

the gentlewoman from Michigan (Mrs. DINGELL) that the House suspend the rules and pass the bill, H.R. 2271, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MATERNAL HEALTH QUALITY IMPROVEMENT ACT OF 2020

Mrs. DINGELL. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4995) to amend the Public Health Service Act to improve obstetric care and maternal health outcomes, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4995

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Maternal Health Quality Improvement Act of 2020”.

SEC. 2. INNOVATION FOR MATERNAL HEALTH.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended—

(1) in the section designation of section 330M of such Act (42 U.S.C. 254c–19) by inserting a period after “330M”; and

(2) by inserting after section 330M of such Act (42 U.S.C. 254c–19) the following:

“SEC. 330N. INNOVATION FOR MATERNAL HEALTH.

“(a) IN GENERAL.—The Secretary, in consultation with experts representing a variety of clinical specialties, State, Tribal, or local public health officials, researchers, epidemiologists, statisticians, and community organizations, shall establish or continue a program to award competitive grants to eligible entities for the purposes of—

“(1) identifying, developing, or disseminating best practices to improve maternal health care quality and outcomes, eliminate preventable maternal mortality and severe maternal morbidity, and improve infant health outcomes, which may include—

“(A) information on evidence-based practices to improve the quality and safety of maternal health care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

“(B) best practices for improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care; and

“(C) information on addressing determinants of health that impact maternal health outcomes for women before, during, and after pregnancy;

“(2) collaborating with State maternal mortality review committees to identify issues for the development and implementation of evidence-based practices to improve maternal health outcomes and reduce preventable maternal mortality and severe maternal morbidity;

“(3) providing technical assistance and supporting the implementation of best practices identified pursuant to paragraph (1) to entities providing health care services to pregnant and postpartum women; and

“(4) identifying, developing, and evaluating new models of care that improve maternal and infant health outcomes, which may include the integration of community-based services and clinical care.

“(b) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (a), an entity shall—

“(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

“(2) demonstrate in such application that the entity is capable of carrying out data-driven maternal safety and quality improvement initiatives in the areas of obstetrics and gynecology or maternal health.

“(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$5,000,000 for each of fiscal years 2021 through 2025.”

SEC. 3. TRAINING FOR HEALTH CARE PROVIDERS.

Title VII of the Public Health Service Act is amended by striking section 763 (42 U.S.C. 294p) and inserting the following:

“SEC. 763. TRAINING FOR HEALTH CARE PROVIDERS.

“(a) GRANT PROGRAM.—The Secretary shall establish a program to award grants to accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

“(b) ELIGIBILITY.—To be eligible for a grant under subsection (a), an entity described in such subsection shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) REPORTING REQUIREMENT.—Each entity awarded a grant under this section shall periodically submit to the Secretary a report on the status of activities conducted using the grant, including a description of the impact of such training on patient outcomes, as applicable.

“(d) BEST PRACTICES.—The Secretary may identify and disseminate best practices for the training of health care professionals to reduce and prevent discrimination (including training related to implicit and explicit biases) in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

“(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$5,000,000 for each of fiscal years 2021 through 2025.”

SEC. 4. STUDY ON TRAINING TO REDUCE AND PREVENT DISCRIMINATION.

Not later than 2 years after date of enactment of this Act, the Secretary of Health and Human Services shall, through a contract with an independent research organization, conduct a study and make recommendations for accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other health professional training programs, on best practices related to training to reduce and prevent discrimination, including training related to implicit and explicit biases, in the provision of health care services related to prenatal care, labor care, birthing, and postpartum care.

SEC. 5. PERINATAL QUALITY COLLABORATIVES.

