

113TH CONGRESS
1ST SESSION

H. R. 2286

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 6, 2013

Ms. ROYBAL-ALLARD (for herself, Mrs. CAPPS, Mrs. CHRISTENSEN, Ms. LEE of California, Ms. MCCOLLUM, Ms. PINGREE of Maine, and Mr. RANGEL) 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”.

1 (b) TABLE OF CONTENTS.—The table of contents for
 2 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. 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 INTERPROFESSIONAL MATERNITY
 WORKFORCE

Sec. 301. Development of interprofessional maternity care educational models
 and tools.
 Sec. 302. Interprofessional training of medical students, residents, and student
 midwives in academic health centers and freestanding birth
 centers.
 Sec. 303. Grants to professional organizations to increase diversity in maternity
 care professionals.

3 **SEC. 2. FINDINGS.**

4 Congress finds the following:

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

9 (A) More than two women die every day in
 10 the United States from pregnancy-related
 11 causes and the maternal mortality rate in the

1 United States has roughly doubled in the past
2 25 years. According to data released in 2010,
3 the maternal mortality ratio was 12.7 percent
4 as compared to 6.6 percent in 1987.

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

10 (C) Severe complications that result in
11 women nearly dying, known as a “near miss”
12 or severe morbidity, increased by 25 percent be-
13 tween 1998 and 2005, to approximately 34,000
14 cases a year.

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

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

1 (A) Despite five years of modest reduction
2 in pre-term births between 2006 and 2011, the
3 United States continues to lag behind most
4 other countries in pre-term birth rates, ranking
5 131 out of 184 countries, according to a 2011
6 report by the March of Dimes and the World
7 Health Organization.

8 (B) The proportion of low birth weight ba-
9 bies increased by 21 percent between 1981 and
10 2008.

11 (C) Non-Hispanic Black infants continue
12 to experience significantly higher rates of both
13 pre-term birth and low birthweight, two of the
14 leading causes of infant mortality in this coun-
15 try.

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

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

1 (B) In the World Health Report 2005, the
2 World Health Organization identified 35 na-
3 tions with lower early neonatal mortality rates
4 (4/1,000 live births) and 33 with lower neonatal
5 mortality rates (5/1,000 live births) than the
6 United States.

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

12 (D) 21 OECD countries (out of 27 report-
13 ing) had lower cesarean section rates than the
14 United States.

15 (4) Maternity care is a major component of the
16 escalating health care costs in the United States, as
17 demonstrated by the following:

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

1 the United States in 2009, nearly one in four
2 were childbearing women and newborns.

3 (B) Combined mother and baby charges
4 for hospitalization, which was \$98,000,000,000
5 in 2008, far exceeded charges for any other
6 hospital condition in the United States.

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

11 (A) In 2008, 26 percent of all hospital
12 charges for which payment was made under the
13 Medicaid program (totaling \$41,000,000,000)
14 was for birthing women and newborns.

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

22 (C) The two most costly conditions for
23 which payment was made under the Medicaid
24 program in 2008 were “mother’s pregnancy and
25 delivery” and care for “newborn infants”, which

1 together accounted for 26 percent of all Med-
2 icaid expenditures.

3 (6) Maternity care facility charges vary signifi-
4 cantly by setting and type of birth. Part of the
5 charge differentials between facilities are attrib-
6 utable to high overhead of hospitals—

7 (A) in 2008, the average charge for a hos-
8 pital cesarean birth with complications was
9 \$20,080, and without complications was
10 \$14,900;

11 (B) in 2008, the average charge for a hos-
12 pital vaginal birth with complications was
13 \$11,410, and without complications was
14 \$8,920; and

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

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

24 (8) Two non-invasive maternity practices, smok-
25 ing cessation programs during pregnancy and exter-

1 nal version to turn breech babies at term, have
2 strong proven correlation with considerable improve-
3 ment in outcomes with no detrimental side effects,
4 but are significantly underused in the United States.

