I

111TH CONGRESS
2D 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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

SEC. 2. FINDINGS.

Congress finds the following:

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

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

(A) the World Health Organization identified 29 nations with lower estimated maternal mortality ratios than the United States (14/100,000 live births);

(B) the World Health Organization identified 35 nations with lower early neonatal mortality rates (5/1,000 live births) and 33 with lower neonatal mortality rates (5/1,000 live births) than the United States;

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

(D) 19 member countries (out of 23 reporting) had lower cesarean section rates than the United States.

(2) Despite maternity expenditures in the United States, childbirth continues to carry significant risks for mothers in this country, as demonstrated by the following:

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

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

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

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

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

(B) The proportion of low birth weight babies increased by 22 percent between 1981 and 2006.

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

(4) Maternity Care is a major component of the escalating health care costs in this country, as demonstrated by the following:

(A) Maternity care for mothers and their newborns is the number one reason for hospitalization in the United States, exceeding such prevalent conditions as pneumonia, cancer, fracture, and heart disease. Of those discharged from hospitals in the United States in 2007, 25 percent were childbearing women and newborns.

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

(5) Maternity care also accounts for a significant proportion of expenditures under the Medicaid program, as demonstrated by the following:

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

(B) Six of the 10 most common procedures reimbursed under the Medicaid program were maternity related, making ''mother's pregnancy and delivery'' the most costly Medicaid expenditure.

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

(A) the average charge for a hospital cesarean birth with complications was $15,900, and without complications was $12,500;

(B) the average charge for a hospital vaginal birth with complications was $8,960, and without complications was $6,970; and

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

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

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

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

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

(B) There is widespread overuse of maternity practices that have been shown to have benefit only in limited situations, which can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous fetal monitoring, labor induction, epidural anesthesia, elective primary cesarean section, and repeat cesarean delivery.

(C) There are multiple non-invasive maternity practices that have been associated with considerable improvement in outcomes with no detrimental side effects, and are significantly underused in this country, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor support, non-supine positions for birth, and external version to turn breech babies at term.

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

(10) There are significant racial and ethnic disparities across the maternity care workforce creating additional access barriers to culturally and linguistically competent maternity services.

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

(12) There is a growing shortage of Obstetrician-Gynecologists in the United States who provide maternity services. Data from the 2006 American College of Obstetricians and Gynecologists (ACOG) Survey on Professional Liability showed a negative trend in length of obstetrical practice, with the average age at which physicians stopped practicing obstetrics being 48 years. At one point this was the near midpoint of an Obstetrician-Gynecologist's professional career.

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

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

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

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

(C) In a nationwide comparison of birth center costs to hospital costs, it is estimated that if 100,000 births were attended in birth centers, access to care would be greatly improved, and annual savings would total more than $314,000,000.

(15) Midwives serve as faculty at many of the Nation's most prominent academic health centers, however, the time they spend training medical students, residents, and midwifery students is not reimbursed as it is for physicians. As a result, medical students, residents, and midwifery students often fail to benefit from the practice experience and physiologic birth expertise of midwives.

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

SEC. 101. ADDITIONAL FOCUS AREA FOR THE OFFICE ON WOMEN'S HEALTH.

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

(1) in paragraph (6), at the end, by striking ''and'';

(2) in paragraph (7), at the end, by striking the period and inserting ''; and''; and

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

''(8) facilitate policy makers, health system leaders and providers, consumers, and other stakeholders in their understanding optimal maternity care and support for the provision of such care, including the priorities of—

''(A) protecting, promoting, and supporting the innate capacities of childbearing women and their newborns for childbirth, breast-feeding, and attachment;

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

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

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

''(D) a shared understanding of the qualifications of licensed providers of maternity care and the best evidence about the safety, satisfaction, outcomes, and costs of their care, and appropriate deployment of such caregivers within the maternity care workforce to address the needs of childbearing women and newborns and the growing shortage of maternity caregivers;

''(E) a shared understanding of the results of the best available research comparing hospital, birth center, and planned home births, including information about each setting's safety, satisfaction, outcomes, and costs; and

''(F) informed decisionmaking by childbearing women.''.

SEC. 102. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

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

"SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

"(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Deputy Assistant Secretary for Women's Health under section 229 and in collaboration with the Federal officials specified in subsection (b), shall establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes (referred to in this subsection as the 'ICCPOM').