Section 317K(a)(2) of the Public Health Service Act (42 U.S.C. 247b–12(a)(2)) is amended by adding at the end the following:

“(E)(i) The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with

other offices and agencies, as appropriate, shall establish or continue a competitive grant program for the establishment or support of perinatal quality collaboratives to improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants. A State, Indian Tribe, or Tribal organization may use funds received through such grant to—

“(I) support the use of evidence-based or evidence-informed practices to improve outcomes for maternal and infant health;

“(II) work with clinical teams; experts; State, local, and, as appropriate, Tribal public health officials; and stakeholders, including patients and families, to identify, develop, or disseminate best practices to improve perinatal care and outcomes; and

“(III) employ strategies that provide opportunities for health care professionals and clinical teams to collaborate across health care settings and disciplines, including primary care and mental health, as appropriate, to improve maternal and infant health outcomes, which may include the use of data to provide timely feedback across hospital and clinical teams to inform responses, and to provide support and training to hospital and clinical teams for quality improvement, as appropriate.

“(ii) To be eligible for a grant under clause (i), an entity shall submit to the Secretary an application in such form and manner and containing such information as the Secretary may require.”

SEC. 6. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

(a) GRANTS.—Title III of the Public Health Service Act is amended by inserting after section 330N of such Act, as added by section 2, the following:

“SEC. 330O. INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.

“(a) IN GENERAL.—The Secretary may award grants to States, Indian Tribes, and Tribal organizations for the purpose of establishing or operating evidence-based or innovative, evidence-informed programs to deliver integrated health care services to pregnant and postpartum women to optimize the health of women and their infants, including to reduce adverse maternal health outcomes, pregnancy-related deaths, and related health disparities (including such disparities associated with racial and ethnic minority populations), and, as appropriate, by addressing issues researched under subsection (b)(2) of section 317K.

“(b) INTEGRATED SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

“(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State, Indian Tribe, or Tribal organization shall work with relevant stakeholders that coordinate care (including coordinating resources and referrals for health care and social services) to develop and carry out the program, including—

“(A) State, Tribal, and local agencies responsible for Medicaid, public health, social services, mental health, and substance use disorder treatment and services;

“(B) health care providers who serve pregnant and postpartum women; and

“(C) community-based health organizations and health workers, including providers of home visiting services and individuals representing communities with disproportionately high rates of maternal mortality and severe maternal morbidity, and including individuals representing racial and ethnic minority populations.

“(2) TERMS.—

“(A) PERIOD.—A grant awarded under subsection (a) shall be made for a period of 5 years. Any supplemental award made to a grantee under subsection (a) may be made for a period of less than 5 years.

“(B) PREFERENCE.—In awarding grants under subsection (a), the Secretary shall—

“(i) give preference to States, Indian Tribes, and Tribal organizations that have the highest rates of maternal mortality and severe maternal morbidity relative to other such States, Indian Tribes, or Tribal organizations, respectively; and

“(ii) shall consider health disparities related to maternal mortality and severe maternal morbidity, including such disparities associated with racial and ethnic minority populations.

“(C) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applications from up to 15 entities described in subparagraph (B)(i).

“(D) EVALUATION.—The Secretary shall require grantees to evaluate the outcomes of the programs supported under the grant.

“(c) DEFINITIONS.—In this section, the terms ‘Indian Tribe’ and ‘Tribal organization’ have the meanings given the terms ‘Indian tribe’ and ‘tribal organization’, respectively, in section 4 of the Indian Self-Determination and Education Assistance Act.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$10,000,000 for each of fiscal years 2021 through 2025.”

(b) REPORT ON GRANT OUTCOMES AND DISSEMINATION OF BEST PRACTICES.—

(1) REPORT.—Not later than February 1, 2026, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes—

(A) the outcomes of the activities supported by the grants awarded under the amendment made by this section on maternal and child health;

(B) best practices and models of care used by recipients of grants under such amendment; and

(C) obstacles identified by recipients of grants under such amendment, and strategies used by such recipients to deliver care, improve maternal and child health, and reduce health disparities.

(2) DISSEMINATION OF BEST PRACTICES.—Not later than August 1, 2026, the Secretary of Health and Human Services shall disseminate information on best practices and models of care used by recipients of grants under the amendment made by this section (including best practices and models of care relating to the reduction of health disparities, including such disparities associated with racial and ethnic minority populations, in rates of maternal mortality and severe maternal morbidity) to relevant stakeholders, which may include health providers, medical schools, nursing schools, relevant State, Tribal, and local agencies, and the general public.