5 (9) There is a growing body of evidence that
6 other non-invasive practices which are underused in
7 current practice may also be associated with im-
8 proved outcomes. These non-invasive practices in-
9 clude group model prenatal care (such as the
10 CenteringPregnancy model), continuous labor sup-
11 port, and non-supine positions for birth.

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

17 (11) There are significant racial and ethnic dis-
18 parities across the maternity care workforce creating
19 additional access barriers to culturally and linguis-
20 tically competent maternity services.

1 **TITLE I—HHS FOCUS ON THE**
2 **PROMOTION OF OPTIMAL MA-**
3 **TERNITY CARE**

4 **SEC. 101. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
5 **WOMEN’S HEALTH.**

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

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

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

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

14 “(8) facilitate policy makers, health system
15 leaders and providers, consumers, and other stake-
16 holders in their understanding optimal maternity
17 care and support for the provision of such care, in-
18 cluding the priorities of—

19 “(A) protecting, promoting, and supporting
20 the innate capacities of childbearing women and
21 their newborns for childbirth, breast-feeding,
22 and attachment;

23 “(B) using obstetric interventions only
24 when such interventions are supported by
25 strong, high-quality evidence, and minimizing

1 overuse of maternity practices that have been
2 shown to have benefit in limited situations and
3 that can expose women, infants, or both to risk
4 of harm if used routinely and indiscriminately,
5 including continuous electronic fetal monitoring,
6 labor induction, epidural analgesia, primary ce-
7 sarean section, and routine repeat cesarean
8 birth;

9 “(C) reliably incorporating non-invasive,
10 evidence-based practices that have documented
11 correlation with considerable improvement in
12 outcomes with no detrimental side effects, such
13 as smoking cessation programs in pregnancy
14 and proven models of group prenatal care that
15 integrate health assessment, education, and
16 support into a unified program;

17 “(D) a shared understanding of the quali-
18 fications of licensed providers of maternity care
19 and the best evidence about the safety, satisfac-
20 tion, outcomes, and costs of their care, and ap-
21 propriate deployment of such caregivers within
22 the maternity care workforce to address the
23 needs of childbearing women and newborns and
24 the growing shortage of maternity caregivers;

1 “(E) a shared understanding of the results
 2 of the best available research comparing hos-
 3 pital, birth center, and planned home births, in-
 4 cluding information about each setting’s safety,
 5 satisfaction, outcomes, and costs; and

6 “(F) high-quality, evidence-based child-
 7 birth education that promotes a natural,
 8 healthy, and safe approach to pregnancy, child-
 9 birth, and early parenting; is taught by certified
 10 educators, peer counselors, and health profes-
 11 sionals; and promotes informed decisionmaking
 12 by childbearing women.”.

13 **SEC. 102. INTERAGENCY COORDINATING COMMITTEE ON**
 14 **THE PROMOTION OF OPTIMAL MATERNITY**
 15 **OUTCOMES.**

16 (a) IN GENERAL.—Part A of title II of the Public
 17 Health Service Act (42 U.S.C. 202 et seq.) is amended
 18 by adding at the end the following new section:

19 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
 20 **THE PROMOTION OF OPTIMAL MATERNITY**
 21 **OUTCOMES.**

22 “(a) IN GENERAL.—The Secretary of Health and
 23 Human Services, acting through the Deputy Assistant
 24 Secretary for Women’s Health under section 229 and in
 25 collaboration with the Federal officials specified in sub-

1 section (b), shall establish the Interagency Coordinating
2 Committee on the Promotion of Optimal Maternity Out-
3 comes (referred to in this subsection as the ‘ICCPOM’).

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

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

23 “(d) DUTIES.—The ICCPOM shall guide policy and
24 program development across the Federal Government with
25 respect to promotion of optimal maternity care, provided,

1 however, that nothing in this section shall be construed
2 as transferring regulatory or program authority from an
3 Agency to the Coordinating Committee.