"(b) OTHER AGENCIES.—The officials specified in this subsection are the Secretary of Labor, the Secretary of Defense, the Secretary of Veterans Affairs, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Agency, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Indian Health Service, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Child Health and Development, the Director of the Agency for Healthcare Research and Quality, the Assistant Secretary for Children and Families, the Deputy Assistant Secretary for Minority Health, the Director of the Office of Personnel Management, and such other Federal officials as

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

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

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

''(e) CONSULTATIONS.—The ICCPOM shall actively seek the input of, and shall consult with, all appropriate and interested stakeholders, including State Health Departments, public health research and interest groups, foundations, childbearing women and their advocates, and maternity focused primary care professional associations and organizations, reflecting racially, ethnically, demographically, and geographically diverse communities.

''(f) ANNUAL REPORT.—

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

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

policies that support the adoption of evidence based maternity care, as defined by timely, scientifically sound systematic reviews;

"(B) all programs and policies of Federal agencies designed to address the problems of maternal mortality and infant mortality, prematurity, and low birth weight;

"(C) the extent of progress in reducing maternal mortality and infant mortality, low birth weight, and prematurity at State and national levels; and

"(D) such other information regarding optimal maternity care as the Secretary determines to be appropriate.

The information specified in subparagraph (C) shall be included in each such report in a manner that disaggregates such information by race, ethnicity, and indigenous status in order to determine the extent of progress in reducing racial and ethnic disparities and disparities related to indigenous status.

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

"(A) The rate of primary cesarean deliveries and repeat cesarean deliveries.

"(B) The rate of vaginal births after cesarean.

"(C) The rate of vaginal breech births.

"(D) The rate of induction of labor.

"(E) The rate of birthing center births.

"(F) The rate of planned and unplanned home birth.

"(G) The rate of attended births by provider, including by an obstetrician-gynecologist, family practice physician, obstetrician-gynecologist physician assistant, certified nurse-midwife, certified midwife, and certified professional midwife.

"(H) The cost of maternity care disaggregated by place of birth and provider of care, including—

"(i) uncomplicated vaginal birth;

"(ii) complicated vaginal birth;

"(iii) uncomplicated cesarean birth; and

"(iv) complicated cesarean birth.

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

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

(b) CONFORMING AMENDMENTS.—

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

(A) in paragraph (7), at the end, by striking ''and'';

(B) in paragraph (8), at the end, by striking the period and inserting ''; and''; and

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

''(9) establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes in accordance with section 229A.''.

(2) TREATMENT OF BIENNIAL REPORTS.—Section 229(d) of such Act (42 U.S.C. 237a(d)) is amended by inserting ''(other than under subsection (b)(9))'' after ''under this section''.

SEC. 103. CONSUMER EDUCATION CAMPAIGN.

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

(1) in subsection (b)—

(A) in paragraph (8), at the end, by striking ''and'';

(B) in paragraph (9), at the end, by striking the period and inserting ''; and''; and

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

''(10) not later than one year after the date of the enactment of the MOMS for the 21st Century Act, develop and implement a 4-year culturally and linguistically appropriate multi-media consumer education campaign to promote understanding and acceptance of evidence based maternity practices and models of care for optimal maternity outcomes among women of childbearing ages and families of such women and that—

''(A) highlights the importance of protecting, promoting, and supporting the innate capacities of childbearing women and their newborns for childbirth, breast-feeding, and attachment;

''(B) promotes understanding of the importance of using obstetric interventions only when supported by strong, high-quality evidence;

"(C) highlights the widespread overuse of maternity practices that have been shown to have benefit only in limited situations, and which can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous fetal monitoring, labor induction, epidural anesthesia, elective primary cesarean section, and repeat cesarean delivery;

"(D) emphasizes the multiple non-invasive maternity practices that have been associated with considerable improvement in outcomes with no detrimental side effects, and are significantly underused in the United States, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor support, non-supine positions for birth, and external version to turn breech babies at term;

"(E) educates consumers about the qualifications of licensed providers of maternity care and the best evidence about their safety, satisfaction, outcomes, and costs;

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

including information about each setting's safety, satisfaction, outcomes, and costs;

"(G) fosters involvement in informed decisionmaking among childbirth consumers; and

"(H) is pilot tested for consumer comprehension, cultural sensitivity, and acceptance of the messages across geographically, racially, ethnically, and linguistically diverse populations.".

SEC. 104. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC REVIEWS FOR CARE OF CHILDBEARING WOMEN AND NEWBORNS.

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

(1) make publicly available an online bibliographic database identifying systematic reviews for care of childbearing women and newborns; and

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

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

(1) scientific journals;

(2) databases, including Cochrane Database of Systematic Reviews, Clinical Evidence, and Database of Abstracts of Reviews of Effects; and

(3) Internet Web sites of agencies and organizations throughout the world that produce such systematic reviews.