SEC. 7. IMPROVING RURAL MATERNAL AND OBSTETRIC CARE DATA.

(a) MATERNAL MORTALITY AND MORBIDITY ACTIVITIES.—Section 301(e) of the Public Health Service Act (42 U.S.C. 241(e)) is amended by inserting “, preventable maternal mortality and severe maternal morbidity,” after “delivery”.

(b) OFFICE OF WOMEN’S HEALTH.—Section 310A(b)(1) of the Public Health Service Act (42 U.S.C. 242s(b)(1)) is amended by striking “and sociocultural contexts,” and inserting “sociocultural (including among American Indians, Native Hawaiians, and Alaska Natives), and geographical contexts”.

(c) SAFE MOTHERHOOD.—Section 317K of the Public Health Service Act (42 U.S.C. 247b-12) is amended—

(1) in subsection (a)(2)(A), by inserting “, including improving collection of data on race, ethnicity, and other demographic information” before the period; and

(2) in subsection (b)(2)—

(A) in subparagraph (L), by striking “and” at the end;

(B) by redesignating subparagraph (M) as subparagraph (N); and

(C) by inserting after subparagraph (L) the following:

“(M) an examination of the relationship between maternal health and obstetric services in rural areas and outcomes in delivery and postpartum care; and”.

(d) OFFICE OF RESEARCH ON WOMEN’S HEALTH.—Section 486 of the Public Health Service Act (42 U.S.C. 287d) is amended—

(1) in subsection (b), by amending paragraph (3) to read as follows:

“(3) carry out paragraphs (1) and (2) with respect to—

“(A) the aging process in women, with priority given to menopause; and

“(B) pregnancy, with priority given to deaths related to preventable maternal mortality and severe maternal morbidity;”;

(2) in subsection (d)(4)(A)(iv), by inserting “, including preventable maternal morbidity and severe maternal morbidity” before the semicolon.

SEC. 8. RURAL OBSTETRIC NETWORK GRANTS.

The Public Health Service Act is amended by inserting after section 330A-1 (42 U.S.C. 254c-1a) the following:

“SEC. 330A-2. RURAL OBSTETRIC NETWORK GRANTS.

“(a) PROGRAM ESTABLISHED.—The Secretary shall award grants or cooperative agreements to eligible entities to establish collaborative improvement and innovation networks (referred to in this section as ‘rural obstetric networks’) to improve maternal and infant health outcomes and reduce preventable maternal mortality and severe maternal morbidity by improving maternity care and access to care in rural areas, frontier areas, maternity care health professional target areas, or jurisdictions of Indian Tribes and Tribal organizations.

“(b) USE OF FUNDS.—Grants or cooperative agreements awarded pursuant to this section shall be used for the establishment or continuation of collaborative improvement and innovation networks to improve maternal health in rural areas by improving infant health and maternal outcomes and reducing preventable maternal mortality and severe maternal morbidity. Rural obstetric networks established in accordance with this section may—

“(1) develop a network to improve coordination and increase access to maternal health care and assist pregnant women in the areas described in subsection (a) with accessing and utilizing maternal and obstetric care, including health care services related to prenatal care, labor care, birthing, and postpartum care to improve outcomes in birth and maternal mortality and morbidity;

“(2) identify and implement evidence-based and sustainable delivery models for maternal and obstetric care (including health care services related to prenatal care, labor care, birthing, and postpartum care for women in the areas described in subsection (a), including home visiting programs and culturally appropriate care models that reduce health disparities;

“(3) develop a model for maternal health care collaboration between health care settings to improve access to care in areas described in subsection (a), which may include the use of telehealth;

“(4) provide training for professionals in health care settings that do not have specialty maternity care;

“(5) collaborate with academic institutions that can provide regional expertise and help identify barriers to providing maternal health care, including strategies for addressing such barriers; and

“(6) assess and address disparities in infant and maternal health outcomes, including among racial and ethnic minority populations and underserved populations in areas described in subsection (a).