4 “(e) CONSULTATIONS.—The ICCPOM shall actively
5 seek the input of, and shall consult with, all appropriate
6 and interested stakeholders, including State Health De-
7 partments, public health research and interest groups,
8 foundations, childbearing women and their advocates, and
9 maternity care professional associations and organiza-
10 tions, reflecting racially, ethnically, demographically, and
11 geographically diverse communities.

12 “(f) ANNUAL REPORT.—

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

16 “(A) all programs and policies of Federal
17 agencies (including the Medicare program
18 under title XVIII of the Social Security Act and
19 the Medicaid program under title XIX of such
20 Act) designed to promote optimal maternity
21 care, focusing particularly on programs and
22 policies that support the adoption of evidence
23 based maternity care, as defined by timely, sci-
24 entifically sound systematic reviews;

1 “(B) all programs and policies of Federal
2 agencies (including the Medicare program
3 under title XVIII of the Social Security Act and
4 the Medicaid program under title XIX of such
5 Act) designed to address the problems of mater-
6 nal mortality and morbidity, infant mortality,
7 prematurity, and low birth weight, including
8 such programs and policies designed to address
9 racial and ethnic disparities with respect to
10 each of such problems;

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

15 “(D) such other information regarding op-
16 timal maternity care as the Secretary deter-
17 mines to be appropriate.

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

24 “(2) CERTAIN INFORMATION.—Each report
25 under paragraph (1) shall include information

1 (disaggregated by race, ethnicity, and indigenous
2 status, as applicable) on the following rates and
3 costs by State:

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

6 “(B) The rate of vaginal births after cesar-
7 ean.

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

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

10 “(E) The rate of freestanding birth center
11 births.

12 “(F) The rate of planned and unplanned
13 home birth.

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

20 “(H) The cost of maternity care
21 disaggregated by place of birth and provider of
22 care, including—

23 “(i) uncomplicated vaginal birth;

24 “(ii) complicated vaginal birth;

1 “(iii) uncomplicated cesarean birth;

2 and

3 “(iv) complicated cesarean birth.

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated, in addition to such
6 amounts authorized to be appropriated under section
7 229(e), to carry out this section \$1,000,000 for each of
8 the fiscal years 2014 through 2018.”.

9 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

23 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
24 tion 229(d) of such Act (42 U.S.C. 237a(d)) is

1 amended by inserting “(other than under subsection
2 (b)(9))” after “under this section”.

3 **SEC. 103. CONSUMER EDUCATION CAMPAIGN.**

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

7 (1) in subsection (b)—

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

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

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

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

23 “(A) highlights the importance of pro-
24 tecting, promoting, and supporting the innate
25 capacities of childbearing women and their

1 newborns for childbirth, breast-feeding, and at-
2 tachment;

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

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

16 “(D) emphasizes the non-invasive mater-
17 nity practices that have strong proven correla-
18 tion or may be associated with considerable im-
19 provement in outcomes with no detrimental side
20 effects, and are significantly underused in the
21 United States, including smoking cessation pro-
22 grams in pregnancy, group model prenatal care,
23 continuous labor support, non-supine positions
24 for birth, and external version to turn breech
25 babies at term;

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

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

10 “(G) fosters participation in high-quality,
11 evidence-based childbirth education that pro-
12 motes a natural, healthy, and safe approach to
13 pregnancy, childbirth, and early parenting; is
14 taught by certified educators, peer counselors,
15 and health professionals; and promotes in-
16 formed decisionmaking by childbearing women;
17 and

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

1 **SEC. 104. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
2 **VIEWS FOR CARE OF CHILDBEARING WOMEN**
3 **AND NEWBORNS.**

4 (a) IN GENERAL.—Not later than one year after the
5 date of the enactment of this Act, the Secretary of Health
6 and Human Services, through the Agency for Healthcare
7 Research and Quality, shall—

8 (1) make publicly available an online biblio-
9 graphic database identifying systematic reviews, in-
10 cluding an explanation of the level and quality of
11 evidence, for care of childbearing women and
12 newborns; and

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

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

19 (1) scientific peer-reviewed journals;

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

23 (3) Internet Web sites of agencies and organi-
24 zations throughout the world that produce such sys-
25 tematic reviews.