(c) FEATURES.—The database shall—

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

(2) include abstracts, as available;

(3) provide reference to companion documents as may exist for each review, such as evidence tables and guidelines or consumer educational materials developed from the review;

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

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

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

(7) offer to users periodic electronic notification of database updates relating to users' topics of interest.

(d) OUTREACH.—Not later than the first date the database is made publicly available and periodically thereafter, the Secretary of Health and Human Services shall publicize the availability, features, and uses of the database under this section to the stakeholders described in subsection (e).

(e) CONSULTATION.—For purposes of developing the database under this section and maintaining and updating such database, the Secretary of Health and Human Services shall convene and consult with an advisory committee composed of relevant stakeholders, including—

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

(2) providers of maternity and newborn care from both academic and community-based settings, including obstetrician-gynecologists, family physicians, midwives, physician assistants, perinatal nurses, pediatricians, and nurse practitioners;

(3) maternal-fetal medicine specialists;

(4) neonatologists;

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

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

(6) employers and purchasers;

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

(8) journalists; and

(9) bibliographic informatics specialists.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,500,000 for each of the fiscal years 2011 through 2013 for the purpose of developing the database and such sums as may be necessary for each subsequent fiscal year for updating the database and providing outreach and notification to users, as described in this section.

TITLE II—RESEARCH AND DATA COLLECTION ON MATERNITY CARE

SEC. 201. MATERNITY CARE HEALTH PROFESSIONAL SHORTAGE AREAS.

Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following new subsection:

''(k)(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall designate maternity care health professional

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

''(2) For purposes of paragraph (1), a complete descriptive list shall be published in the Federal Register not later than July 1 of 2011 and each subsequent year.

''(3) The provisions of subsections (b), (c), (e), (f), (g), (h), (i), and (j) (other than (j)(1)(B)) of this section shall apply to the designation of a maternity care health professional shortage area in a similar manner and extent as such provisions apply to the designation of health professional shortage areas, except in applying subsection (b)(3), the reference in such subsection to 'physicians' shall be deemed to be a reference to 'physicians, obstetricians, family practice physicians who practice full-scope maternity care, certified nurse-midwives, certified midwives, and certified professional midwives'.

''(4) For purposes of this subsection, the term 'maternity care health professional shortage area' means—

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

care health services, including obstetricians, family practice physicians who practice full-scope maternity care, certified nurse-midwives, certified midwives, and certified professional midwives, and shall also include urban or rural areas that have lost a significant number of local hospital labor and delivery units;

''(B) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a shortage of hospital or birth center labor and delivery units, or areas that lost a significant number of these units in during the 10-year period beginning with 2000; or

''(C) a population group which the Secretary determines has such a shortage of providers or facilities.''.

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

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

vention Research Center Program administered by the Centers for Disease Control and Prevention. Such additional centers shall each be known as a Center for Excellence on Optimal Maternity Outcomes.

(b) RESEARCH.—Each Center for Excellence on Optimal Maternity Outcomes shall—

(1) conduct at least one focused program of research to improve maternity outcomes, including the reduction of cesarean birth rates, prematurity rates, and low birth weight rates within an underserved population that has a disproportionately large burden of suboptimal maternity outcomes, including maternal mortality and morbidity, cesarean section rates, infant mortality, prematurity, or low birth weight;

(2) work with partners on special interest projects, as specified by the Centers for Disease Control and Prevention and other relevant agencies within the Department of Health and Human Services, and on projects funded by other sources; and

(3) involve a minimum of two distinct birth setting models, such as a hospital labor and delivery model and birth center model; or a hospital labor and delivery model and planned home birth model.

(c) INTERDISCIPLINARY PROVIDERS.—Each Center for Excellence on Optimal Maternity Outcomes shall include the following interdisciplinary providers of maternity care:

(1) Obstetrician-gynecologists.

(2) Certified nurse midwives or certified midwives.

(3) At least two of the following providers:

(A) Family practice physicians.

(B) Women's health nurse practitioners.

(C) Obstetrician-gynecologists physician assistants.

(D) Certified professional midwives.

(d) SERVICES.—Research conducted by each Center for Excellence on Optimal Maternity Outcomes shall include at least 2 (and preferably more) of the following supportive provider services:

(1) Mental health.

(2) Doula labor support.

(3) Nutrition education.

(4) Childbirth education.

(5) Social work.

(6) Physical therapy or occupation therapy.

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

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

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

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

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

''(xxi) Promoting evidence-based group prenatal care models, doula support, and out-of-hospital births, including births at home or a birthing center.''.