“(c) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITIES.—The term ‘eligible entities’ means entities providing maternal health care services in rural areas, frontier areas, or medically underserved areas, or to medically underserved populations or Indian Tribes or Tribal organizations.

“(2) FRONTIER AREA.—The term ‘frontier area’ means a frontier county, as defined in section 1886(d)(3)(E)(iii)(III) of the Social Security Act.

“(3) INDIAN TRIBES; TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal organization’ have the meanings given the terms ‘Indian tribe’ and ‘tribal organization’, respectively, in section 4 of the Indian Self-Determination and Education Assistance Act.

“(4) MATERNITY CARE HEALTH PROFESSIONAL TARGET AREA.—The term ‘maternity care health professional target area’ has the meaning described in section 332(k)(2).

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$3,000,000 for each of fiscal years 2021 through 2025.”

SEC. 9. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

Section 330I of the Public Health Service Act (42 U.S.C. 254c-14) is amended—

(1) in subsection (f)(3), by adding at the end the following:

“(M) Providers of maternal care, including prenatal, labor care, birthing, and postpartum care services and entities operating obstetric care units.”; and

(2) in subsection (h)(1)(B), by inserting “labor care, birthing care, postpartum care,” before “or prenatal”.

SEC. 10. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.

Subpart 1 of part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

“SEC. 764. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.

“(a) IN GENERAL.—The Secretary shall award grants to accredited schools of allopathic medicine, osteopathic medicine, and nursing, and other appropriate health professional training programs, to establish a training demonstration program to support—

“(1) training for physicians, medical residents, fellows, nurse practitioners, physician assistants, nurses, certified nurse midwives, relevant home visiting workforce professionals and paraprofessionals, or other professionals who meet relevant State training and licensing requirements, as applicable, to provide maternal health care services in rural community-based settings; and

“(2) developing recommendations for such training programs.

“(b) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) ACTIVITIES.—

“(1) TRAINING FOR HEALTH CARE PROFESSIONALS.—A recipient of a grant under subsection (a)—

“(A) shall use the grant funds to plan, develop, and operate a training program to provide maternal health care in rural areas; and

“(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty

development, or departments, divisions, or other units necessary to implement such training.

“(2) TRAINING PROGRAM REQUIREMENTS.—The recipient of a grant under subsection (a) shall ensure that training programs carried out under the grant are evidence-based and address improving maternal health care in rural areas, and such programs may include training on topics such as—

“(A) maternal mental health, including perinatal depression and anxiety;

“(B) substance use disorders;

“(C) social determinants of health that affect individuals living in rural areas; and

“(D) implicit and explicit bias.

“(d) EVALUATION AND REPORT.—

“(1) EVALUATION.—

“(A) IN GENERAL.—The Secretary shall evaluate the outcomes of the demonstration program under this section.

“(B) DATA SUBMISSION.—Recipients of a grant under subsection (a) shall submit to the Secretary performance metrics and other related data in order to evaluate the program for the report described in paragraph (2).

“(2) REPORT TO CONGRESS.—Not later than January 1, 2025, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that includes—

“(A) an analysis of the effects of the demonstration program under this section on the quality, quantity, and distribution of maternal health care services, including health care services related to prenatal care, labor care, birthing, and postpartum care, and the demographics of the recipients of those services;

“(B) an analysis of maternal and infant health outcomes (including quality of care, morbidity, and mortality) before and after implementation of the program in the communities served by entities participating in the demonstration program; and

“(C) recommendations on whether the demonstration program should be continued.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$5,000,000 for each of fiscal years 2021 through 2025.”

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Michigan (Mrs. DINGELL) and the gentleman from Montana (Mr. GIANFORTE) each will control 20 minutes.

The Chair recognizes the gentlewoman from Michigan.

GENERAL LEAVE

Mrs. DINGELL. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 4995.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Michigan?

There was no objection.

Mrs. DINGELL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 4995, the Maternal Health Quality Improvement Act of 2020.