26 (c) FEATURES.—The database shall—

1 (1) provide bibliographic citations for each
2 record within the database, and for each such cita-
3 tion include an explanation of the level and quality
4 of evidence;

5 (2) include abstracts, as available;

6 (3) provide reference to companion documents
7 as may exist for each review, such as evidence tables
8 and guidelines or consumer educational materials de-
9 veloped from the review;

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

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

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

17 (7) offer to users periodic electronic notification
18 of database updates relating to users' topics of inter-
19 est.

20 (d) OUTREACH.—Not later than the first date the
21 database is made publicly available and periodically there-
22 after, the Secretary of Health and Human Services shall
23 publicize the availability, features, and uses of the data-
24 base under this section to the stakeholders described in
25 subsection (e).

1 (e) CONSULTATION.—For purposes of developing the
2 database under this section and maintaining and updating
3 such database, the Secretary of Health and Human Serv-
4 ices shall convene and consult with an advisory committee
5 composed of relevant stakeholders, including—

6 (1) Federal Medicaid administrators and State
7 agencies administering State plans under title XIX
8 of the Social Security Act pursuant to section
9 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

10 (2) providers of maternity and newborn care
11 from both academic and community-based settings,
12 including obstetrician-gynecologists, family physi-
13 cians, certified nurse midwives, certified midwives,
14 certified professional midwives, physician assistants,
15 perinatal nurses, pediatricians, and nurse practi-
16 tioners;

17 (3) maternal-fetal medicine specialists;

18 (4) neonatologists;

19 (5) childbearing women and advocates for such
20 women, including childbirth educators certified by a
21 nationally accredited program, representing commu-
22 nities that are diverse in terms of race, ethnicity, in-
23 digenous status, and geographic area;

24 (6) employers and purchasers;

- 1 (7) health facility and system leaders, including
- 2 both hospital and birth center facilities;
- 3 (8) journalists; and
- 4 (9) bibliographic informatics specialists.

5 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
 6 authorized to be appropriated \$2,500,000 for each of the
 7 fiscal years 2014 through 2016 for the purpose of devel-
 8 oping the database and such sums as may be necessary
 9 for each subsequent fiscal year for updating the database
 10 and providing outreach and notification to users, as de-
 11 scribed in this section.

12 **TITLE II—RESEARCH AND DATA** 13 **COLLECTION ON MATERNITY** 14 **CARE**

15 **SEC. 201. MATERNITY CARE HEALTH PROFESSIONAL** 16 **SHORTAGE AREAS.**

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

20 “(k)(1) The Secretary, acting through the Adminis-
 21 trator of the Health Resources and Services Administra-
 22 tion, shall designate maternity care health professional
 23 shortage areas in the States, publish a descriptive list of
 24 the area’s population groups, medical facilities, and other

1 public facilities so designated, and at least annually review
2 and, as necessary, revise such designations.

3 “(2) For purposes of paragraph (1), a complete de-
4 scriptive list shall be published in the Federal Register not
5 later than one year after the date of the enactment of the
6 MOMS for the 21st Century Act and annually thereafter.

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

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

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

1 determines has a shortage of providers of maternity
 2 care health services including those referenced in
 3 paragraph (3) or an urban or rural area that the
 4 Secretary determines has lost a significant number
 5 of such providers during the 10-year period begin-
 6 ning with 2004 or has no obstetrical providers li-
 7 censed to provide operative obstetrical services;

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 labor and
 13 delivery units, hospital birth center units, or free-
 14 standing birth centers or an area that lost a signifi-
 15 cant number of these units during the 10-year pe-
 16 riod beginning with 2003; or

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

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

23 (a) IN GENERAL.—Not later than one year after the
 24 date of the enactment of this Act, the Secretary of Health
 25 and Human Services, shall support the establishment of

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

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

8 (1) conduct at least one focused program of re-
9 search to improve maternity outcomes, including the
10 reduction of cesarean birth rates, elective inductions,
11 prematurity rates, and low birth weight rates within
12 an underserved population that has a disproportion-
13 ately large burden of suboptimal maternity out-
14 comes, including maternal mortality and morbidity,
15 infant mortality, prematurity, or low birth 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 freestanding birth center model; or a hos-
24 pital labor and delivery model and planned home
25 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) Nurse practitioners.