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

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

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

and Human Services, acting in conjunction with the Administrator of Health Resources and Services Administration, shall convene, for a 1-year period, a Maternity Curriculum Commission to discuss and make recommendations for—

(1) a shared core maternity care curriculum;

(2) strategies to integrate and coordinate education across maternity care disciplines, including suggestions for multi-disciplinary use of the shared core curriculum; and

(3) pilot demonstrations of interdisciplinary educational models.

(b) PARTICIPANTS.—The Commission shall include maternity care educators, curriculum developers, service leaders, certification leaders, and accreditation leaders from the various professions that provide maternity care in this country. Such professions shall include obstetrician-gynecologists, certified nurse midwives, certified midwives, family practice physicians, women's health nurse practitioners, obstetrician-gynecologists physician assistants, certified professional midwives, and perinatal nurses.

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

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

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

(3) include cultural sensitivity and strategies to decrease disparities in maternity outcomes.

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

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

(2) make such report publicly available.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of the fiscal years 2011 and 2012, and such sums as are necessary for each of the fiscal years 2013 through 2015.

SEC. 302. INTERDISCIPLINARY TRAINING OF MEDICAL STUDENTS, RESIDENTS, AND STUDENT MIDWIVES IN ACADEMIC HEALTH CENTERS.

(a) INCLUDING WITHIN INPATIENT HOSPITAL SERVICES UNDER MEDICARE SERVICES FURNISHED BY CERTAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED BY CERTIFIED NURSE MIDWIVES.—Section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (6), by striking ''; or'' and inserting '', or in the case of services in a hospital or osteopathic hospital by a student midwife or an intern or resident-in-training under a teaching program previously described in this paragraph who is in the field of obstetrics and gynecology, if such student midwife, intern, or resident-in-training is supervised by a certified nurse-midwife to the extent permitted under applicable State law and as may be authorized by the hospital;'';

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

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

''(8) a certified nurse-midwife where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all certified nurse-midwives in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.''.

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

SEC. 303. LOAN REPAYMENTS FOR MATERNAL CARE PROFESSIONALS.

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

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

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

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

(B) in an area that is either a health professional shortage area (as designated under section 332 of the Public Health Service Act) or a maternity care health professional shortage area (as designated under subsection (k) of such section, as added by section 201 of this Act); and

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

(c) SERVICE REQUIREMENT.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, a freestanding birth center, or any other appropriate health care entity.

(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D of title III of the Public Health Service Act shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

(e) DEFINITION.—In this section, the term ''eligible individual'' means—

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

(2) a certified nurse-midwife or certified midwife;

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

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

SEC. 304. GRANTS TO PROFESSIONAL ORGANIZATIONS TO INCREASE DIVERSITY IN MATERNITY CARE PROFESSIONALS.

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

(1) for fiscal year 2011, planning grants described in subsection (b); and

(2) for the subsequent 4-year period, implementation grants described in subsection (c).

(b) PLANNING GRANTS.—

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

(A) To collect data and identify any workforce disparities, with respect to a health profession, at each of the following areas along the health professional continuum:

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

(ii) Entrance into the training program for the profession.

(iii) Graduation from such training program.

(iv) Entrance into practice.

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

(B) To develop one or more strategies to address the workforce disparities within the health profession, as identified under (and in response to the findings pursuant to) subparagraph (A).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health professional organization shall submit to the Secretary of Health and Human Services an application in such form and manner and containing such information as specified by the Secretary.

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

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

(A) information on the extent and distribution of workforce disparities identified through the grant; and

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

(c) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—Implementation grants described in this subsection are grants to implement one or more of the strategies developed pursuant to a planning grant awarded under subsection (b).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health professional organization shall submit to the Secretary of Health and Human Services an application in such form and manner as specified by the Secretary. Each such application shall contain information on the capability of the organization to carry out a strategy described in paragraph (1), involvement of partners or coalitions, plans for developing sustainability of the efforts after the culmination of the

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

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

(4) REPORTS.—For each of the first 3 years for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary of Health and Human Services a report on the activities carried out by such organization through the grant during such year and objectives for the subsequent year. For the fourth year for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary a report that includes an analysis of all the activities carried out by the organization through the grant and a detailed plan for continuation of outreach efforts.

(d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZATION DEFINED.—For purposes of this section, the term ''eligible health professional organization'' means a professional organization representing obstetrician-gynecologists, certified nurse midwives, certified midwives,

family practice physicians, women's health nurse practitioners, obstetrician-gynecologist physician assistants, or certified professional midwives.

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

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