Every 12 hours, an American woman dies of a pregnancy-related complication. This is a public health crisis, and the Maternal Health Quality Improvement Act creates robust new programs to meet this need. This includes improving rural maternal healthcare through the creation of rural obstetric

network grants, as well as expanding the use of telehealth.

The legislation also promotes innovation in maternal healthcare by creating a new grant program to develop and disseminate best practices to improve health quality and outcomes and help eliminate maternal mortality.

Additionally, the Maternal Health Quality Improvement Act includes provisions to address racial disparities in maternal health outcomes by funding training programs for healthcare professionals, as well as allowing HHS to disseminate best practices to reduce and prevent discrimination.

Finally, the legislation authorizes funding for perinatal quality collaboratives, multi-State networks to improve health outcomes for pregnant and postpartum women and their infants, as well as creating a grant program to integrate services and reduce adverse maternal health outcomes.

Madam Speaker, these robust provisions represent a strong step toward addressing the ongoing health crisis facing America's pregnant and postpartum women.

Madam Speaker, I thank my colleagues, Representatives ENGEL, BUCSHON, TORRES SMALL, LATTA, ADAMS, and STIVERS, for their tireless work on this legislation.

Madam Speaker, I urge my colleagues to support this legislation, and I reserve the balance of my time.

Mr. GIANFORTE. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise today in support of H.R. 4995, the Maternal Health Quality Improvement Act, which was introduced by Representatives ENGEL, BUCSHON, TORRES SMALL, LATTA, ADAMS, and STIVERS.

The legislation authorizes grants for developing and sharing maternal health best practices and training health professionals.

It also supports the Health Resources and Services Administration's establishment of rural health networks to reduce maternal and child mortality rates and reduce inequities in health outcomes amongst different populations.

It also ensures obstetric care is an eligible service for telehealth grants.

Madam Speaker, I want to thank the American Hospital Association, the March of Dimes, the American Medical Association, and others for their support of this legislation.

Madam Speaker, I urge my colleagues to support this bipartisan legislation, and I reserve the balance of my time.

Mrs. DINGELL. Madam Speaker, I reserve the balance of my time.

Mr. GIANFORTE. Madam Speaker, I yield 3 minutes to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Madam Speaker, as a physician and a father of four, I understand the importance of ensuring the health of mothers during pregnancy and after the delivery of their

newborns. This is a critical time for both the mother and the child.

Sadly, Indiana has an unacceptably high maternal mortality rate, ranking third in the country. We can do better.

We must do better in our approach across the entire Nation, especially in rural America, to use best practices and provide the necessary resources to stop preventable maternal mortality. The Maternal Health Quality Improvement Act is a great first step toward doing just that.

H.R. 4995 includes the Excellence in Maternal Health Act, legislation I introduced along with my fellow Hoosier, Representative ANDRÉ CARSON.

This bipartisan legislation will benefit patients and communities that are currently struggling, like those in my home State of Indiana, by providing them with the support and the training they so desperately need.

Madam Speaker, together, we can work to help mothers and their children achieve better health outcomes. I urge my colleagues to support H.R. 4995.

Mrs. DINGELL. Madam Speaker, I reserve the balance of my time.

Mr. GIANFORTE. Madam Speaker, I appreciate Dr. BUCSHON's leadership on this bill. I am excited to see this pass the House.

Madam Speaker, I urge my colleagues to support this important legislation, and I yield back the balance of my time.

Mrs. DINGELL. Madam Speaker, I agree with my colleagues passionately in the need to take care of our mothers when they are pregnant, the newborns, and then their postpartum health. This bill is an important first step, and I urge my colleagues to support this legislation.

Madam Speaker, I yield back the balance of my time.

Mr. CARSON of Indiana. Madam Speaker, I rise today in strong support of the Maternal Health Quality Improvement Act of 2019 (H.R. 4995). This important bill includes my legislation, the Excellence in Maternal Health Act of 2019 (H.R. 4215), that I introduced last year with my fellow Hoosier, Rep. BUCSHON. I want to thank Rep. ENGEL for including my legislation in this package. I urge my House colleagues to pass H.R. 4995 without delay.