11 (C) Physician assistants.

12 (D) Certified professional midwives.

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

17 (1) Mental health.

18 (2) Doula labor support.

19 (3) Nutrition education.

20 (4) Childbirth education.

21 (5) Social work.

22 (6) Physical therapy or occupation therapy.

23 (7) Substance abuse services.

24 (8) Home visiting.

1 (e) COORDINATION.—The programs of research at
2 each of the two Centers of Excellence on Optimal Mater-
3 nity Outcomes shall compliment and not replicate the
4 work of the other.

5 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 \$2,000,000 for each of the fiscal years 2014 through
8 2018.

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

12 Section 1115A(b)(2)(B) of the Social Security Act
13 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
14 end the following new clause:

15 “(xxi) Promoting evidence-based mod-
16 els of prenatal care that have been associ-
17 ated with reductions in maternal and in-
18 fant health disparities; incorporating the
19 use of doula and promotoras support; and
20 advancing out-of-hospital births, including
21 births at home and in freestanding birth
22 centers.”.

1 **TITLE III—ENHANCEMENT OF A**
2 **GEOGRAPHICALLY, RA-**
3 **CIALLY, AND ETHNICALLY DI-**
4 **VERSE INTERPROFESSIONAL**
5 **MATERNITY WORKFORCE**

6 **SEC. 301. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
7 **NITY CARE EDUCATIONAL MODELS AND**
8 **TOOLS.**

9 (a) IN GENERAL.—Not later than 6 months after the
10 date of the enactment of this Act, the Secretary of Health
11 and Human Services, acting in conjunction with the Ad-
12 ministrator of Health Resources and Services Administra-
13 tion, shall convene, for a 1-year period, an Interprofes-
14 sional Maternity Provider Education Commission to dis-
15 cuss and make recommendations for—

16 (1) a consensus standard physiologic maternity
17 care curriculum that takes into account the core
18 competencies for basic midwifery practice such as
19 those developed by the American College of Nurse
20 Midwives and the North American Registry of Mid-
21 wives, and the educational objectives for physicians
22 practicing in obstetrics and gynecology as deter-
23 mined by the Council on Resident Education in Ob-
24 stetrics and Gynecology;

1 (2) suggestions for multi-disciplinary use of the
2 consensus physiologic curriculum;

3 (3) strategies to integrate and coordinate edu-
4 cation across maternity care disciplines, including
5 recommendations to increase medical and midwifery
6 student exposure to out-of-hospital birth; and

7 (4) pilot demonstrations of interprofessional
8 educational models.

9 (b) PARTICIPANTS.—The Commission shall include
10 maternity care educators, curriculum developers, service
11 leaders, certification leaders, and accreditation leaders
12 from the various professions that provide maternity care
13 in this country. Such professions shall include obstetri-
14 cian-gynecologists, certified nurse midwives or certified
15 midwives, family practice physicians, nurse practitioners,
16 physician assistants, certified professional midwives, and
17 perinatal nurses. Additionally, the Commission shall in-
18 clude representation from maternity care consumer advo-
19 cates.

20 (c) CURRICULUM.—The consensus standard physio-
21 logic maternity care curriculum described in subsection
22 (a)(1) shall—

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

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

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

5 (4) incorporate recommendations to ensure re-
6 spectful, safe, and seamless consultation, referral,
7 transport, and transfer of care when necessary; and

8 (5) include cultural sensitivity and strategies to
9 decrease disparities in maternity outcomes.

