enactment of this Act, the Secretary of Health
 20 and Human Services, acting in conjunction with the Ad-
 21 ministrator of Health Resources and Services Administra-
 22 tion, shall convene, for a 1-year period, a Maternity Cur-
 23 riculum Commission to discuss and make recommenda-
 24 tions for—

25 (1) a shared core maternity care curriculum
 26 that takes into account the core competencies for

1 basic midwifery practice as developed by the Amer-
2 ican College of Nurse Midwives, and the educational
3 objectives in obstetrics and gynecology as determined
4 by the Council on Resident Education in Obstetrics
5 and Gynecology;

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

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

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

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

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

1 (2) foster physiologic childbearing and patient
2 and family centered care;

3 (3) incorporate strategies to reduce maternal
4 mortality and infant mortality; and

5 (4) include cultural sensitivity and strategies to
6 decrease disparities in maternity outcomes.

7 (d) REPORT.—Not later than 6 months after the final
8 day of the summit, the Secretary of Health and Human
9 Services shall—

10 (1) submit to Congress a report containing the
11 recommendations made by the summit under this
12 section; and

13 (2) make such report publicly available.

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 \$1,000,000 for each of the fiscal years 2012 and 2013,
17 and such sums as are necessary for each of the fiscal years
18 2014 through 2016.

19 **SEC. 302. INTERDISCIPLINARY TRAINING OF MEDICAL STU-**
20 **DENTS, RESIDENTS, AND STUDENT MIDWIVES**
21 **IN ACADEMIC HEALTH CENTERS.**

22 (a) INCLUDING WITHIN INPATIENT HOSPITAL SERV-
23 ICES UNDER MEDICARE SERVICES FURNISHED BY CER-
24 TAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED
25 BY CERTIFIED NURSE MIDWIVES.—Section 1861(b) of

1 the Social Security Act (42 U.S.C. 1395x(b)) is amend-
2 ed—

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

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

15 (3) by adding at the end the following new
16 paragraph:

17 “(8) a certified nurse-midwife where the hos-
18 pital has a teaching program approved as specified
19 in paragraph (6), if (A) the hospital elects to receive
20 any payment due under this title for reasonable
21 costs of such services, and (B) all certified nurse-
22 midwives in such hospital agree not to bill charges
23 for professional services rendered in such hospital to
24 individuals covered under the insurance program es-
25 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 2012, 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 2012 and \$3,000,000 for each
7 of the fiscal years 2013 through 2016.

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