Maternal mortality—which occurs when a woman dies during pregnancy or within one year of delivery—is a nationwide, public health emergency. The United States has the highest maternal death rate in the developed world; 26 women die for every 100,000 live birth in our country. This unacceptably high level of maternal mortality robs our country of between 700 and 900 women from causes related to pregnancy and childbirth.

However, this crisis does not affect all states equally. Maternal mortality is especially devastating in states like Indiana. Our state has the third highest maternal mortality rate in the country where, often due to preventable complications, a staggering 43 out of 100,000 women die during or shortly after giving birth.

The maternal mortality crisis also does not affect all mothers equally; in fact, the racial and ethnic disparities in maternal mortality are

extremely stark. Nationwide, Black women are three to four times more likely to die from maternal health complications than white women. In Indiana, Black women are 29 percent more likely to die during childbirth than white women, as 53 black women die per 100,000 live births versus 41 deaths among white women. Research consistently shows that disparities in access to quality health care, inadequate health care training, discrimination and bias, and the lack of high-quality integrated maternal health care continue to compound existing health care disparities that produce the disproportionate levels of maternal mortality among Black mothers.

That's why in August 2019, I introduced the Excellence in Maternal Health Act of 2019 with my fellow Hoosier, Rep. BUCSHON. Our bipartisan legislation works to improve maternal health access and quality, reduce racial and ethnic disparities and discrimination in health care delivery, and create grant programs to implement best practices and strengthen training for health care providers.

Specifically, our legislation provides \$10 million to help develop and enact best practices to eliminate maternal mortality through improved maternal health access and quality. Additionally, our legislation provides \$25 million over five years to establish a grant program to train health care professionals on ways to reduce and prevent racial discrimination in providing prenatal care, labor care, birthing, and postpartum care. Finally, our legislation provides \$15 million in grants to help states deliver integrated health care services that reduce maternal mortality and related health disparities.

I was pleased that in November 2019, the House Energy and Commerce Committee included our Carson/Bucshon legislation into Rep. ENGEL's larger legislative package, the Maternal Health Quality Improvement Act of 2019 and was unanimously approved by the Committee. I urge all of my House colleagues to now pass H.R. 4995 to implement the programs and reforms in my legislation that will help end the scourge of preventable maternal mortality in our country and ensure the birth of a child is a joyous and safe occasion for families across America.

The SPEAKER pro tempore (Ms. STEVENS). The question is on the motion offered by the gentlewoman from Michigan (Mrs. DINGELL) that the House suspend the rules and pass the bill, H.R. 4995, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

PROTECTING PATIENTS TRANSPORTATION TO CARE ACT

Mrs. DINGELL. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 3935) to amend title XIX of the Social Security Act to provide for the continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3935

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting Patients Transportation to Care Act".

SEC. 2. MEDICAID COVERAGE OF CERTAIN MEDICAL TRANSPORTATION.

(a) CONTINUING REQUIREMENT OF MEDICAID COVERAGE OF NECESSARY TRANSPORTATION.—

(1) REQUIREMENT.—Section 1902(a)(4) of the Social Security Act (42 U.S.C. 1396a(a)(4)) is amended—

(A) by striking "and including provision for utilization" and inserting "including provision for utilization"; and

(B) by inserting after "supervision of administration of the plan" the following: "; and, subject to section 1903(i), including a specification that the single State agency described in paragraph (5) will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the methods that such agency will use to ensure such transportation".

(2) APPLICATION WITH RESPECT TO BENCHMARK BENEFIT PACKAGES AND BENCHMARK EQUIVALENT COVERAGE.—Section 1937(a)(1) of the Social Security Act (42 U.S.C. 1396u-7(a)(1)) is amended—

(A) in subparagraph (A), by striking "sub-section (E)" and inserting "subparagraphs (E) and (F)"; and

(B) by adding at the end the following new subparagraph:

"(F) NECESSARY TRANSPORTATION.—Notwithstanding the preceding provisions of this paragraph, a State may not provide medical assistance through the enrollment of an individual with benchmark coverage or benchmark equivalent coverage described in subparagraph (A)(i) unless, subject to section 1903(i)(9) and in accordance with section 1902(a)(4), the benchmark benefit package or benchmark equivalent coverage (or the State)—

"(i) ensures necessary transportation for individuals enrolled under such package or coverage to and from providers; and

"(ii) provides a description of the methods that will be used to ensure such transportation.".