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

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

16 (2) make such report publicly available.

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated to carry out this section
19 \$1,000,000 for each of the fiscal years 2014 and 2015,
20 and such sums as are necessary for each of the fiscal years
21 2016 through 2018.

1 **SEC. 302. INTERPROFESSIONAL TRAINING OF MEDICAL**
2 **STUDENTS, RESIDENTS, AND STUDENT MID-**
3 **WIVES IN ACADEMIC HEALTH CENTERS AND**
4 **FREESTANDING BIRTH CENTERS.**

5 (a) INCLUDING WITHIN INPATIENT HOSPITAL SERV-
6 ICES UNDER MEDICARE SERVICES FURNISHED BY CER-
7 TAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED
8 BY CERTIFIED NURSE MIDWIVES.—Section 1861(b) of
9 the Social Security Act (42 U.S.C. 1395x(b)) is amend-
10 ed—

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

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

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

25 “(8) a certified nurse-midwife where the hos-
26 pital has a teaching program approved as specified

1 in paragraph (6), if (A) the hospital elects to receive
 2 any payment due under this title for reasonable
 3 costs of such services, and (B) all certified nurse-
 4 midwives in such hospital agree not to bill charges
 5 for professional services rendered in such hospital to
 6 individuals covered under the insurance program es-
 7 tablished by this title.”.

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

11 **SEC. 303. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
 12 **INCREASE DIVERSITY IN MATERNITY CARE**
 13 **PROFESSIONALS.**

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

19 (1) for fiscal year 2014, planning grants de-
 20 scribed in subsection (b); and

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

23 (b) PLANNING GRANTS.—

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

1 (A) To collect data and identify any work-
2 force disparities, with respect to a health pro-
3 fession, at each of the following areas along the
4 health professional continuum:

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

9 (ii) Entrance into the training pro-
10 gram for the profession.

11 (iii) Graduation from such training
12 program.

13 (iv) Entrance into practice.

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

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

21 (2) APPLICATION.—To be eligible to receive a
22 grant under this subsection, an eligible health pro-
23 fessional organization shall submit to the Secretary
24 of Health and Human Services an application in

1 such form and manner and containing such informa-
2 tion as specified by the Secretary.

3 (3) AMOUNT.—Each grant awarded under this
4 subsection shall be for an amount not to exceed
5 \$300,000.

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

9 (A) information on the extent and distribu-
10 tion of workforce disparities identified through
11 the grant; and

12 (B) reasonable objectives and strategies
13 developed to address such disparities within a
14 5-, 10-, and 25-year period.

15 (c) IMPLEMENTATION GRANTS.—

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

20 (2) APPLICATION.—To be eligible to receive a
21 grant under this subsection, an eligible health pro-
22 fessional organization shall submit to the Secretary
23 of Health and Human Services an application in
24 such form and manner as specified by the Secretary.
25 Each such application shall contain information on

1 the capability of the organization to carry out a
2 strategy described in paragraph (1), involvement of
3 partners or coalitions, plans for developing sustain-
4 ability of the efforts after the culmination of the
5 grant cycle, and any other information specified by
6 the Secretary.

7 (3) AMOUNT.—Each grant awarded under this
8 subsection shall be for an amount not to exceed
9 \$500,000 each year during the 4-year period of the
10 grant.

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

1 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
2 TION DEFINED.—For purposes of this section, the term
3 “eligible health professional organization” means a profes-
4 sional organization representing obstetrician-gyne-
5 cologists, certified nurse midwives, certified midwives,
6 family practice physicians, nurse practitioners whose scope
7 of practice includes maternity care, physician assistants
8 whose scope of practice includes obstetrical care, or cer-
9 tified professional midwives.

10 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
11 authorized to be appropriated to carry out this section
12 \$2,000,000 for fiscal year 2014 and \$3,000,000 for each
13 of the fiscal years 2015 through 2018.

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