(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting after paragraph (8) the following new paragraph:

"(9) with respect to any amount expended for non-emergency transportation authorized under section 1902(a)(4), unless the State plan provides for the methods and procedures required under section 1902(a)(30)(A); or".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act and shall apply to transportation furnished on or after such date.

(b) MEDICAID PROGRAM INTEGRITY MEASURES RELATED TO COVERAGE OF NONEMERGENCY MEDICAL TRANSPORTATION.—

(1) GAO STUDY.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to Congress, a report on coverage under the Medicaid program under title XIX of the Social Security Act of nonemergency transportation to medically necessary services. Such study shall take into account the 2009 report of the Office of the Inspector General of the Department of Health and Human Services, titled "Fraud and Abuse Safeguards for Medicaid Nonemergency Medical Transportation" (OEI-06-07-003200). Such report shall include the following:

(A) An examination of the 50 States and the District of Columbia to identify safeguards to prevent and detect fraud and abuse with respect to coverage under the Medicaid program of non-

emergency transportation to medically necessary services.

(B) An examination of transportation brokers to identify the range of safeguards against such fraud and abuse to prevent improper payments for such transportation.

(C) Identification of the numbers, types, and outcomes of instances of fraud and abuse, with respect to coverage under the Medicaid program of such transportation, that State Medicaid Fraud Control Units have investigated in recent years.

(D) Identification of commonalities or trends in program integrity, with respect to such coverage, to inform risk management strategies of States and the Centers for Medicare & Medicaid Services.

(2) STAKEHOLDER WORKING GROUP.—

(A) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Centers for Medicare & Medicaid Services, shall convene a series of meetings to obtain input from appropriate stakeholders to facilitate discussion and shared learning about the leading practices for improving Medicaid program integrity, with respect to coverage of nonemergency transportation to medically necessary services.

(B) TOPICS.—The meetings convened under subparagraph (A) shall—

(i) focus on ongoing challenges to Medicaid program integrity as well as leading practices to address such challenges; and

(ii) address specific challenges raised by stakeholders involved in coverage under the Medicaid program of nonemergency transportation to medically necessary services, including unique considerations for specific groups of Medicaid beneficiaries meriting particular attention, such as American Indians and tribal land issues or accommodations for individuals with disabilities.

(C) STAKEHOLDERS.—Stakeholders described in subparagraph (A) shall include individuals from State Medicaid programs, brokers for non-emergency transportation to medically necessary services that meet the criteria described in section 1902(a)(70)(B) of the Social Security Act (42 U.S.C. 1396a(a)(70)(B)), providers (including transportation network companies), Medicaid patient advocates, and such other individuals specified by the Secretary.

(3) GUIDANCE REVIEW.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Centers for Medicare & Medicaid Services, shall assess guidance issued to States by the Centers for Medicare & Medicaid Services relating to Federal requirements for nonemergency transportation to medically necessary services under the Medicaid program under title XIX of the Social Security Act and update such guidance as necessary to ensure States have appropriate and current guidance in designing and administering coverage under the Medicaid program of nonemergency transportation to medically necessary services.

(4) NEMT TRANSPORTATION PROVIDER AND DRIVER REQUIREMENTS.—

(A) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(i) by striking "and" at the end of paragraph (85);

(ii) by striking the period at the end of paragraph (86) and inserting "; and"; and

(iii) by inserting after paragraph (86) the following new paragraph:

"(87) provide for a mechanism, which may include attestation, that ensures that, with respect to any provider (including a transportation network company) or individual driver of nonemergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), at a minimum—